Health & Wellbeing

FINDINGS FROM THE 2022 U.S. TRANS SURVEY

2022 U.S. TRANS SURVEY

Health and Wellbeing: A Report of the 2022 U.S. Transgender Survey

JUNE 2025

Authors: Ankit Rastogi, Leesh Menard, Gabe H. Miller, Will Cole, Daniel Laurison, Josie Caballero, Sinéad Murano-Kinney, Rodrigo Heng-Lehtinen

Recommended Citation: Rastogi, A., Menard, L., Miller, G. H., Cole, W., Laurison, D., Caballero, J. R., Murano-Kinney, S., & Heng-Lehtinen, R. (2025, June). *Health and wellbeing: A report of the 2022 U.S. Transgender Survey*. Advocates for Transgender Equality. https://ustranssurvey.org/download-reports/

ACKNOWLEDGMENTS

The research team at Advocates for Trans Equality (A4TE) first wish to thank all the trans and nonbinary individuals who took the 2022 U.S. Transgender Survey for continuing to inform us about their life experiences. We also express our gratitude for our partners: the Black Trans Advocacy Coalition, National Queer Asian Pacific Islander Alliance, and TransLatin@ Coalition for helping us present the survey; the 2022 USTS Scientific Advisory Council for their guidance on the Survey; and the Outreach Council for disseminating information about the survey. We thank all those involved with developing the questionnaire and the innumerable volunteers that contributed at every phase of the survey. We also thank Analysis Group, Burness, Pickaxe, Qualtrics, and the Williams Institute for their contributions to the project.

Special thanks to several A4TE staff and contractors: Illyana Bocanegra, Ezra Cukor, Laura Durso, Andrew Flores, Jody Herman, Brendon Holloway, Olivia Hunt, Sandy James, Alana Jochum, Lisa Mottet, Devon Ojeda, Kathryn O'Neill, Alex Del Rosario, Sybastian Smith, Tekla Taylor, and Leroy Thomas

Lastly, we thank the Robert Wood Johnson Foundation, TAWANI Foundation, and Capital One Foundation for their generous support.

TABLE OF CONTENTS

Acknowledgments 3
Executive Summary 5
Introduction 14
Methodology 16

CHAPTER 1
General Health and Access to Healthcare

Key Findings 24
General Health 26
Access to Healthcare 27
Experiences with Healthcare Providers 30
Health Insurance Coverage and Experiences 32
Conclusion 37

CHAPTER 2
Experiences with Transition-related Care

Key Findings 42
Provider Knowledge and Care Accessibility 43
Transition-related Healthcare 45
Continuity of Transition 51
Conclusion 52

CHAPTER 3
Sexual and Reproductive Health and HIV/AIDS

Key Findings 56
Reproductive Health 57
HIV Testing, Care, and Prevention 62
Conclusion 69

CHAPTER 4
Mental Health and Experiences with Mental Health Providers

Key Findings 74
Psychological Distress and Depressive Symptoms 75
Suicidality 80
Experiences with Mental Health Providers (MHPs) 83
Conclusion 86

CHAPTER 5
Happiness, Life Evaluation, and Life Satisfaction

Key Findings 92
General Happiness 92
Life Evaluation 94
Life Satisfaction 95
Conclusion 97

CHAPTER 6
Substance Use

Key Findings 100
Alcohol 100
Cigarettes 101
E-Cigarettes or Vaping Products 103
Marijuana 103
Illicit Drugs 106
Nonmedical Prescription Drug Use 106
Perceived Problems with Drug or Alcohol Use 107
Conclusion 107

Executive Summary

EXECUTIVE SUMMARY

The 2022 U.S. Transgender Survey (USTS) is the largest survey that examines the experiences of transgender people in the United States. The National Center for Transgender Equality (now Advocates for Trans Equality) conducted the survey in the fall of 2022 and 92,329 binary and nonbinary transgender respondents from all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases took the survey. The USTS was an anonymous, online survey for transgender people ages 16 and older in the United States and was available in both English and Spanish. The 2022 survey followed the 2015 USTS and the 2008-09 National Transgender Discrimination Survey. These surveys provided extensive description of trans communities across the United States and played critical roles in shifting how policymakers and the public view the lives of transgender people. Further, these surveys were crucial resources for educators, policymakers, and healthcare providers to better serve the needs of transgender people.

This report, coming from the 2022 USTS, provides an updated, detailed look at the health and healthcare of trans and nonbinary respondents. Topics focus on general health and access to healthcare, transition-related healthcare, sexual and reproductive health, mental health, life satisfaction and happiness, and substance use. The findings reveal a complex portrait of strengths and challenges that our respondents experience in their lives when seeking healthcare.

Thematic Overview

Self-Rated Health, Wellbeing, and the Importance of Transition and Social Support

The findings present a nuanced portrait of the health of USTS respondents. USTS respondents reported poor outcomes across many domains of health and wellbeing—but crucial factors, like social and medical transition, were associated with better outcomes. Social transition includes taking steps to align outward presentation with internal gender identity like adopting a new name or clothing style; medical transition involves undergoing medical interventions like gender-affirming hormone therapy (GAHT). For example, in Chapter 1, we see that 66% of 2022 USTS respondents reported they were in “excellent,” “very good,” or “good” health, which was substantially lower than the 81% in the general adult population and the 78% in the 2015 USTS. But those who had socially or medically transitioned had a higher prevalence of reporting good health compared to those who had not (67% vs. 61% for social transition; 70% vs. 58% for medical transition).

The Relationship between Mental Health, Social Acceptance, and Discrimination

Adverse mental health indicators, such as depressive symptoms, psychological distress, and suicidality, were elevated among respondents compared to the general U.S. population. However, several factors were associated with better mental health, including support from family members. Discrimination and

harassment were associated with worse outcomes. For example, the lifetime prevalence of suicidality among 2022 USTS respondents was striking—78% reported lifetime suicidal thoughts and 40% reported lifetime attempts. But those with supportive families reported less suicidality compared to those with unsupportive families—78% of respondents with supportive families reported suicidal thoughts compared to 88% of those with unsupportive families. Moreover, state-level discriminatory laws and policies, as well as stigma and hostile sociopolitical climates, may have contributed to the disproportionately high prevalence of suicidality.[1] Thirty-one percent (31%) of those who experienced no discrimination or harassment reported past-year suicidal thoughts compared to 50% of those who were verbally harassed, 53% of those who were denied equal treatment, and 63% of those who were physically assaulted.

Gender Transition as a Source of Life Satisfaction

Social and medical transition were profound sources of life satisfaction among USTS respondents. Our results show that over half of respondents (59%) had accessed some form of medical transition; 56% had received gender-affirming hormone therapy (GAHT), and 90% of those were still taking hormones. Nearly all respondents who were on GAHT (98%) or had received surgery (97%) were more satisfied with their lives after GAHT or surgery. Further, respondents who reported social or medical transition consistently reported higher happiness, thriving, and satisfaction. Those who reported social transition more often reported they were "very to pretty happy" (71% vs. 52%), "thriving" (36% vs. 18%), and satisfied with their lives (43% vs. 24%) compared to those who have not socially transitioned. We found similar results for medical transition and happiness (72% vs. 55%), reports of thriving (37% vs. 19%), and life satisfaction (43% vs. 27%).

The Need for Respectful and Competent Healthcare Providers

Access to respectful and competent healthcare providers is critical for the wellbeing of transgender people.[2] The 2022 respondent sample reported higher access to healthcare providers who could provide quality healthcare compared to the 2015 USTS. For example, 2022 respondents reported a higher prevalence of outness to all healthcare providers than 2015 respondents (50% vs. 40%), and more respondents had a dedicated transition-related healthcare provider in 2022 than 2015 (57% vs. 44%). Moreover, 2022 respondents reported their transition-related healthcare providers had greater knowledge than the 2015 sample: 77% of 2022 respondents reported their transition-related healthcare provider knew almost everything about providing healthcare for trans people, compared to 65% in the 2015 USTS. Further, fewer respondents had to teach their healthcare provider about trans people to receive appropriate care (18% in 2022 vs. 24% in 2015), and more respondents who were out as trans felt they were treated with respect by at least one provider (73% in 2022 vs. 62% in 2015). Taken together, 2022 USTS respondents reported a higher degree of outness, a higher prevalence of having a dedicated transition-related healthcare provider, and a higher frequency of providers knowing almost everything about providing healthcare for trans people than the 2015 USTS sample.

Despite greater access to and visibility in healthcare settings, many barriers to quality care persisted. Nearly half (47%) of respondents had at least one negative experience with a healthcare provider in the 12 months before the survey. About a quarter (24%) of respondents avoided care in the past year due to fear of mistreatment, similar to 2015 (23%).

Insurance, Cost, and Healthcare Access

Our findings show that USTS respondents faced multiple structural barriers when navigating the U.S. healthcare system. For example, fewer of our respondents had health insurance coverage compared to the general adult population (87% vs. 92%). Forty-five percent (45%) of respondents seeking transition-related procedures had only partial coverage by their health insurance—higher than the 42% in the 2015 USTS. Moreover, 28% of respondents did not see a healthcare provider the year before the survey due to cost, and this prevalence was highest for American Indians and Alaska Natives (33%), Latines (32%), and Bi/Multiracial people (34%). Insurance coverage overall varied by race—80% of American Indians and Alaska Natives had comprehensive health insurance coverage.

However, our results showed some encouraging trends in healthcare access—2022 respondents had fewer health insurance denials for transition-related care compared to 2015 respondents. For example, 55% of those seeking transition-related surgeries were denied by their health insurance company in 2015 compared to 20% in 2022. A quarter (25%) of those seeking gender-affirming hormone therapy were denied in 2015 compared to 11% in 2022. Lastly, 17% of respondents in 2015 reported health insurance companies refused to update their gender markers on their records compared to 12% in 2022.

Sexual and Reproductive Health

Transgender and nonbinary people have routine and unique needs in sexual and reproductive care, including preventive care, birth control, fertility options in the context of gender-affirming care, access to safe abortion, and prevention and treatment of sexually transmitted infections, including HIV. Reproductive healthcare access remained uneven, however. More than one in three (35%) respondents received routine reproductive care from their transition-related provider, while 43% received no routine reproductive care at all.

Among respondents assigned female at birth (AFAB) who wanted birth control, about half (56%) discussed it with their provider. Others avoided providers because they were uncomfortable in women's health settings (29%), feared mistreatment (23%), and because of the cost (25%). Abortion was rare; only 3% of respondents needed or wanted an abortion, and a small percentage had difficulty finding a trans-competent provider or felt unwelcome at clinics.

HIV prevalence was disproportionately high, with 1.1% of USTS respondents living with HIV, more than three times the national prevalence (0.3%). Trans women faced the highest burden (2.4%), and Black trans women reported the highest prevalence (15.5%).

Key Findings

General Health and Access to Healthcare

General Health

- USTS respondents reported worse overall health compared to the general population: 66% rated their health as "excellent," "very good," or "good," compared to 81% in the general population. Thirty-four percent (34%) reported "fair" or "poor" health, compared to 18% in the general population.
- Self-reported health varied by age, family support, and transition status:
  - Older respondents reported better health than younger respondents—78% of those 65+ vs. 60% of those 18 to 24 rated their health as good or better.
  - Family support was linked to better health—69% of those with supportive families reported good or better health, compared to 56% of those who reported unsupportive families.

- Social and medical transition was associated with better health—67% of respondents who had socially transitioned reported good or better health compared to 61% of those who had not. Further, 70% of respondents who had medically transitioned rated their health as good or better, compared to 58% of respondents who had not medically transitioned.

Access to Healthcare

- Twenty-eight percent (28%) of respondents did not see a healthcare provider in the past year due to cost. Though a different cross-sectional sample than the 2022 USTS, 33% of 2015 USTS respondents did not see a provider due to cost.
- Cost was a greater barrier for some racial groups, especially Bi/Multiracial (34%), American Indian/Alaska Native (33%), and Latine (32%) respondents.
- Twenty-four percent (24%) of respondents avoided healthcare in the past year due to fear of being mistreated as a trans person, similar to 2015 (23%).
- American Indian/Alaska Native respondents (32%) reported the highest shares of avoiding care.
- Trans men (32%) and nonbinary individuals assigned female at birth (AFAB) (24%) were the most likely to avoid care due to mistreatment concerns, followed by trans women (20%), nonbinary individuals assigned male at birth (AMAB) (16%), and crossdressers (9%).

Experiences with Healthcare Providers

- Nearly eight in ten (79%) of respondents visited a healthcare provider in the past year. Though a different cross-sectional sample than the 2015 USTS, this was lower than the nearly nine in ten (87%) in 2015.
- Half (50%) of respondents said all their healthcare providers knew they were transgender, greater than two in five (40%) in 2015.
- Roughly one-fourth (24%) of respondents said none of their providers knew that they were transgender. This is less than the nearly one-third (31%) of respondents who reported that none of their healthcare providers knew they were transgender in 2015.
- Nearly three in four (73%) respondents who disclosed their transgender status felt treated with respect by at least one provider, higher than the 62% in 2015.
- Almost half (47%) experienced at least one negative interaction with a healthcare provider. The most frequent negative interactions included healthcare providers using the wrong names or pronouns (37%), respondents having to teach their healthcare provider about trans people to receive appropriate care (18%), and healthcare providers asking unnecessary or invasive questions about the individual's trans status that was unrelated to the visit (11%).
- Nonbinary AFAB people and trans men reported the greatest proportions of negative experiences with healthcare providers (55% and 53%, respectively), followed by trans women (41%), AMAB nonbinary people (38%), and crossdressers (10%).
- More than half (58%) of respondents with disabilities reported any negative experience with a healthcare provider.

Health Insurance Coverage and Experiences

- Eighty-seven percent (87%) of respondents had health insurance at the time of the survey, comparable to 86% in the 2015 USTS, but lower than 92% coverage in the general population.
- Insurance coverage varied by race, with American Indians and Alaska Natives (80%) and Latine respondents (84%) having the lowest shares of being insured.

- Twenty-six percent (26%) of insured respondents reported negative experiences with their health insurance related to being transgender.
- Although the 2015 and 2022 USTS samples are different cross-sectional samples, health insurance denials for transition-related care were lower in 2022 compared to 2015: transition-related surgery denials were 55% in 2015 compared to 20% in 2022, hormone therapy denials were 25% in 2015 compared to 11% in 2022, and refusals to update gender markers on insurance records were 17% in 2015 compared to 12% in 2022.
- Partial coverage—when some procedures are covered and others are not—for transition-related procedures remains a barrier. Forty-five percent (45%) of respondents had only some procedures covered—slightly higher than in 2015 (42%).

COVID-19

- Almost half (45%) of respondents had been infected with COVID-19 at least once by the time of the survey, a lower prevalence than the general U.S. population (78%) at the end of 2022.[i]
- A majority of respondents (92%) received at least one dose of a COVID-19 vaccine by the time of the survey, exceeding the national share (81%) at the same time.[2]
- Half (50%) of respondents delayed or missed some form of healthcare during the pandemic, with routine care (34%) and counseling or therapy (24%) being the most common.

Experiences with Transition-related Care

Provider Knowledge and Care Accessibility

- Nineteen percent (19%) of respondents saw the same provider for both transition-related and routine healthcare, compared to 51% in 2015. Thirty-nine percent (39%) had a different provider for routine care, greater than 33% in 2015. Forty-two percent (42%) of the 2022 respondents reported they did not receive any routine healthcare, greater than 15% in 2015.
- Fifty-seven percent (57%) of respondents had a dedicated transition-related healthcare provider, compared to 44% in 2015.
- Of those who had a transition-related healthcare provider, 77% of respondents indicated that their transition-related healthcare provider knew almost everything or most things about providing care for trans people.
- Only 8% of respondents who received routine care from a provider different than their transition-related healthcare provider said their routine healthcare provider knew almost everything or most things about trans healthcare.
- Respondents were twice as likely to travel more than 50 miles for transition-related care than for routine care (11% in 2022 vs. 5% in 2015).

Transition-related Healthcare

- Over half of the respondents (60%) reported undergoing some form of medical transition, including hormones or surgeries.
- Eighty-eight percent (88%) of respondents expressed a desire for gender-affirming hormone therapy (GAHT), but only 56% reported ever receiving hormone therapy.
- Among those who have started hormone therapy, 90% were currently taking hormones, indicating a high prevalence of continuation.
- Twenty-nine percent (29%) of respondents reported receipt of at least one gender-affirming surgery.
- Ninety-eight percent (98%) of respondents taking GAHT reported that taking GAHT made them more satisfied with their lives, and 97% of respondents

who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives.

Continuity of Transition

- All respondents currently identified as trans and nonbinary, but 9% had gone back to living as their sex assigned at birth at least for a little while at some point in their lives due predominantly to challenges related to social acceptance.
- Respondents primarily reported social and structural reasons for living as their sex assigned at birth. For example, the most common reason was that it was "just too hard to be transgender in [their] community." Other common reasons included pressure from a parent and experiencing too much harassment or discrimination.
- Of all respondents who had medically transitioned, only 0.36% went back to living in their sex assigned at birth at least for a while because gender transition was not for them.

Sexual and Reproductive Health and HIV/AIDS

Reproductive Health

- Respondents who asked to receive questions for individuals assigned female at birth received questions about birth control. Since they started to know themselves to be transgender or nonbinary, about half of respondents (44%) wanted birth control. Of those who wanted birth control, more than half (56%) talked to providers about it, and once they talked to providers about it, most obtained it (88%).
- Respondents' primary reasons for not asking providers about birth control, despite wanting it, included being uncomfortable in women's health settings (29%), believing they would be mistreated because they are trans (23%), and the cost of provider visits and/or birth control (25%).
- Among respondents who did not want birth control, the primary reason was having a partner who cannot get them pregnant (62%).
- A small number of respondents needed or wanted abortion services (3%), and 7% of them had problems obtaining the necessary services, including not being able to find a trans-competent provider and not feeling welcome at the clinic because they are trans or nonbinary.

Intersection of Transition-related Care and Reproductive Health

- Over a third of respondents (35%) saw their transition-related healthcare provider for routine sexual and reproductive care, 22% sought care from a different provider and 43% did not receive any routine reproductive healthcare.
- Over three-quarters of respondents (78%) had at least one healthcare provider discuss how gender-affirming treatments might impact their fertility, while 22% reported never having such discussions with a provider.
- Almost all (95%) of those who consulted a provider about hormones and 85% of those who saw a provider for transition-related surgery had fertility discussions.

HIV Testing, Care, and Prevention

- Transgender and nonbinary people were more likely to have tested for HIV compared to the general population in the U.S. (43% vs. 36%), and more trans/nonbinary people assigned male at birth tested for HIV compared to those assigned female at birth (51% of trans women, 46% of nonbinary AMAB, 40% of trans men, and 36% of nonbinary AFAB).
- The percentage of respondents who were living with HIV was three times larger than the U.S. general population (1.1% vs. 0.3%).
- Transgender women had the highest prevalence of living with HIV (2.4%), with Black transgender women having 6 times higher prevalence than all transgender women (15.5%).

Mental Health and Experiences with Mental Health Providers

Psychological Distress and Depression

- The USTS sample showed a high prevalence of serious psychological distress and depression.
- Forty-four percent (44%) of respondents met the criteria for serious psychological distress, compared to less than 4% of the general U.S. population.
- A majority (81%) of respondents indicated that they felt down, depressed or hopeless at least several days over the past two weeks.
- Three-quarters (77%) reported little interest or pleasure in doing things at least several of the days over the past two weeks.

Suicidality

- In the year prior to the survey, 38% of respondents considered suicide. Of those who considered suicide, 41% made corresponding plans. These numbers are dramatically higher than the general population's at 5% and 1% respectively.
- Victimization, such as being verbally harassed, denied equal treatment or service for any reason—such as at a place of business, government agency, or public place—or physically attacked, was associated with greater suicidality.
- Thirty-one percent (31%) of those who had no victimization considered suicide in the past year, compared to 50% for those who were verbally harassed, 53% for those who were denied equal treatment, and 63% for those who were physically assaulted.
- Seventy-eight percent (78%) of respondents considered suicide and 40% attempted suicide at some point in their lifetime. These statistics far exceed the 13.2% and 2.4% reported for the general population.
- Among those who attempted suicide in the year prior to the survey, fewer USTS respondents received medical attention compared to the general population (38% vs. 47%), but a higher proportion required an overnight hospital stay (72% vs. 31%). This suggests that trans respondents receive care less often, despite having a greater need for it.

Experiences with Mental Health Providers

- A majority (58%) of respondents received counseling or therapy from a mental health provider (MHP) in the 12 months prior to the survey, compared to 22% of the general U.S. population. Of those who received counseling in the past 12 months, 67% were receiving care at the time of the survey.
- Our results highlight barriers and challenges with mental healthcare.
- While 78% of respondents wanted counseling for gender identity or transition, only 48% received mental healthcare for it.
- Among respondents who discussed gender identity with a counselor, 12% reported that their MHP tried to persuade them to identify only as their sex assigned at birth. Notably, this was much higher (50%) among those who consulted with religious counselors or therapists.

Happiness, Life Evaluation, and Life Satisfaction

General Happiness

- Two thirds of respondents (66%) reported being "Very to pretty happy." However, a third (34%) indicated they were "Not too happy."

Life Evaluation

- Thirty percent (30%) of respondents reported that they were thriving, the majority (63%) were struggling, and 7% were suffering.

Life Satisfaction

- The section on transition-related care discusses how transition-related care impacted life satisfaction; 98% of respondents taking GAHT reported that taking GAHT made them

more satisfied with their lives, and 97% of respondents who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives.

- This section discusses general life satisfaction. Thirty-seven percent (37%) of respondents reported being overall satisfied with their lives, while the majority (59%) expressed varying levels of dissatisfaction. Four percent (4%) of respondents felt neutral.

Differences by Transition Status, Age, and Gender

- Medically and socially transitioned respondents showed markedly higher prevalences of happiness, thriving, and satisfaction compared to those who had not transitioned.
- Seventy-two percent (72%) of medically transitioned and 71% of socially transitioned respondents were "Very to pretty happy" (72%) compared to 55% and 52% of those who had not medically or socially transitioned, respectively.
- Medically and socially transitioned respondents were thriving more (37% and 36%, respectively) compared to those who had not transitioned (19% and 18%, respectively).
- Respondents who had medically or socially transitioned reported substantially higher life satisfaction (43% and 43%, respectively), compared to 27% and 24% among those who had not medically or socially transitioned, respectively.
- Happiness, life evaluation, and life satisfaction varied by age, gender, and transition status among respondents.
- Older individuals (65+) reported the highest levels across these measures: 82% described themselves as happy, 55% as thriving, and 61% reported being satisfied with life. Younger individuals aged 18 to 24 showed the lowest levels across these measures: 58% happy, 20% thriving, and 27% satisfied with their lives.
- Gender differences revealed that crossdressers reported relatively high prevalences of being happy (72%), thriving (33%) and satisfied (41%), while AFAB nonbinary individuals reported low prevalences across categories (61% happy, 25% thriving, and 34% satisfied).

Substance Use

- USTS respondents reported drinking and smoking less often than the U.S. general population.
- A smaller percentage of 2022 USTS respondents drank alcohol than the U.S. general population: 46% of the sample drank alcohol in the past month compared to 53% of the U.S. adult population.
- Among current drinkers, USTS respondents reported binge drinking less often than the general population (18% vs. 24%).
- Respondents reported less smoking than the general population: 12% were current smokers compared to 16% of the U.S. adult population. Further, current smokers reported smoking every day less often than the general population (43% vs. 56%).
- Thirty-five percent (35%) of respondents used marijuana in the past month, more than double that of the general population (17%).
- One-quarter (25%) of the sample said that they had a problem with drugs or alcohol at some point in their lives. About 14% of respondents said that they were in recovery.

---

1. Price, M.A., Hollinsaid, N. L., McKetta, S., Mellen, E.J., & Rakhilin, M. (2023). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. *Social Psychiatry and Psychiatric Epidemiology*, 59. https://doi.org/10.1007/s00127-023-02482-4

   dickey, l. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75(3), 380–390. https://doi.org/10.1037/amp0000619

2. Miller, G. H., Marquez-Velarde, G., Mills, A. R., Hernandez, S. M., Brown, L. E., Mustafa, M., & Shircliff, J. E. (2023). Patients' perceived level of clinician knowledge of transgender health care, self-rated health, and psychological distress among transgender adults. *JAMA network open*, 6(5), e2315083-e2315083.

Introduction

For over 20 years, Advocates for Trans Equality (A4TE, formerly National Center for Transgender Equality, NCTE) has fought for the rights and liberation of trans and gender diverse people through policy, law, and education. As part of this mission, A4TE conducts research on the lives of trans people across the United States to raise awareness among advocates, policymakers, healthcare providers, educators, researchers, and the public and inform policy recommendations that advance the lives of trans people. Moreover, A4TE works in partnership with advocates, including the Black Trans Advocacy Coalition, National Queer Asian Pacific Islander Alliance, and TransLatin@ Coalition, to help ensure that the perspectives of often underrepresented groups—such as trans people of color, older transgender adults, and others frequently marginalized in research—are meaningfully included in A4TE's research program.

A4TE's core research focus is to administer the historic U.S. Transgender Survey (USTS), the most recent iteration being the 2022 USTS. The USTS is the largest survey of binary and nonbinary trans people ever in the United States with 84,170 adult respondents 18 years old and older[1] and covers wide-ranging topics critical to understanding the lives of trans people, including health and healthcare, family and community belonging, and civic participation. This report provides foundational knowledge on the experiences of trans and nonbinary people, on which further research can be built. It directs us towards the most pressing policy issues that we can fight to change.

This report focuses on the health and healthcare of adult USTS respondents. It is the third report to emerge from the 2022 USTS, following the Early Insights and the Civic Engagement reports. This report covers several topics: General Health and Access to Healthcare; Transition-related Healthcare; Sexual and Reproductive Health, including HIV Testing, Care, and Prevention; Mental Health and Experiences with Mental Health Providers; Life Satisfaction and Happiness; and Substance Use. The 2022 USTS offers a broad understanding of the conditions that allow trans adults to flourish and describes the challenges and barriers that trans people face. Where appropriate we make comparisons to 2015 USTS survey findings, offering insight into the social and political context affecting trans people over the last decade. We also include comparisons to the U.S. adult general population where applicable to contextualize trans health outcomes among all U.S. adults, highlighting both the strengths of the 2022 USTS sample and systemic inequities that they faced. Ultimately, the 2022 USTS Health and Wellbeing Report provides critical insights which we hope will advance the lives of trans people in the U.S.

Lastly, as one reviews the data presented in this report, it is important to consider the environmental context in which the 2022 USTS was conducted. From 2015 to 2022, state-level policy environments became more protective in some ways for trans people; however, in 2022 alone, when the USTS was administered, 315 anti-LGBTQ bills were introduced across the country, many of which harm trans and nonbinary people's access to healthcare, participation in sports, access to public facilities, or other facets of public life.[2] This political landscape has only worsened since the administration of the 2022 USTS, with the introduction of 571 anti-LGBTQ nationwide in 2023 and 489 in 2024.[3] At the time of writing, data on trans and nonbinary people has been erased from federal health surveys. As funding for LGBTQ research is stripped away, the USTS has become an ever more critical resource on the lived experiences of trans and nonbinary people.

1. The survey included 16- and 17-year-olds as well totaling 92,329; however, we limit this report to the adult sample 18 and older.
2. Casey, L. (2025). Anti-LGBTQ State Bills 2010-2024 (V4). Movement Advancement Project. Accessed May 21, 2025. https://public.flourish.studio/visualisation/21588230/
3. Casey, L. (2025). Anti-LGBTQ State Bills 2010-2024 (V4). Movement Advancement Project. Accessed May 21, 2025. https://public.flourish.studio/visualisation/21588230/

Methodology

Overview

The 2022 U.S. Transgender Survey (USTS) is the largest survey of binary and nonbinary trans people in the United States. The USTS was administered online in both English and Spanish and was open to any transgender identifying person—both binary and nonbinary—aged 16 and older living in the United States, U.S. territories, or on a U.S. military base overseas. The survey covered a broad range of topics, including healthcare, employment, education, housing and public accommodation.

The 2022 USTS was accessible exclusively through the USTS website (USTransSurvey.org) and was hosted on Qualtrics. Data collection occurred from October 19 to December 5, 2022. The 2022 USTS sample includes 84,170 adults (18+) and 8,159 youth aged 16 and 17, for a total sample 92,329 transgender identifying individuals from all 50 states, the District of Columbia, five U.S. territories, and overseas military bases. In this report, we limit analyses to adult respondents only.

History of the U.S. Transgender Survey

The 2022 USTS follows the 2015 USTS, which was led by the National Center for Transgender Equality (NCTE). At the time, the 2015 USTS was the largest and most comprehensive survey of transgender identifying individuals in the United States, with 27,715 participants. The 2015 USTS followed the National Transgender Discrimination Survey (NTDS), which was administered by NCTE and the National LGBTQ Task force in 2008 and 2009. From the NTDS to the 2015 USTS to the 2022 USTS, USTS and NTDS researchers and authors worked to refine survey question design and expand the content included in each survey. With each new survey, USTS and NTDS researchers have made an effort to investigate gaps in knowledge, explore emerging topics, document changes in experiences and outcomes across time, and facilitate comparisons between transgender individuals and the general U.S. population. Advocates, practitioners, and researchers were consulted throughout the development of the 2022 USTS with those considerations in mind.

USTS Respondents

The USTS captures the lived experiences of transgender individuals, defined as anyone whose gender identity differs from the sex assigned to them at birth. The USTS was intentionally inclusive of both binary and nonbinary transgender identities and other transgender identities. “Transgender” or “trans” was thus defined broadly to include a wide range of identities. Outreach materials emphasized that the survey was meant for a range of gender-expansive identities and open to all trans and nonbinary people.

USTS participation was limited to individuals currently residing in a U.S. state or territory, or on a military base overseas. Different from the 2015 USTS, which limited participation to those 18 and older, the 2022 USTS was open to individuals aged 16 and older at the time of survey completion. However, the findings presented in this report only include respondents aged 18 and over.

As reported in Early Insights: A Report of the 2022 U.S. Transgender Survey, key characteristics of 2022 USTS adult respondents include:

- **Gender:** Thirty-eight percent (38%) of respondents identified as nonbinary, 35% as a transgender woman, 25% as a transgender man, and 2% identified as a crossdresser.
- **Intersex Status:** Five percent (5%) of respondents reported they were born with a variation in physical sex characteristics or had an intersex variation or Difference in Sex Development. Seventy-two percent (72%) reported they were not, and 23% reported that they did not know.
- **Race:** One percent (1%) of respondents identified as American Indian or Alaska Native, 7% as Asian/Asian American or Native Hawaiian/Pacific Islander, 8% as Black or African American, 14% as Latino(a)(x)(e)/Hispanic, less than 1% as Middle Eastern or North African, 56% as white or European American, and 13% identified as two or more races. Less than 1% identified as "a racial or ethnic identity no listed above."
- **Age:** Forty-three percent (43%) of respondents were age 18 to 24, 6% were age 25 to 44, 9% were age 45 to 54, 6% were age 55 to 64, and 7% were over the age of 65.
- **Educational Attainment:** Thirty-five percent (25%) of respondents had completed high school or obtained a GED, 26% had completed some college, 13% had not completed high school, 11% had a bachelor's degree, 7% had an associate's degree, and 7% had a master's degree or higher.
- **Geographic Location:** USTS respondents resided in all fifty states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the U.S. Virgin Islands, and U.S. military bases overseas. Based on U.S. Census Bureau regions, 41% resided in the South, 23% in the West, 19% in the Northeast, and 17% in the Midwest.

Developing the Survey Instrument

The development of the 2022 USTS survey instrument was a year-long effort led by the USTS research team in collaboration with the Scientific Advisory Committee and numerous individuals with lived experience, advocacy backgrounds, and research and subject matter expertise. Building on the foundation of the 2015 USTS, the research team aimed to expand and update the survey to address existing data and research gaps and reflect changes in the social, political, and environmental context. A key priority in survey instrument development was ensuring the 2022 instrument captured a broader range of topics while maintaining comparability with 2015 data. For example, the research team considered how the COVID-19 pandemic might have impacted respondents' experiences. As a result, the 2022 survey instrument included new or revised questions to provide context (e.g., pandemic-related experiences), respond to legal and policy developments (e.g., healthcare access, participation in sports), and generate more detailed insights into areas such as physical health, transition-related care, education, and life satisfaction.

Pilot Survey

The USTS research team conducted a pilot study with close to 100 individuals to evaluate and further refine the survey instrument. Respondents were offered a $25 gift card for their participation in the pilot study. Pilot participants represented diverse backgrounds and experiences that reflected the target population. The pilot was administered through an online platform that mirrored the format of the final survey. The primary goal of the pilot was to assess both the content and technical functionality of the survey. Participants provided feedback on individual questions, the overall survey structure, and specific

areas identified by the research team. Insights were reviewed and used to guide final revisions to the survey instrument.

Final Survey

The final survey included 605 possible questions organized across thirty-eight sections—an increase from the 324 possible questions in the 2015 USTS. New questions aimed to deepen understanding across a wide range of topics that potentially only affected some respondents rather than resulting in more questions for all respondents. No single respondent received all 605 questions as the online survey platform allowed for efficient movement and skip logic so that respondents only received questions appropriate for them based on previous responses. As a result, the 2022 USTS maintained an average completion time of 60 minutes.

Outreach and Communications

Outreach and Communications efforts focused on raising awareness of the survey and providing opportunities for survey completion. Efforts also focused on increasing representation of those who are often underrepresented in survey research, including people of color, seniors, people residing in rural areas, and low-income individuals.

More detailed information regarding Outreach and Communication efforts can be found in Early Insights: A Report of the 2022 U.S. Transgender Survey.

Institutional Review Board and Confidentiality

The USTS received Institutional Review Board (IRB) approval from the University of California, Los Angeles, North General IRB. Institutional Review Boards are meant to ensure confidentiality and protect the rights of individuals participating in a research study. The USTS IRB approval included review and approval of study design, survey instrument and questionnaire, recruitment materials, and fielding of the survey in English and Spanish. The survey began with a study information sheet that described aspects of the study and highlighted participants' rights in the study. At the end of the information sheet, respondents were required to consent to taking the survey.

The USTS was administered in a way that maintained privacy and confidentiality in the collection and maintenance of survey data in order to protect respondent anonymity. The USTS research team obtained a Certificate of Confidentiality from the National Institutes of Health.[1] This can be used to legally refuse the disclosure of information that could identify respondents in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings.

Survey Hosting, Data Collection, and Cleaning

The USTS was programmed and hosted by Qualtrics, and data collection was managed by Qualtrics throughout the fielding of the survey. Once data collection was completed, the dataset was securely transferred to the USTS research team for data cleaning and analysis. To improve the quality of the final sample, the USTS research team used standard practices for data cleaning and conducted additional cleaning for eligibility to remove responses that did not belong in the sample (e.g., illogical responses, incomplete responses, duplicate records).

