

The Stench of Bathroom Bills and Anti-Transgender Legislation: Anxiety and Depression Among Transgender, Nonbinary, and Cisgender LGBTQ People During a State Referendum

Sharon G. Horne¹, Mallaigh McGinley¹, Nedim Yel¹, and Meredith R. Maroney²

¹ Department of Counseling and School Psychology, University of Massachusetts Boston

² Werklund School of Education, University of Calgary

Informed by structural stigma theory, this article presents the results of two studies that explored mental health experiences of transgender, nonbinary, and gender-diverse (TNG) individuals and cisgender lesbian, gay, bisexual, and queer (LGBQ) individuals ($N = 523$) prior to and following a state referendum to remove gender-based protections. In the Preelection Study, a path model explored relationships among individual factors (i.e., TNG identity, history of gender-based victimization), interpersonal variables (i.e., Referendum familiarity, exposure to Referendum-related messages, sexual orientation, and gender identity-specific social support), and mental health factors (i.e., Referendum-related anxiety and depressive symptomatology). Referendum-related anxiety mediated the relationships between TNG identity, gender-based victimization, sexual orientation and gender identity social support, and depressive symptomatology, explaining 40% of the variance in depressive symptomatology. Postelection, a subsample of participants ($N = 117$) was used to test a model of differences from pre- to postelection. Neither TNG identity nor victimization predicted Postelection mental health, however, Referendum-related anxiety and depressive symptomatology were significantly lower following the ballot vote that retained gender-based rights. Clinical implications suggest sexual and gender minorities may report increased anxiety in the face of anti-lesbian, gay, bisexual, transgender, and queer (LGBTQ) legislation, which may be associated with heightened symptoms of depression. TNG people and LGBTQ people with histories of gender-based victimization may be more at risk for mental health concerns related to anti-TNG legislation.

Public Significance Statement

This study suggests that public debate over and legislative attempts to restrict protections for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people present an ongoing threat to mental health for LGBTQ people, and particularly for transgender, nonbinary, and gender diverse (TNG) individuals. Even when legislative outcomes are favorable, LGBTQ people may suffer anxiety and depression, especially those who identify as TNG or who have histories of gender-based victimization.

Keywords: LGBTQ, transgender, nonbinary, depression, legislation

Despite groundbreaking achievements in marriage equality (e.g., *Obergefell v. Hodges*, 2015), and most recently, employment equality

(e.g., *Bostock v. Clayton County*, 2020), legislative efforts to curtail lesbian, gay, bisexual, transgender, and queer (LGBTQ) rights persist at the local and state levels. As of February 24, 2021, there were more than 90 anti-LGBTQ bills introduced, pending, or recently passed at the state level in the U.S. This includes legislation excluding non-cisgender heterosexual couples from adoption and foster parenting, eliminating health care protections for sexual orientation and gender identity (SOGI), and gender restrictions on public accommodations (*American Civil Liberties Union [ACLU]*, 2021; *Levitt et al.*, 2020). In particular, transgender, nonbinary, and gender diverse (TNG) people increasingly are the targets of the legislation. For example, in March 2020, the Idaho Governor signed two bills limiting the rights of TNG people—one which prohibited transgender girls from playing on girls' and women's sports teams and another that prohibited transgender people from changing their gender on their birth certificates—though both bills have since been overturned in court (*H0500aaS*, 2020; *H0509*, 2020; *Holcombe & Rose*, 2020; *Inglot*, 2020; *Rose & Silverman*, 2020). The current study is an exploration of the mental health impact on TNG and cisgender lesbian, gay, bisexual, and queer (LGBQ) individuals living in Massachusetts

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Sharon G. Horne  <https://orcid.org/0000-0002-8197-7467>

Meredith R. Maroney  <https://orcid.org/0000-0002-4622-2683>

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Correspondence concerning this article should be addressed to Sharon G. Horne, Department of Counseling and School Psychology, University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125, United States. Email: sharon.horne@umb.edu

during a public accommodations Referendum, one of the only instances of a legislative initiative to *rollback* LGBTQ rights (i.e., remove existing protections). It was unknown how such an attempt might impact the psychological health of TNG and cisgender LGBTQ people leading up to and following the vote.

Discrimination based on a person's gender identity in public accommodations (i.e., equitable access to public settings such as retail shops, restaurants, transportation, and bathrooms) is commonly reported by TNG people (Kosciw et al., 2016; Puckett et al., 2020; Wang et al., 2016). In the 2015 U.S. National Transgender Discrimination Survey study, which included data from 27,715 TNG individuals from all 50 states and territories (James et al., 2016), among participants who reported that they believed their status as a TNG person was known by staff at a place of public accommodation, nearly one-third (31%) experienced at least one negative experience in the year prior. These included being verbally harassed (24%), denied equal treatment or service (14%), and/or physically attacked (2%). One-fifth (20%) of respondents avoided a place of public accommodation in the year prior due to concerns about discrimination. Such discriminatory experiences have been shown to harm TNG people by negatively impacting their education, employment, health, and participation in public life (Herman, 2013). Policies, intended to institutionalize such discrimination, popularly referred to as *bathroom bills* began gaining national attention in 2013 in the case of Coy Mathis, a first grader in Colorado whose parents filed a complaint accusing her school district of violating the state's antidiscrimination law by prohibiting Mathis from using the girl's restroom (Buckley, 2016). In the ensuing years, states such as North Carolina have attempted to enact legislation that would prohibit TNG people from accessing public accommodations in alignment with their gender (Ehrenhalt, 2018). In addition, the Trump administration refuted an interpretation of Title IX that supports protections for TNG people (U.S. Department of Education, 2017; U.S. Department of Justice and Department of Education, 2017; U.S. Deputy Solicitor General, 2017), which sent a message that the federal government would not interfere in restrictions. Immediately upon inauguration, the Biden administration attempted to reverse the anti-LGBTQ impact of the previous administration by expanding Title VII and IX protections on the basis of gender identity or sexual orientation (Exec. Order No. 13988, 2021).

The experience of being denied access to bathrooms that correspond to one's gender is significantly related to reported suicidality among TNG college students (Seelman, 2016). Additionally, TNG adults' experiences of discrimination when attempting to use gender-segregated public restrooms have been linked to physical health consequences (Herman, 2013). TNG people have reported that explicitly gendered spaces such as public bathrooms are the places where they expect the most rejection due to the fact that gender-segregated spaces require people to select a space that may reveal their TNG gender identity (Rood et al., 2016). For many TNG people, there are a number of safety considerations when deciding which bathroom to use. Nonbinary TNG people report pressure to present their gender as more feminine or masculine when using the women's or men's restroom, respectively, in order to mitigate scrutiny related to their nonbinary gender identity and presentation (Weinhardt et al., 2017). TNG people have described assaults in public restrooms due to their perceived gender nonconformity (Lang, 2016).

In the year following the passage of a Massachusetts state law that provided broad legal protections on the basis of gender identity (i.e., in employment, credit, public education, housing, and hate crimes) but *excluded* public accommodations, 65% of a community sample of 452 TNG respondents reported discrimination in public settings (Reisner et al., 2015). Despite the lack of evidence of criminal incidents in public bathrooms amid the presence of nondiscrimination laws based on gender identity (Hasenbush et al., 2019), bathroom bills serve to exacerbate a focus on biological sex and increase *gender panic* in association to TNG people (i.e., "situations where people react to disruptions to biology-based gender ideology by frantically reasserting the naturalness of a male-female binary"; Westbrook & Schilit, 2014, p. 34). This panic, or fear of gender diverse people, emanating from gender stereotypes, reduces the social valence of TNG people (Hughto, et al., 2021; Miller et al., 2017), and fuels the role of transphobia (and homophobia), both powerful political tools to impassion voters (e.g., Parent & Silva, 2018).

In a bipartisan act in 2016, the Massachusetts Public Accommodations Law was expanded to include gender identity in admission to and in treatment in any public accommodations setting (Malone, 2016). Senate Bill, *An Act Relative to Transgender Anti-Discrimination* (S.2407; 2016), was signed by Massachusetts Governor Charlie Baker on July 8, 2016 and subsequently adopted into state law. However, this act was subsequently challenged, and in November 2018, just 2 years after the broad protections went into effect enshrining public accommodation rights for TNG people in Massachusetts, the *Gender Identity Anti-Discrimination Veto Referendum* went to a popular vote on the state ballot (Associated Press, 2018).

Structural Stigma and Anti-LGBTQ Legislation

Public accommodations bills based on gender identity, and in particular, bathroom bills, represent forms of *structural stigma* that perpetuate prejudice directed toward sexual and gender minorities (Hatzenbuehler, 2016). *Structural stigma* refers to the "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized" (Hatzenbuehler & Link, 2014, p. 2), such as same-sex marriage bans, religious freedom bans that allow for exclusions based on SOGI, and public accommodations restrictions (Hatzenbuehler, 2016). In contrast, *individual stigma* refers to the psychological mechanisms individuals engage in as a response to stigma, including selective self-disclosure of SOGI identities (e.g., Mereish & Poteat, 2015), and *interpersonal stigma* includes potentially harmful interactions such as microaggressions or anti-LGBTQ media messages aimed at the stigmatized by the non-stigmatized (Balsam et al., 2011; Frost & Fingerhut, 2016; Mohr, 2016; Mohr & Sarno, 2016). These experiences of LGBTQ-related victimization, discrimination, prejudice, and individual stigma are associated with increased psychological distress, and a range of mental health concerns and minority stressors among LGBTQ individuals (Bockting, et al., 2013; Brooks, 1981; Hughto et al., 2017; Lloyd et al., 2019; Meyer, 2003; Nemoto et al., 2011; Reisner et al., 2015; Tebbe & Moradi, 2016; Testa et al., 2015; 2017; Timmins et al., 2017; Velez et al., 2016). Drawing upon the theory of structural stigma, we posited that *individual stigma* (i.e., TNG identity, experiences of gender-related victimization) and *interpersonal stigma* (i.e., exposure to anti-LGBTQ messages,

familiarity with the Referendum) would be integral to the mental health experiences (i.e., Referendum-related anxiety, depressive symptomatology) of a pending form of *structural stigma* (i.e., a Referendum on the ballot).

A growing body of research has found that anti-LGBTQ legislation is related to psychological distress for LGBTQ people and their family members during anti-LGBTQ initiatives (e.g., Arm et al., 2009; Frost & Fingerhut, 2016; Grzanka et al., 2020; Horne et al., 2011; Levitt et al., 2009; Lin et al., 2019; Rostosky et al., 2009; Riggle et al., 2010; Russell, 2007; Russell & Richards, 2003), and that the trauma-related effects of these campaigns are reported to be long-lasting (Russell et al., 2011). Living in states without LGB protections, or with an explicit denial of services to LGB people, is related to increased mental health concerns among LGB people when compared with LGB people living in jurisdictions with sexual orientation protections (Hatzenbuehler et al., 2010; Lin et al., 2019; Raifman et al., 2018; Tatum, 2017). In contrast, policies *supportive* of LGBTQ people and their rights appear to provide psychological health benefits for LGBTQ people living in those jurisdictions (Erlangsen et al., 2020; Everett et al., 2016; Flores & Barclay, 2015; Hatzenbuehler et al., 2012; Riggle et al., 2010; Wight et al., 2013; Woodford et al., 2018). Although many of these studies pertain to sexual orientation policies, the presence of statewide nondiscrimination laws based on gender identity has been found similarly to relate to lower perceived stigma among TNG people, and is associated with lower reports of discrimination, victimization, anxiety, and attempted suicide in comparison to TNG people living in nonprotective contexts (Gleason et al., 2016). In the face of the loss of public accommodation rights, it would be expected that TNG people would report mental health distress leading up to an election (and following the election lower mental health distress if those rights were retained or higher mental health distress if rights were rescinded).

Depressive symptomatology and anxiety are commonly reported by LGBTQ people in relation to minority stress indices, such as internalized stigma, and gender-related victimization and discrimination (e.g., Sarno et al., 2020; Testa et al., 2015; Timmins et al., 2017). Moreover, these constructs have been utilized in studies assessing minority stress and structural stigma in relation to anti-LGBTQ initiatives (Grzanka et al., 2020; Horne et al., 2011; Rostosky et al., 2009, 2010; Russell, 2007), and in assessing gender-related discrimination and coping strategies of TNG individuals (Budge et al., 2013; Lloyd et al., 2019). Exploring depressive symptomatology and anxiety may shed light on how LGBTQ individuals respond to policy-related structural stigma, which may inform interventions and coping strategies.