Duplicates Assessment

Duplicate responses were possible for a variety of reasons (e.g., internet connection disruptions, moving from one device to another for completion,

forgetting previous participation). The USTS research team assessed duplicate responses through an iterative process. Questions that were required to be answered, IP addresses, zip codes, and state of residence provided a first screening for duplicates. The research team assessed duplicate grouping where unique flags were created for possible duplicate responses. If responses were determined to be duplicates, an assessment determined which observation to retain for the final USTS sample. Where duplicates had different progression through the survey, the most complete response was retained. Where duplicates had the same degree of completion, the earliest response was retained.

Survey Weights

Survey weights were developed to reduce sampling bias and correct for representativeness of the U.S. transgender population along age, race/ethnicity, education, and geographic region. Findings in this report reflect those corrections. Separate weights were developed for the full sample (those ages 16+) as well as for the adult sample (those 18+). Weights were constructed based on two targets: 1) Center for Disease Control and Prevention's 2020-2021 Behavioral Risk Factor Surveillance System (BRFSS) and 2) 2019 American Community Survey 3-Year estimates. The BRFSS is administered to be representative of each state, and data are weighted for probabilities of selection and sample adjustment to population targets. Each state fields a common questionnaire, and optional modules are available for states to include. One optional module is the Sexual Orientation and Gender Identity (SOGI) Module. We obtained targets for USTS weighting based on the 37 states that included the SOGI module. Second, we used 2019 American Community Survey 3-Year estimates to adjust the USTS sample to match the demographic distribution of the general population. Weights were scaled to have a mean of one so that the sum of weights adds to the total sample size.

Data Cleaning and Recoding

Data were cleaned and recoded as needed, including recoding of write-in responses across survey questions. Write-in responses were recoded into existing answer choices where possible; in some cases, new response categories were created for frequent write-in responses.

Presentation of Findings

We present results only for respondents aged 18 and older, and explore variation in outcomes across key sample characteristics, such as gender, transition status, race, and experiences of family support or rejection. We conducted statistical tests to compare differences, but given the large sample size, these tests were largely highly significant, even when differences were small and not substantively meaningful. Therefore, we do not report tests of statistical significance in this report.

Throughout the report, we compare 2022 USTS findings to 2015 USTS findings. It is important to note that each dataset represents a different cross-sectional sample. As such, these comparisons are not longitudinal and should be interpreted with caution—they do not capture within-person change over time or establish causal trends across cohorts.

All findings are presented as weighted percentages of the entire sample or of the subgroup being examined. For example, prevalence of suicidality is presented as a percentage of the entire sample, while data on experiences with transition-related medical procedures are separated out by sex assigned at birth. In all tables and figures, we provide the number (n) of respondents who received the relevant

questions for that table or figure; however, due to weighting, readers cannot directly cross-reference percentages with the number of respondents who received those questions.

We round percentages to whole numbers, except where exact comparisons to national data or 2015 USTS data were required, or where more finite percentages were necessary due to small percentages. When rounding, the following convention was generally used: decimals of 0.50 and above were rounded up, and decimals of 0.49 and below were rounded down (e.g., 1.50% was rounded to 2% and 1.49% was rounded to 1%). Throughout the report, results are presented in various tables and figures. The percentages presented may not always add up to 100% due to respondents being able to select multiple options or because of rounding.

---

1. National Institutes of Health. (2024). Information Protected by a CoC | Grants & Funding. (2024). Nih.gov. Retrieved June 3, 2025 from https://grants.nih.gov/policy-and-compliance/policy-topics/human-subjects/coc/information-protected-coc

CHAPTER 1

General Health and Access to Healthcare

IN OUR OWN VOICES

"Even though I am 18 and insured through my mom's work, I am unable to access my information in order to get hormones. My mother has made it clear that if I started transitioning medically she would ask me to leave. My dad has been more accepting, but does not want me to start hormones either. I don't have a job, so I am unable to pay for my own medical care. I really wish there was more resources to help young people navigate using their healthcare for trans-related medical help."

TK
nonbinary transgender man, multiracial

Age range: 18-24

"I went to have an ultrasound done. When I went to sign the forms, I noticed that one of them listed me as 'female.' The receptionist fixed it in their computer, and I crossed out the 'female' and wrote in 'male' before signing it. When I went in to get my ultrasound, I made sure that the ultrasound machine had me listed as male before I had them do the procedure. I do not like having to check with the various specialist offices as to what my gender is before any procedure is done. I shouldn't be uncomfortable whenever I go to see my doctor."

RYAN
transgender man, multiracial

Age range: 40-60

"I am very fortunate to have been able to access gender-affirming health providers for my hormones, mental health, sexual health, and overall well-being. I've purposely selected doctors who provided me with all of the services I need. On the other hand, my negative experiences included a previous primary physician and the lack of insurance coverage for gender-affirming surgical care. "

RJ
nonbinary, Asian/Asian American,

Age range: 25-40

"Many of the health care offices here either reject transgender patients outright, or have no idea how to treat transgender patients. I was denied by every endocrinologist in the state except for one office, which was a center of excellence for transgender people."

KARA
nonbinary transgender woman, white,

Age range: 25-40

INTRODUCTION

Access to quality healthcare is essential for overall wellbeing, yet transgender and nonbinary individuals often face significant barriers to accessing medical services.[1] This chapter explores self-reported overall health status, experiences with accessing healthcare, experiences with healthcare providers, and health insurance coverage. It also examines the impact of the COVID-19 pandemic on healthcare access, including delays in treatment and the increasing role of telehealth. While progress has been made in some areas, systemic disparities remain, highlighting the need for policies that promote equitable and inclusive healthcare for trans and nonbinary people.

Key Findings

General Health

- USTS respondents reported worse overall health compared to the general population: 66% rated their health as "excellent," "very good," or "good," compared to 81% in the general population. Thirty-four percent (34%) reported "fair" or "poor" health, compared to 18% in the general population.
- Self-reported health varied by age, family support, and transition status:
  - Older respondents reported better health than younger respondents—78% of those 65+ vs. 60% of 18 to 24 year olds rated their health as good or better.
  - Family support was linked to better health—69% of those with supportive families reported good or better health, compared to 56% of those who reported unsupportive families.
- Social and medical transition was associated with better health—67% of respondents who had socially transition reported good or better health compared to 61% of those who had not. Further, 70% of respondents who had medically transitioned rated their health as good or better, compared to 58% of respondents who had not medically transitioned.

Access to Healthcare

- Twenty-eight percent (28%) of respondents did not see a healthcare provider in the past year due to cost. Though a different cross-sectional sample than the 2022 USTS, 33% of 2015 USTS respondents did not see a provider due to cost.
- Cost was a greater barrier for some racial groups, especially Bi/Multiracial (34%), American Indian/Alaska Native (33%), and Latine (32%) respondents.
- Twenty-four percent (24%) of respondents avoided healthcare in the past year due to fear of being mistreated as a trans person, similar to 2015 (23%).
- American Indian/Alaska Native respondents (32%) and Middle Eastern/North African respondents (37%) reported the highest shares of avoiding care.
- Trans men (32%) and nonbinary individuals assigned female at birth (AFAB) respondents (24%) were the most likely to avoid care due to mistreatment concerns, followed by trans women (20%), nonbinary individuals assigned male at birth (16%), and crossdressers (9%).

Experiences with Healthcare Providers

- Nearly eight in ten (79%) respondents visited a healthcare provider in the past year. Though a different cross-sectional sample than the 2015 USTS, this was lower than the nearly nine in ten (87%) in 2015.
- Half (50%) of respondents said all their healthcare providers knew they were transgender, greater than two in five (40%) in 2015.
- Roughly one-fourth (24%) of respondents said none of their providers knew that they were transgender. This is less than the nearly one-third (31%) of respondents who reported that none of their healthcare providers knew they were transgender in 2015.
- Nearly three in four (73%) respondents who disclosed their transgender status felt treated with respect by at least one provider, higher than the 62% in 2015.
- Almost half (47%) experienced at least one negative interaction with a healthcare provider. The most frequent negative interactions included healthcare providers using the wrong names or pronouns (37%), respondents having to teach their healthcare provider about trans people to receive appropriate care (18%), and healthcare providers asking unnecessary or invasive questions about the individual's trans status that was unrelated to the visit (11%).
- Nonbinary AFAB people and trans men reported the greatest proportions of negative experiences with healthcare providers (55% and 53%, respectively), followed by trans women (41%), AMAB nonbinary people (38%), and crossdressers (10%).
- More than half (58%) of respondents with disabilities reported any negative experience with a healthcare provider.

Health Insurance Coverage and Experiences

- Eighty-seven percent (87%) of respondents had health insurance at the time of the survey, comparable to 86% in the 2015 USTS, but lower than 92% coverage in the general population.[1]
- Insurance coverage varied by race, with American Indians and Alaska Natives (80%) and Latine respondents (84%) having the lowest shares of being insured.
- Twenty-six percent (26%) of insured respondents reported negative experiences with their health insurance related to being transgender.
- Although the 2015 and 2022 USTS samples are different cross-sectional samples, health insurance denials for transition-related care were lower in 2022 compared to 2015: transition-related surgery denials were 55% in 2015 compared to 20% in 2022, hormone therapy denials were 25% in 2015 compared to 11% in 2022, and refusals to update gender markers on insurance records were 17% in 2015 compared to 12% in 2022.
- Partial coverage—when some procedures are covered and others are not—for transition-relatedprocedures remains a barrier. Forty-five percent (45%) of respondents had only some procedures covered—slightly higher than in 2015 (42%).

COVID-19

- Almost half (45%) of respondents had been infected with COVID-19 at least once by the time of the survey, a lower prevalence than the general U.S. population (78%) at the end of 2022.[2]
- A majority of respondents (92%) received at least one dose of a COVID-19 vaccine by the time of the survey, exceeding the national share (81%) at the same time.[2]
- Half (50%) of respondents delayed or missed some form of healthcare during the pandemic, with routine care (34%) and counseling or therapy (24%) being the most common.

General Health

Self-reported health provides valuable insight into overall wellbeing.[3] We follow the Center for Disease Control's Behavioral Risk Factor Surveillance System Survey (BRFSS) to measure self-reported health.[4] The survey asked respondents to rate their own health as "excellent," "very good," "good," "fair," or "poor". Our respondents had dramatically lower self-reported health compared to the general population. For example, 66% of USTS respondents said they were in excellent, very good, or good health compared to 81% in the BRFSS (Table 1.1).[4] Further, 34% of USTS respondents reported Fair or Poor health compared to only 18% in the general population.[4]

To simplify analyses with other critical characteristics, we collapsed "good," "very good," and "excellent" into a single category of "good or better health." We see that self-reported health varied crucially by age, family support, transition status, and gender identity. For example, older respondents had better self-reported health compared to younger respondents. Seventy-eight percent (78%) of respondents 65 and over described their health as good or better, compared to 60% of those 18 to 24 (Figure 1.1).

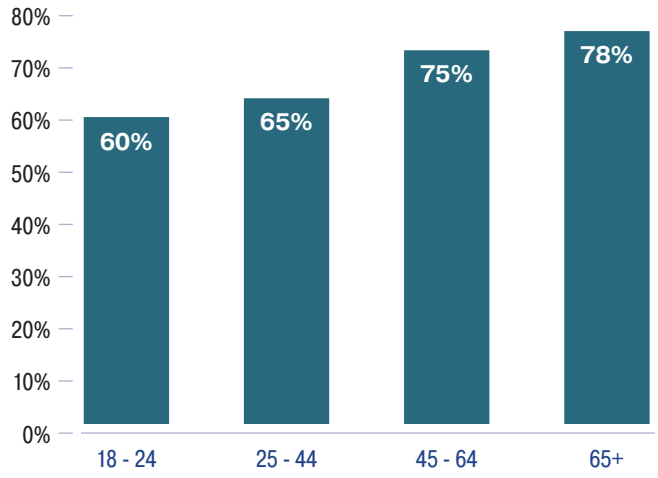
Table 1.1

Respondents' Self-reported Health Condition, Compared to the U.S. General Population (2022 USTS [n = 84,069] and BRFSS[5])

Condition	USTS (%)	BRFSS (%)
Excellent	6	17
Very good	24	32
Good	36	32
Fair	25	14
Poor	9	4

Figure 1.1

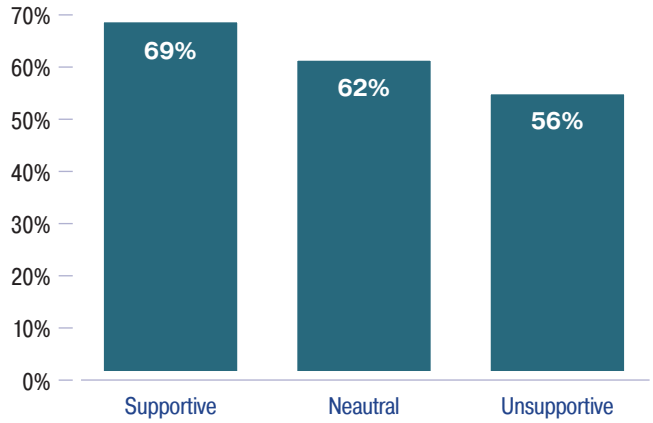
Respondents Who Reported Good, Very Good, or Excellent Health, by Age (n = 84,069)



Self-reported health also varied by family support as well—respondents with supportive families had substantially better self-reported health (69%) compared to those with unsupportive families (56%) (Figure 1.2).[6]

Figure 1.2

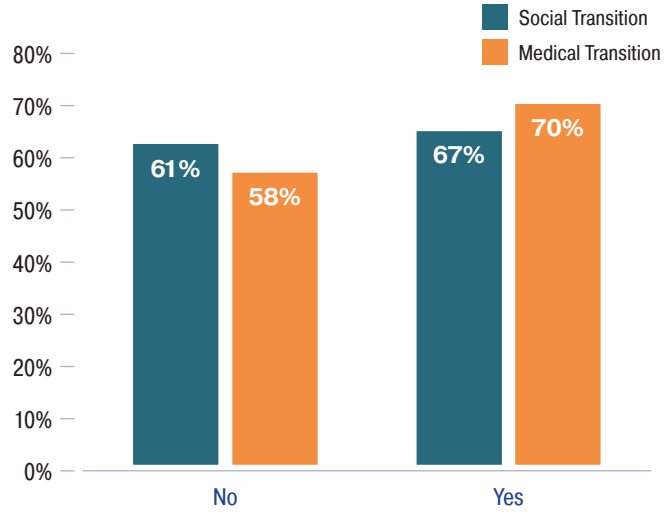
Respondents Who Reported Good, Very Good, or Excellent Health, by Family Support (n = 65,962)



Additionally, respondents who had socially or medically transitioned reported better health than those who had not (Figure 1.3).

Figure 1.3

Respondents Who Reported Good, Very Good, or Excellent Health, by Transition Status

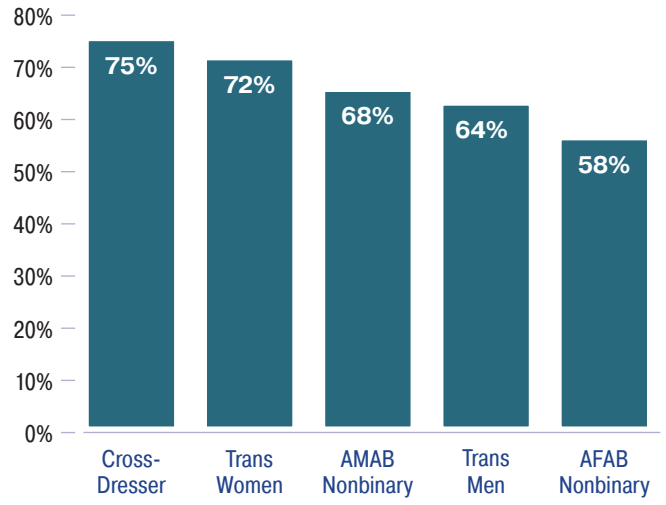


Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: social transition (n = 83,533) & medical transition (n = 81,895).

Lastly, among gender categories, trans men and AFAB nonbinary individuals showed the poorest self-reported health (64% and 58%, respectively) (Figure 1.4).

Figure 1.4

Respondents Who Reported Good, Very Good, or Excellent Health, by Gender (n = 84,069)



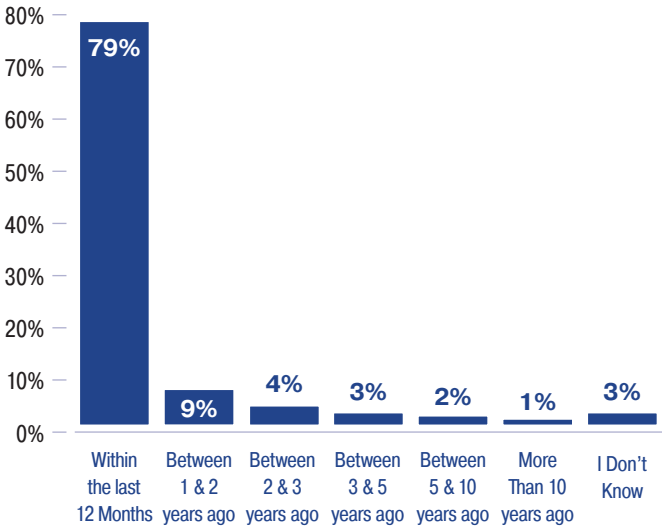
Access to Healthcare

Access to respectful, competent healthcare is essential for overall wellbeing, particularly for transgender and nonbinary individuals, who often face unique medical needs and systemic barriers.

We asked respondents about their experiences with accessing healthcare. Seventy-nine percent (79%) of respondents saw a healthcare provider in the year before the survey; lower than the 87% of respondents in the 2015 USTS (Figure 1.5)

Figure 1.5

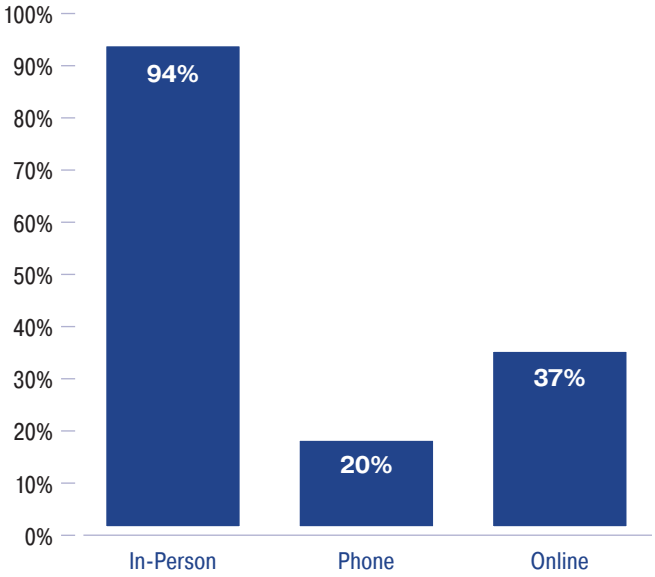
Duration Since Last Healthcare Visit (n = 83,976)



Almost all (94%) of these visits occurred in-person (Figure 1.6).

Figure 1.6

Type of Healthcare Visit in Past 12 Months (n = 68,609)

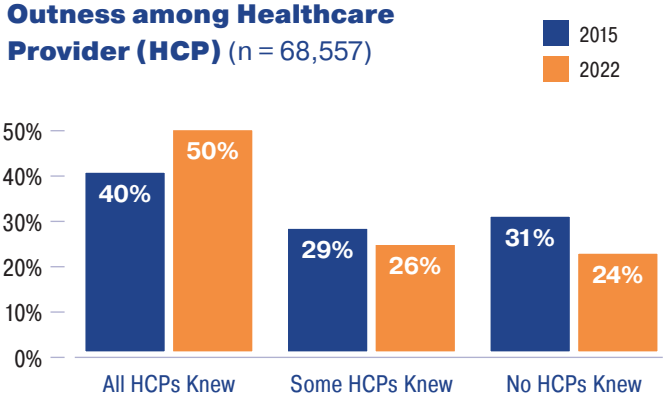


Note: Percents sum to greater than 100% because respondents could select multiple responses.

Of respondents who saw a provider in the past year, 50% reported that all their healthcare providers knew they were trans while roughly a quarter (24%) said that none of their providers knew they were transgender (Figure 1.7). Although the 2015 and 2022 USTS samples are different cross-sections, this is a higher share of outness compared to 2015 when only 40% of respondents reported that all their providers knew they were trans (Figure 1.7).

Figure 1.7

Outness among Healthcare Provider (HCP) (n = 68,557)



Barriers to Access

Twenty-eight percent (28%) of respondents did not see a healthcare provider in the year prior to the survey due to cost, compared to 33% in the 2015 USTS.[7] When broken down by insurance coverage, 23% with health insurance and 60% without health insurance did not see a provider in the past year due to cost. Cost was disproportionately a prohibitive factor for Multiracial (34%), American Indians/ Alaska Native (33%), and Latine respondents (32%) (Table 1.2). Trans men and AFAB nonbinary people show the highest burden with 31% and 34%, respectively, reporting that they did not see a healthcare provider because of cost (Figure 1.8).

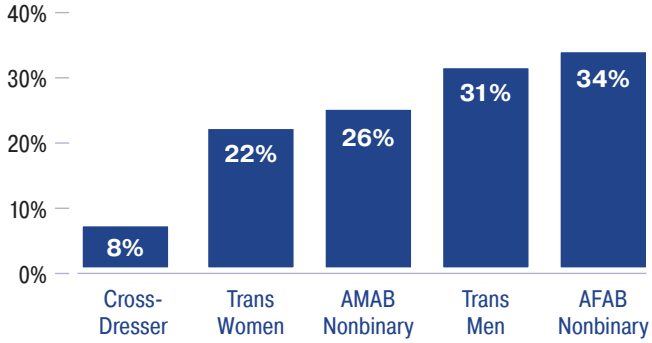
Table 1.2

Respondents That Did Not See a Healthcare Provider in the 12 Months Prior to Survey Because of Cost, by Race (n = 83,669)

Race	Percent
Overall	28
American Indian or Alaska Native (AIAN)	33
Asian or Native Hawaiian or Pacific Islander (A/NHPI)	22
Black or African American (Black)	27
Latine	32
White	26
Two or More Races/Multiracial	34

Figure 1.8

Respondents That Did Not See a Healthcare Provider in the 12 Months Prior to Survey Because of Cost, by Gender
(n = 83,962)



Beyond cost, another critical barrier to accessing healthcare was respondents' fear of being disrespected or mistreated as a trans person. Nearly a quarter (24%) of respondents did not see a healthcare provider in the 12 months prior to the survey because they thought they would be disrespected or mistreated as a trans person, similar to what was reported by respondents in the 2015 USTS (23%).[8] American Indians and Alaska Natives continue to show high burden with 32% reporting that they did not see a healthcare provider because they thought they would be disrespected or mistreated (Table 1.3). As for gender, we continue to see the same trends—trans men and AFAB nonbinary individuals show the highest shares of not seeing a healthcare provider due to fear of disrespect or mistreatment (32% and 24%, respectively) compared to trans women (20%), AMAB nonbinary people (16%), and crossdressers (9%) (Figure 1.9).

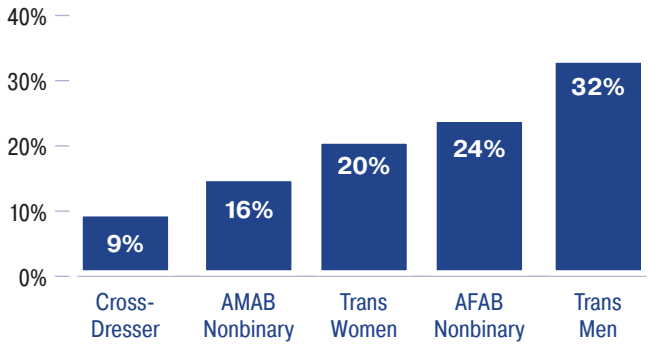
Table 1.3

Respondents Who Did Not See a Healthcare Provider in the 12 Months Because They Thought They Would Be Disrespected or Mistreated as a Trans Person, by Race
(n = 83,615)

Race	Percent
American Indian or Alaska Native (AIAN)	32
Asian or Native Hawaiian or Pacific Islander (A/NHPI)	18
Black or African American (Black)	22
Latine	26
White	23
Two or More Races/Multiracial	29
Total	24

Figure 1.9

Respondents That Did Not See a Healthcare Provider in the 12 Months Because They Thought They Would Be Disrespected or Mistreated as a Trans Person, by Gender
(n = 83,907)



Experiences with Healthcare Providers

Access to quality healthcare is a critical component of overall wellbeing, yet many trans and nonbinary individuals face barriers and challenges when seeking care, such as negative experiences with healthcare providers. This section explores respondents' recent experiences with healthcare providers, shedding light on trends in access, treatment, and interactions.

Among respondents who visited a healthcare provider in the past year, nearly three-quarters (73%) said they had at least one healthcare provider that knew they were trans and treated them with respect—greater than the 62% of respondents in the 2015 USTS. However, nearly half (47%) experienced at least one negative interaction with a healthcare provider (Table 1.4).

The most common negative interactions were that healthcare providers used the wrong names or pronouns (37%), respondents had to teach their healthcare provider about trans people to receive appropriate care (18%), and healthcare providers asked unnecessary or invasive questions about the individual's trans status that were unrelated to the visit (11%) (Table 1.4). Though these challenges persist, some specific types of negative experiences were reported less frequently in 2022 compared to 2015, including teaching a doctor about trans people so they could get appropriate care and being refused transition-related care. Among respondents that were refused transition-related care, the most common reason was that the provider was not familiar with treating trans people (41%, Table 1.5).

Table 1.4

Negative Experiences with Healthcare Providers in the 12 Months Prior to the USTS

Negative Experience	2022 (%)	2015 (%)
One or more negative experience	47	N/A[9]
A doctor or other healthcare provider called me by the wrong name or pronouns (such as he or she)	37	N/A
I had to teach my doctor or other healthcare provider about trans people so that I could get appropriate care	18	24
My doctor or other healthcare provider asked me unnecessary/invasive questions about my trans status that were not related to the reason for my visit	11	15
A doctor or other healthcare provider refused to give me transition-related care	5	8
A doctor or other healthcare provider used harsh or abusive language when treating me	4	5
I was verbally harassed in a healthcare setting (such as a hospital, office, clinic)	4	6
A doctor or other healthcare provider refused to give me other healthcare (such as for like physicals, flu, diabetes)	3	3
A doctor or other healthcare provider was physically rough or abusive when treating me	2	2
I was physically attacked by someone during my visit in a healthcare setting (such as a hospital, office, clinic)	1	1
I experienced unwanted sexual contact in a healthcare setting (such as a hospital, office, clinic)	1	1

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items The sample sizes for the corresponding responses can be found in the end note.[10]

Table 1.5

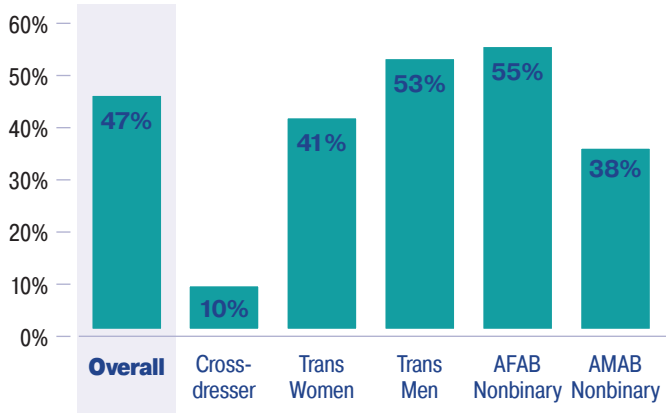
Reasons for Refusal of Transition-related Healthcare (n = 3,107)

Reasons for Refusal	Percent
Provider stated they weren't familiar with treating trans people	41
A reason not stated above	26
They didn't give me a reason	22
Provider's personal religious beliefs	14
Provider stated that I could not receive transition-related care because of another medical or health condition	13
Provider stated they are not accepting new patients	9
Religious affiliation of the health facility	7
I am not sure	6

Negative experiences with healthcare providers varied by gender identity: crossdressers reported the lowest rate (10%), followed by trans women and nonbinary AMAB individuals (41%, 38% respectively), and trans men and nonbinary AFAB individuals reported the highest rates of negative experiences (53%, 55%, respectively) (Figure 1.10).

Figure 1.10

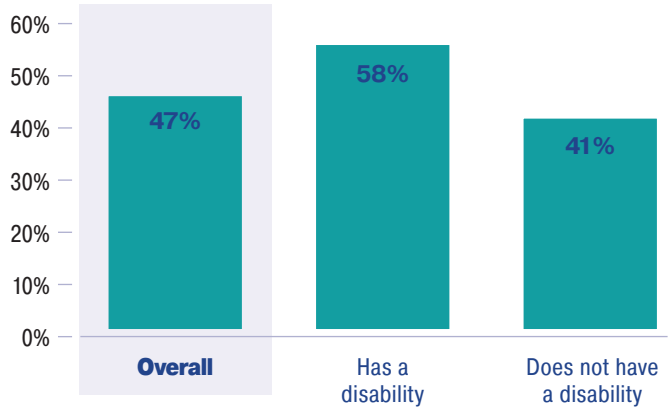
Negative Experiences with Healthcare Providers in the Last 12 Months, by Gender Identity (n = 67,792)



Respondents with disabilities also had higher rates of negative experiences, compared to those without a disability (58% vs. 41%, respectively) (Figure 1.11).[11]

Figure 1.11

Negative Experiences with Healthcare Providers in the Last 12 Months, by Disability Status (n = 67,689)



A small portion (3%) of respondents reported that a healthcare provider refused to give them care not related to gender transition (such as physicals or care for the flu or diabetes). When this occurred, a third of the time (32%) the provider did not give a reason for denying care. Of those who were refused care, one in five (21%) reported that, although the care was not Trans-Related, they were denied other healthcare because their provider stated they weren't familiar with treating trans people (Table 1.6). A tenth (11%) of respondents who were refused care reported that their provider attributed their condition to their gender-affirming hormone therapy (GAHT) and would not treat them unless they stopped taking hormones. Ten percent (10%) of respondents also reported that their provider's personal religious beliefs were the reason they did not receive other healthcare.

Table 1.6

Reasons for Refusal of Non-Transgender-related Healthcare (n = 3,107)

Reasons	Percent
They didn't give me a reason	32
A reason not stated above	26
Provider stated they weren't familiar with treating trans people	21
Provider stated that my condition was caused by HRT, and they would not treat me unless I stopped taking hormones	11
Provider's personal religious beliefs	10
I am not sure	10
Provider stated they are not accepting new patients	9
Religious affiliation of the health facility	5

Health Insurance Coverage and Experiences

The survey asked respondents a series of questions regarding health insurance coverage. In a mixed private and public system, health insurance coverage is critical for people to access healthcare at a cost that is affordable to them. At the time of the survey, 87% of respondents had health insurance, similar to the 86% reported in the 2015 USTS but 5 percentage points lower than the 92% coverage rate in the general population (Figure 1.12).[12,13] Notably, American Indians and Alaska Natives had the lowest rates of insurance coverage with roughly 20% being uninsured, followed by Latines at 16% (Figure 1.13)

Figure 1.12

USTS Respondents Covered by Health Insurance (n = 83,988)

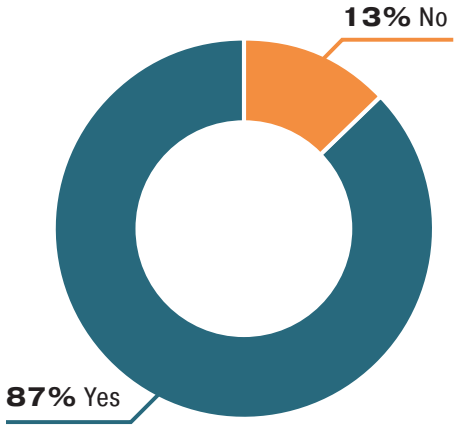


Figure 1.13

Respondents Uninsured, by Race/Ethnicity (n = 83,988)

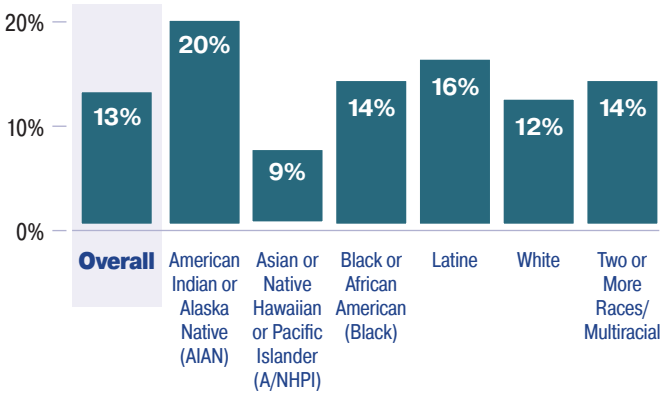


Table 1.7 compares types of health insurance coverage among respondents to the general U.S. population. Among insured respondents (n = 76,113), the majority had coverage through an employer or union or someone else's employer or union (like a family member), similar to the general population (57% vs. 55%, respectively).

Table 1.7

Type of Health Insurance Coverage, Compared to the U.S. General Population (n = 76,113)

Type	USTS (%)	U.S. General Population[13] (%)
Current or former employer or union (belonging to respondent or someone else like a family member)	57	55
Medicaid	25	19
Medicare	10	19
Marketplace	7	4
Directly from Insurance Company	7	10
Other	4	N/A
TRICARE/Military	3	2
VA	2	1
Indian Health Services	<1	**[15]

Fewer were enrolled in Medicare, likely due to the young age distribution of the sample, and more had Military or VA health insurance coverage.

Notably, the USTS sample had a substantially higher share of those enrolled in Medicaid compared to the general population (25% vs. 19%), reflecting greater poverty in the USTS sample compared to the general population.

Negative Experiences with Health Insurance

Roughly a quarter (26%) of insured respondents had negative experiences with their health insurance company related to being trans. However, negative experiences with their health insurance company were less common compared to respondents in the 2015 USTS (Table 1.8) — though the 2015 and 2022 USTS were different cross-sectional samples.

Table 1.8

Negative Experience with Health Insurance in the Year Prior to the Survey (2022 and 2015 USTS)

In the last 12 months, my health insurance company...	2022 (%)	2015 (%)
Any negative experiences	26	N/A[16]
For those seeking specific coverage		
Only covered some of my transition-related surgical care	45	42
Denied me other transition-related medical care	23	N/A
Denied me transition-related surgery	20	55
Covers surgery but didn't have any in-network providers	17	21
Wouldn't change my records to list current gender	16	N/A
Wouldn't change my records to list my current name	12	17
Denied me transition-related hormone therapy	11	25
Denied me gender-specific healthcare because I am trans	5	13
Denied me routine healthcare because I am trans	3	7

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. For example, only those seeking transition-related surgical care received questions regarding health insurance coverage for surgical care. The sample sizes for the corresponding responses can be found in the endnotes.[17]

For example, of those seeking surgery, 20% were denied transition-related surgery compared to 55% in 2015; of those seeking to change their name, 12% had insurance that wouldn't change records to list their current name compared to 17% in 2015; and of those seeking hormone therapy, 11% were denied hormone therapy compared to 25% in 2015. One notable exception to this trend was partial coverage for procedures—45% of respondents had only some of their procedures covered by their health insurance in 2022, which is 3 percentage points higher than in the 2015 USTS (42%).