Purpose of the Study

Although there is growing evidence that anti-LGBTQ legislative initiatives may be harmful to the mental health of LGBTQ people, they have primarily been conducted during initiatives that have *restricted* LGBTQ rights (e.g., marriage amendments, the TN counseling discrimination law). No empirical study to date has explored structural stigma and mental health experiences of TNG individuals in the face of a Referendum intended to remove rights to public bathrooms and other accommodations. Therefore, this Referendum provided an opportunity to explore structural stigma as a contextual factor in the relationships among minority stressors (e.g., victimization), interpersonal variables

(e.g., social support, exposure to negative Referendum messages), and mental health factors (e.g., anxiety and depression; Hatzenbuehler, 2016). Although the aim of the Referendum was to remove protections based on gender, the discourse surrounding the Referendum was couched in broader aims of rolling back LGBTQ rights in one of the most progressive states in the nation; the Referendum, therefore, posed a broad threat for LGBTQ people and we expected a positive relationship between anxiety about the referendum and depression in our LGBTQ sample. Although anti-LGBTQ policies appear to have a mental health impact on LGBTQ individuals, public accommodations restrictions, and specifically, bathroom bills, are aimed at TNG people. Interviews with TNG people have revealed the importance of gender-inclusive bathrooms in fostering a sense of safety and inclusivity (Porta et al., 2017). Thus, it would be expected that TNG people may report greater anxiety and depressive symptomatology in the face of such legislative threats in comparison to cisgender LGBQ people. In addition, there are increased multiple minority stress concerns for sexual and gender minority People of Color (POC; Balsam et al., 2011; Cyrus, 2017), particularly with respect to bathroom bills. As a sociologist, Dr. Phoebe Godfrey explained, the fear-based language used to support anti-transgender “bathroom bills” evokes Jim Crow era rhetoric of “uncleanliness, disease, intrusion, and a sense of personal space and privacy being violated by The Other” (as cited in Lipsitz, 2016, para. 9), highlighting the ways in which racism and transphobia operate in tandem in the policing of such public spaces. TNG individuals at the intersection of racial and gender minority identities may be subject to increased rates of scrutiny and violence in such spaces, as evident by the epidemic of violence committed against Black transgender women (Human Rights Campaign, 2019). At the same time, resiliency in the face of stressors has been documented among TNG POC (Singh & McKleroy, 2011). We thus explored whether race/ethnicity would moderate the relationships of TNG identity and Referendum-related anxiety. As well, we expected that social support specific to SOGI during the Referendum would negatively relate to mental health factors (i.e., Referendum-related anxiety, depression; Budge et al., 2013). Specifically, we hypothesized:

Study 1 Preelection Hypothesis 1: The path model will provide a good fit to the data, that is, individual factors (i.e., TNG identity, history of gender-based victimization) and interpersonal variables (i.e., exposure to negative Referendum messages, Referendum familiarity, and SOGI-related social support) will be significantly associated with mental health factors (i.e., Referendum-related anxiety and depressive symptomatology).

Study 1 Preelection Hypothesis 2: Referendum-related anxiety will mediate the relationships among individuals (i.e., TNG identity), interpersonal variables (e.g., message exposure, Referendum familiarity), and depressive symptomatology.

Study 2 Postelection Hypothesis 1: Preelection individual factors (TNG, history of victimization) will predict Postelection mental health and SOGI-related social support.

Study 2 Postelection Hypothesis 2: If the Referendum passes and rights are retained, scores on Postelection anxiety and depression will be significantly lower than Preelection scores; if the Referendum is not passed and rights are rescinded, scores on Postelection mental health factors will be equivalent or higher

than Preelection scores. Social support scores will not significantly differ from Preelection to Postelection.

Method

Participants

For Study 1, the total sample of 523 LGBTQ participants ranged in age from 18 to 68 ($M = 27.75$, $SD = 8.91$). All participants lived in Massachusetts, except six participants who resided near the border and commuted into Massachusetts for school or work. Participants who opted to enter unique text for demographic variables were coded into categories of best fit across gender identity, sexual orientation, and race (e.g., “Chinese” was coded as “Asian/South Asian/East Asian”). Due to a range of gender identities that do not reflect adherence to a particular binary gender identification (Matsuno & Budge, 2017), participants who reported a nonbinary, genderfluid, genderqueer, or other gender-diverse identity that did not reflect a binary gender were coded as nonbinary. Participants who identified as both cisgender and heterosexual were excluded from analyses, and a total of 190 (36.33%) of participants identified as something other than cisgender. See Table 1, for participant characteristics.

Measure

The Center for Epidemiological Studies Depression-Short Form

The Center for Epidemiological Studies Depression-Short Form (CES-D-10) is a shortened and revised version of the original 20-item CES-D used to assess for the presence of depressive symptoms (Andresen et al., 1994; Radloff, 1977). In Study 1, participants were asked to record how often they experienced identified depressive symptoms over the past week (e.g., “I felt depressed”). Responses used a 4-point Likert-type scale ranging from 0 (*rarely or none of the time—less than one day*) to 3 (*most or all of the time, 5–7 days*). Total scores range from 0 to 30; scores of 10 or higher suggest elevated depressive symptomatology. The CES-D-10 demonstrated good predictive accuracy when compared to the original, a test-retest correlation of .59 over 12 months, and has been shown to be a reliable and valid measure of dysphoric mood and depressive symptoms; it has been used among nonclinical samples and LGB and TNG samples (Balsam et al., 2011; Grzywacz et al., 2006; Testa et al., 2015), including research specific to the impact of anti-LGBTQ policies on LGBTQ mental health (Rostosky et al., 2009). Internal consistency was reported for Pre- and Postelection studies, respectively ($\alpha = .86$; $\alpha = .86$). In Postelection Study 2, participants responded to the questions reflecting on the past 48 hr (the period of time lapsed since the close of the election to assess for immediate experiences following the election).

Generalized Anxiety Disorder (GAD-7) & Referendum-Related Anxiety GAD-7

The GAD-7 (Spitzer et al., 2006), a seven-item questionnaire developed to assess for generalized anxiety disorder (GAD), was used to assess for the general presence of anxiety symptoms. Respondents were asked to indicate how often they had been bothered by each symptom (e.g., feeling nervous anxiety or on

edge) on a 4-point Likert-type scale ranging from 0 (*not at all*) to 3 (*nearly every day*); range = 0–21. Preelection data collection was shortened to 1 week to ensure that participants were reporting on symptoms experienced as close to the election as possible, and to be congruent with the time frame of the depression scale. The GAD-7 is often used in LGBTQ research to assess the psychological impact of minority stress (e.g., Pflum et al., 2015; Timmins et al., 2017; Woodford, et al., 2018). For the administration of this GAD-7, Cronbach’s alpha for internal consistency was .94 (Preelection), and .89 (Postelection).

In addition to the original GAD-7 included in this study, we explored anxiety specific to the Referendum. Participants indicated how often they had been bothered by each symptom in the past week “when thinking specifically about the Massachusetts Ballot Question 3, Gender Identity Anti-Discrimination Veto Referendum.” Adapted versions of the GAD-7 have been used to respond to current events, for which to date no state-trait measures exist, such as anxiety related to the COVID-19 pandemic during the week prior (see Keeter, 2020). All scoring for the current version reflects the protocol for the GAD-7, and total scale scores represent the sum of the seven-item scores, ranging from 0 to 21. For Postelection Study

Table 1
Participant Sociodemographic Characteristics

Sociodemographic Characteristics	Study 1 (<i>n</i> = 523)	Study 2 (<i>n</i> = 117)
Residency		
MA resident	517 (98.85%)	113 (96.58%)
MA commuter	6 (1.15%)	4 (3.42%)
Race/Ethnicity		
White/European	395 (75.53%)	101 (86.32%)
Multiracial	50 (9.56%)	5 (4.28%)
Latinx/Hispanic	30 (5.74%)	3 (2.56%)
Asian/South Asian/East Asian	26 (4.97%)	5 (4.28%)
African American/Black/African	17 (3.25%)	2 (1.71%)
Middle Eastern/North African/Arabic	3 (0.57%)	1 (0.85%)
Native American/Alaskan Native	2 (0.38%)	0 (0.00%)
Gender Identity		
Cisgender woman	258 (49.33%)	38 (32.48%)
Nonbinary	115 (22.00%)	34 (29.06%)
Cisgender man	75 (14.34%)	13 (11.11%)
Transgender man	38 (7.26%)	17 (14.53%)
Transgender woman	34 (6.50%)	12 (10.26%)
Something else	3 (0.57%)	3 (2.56%)
Sexual Orientation		
Bisexual/pansexual	213 (40.73%)	43 (36.75%)
Queer	117 (22.37%)	35 (29.92%)
Lesbian	95 (18.16%)	19 (16.24%)
Gay	64 (12.24%)	16 (13.68%)
Asexual/demisexual	26 (4.97%)	3 (2.56%)
Noncisgender heterosexual	6 (1.15%)	1 (0.85%)
Questioning	2 (0.38%)	0 (0.00%)
Education		
Some college education	148 (28.30%)	21 (17.95%)
Bachelor’s degree	139 (26.58%)	36 (30.77%)
Master’s degree	124 (23.71%)	41 (35.04%)
High school diploma/GED	48 (9.18%)	7 (5.99%)
Doctoral/professional degree	39 (7.45%)	9 (7.69%)
Associates degree	23 (4.40%)	2 (1.71%)
Vocational/technical degree	2 (0.38%)	1 (0.85%)
Age		
Mean (<i>SD</i>)	27.75 (8.91)	29.78 (9.79)
Median [Min, Max]	26 [18, 68]	28 [18, 68]

2, the time frame was shortened to the “past 48 hr (approximately 2 days),” to reflect immediate changes to generalized anxiety following the conclusion of the election and the outcome of the referendum. Internal consistency (Pre and Postelection) of the measure was $\alpha = .94$, $\alpha = .93$, respectively.

Social Support Questionnaire-Short 6 (SSQ6)

The Social Support Questionnaire, six item Short Form is based on the original SSQ scale (SSQS; Sarason et al., 1983), and assessed participants’ satisfaction with the perceived social supports available to them. Participants were asked to record how satisfied they were with the individuals in their lives who provide help or support (e.g., “people whom you can really count on to distract you from your worries when you feel under stress”). Responses used a 6 point Likert-type scale ranging from 1 (*very dissatisfied*) to 6 (*very satisfied*). Scores were summed and ranged from 6 to 36 ($M = 28.18$, $SD = 6.57$). Given the importance of LGBTQ-related support during challenging experiences (Frost & Meyer, 2012; Wong et al., 2014), and for TNG people (Barr et al., 2016; Bockting et al., 2013), we included two items to reflect social support specific to LGBTQ identity. These items asked participants to think about “people who really accept and support your LGBTQ identity” and “people whom you can really count on to encourage you when you are experiencing difficulty as a sexual or gender minority person.” Scores ranged from 2 to 12 ($M = 4.9$, $SD = 1.2$). Internal consistency for the SSQ6 Preelection and Postelection was $\alpha = .94$, $\alpha = .94$, respectively, and for SOGI-related social support items, $\alpha = .87$; $\alpha = .77$.

Gender-Related Victimization Subscale of the Gender Minority Stress and Resilience Scale

The gender-related victimization subscale of the Gender Minority Stress and Resilience Measures was used (GMSR; Testa et al., 2015) to assess minority stress and resilience factors in transgender and gender-nonconforming populations. Participants were asked six questions in relation to their gender identity or expression: Verbally harassed or teased; threatened with being outed or blackmailed; personal property damaged; threatened with physical harm; pushed, shoved, hit or had something thrown at me; had sexual contact against my will. Scores for this administration ranged from 1 to 6 ($M = 1.16$; $SD = 1.51$). Response options (never, before age 18, after age 18, and in the past year) were scored 0–1 with any report of experienced victimization in the lifetime scored as 1, consistent with scale validation procedures.

Exposure to Referendum-Related Anti-LGBTQ Messaging and Referendum Familiarity

To assess for anti-LGBTQ message exposure via No on Three signs, No on Three ads, and No on Three conversations that supported the Referendum (and, therefore, removing protections for TNG individuals), participants were asked to respond to the following three items: “How often have you seen Vote No on Three ads in the last week?”; “How often have you seen Vote No on Three street signs/billboards in the last week?”; and “How often in the past week have you been exposed to conversations opposed to Massachusetts Question 3 (people wanting to remove gender

protections)?” Responses were recorded on a Likert-type scale with the following responses: 0 (*not at all*), 1 (*any exposure*). A single item of exposure was developed with a sum of the three items. Responses ranged from 0 to 3 ($M = 1.66$, $SD = .65$).

To assess for familiarity with the proposed Referendum, participants responded to the following original item: “How familiar are you with Massachusetts Question 3?” Participant responses were recorded on a Likert-type scale ranging from 0 (*not familiar*) to 5 (*very familiar*). On average, participants reported relatively high familiarity ($M = 4.05$; $SD = 1.31$).

Procedure

Following approval by an university’s Institutional Review Board for an online study of mental health of LGBTQ adults, participants were recruited through emails to Massachusetts LGBTQ community centers, college campuses, social media groups, and at LGBTQ events. For the Preelection survey, 732 people clicked on the survey. Participant IP addresses were checked prior to analysis to determine duplicates (Kraut et al., 2004), and all duplicated IP addresses were assessed to determine if they reflected different participants; given that computers are often shared by household members, we elected to retain participants whose demographic data entries differed even though it was the same IP address (Gosling et al., 2004). As an additional check, participants were asked to fill in open-ended questions at several designated points (e.g., “please write the word ‘green’”) to prevent undue influence from algorithmic bots. To aid in recruitment methods and survey design, researchers collaborated with two community members who identified as a transgender man and a nonbinary person. Of the 732 clicks, 209 were excluded: 36 of the respondents had incomplete demographic information at the beginning of the survey; 81 indicated they were cisgender and heterosexual; 6 were under age 18; and 86 were determined to not be living in MA or on the border (as assessed by zip code). Our final sample included 523 respondents who completed the majority of the survey (the first third of questions were forced responses), of which 176 participants had 1.8%–11.2% missing data. We conducted Little’s Missing Completely at Random (MCAR) test, which suggested that data were not MCAR, $\chi^2(29, N = 523) = 156.57$, $p < .001$. It’s important to note that the chi-square test is sensitive to sample size and powerful with large sample sizes. As a result, it might detect small mean differences between the participants who responded and did not respond to the items (Peugh and Enders, 2004). After examining the focused study variables, we concluded that the missingness was not related to the questions themselves (Missing Not at Random), and the data followed a Missing at Random (MAR) mechanism. Thus, we utilized full-information maximum likelihood, which in path modeling can account for missing data without replacing or recalculating data points (Schlomer et al., 2010).