Health insurance denials varied by insurance type (Table 1.9). A quarter of the sample was on Medicaid and respondents on Medicaid had the highest prevalences of hormone therapy denials compared to other insurance types. This trend is consistent with the 2015 USTS and suggests that respondents living in poverty have the lowest access to critical gender-affirming care. In contrast, for transition-related surgery, the pattern is less clear—respondents on Medicaid and Medicare had the lowest prevalences of denial for such care (Table 1.10).

Table 1.9

Respondents Denied Hormone Therapy in the 12 Months Prior to the Survey, by Type of Health Insurance
(2022 and 2015 USTS, n = 38,814)

Insurance Type	2022 (%)	2015 (%)
Overall	11	25
Medicaid only	14	29
Private only	11	26
Other	10	20
Multiple	9	21
Medicare only	7	14

Table 1.10

Respondents Denied Transition-related Surgery in the 12 Months Prior to the Survey, by Type of Health Insurance (2022 and 2015 USTS, n = 22,285)

Insurance Type	2022 (%)	2015 (%)
Overall	20	55
Medicaid only	35	55
Private only	22	54
Other	19	55
Multiple	18	55
Medicare only	15	48

Denials for both hormone therapy and transition-related surgery in 2022 occurred less frequently than in the 2015 USTS. However, differences by gender persist, highlighting disparities in access to gender-affirming care (Table 1.11). In 2022, AFAB nonbinary respondents and trans men faced the highest shares of hormone therapy denials at 14% and 13%, respectively, followed by trans women (9%), AMAB nonbinary people (8%) and crossdressers (8%) (Table 1.11).

Table 1.11

Respondents Denied Hormone Therapy in the 12 Months Prior to the Survey, by Gender
(2022 and 2015 USTS, n = 38,814)

Gender	2022 (%)	2015 (%)
AFAB Nonbinary	14	36
Trans Men	13	32
Trans Women	9	18
Crossdresser	8	N/A
AMAB Nonbinary	8	16

Trans women (21%) and trans men (19%) reported the highest shares of transition-related surgery denials (Table 1.12).

Table 1.12

Respondents Denied Transition-related Surgery in the 12 Months Prior to the Survey, by Gender

(2022 and 2015 USTS, n = 22,285)

Gender	2022 (%)	2015 (%)
Trans Women	21	54
Trans Men	19	57
AMAB Nonbinary	17	35
AFAB Nonbinary	17	49
Crossdresser	6	N/A

COVID-19

Transgender and nonbinary individuals experienced significant impacts from the COVID-19 pandemic beginning in 2020. This section explores their experiences during that time, including COVID infection and vaccine uptake and disruptions to routine and gender-affirming healthcare. Additionally, many transgender and nonbinary people experienced expanded access to online healthcare.

COVID Infection and Vaccine Uptake

When surveyed in the Fall of 2022, 45% of USTS respondents reported they had contracted COVID at least once (Table 1.13). This estimate is notably lower than the general population. The CDC estimates that 68% of the U.S. had COVID at least once by the end of 2022.[18]

A majority of respondents (92%) received at least one dose of a COVID-19 vaccine by the time of the survey (Table 1.13), a substantially higher uptake than

Table 1.13

COVID-19 Infection and Vaccination Insights

Insights	USTS Respondents (%)
Diagnosed with or tested positive for COVID-19	45
Received at least one dose of a COVID-19 vaccine?	92
Have not received the vaccine but plan to	3
Unvaccinated and concerned about the side effects and safety of the vaccine	3

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[19]

the general population at that time (81%)[19]. Among respondents who had not yet been vaccinated, about a third—approximately 3% of overall respondents—had intentions to be vaccinated. Among those who did not plan to get vaccinated, or who weren't sure, (3% don't plan to, 2% are unsure) the most common reason was concern about the vaccine's safety or side effects (64% of the unvaccinated, or about 3% of overall respondents).

COVID-era Healthcare Delays

Half (50%) of trans and nonbinary people who took the survey delayed or did not receive at least one form of healthcare because of the pandemic. Respondents delayed or missed routine healthcare (e.g., annual physical exams or care for chronic conditions) (34%) at higher shares compared to other forms of healthcare. Close to a quarter (24%) reported delaying or not receiving counseling or therapy, 14% delayed or did not receive hormone therapy, and 10% delayed or did not receive gender-affirming surgery because of the pandemic

(Figure 1.14). Respondents who identified as having a disability were more likely to experience at least one kind of delayed, or unreceived, care than those without a disability (59% vs. 44%, respectively) (Figure 1.15).

Figure 1.14

Kinds of Delayed or Missed Healthcare (n = 81,533)

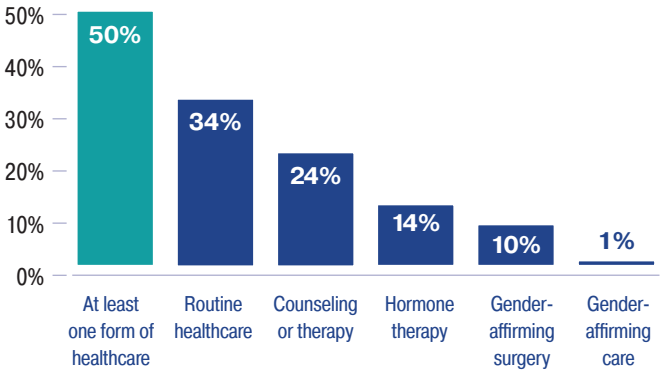
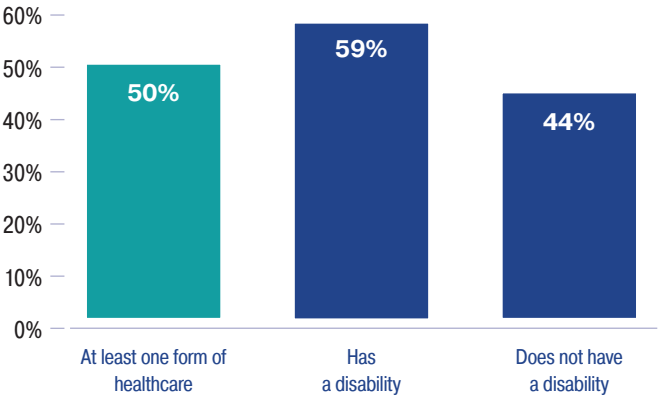


Figure 1.15

Delayed or Missed Healthcare, by Disability Status (n = 81,386)

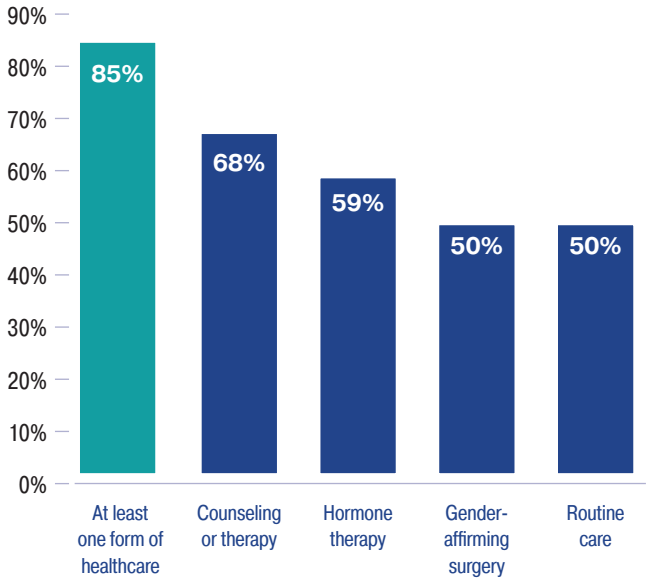


Desires for Telehealthcare

The COVID pandemic necessitated increased usage of online and telephone healthcare, often referred to as telehealth or telemedicine, across a wide variety of specialties. Our survey asked respondents what kinds of telehealth they would like access to. Over 85% of our respondents wanted remote options for one or more types of healthcare; the most mentioned was counseling and therapy (68% of respondents), followed by hormone therapy (59%), appointments related to gender-affirming surgery (50%), and routine health visits (50%) (Figure 1.16).

Figure 1.16

Kinds of Telehealth Desired (n = 82,760)



CONCLUSION

Access to quality healthcare is critical to one's wellbeing, yet transgender and nonbinary individuals often face significant disparities in both health outcomes and access to care. This chapter examined self-reported health status, barriers to accessing medical services, interactions with healthcare providers, health insurance coverage, and the impact of the COVID-19 pandemic on healthcare access.

Our findings highlight that trans and nonbinary respondents reported poorer general health compared to the U.S. general adult population. Self-rated health varied by age, familial support, and transition status, with younger respondents, those without familial support, and those who had not transitioned reporting poorer self-rated health.

Barriers to healthcare access remain a persistent challenge. Although the 2015 and 2022 USTS were different cross-sectional samples, financial barriers were slightly lower in 2022 compared 2015; however, nearly 3 in 10 respondents (28%) avoided seeking medical care due to cost, with disproportionately higher shares among American Indians and Alaska Natives. In addition, nearly one in four respondents (24%) reported avoiding care due to fear of mistreatment or discrimination for being trans, a concern that remains unchanged from the 2015 USTS.

While 50% of 2022 USTS respondents reported that their providers were aware of their transgender status and 73% of 2022 USTS respondents reported their providers treated them with respect, nearly half (47%) reported at least one negative healthcare interaction. Misgendering, lack of provider knowledge regarding providing healthcare to trans people, and inappropriate questioning were among the most common negative interactions reported, and trans men and AFAB nonbinary individuals reported the highest prevalences of mistreatment.

Health insurance coverage was similar when comparing the 2015 and 2022 surveys, with 87% of respondents reporting they were insured at the time of the survey—a share lower than the general U.S. population (92%). Medicaid enrollment among USTS respondents was significantly higher than the general population, reflecting a potentially higher prevalence of poverty in the USTS sample. Despite greater health insurance access in 2022 compared to 2015, 26% of insured respondents reported insurance-related discrimination, including denied claims for transition-related medical care.

The COVID-19 pandemic impacted transgender and nonbinary individuals' ability to access necessary care. At the time of the survey, half (50%) of respondents delayed or missed medical care due to the pandemic, particularly routine checkups and mental health services. However, 85% of respondents expressed a desire for virtual care options, especially for therapy and hormone treatment.

This chapter underscores that transgender and nonbinary individuals face significant disparities in health and access to care. As such, policies and programs that improve healthcare access, reduce health disparities, and ensure equitable treatment for transgender and nonbinary people are critically needed. Continued efforts to address financial, systemic, and social barriers to care remain necessary.

1. Kcomt, L., Gorey, K. M., Barrett, B. J., & McCabe, S. E. (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM - Population Health*, 11(11), 100608. https://doi.org/10.1016/j.ssmph.2020.100608.
2. Centers for Disease Control and Prevention. (2025, April 29). COVID data tracker. U.S. Department of Health and Human Services. https://covid.cdc.gov/covid-data-tracker

3. Miller, G. H., Marquez-Velarde, G., Mills, A. R., Hernandez, S. M., Brown, L. E., Mustafa, M., & Shircliff, J. E. (2023). Patients' perceived level of clinician knowledge of transgender healthcare, self-rated health, and psychological distress among transgender adults. JAMA network open, 6(5), e2315083-e2315083.

4. The self-reported health scale asks respondents if their general health is "excellent," "very good," "good," "fair," or "poor."

   Centers for Disease Control and Prevention (CDC). (2023). *Behavioral Risk Factor Surveillance System survey data*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

5. Centers for Disease Control and Prevention (CDC). (2023). *Behavioral Risk Factor Surveillance System survey data*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/annual_data/annual_2022.html

6. Transition status is split into two categories: social transition and medical transition. Social transition refers to steps like adopting a new name, pronouns, and clothing style. Medical transition refers to the medical interventions individuals take to align themselves with their gender identity, such as hormone therapy or surgeries.

7. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey* (p. 98). Washington, DC: National Center for Transgender Equality.

8. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey* (p. 98). Washington, DC: National Center for Transgender Equality.

9. The 2015 USTS Main Report provides a total of "one or more negative experiences" with a healthcare provider. We leave this number out here because it's not direclty comparable to 2022 data. For example, the 2015 USTS did not ask about whether a doctor or other healthcare provider called the respondent by the wrong name or pronouns.

10. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - One or more negative experience (n = 67,792)
      A doctor or other healthcare provider called me by the wrong name or pronouns (such as he or she) (n = 67,731)
    - I had to teach my doctor or other healthcare provider about trans people so that I could get appropriate care (n = 67,775)
    - My doctor or other healthcare provider asked me unnecessary/invasive questions about my trans status that were not related to the reason for my visit (n = 67,719)
    - A doctor or other healthcare provider refused to give me transition-related care (n = 67,740)
    - A doctor or other healthcare provider used harsh or abusive language when treating me (n = 67,749)
    - I was verbally harassed in a healthcare setting (such as a hospital, office, clinic) (n = 63,348)
    - A doctor or other healthcare provider refused to give me other healthcare (such as for like physicals, flu, diabetes) (n = 67,758)
    - A doctor or other healthcare provider was physically rough or abusive when treating me (n = 63,351)
    - I was physically attacked by someone during my visit in a healthcare setting (such as a hospital, office, clinic) (n = 63,353)
    - I experienced unwanted sexual contact in a healthcare setting (such as a hospital, office, clinic) (n = 63,325)

11. The survey asked respondents if they identified as a disabled person or a person with a disability.

12. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey* (p. 94). Washington, DC: National Center for Transgender Equality.

13. Kiesler-Starkey, K., Bunch, L. N., & Lindstrom, R. A. (2023). Health insurance coverage in the United States: 2022 (Report No. P60-281). U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf

14. Kiesler-Starkey, K., Bunch, L. N., & Lindstrom, R. A. (2023). Health insurance coverage in the United States: 2022 (Report No. P60-281). U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf

15. Kiesler-Starky, Bunch, and Lindstrom (2023) consider people uninsured if they only had coverage through Indian Health Services (IHS) because IHS coverage is not comprehensive.

16. James, et al (2016) reports "any negative experiences" with health insurance coverage; however, we leave this number out here as it is not directly comparable to the 2022 numbers—the 2015 USTS did not ask respondents about being "denied other transition-related medical care" or "wouldn't change my records to list current gender."

17. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - Any negative experiences (n = 76,416)
    - Only covered some of my transition-related surgical care (n = 25,180)
    - Denied me other transition-related medical care (n = 19,983)
    - Denied me transition-related surgery (n = 22,285)

- Covers surgery but didn't have any in-network providers (n = 22,470)
- Wouldn't change my records to list current gender (n = 19,291)
- Wouldn't change my records to list my current name (n = 20,326)
- Denied me transition-related hormone therapy (n = 38,814)
- Denied me gender-specific healthcare because I am trans (n = 25,899)
- Denied me routine healthcare because I am trans (n = 40,126)

18. Centers for Disease Control and Prevention. (2025, April 29). COVID data tracker. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker

19. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - Diagnosed with or tested positive for COVID-19 (n = 84,126)
    - Received at least one dose of a COVID-19 vaccine (n = 84,123)
    - Have not received the vaccine but plan to (n = 84,123)
    - Unvaccinated and concerned about the side effects and safety of the vaccine (n = 84,102)

20. Centers for Disease Control and Prevention. (2025, April 29). COVID data tracker. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker

CHAPTER 2

Experiences with Transition-related Care

IN OUR OWN VOICES

"Trans medical care is medically necessary. Gender dysphoria is real. I went from being depressed for almost a decade to not being depressed for the past year since starting gender-confirming treatment in October 2022. It's dramatically impacted my work and personal life for the better. I'm happier, more productive, and more confident."

AYLEN
transgender man, Asian/Asian American

Age range: 41-64

"I have been through so much pain and sorrow in my journey as a trans person navigating the hellscape that is the healthcare system, and I vowed to myself and my trans siblings that I would do something about it. It took me over 3 years to find a top surgeon who would do my top surgery. My chest caused me such massive dysphoria I couldn't handle it and dozens of providers in my state turned me down because I had just slightly too high of a BMI. But now, I have worked my way up from the front desk in the hospital I work in, to creating trainings for entire departments that will soon move forward into massive trans/nonbinary education across an entire hospital system over the whole state. We've got a little task force of queers making massive changes. Oh, and that BMI requirement at our hospital system? We're getting that removed. Be the change you want to see. Do it for each other."

AIDEN
nonbinary, white

Age range: 25-40

"I was in a place where I needed to get surgery, finally. But I just couldn't afford it and the insurance companies wouldn't cover any of it. Being disabled, I was also on Medicare, which really didn't cover much.

Miraculously, the world changed. The Affordable Care Act went through, and the rules for insurance started changing. Eventually, Medicare even started covering some trans healthcare. In June of 2020, after almost fourteen years of transition, I had vaginoplasty. I was finally myself. Life was finally amazing!"

HILLARY
transgender woman, white

Age range: 25-40

"When I finally came out, my healthcare provider was one of my biggest supporters. She has treated me as a female and has made sure I have received all of the preventative women's health care afforded to me. She has been quite the inspiration and support that any woman would want. After my orchiectomy, she made sure that all my medication was correct for me to achieve my goals. She also is a very good listener and directs me to the other professionals I need. I strongly believe she is responsible for me being here today."

ANNA
transgender woman, white

Age range: 41-64

INTRODUCTION

This chapter examines access to and experiences with transition-related healthcare. Transitioning is a highly individualized process that may involve social, legal, and medical changes, such as adopting a new appearance, updating identity documents, or undergoing hormone therapy and surgeries. Many members of the community may not conceptualize their individual experiences with these forms of care as a "transition," but we use the term to describe access to medical interventions for the purposes of affirming one's gender identity. While some pursue many forms of transition, others make selective changes based on their needs, circumstances, and goals. This chapter focuses on medical transitioning, such as having access to hormones and undergoing surgery.

Access to competent, affirming healthcare providers is crucial for trans individuals' wellbeing, yet systemic obstacles persist, including provider inexperience and long travel distances. This chapter explores how trans individuals navigate hormone therapy, surgeries, and routine health services, and addresses provider expertise with transition-related healthcare, appointment accessibility, travel burdens, and the impact of medical transition on life satisfaction.

Key Findings

Provider Knowledge and Care Accessibility

- Nineteen percent (19%) of respondents saw the same provider for both transition-related and routine healthcare, compared to 51% in 2015. Thirty-nine percent (39%) had a different provider for routine care, greater than 33% in 2015. Forty-two percent (42%) of 2022 respondents reported they did not receive any routine healthcare.
- Fifty-seven percent (57%) of respondents had a dedicated transition-related healthcare provider, compared to 44% in 2015.
- Of those who had a transition-related healthcare provider, 77% of respondents indicated that their transition-related healthcare provider knew almost everything or most things about providing care for trans people.
- Only 8% of respondents who received routine care from a provider different than their transition-related healthcare provider said their routine healthcare provider knew almost everything or most things about trans healthcare.
- Respondents were twice as likely to travel more than 50 miles for transition-related care than for routine care (11% in 2022 vs. 5% in 2015).

Transition-related Healthcare

- Over half of the respondents (60%) reported undergoing some form of medical transition, including hormones or surgeries.
- Eighty-eight percent (88%) of respondents expressed a desire for gender-affirming hormone therapy (GAHT), but only 56% reported ever receiving hormone therapy.
- Among those who have started hormone therapy, 90% were currently taking hormones, indicating a high prevalence of continuation.
- Twenty-nine percent (29%) of respondents reported receipt of at least one gender-affirming surgery.

- Ninety-eight percent (98%) of respondents taking GAHT reported that taking GAHT made them more satisfied with their lives, and 97% of respondents who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives.

Continuity of Transition

- All respondents currently identified as trans and nonbinary, but 9% had gone back to living as their sex assigned at birth at least for a little while at some point in their lives due to challenges related to social acceptance.
- Respondents primarily reported social and structural reasons for living as their sex assigned at birth. For example, the most common reason was that it was "just too hard to be transgender in [their] community." Other common reasons included pressure from a parent and experiencing too much harassment or discrimination.
- Of all respondents who had medically transitioned, only 0.36% went back to living in their sex assigned at birth at least for a while because gender transition was not for them.

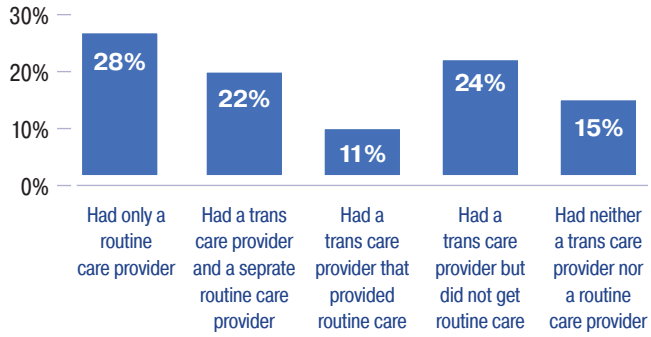
Provider Knowledge and Care Accessibility

Access to both transition-related and routine care is essential for supporting the overall health and wellbeing of transgender and nonbinary individuals. Provider expertise in trans healthcare is also a critical factor in ensuring competent and affirming medical treatment for transgender individuals. Data from the U.S. Transgender Survey (USTS) highlight that a majority of respondents had a dedicated transition-related healthcare provider; however, findings show significant gaps in provider knowledge about trans people, both in transition-related and routine healthcare settings.

Figure 2.1 describes where respondents received their routine care (e.g., care for physicals, diabetes, flu, etc.), highlighting the types of healthcare settings and providers most accessed. Most commonly (28%), respondents only had access to a routine care provider. Eleven percent (11%) of respondents received their routine care from their transition-related healthcare provider. More common, however, was to have neither a transition-related nor routine care provider (15%).

Figure 2.1

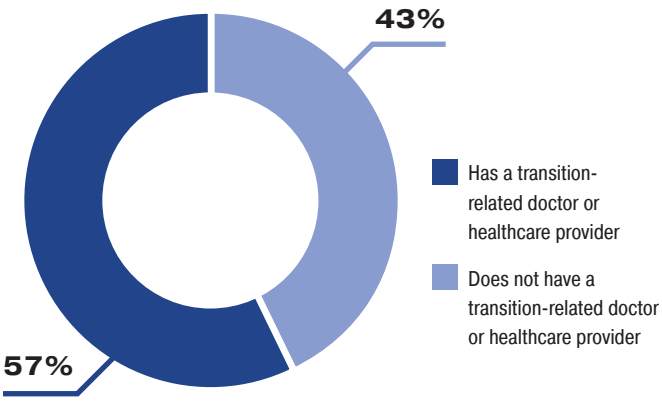
Provider Access Among USTS Respondents (n = 83,433)



The survey asked respondents if they go to a specific healthcare provider for their transition-related healthcare. Forty-three percent (43%) did not have a dedicated transition-related healthcare provider (Figure 2.2), compared to 56% in the 2015 USTS.[1]

Figure 2.2

Respondents with a Specific Transition-related Healthcare Provider (n = 83,882)



Of those who reported having a transition-related healthcare provider, 77% indicated that their transition-related healthcare provider knew almost everything or most things about providing healthcare for trans people (Table 2.1). Smaller percentages said their providers had only some (13%) or almost no (3%) knowledge.

Table 2.1

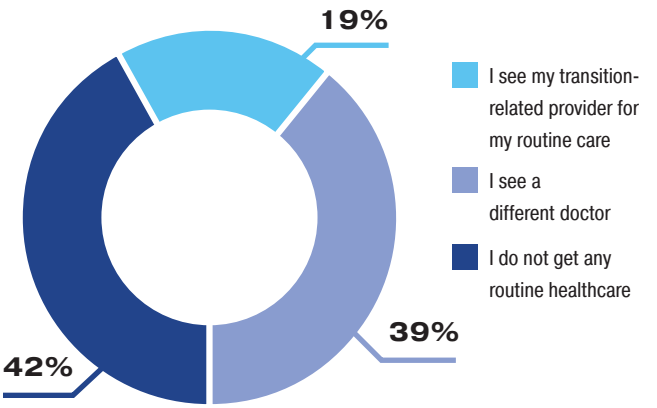
Respondents Evaluation of Transition-related Healthcare Providers' Knowledge of Trans Healthcare (n = 49,107)

Provider knew...	Percent
Almost everything about trans healthcare	46
Most things about trans healthcare	31
Some things about trans healthcare	13
Almost nothing about trans healthcare	3
Unsure of provider's knowledge	8

As seen in Figure 2.3, of those who had a transition-related healthcare provider, 19% of respondents reported that they saw the same provider for transition-related care and other routine healthcare (e.g., physicals, flu, diabetes, etc.), notably lower than the 51% in the 2015 USTS.[2] Over a third (39%) had a different provider for routine care than the provider they saw for transition-related care, higher than in the 2015 USTS (33%).[3] Forty-two percent (42%) reported not receiving any routine healthcare.

Figure 2.3

Use of Transition-related Healthcare Providers for Routine Medical Care (n = 48,719)



Of those with a transition-related healthcare provider, over a third of respondents (39%) either had a separate provider for routine healthcare like physicals, flu, or diabetes or only had a routine healthcare provider (Figure 2.3). Among these respondents, 40% reported that their routine healthcare provider knew some or almost nothing about healthcare for trans people, and nearly half (48%) of respondents said they were unsure of that providers knowledge regarding trans people (Table 2.2).

Table 2.2

Respondents' Evaluation of Routine Healthcare Providers' Knowledge of Trans Healthcare (n = 41,405)

Provider knew...	Percent
Almost everything about trans healthcare	3
Most things about trans healthcare	8
Some things about trans healthcare	24
Almost nothing about trans healthcare	16
Unsure of provider's knowledge	48

Accessibility

To examine the geographic accessibility of respondents' healthcare providers, respondents were asked how far they had to travel to receive routine care and care related to gender transition. Most (80%) respondents saw their transition-related healthcare provider in person (Table 2.3). Moreover, these respondents traveled further for transition-related care than routine care. Less than half (44%) received their transition-related healthcare within 10 miles of their home, but 58% received routine care from providers within 10 miles of their home (Figure 2.4).

Table 2.3

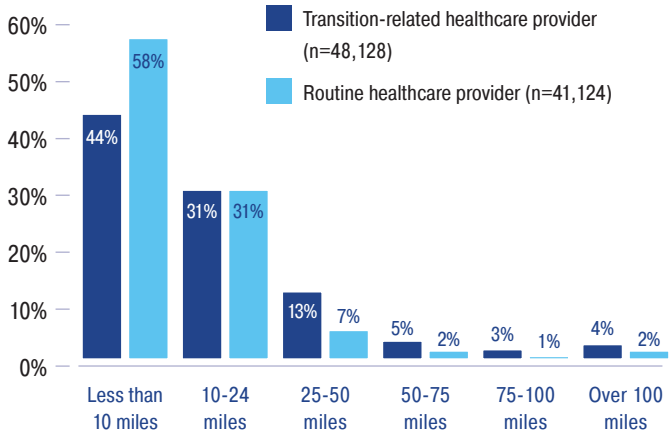
Format of Appointment with Transition-related Healthcare Provider (In-Person, Online, Or Phone) (n = 48,128)

Format	Percent
In-Person	80
Online	49
Phone	23

Note: Percents sum to greater than 100% because respondents could select multiple responses.

Figure 2.4

Distance Traveled for Transition-related and Routine Healthcare



Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items: 48,128 respondents for the question on transition-related healthcare and 41,125 respondents for the question on routine medical care

Transition-related Healthcare

The survey asked respondents whether they had or wanted to have a range of potential healthcare services related to gender transition. Here, we discuss gender-affirming hormone therapy and surgical procedures. Further, we discuss satisfaction with transition-related healthcare.

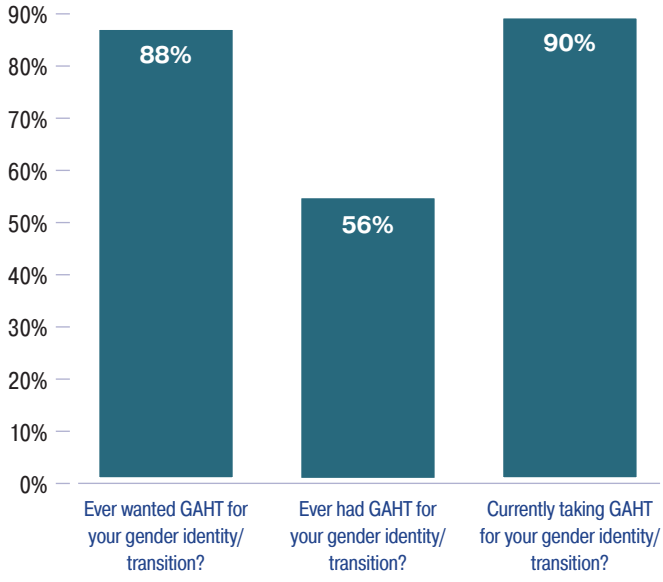
Gender-affirming Hormone Therapy

Gender-affirming hormone therapy (GAHT) is a medical treatment that involves taking hormones to align an individual's physical characteristics with their gender identity. For transgender women and transfeminine individuals, GAHT typically includes estrogens and anti-androgenic medications to promote feminizing effects, such as breast development and reduced body hair. For transgender men and transmasculine individuals, GAHT usually consists of testosterone to induce masculinizing changes, such as deepened voice, facial hair growth, and increased muscle mass. It is important to note that the paths of care may vary among individuals based on their goals. GAHT plays a vital role in gender-affirming care, helping many trans individuals feel more comfortable in their bodies.

Roughly 88% of adult USTS respondents wanted GAHT at some point in their lives, but there was a substantial gap with those who received GAHT, with only 56% having had GAHT (Figure 2.5).

Figure 2.5

Gender-affirming Hormone Therapy (GAHT) Desire and Usage



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[4]

Among those who have had GAHT, 90% were currently taking hormones at the time of the survey, suggesting that those who begin hormones usually continue to use them.

Surgeries and Other Procedures

Respondents were asked a series of questions about whether they had received or wanted to have specific surgical and other procedures, separate from gender-affirming hormone therapy. Respondents selected if they wanted to receive questions about procedures or surgeries for those assigned female at birth (such as chest surgery or metoidioplasty) or questions about procedures or surgeries for those assigned male at birth (such as breast augmentation or vaginoplasty). Respondents who indicated they were born with a variation in physical sex characteristics or described themselves as intersex were able to select either set of questions or a third option that included questions about both types of procedures and surgeries. Eighty-four percent (84%) of respondents indicated that they desired one or more transition-related procedures or surgeries, separate from gender-affirming hormone therapy. Thirty-one percent (31%) reported receiving one or more of these procedures or surgeries.

Experiences of Respondents Assigned Female at Birth

The data on gender-affirming procedures for individuals assigned female at birth (AFAB) highlight varying levels of interest and access across different interventions (Table 2.4). Top surgery, also known as surgical chest reconstruction, was the most commonly sought-after procedure type. Fifty-seven percent (57%) expressed interest and 20% had already undergone it, indicating both high demand

Table 2.4

Procedures or Surgeries for Those Assigned Female at Birth

Type of Procedure	Had it but not for gender identity/ transition	Have had it	Want it some day	Not sure if I want this	Do not want this
Top/chest surgery reduction or reconstruction	1%	20%	57%	15%	8%
Hysterectomy/"hysto" (removal of the uterus, ovaries, fallopian tubes, and/or cervix)	2%	6%	51%	28%	13%
Metoidioplasty/"meta" (clitoral release)	<1%	1%	13%	42%	45%
Phalloplasty/"phallo" (creation of a penis)	<1%	1%	11%	31%	57%
Laser hair removal/electrolysis	1%	1%	10%	21%	67%
Testicular implants	<1%	1%	10%	27%	63%
Vaginectomy (removal of the vagina)	<1%	1%	9%	28%	62%
Voice therapy (non-surgical)	<1%	2%	37%	29%	31%
Voice surgery	<1%	1%	5%	31%	64%

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[5]

and relatively greater access compared to other procedures. AFAB respondents also widely desired hysterectomies—51% of respondents wanted it. Yet only 6% had a hysterectomy, suggesting potential barriers to accessing the procedure. In contrast, fewer respondents reported interest in metoidioplasty (13%), phalloplasty (11%), vaginectomy (9%), and testicular implants (10%), with a majority of respondents either unsure or uninterested in these procedures. AFAB respondents wanted surgical voice modification at the lowest prevalence compared to other procedures. Only 5% expressed interest and less than 1% had undergone vocal surgery. Non-surgical voice therapy was more commonly desired (37%), though only 2% had received it. Notably, nearly two-thirds (67%) of AFAB respondents did not want laser hair removal. Overall, the data suggest that while certain gender-affirming procedures, particularly top surgery and hysterectomy, were in high demand, a smaller share reported interest in other procedures. Further, there were significant gaps between those who wanted care and those who had received it.

Access to gender-affirming care (GAC) varied across gender identity when comparing trans men to AFAB nonbinary individuals (Table 2.5). For example, both groups highly desired top surgery; however, trans men were significantly more likely to have already undergone the procedure (32%) compared to AFAB nonbinary individuals (10%). Both groups also showed interest in hysterectomies, though access again differed, as 10% of trans men had undergone a hysterectomy, while only 2% of AFAB nonbinary individuals had. Overall, this indicates that while transgender men and AFAB nonbinary individuals often seek similar forms of care, nonbinary individuals experience a larger gap between desiring a procedure and receiving it, possibly due to systemic barriers or variations in how medical providers approach nonbinary transition-related care.