At the completion of the survey, respondents were offered the opportunity to participate in a raffle to win a \$25 gift card. One winner was randomly drawn for every 100 participants. Participants completed a consent form specific to this study and an online confidential survey. Data collection began October 23, 2018, exactly 2 weeks prior to the election, and concluded 48 hr following. The MA Referendum occurred on November 6, 2018, and resulted in a rejection of Question 3, with voters retaining gender identity

rights to public access, housing, and accommodations (67.8% voted in favor; 32.2% against). Following the election, participants ($N = 300$) who indicated a willingness to be contacted for a follow-up survey were sent an email, resulting in 165 participants who responded to the Postelection survey (55% response rate). Of these, 129 fully completed the survey. Postelection participants were matched with corresponding responses to the Preelection survey using IP address, zip code, and other unique identifiers. Due to a lack of corresponding matching identifiers with the Preelection survey, 12 respondents were excluded from analyses, resulting in a Postelection sample of $N = 117$.

Data Analytic Strategy

For all analyses, we used R3.6.1 (R Development Core Team, 2019). We conducted a power analysis to determine the required sample size for our main model using the online calculator developed by Preacher and Coffman (2006) assuming 0.05 α , .80 desired power, 9 df , and 0.08 RMSEA. The results showed that 273 participants were needed. For the Preelection study, we first assessed differences among groups (e.g., transgender compared with nonbinary participants) on the primary variables, and conducted a correlation analysis as well as a path model to assess mediation and indirect effects of Referendum-related anxiety on depression for LGBTQ people. We used lavaan in R to run the mediation analysis. To calculate the indirect effects we specified new parameters ($a * b$ where a path = $X \rightarrow M$, b path = $M \rightarrow Y$), based on the paths involved in the mediation analysis. For the Postelection study, we conducted a path analysis to explore whether TNG identity and a history of gender-based victimization predicted anxiety and depressive symptomatology following the election, and paired-samples t -tests to assess differences on measures from Preelection to Postelection.

Results

Preelection Study One

In advance of the primary analyses, frequencies and independent t -tests were conducted on the outcome measures to assess whether there were important differences on Referendum-related anxiety or depression for binary transgender versus nonbinary people. Three participants who indicated they were “something else” were included in the nonbinary group given their responses indicated they may not have considered themselves a privileged part of the binary (Plöderl & Tremblay, 2015). A total of 80.6% of binary

transgender people reported symptoms of depression equal to or greater than the suggested clinical cutoff of 10 ($M = 15.19$; $SD = 7.38$) and a total of 79.7% of nonbinary people reported depression symptoms greater than the suggested cutoff ($M = 15.51$; $SD = 6.21$). T -tests comparing transgender and nonbinary people were not statistically significant for the primary variables of depression, $t(131.69) = 0.30$, $p = .76$, Referendum-related anxiety, $t(148.24) = -0.77$, $p = .43$, general social support, $t(142.62) = 1.00$, $p = .31$, or SOGI-related social support, $t(146.38) = -0.30$, $p = .76$. Similarly, there were no significant differences between transgender women and transgender men on these variables (Depressive symptomatology, $t(69.93) = -1.20$, $p = .23$, Referendum-related anxiety, $t(67.07) = -1.59$, $p = .31$, General social support, $t(66.35) = 1.65$, $p = .10$, or SOGI-related social support, $t(66.44) = 1.00$, $p = .32$). Because the Referendum was intended to remove protections based on gender identity and there were no differences between the transgender and nonbinary groups, we combined them into one TNG (transgender, nonbinary, and gender diverse) group. Next, we explored differences between the white participants ($N = 395$) and Participants of Color ($N = 128$) on the major variables. Again, there were no differences on depressive symptomatology, $t(214.02) = 0.15$, $p = .87$, $p = .36$, general social support, $t(208.04) = -1.42$, $p = .15$, or SOGI-related social support, $t(206.64) = -1.79$, $p = .07$. However, white participants ($M = 5.8$; $SD = 6.05$) reported greater Referendum-related anxiety than Participants of Color ($M = 4.19$; $SD = 5.74$), $t(225.71) = -2.70$, $p = .007$. Therefore, we included race/ethnicity as a potential moderator in the model. Means, standard deviations, and correlations among measures are provided in Table 2.

We explored a multiple mediation path model using the lavaan package (Rosseel, 2012) and R (Version 3.6.1, 2019) with full-information maximum likelihood estimation to explore the relationships among individual (i.e., TNG or cisgender LGBTQ identity, history of gender-based victimization), interpersonal (i.e., familiarity with the Referendum, exposure to anti-Referendum messages, and SOGI-social support) and mental health factors (i.e., Referendum-related anxiety, depressive symptomatology). We included age as a covariate due to its association with depression and race/ethnicity as a moderator of TNG identity and Referendum anxiety. We utilized the following recommendations (Hu & Bentler, 1999; Weston & Gore, 2006), for fit indices: The comparative fit index ($CFI \geq .95$ suggests good fit; $\geq .90$ acceptable); the root-mean-square error of approximation ($RMSEA \leq .06$ suggests good fit, and $>.06$ and $\leq .10$

Table 2
Means, Standard Deviations and Correlations ($N = 523$)

Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8
1. Age	27.75	8.91								
2. Ref. Familiarity	4.05	1.31	0.28***							
3. Ref. Exposure	1.01	1.06	0.01	0.22***						
4. SOGI-Soc. S.	9.84	2.4	0.05	0.01	-0.06					
5. Gen-Soc. S.	28.18	6.57	0.09	-0.02	-0.02	0.67***				
6. Victimiz.	1.16	1.51	0.13**	0.12**	0.28***	-0.17***	-0.19***			
7. Anxiety	10.18	5.73	-0.1*	0.08	0.12**	-0.3***	-0.38***	0.29***		
8. Ref-Anxiety	6.92	6.12	0.11*	0.3***	0.22***	-0.19***	-0.2***	0.37***	0.63***	
9. Depression	13.99	6.52	-0.08	0.13**	0.12**	-0.33***	-0.44***	0.34***	0.82***	0.58***

Note. Soc. S. = Social Support.

* $p < .05$. ** $p < .01$. *** $p < .001$.

for adequate fit), and standardized root-mean-square residual (SRMR $\leq .05$ indicates good fit, and $> .05$ and $\leq .08$ indicative of acceptable model fit). As shown in Table 3, our path model provided a good fit to the data: CFI = .955; RMSEA = .058; SRMR = .030; $\chi^2(24) = 373.254, p = .001$. The model explained 40% of the variance in depressive symptomatology, and 25% of Referendum-related anxiety (see Figure 1). Given the MCAR test had been significant with deletions of cases with missing data, we ran the model with an intact sample ($N = 377$), resulting in a model with no differences in significant pathways, although with a slightly improved fit, CFI = .976; RMSEA = .044; SRMR = .030; $\chi^2(24) = 355.391, p = .001$. The model explained 42% of the variance in depressive symptomatology, and 25% of Referendum-related anxiety. Because of the congruence of the models, we retained the original model with the full sample.

Our Preelection Hypothesis 1 was supported via significant relationships among individual, interpersonal, and mental health factors. Both TNG identity and history of gender-based victimization predicted Referendum-related anxiety, which in turn predicted depressive symptoms. Also, exposure to Referendum messages, Referendum familiarity, and SOGI-related social support (inversely) predicted Referendum-related anxiety. Our Preelection Hypothesis 2 was supported, as well. Referendum-related anxiety fully mediated the relationship between TNG identity and depression ($\beta = .075, SE = .026, p = .004$), and partially mediated the relationship between a history of gender-based victimization and depression ($\beta = .125, SE = .025, p = .001$), and between social support and depressive symptomatology ($\beta = -.053, SE = .024, p = .026$). In addition, SOGI-related social support fully mediated the relationship between TNG identity and depressive symptomatology ($\beta = .026, SE = .011, p = .017$). Referendum-related anxiety also fully mediated the relationship between familiarity with the Referendum and depressive symptomatology ($\beta = .119, SE = .026, p = .001$), and between exposure to anti-LGBTQ referendum ads, signs, and

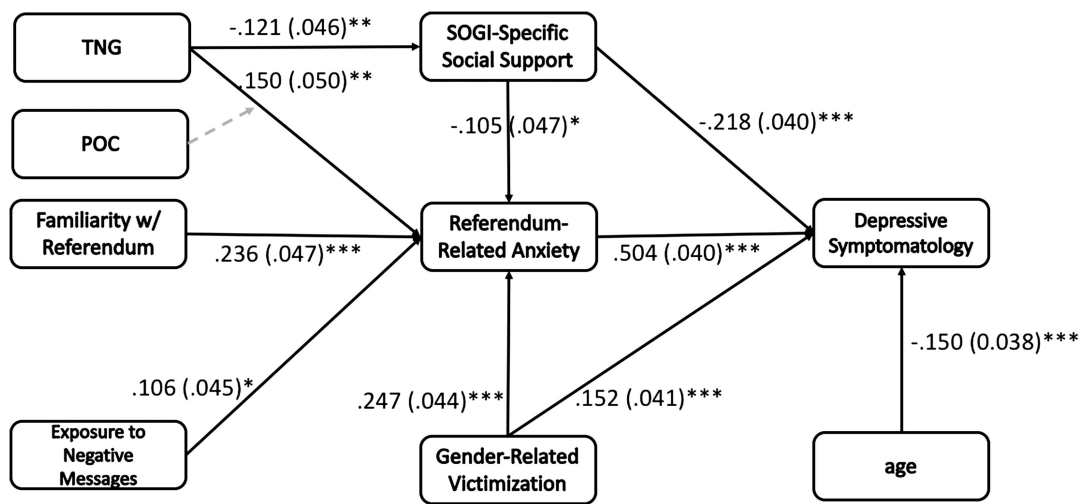
conversations and depressive symptomatology ($\beta = .053, SE = .023, p = .021$). See Tables 3 and 4 for the standardized path coefficients, standard errors, and confidence intervals for direct and indirect effects, respectively.

Postelection Study 2

To assess Postelection Hypothesis 1, we used a path analysis model ($N = 117$) to explore TNG and gender-based victimization as predictors of Postelection depressive symptomatology, Referendum-related anxiety, generalized anxiety, and SOGI-related social support. Using fit indices described above, our model provided a good fit to the data: CFI = .996; RMSEA = .029; SRMR = .045; $\chi^2(30) = 285.555, p < .001$. The model explained 25% of the variance in depressive symptomatology, 14% of Referendum-related anxiety, 28% of generalized anxiety, and 53% of SOGI-related social support. Contrary to the hypothesis, neither TNG identity ($\beta = .091, SE = .101, p = .367$) nor gender-based victimization ($\beta = .001, SE = 0.097, p = .991$) were significant predictors of Postelection depressive symptomatology when grouped with Preelection depressive symptomatology ($\beta = .545, SE = 0.087, p < .001$); Postelection Referendum-related anxiety [TNG: $\beta = -.012, SE = 0.102, p = .904$; Victimization: $\beta = .077, SE = 0.101, p = .449$] when grouped with Preelection Referendum-related anxiety ($\beta = .341, SE = 0.088, p < .001$); Postelection generalized anxiety [TNG: $\beta = .022, SE = 0.093, p = .810$; Victimization: $\beta = -.074, SE = 0.093, p = .426$] when grouped with Preelection generalized anxiety ($\beta = .557, SE = 0.072, p < .001$); or Preelection SOGI-related social support [TNG: $\beta = .025, SE = 0.074, p = .096$; Victimization: $\beta = -.065, SE = 0.074, p = .385$] when grouped with Postelection SOGI-related social support ($\beta = .702, SE = 0.055, p < .001$). However, Postelection Hypothesis 2 was supported; there was a significant difference from Preelection to Postelection on mental health variables. We used a series of paired-samples *t*-tests using

Figure 1

Specified Model of Variable Relationships. Unstandardized Path Coefficients for Structural Paths Are Followed by Standard Errors in Parentheses



* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3
Path Analysis Direct Effects