Table 2.5

AFAB Transition-related Care Access, by Gender

Type of Procedure	Trans men		AFAB Nonbinary Individuals	
	Desired Care	Received Care	Desired Care	Received Care
Top/chest surgery	62%	32%	52%	10%
Hysterectomy	55%	10%	47%	2%
Metoidioplasty	21%	1%	6%	<1%
Phalloplasty	19%	1%	5%	<1%
Vaginectomy	16%	2%	3%	<1%
Testicular implants	19%	1%	2%	<1%
Voice surgery	7%	0%	4%	<1%
Voice therapy	39%	3%	35%	2%
Laser hair removal/electrolysis	7%	1%	14%	1%

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[6]

Experiences of Respondents Assigned Male at Birth

The data on gender-affirming procedures for individuals assigned male at birth (AMAB) reveal varying levels of interest and access across different interventions (Table 2.6). AMAB individuals pursued laser hair removal most commonly. Thirty-four percent (34%) had laser hair removal or electrolysis and 55% wanted it in the future. Forty-two percent (42%) of AMAB individuals wanted vaginoplasty and orchiectomy, but there was a substantial gap between interest and access—only 9% and 11% had these surgeries respectively. The sample showed moderate interest in facial surgery and top surgery/breast augmentation (41% and 36%, respectively), but low prevalences of completion (5% and 8%, respectively). Fewer respondents wanted silicone injections (11%) and tracheal shaves (28%), and the majority were unsure if they wanted or did not want these procedures. AMAB individuals wanted voice therapy at higher prevalences than voice surgery (56% vs. 22%). Notably, 16% already had voice therapy and only 1% had voice surgery. Overall, these findings indicate that the 2022 USTS sample desired many procedures at high prevalences, though there was a gap between desire and accessing these procedures. When

Table 2.6

Procedures or Surgeries for Those Assigned Male at Birth (AMAB) (n = 31,045)

Type of Procedure	Had it but not for gender identity/ transition	Have had it	Want it some day	Not sure if I want this	Do not want this
Laser Hair Removal/Electrolysis	1%	34%	55%	6%	4%
Vaginoplasty/Labiaplasty/SRS/GRS	<1%	9%	42%	27%	21%
Orchiectomy/"Orchi" (Removal of Testes)	<1%	11%	42%	25%	21%
Facial Surgery (Such as Nose, Brow, Chin, Cheek)	<1%	5%	41%	33%	21%
Top Surgery/Breast Augmentation	<1%	8%	36%	36%	20%
Tracheal Shave (Adam's Apple or Thyroid Cartilage Reduction)	1%	3%	28%	36%	33%
Silicone Injections	<1%	2%	11%	37%	51%
Voice Therapy (Non-Surgical)	<1%	16%	56%	16%	11%
Voice Surgery	<1%	1%	22%	39%	37%

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[7]

comparing across gender, some similarities exist between transgender women and AMAB nonbinary individuals in their desires for certain procedures (Table 2.7). For instance, both groups wanted laser hair removal at high prevalences (54% of trans women and 58% of AMAB nonbinary individuals). However, transgender women were far more likely to have undergone the procedure (40%) compared to AMAB nonbinary individuals (15%), suggesting a greater gap between desire and access. In contrast, desires for surgical procedures diverge between trans women and AMAB nonbinary respondents. Trans women wanted vaginoplasty at much higher prevalences than AMAB nonbinary individuals (48% vs. 17%), and a substantially larger percentage of trans women already had the procedure (11% vs. 1%). These findings highlight that gender-affirming needs are not uniform across gender identity.

Table 2.7

Gender-Affirming Care Access for those Assigned Male at Birth (AMAB), by Gender

Type of Procedure	Trans women		AMAB Nonbinary Individuals	
	Desired Care	Received Care	Desired Care	Received Care
Laser Hair Removal/Electrolysis	54%	40%	58%	15%
Top Surgery/Breast Augmentation	39%	10%	20%	1%
Silicone Injections	12%	2%	4%	1%
Vaginoplasty	48%	11%	17%	1%
Orchiectomy	47%	13%	25%	2%
Tracheal Shave	45%	7%	23%	1%
Facial Surgery	39%	10%	20%	1%
Voice Surgery	58%	19%	47%	6%
Voice Therapy	54%	40%	58%	15%

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[8]

Life Satisfaction

Chapter 5 discusses general life satisfaction. Thirty-seven percent (37%) of respondents reported being overall satisfied with their lives, while the majority (59%) expressed varying levels of dissatisfaction. Four percent (4%) of respondents felt neutral. In this section, we explore how transition-related care may impact life satisfaction. The survey asked respondents if gender-affirming care, including gender-affirming hormone therapy (GAHT) and surgeries, made them more satisfied with their lives. Gender-affirming care appears to have a profoundly positive impact on life satisfaction for transgender individuals. Ninety-eight percent (98%) of respondents taking GAHT reported that taking GAHT made them more satisfied with their lives (Table 2.8). Similarly, 97% of respondents who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives (Table 2.8). A very small percentage of respondents reported no change or a decrease in satisfaction, highlighting the overwhelmingly positive effects of gender-affirming medical care.

Table 2.8

Association Between Transition-related Care and Life Satisfaction

Has receiving transition-related care made you more or less satisfied with your life?	Gender-Affirming Care	
	GAHT	Transition-related surgery
A lot more satisfied	84%	88%
A little more satisfied	14%	9%
Neither more nor less satisfied	1%	1%
A little less satisfied	<1%	<1%
A lot less satisfied	<1%	<1%

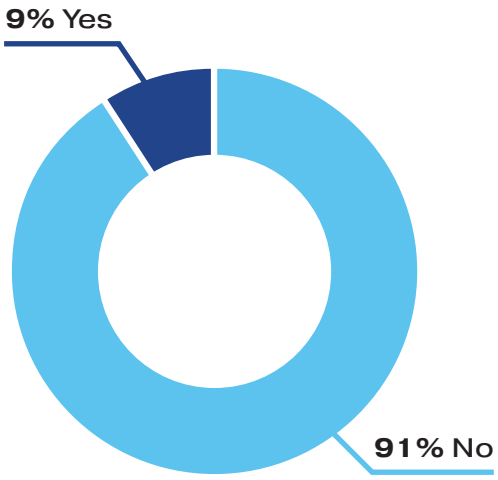
Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items: GAHT (n = 43,334) and transition-related surgery (n = 18,686).

Continuity of Transition

At the time of the survey, all respondents identified as trans or nonbinary, but the survey asked if respondents had "ever gone back to living as [their] sex assigned at birth, at least for a while"? Of respondents who had transitioned, 9% had gone back to living as their sex assigned at birth at some point in their lives, predominantly due to social and structural stigma (Figure 2.6, table 2.9).

Figure 2.6

Have You Gone Back to Living As Your Sex Assigned at Birth at Least for a While?
(n = 64,843)



Social and structural explanations dominated the reasons why respondents reported going back to living in their sex assigned at birth at some point (Table 2.9). Among the 9% of respondents who had ever gone back to living in their sex assigned at birth for a period, the most common reason was that it was "just too hard to be trans in my community" (41%). Pressure from respondents' relationships figured prominently as well—37% cited pressure from a parent, 24% cited pressure from other family members, 16% from a spouse or partner, 14% from friends, 9% from an employer, 8% from a religious counselor or leader, and 4% from a mental health professional. Further, a third (33%) of those who went back to living as their sex assigned at birth for a period of time did so because they faced too much harassment and discrimination for being trans. Taken together, 82% of those who went back to living as their sex assigned at birth at least for a little while did so because of social and structural factors that made it difficult to be trans in their community. Only 4% of people who went back to living in their sex assigned at birth for a while cited that their reason was because they realized that gender transition was not for them. When considering all respondents who had transitioned, this number equates to only 0.36%.

Table 2.9

Reasons for Living in Respondents' Sex Assigned At Birth (SAAB) at Least for a Little While (n = 4,880)

Reason	Went back to SAAB (%)	Transitioned (%)
It was just too hard for me to be trans in my community	41	3.69
Pressure from a parent	37	3.28
I faced too much harassment/ discrimination	33	2.95
I thought my dysphoria would get better, but it did not	29	2.61
I couldn't afford transition-related healthcare or other transition-related expenses	28	2.50
Pressure from other family members	24	2.16
Pressure from spouse or partner	16	1.45
Pressure from friends	14	1.23
I had trouble getting a job	14	1.23
Pressure from my employer	9	0.82
Pressure from a religious counselor or leader	8	0.68
Medical reasons	7	0.63
Pressure from a mental health professional	4	0.37
I realized that gender transition was not for me	4	0.36

CONCLUSION

Access to competent, affirming healthcare is essential for the wellbeing of transgender individuals, yet significant barriers persist. This chapter highlighted gaps in provider knowledge, challenges in accessing gender-affirming treatments, and disparities in routine healthcare for trans individuals. Gender-affirming hormone therapy and surgeries improve life satisfaction, yet many who seek these treatments face obstacles such as financial constraints, provider inexperience, and long travel distances. All respondents identified as trans and nonbinary at the time of the survey, yet some went back to living as their sex assigned at birth at least for a little while at some point in their lives. The data reveal that external pressures—such as discrimination, harassment, and lack of community support—are more prevalent determinants of living in their sex assigned at birth than personal identity challenges such as realizing that gender transition was not for them.

1. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 97). National Center for Transgender Equality.
2. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 97). National Center for Transgender Equality.
3. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 97). National Center for Transgender Equality.
4. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
   - Ever wanted GAHT (n = 84,011)
   - Ever had GAHT (n = 84,011)
   - Currently taking GAHT (n = 47,088)

5. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

   - Top/chest surgery reduction or reconstruction (n = 51,127)
   - Hysterectomy (removal of the uterus, ovaries, fallopian tubes, and/or cervix) (n = 51,101)
   - Metoidioplasty/"meta" (clitoral release) (n = 51,021)
   - Phalloplasty/"phallo" (creation of a penis) (n = 51,076)
   - Laser hair removal/electrolysis (n = 51,063)
   - Testicular implants (n = 51,083)
   - Vaginectomy (removal of the vagina) (n = 51,070)
   - Voice therapy (non-surgical) (n = 51,076)
   - Voice surgery (n = 51,043)

6. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

   - Top/chest surgery reduction or reconstruction (trans man, n =20,872 & AFAB nonbinary n = 30,211)
   - Hysterectomy (removal of the uterus, ovaries, fallopian tubes, and/or cervix) (trans man, n = 20,820 & AFAB nonbinary n = 30,192)
   - Metoidioplasty/"meta" (clitoral release) (trans man, n = 20,776 & AFAB nonbinary n =30,156)
   - Phalloplasty/"phallo" (creation of a penis) (trans man, n = 20,810 & AFAB nonbinary n = 30,177)
   - Laser hair removal/electrolysis (trans man, n = 20,802 & AFAB nonbinary n = 30,172)
   - Testicular implants (trans man, n = 20,813 & AFAB nonbinary n = 30,181)
   - Vaginectomy (removal of the vagina) (trans man, n = 20,807 & AFAB nonbinary n = 30,174)
   - Voice therapy (non-surgical) (trans man, n = 20,803 & AFAB nonbinary n = 30,184)
   - Voice surgery (trans man, n = 20,785 & AFAB nonbinary n = 30,169)

7. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

   - Laser Hair Removal/Electrolysis (n = 31,526)
   - Vaginoplasty/Labiaplasty/SRS/GRS (n = 31,505)
   - Orchiectomy/"Orchi" (Removal of Testes) (n=31,391)
   - Facial Surgery (n = 31,479)
   - Top Surgery/Breast Augmentation (n = 31,517)
   - Tracheal Shave (n = 31,425)
   - Penectomy (Removal of All or Part of Penis) (n = 31,284)
   - Silicone Injections (n = 31,426)
   - Voice Therapy (Non-Surgical) (n = 31,487)
   - Voice Surgery (n = 31,698)

8. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

   - Laser Hair Removal/Electrolysis (trans women, n =23,784 & AMAB nonbinary n = 7,294)
   - Vaginoplasty/Labiaplasty/SRS/GRS (trans women, n = 23,767 & AMAB nonbinary n = 7,298)
   - Orchiectomy/"Orchi" (Removal of Testes) (trans women, n = 23,662& AMAB nonbinary n = 7,282)
   - Facial Surgery (trans women, n = 23,745 & AMAB nonbinary n = 7,284)
   - Top Surgery/Breast Augmentation (trans women, n = 23,776 & AMAB nonbinary n = 7,292)
   - Tracheal Shave (trans women, n = 23,698 & AMAB nonbinary n = 7,281)
   - Silicone Injections (trans women, n = 23,702 & AMAB nonbinary n = 7,279)
   - Voice Therapy (Non-Surgical) (trans women, n = 23,751 & AMAB nonbinary n = 7,287)
   - Voice Surgery (trans women, n = 23,725 & AMAB nonbinary n = 7,280)

CHAPTER 3

Sexual and Reproductive Health and HIV/AIDS

IN OUR OWN VOICES

"I was very lucky to have had a PCP who was accepting of my trans identity when I came out to her. She did her best to accommodate my preferred name and pronouns, and she did her best to provide me with appropriate care. After I began to medically transition using HRT, I saw my PCP, told her that I wanted an IUD, and that I needed a referral to a gynecologist. I was used to advocating for myself with medical professionals at this point. She looked at me, confused, and said 'Why would you want birth control?' I was shocked, because she knew I was born female. I said 'I still need some form of birth control. I don't want to get pregnant.'

She responded 'But testosterone makes it so that you can't get pregnant.' Now, I had done my research, like I so often must do when it comes to my healthcare. I knew that testosterone was not a form of birth control. I told my PCP this, and she was shocked, but believed me and referred me to the gynecologist. I will never forget that if I had trusted my doctor at that moment, it could have resulted in an unwanted pregnancy. We are supposed to be able to trust our doctors. But with any healthcare for a trans person, the patient is often forced to be a teacher."

CONRAD
nonbinary transgender man, white

Age range: 18-24

"I went to the emergency room with what I assumed was just a 'bad period.' I woke up, discovered my mattress was soaked in blood, and wondered if my IUD had punctured my uterus. I finally went to the emergency room and was treated with disrespect and discrimination by the hospital staff. After my ultrasound, the hospital essentially threw me out and told me it was my 'cross-sex hormones.' They neglected to tell me that the cause of the bleeding was in fact a perforated uterus. Through my discharge paperwork, I found out that I was also pregnant, and this was most likely a miscarriage. I came in holding a clot and begged them to biopsy it, but they refused. The reproductive healthcare systems fails our pregnant trans men, especially in traumatic instances such as miscarriages. "

JAVIER
nonbinary trans man, multiracial

Age range: 18-24

INTRODUCTION

Sexual and reproductive health is a crucial aspect of wellbeing, yet transgender and nonbinary people are often excluded from research, policy, and service delivery in this area. Historically, reproductive health frameworks have centered cisgender women, leaving significant gaps in understanding the reproductive needs, desires, and barriers experienced by trans and nonbinary people.

The 2022 U.S. Transgender Survey (USTS) was the first USTS to ask respondents comprehensive questions about their reproductive health experiences, including access to and use of birth control, reasons for not using or seeking it, and experiences with abortion services. These data offer new insight into how reproductive health intersects with gender identity and structural barriers. This chapter also explores HIV/AIDS testing, care, and prevention among respondents. Trans and nonbinary people often face heightened vulnerability to HIV/AIDS due to systemic inequities, social marginalization, and persistent gaps in access to culturally competent care. The survey included detailed questions about HIV testing history, care engagement, antiretroviral therapy (ART), and viral suppression, as well as awareness and use of HIV prevention tools like pre-exposure prophylaxis (PrEP). Respondents were also asked about testing locations, reasons for not being tested, and challenges in accessing care, allowing for comparisons with both the 2015 USTS and national population surveys.

This chapter presents a nuanced picture of sexual and reproductive health among trans and nonbinary respondents, with attention to both structural vulnerabilities and individual-level behaviors. The data reveal not only where disparities persist, but also where progress is being made.

Key Findings

Reproductive Health

- Respondents who asked to receive questions for individuals assigned female at birth received questions about birth control. Since they started to know themselves to be transgender or nonbinary, about half of respondents (44%) wanted birth control. Of those who wanted birth control more than half (56%) talked to providers about it, and once they talked to providers about it, most obtained it (88%).
- Respondents' primary reasons for not asking providers about birth control, despite wanting it, included being uncomfortable in women's health settings (29%), believing they would be mistreated because they are trans (23%), and the cost of provider visits and/or birth control (25%).
- Among respondents who did not want birth control, the primary reason was having a partner who cannot get them pregnant (62%).
- A small number of respondents needed or wanted abortion services (3%), and 7% of them had problems obtaining the necessary services, including not being able to find a trans-competent provider and not feeling welcome at the clinic because they are trans or nonbinary.

Intersection of Transition-related Care and Reproductive Health

- Over a third of respondents (35%) saw their transition-related healthcare provider for routine sexual and reproductive care, 22% sought care from a different provider, and 43% did not receive any routine reproductive healthcare.
- Over three-quarters of respondents (78%) had at least one healthcare provider discuss how gender-affirming treatments might impact their fertility, while 22% reported never having such discussions with a provider.

- Almost all (95%) of those who consulted a provider about hormones and 85% of those who saw a provider for transition-related surgery had fertility discussions.

HIV Testing, Care, and Prevention

- Transgender and nonbinary people were more likely to have tested for HIV compared to the general population in the U.S. (43% vs. 36%), and more trans/nonbinary people assigned male at birth tested for HIV compared to those assigned female at birth (51% of trans women, 46% of nonbinary individuals assigned male at birth [AMAB], 40% of trans men, and 36% of nonbinary individuals assigned female at birth [AFAB]).
- The percentage of respondents who were living with HIV was three times larger than the U.S. general population (1.1% vs. 0.3%).
- Transgender women had the highest prevalence of living with HIV (2.4%), with Black transgender women having 6 times higher prevalence than all transgender women (15.5%).

Reproductive Health

Reproductive health is an important aspect of health for transgender and nonbinary people. A recent review suggests that more transgender and nonbinary people are now openly accessing reproductive health services to either prevent pregnancy or to have children.[1] In one national study among transgender and nonbinary people assigned female or intersex at birth, 12% had been pregnant, and 21% of those pregnancies ended in abortion. Of all pregnancies, 54% had been unintended, and 3% of pregnancies occurred after initiating testosterone.[2] In another study of transgender men over 18, 34% were using birth control pills.[3]

The 2022 USTS asked questions about birth control and abortion access. The 2015 USTS did not include reproductive health questions, so no comparisons are made between 2015 and 2022 data; but, where relevant, data are compared to the U.S. population.

Birth Control

The survey asked respondents whether they would like to receive questions for individuals assigned female at birth, male at birth, or both sets of questions. The survey gave questions regarding birth control to respondents who chose questions for those assigned female at birth or both.

First, the survey asked if respondents accessed birth control (such as pills, a patch, or an intrauterine device [IUD]) to prevent pregnancy since they began knowing themselves to be trans or nonbinary (Table 3.1).

Forty-four percent (44%) wanted birth control since they began thinking of themselves as trans/nonbinary. Of those individuals who wanted birth control, 56% had asked a healthcare provider about getting it (Table 3.1). Once they talked to their providers, nearly all of respondents (88%) successfully obtained birth control. Notably, respondents who talked to providers about birth control said that some (20%) or all (35%) of those providers thought or knew they were trans/nonbinary, while 45% did not know.

Table 3.1

Birth Control Need, Access, and Usage
(n = 51,315)

Birth Control Need, Access, and Usage	Percent
Wanted birth control	44
Of those, discussed birth control with healthcare provider	56
Got birth control, of those who discussed	88
Provider thought or knew respondent is trans	55

Note: Total n=51,315, which includes people who were assigned female at birth or reported being intersex

An alternative way to conceptualize these data is as a continuum, wherein each successive step toward obtaining birth control reflects a narrowing pathway due to various barriers and challenges. As individuals encounter obstacles, fewer respondents progress to the next stage of care. This pattern is shown in Figure 3.1. While 44% of respondents reported wanting birth control, only 25% discussed it with a healthcare provider, and 22% ultimately obtained it.

Birth control access differed by several factors, including gender, sexual orientation, and race/ethnicity. Fewer people who reported a binary transgender identity wanted birth control (38%) compared to nonbinary people (48%). Since knowing themselves to be trans, more people who were pansexual (51%), bisexual (53%), or a sexual orientation not listed (47%) reported wanting birth control than people who were asexual (37%), heterosexual/straight (7%), or Two-spirit (19%) (Figure 3.2).

In terms of race (Figure 3.3), Black/African American respondents (38%) and people whose racial identity was not listed (35%) reported wanting birth control least often, while Asian respondents (47%) and multiracial people (46%) reported it most often (Figure 3.3).

Figure 3.1

Birth Control Care (n = 51,315)

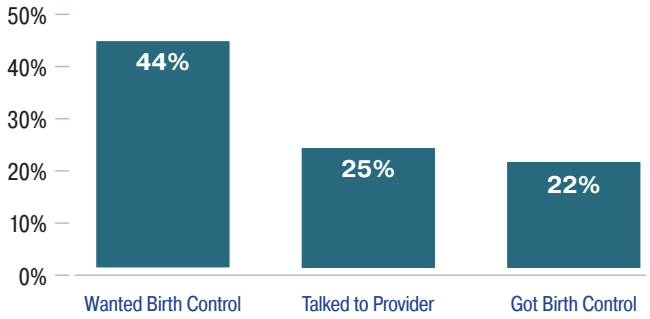


Figure 3.2

Desire for Birth Control Since Respondents Began Knowing Themselves to Be Trans, by Sexual Orientation (n = 51,141)

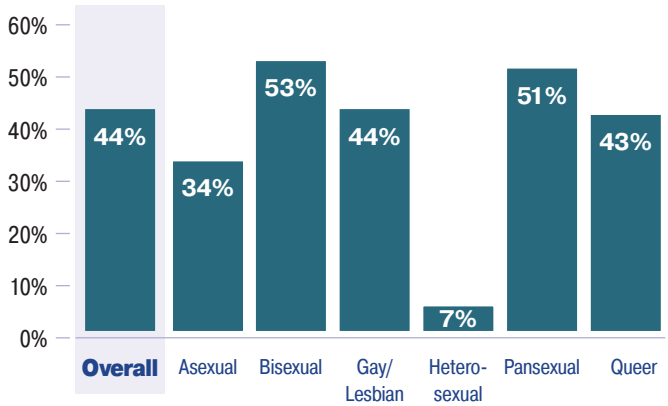
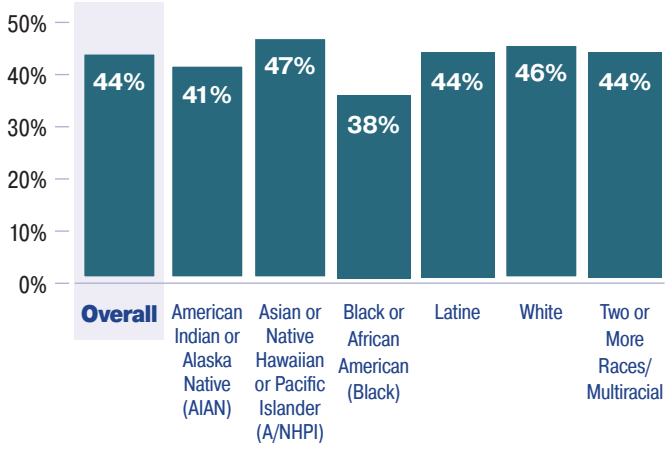


Figure 3.3

Desire for Birth Control Since Respondents Began Thinking of Themselves as Trans, by Race/Ethnicity (n = 51,033)



In total, 19% of respondents wanted birth control to prevent pregnancy but did not ask a healthcare provider about getting it. The most common reported reasons for not talking to a provider about it were not wanting to go to a women's health clinic (29%) and that it was too expensive to see a provider (25%) (Table 3.2). Some respondents reported fears of discrimination or privacy: 23% worried that they would be disrespected or mistreated as a trans person, and 16% worried they would be outed as trans (16%) (Table 3.2). Twelve percent (12%) of those who wanted birth control and talked to a provider about it did not receive it. Table 3.3 presents the reasons why these respondents did not receive birth control. Some healthcare providers denied individuals birth control because they were on testosterone (11%), despite testosterone not being an effective birth control method. Six percent (6%) reported that their healthcare provider denied them birth control because they are trans (Table 3.3).

Table 3.2

Reasons for Not Asking a Provider about Getting Birth Control (n = 8,058)

Reasons	Percent
I don't want to go to a women's health clinic	29
Too expensive to see a healthcare provider	25
I thought I would be disrespected or mistreated as a trans person	23
Birth control is too expensive	24
I already have the birth control I need	17
I am worried about being outed as trans	16
I get birth control through friends or unlicensed sources	<1
Another reason not listed	44

Note: Percentages sum to >100 because respondents could mark all that apply

Table 3.3

Reasons for Not Getting Birth Control to Prevent Pregnancy (n = 28,652)

Reasons Did Not Get Birth Control to Prevent Pregnancy	Percent
Too expensive	22
Healthcare provider (HCP) said no because of testosterone	11
HCP said no for non-trans medical reasons	8
Insurance wouldn't pay	8
HCP refused because I am trans	6
A reason not listed above	69

Note: Percentages sum to >100 because respondents could mark all that apply.

Reasons for Not Wanting Birth Control

While 44% of the respondents wanted birth control, the remaining 56% did not want birth control. The most common reason was having a partner who could not get them pregnant (62%) (Table 3.4).

Table 3.4

Reasons for Not Wanting Birth Control to Prevent Pregnancy (n = 28,652)

Reasons Did Not Get Birth Control to Prevent Pregnancy	Percent
Partner cannot get me pregnant	62
I am unable for medical reasons (including hysterectomy)	13
I take birth control for other reasons than pregnancy prevention	12
I am too old to get pregnant	5
I believe I cannot get pregnant because I am on testosterone	4
I want to get pregnant	3
None of the above reasons	20

Note: Percentages sum to >100 because respondents could mark all that apply.

Another 13% could not get pregnant for non-transition-related medical reasons, such as having a hysterectomy. Twelve percent (12%) reported using birth control, but not to prevent pregnancy. Although testosterone is not effective birth control,[4] some trans people and providers may believe it is. Notably, few respondents (4%) reported not wanting birth control because they believed testosterone would prevent pregnancy. Only 3% of the respondents said they were not using birth control because they wanted to get pregnant.

Abortion

A small proportion (3%) of respondents reported wanting or needing an abortion at some point since they've thought of themselves as trans or nonbinary (Table 3.5). Slightly fewer binary trans people (2%) reported wanting or needing an abortion compared to nonbinary people (3%). Of those individuals, 7% reported problems getting the abortion services they needed because they were trans/nonbinary.

Table 3.5

Abortion Need and Access (n = 51,315)

Abortion Need and Access	Percent
Wanted or needed an abortion	3
Of those, problems getting abortion services because they were trans/nonbinary	7

Respondents shared barriers that they encountered when attempting to access abortion services (Table 3.6). A substantial proportion reported experiencing challenges related to provider knowledge, discrimination, and mistreatment. Over one-third of respondents (37%) indicated that they were unable to locate a provider who was knowledgeable about transgender healthcare, highlighting a critical gap in provider competency.

Table 3.6

Barriers to Abortion Services (n = 80)

Problems	Percent
Unable to find abortion provider who knew about trans healthcare	37
Because I am Trans…	
I didn't feel welcome in an abortion providers office/clinic	79
Provider used harsh or abusive language	38
I was verbally harassed by staff or others at the provider's office	32
Provider refused	24
Provider was physically rough with me	15
A problem not listed above	25

Note: Percentages sum to >100 because respondents could mark all that apply.

Additionally, a majority (79%) reported feeling unwelcome in the clinical environment where abortion services were offered, underscoring the emotional and psychological burden of navigating spaces that may not affirm or recognize their gender identity.

Several respondents also described more overt forms of discrimination or mistreatment. Nearly one-quarter (24%) reported being outright refused care, while others experienced verbal abuse, either from healthcare providers (38%) or from staff members at the clinic or facility (32%). A smaller but notable percentage (15%) stated that they were treated physically roughly during their care encounter. These findings point to both systemic and interpersonal barriers that can severely limit access to safe, affirming abortion care for transgender and nonbinary individuals, and reflect broader patterns of healthcare discrimination documented in other areas of reproductive and sexual health.

The Intersection of Transition-related Care and Receiving Reproductive Care

As seen in Chapter 2, 57% of respondents had a dedicated transition-related healthcare provider. Among these respondents, 35% saw this provider for routine sexual and reproductive care, 22% sought care from a different provider, and 43% did not receive any routine reproductive healthcare at all.

Among respondents who received any transition-related healthcare, 78% reported that at least one of their healthcare providers discussed how transition-related healthcare might impact their fertility, while 22% received no such discussion (Table 3.7). Notably, 94% of individuals who consulted a provider about hormones and 85% of those who saw a provider for transition-related surgery had fertility discussions. Forty-five percent (45%) of respondents discussed fertility with a mental health professional.

Figure 3.4

Use of Transition-related Healthcare Providers for Sexual and Reproductive Health (n = 48,683)

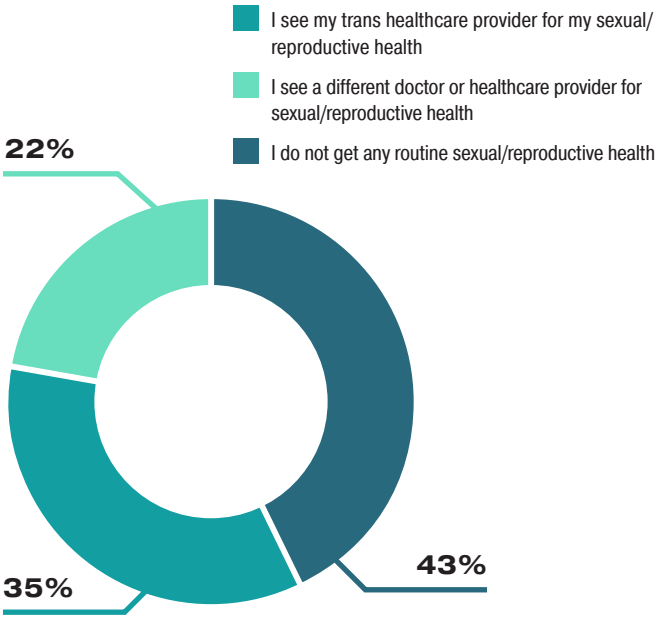


Table 3.7

Providers Discussed How Transition-related Healthcare Might Affect Fertility or Reproduction

Discussed Fertility or Reproduction	Percent
Some or all of my providers	78
None of my providers	22
A mental health professional (such as a therapist)	45
A provider I saw about puberty blockers	73
A provider I saw about hormones	94
A provider I saw about a transition-related surgical procedure	85

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[5]

Table 3.8

Timing of Fertility and Reproduction Discussions in Regard to Medical Transition

Timing	Percent
When I first came to see them about my gender identity/transition	68
Before I began taking puberty blockers	66
After I began taking puberty blockers	27
Before I began taking hormones	79
After I began taking hormones	19
Before a surgical procedure that could affect fertility or reproduction (such as bottom surgery)	78
After a surgical procedure that could affect fertility or reproduction (such as bottom surgery)	13

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[6]

The timing of these conversations was noteworthy (Table 3.8). A large majority (68%) of individuals had fertility discussions with their providers when they first came to see them about their gender identity and transition. Further, 66% had these discussions before taking puberty blocking medications; 79% had them before starting hormones, 78% had them before undergoing surgery, and far fewer had them afterward.

HIV Testing, Care, and Prevention

Transgender and nonbinary people make up 0.3% of the U.S. population but constituted 2% of new diagnoses of HIV in 2019.[7] Trans and nonbinary people have a higher prevalence of HIV and AIDS (9%)[8] than the U.S. general population (0.3%).[9]

Multiple social and structural factors increase transgender and nonbinary people's vulnerability for HIV according to the Centers for Disease Control and Prevention, including stigma, poor access to healthcare, poverty, and discrimination.[10]

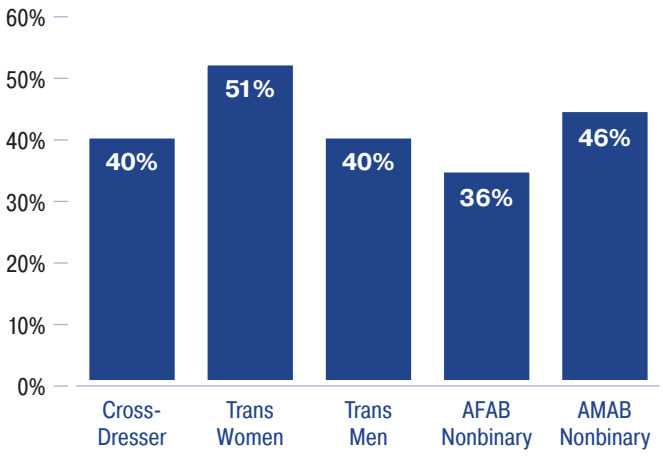
The 2022 USTS asked respondents several questions about their experiences related to HIV testing, HIV care, and living with HIV. Several of the questions in this section were the same as on national surveys, including the National Health Interview Survey (NHIS)[11] and Behavioral Risk Factor Surveillance System (BRFSS) so answers could be compared to the U.S. population.[12]

HIV Testing

Respondents reported whether they had ever been tested for HIV, excluding testing obtained while donating blood. Forty-three percent (43%) of adult respondents had been tested for HIV, compared to 36% of the U.S. adult population.[13] Of note, this is lower than the 55% of the 2015 respondents who had been tested. Testing history varied by demographic characteristics and experiences. Transgender women (51%) and nonbinary people assigned male at birth (AMAB) (46%) were more likely to have ever tested than transgender men (40%), crossdressers (40%), and nonbinary people who were assigned female at birth (AFAB) (36%) (Figure 3.5).

Figure 3.5

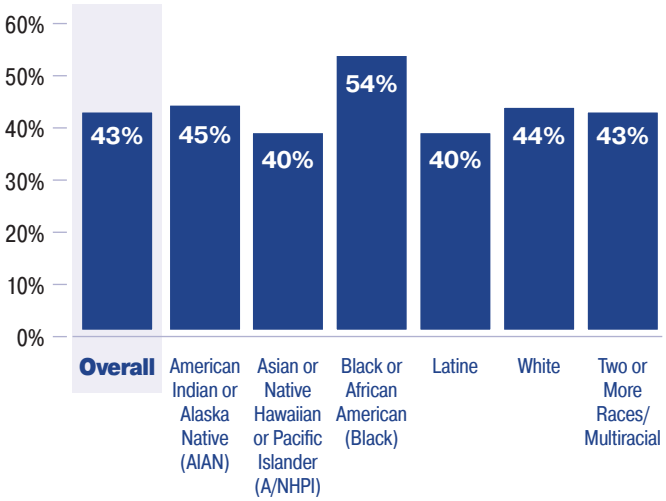
Lifetime HIV Testing, by Gender
(n = 84,170)



Black (54%) respondents were more likely to have been tested (Figure 3.6) than other races/ethnicities. Of the respondents who were recently (in the past 12 months) engaged in sex work or the sex industry or who were paid for selling drugs or other work that is currently considered illegal, 75% had ever tested for HIV compared to 78% in the 2015 USTS.

Figure 3.6

Lifetime HIV Testing, by Race/Ethnicity (n = 84,170)



Test Location

Those who had tested for HIV received tests in a variety of locations or settings, with the most common locations being a private doctor or HMO office (34%), a public health clinic (20%), an LGBTQ or trans resource center (9%) and a family planning or obstetrics clinic (7%) (Table 3.9). Testing locations were similar to the 2015 USTS, except this survey had additional response options, which filled spots 3 through 5 in the top 5 most commons locations where respondents tested for HIV.