Outcome	Predictor	Standardized Direct Effects		95% CI		<i>p</i>
		β	<i>SE</i>	Lower bound	Upper bound	
Depression	Ref-Anxiety	0.504	0.040	0.425	0.584	<.001
Depression	Age	-0.150	0.038	-0.225	-0.075	<.001
Depression	TNG	0.005	0.039	-0.072	0.082	.903
Depression	SOGI-SoS	-0.218	0.040	-0.295	-0.140	<.001
Depression	Victimization	0.152	0.041	0.072	0.232	<.001
Depression	Q3familiar	0.010	0.042	-0.072	0.092	.809
Depression	Familiarity	-0.045	0.038	-0.120	0.030	.240
Ref-Anxiety	Q3familiar	0.236	0.047	0.144	0.329	<.001
Ref-Anxiety	Familiarity	0.106	0.045	0.018	0.193	.018
Ref-Anxiety	Victimization	0.247	0.044	0.161	0.334	<.001
Ref-Anxiety	SOGI-SoS	-0.105	0.047	-0.196	-0.013	.025
Ref-Anxiety	TNG	0.150	0.050	0.052	0.247	.003
Ref-Anxiety	POC	0.013	0.057	-0.098	0.124	.822
Ref-Anxiety	TNG:POC	-0.022	0.057	-0.133	0.090	.699
SOGI-SoS	TNG	-0.121	0.046	-0.211	-0.030	.009

Note. CI = confidence interval; TNG = Transgender, Nonbinary, and Gender Diverse; Ref-Anx = Referendum anxiety; POC = People of color; Exposure = Exposure to negative messages; Familiarity = Familiarity with the Referendum; Victimization = History of gender-based victimization. SOGI-SoS = SOGI Social Support. The bolded text indicates significant coefficients at $\alpha = .05$.

a Bonferroni correction ($\alpha = .05/4 = .0125$) to counteract the multiple comparisons/inflated Type I error rate issue. Given the favorable outcome of the Referendum for LGBTQ people, it was hypothesized that Referendum-related anxiety and depressive symptomatology scores would be significantly lower following the election in comparison to Preelection scores. Participants indeed reported significantly higher depressive symptoms Preelection ($M = 23.75, SD = 6.61$) in comparison to Postelection ($M = 19.83, SD = 5.62$), $t(116) = -7.564, p < .001$. Preelection Referendum-related anxiety ($M = 7.43, SD = 6.47$) was significantly higher than Postelection Referendum-related anxiety ($M = 3.2, SD = 4.40$), $t(93) = -6.69, p < .001$. And, for generalized anxiety, participants reported higher Preelection generalized anxiety ($M = 10.20, SD = 5.64$) than Postelection generalized anxiety ($M = 6.58, SD = 4.33$), $t(116) = -8.052, p < .001$. As expected, for SOGI-specific social support, there was no significant difference from Preelection ($M = 10.07, SD = 2.12$) to Postelection scores ($M = 10.10, SD = 2.01$), $t(114) = .2355, p = .814$. See Table 5 for results including effect sizes.

Discussion

This study explored the mental health impact on LGBTQ people during the first statewide attempt to invalidate extant protections based on gender during the Massachusetts Referendum Question 3. Given recent findings that the current sociopolitical climate is related to increased discrimination concerns of LGBTQ people (Reynolds, 2017; Steinmetz, 2017) and that there was a reported national decrease in acceptance for LGBTQ people following the 2016 election (GLAAD, 2018), public debate over and legislative attempts to restrict protections for LGBTQ people present an ongoing threat to mental health for LGBTQ people, and particularly for TNG individuals. This study highlighted the potential harmful effects of anti-LGBTQ legislation for LGBTQ people even when the outcome is favorable. TNG participants reported experiencing more Referendum-related anxiety, which was related to greater depression in comparison to cisgender-LGBTQ people. Moreover, both TNG and LGBTQ people with a history of gender-related victimization reported greater Referendum-related anxiety, suggesting that past gender-based discrimination and stigma may increase anxiety about ballot initiatives. The relationship of

Table 4
Path Analysis Mediated Effects (Indirect Effects)

Paths	Standardized Indirect Effect		95% CI		<i>p</i>
	β	<i>SE</i>	Lower bound	Upper bound	
TNG -> Ref-anx -> Dep.	0.075	0.026	0.025	0.126	.004
TNG -> Soc. Supp. -> Dep.	0.026	0.011	0.005	0.048	.017
Victimization -> Ref-anx. -> Dep.	0.125	0.025	0.076	0.173	<.001
Familiarity -> Ref-anx. -> Dep.	0.119	0.026	0.068	0.171	<.001
Exposure -> Ref-anx. -> Dep.	0.053	0.023	0.008	0.098	.021
Social Support -> Ref-anx. -> Dep.	-0.053	0.024	-0.099	-0.006	.026

Note. CI = confidence interval; TNG = Transgender, Nonbinary, and Gender Diverse; Ref-Anx = Referendum anxiety; Dep = Depression; Exposure = Exposure to negative messages; Familiarity = Familiarity with the Referendum; Soc. Supp. = Social Support; Victimization = History of gender-based victimization. The bolded text indicates significant coefficients at $\alpha = .05$.

Table 5
Results of Dependent Samples *t*-tests

Variable	Preelection		Postelection		<i>t</i> -test		95% CI		<i>p</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>df</i>	<i>t</i> statistic	Lower bound	Upper bound		
Depression	23.75	6.61	19.83	5.62	116	-7.564	-0.491	-2.876	<.001	0.699
Ref-Anxiety	7.43	6.47	3.20	4.40	93	-6.69	-5.794	-3.141	<.001	0.690
Anxiety	10.20	5.64	6.58	4.33	116	-8.052	-4.504	-2.276	<.001	0.744
SOGI-SoS	10.07	2.12	10.10	2.01	114	0.2355	-0.257	0.327	.814	0.022

Note. CI = confidence interval (95%); Ref-Anx = Referendum anxiety; SOGI-SoS = SOGI Social Support. The bolded text indicates significance at $p < .001$.

interpersonal stigma to structural stigma was also found; LGBTQ people who were exposed to more negative ads, billboards, and conversations leading up to the Referendum and those with the most familiarity with the Referendum approaching the election reported greater Referendum-related anxiety, raising their risk for depression. Referendum-related anxiety mediated the relationships between individual and interpersonal stigma factors and depressive symptomatology, suggesting that the anxiety that may be experienced in response to individual and interpersonal stigma (e.g., message exposure) could be a depression risk factor.

Congruent with research comparing TNG people's social support to that of cisgender LGBQ people, TNG people in this study reported lower SOGI-related support in comparison to cisgender LGBQ participants (e.g., Factor & Rothblum, 2007). SOGI-related social support was also negatively related to Referendum-related anxiety, raising concerns that TNG people may not be receiving sufficient SOGI-related support, even though SOGI-social support may be inversely associated with Referendum-related anxiety. SOGI-related social support also partially mediated the relationship between TNG identity and depression, suggesting lower SOGI-related social support among TNG participants may present a mental health concern for those lacking supports for their gender identities. SOGI-related social support, however, was only a partial mediator of these relationships and TNG identity directly predicted Referendum anxiety, suggesting social support alone may not counter the potential harm of threats to remove public accommodations. Nevertheless, having supportive others may help LGBTQ people feel less alone during these initiatives and offset feelings of anxiety; having such LGBTQ community support may provide a movement perspective that could counter the fears about the passage of such bills (Russell, 2007). LGBTQ people may need other coping supports to manage worries about pending anti-LGBTQ policies (Wheeler et al., 2018). Qualitative research could be used to explore these experiences of coping and social support in greater depth.