Table 3.9

Location or Setting of Most Recent HIV Test (n = 38,427)

Location	2022 (%)	2015 (%)
Private doctor or HMO office	34	45
Public health clinic or community health center	20	26
Family planning or obstetrics clinic	7	N/A
LGBTQ/Trans resource center	9	N/A
HIV counseling and testing site	4	11
Military/Veterans Administration	4	2
Hospital inpatient	4	3
HIV street outreach or mobile clinic	3	2
School/University health services	2	N/A
Home	2	1
Emergency room	1	1
Drug treatment program	<1	<1
Needle or syringe exchange program	<1	N/A
Correctional facility (jail or prison)	<1	<1
Somewhere else	5	9

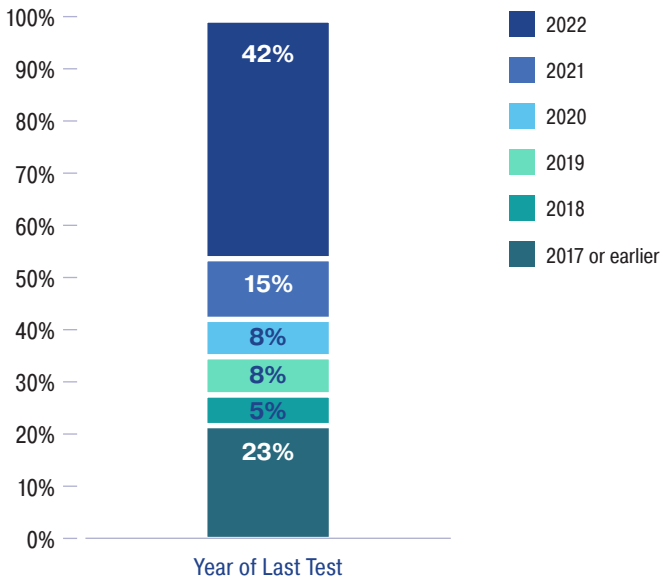
Note: Percentages sum to >100 due to rounding.

Year of Last Test

Forty-two percent (42%) of respondents who had ever been tested for HIV had most recently tested within the past 12 months (Figure 3.7), compared to 38% in the 2015 USTS. Sixty-four percent (64%) had tested in 2020 through 2022, while almost a quarter (23%) had not been tested since 2017 or earlier.

Figure 3.7

Year of Most Recent HIV Test



Reason for Not Being Tested

Fifty-eight percent (58%) of respondents reported that they had never been tested for HIV. Of those who had not been tested, 57% reported that the main reason for not being tested was that they believed they were at low risk for HIV infection, compared to 86% in 2015, and the 83% in the U.S. general population (Table 3.10).[14]

HIV Status

The percentage of respondents who were living with HIV (1.1%) was three times larger than the U.S. general population (0.3%).[15] On respondents' most recent HIV test, 99% of their tests were negative, meaning they were not living with HIV. A small number

Table 3.10

Reasons for History of No HIV Testing
(n = 44,814)

Main Reason for Having Never Been Tested for HIV	2022 USTS (%)	2015 USTS (%)	U.S. Population, 2018 NHIS (%)
Thinks to be at low risk for HIV infection*	57	86	83
No particular reason	20	6	15
Healthcare provider never mentioned testing	8	3	N/A
Some other reason	9	2	1
Didn't know where to test	2	1	<1
Doesn't like needles	1	1	<1
Worried about cost	1	N/A	N/A
Didn't have time	<1	N/A	N/A
Didn't want to think about HIV	<1	N/A	<1
Didn't have transportation	<1	N/A	N/A
Afraid of finding out if had HIV	<1	1	<1
Thought would be disrespected or mistreated as trans	<1	N/A	N/A
Thought would be disrespected or mistreated for another reason	<1	N/A	N/A

Notes: In USTS 2015 and NHIS 2018, the phrasing was "unlikely to be exposed to HIV"

(n=227) of those who tested did not receive the results of their most recent HIV test, so they did not know whether the results were negative or positive.

HIV status varied by gender identity, with transgender women (2.4%) and AMAB nonbinary respondents (1.5%) being most likely to report they were living with HIV, followed by crossdressers (0.9%) (Table 3.9).

Very few trans men (0.3%) and nonbinary AFAB respondents reported living with HIV (<0.1%). Compared to the 2015 survey (1.4%), the 2022 sample of respondents were less likely to report living with HIV (Table 3.11).

Table 3.11

Living with HIV, by Gender
(ages 25+, n = 83,955)

Gender	2022 (%)	2015 (%)
Overall	1.1	1.4
Crossdresser	0.9	2.1
Trans Women	2.4	3.4
Trans Men	0.3	0.3
AFAB Nonbinary	0.04	0.2
AMAB Nonbinary	1.5	1.0

Among those living with HIV, the gender breakdown was similar to that of 2015. That is, of all the respondents living with HIV, the greatest proportion of them were trans women in 2022 (48%) and in 2015 (49%). The next largest gender groups among those living with HIV were nonbinary AMAB respondents (29% in 2022; 14% in 2015) and people who were crossdressers (17% in 2022, 30% in 2015). (Figure 3.8.)

The prevalence of HIV differed by race and ethnicity, with Black respondents having over four times higher prevalence of living with HIV (4.5%) than the overall prevalence (1.1%) (see Figure 3.9).

Figure 3.8

Gender Among Those Living with HIV

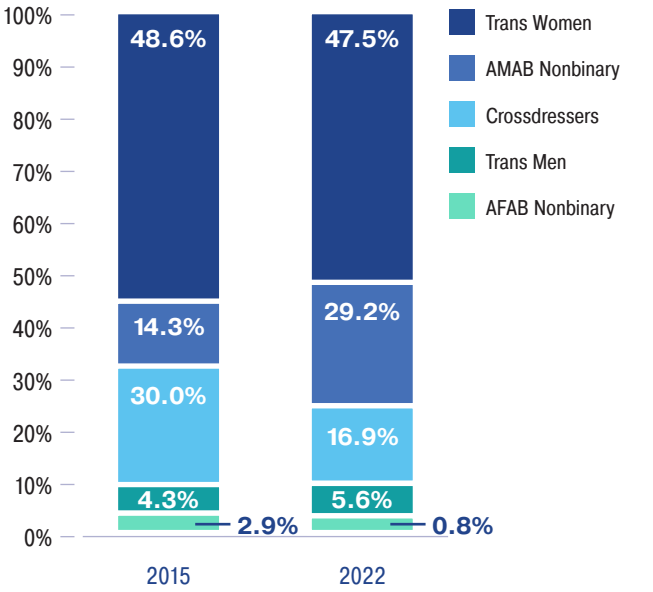
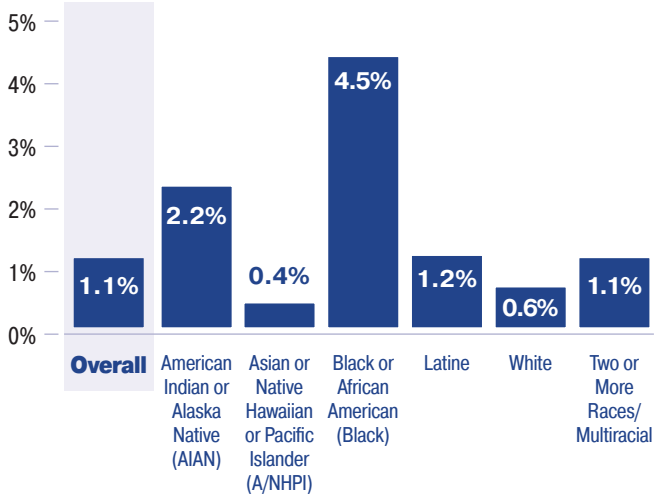


Figure 3.9

Living with HIV, by Race/Ethnicity (n = 83,664)



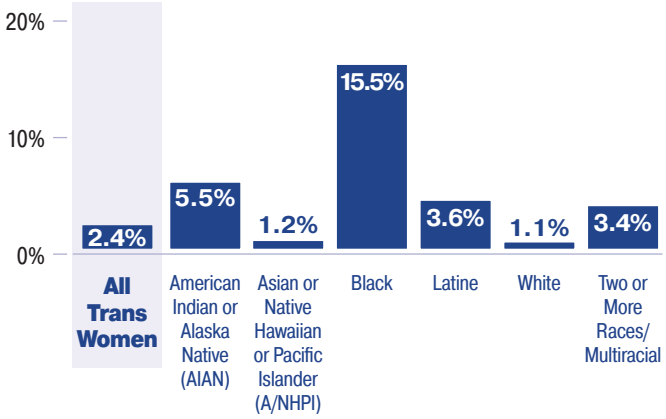
The pattern of HIV prevalence by race/ethnicity is similar to that in 2015, with Black respondents being almost five times higher prevalence of living with HIV.

As noted above, transgender women are more likely than other gender groups to be living with HIV, and this differs by race/ethnicity among transgender women. Black transgender women are 6 times more likely to report living with HIV compared to all transgender women of all races/ethnicities, and 14 times more

likely to report living with HIV compared to white trans women (Figure 3.10). American Indian (5.5%), Latine (3.6%), and multiracial trans women (3.4%) also had elevated HIV prevalence compared to white women (Figure 3.10).

Figure 3.10

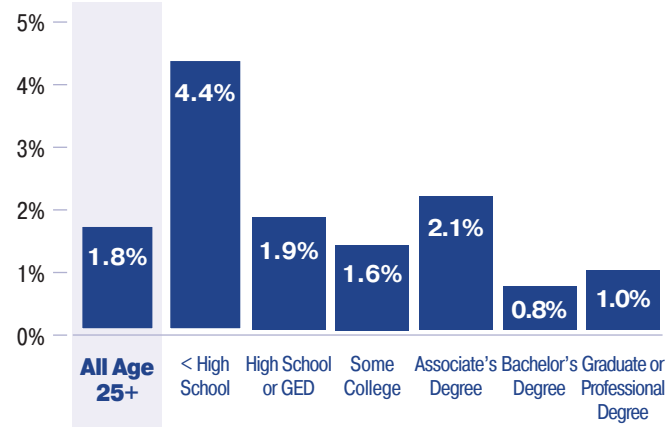
Transgender Women Living with HIV, by Race/Ethnicity (n = 24,035)



Educational attainment is a measure of socioeconomic status. Prevalence of HIV differed by educational attainment among those aged 25 and older (people under 25 were excluded here because they are likely to be still pursing high school and/or further education). Those who did not complete high school had the highest HIV prevalence (4.4%), and those who had finished bachelor's degrees or higher had lower HIV prevalence (0.8%, Figure 3.11).

Figure 3.11

HIV Prevalence, by Educational Attainment (ages 25+, n = 49,195)

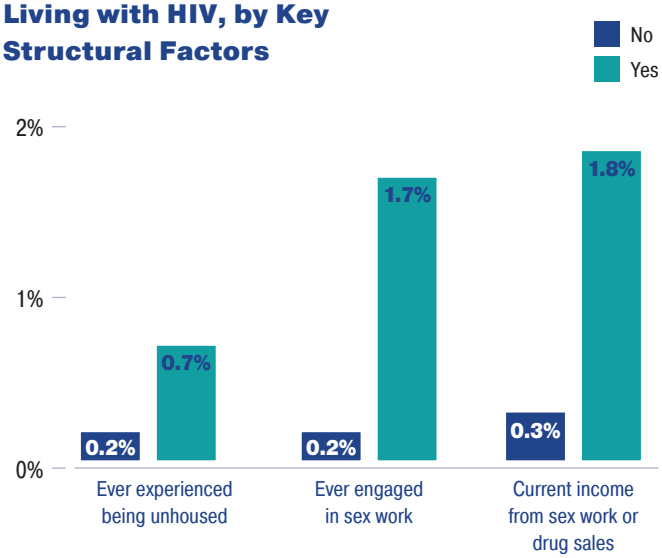


Similar trends were found in the 2015 survey: 7.2% of respondents who had not completed high school and less than 1% of those with bachelor's or graduate degrees were living with HIV.

The prevalence of HIV was almost six times larger among respondents whose current source of income was from the sex industry or who were paid for selling drugs or other work that was currently considered illegal (1.8% vs. 0.3%), eight times larger among respondents who had ever engaged in sex work (1.7% vs. 0.2%), and three times larger among those who have ever experienced houselessness (0.7% vs. 0.2%) (Figure 3.12).

Figure 3.12

Living with HIV, by Key Structural Factors



Note. Total samples were 81,225, 83,337, and 82,772 for living with HIV and ever experienced being unhoused, ever engaged in sex work, and having a current income from sex work or drug sales, respectively.

HIV Healthcare

Effective HIV treatment and management are commonly conceptualized through the framework of the HIV care continuum, which includes a series of critical steps: diagnosis through testing, linkage to HIV-specific medical care, retention in ongoing care, initiation and adherence to antiretroviral therapy (ART), and the achievement and maintenance of viral suppression. In the 2022 U.S. Transgender Survey, respondents who reported living with HIV were asked

whether they had received HIV-specific healthcare within the past year, along with additional questions addressing key stages of the HIV care continuum.

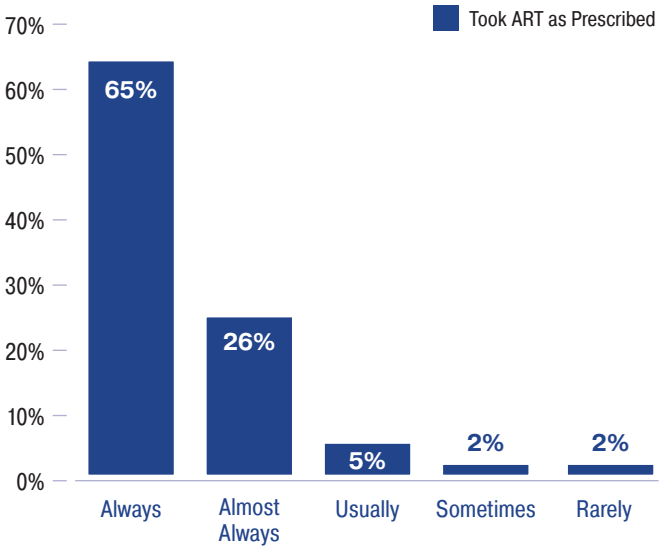
Most respondents living with HIV had received HIV-specific healthcare within the past year (87%) and within the past 6 months (82%), not including care received during an emergency room visit or during a hospital stay. This compares to 76% of those living with HIV in the U.S. general population.[16] Respondents who received HIV-specific care had providers who also offered hormones (59%), sexual and reproductive health (43%), and routine healthcare (such as physicals, flu, or diabetes care) (69%). Only 16% reported that their HIV-specific care providers provided none of those services.

Antiretroviral Medications

Nearly all the respondents living with HIV reported currently taking HIV medicines (93%), also called antiretroviral medicine or antiretroviral therapy (ART). This is similar to the 94% of those living with HIV in the general population[17] and greater than the 81% in the 2015 USTS sample. Of those currently taking ART, two-thirds reported taking it as prescribed always (65%). These numbers are similar to the 2015 respondents, with 64% taking it regularly (Figure 3.13).

Figure 3.13

Adherence to HIV Medications (n = 267)



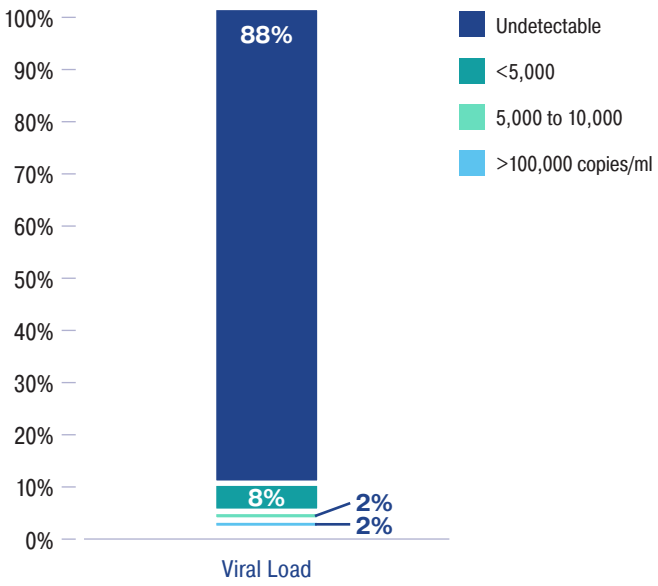
Viral load

Testing is an important part of monitoring the health of a person with HIV. Eighty-two percent (82%) of HIV-positive respondents had their blood tested to determine their viral load within the past 6 months, and 94% had tested within the past 12 months. Only 3% reported never having been tested to determine their viral load. These numbers are similar to the 2015 USTS sample—82% and 5%, respectively.

Among respondents living with HIV, the majority (88%) reported having an undetectable viral load at the time of their most recent test. This means there were so few copies of the virus present in their blood that standard viral load laboratory tests cannot detect them (Figure 3.14).

Figure 3.14

Viral Load Among People with HIV and on ART



In the general U.S. population living with HIV, 65% had undetectable viral loads.[18] Achieving and maintaining an undetectable viral load is a central goal of HIV treatment, as it is strongly associated with improved long-term health outcomes, including reduced HIV-related morbidity and mortality. Viral suppression has critical public health implications:

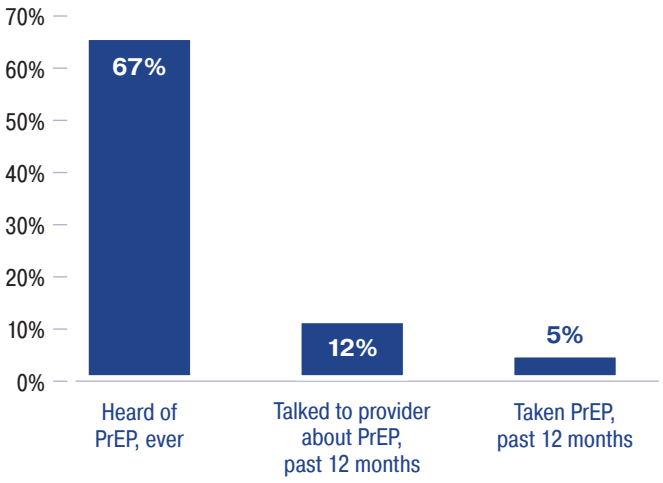
individuals with sustained undetectable viral loads cannot transmit HIV to sexual partners. This scientific consensus is reflected in the public health framework known as "Undetectable = Untransmittable," or U=U, which emphasizes that effective antiretroviral therapy not only benefits the individual but also serves as a powerful tool for HIV prevention.[19] The high prevalence of viral suppression among USTS respondents suggests strong adherence to ART among those in care and highlights the importance of continued access to HIV-specific health services that are affirming and responsive to the needs of transgender and nonbinary people.

HIV Prevention

People who are not living with HIV can take one of multiple medications to reduce the risk of getting HIV, called pre-exposure prophylaxis, or PrEP. Different types of PrEP include Truvada (oral pill), Descovy (oral pill), and Apretude (injections). Two in three respondents (67%) had heard of PrEP before taking the survey, but only 5% of those had taken it in the past 12 months (Figure 3.15).

Figure 3.15

Pre-exposure Prophylaxis (PrEP) Awareness, Interest, and Usage

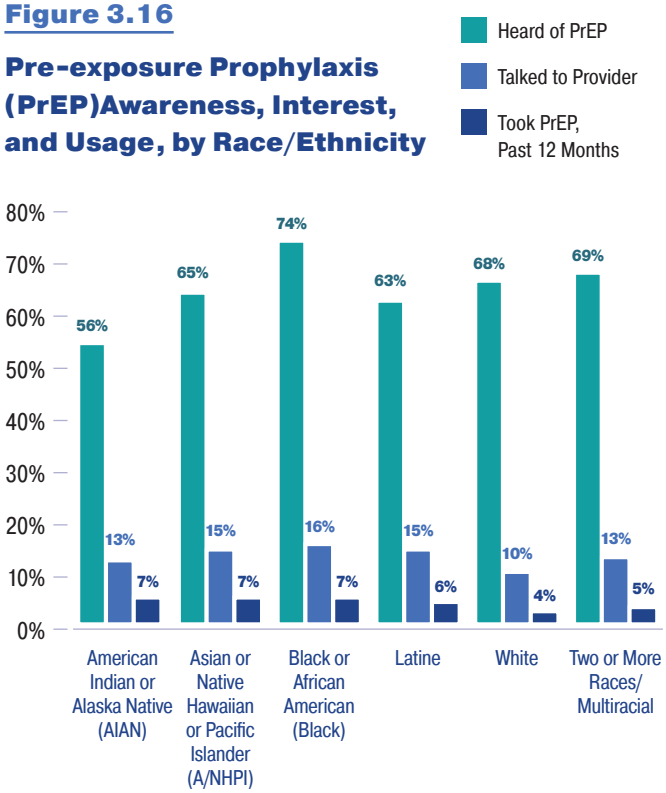


Note: 83,502 respondents received a question regarding whether they heard of PrEP; 64,150 received question asking if they talked to a provider about PrEP; and 65,139 received a question asking if they had taken PrEP.

About half a million people were taking PrEP in the U.S. in 2023,[20] and the number is increasing, but racial disparities exist. For example, in the US, 64% of PrEP users are white, yet white individuals make up 25% of new HIV diagnoses. Black individuals, however, make up 14% of PrEP users but 40% of new diagnoses.[21] In the survey, those racial disparities do not appear: Black transgender and nonbinary people were the most likely to be aware of PrEP, most likely to talk to a provider about it, and most likely to use PrEP (Figure 3.16).

Figure 3.16

Pre-exposure Prophylaxis (PrEP)Awareness, Interest, and Usage, by Race/Ethnicity



Note. 83,502 respondents received a question regarding whether they heard of PrEP; 64,150 received a question asking if they talked to a provider about PrEP; and 65,139 received a question asking if they had taken PrEP.

Most survey respondents did not take PrEP. The primary reasons for not taking PrEP were not engaging in sexual activity, not seeing themselves as engaging in activity where they could acquire HIV, and being in a monogamous relationship (Table 3.12). Four percent (4%) of respondents were afraid PrEP might cause problems with their gender-

affirming hormones; however, PrEP and hormones can be taken together safely, and PrEP is recommended for sexually active transgender and nonbinary people who are PrEP indicated (Table 3.12).[22]

Table 3.12

Reasons to Not Take Pre-Exposure Prophylaxis (PrEP) (n = 61,034)

Reasons	Percent
Not sexually active	54
Not at high enough risk for HIV	37
In a monogamous relationship	31
Don't know enough about it	10
Prefer to use condoms	7
Don't have a way to pay	7
Concerned about side effects	4
Don't want to take a pill every day	4
Afraid it would cause problems with hormones	4
Don't want to talk to a provider about my sex life	3
Don't want my family or friends to find out	2
If on PrEP, partners will expect condomless sex	<1
Don't want people to think I'm HIV positive	<1
Don't believe it works well enough	<1
Another reason not listed	5

CONCLUSION

Results in this chapter point toward health disparities in access to trans-competent sexual and reproductive healthcare, including several barriers to accessing reproductive healthcare when respondents wanted it. These barriers include anticipated stigma (fear of being mistreated) that keep respondents from seeking care, and enacted stigma (experiencing discrimination) when they do access services. Clinics that provide birth control and/or abortion services and are branded as "women's health" may deter some transgender and nonbinary people from attending, despite needing the services.

Transgender and nonbinary people test for HIV more often than the general U.S. population and have comparable or favorable prevalences of accessing HIV-specific care, adhering to antiretroviral medications, and achieving viral suppression. Within the trans/nonbinary communities, trans women and especially Black and Latina trans women are the most vulnerable to HIV due to stigma and discrimination compounded by the intersection of sexism and racism.[23]

1. See Rodriguez-Wallberg, K., J. Obedin-Maliver, B. Taylor, N. Van Mello, K. Tilleman and L. Nahata (2023). "Reproductive health in transgender and gender diverse individuals: A narrative review to guide clinical care and international guidelines." Int J Transgend Health 24(1): 7-25.

   Moseson, H., L. Fix, J. Hastings, A. Stoeffler, M. R. Lunn, A. Flentje, M. E. Lubensky, M. R. Capriotti, S. Ragosta, H. Forsberg and J. Obedin-Maliver (2021). "Pregnancy intentions and outcomes among transgender, nonbinary, and gender-expansive people assigned female or intersex at birth in the United States: Results from a national, quantitative survey." International Journal of Transgender Health 22(1-2): 30-41.

2. Moseson, H., L. Fix, J. Hastings, A. Stoeffler, M. R. Lunn, A. Flentje, M. E. Lubensky, M. R. Capriotti, S. Ragosta, H. Forsberg and J. Obedin-Maliver (2021). "Pregnancy intentions and outcomes among transgender, nonbinary, and gender-expansive people assigned female or intersex at birth in the United States: Results from a national, quantitative survey." International Journal of Transgender Health 22(1-2): 30-41.

3. Grindlay, K., Juno Obedin-Maliver, Ragosta, S., Hastings, J., Lunn, M. R., Flentje, A., Capriotti, M. R., Zubin Dastur, Lubensky, M. E., & Moseson, H. (2024). "Interest in over-the-counter progestin-only pills among transgender, nonbinary, and gender-expansive individuals in the United States. American Journal of Obstetrics and Gynecology." https://doi.org/10.1016/j.ajog.2024.02.006

4. Coleman, E., A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R., et al (2022). "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." International Journal of Transgender Health 23(sup1): S1-S259.

5. 56,328 respondents received the questions of whether some, all, or none of their healthcare providers had discussions regarding transition-related healthcare and fertility; 45,565 received the question specific to mental health providers; 690 received the question specific to puberty blockers; 42,094 received the question specific to hormone replacement therapy; and 6,327 received the question specific to surgical procedures.

6. 45,387 respondents received questions about discussing fertility and reproduction with their healthcare providers when they first came to their providers regarding their gender identity and transition; 686 received these questions in relation to puberty-blocking medications; 42,080 received these questions in relation to hormone-replacement therapy; and 6,323 received these questions in relation to surgical procedures.

7. Centers for Disease Control and Prevention. (2024, March 28). *Fast facts: HIV and transgender people.* https://www.cdc.gov/hiv/data-research/facts-stats/transgender-people.html (Retrieved December 18, 2024)

8. Becasen, J. S., Denard, C. L., Mullins, M. M., Higa, D. H., & Sipe, T. A. (2019). Estimating the prevalence of HIV and sexual behaviors among the U.S. transgender population: A systematic review and meta-analysis, 2006–2017. American Journal of Public Health, 109(1), e1–e8. https://doi.org/10.2105/AJPH.2018.304727

9. HIV.gov. (2024, August 15). *U.S. statistics: Fast facts.* https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics (Retrieved December 18, 2024). (This article reports 1.2 million people in the U.S. are living with HIV. Prevalence calculated as 1.2 million/345,000,000 people= 0.3478%.)

10. Centers for Disease Control and Prevention. (2024, March 28). *Fast facts: HIV and transgender people.* https://www.cdc.gov/hiv/data-research/facts-stats/transgender-people.html (*Retrieved December 18, 2024*)

11. National Center for Health Statistics. (2021). Survey description, National Health Interview Survey, 2020. U.S. Department of Health and Human Services. https://www.cdc.gov/nchs/nhis/documentation/2020-nhis.html

12. Centers for Disease Control and Prevention. (2020). BRFSS prevalence & trends data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/brfssprevalence/index.html

13. Centers for Disease Control and Prevention. (2020). BRFSS prevalence & trends data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/brfssprevalence/index.html

14. National Center for Health Statistics. (2019, September 3). 2018 National Health Interview Survey (NHIS): Sample Adult Public Use File (samadult), IDN variables. Centers for Disease Control and Prevention. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2018/samadult_freq.pdf

15. HIV.gov. (2024, August 15). *U.S. statistics: Fast facts.* https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics (This article reports 1.2 million people in the U.S. are living with HIV. Prevalence calculated as 1.2 million/345,000,000 people= 0.3478%.)

16. HIV.gov. (2024, August 15). *U.S. statistics: Fast facts.* https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

17. Hughes, A. J., Mattson, C. L., Scheer, S., Beer, L., & Skarbinski, J. (2014). Discontinuation of antiretroviral therapy among adults receiving HIV care in the United States. *Journal of Acquired Immune Deficiency Syndromes*, 66(1), 80–89.

18. HIV.gov. (2024, August 15). *U.S. statistics: Fast facts.* https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

19. HIV.gov. (2024, August 15). *U.S. statistics: Fast facts.* https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

20. AIDSVu. (2024). Deeper look: PrEP. https://map.aidsvu.org/profiles/nation/usa/prevention-and-testing#1-1-PrEP

21. AIDSVu. (2024). Deeper look: PrEP. https://map.aidsvu.org/profiles/nation/usa/prevention-and-testing#1-1-PrEP

22. Centers for Disease Control and Prevention. (2021). PrEP for the prevention of HIV infection in the United States – 2021 update. Formerly available at: https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

23. Poteat, T., A. Scheim, J. Xavier, S. Reisner and S. Baral (2016). "Global Epidemiology of HIV Infection and Related Syndemics Affecting Transgender People." J Acquir Immune Defic Syndr 72 Suppl 3(Suppl 3): S210-219.

CHAPTER 4

Mental Health and Experiences with Mental Health Providers

IN OUR OWN VOICES

"When I was 13, having been in therapy for depression and suicidal ideation for over a year, I finally felt safe enough to come out to my therapist. But after expressing my thoughts of self-harm related to my breasts, he told me that it was 'normal' to have those thoughts during puberty. That made me no longer feel safe seeing him. Now, I'm very specific before even seeing most doctors that they are comfortable with or trained in trans-related healthcare."

ALLEN
transgender man, white

Age range: 25-40

"I make it paycheck to paycheck taking care of my partner and myself, who we are both trans without any healthcare. Mental health is poor for both of us. The amount of convincing ourselves to make it another day would shatter those who have not endured it for years. Don't let us go unheard. Our entire country needs to understand: we exist, we are real, and we have always been real. As long as humanity persists, we are never going away. See us as equals."

RINNA
transgender, white

Age range: 25-40

"As early as 3 years old, I wanted nothing more than to be a girl. My parents did not accept this. Once I moved away, I immediately began affirming my gender. But at 18, puberty was starting to finally take effect, and I was about to be forced into manhood. I chose to attempt suicide. It can only be called a miracle that I survived. Eventually, I found community with people who helped me realize it was okay for me to be myself; their acceptance cured my self-hatred and made me feel supported, which gave me the confidence to transition and be my true self. I've been happy ever since. Being accepted and having community is the cornerstone of good mental health and even saves lives."

CARLA
transgender woman, Black/African-American

Age range: 18-24

"Before beginning hormone replacement therapy, I was so anxious that I couldn't go to the grocery store without having a panic attack. I was so depressed that I genuinely didn't believe happiness existed; I thought everyone who appeared happy was faking it to put on a strong face. I couldn't try new things or make friends.

I refused to get mental healthcare because my anxiety made it impossible to talk to other people and because I feared being hospitalized for suicidality. Three weeks after starting estrogen on hormone replacement therapy, I began to dance for no reason. Suddenly I could laugh, and cry, and seek the help I needed. After six years of transition, I am happy, healthy, and able to handle anything life throws at me."

VIVA
transgender woman, white

Age range: 25-40

INTRODUCTION

Transgender individuals face substantial mental health challenges, often shaped by unique stressors, systemic inequities, and limited access to affirming care. For example, research shows that, overall, trans people consistently experience higher levels of depressive symptoms, suicidal thoughts, interpersonal trauma, anxiety, and general distress.[1] Research linking the 2015 USTS data with data on state-level discriminatory laws, policies, and prejudicial attitudes shows that these structural factors are associated with psychological distress and past-year suicidal thoughts, plans, and attempts.[2] Further, current public health theories suggest that stigma and hostile sociopolitical climates contribute to the vast disparities in mental health that trans and nonbinary people face.[3] At the same time, social support, legal protections and access to social and medical transition, act as protective factors.[4]

This chapter explores the mental health experiences of USTS respondents, focusing on psychological distress, depression, and suicidality. Additionally, this chapter delves into respondents' interactions with mental health providers, shedding light on care and the quality of their experiences. Please note that some of the information in this chapter may be distressing to readers.

Key Findings

Psychological Distress and Depression

- The USTS sample showed a high prevalence of serious psychological distress and depression.
  - Forty-four percent (44%) of respondents met the criteria for serious psychological distress, compared to less than 4% of the general U.S. population.[15]
  - A majority (81%) of respondents indicated that they felt down, depressed or hopeless at least several days over the past two weeks.
  - Three-quarters (77%) reported little interest or pleasure in doing things at least several of the days over the past two weeks.

Suicidality

- In the year prior to the survey, 38% of respondents considered suicide. Of those who considered suicide, 41% made corresponding plans. These numbers are dramatically higher than the general population's at 5% and 1% respectively.[5]
- Victimization, such as being verbally harassed, denied equal treatment or service for any reason, such as at a place of business, government agency, or public place, or physically attacked, was associated with greater suicidality.
  - Thirty-one percent (31%) of those who had no victimization considered suicide in the past year, compared to 50% for those who were verbally harassed, 53% for those who were denied equal treatment, and 63% for those who were physically assaulted.
  - Seventy-eight percent (78%) of respondents considered suicide and 40% attempted suicide at some point in their lifetime. These statistics far exceed the 13.2% and 2.4% reported for the general population.[6]

- Among those who attempted suicide in the year prior to the survey, fewer USTS respondents received medical attention compared to the general population (38% vs. 47%), but a higher proportion required an overnight hospital stay (72% vs. 31%). This suggests that trans respondents receive care less often, despite having a greater need for it.[7]

Experiences with Mental Health Providers

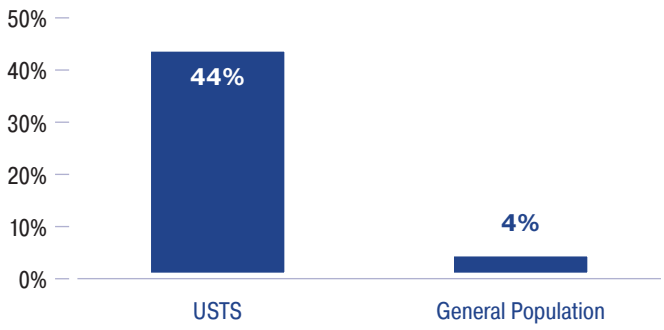
- A majority (58%) of respondents received counseling or therapy from a mental health provider (MHP) in the 12 months prior to the survey, compared to 22% of the general U.S. population.[8] Of those who received counseling in the past 12 months, 67% were receiving care at the time of the survey.
- Our results highlight barriers and challenges with mental healthcare.
  - While 78% of respondents wanted counseling for gender identity or transition, only 48% received mental healthcare for it.
  - Among respondents who discussed gender identity with a counselor, 12% reported that their MHP tried to persuade them to identify only as their sex assigned at birth. Notably, this was much higher (50%) among those who consulted with religious counselors or therapists.

Psychological Distress and Depressive Symptoms

Trans individuals face disproportionately high psychological distress. For example, in the 2015 USTS, a staggering 39% of respondents met the criteria for serious psychological distress in the month prior to completing the survey.[9] Moreover, research using the 2015 USTS linked psychological distress to discriminatory laws and policies and local prejudicial attitudes.[10] To examine whether this trend continued in the 2022 USTS, respondents were presented the Kessler 6 Psychological Distress Scale to understand Serious Psychological Distress (SPD). This scale measures distress based on six questions[11] about feelings over the past 30 days. These questions ask how often individuals felt nervous, hopeless, restless, sad, that everything was an effort, or down on themselves. When respondents report higher frequencies of these issues, they are considered to have SPD.[12] In our sample, 44% of respondents meet the criteria for SPD (Figure 4.1). According to the National Health Interview Survey, less than 4% of the general U.S. adult population met the criteria for SPD.[13]

Figure 4.1

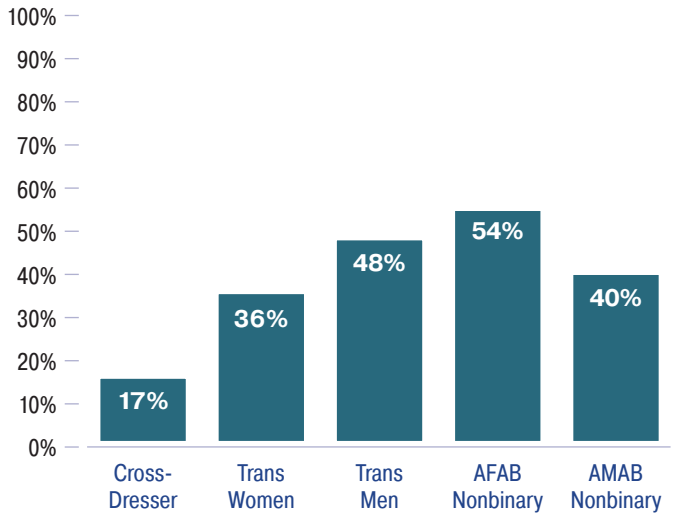
Serious Psychological Distress (SPD) in the Past Month (n = 83,783)



Reports of SPD in the past month differ by both gender and age. Among gender groups, nonbinary individuals assigned female at birth (AFAB) have the highest prevalence SPD (54%), while crossdressers (17%) had the lowest (Figure 4.2).

Figure 4.2

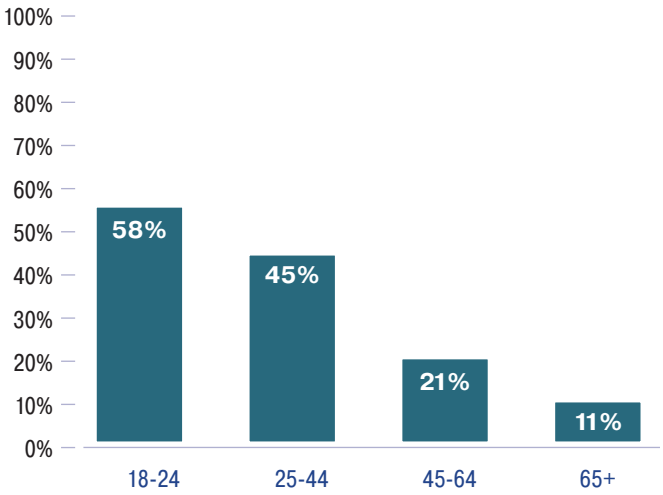
Serious Psychological Distress in the Past Month, by Gender (n = 83,783)



Age plays a significant role, with younger individuals more likely to meet the criteria for SPD. Over half (57%) of individuals aged 18 to 24 years old met the criteria for SPD, while only 11% of those 65+ did (Figure 4.3).

Figure 4.3

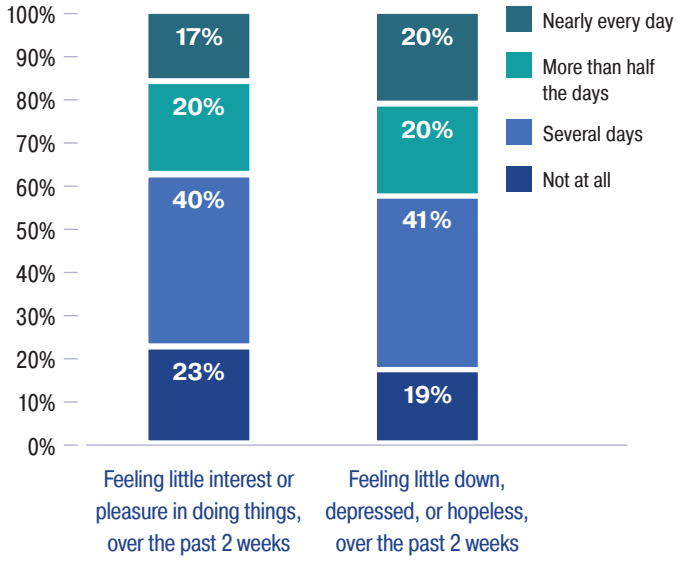
Respondents with Serious Psychological Distress in the Past Month, by Age (n = 83,783)



The Patient Health Questionnaire-2 (PHQ-2) assessed depressive symptoms in the two weeks prior to the survey. The PHQ-2 consists of two questions that inquire about depressed mood and lack of interest or pleasure in activities.[14] A majority (81%) of our respondents indicated that they felt down, depressed or hopeless at least several days over the past two weeks (Figure 4.4). Similarly, three-quarters (77%) reported little interest or pleasure in doing things in the past two weeks at least several of the days (Figure 4.4). This is markedly higher than the general U.S. population (57% and 58%, respectively) at that time.[15]

Figure 4.4

Frequency of Depressive Symptoms



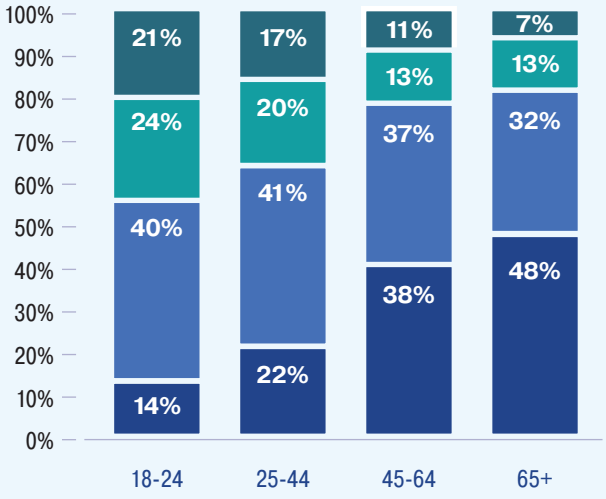
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Feeling down, depressed, or hopeless, over the past 2 weeks (n =84,007) & Feeling little interest or pleasure in doing things, over the past 2 weeks (n = 84,026)

Depressive symptoms varied by demographics and experiences. First, older respondents reported lower depressive symptoms in the two weeks prior to the survey. For example, half (52%) of those 65+ reported that they felt "little interest or pleasure in doing things" not at all in the past two weeks, but only 14% of those 18 to 24 reported similarly (Figure 4.5a). The trend was similar for "feeling down, depressed, or hopeless" in the two weeks prior to taking the survey (Figure 4.5b).

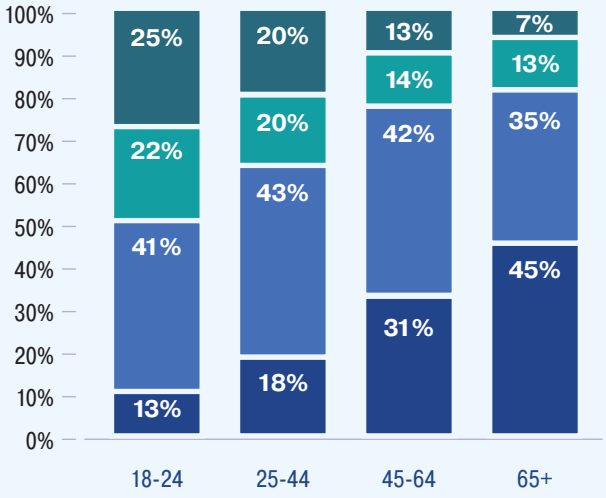
Figure 4.5

Depressive Symptoms, by Age

A. Feeling Little Interest or Pleasure in Doing Things, over the Past 2 Weeks, by Age



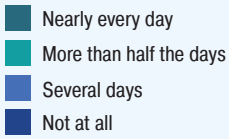
B. Feeling Down, Depressed, or Hopeless, over the Past 2 Weeks, by Age



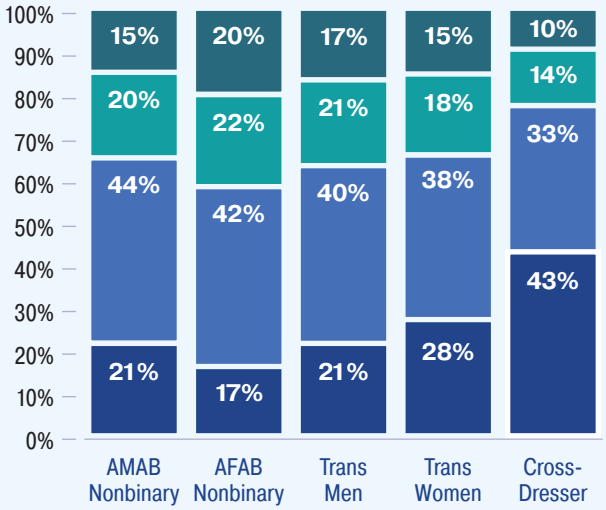
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Feeling down, depressed, or hopeless, over the past 2 weeks (n =84,007) & Feeling little interest or pleasure in doing things, over the past 2 weeks (n = 84,026)

Figure 4.6

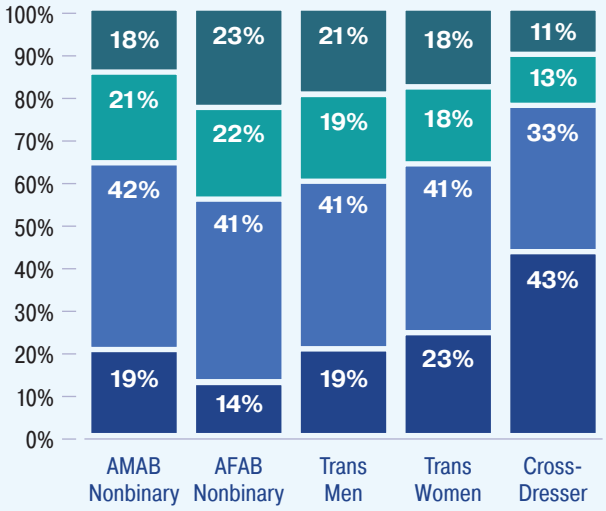
Depressive Symptoms, by Gender



A. Feeling Little Interest or Pleasure in Doing Things, over the Past 2 Weeks, by Gender



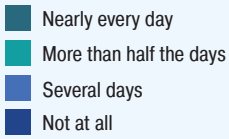
B. Feeling Down, Depressed, or Hopeless, over the Past 2 Weeks, by Gender



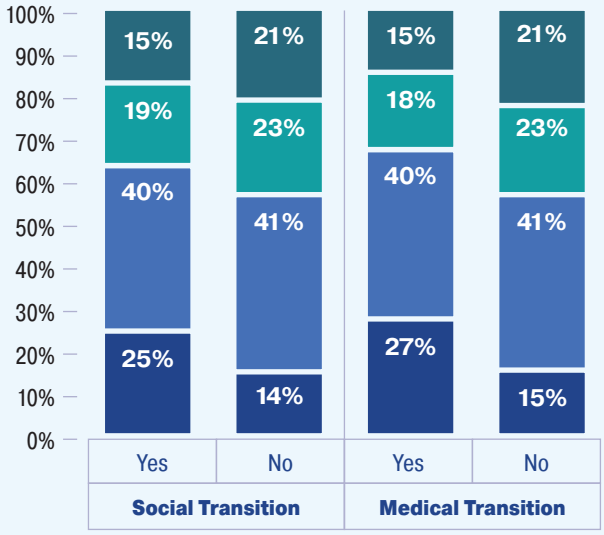
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Feeling down, depressed, or hopeless, over the past 2 weeks (n =84,007) & Feeling little interest or pleasure in doing things, over the past 2 weeks (n = 84,026)

Figure 4.7

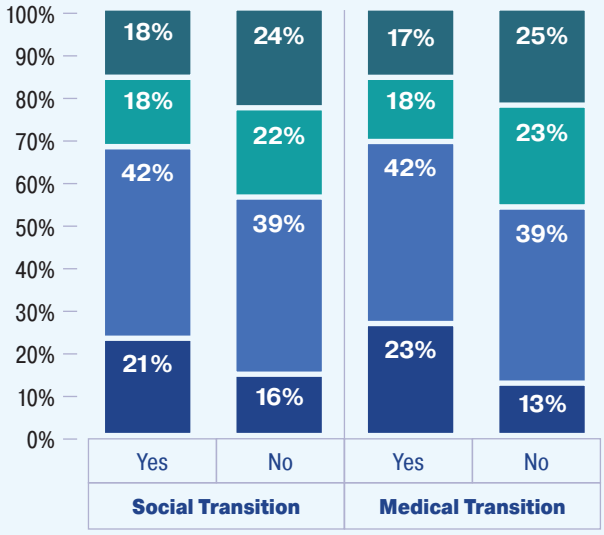
Depressive Symptoms, by Transition Status (%)



A. Feeling Little Interest or Pleasure in Doing Things, over the Past 2 Weeks, by Transition Status



B. Feeling Down, Depressed, or Hopeless, over the Past 2 Weeks, by Transition Status



Note: Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end notes.[16]

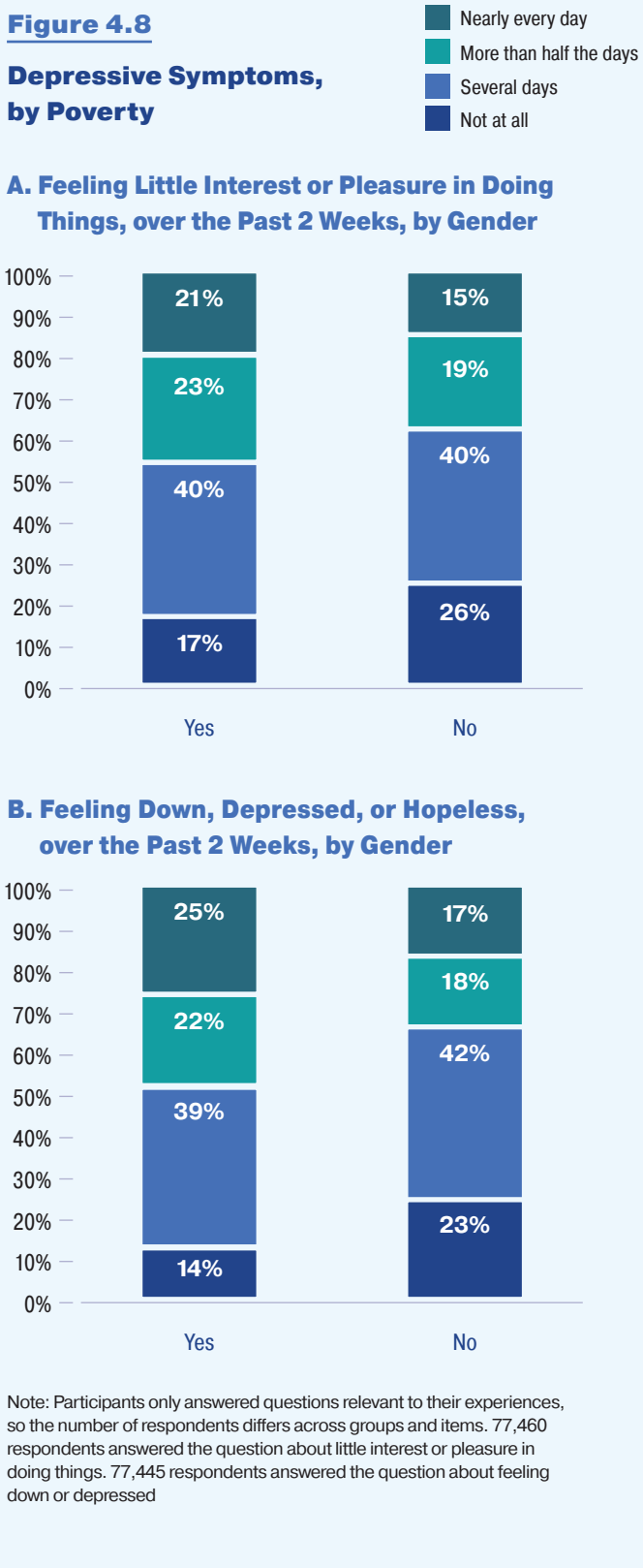
Crossdressers reported lower depressive symptoms than other gender identities. Fifty-seven percent (57%) felt little interest or pleasure in doing things at least some of the time in the two weeks prior to the survey (Figure 4.6a). In contrast, this number was 87% for AFAB nonbinary people. The trends were similar for "feeling down, depressed, or hopeless" in the two weeks prior to the survey (Figure 4.6b).Depressive symptoms showed distinct patterns between people who had and had not medically or socially transitioned (Figure 4.7).

At the time of the survey, all respondents identified as trans and/or nonbinary, but respondents who had not transitioned, either medically or socially, reported greater depressive symptoms compared to those who had transitioned. For example, 84% of people who had not socially transitioned reported feeling little pleasure at least some of the time, while 75% of people who had socially transitioned reported so. Findings were similar among those who have or haven't medically transitioned. Further, the same pattern appeared for "feeling down, depressed, or hopeless"; people who had socially or medically transitioned reported fewer days of feeling depressed or hopeless.

Individuals living at or near the poverty line reported greater depressive symptoms (Figure 4.8). For example, those who were living at or near poverty reported more days of feeling little interest in pleasure in things, compared to those who were not living at or near poverty (83% vs. 76%, respectively). Similar findings were found for feelings of being down, depressed or hopeless (86% vs. 77%, respectively).

Figure 4.8

Depressive Symptoms, by Poverty



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. 77,460 respondents answered the question about little interest or pleasure in doing things. 77,445 respondents answered the question about feeling down or depressed

Suicidality

Suicidality refers to a range of thoughts and behaviors related to suicide, including suicidal thoughts, suicide attempts, and completed suicide. In this section, we explore suicidality and critical factors that may shape suicidality like victimization, race and ethnicity, family support, and family rejection. The survey asked respondents whether they had seriously considered suicide, planned, or attempted suicide, both in the year preceding the 2022 survey and over their lifetime.[17]

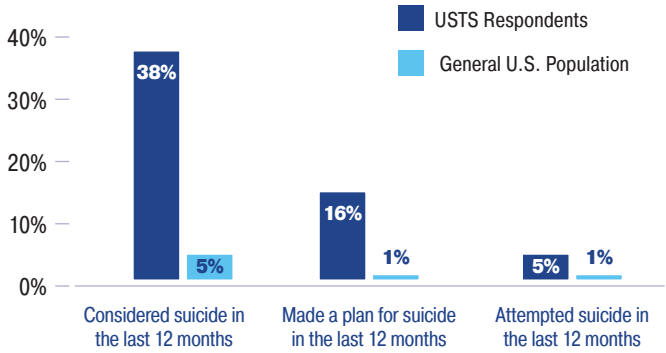
In the year prior to the survey, 38% of 2022 USTS respondents considered suicide. Of those who considered, 16% made a plan for suicide, and 5% attempted suicide. This is lower than the 2015 sample, in which 7% attempted suicide in the year prior to the survey.[18]

Our findings highlight stark disparities in suicidality between respondents of the USTS and the general U.S. population. The USTS sample had 6 times the prevalence of past-year suicidal ideation compared to the general population (38% vs. 5%) (Figure 4.9). Further, 16% of USTS respondents made a plan to attempt suicide, substantially higher than the 1% reported in the general population.[19]

Research suggests that structural factors like state-level discriminatory laws and policies, as well as stigma and hostile sociopolitical climates, contribute to the disproportionately high prevalence of suicidality seen among the trans and nonbinary community.[21] Our findings support this; past year suicidality was more prevalent among respondents who experienced victimization. Respondents who were verbally harassed, denied equal treatment or service for any reason, such as at a place of business, government agency, or public place, or were physically attacked, had a higher prevalence of considering, making a plan for, and attempting suicide, compared to respondents who did not experience victimization. For example, when examining those who have considered suicide in the past year, 31% of those who had no victimization considered suicide, while the prevalence was 50% for those who were verbally harassed, 53% for those who were denied equal treatment, and as high as 63% for those who were physically assaulted. This trend continued with both making a plan for and attempting suicide in the past year (Figure 4.10)

Figure 4.9

Respondents Reporting Suicidal Behaviors in the Prior 12 Months (USTS, SAMHSA)

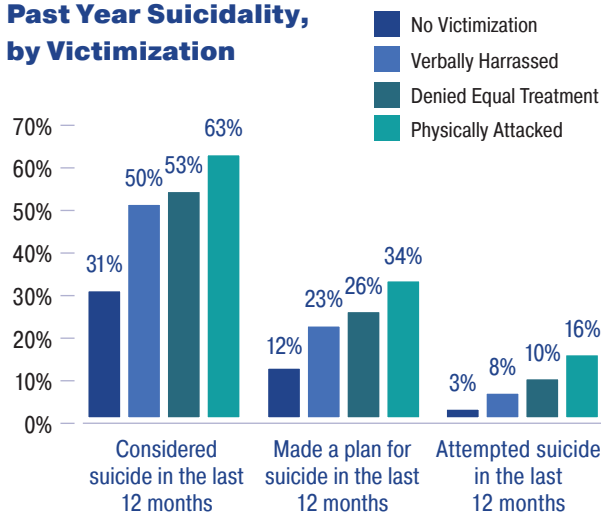


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[20]

Figure 4.10

Past Year Suicidality, by Victimization

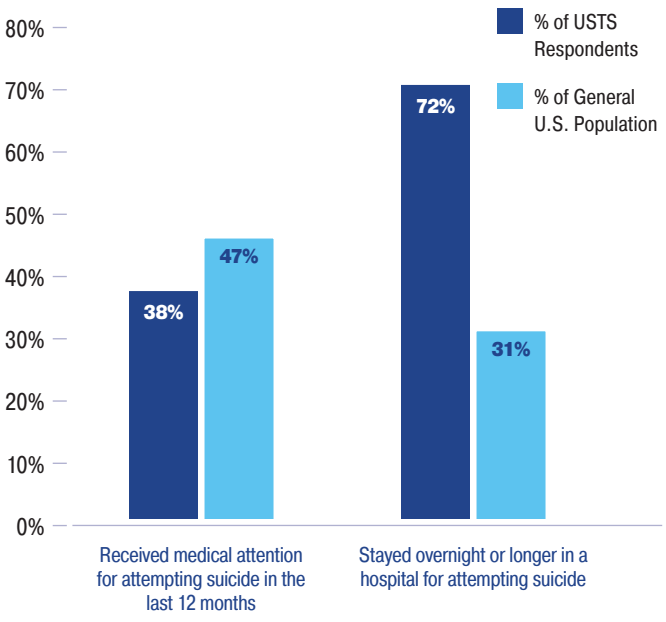


Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[25]

The impact of victimization on suicidality is deeply concerning—especially given how widespread experiences of victimization are among transgender and nonbinary individuals. Data from the National Crime Victimization Survey found that trans people experienced victimization at nearly four times the rate of cisgender people.[22] In our survey, 39% of respondents reported some form of victimization, and respondents often cited their gender as to why they were targeted.[23] Ninety-one percent (91%) of those denied equal treatment, 84% of those verbally harassed, and 63% of those physically attacked reported that they believed they were targeted because of their transgender status, gender expression, or gender identity.[24]

Figure 4.11

Prevalence of Medical Attention and Hospitalization Among Those Who Attempted Suicide in the Past 12 Months (USTS, SAMHSA)



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Received medical attention for attempted suicide in the last 12 months (n = 3,145) & Stayed overnight or longer in a hospital for suicide attempt (n = 1,311).

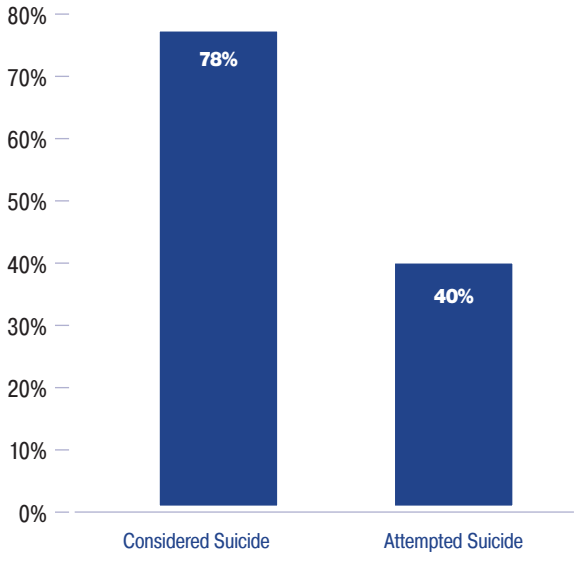
The USTS also reveals disparities in suicide-related medical care, with fewer respondents receiving treatment compared to the general population (38% vs. 47%) (Figure 4.11).

Notably, a significantly higher proportion of USTS respondents who received medical attention were required to stay overnight or longer in a hospital (72% vs. 31%) (Figure 4.10). This indicates that while fewer trans individuals are receiving care, their conditions may be more severe, require more intensive intervention, are treated differentially, or trans individuals delay seeking care until their symptoms are more severe. This disparity also suggests a potential gap in access to or availability of necessary care for this population.

Reports of suicidality occurring at some point in their life are equally concerning. Forty percent (40%) of respondents attempted suicide in their lifetime in the 2015 USTS.[26] This pattern persists in 2022 USTS respondents: 78% considered suicide and 40% attempted suicide in their lifetime (Figure 4.12).

Figure 4.12

Lifetime Suicidal Thoughts and Behaviors (n = 83,829)

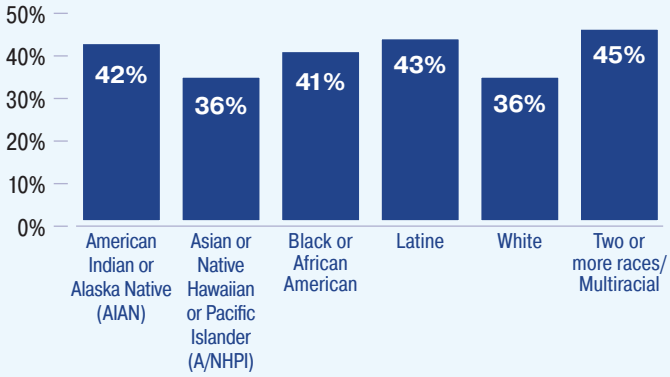


Suicidality varied substantially by race and ethnicity (Figure 4.13). Most people of color reported higher prevalence than white respondents. Respondents who were two or more races or multiracial reported the highest prevalence of considering (45%) and planning (20%) suicide in the past 12 months. American Indian/Alaska Native had the highest prevalence of attempting suicide (10%). White/European American and Asian/NHPI respondents reported the lowest prevalence of suicide attempts (4% and 4%, respectively).

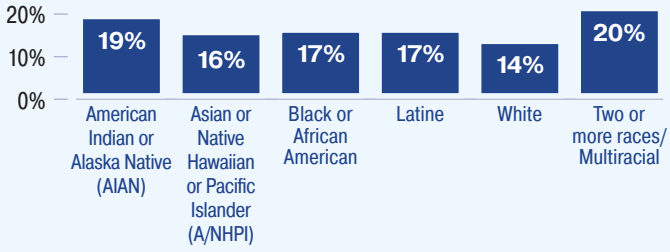
Figure 4.13

Respondents Experiencing Suicidal Thoughts and Behaviors in the Previous 12 Months, by Race

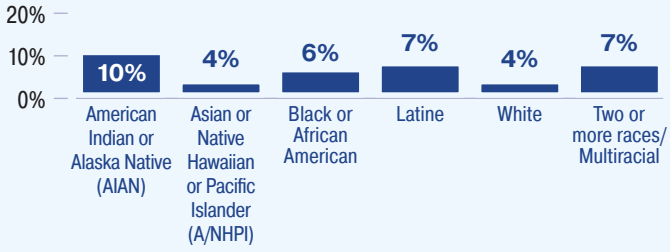
A. Considered Suicide



B. Made A Plan For Suicide



C. Attempted Suicide

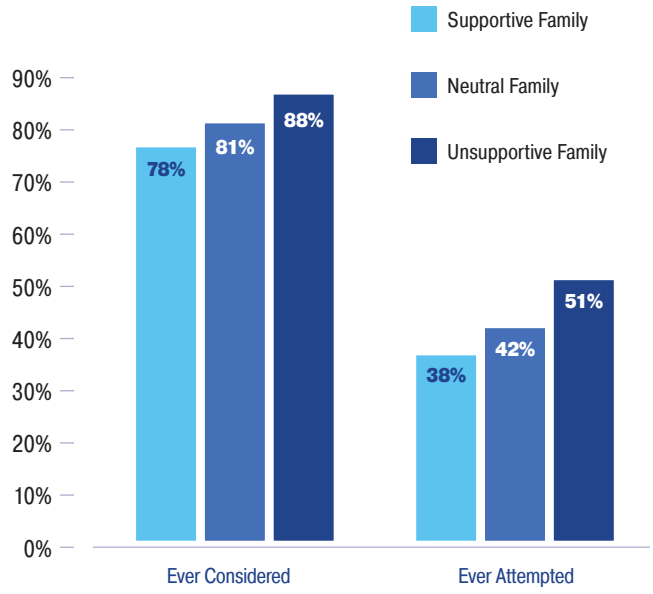


Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[27]

Public health research shows that social support is a key protective factor in preventing suicide in the general population.[28] Further, research focused on trans and nonbinary people have found that social support may be one of the most important factors in reducing suicidal thoughts and suicide attempts.[29] Supportive families may play a crucial role in the wellbeing of USTS respondents. The survey asked respondents who were out to their family how supportive their immediate family was. Those with supportive families reported less suicidality compared to those with unsupportive families: 78% vs. 85% for ever considering suicide and 38% vs. 51% for ever attempting suicide (Figure 4.14).

Figure 4.14

Lifetime Suicidal Thought and Behaviors, by Family Support

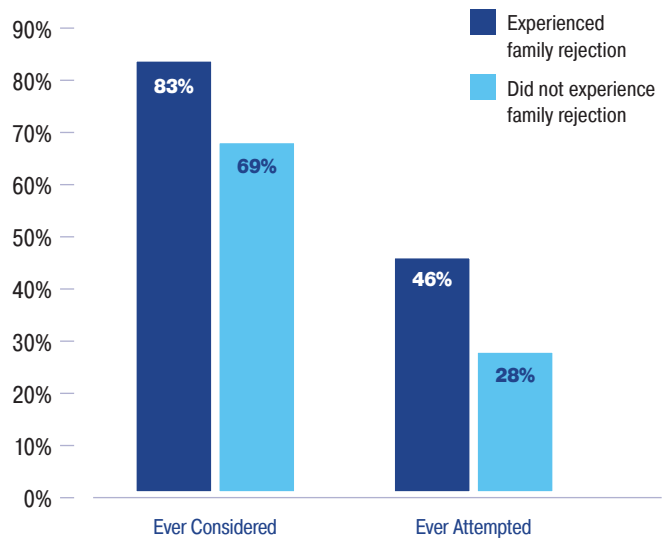


Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Ever considered suicide and out to immediate family (n = 65,872) & Ever attempted to kill themselves and out to immediate family (n = 65,978).

Further, the survey asked if respondents' families rejected them, for example, by stopping speaking to them, ending their relationship, or teasing and ridiculing them. In 2015, those respondents who experienced family rejection had a higher frequency of attempted suicide (49%) than those who were not rejected (33%).[30] This pattern persisted in 2022 (Figure 4.15)—those who experienced family rejection were more likely to report considering suicide (83%) and attempting suicide (46%) compared to those who did not experience such rejection (69% and 28%, respectively).

Figure 4.15

Lifetime Suicidal Thoughts and Behaviors, by Family Rejection



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Ever considered suicide (n = 82,047) & Ever attempted to kill themselves (n = 81,938).

Experiences with Mental Health Providers (MHPs)

This section explores interactions with mental health professionals, such as psychiatrists, psychologists, or clinical social workers, as well as religious counselors, to better understand the support, barriers, and outcomes faced by trans people in seeking mental healthcare.

In 2022, most (58%) respondents reported using mental healthcare (Table 4.1). That is, receiving counseling or therapy from an MHP in the 12 months prior to the survey). This number is more than 2.5 times that of the U.S. general adult population (22%).[31] Of those who received counseling in the past 12 months, two-thirds (67%) reported currently receiving counseling from a MHP at the time of the survey.

Table 4.1

Experiences with Mental Health Providers

Experiences	Percent
Received counseling or therapy from a MHP during the last 12 months	58
Of those who received counseling in the past 12 months, currently receiving counseling or therapy from an MHP	67
Ever wanted counseling or therapy for gender identity/transition	78
Ever had counseling or therapy for gender identity/transition	48

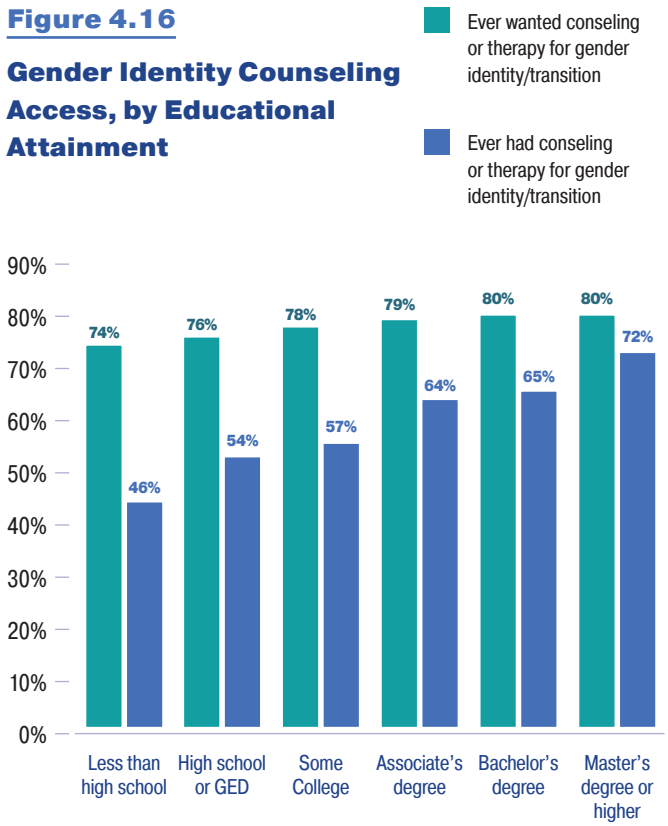
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the end note.[33]

Despite the high overall utilization of mental healthcare, there remains a notable gap when it comes to counseling related to gender identity and transition. More than three-quarters (78%) of respondents had a desire for counseling specifically related to their gender identity and/or transition; however, only half (48%) received such care. In the 2015 USTS, 77% of respondents said they wanted counseling or therapy for their gender identity or gender transition at some point in their life, but more (58%) had ever received such counseling or therapy.[32]

Notably, mental healthcare access varied by important class characteristics: education and income. Similar proportions of respondents across the education spectrum wanted counseling related to gender identity (range: 74% to 80%) (Figure 4.16).