These findings suggest clinical implications for working with LGBTQ people during anti-LGBTQ referenda. First, counseling psychologists can consider the potential impact of structural stigma in the form of bills and policies and the role these initiatives can play in mental health risks, particularly if clients are members of a targeted group (e.g., TNG people for TNG people during bans on gender-affirming health care). Clinical assessments could include questions about exposure to messages, familiarity or engagement with the pending legislation, and levels of anxiety related to the legislation. This approach would be de-pathologizing as it conceptualizes distress as an expected reaction to external structural stressors and may help to increase insight about ways to reduce

exposure to anti-LGBTQ messages, which was related to heightened anxiety among our sample of TNG and cisgender LGBQ people. During an election that is particularly threatening, it may be helpful for clients to explore ways to navigate conversations with family members or friends who may hold different political beliefs (Israel, 2020), or among those who may not view anti-LGBTQ legislation as a human rights issue (Horne & Manalastas, 2020). Second, counseling psychologists should be aware that individual stigma experiences, such as a history of gender-related victimization and interpersonal stigma in the form of negative messages, may relate to an increase in anxiety in the face of legislative threats, which may, in turn, relate to increased client vulnerability to depression. Finally, counseling psychologists should assess social support, particularly for TNG clients, and recognize that clients may need strategies to combat stressors, such as engaging in advocacy or activism, self-care, and developing a movement perspective that allows clients to consider the ebb and flow of rights and gain perspective on the likelihood of forward momentum of LGBTQ rights (Horne, 2020).

Although TNG people reported heightened Preelection stressors, they did not differ from cisgender LGBQ participants on Postelection measures, suggesting that people under direct threat may return to a prethreat baseline once the threat is removed. There have been several recent and conflicting changes regarding the status of legal protections for LGBTQ people, and specifically for TNG people, including the reversal of Trump-era restrictions (Simmons-Duffin, 2020), and expansion of Title VII and IX protections on the basis of gender identity or sexual orientation with the Biden Administration (Exec. Order No., 13,988, 2021). However, whether TNG people are guaranteed access to public facilities consistent with their gender identity continues to be debated at the state and local levels and efforts to restrict gender based rights to access health care and play sports are proliferating. In spite of the human rights concerns with these initiatives, LGBTQ people report increased anxiety and depression during these events, and thus, counseling psychologists may engage in raising awareness about the potential negative impact of putting minority rights to popular referenda, and the role of prevention in reducing the impact of these threats and their associated messages (American Psychological Association [APA], 2020; Bränström & Pachankis, 2021).

There are a number of limitations to the study. Our sample was limited by self-report measures, dependent primarily upon short forms of standardized instruments and relied upon a modified time frame and adapted prompt in the case of Referendum-related anxiety. The study also was susceptible to self-selection bias. Although it is not generalizable to LGBTQ people living in MA, we had broad participation from individuals across MA, representing diversity in gender and sexual identities, education, and age.

Our majority-white sample (75.52%) and the broad variability across groups of racial and ethnic minority participants precluded within-group comparisons, though our sample was not divergent from state population estimates (e.g., 71.1% non-Latino White; U.S. Census Bureau, 2019). Also, our sample size limited our capacity to explore sufficiently the differences among gender diverse individuals (e.g., experiences of transgender women vs. nonbinary people). Therefore, our facility to explore intersectional stigma was limited. As genderqueer individuals have been found to experience harassment, sexual abuse, and other traumatic events at significantly higher rates than their cisgender and binary transgender counterparts (Lefevor et al., 2019), exploration of experiences of stigma faced by nonbinary people and TNG POC is essential.

In addition, due to the lack of a comparison group of LGBTQ people living in a non-Referendum context, the study design could not determine whether it was the structural stigma of the Referendum that may have exerted health effects. However, the documented difference in Preelection and Postelection scores on mental health measures, the differences on mental health measures between TNG and cisgender LGBQ people leading up to the Referendum, and the similar levels of mental health between these groups following the Referendum suggest we were capturing particular effects for TNG people, which is consistent with structural stigma theory (Hatzenbuehler, 2016). Another factor that may influence attribution of the findings to the anxiety related to the Referendum may be alternative explanations of these mental health indices, however, there were no other LGBTQ-related structural stigma events occurring in the state at the time, and the restriction of the time frame of the study to exactly 2 weeks prior to the election and approximately 48 hr postelection reduced the potential impact of other experiences of individual or interpersonal stigma. The internal validity of the study is limited by the impact of expectancy effects; it would be apparent to participants that the research was assessing concerns about the Referendum, thus participants may have responded with these expectations in mind, and could have amplified their endorsement of mental health measures. However, within the sample there was variability on these measures, with some participants reporting little to no impact. Yet, the fact that most participants had familiarity with the Referendum indicates that we may have had a self-selected sample of LGBTQ people who were more informed about the Referendum than in general. Future research may employ comparison groups, baseline mental health measures with a sufficient lead time prior to the anti-LGBTQ event with multiple time points, and publicly available data sources to reduce these methodological limitations.

Notably, a higher percentage of TNG people (56.4%) responded to the follow-up survey for Study 2 as compared to Preelection (38.6%), which may indicate increased personal salience of this research for TNG participants given the nature of the Referendum. In line with recommendations for conducting affirming research with TNG populations (Tebbe & Budge, 2016), several steps were undertaken in this research to recruit TNG participants: Partnering with TNG community members; intentionality in recruitment methods and materials; as well as transparency around research goals, motivations, and plans for distribution of findings. Such steps may have encouraged TNG participants to participate at higher rates Postelection than their cisgender peers. In addition, they may have experienced the most relief from the outcomes of the Referendum and may have been motivated to share these experiences.

Even in progressive political contexts that generally favor LGBTQ rights, the threat of revocation of rights appears to pose serious mental health implications. Leading up to the election, LGBTQ participants reported concerning levels of Referendum-related anxiety and depressive symptomatology. In particular, participants with a history of gender-related victimization reported high rates of Referendum-related anxiety, which was associated with depression, and levels of depressive symptomatology reported in the sample were at alarming levels. This study illustrates how even positive political outcomes can be associated with increased mental health concerns for LGBTQ people and communities who, due to the impact of structural stigma and minority stress, are already vulnerable to psychological distress.

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