Figure 4.16

Gender Identity Counseling Access, by Educational Attainment



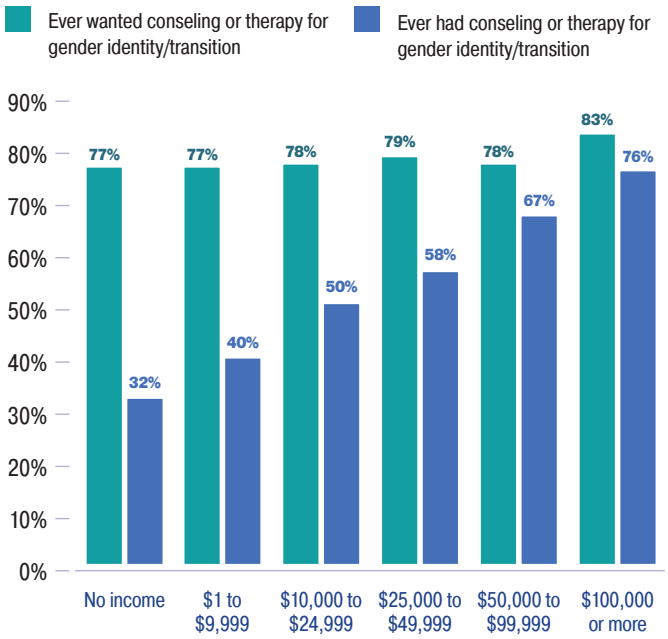
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items The sample sizes are as follows: Ever wanted counseling or therapy for gender identity/transition (25+, n = 49,223) & ever had counseling or therapy for gender identity/transition (25+, n = 49,213)

However, respondents with less education accessed this care dramatically less often (less than high school, 46%; master's degree or higher, 72%). A similar trend exists for income: similar proportions of respondents across income wanted therapy for their gender identity (range: 77%-83%); but roughly a third (32%) of those with no income received therapy for their gender identity compared to 76% to those who made $100k or more (Figure 4.17).

As aforementioned, 78% of respondents had a desire for counseling specific to their gender identity and/or transition; however, fewer than half (48%) received

Figure 4.17

Gender Identity Counseling, by Income



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: Ever wanted counseling or therapy for gender identity/transition (n = 82,068) & Ever had counseling or therapy for gender identity/transition (n = 82,067)

such care. Despite this difference, many brought up the topic in their standard counseling visits. Of those who did not receive counseling specifically for the gender identity or transition, about a quarter (25%) still discussed their gender identity or trans identity with a MHP at some point (Table 4.2). Notably, many of these respondents reported that the MHPs invalidated their trans experience. (Table 4.3) For example, 12% of respondents who either went to therapy for their gender identity or discussed their gender identity with their MHP reported that their MHP tried to persuade them to identify only with their sex assigned at birth. Interactions with religious counselors or therapists were less common, with 7% reporting such discussions; however, these encounters were more frequently marked by such practices, with 50% stating that the religious counselor or therapist tried to make them identify solely as their sex assigned at birth. (Table 4.3)

Table 4.2

Gender Identity Counseling Access

Type of Counseling	Percent
Discussed gender identity or transition with a mental health provider (MHP) at some point, either one they saw specifically for gender-related counseling or one they were seeing for other reasons.	71
Of those, saw an MHP specifically for gender identity (GI)/transition	48
Of those, saw an MHP not specific to GI/transition	25
Discussed GI or transition with a religious counselor/therapist	7

Note: Because respondents could select multiple options, the percentages do not sum and does not necessarily reflect the number of unique individuals. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[34]

Table 4.3

Counselor or Provider Attempts to Change Gender Identity

Type of Counseling	Percent
Of those that saw a MHP specifically for gender identiy (GI)/transition, provider tried to make them identify with their sex assigned at birth	13
Saw a someone else for specifically GI/transition counseling, provider tried to make them identify with their sex assigned at birth	17
Of those that discussed GI with a MHP (but not specifically for GI counseling), provider tried to make them identify with their sex assigned at birth	12
Of those that discussed GI/transition with a religious counselor/therapist, provider tried to make them identify with their sex assigned at birth	50

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[35]

CONCLUSION

This chapter underscored the urgent mental health needs of the transgender community and the systemic barriers they face in accessing affirming mental healthcare. Transgender and nonbinary communities report disproportionate burden of serious psychological distress, depression, and suicidality. Further, while many respondents utilize mental health services, there remain significant gaps in access to gender-affirming mental healthcare, as well as a high prevalence of harmful practices.

1. Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. Clinical Pyschology Review. 66:24-38. doi: 10.1016/j.cpr.2018.03.003
2. Price, M.A., Hollinsaid, N. L., McKetta, S., Mellen, E.J., & Rakhilin, M. (2023). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. Social Psychiatry and Psychiatric Epidemiology, 59. https://doi.org/10.1007/s00127-023-02482-4
3. dickey, l. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. American Psychologist, 75(3), 380–390. https://doi.org/10.1037/amp0000619
4. dickey, l. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. American Psychologist, 75(3), 380–390. https://doi.org/10.1037/amp0000619
5. Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
6. Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
7. Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
8. National Center for Health Statistics. (2022). National Health Interview Survey, 2019–2021: Table from Data Brief No. 444. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/databriefs/db444-tables.pdf#1
9. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. Transgender Survey (p. 105). Washington, DC: National Center for Transgender Equality
10. Price, M.A., Hollinsaid, N. L., McKetta, S., Mellen, E.J., & Rakhilin, M. (2023). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. Social Psychiatry and Psychiatric Epidemiology, 59. https://doi.org/10.1007/s00127-023-02482-4
11. The SPDMON score (Serious Psychological Distress for the past month) is based on the K6SCMON scale, which measures psychological distress using six variables that assess feelings experienced over the past 30 days. Each of these variables is assigned a numeric score based on the frequency of the feeling during the past month.

    The scores for all six variables are then summed to create the K6SCMON score, which ranges from 0 to 24. Based on this score, individuals are classified into two groups: those with serious psychological distress (SPDMON = 1) if their total score is 13 or greater, and those without serious psychological distress (SPDMON = 0) if their total score is less than 13. This classification provides a standardized way to identify individuals experiencing high levels of distress over the past month. More information about scoring can be found at: https://www.samhsa.gov/data/system/files/media-puf-file/NSDUH-2008-DS0001-info-codebook.pdf

12. The Kessler 6 score ranges from 0 to 24. Each individual item (felt nervous, hopeless, restless, sad, that everything was an effort, or down on themselves) is scored from 0 to 4. A total score of 13 or higher meets the criteria for serious psychological distress.

13. National Center for Health Statistics. (2022). National Health Interview Survey, 2021: Public-use data file and documentation. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nhis/data-questionnaires-documentation.htm

14. The PHQ-2 is a brief, self-administered screening tool derived from the Patient Health Questionnaire (PHQ), itself an adaptation of the PRIME-MD tool used by healthcare providers to assess common mental health disorders. The PHQ-2 focuses on the frequency of depressed mood and lack of interest or pleasure (anhedonia) over the past two weeks, with scores ranging from 0 to 6. Response options included: "not at all," "several days," "more than half the days," and "nearly every day."

    A cut-off score of 3 is recommended for identifying potential depression, though a cut-off of 2 improves sensitivity. The PHQ-2 is not intended for diagnosis or tracking depression severity but serves as a preliminary screen, with positive results warranting further evaluation using the PHQ-9. More information about the PHQ-2 can be found at: https://cde.nida.nih.gov/instrument/fc216f70-be8e-ac44-e040-bb89ad433387

15. National Center for Health Statistics. (2022). National Health Interview Survey, 2021: Public-use data file and documentation. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nhis/documentation/2021-nhis.html

16. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    Feeling little interest or pleasure in doing things, over the past 2 weeks by Transition Status:

    - Have not Medically Transitioned (n = 81,799)
    - Have Medically Transitioned (n = 81,799)
    - Have not Socially Transitioned (n = 82,763)
    - Have Socially Transitioned (n = 82,763)

    Feeling down, depressed, or hopeless, over the past 2 weeks by Transition Status:

    - Have not Medically Transitioned (n = 81,782)
    - Have Medically Transitioned (n = 81,782)
    - Have not Socially Transitioned (n = 82,744)
    - Have Socially Transitioned (n = 82,744)

17. The questions used to measure suicidality were adapted from the National Survey on Drug Use and Health to allow for comparability with data from the general U.S. population.

18. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. Transgender Survey (p. 112). Washington, DC: National Center for Transgender Equality.

19. Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

20. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - Considered suicide in the last 12 months (n = 83,983)
    - Made a plan for suicide in the last 12 months (n = 83,968)
    - Attempted suicide in the last 12 months (n = 83,962)

21. Price, M.A., Hollinsaid, N. L., McKetta, S., Mellen, E.J., & Rakhilin, M. (2023). Structural transphobia is associated with psychological distress and suicidality in a large national sample of transgender adults. Social Psychiatry and Psychiatric Epidemiology, 59. https://doi.org/10.1007/s00127-023-02482-4

    dickey, l. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. American Psychologist, 75(3), 380–390. https://doi.org/10.1037/amp0000619

22. Flores, A. R., Meyer, I. H., Langton, L., & Herman, J. L. (2021). Gender identity disparities in criminal victimization: National Crime Victimization Survey, 2017–2018. American Journal of Public Health, 111(4), 726-729.

    Trans people experienced 86.2 victimizations per 1000 persons compared with cisgender people's 21.7 per 1000 persons.

23. n = 82,450

24. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - Denied equal treatment due to transgender status, gender expression, of gender identity (n = 8,715)
    - Verbally harassed due to transgender statuts, gender expression, of gender identity (31,889)

- Physically attacked due to transgender statuts, gender expression, of gender identity (n = 3,715)

25. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
    - Considered suicide in the past 12 months / Any victimization (n = 82,329)
    - Considered suicide in the past 12 months / Denied equal treatment (n = 82,375)
    - Considered suicide in the past 12 months / Verbally Harassed (n = 82,386)
    - Considered suicide in the past 12 months / Physically attacked (n = 82,348)
    - Made a plan for suicide in the past 12 months / Any victimization (n = 82,317)
    - Made a plan for suicide in the past 12 months / Denied equal treatment (n = 82,363)
    - Made a plan for suicide in the past 12 months / Verbally Harassed (n = 82,374)
    - Made a plan for suicide in the past 12 months / Physically attacked (n = 82,336)
    - Attempted suicide in the past 12 months / Any victimization (n = 82,314)
    - Attempted suicide in the past 12 months / Denied equal treatment (n = 82,359)
    - Attempted suicide in the past 12 months / Verbally Harassed (n = 82,370)
    - Attempted suicide in the past 12 months / Physically attacked (n = 82,332)
26. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. Transgender Survey (p. 114). Washington, DC: National Center for Transgender Equality.
27. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
    - Considered suicide in the last 12 (n = 83,689)
    - Made a plan for suicide in the last 12 months (n = 83,674)
    - Attempted suicide in the last 12 months (n = 83,668)
28. Kleiman, E. M., & Liu, R. T. (2013). Social support as a protective factor in suicide: Findings from two nationally representative samples. Journal of Affective Disorders, 150, 540–545. http://dx.doi.org/10.1016/j.jad.2013.01.033
29. dickey, l. m., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. American Psychologist, 75(3), 380–390. https://doi.org/10.1037/amp0000619
30. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. Transgender Survey (p. 65). Washington, DC: National Center for Transgender Equality.
31. Data for U.S. general population comparison were sourced from the National Center for Health Statistics, National Health Interview Survey, 2019–2021. https://www.cdc.gov/nchs/data/databriefs/db444-tables.pdf
32. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. Transgender Survey (p. 99). Washington, DC: National Center for Transgender Equality.
33. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
    - Received counseling or therapy from a MHP during the last 12 months (n = 84,089)
    - Currently receiving counseling or therapy from a MHP (n = 55,618)
    - Ever wanted counseling or therapy for gender identity/transition (n = 84,035)
    - Ever had counseling or therapy for gender identity/transition (n = 84,042)
34. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
    - Discussed gender identity or transition with a mental health provider (MHP) at some point, either one they saw specifically for gender-related counseling or one they were seeing for other reasons (n = 84,170)
    - Had counseling specifically for gender identity (GI)/transition (n = 84,042)
    - Discussed GI/transition with a MHP (who they were not specifically seeing for GI/transition counseling) (n = 84,170)
    - Discussed GI/transition with a religious counselor/therapist (n = 84,036)

35. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:

    - Saw a MHP for GI/transition counseling, and provider tried to make them identify with their sex assigned at birth (n = 43,437)
    - Saw a someone else for GI/transition counseling, and provider tried to make them identify with their sex assigned at birth (n = 43,437)
    - Discussed with a MHP but not specifically for GI counseling, and tried to make them identify with their sex assigned at birth (n = 64,065)
    - Discussed GI/transition with a religious counselor/therapist, and provider tried to make them identify with their sex assigned at birth (n = 4,639)

CHAPTER 5

Happiness, Life Evaluation, and Life Satisfaction

IN OUR OWN VOICES

"Ever since I have been able to medically transition, I have been happier than I have ever been. I can actually look at myself in the mirror and recognize who I am."

ARACELI
Latine/Hispanic transgender woman

Age range: 18-24

"I have thrived in the past 12 months in transition, I have a genuine smile on my face most days & laugh with genuine joy. I have grown into the woman I was meant to be, I have hit peaks & also troughs. I wish I had started my transition earlier in life but am glad to have done it at all."

CHARLOTTE
Latine/Hispanic transgender woman

Age range: 18-24

"Once I learned what it meant to be trans, I never looked back. I traded in my Regina George-esque life for a future with a balding head and a predisposition for a beer gut. I've never been more happy to be alive—every single day. "

ROO
Afro-Caribbean, trans, nonbinary

Age range: 25-40

INTRODUCTION

The previous chapter on mental health described poor outcomes among USTS respondents for serious psychological distress, depression, and suicidality and showed that these outcomes were associated with factors like transition status, victimization, and family support. In contrast, this chapter focuses on features of wellbeing and the conditions that may support them. This section explores three critical dimensions of wellbeing: (1) happiness, (2) life evaluation, and (3) life satisfaction. Happiness captures respondents' general emotional state, reflecting feelings of joy and contentment in daily life. Life evaluation assesses their current and anticipated future life quality on a continuum from negative to positive. Life satisfaction encompasses a deeper sense of fulfillment and contentment with one's life.

First, this chapter discusses general findings among all respondents, and, second, how these factors vary across transition status, age, and gender. Transition status is split into two categories: social transition and medical transition. Social transition refers to steps like adopting a new name, pronouns, and clothing style. Medical transition refers to the medical interventions individuals take to align themselves with their gender identity, such as hormone therapy or surgeries. The data reveals that taking steps towards transition may support better wellbeing among our respondents. For example, findings show that medically and socially transitioned respondents had substantially higher prevalences of happiness, thriving, and life satisfaction compared to those who had not transitioned. Exploring these factors offers a deeper understanding of the distinct and varied lived experiences within transgender and nonbinary communities.

Key Findings

General Happiness

- Two thirds of respondents (66%) reported being "Very to pretty happy." However, a third (34%) indicated they were "Not too happy."

Life Evaluation

- Thirty percent (30%) of respondents reported that they were thriving, the majority (63%) were struggling, and 7% were suffering.

Life Satisfaction

- Chapter 2 discusses how transition-related care impacted life satisfaction; 98% of respondents taking GAHT reported that taking GAHT made them more satisfied with their lives, and 97% of respondents who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives.
- This chapter discusses general life satisfaction. Thirty-seven percent (37%) of respondents reported being overall satisfied with their lives, while the majority (59%) expressed varying levels of dissatisfaction. Four percent (4%) of respondents felt neutral.

Differences by Age, Gender, and Transition Status

- Medically and socially transitioned respondents showed markedly higher prevalences of happiness, thriving, and satisfaction compared to those who had not transitioned.
  - Seventy-two percent (72%) of medically transitioned and 71% of socially transitioned respondents were "Very to pretty happy" (72%) compared to 55% and 52% of those who had not medically or socially transitioned, respectively.
  - Medically and socially transitioned respondents were thriving more (37% and 36%, respectively) compared to those who had not transitioned (19% and 18%, respectively).
  - Respondents who had medically or socially transitioned reported substantially higher life satisfaction (43% and 43%, respectively), compared to 27% and 24% among those who had not medically or socially transitioned, respectively.
- Happiness, life evaluation, and life satisfaction varied by age, gender, and transition status among respondents.
- Older individuals (65+) reported the highest levels across these measures: 82% described themselves as happy, 55% as thriving, and 61% reported being satisfied with life. Younger individuals aged 18 to 24 showed the lowest levels across these measures: 58% happy, 20% thriving, and 27% satisfied with their lives.
- Gender differences revealed that crossdressers reported relatively high prevalences of being happy (72%), thriving (33%) and satisfied (41%), while nonbinary individuals assigned female at birth (AFAB) reported low prevalences across categories (61% happy, 25% thriving, and 34% satisfied).

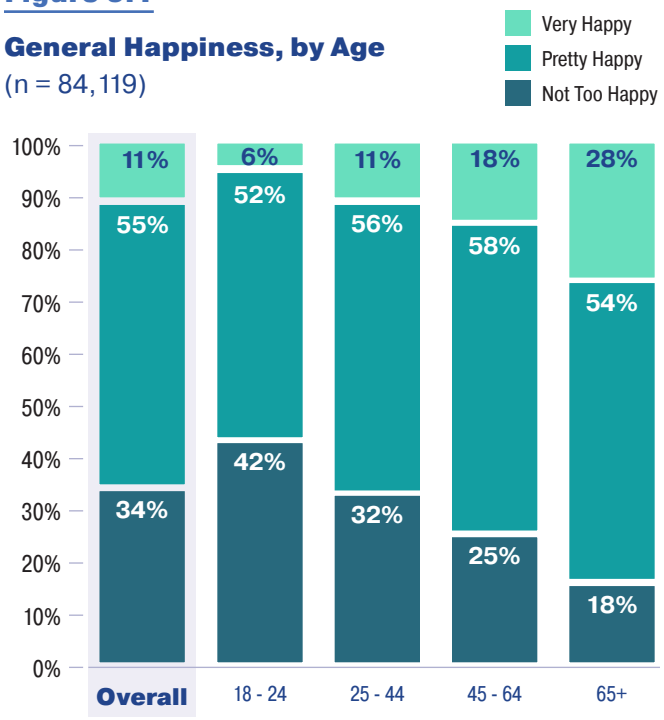
General Happiness

The survey asked respondents to evaluate their general happiness with the prompt: "Generally, how would you say things are these days in your life? Would you say that you are: Very happy, Pretty happy, or Not too happy?" Over half of respondents (55%) reported being "Pretty happy," while a smaller percentage (11%) reported being "Very happy," and 34% of respondents indicated that they were "Not too happy" (Figure 5.1).

Happiness varied by age (Figure 5.1) and gender (Figure 5.2).

Figure 5.1

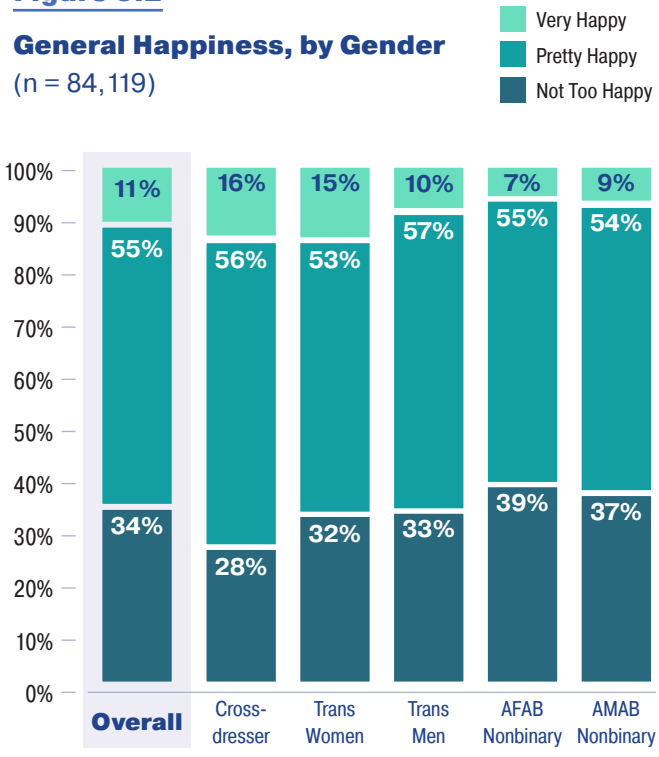
General Happiness, by Age
(n = 84,119)



Note: Percentages may not sum to 100 due to weighting and rounding.

Figure 5.2

General Happiness, by Gender
(n = 84,119)

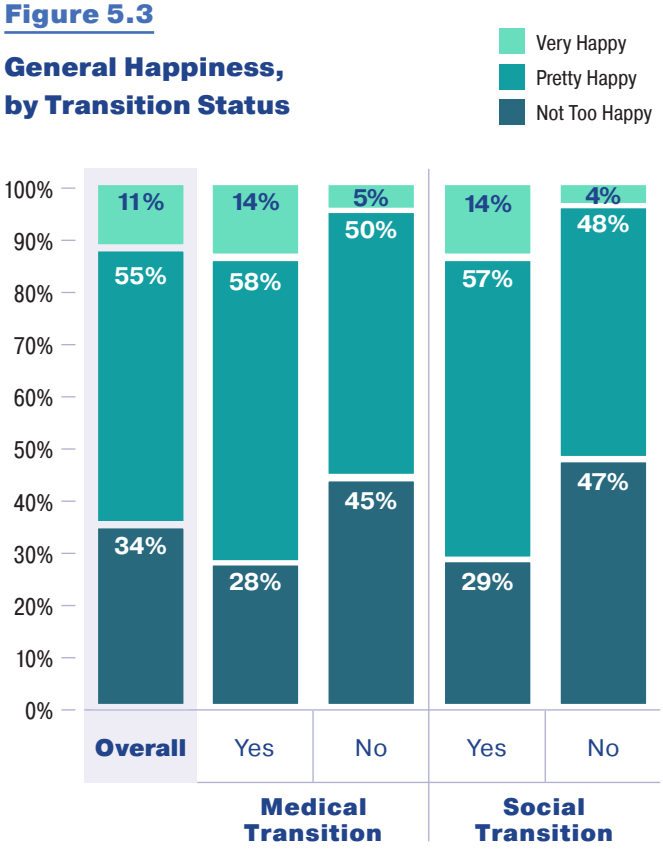


Older respondents were happier than younger respondents. Eighty-two percent (82%) of respondents aged 65+ years old reported they are "Very to pretty happy," compared to only 58% among those aged 18 to 24 years old. Crossdressers reported the highest happiness levels, with 72% indicating they were either "Pretty" or "Very happy." AFAB nonbinary individuals had the highest rating of being "Not happy" (39%) across all groups.

Happiness levels varied substantially by social and medical transition status: nearly three-quarters of those who had medically transitioned reported being "Very to pretty happy" (72%) compared to over half of those who had not (55%); those who had socially transitioned also report higher happiness (71%) compared to roughly half of those who had not (52%). (Figure 5.3)

Figure 5.3

General Happiness, by Transition Status



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: medical transition (n = 81,844) & social transition (n = 82,849).

Life Evaluation

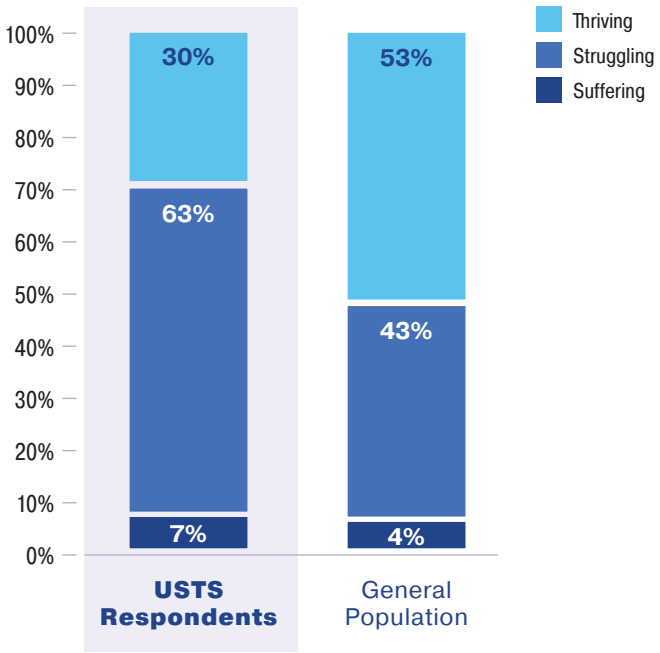
The 2022 USTS used the Cantril Self-Anchoring Striving Scale to gauge respondents' perceptions of their current and future lives[1]: thriving, struggling, or suffering.[2]

Thirty percent (30%) of respondents rated themselves as thriving, meaning they rated their current life satisfaction highly and had optimistic expectations for the future (Figure 5.4). However, about two thirds of respondents (63%) rated themselves as struggling, indicating that they are neither thriving nor suffering. Seven percent (7%) of respondents rated themselves as suffering, reflecting a much lower quality of life and bleak future expectations.

USTS respondents reported much lower life evaluations compared to the U.S. general population. We found that 30% of USTS respondents were thriving, compared to 53% of the general U.S. population, 63% were struggling (versus 43%), and 7% were suffering (versus 4%) (Figure 5.4).

Figure 5.4

Life Evaluation Index (USTS, n = 83,817, Gallup[3])



Life evaluation varied by age (Figure 5.5), gender (Figure 5.6), and transition status (Figure 5.8). Older respondents reported a higher prevalence of thriving (55% aged 65+ years old) compared to younger respondents (20% aged 18 to 24 years old). Trans women reported the highest prevalence of thriving (35%) while AFAB nonbinary individuals reported the lowest prevalence (25%).

Medically and socially transitioned respondents showed markedly higher prevalences of thriving (37% and 36%, respectively) compared to those who have not transitioned (19% and 18%, respectively) (Figure 5.7).

Figure 5.5

Life Evaluation Index, by Age (n = 83,817)

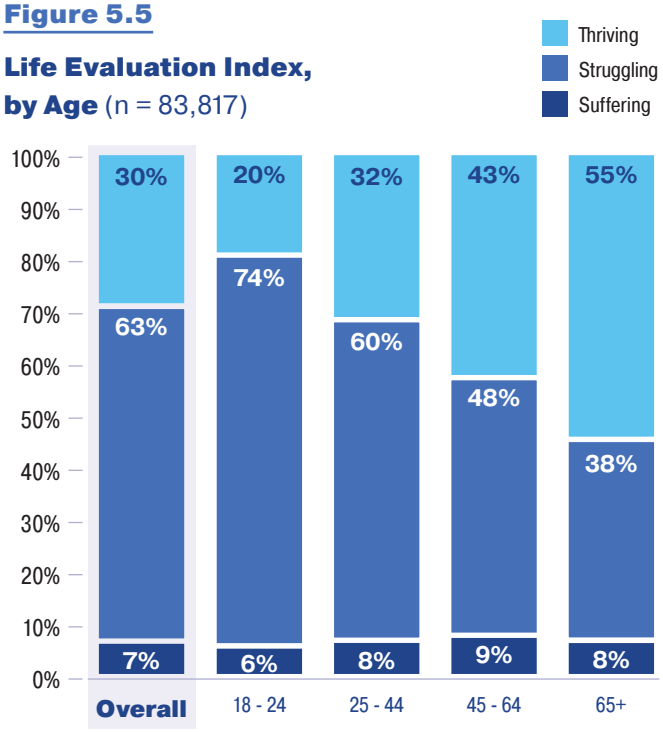


Figure 5.6

Life Evaluation Index, by Gender (n = 83,817)

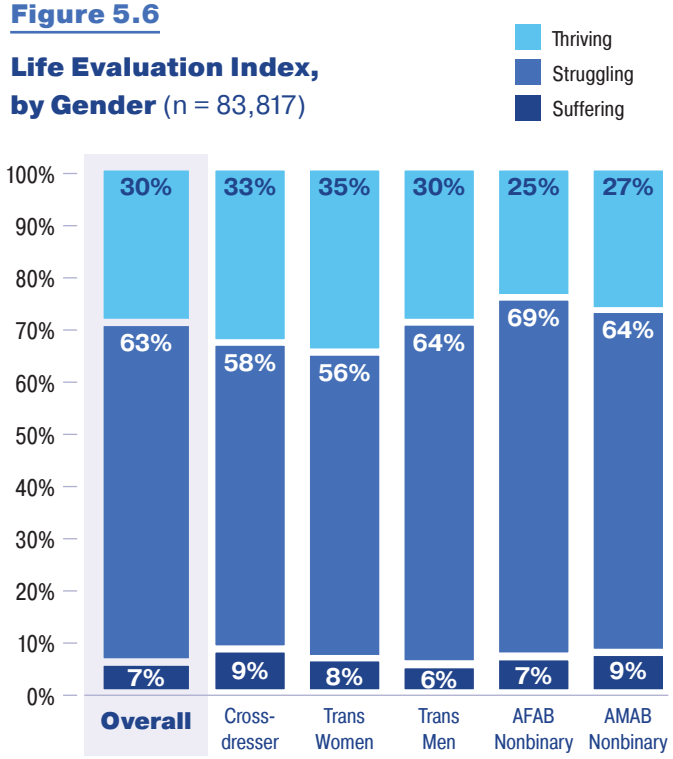
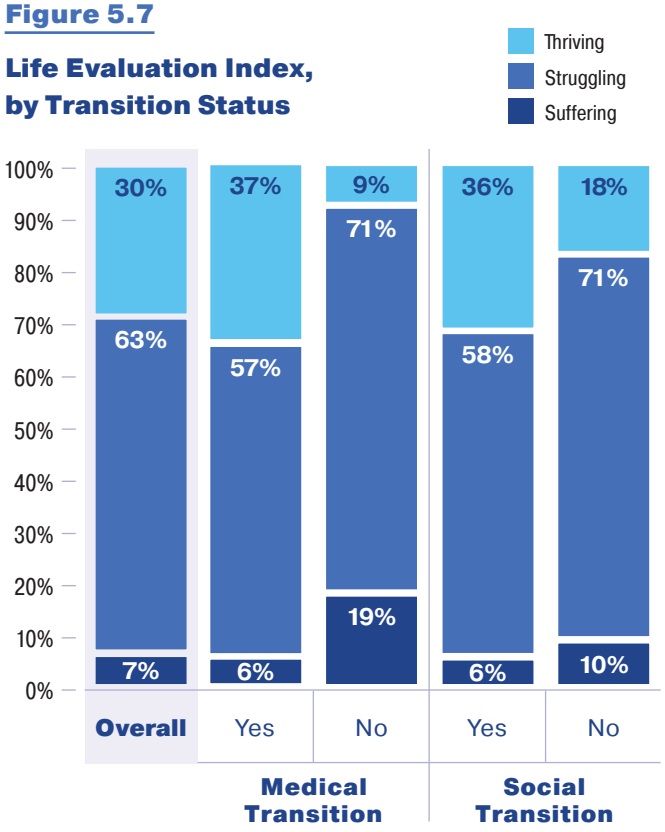


Figure 5.7

Life Evaluation Index, by Transition Status



Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes are as follows: medical transition (n = 81,844) & social transition (n = 82,849). Percentages may not sum to 100 due to weighting and rounding.

Life Satisfaction

Chapter 2 discussed how transition-related care impacted life satisfaction; 98% of respondents taking GAHT reported that taking GAHT made them more satisfied with their lives, and 97% of respondents who underwent gender-affirming surgery reported their surgery made them more satisfied with their lives. This chapter discusses general life satisfaction. More specifically, the USTS asked respondents to rate their agreement with five core statements reflecting overall contentment with their lives.[4] Combined, 37% of respondents reported that they were satisfied with their lives (4% extremely satisfied, 14% satisfied, and 19% slightly satisfied). In contrast, more than half (59%) expressed dissatisfaction with their life (21% slightly dissatisfied, 22% dissatisfied, and 16% extremely dissatisfied, Table 5.1).

Older respondents reported higher life satisfaction compared to younger respondents (Figure 5.8). Those aged 65+ years old reported a prevalence of satisfaction more than double of those aged 18 to 24 years old (61% vs. 27%, respectively).

Figure 5.8

Life Satisfaction, by Age (n = 83,872)

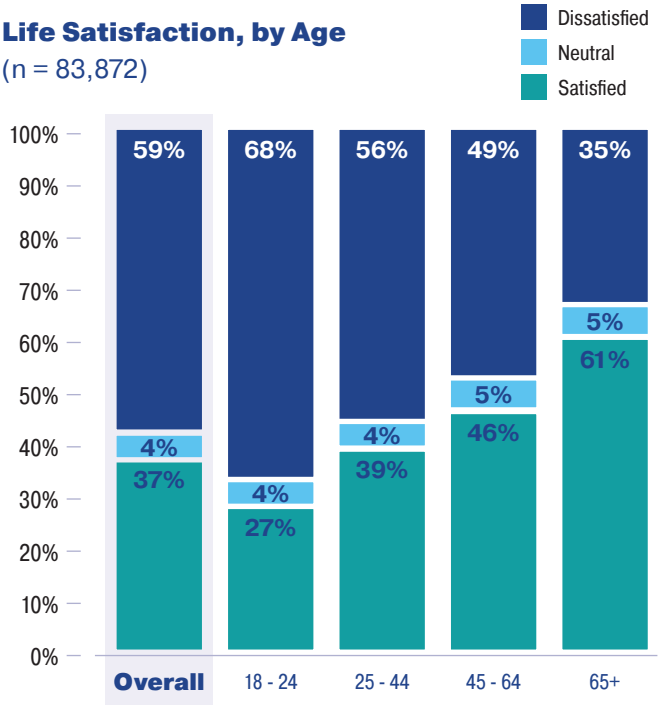


Table 5.1

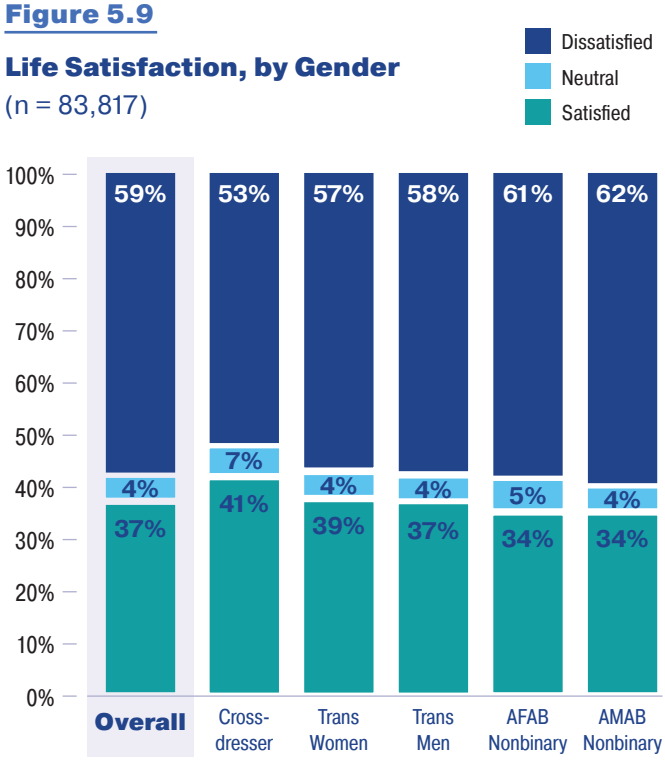
Life Satisfaction
(n = 83,872)

Satisfaction	Percent
Extremely Satisfied	4
Satisfied	14
Slightly Satisfied	19
Neutral	4
Slightly Dissatisfied	21
Dissatisfied	22
Extremely Dissatisfied	16

Across gender groups, crossdressers reported the highest satisfaction levels (41%), while AFAB and AMAB nonbinary individuals reported the lowest (both 34%) (Figure 5.9).

Figure 5.9

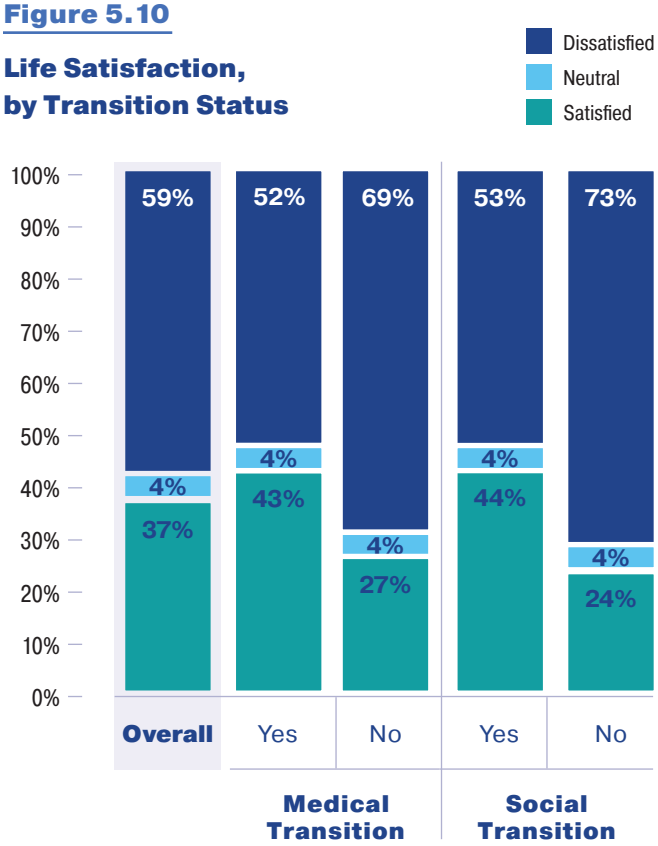
Life Satisfaction, by Gender
(n = 83,817)



Respondents who had medically or socially transitioned reported substantially higher life satisfaction (43% and 43%, respectively), compared to 27% and 24% among those who had not medically or socially transitioned, respectively (Figure 5.10).

Figure 5.10

Life Satisfaction, by Transition Status



Note: Percentages may not sum to 100 due to weighting and rounding.

CONCLUSION

The 2022 USTS presents a nuanced picture of transgender and nonbinary respondents' wellbeing. Here, we focused on happiness, life evaluation, and life satisfaction. These results are complex—while happiness levels appeared relatively high, fewer respondents felt their lives were thriving or fulfilling. Most (66%) respondents reported being "Very to pretty happy." But life evaluation and satisfaction were relatively low: only 30% of respondents were thriving, and just 37% reported being satisfied with their lives. The data reveal variations by age, gender, and transition status: older respondents reported greater happiness, life satisfaction, and life evaluation. Nonbinary individuals consistently reported poorer outcomes across these wellbeing measures compared to trans men, trans women, and crossdressers. Most notably, respondents who had medically or socially transitioned reported much higher prevalences of happiness, thriving, and life satisfaction compared to those who had not. Together, this chapter highlights diverse experiences within the USTS population.

1. The Cantril Self-Anchoring Striving Scale (Cantril, 1965) is used scale to assess wellbeing. This scale asks individuals to imagine a ladder where the lowest rung (0) represents the worst possible life, and the highest rung (10) represents the best possible life. Respondents rate where they currently stand and where they expect to be in five years.
2. This report used the three categories established by Gallup (https://news.gallup.com/poll/122453/Understanding-Gallup-Uses-Cantril-Scale.aspx)—Thriving, Struggling, and Suffering. "Thriving" respondents rate their current life as 7+ and their future life as 8+, reflecting strong and progressing wellbeing with fewer health issues and positive daily experiences. "Struggling" individuals show moderate or inconsistent wellbeing, with moderate or negative views of either their present or future. Respondents are classified as "suffering"if they rate both their current and future life as 4 or below, indicating high-risk wellbeing, with greater exposure to health problems, financial insecurity, and emotional distress.
3. General population life evaluation numbers come from Gallup's U.S. Life Evaluation Index. We reported numbers from July 2022—the results that directly preceded the 2022 USTS. More information can be found at Gallup. (2024). *Life Evaluation Index: Global indicator of life satisfaction and wellbeing.* Retrieved from https://www.gallup.com/394505/indicator-life-evaluation-index.aspx.
4. Respondents indicated agreement on a 7-point Likert scale (from "Strongly disagree" to "Strongly agree") for five statements: "In most ways, my life is close to my ideal," "The conditions of my life are excellent," "I am satisfied with life," "So far, I have gotten the important things I want in life," and "If I could live my life over, I would change almost nothing." Higher scores reflect greater contentment and a more positive life outlook.

CHAPTER 6

Substance Use

IN OUR OWN VOICES

"I acquired some addictions and obsessive behavior to cover up the pain of my gender dysphoria. My cigarette addiction calmed me without putting me into a stupor, and alcoholism came a decade later. I got a good wife and two beautiful young children before alcoholism claimed me. I nearly lost everything, and I would have lost it all except that I was saved by Alcoholics Anonymous. AA saved my life, including helping me quit smoking, and I got to be a good partner and parent."

RILLA
transgender woman, white

Age range: 65+

"I've lost so many gender non-conforming friends to suicide and drug and alcohol abuse over the years. I think a lot of that had to do with the fact that people never really get over being rejected by their families. I wish more people were educated on the lifelong harm that they do when they reject and mistreat their family members."

AMES
nonbinary, Black/African American

Age range: 41-61

"Pretransition, I'd been hospitalized after a suicide attempt. At that time, I was drinking heavily. Eventually, though, I got help. I got a job where I presented as trans. I quit drinking. I exercised. I got therapy. I started HRT. I came out as trans. Now, I am a better parent and person for those who depend on me."

JANEY
nonbinary, white

Age range: 41-64

INTRODUCTION

Substance use is a critical indicator of mental and physical wellbeing.[1] To assess patterns of substance use among transgender and nonbinary respondents, the USTS adapted questions from the National Survey on Drug Use and Health (NSDUH).[2] Respondents answered whether they had ever used specific substances, including alcohol, cigarettes, e-cigarettes or vapes, marijuana, illicit drugs (such as cocaine, heroin, or inhalants), and prescription medications for non-medical purposes. Additionally, the survey sought information on the frequency and quantity of their substance use, and their perceptions on whether they thought they ever had a problem with their own drug or alcohol use.

Key Findings

- Transgender and nonbinary respondents to the USTS reported drinking and smoking less often than the U.S. general population.
  - A smaller percentage of 2022 USTS respondents drank alcohol than the U.S. general population: 46% of the sample drank alcohol in the past month compared to 53% of the U.S. adult population.
  - Among current drinkers, USTS respondents reported binge drinking less often than the general population (18% vs. 24%).
  - Respondents reported less smoking than the general population: 12% were current smokers compared to 16% of the U.S. adult population. Further, current smokers reported smoking every day less often than the general population (43% vs. 56%).
- Thirty-five percent (35%) of respondents used marijuana in the past month, more than double that of the general population (17%).
- One-quarter (25%) of the sample said that they had a problem with drugs or alcohol at some point in their lives. About 14% of respondents said that they were in recovery.

Alcohol

To understand alcohol consumption patterns among transgender individuals, the survey examined both lifetime and recent drinking behaviors among USTS respondents (Table 6.1).

Table 6.1

Alcohol Use and Binge Drinking
(2022 USTS, 2022 NSDUH)

Alcohol Usage	Percent
Ever had alcohol	8
Had alcohol within the last 30 days	46
Binge-drank in the month prior to the survey, overall sample	18
Binge-drank in the month prior to the survey, current drinkers (USTS)	33
Binge-drank in the month prior to the survey, U.S. general population (NSDUH)	24

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding responses can be found in the endnotes.[3]

Eighty-four percent (84%) of respondents reporting having a drink of an alcoholic beverage, such as beer, wine, or hard liquor, in their lifetime, compared to 90% in the 2015 USTS[4] sample and 84% in the U.S. adult population.[5] Forty-six percent (46%) of the sample currently drank alcohol (i.e., used alcohol within the 30 days prior to the survey) compared to 53% in the general adult population.[6]

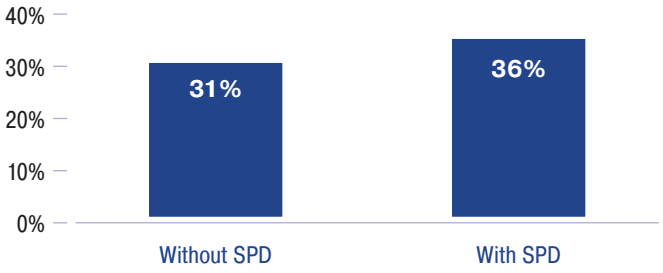
Of current users, 34% consumed alcohol one to two days in the month prior to the survey; 30% drank three to five days; 17% drank six to ten days; and 19% drank 11+ days in the month prior to the survey.

The survey asked current users how frequently they consumed five or more drinks on the same occasion—at the same time or within a couple hours. This measure follows federal definitions of binge drinking.[7] One third (33%) of current drinkers binge-drank in the month prior to the survey, equaling 18% of the overall sample (Table 6.1).

This is lower than the U.S. general population of 24%.[8] USTS respondents who binge-drank in the prior month did so with an average frequency of four days per month. Binge drinking was more common among those who met the criteria for serious psychological distress (SPD, Figure 6.1) as measured by the Kessler 6 Psychological Distress Scale.[9]

Figure 6.1

Binge-Drinking in the Last Month, by Serious Psychological Distress (SPD) (n = 45,000)

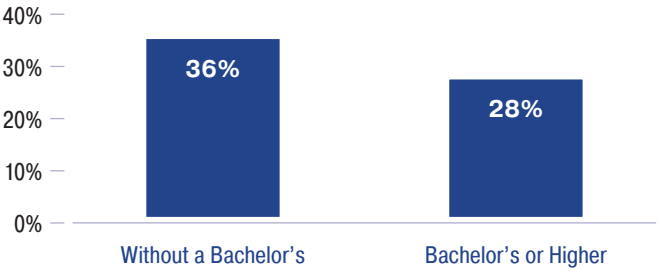


Among current users, 36% of those who met the criteria for SPD binge-drank in the last month compared to 31% of those who did not meet the criteria for SPD. Those who met the criteria for SPD had a slightly higher frequency of binge-drinking: an average of 4.6 days in the month compared to 4.2 days for those who did not meet the criteria for SPD.

Education may be associated with substance use. Consistent with the Census Bureau, educational attainment was measured here in respondents over the age of 25.[10] Respondents with more education reported less binge drinking (Figure 6.2).

Figure 6.2

Binge-Drinking in the Last Month among Current Drinkers, by Educational Attainment (ages 25+, n = 29,246)



Among those who currently consumed alcohol, 36% of those without a bachelor's degree binge-drank in contrast to 28% of those with a bachelors's degree or higher.

Cigarettes

To assess cigarette smoking behaviors among transgender and nonbinary individuals, the survey asked about both lifetime and recent smoking patterns among USTS respondents, which are then compared across age and educational attainment. Forty-four percent (44%) of adult respondents smoked a cigarette at least once; this was less than the 2015 USTS sample (57%)[11] and the general adult population (56%) (Table 6.2).[12]

Table 6.2

Lifetime and Current Cigarette Use (2022 USTS, 2015 USTS, 2022 NSDUH)

Cigarette Usage	2022 USTS (%)	2015 USTS (%)	2022 General U.S. Population (%)
Ever smoked a cigarette	44	57	56
Current smoker	12	N/A	16

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows: Ever used (n = 83,649) & Current user (n = 83,600).

We define current smokers as those that smoked a cigarette in the 30 days prior to the survey; 12% of the sample were current smokers compared to 16% of the U.S. adult population.[13] Older respondents tended to have higher prevalence of current smoking with the exception of the oldest respondents (Figure 6.3): 8% of 18 to 24 year-olds; 15% of 25 to 44 year-olds; 19% of 45 to 64 year-olds; and 13% of those 65+ years old. Further, when limiting the sample to respondents 25 and older, those with higher educational attainment smoked less (Figure 6.4): 18% of those without a bachelor's degree compared to 9% with bachelor's degree or higher.

Figure 6.3

Current Smokers, by Age
(n = 83,600)

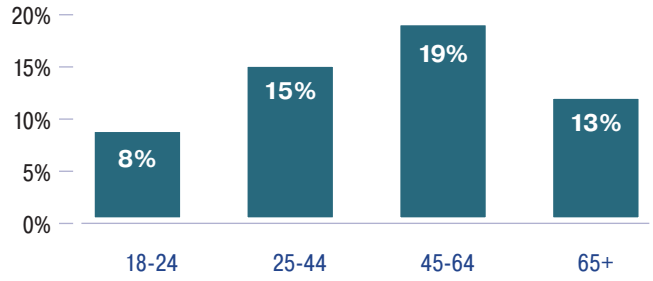
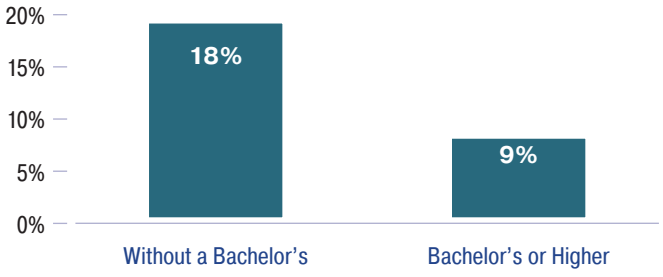


Figure 6.4

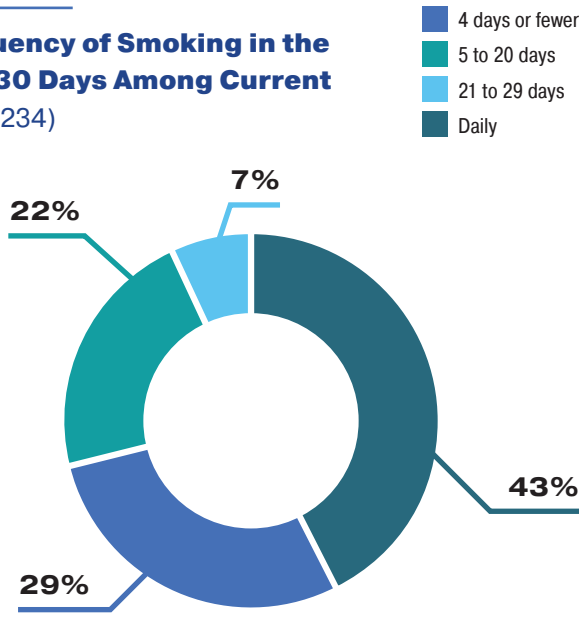
Current Smokers, by Educational Attainment
(ages 25+, n = 48,982)



Current smokers smoked on average 17 days in the month prior to the survey. As seen in Figure 6.5, 29% smoked four days or fewer; 22% smoked five to 20 days; 7% smoked 21 to 29 days; and 43% smoked daily. This is notably less than the general adult population, in which 59% of current smokers smoked daily.[14]

Figure 6.5

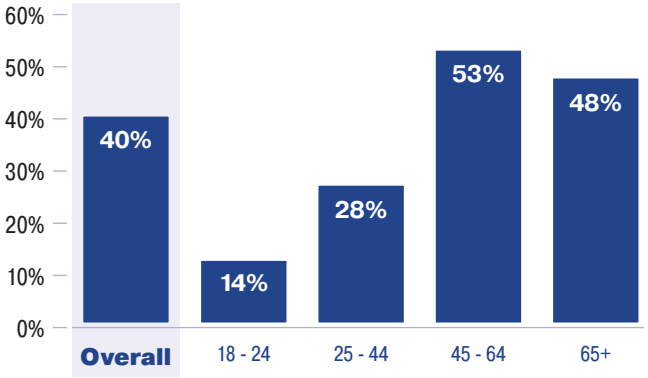
Frequency of Smoking in the Past 30 Days Among Current
(n = 8,234)



As seen in Figure 6.6, among daily smokers, 40% smoked a pack a day, the same as in the general adult population (40%).[15] Older daily smokers were more likely to smoke one or more packs a day: 14% of 18-24 year-olds; 28% of 25-44 year-olds; 53% of 45-64 year-olds; and 58% of those 65+.

Figure 6.6

Daily Smokers Who Smoked One or More Packs a Day, by Age (n = 2,490)



E-Cigarettes or Vaping Products

We analyzed lifetime and recent usage patterns for e-cigarettes and vaping products. As seen in Table 6.3, 40% of the 2022 USTS sample used e-cigarettes or vaping products in their lifetime, compared to 36% in the 2015 USTS[16] sample and 24% of the U.S. general adult population.[17] Sixteen percent (16%) were current users, i.e., used e-cigarettes or vaping products in the 30 days before the survey—substantially higher than 9% of the general adult population. Notably, younger respondents were more likely to be current vape users compared to older respondents (Figure 6.7): 17% of 18 to 24 year-olds; 20% of 25 to 44 year-olds; 11% of 45 to 64 year-olds; and 4% of those aged 65+ years old.

Table 6.3

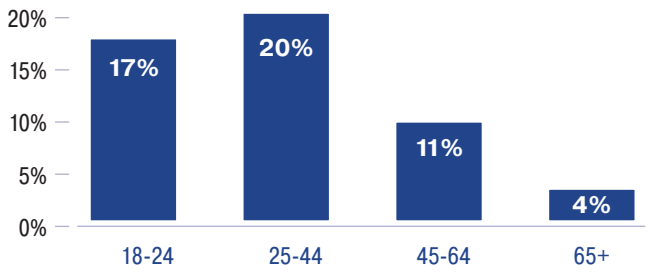
Lifetime and Current Usage of E-cigarettes or Vaping Products

E-cigarette Usage	2022 USTS (%)	2015 USTS (%)	2022 General U.S. Population (%)
Ever used	40	36	24
Current user	16	N/A	9

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions were Ever used (n = 83,286) & Current user (n = 83,257).

Figure 6.7

Current E-cigarette Users among All Respondents, by Age (n = 82,257)



Further, education may moderate use of vaping products (Figure 6.8): 11% of respondents 25+ with a bachelor's degree or higher used vaping products compared to 18% of respondents with less than a bachelor's degree.

Figure 6.8

Current E-cigarette Users among All Respondents Aged 25 or Older, by Educational Attainment (25+, n = 48,627)

Lastly, respondents who met the criteria for serious psychological distress (SPD) showed greater use of vaping products compared to those who did not meet the criteria for SPD (20% vs. 14%) (Figure 6.9).

Figure 6.9

Current E-Cigarette Use, by Serious Psychological Distress (n = 82, 935)

Marijuana

Lifetime and recent usage patterns of marijuana and hashish were compared between the 2022 USTS, 2015 USTS, and the general U.S. population. Differences across age, education, and psychological distress are shown for both current users and among current users, daily use.

As seen in Table 6.4, about two-thirds (66%) of the 2022 USTS sample reported that they had used marijuana or hashish at some point in their lives. This number is similar to the 64% of the 2015 USTS sample[18] and substantially higher than 50% in the general adult population.[19] Current use (used marijuana in the 30 days prior to the survey) was higher in 2022 compared to 2015 (35% vs. 25%), and more than double that of the general adult population (17%) in 2022.[20]

Table 6.4

Lifetime and Current Marijuana or Hashish Use (2022 USTS, 2015 USTS, 2022 NSDUH)

Marijuana	2022 USTS (%)	2015 USTS (%)	2022 General U.S. Population (%)
Ever used marijuana or hashish	66	64	50
Current user	35	25	17

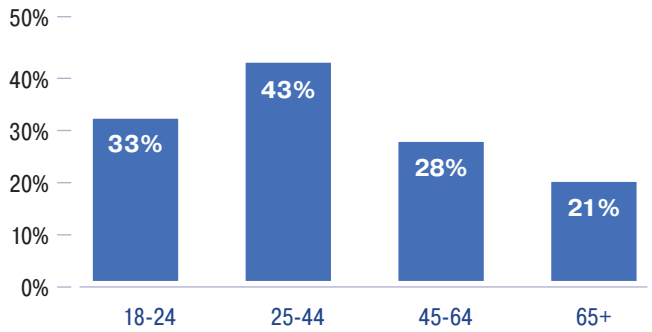
Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes were Ever used (n = 83,881) & Current user (n = 83,834).

Current Marijuana Use

Current marijuana use differed by age group, with use peaking in 25 to 44 year olds (43%), and those 65+ reported the lowest use (21%) (Figure 6.10).

Figure 6.10

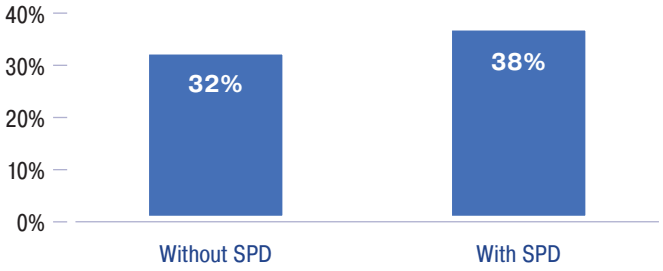
Current Marijuana or Hashish Use, by Age (n = 83,834)



Respondents who met the criteria for serious psychological distress (SPD) in the prior month reported more current marijuana use compared to those who did not meet the criteria for SPD (38% vs. 32%, Figure 6.11).

Figure 6.11

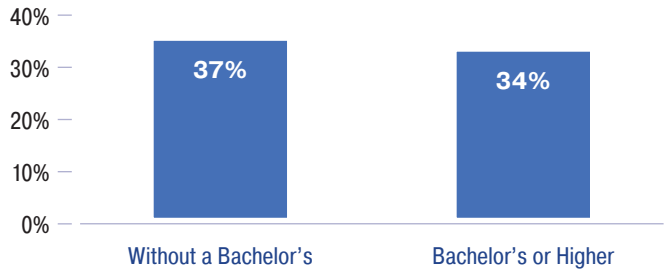
Current Marijuana or Hashish Use, by Serious Psychological Distress (n = 83,510)



Notably, current marijuana use was similar among those with bachelor's degrees or higher and those with less than a bachelor's degree (34% vs. 37%, Figure 6.12).

Figure 6.12

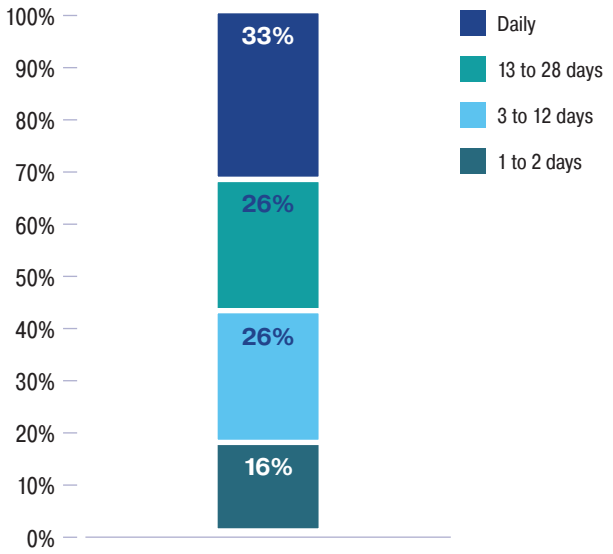
Current Marijuana or Hashish Use, by Educational Attainment (25+, n = 49,124)



Among current users, frequency of use varied. Sixteen percent (16%) of current users reported that they used marijuana one to two days in the past month, 26% reported three to 12 days; an additional 26% reported 13 to 28 days, and one-third (33%) reported that they used marijuana nearly every day or every day in the 30 days prior to the survey (Figure 6.13).

Figure 6.13

Frequency of Marijuana Use among Current Users (n = 32,560)

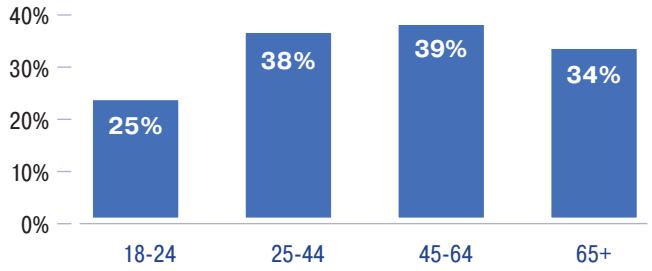


Daily Marijuana Use

The youngest respondents were the least likely to be near daily or daily users (25%) compared to older respondents (45 to 64-year-olds, 39%; 65+, 34%; Figure 6.14).

Figure 6.14

Daily Users of Marijuana, by Age (n = 32,560)



Respondents who met the criteria for serious psychological distress (SPD) in the past month had modestly higher daily use compared to those who did not meet the criteria for SPD (34% vs. 31%, Figure 6.15). Lastly, respondents 25 or older with a college degree showed notably lower near-daily/daily-use compared to those with less than college (28% vs. 41%, Figure 6.16).

Figure 6.15

Daily Marijuana or Hashish Use, by Serious Psychological Distress (n = 32,444)

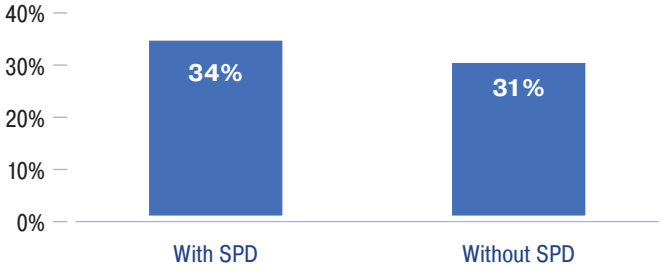
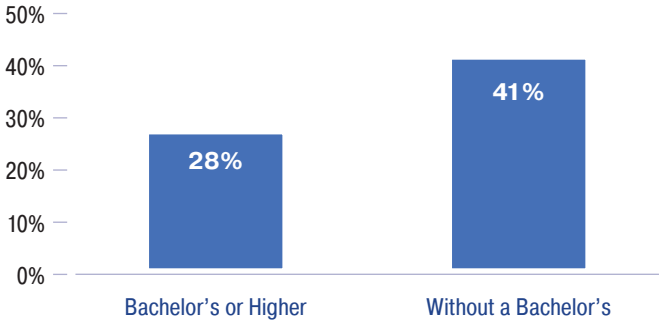


Figure 6.16

Daily Marijuana Use Among Current Users, by Educational Attainment among Those Aged 25 and Older (25+, n = 19,969)



Illicit Drugs

Twenty-seven percent (27%) of adult respondents reported using illicit drugs like cocaine, heroin, LSD, or inhalants (excluding marijuana) at some point in their lifetime (Table 6.5), similar to the 2015 USTS sample (29%). Four percent (4%) were current users of illicit drugs (i.e., use in the 30 days prior to the survey)—the same percentage as in the 2015 USTS sample[21] and the general U.S. adult population.[22]

Table 6.5

Lifetime and Current Illicit Drug Use
(2022 USTS, 2015 USTS)

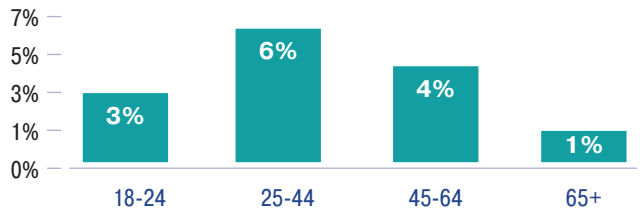
Illicit Drug Use	2022 USTS (%)	2015 USTS (%)	2022 General U.S. Population (%)
Ever use	27	29	N/A
Current user	4	4	4

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes were Ever used (n = 83,381) & Current user (n = 83,351).

Much like marijuana use, current use displayed a curvilinear relationship with age—peaking among 25- to 44-year-olds (6%) and falling among 65+ year olds (1%) (Figure 6.17). Use of illicit drugs did not differ by serious psychological distress (SPD) and college education.

Figure 6.17

Current Illicit Drug Use, by Age (n = 83,351)



Nonmedical Prescription Drug Use

The survey asked respondents if they took prescription drugs like oxycontin, Xanax, or Adderall that were not prescribed to them (i.e., for "nonmedical use"). Twenty-six percent (26%) reported nonmedical prescription drug use at least once, lower than the 34% in the 2015 USTS sample (Table 6.6).[23] Four percent (4%) reported nonmedical prescription drug use in the 30 days prior to the survey (i.e., were current users), double the percent in the general population (2%).[24]

Table 6.6

Lifetime and Current Nonmedical Prescription Drug Use
(2022 USTS, 2015 USTS, 2022 NSDUH)

Nonmedical prescription drugs	2022 USTS (%)	2015 USTS (%)	2022 General U.S. Population (%)
Ever use	26	34	N/A
Current user	4	N/A	2

Note: Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows: Ever used (n = 83,371) & Current user (n = 83,295).

As seen in Figure 6.18, respondents who met the criteria for serious psychological distress (SPD) in the month prior to the survey had more nonmedical prescription drug use compared to those who did not meet the criteria for SPD (5% vs. 3%). Those 25 years and older without a college degree had more nonmedical prescription drug use compared to those with a college degree (5% vs. 3%).

Figure 6.18

Current Nonmedical Prescription Drug Use, by Serious Psychological Distress (n = 82,974)

Perceived Problems with Drug or Alcohol Use

The survey asked respondents whether they thought they ever had a problem with their own drug or alcohol use. A quarter of respondents (25%) said yes. This varied by serious psychological distress (SPD)—27% of those who met the criteria for SPD in the prior month reported having ever had a problem

Table 6.7

Ever Had a Problem with their Substance Use, by Serious Psychological Distress
(n = 83,701)

Serious Psychological Distress	Percent
With SPD	27
Without SPD	23

with their drug or alcohol use compared to 23% of those who did not (Table 6.7).

Among respondents who said they had ever had a problem with their substance use (n = 22,113), 55% identified themselves to be in recovery, equaling roughly 14% of the overall USTS sample. Respondents who were either in recovery or were not sure they were in recovery (n = 16,014) had varying definitions of what recovery meant to them: abstinence from all drugs and alcohol

(21%); abstinence from only those drugs or alcohol with which they had a problem (38%); and non-problematic or moderate use of drugs or alcohol including those with which they had a problem (40%).

This chapter examined substance use patterns of 2022 USTS respondents, including use of alcohol, cigarettes, e-cigarettes and vaping products, marijuana, illicit drugs, and prescription drugs for nonmedical purposes. The chapter highlighted both

CONCLUSION

similarities and differences between transgender and nonbinary respondents and the general U.S. population. While a smaller proportion of USTS respondents reported alcohol and cigarette use compared to the general population, USTS respondents reported more marijuana and e-cigarette use, along with slightly elevated nonmedical prescription drug use. These trends suggest that while transgender and nonbinary people may use alcohol and cigarettes less frequently, use of other substances—particularly marijuana and vaping—may be more common.

Additionally, one in four respondents reported struggling with drug or alcohol use at some point in their lives, and more than half of them identified as being in recovery. Psychological distress appears to play a significant role in substance use behaviors, with those experiencing distress reporting more binge drinking, daily marijuana use, and nonmedical prescription drug use. These findings underscore the importance of considering mental health and social stressors when addressing substance use in the transgender and nonbinary community.

1. National Institute on Drug Abuse. (2020, April). *Common comorbidities with substance use disorders research report.* National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK571451/
2. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables
3. Participants only answered questions relevant to their experiences, so the number of respondents differs across groups and items. The sample sizes for the corresponding questions are as follows:
    - Ever had alcohol (n = 83,969)

- Had alcohol within the last 30 days (n = 83,908)
- Binge-drank in the month prior to the survey, overall sample (n = 83,621)
- Binge-drank in the month prior to the survey, among current drinkers (n = 45,159)

4. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 116). Washington, DC: National Center for Transgender Equality.
5. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.1b.
6. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.1b.
7. National Institute on Alcohol Abuse and Alcoholism. (2025, February). Binge drinking [Brochure]. U.S. Department of Health and Human Services, National Institutes of Health. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/binge-drinking
8. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.1b.
9. This Kessler 6 scale measures distress based on six questions about feelings over the past 30 days. These questions ask how often individuals felt nervous, hopeless, restless, sad, that everything was an effort, or down on themselves. https://www.samhsa.gov/data/system/files/media-puf-file/NSDUH-2008-DS0001-info-codebook.pdf
10. U.S. Census Bureau. (n.d.). Educational attainment. U.S. Department of Commerce. https://www.census.gov/topics/education/educational-attainment.html
11. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 116). Washington, DC: National Center for Transgender Equality.
12. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.16b.
13. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.18b.
14. Center for Behavioral Health Statistics and Quality. (2023). Results from the 2022 National Survey on Drug Use and Health: Detailed tables. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 8.4b.
15. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 8.4b.
16. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 117). Washington, DC: National Center for Transgender Equality.
17. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 2.1b.
18. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 117). Washington, DC: National Center for Transgender Equality.
19. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 1.3b.
20. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 1.3b.

21. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 118). Washington, DC: National Center for Transgender Equality.

22. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 1.3b.

23. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey (p. 118). Washington, DC: National Center for Transgender Equality.

24. Center for Behavioral Health Statistics and Quality. (2023). *Results from the 2022 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables. Table 1.3b.

Health and Wellbeing: A Report Of The 2022 U.S. Transgender Survey.
June 2025

Recommended Citation: Rastogi, A., Menard, L., Miller, G. H., Cole, W., Laurison, D., Caballero, J. R., Murano-Kinney, S., & Heng-Lehtinen, R. (2025, June). *Health and wellbeing: A report of the 2022 U.S. Transgender Survey*. Advocates for Transgender Equality. https://ustranssurvey.org/download-reports/

A4TE Education Fund

BTAC

NQAPIA

TransLatin@ Coalition