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PREDICTORS OF BODY DISSATISFACTION IN TRANS MEN AND WOMEN

by

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A Dissertation

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Abstract

Body dissatisfaction has been found to affect individuals regardless of gender or sexual identity. However, research on body dissatisfaction among transgender men and women is lacking despite findings that these individuals experience body dissatisfaction to a greater extent than cisgender men and women. This study used hierarchical regression to explore whether factors associated with Objectification Theory, one's experience of gender related violence, whether one has undergone medical transition, and the extent to one identifies with stereotypical feminine or masculine norms predicted body dissatisfaction in a sample of 140 transgender men and 94 transgender women. Results suggest that factors related to Objectification Theory, particularly internalization of the thin ideal, internalization of the muscular ideal, and perceived media pressure predict body dissatisfaction in transgender men and women. Moreover, among transgender women, having experienced gender related violence predicted greater body dissatisfaction, whereas having undergone some form of medical transition predicted lower levels of body dissatisfaction. Clinical and research implications and limitations of the findings are discussed.

Predictors of Body Dissatisfaction in Trans Men and Women

It is well documented that body dissatisfaction strongly predicts substantive physical and mental health concerns for men and women. Poor body image may contribute to increased likelihood of mental health concerns such as depression and anxiety (Davidson & McCabe, 2005; Stice & Bearman, 2001), disordered eating behaviors (Noll & Fredrickson, 1998; Polivy & Herman, 2002), and other unsafe practices such as illegal steroid use and excessive exercise (McCabe & Ricciardelli, 2004; Olivardia, Pope Jr., Borowiecki III, & Cohane, 2004). Research has explored theoretical causes and related predictors of body dissatisfaction with many studies utilizing objectification theory as a framework, which posits that objectifying experiences contribute to a tendency to place one's worth on one's appearance. Researchers have found that factors central to objectification theory such as experiences of sexual objectification, internalization of cultural standards of attractiveness, media exposure, and self-objectification are, individually, significant predictors of poor body image (Harper & Tiggemann, 2008; Moradi, Dirks, & Matteson, 2005). The available information on body dissatisfaction for cisgender (cis; a term to describe those whose gender identity, or personal conception of oneself as male or female, both or neither, matches the sex they were assigned at birth; American Psychological Association, 2015) individuals is extensive. However, there is a notable lack of information on body dissatisfaction and its causes and treatments for transgender (trans; a term to describe those whose gender identity is not congruent with the sex they were assigned at birth; American Psychological Association, 2015) individuals. Despite literature that suggests that body dissatisfaction occurs to a greater extent in trans men and women than in cis men and women (Bandini et al., 2013; Vocks, Stahn, Loenser & Legenbauer, 2009), there is scant research examining predictors of body dissatisfactions in trans men and women. Whereas

factors associated with objectification theory may predict body dissatisfaction among trans men and women similarly to cis men and women, there may be additional predictors specific to the unique gendered experiences of trans men and women that may be relevant to explore. Given that knowledge of predictors of body dissatisfaction can inform treatment, focused research on predictors of body dissatisfaction in trans persons is needed to ensure appropriate and comprehensive treatment for trans persons.

Body Dissatisfaction Prevalence and Correlates

Historically, literature on body dissatisfaction has focused on the experience of heterosexual, cis women (McCabe & Ricciardelli, 2003). However, there has been an increase in literature exploring body dissatisfaction and its correlates in heterosexual, cis men, and sexual minority cis men and women (Morrison, Morrison, & Sager, 2004). Peplau et al. (2009) found that gay, cis men and lesbian and heterosexual cis women exhibit similar levels of body dissatisfaction, with heterosexual cis men reporting relatively more satisfaction with their body and appearance. Research related to body dissatisfaction in trans persons is limited; however, two studies have explored prevalence of body dissatisfaction in trans persons. Vocks et al. (2009) found that those who identified as male-to-female (MtF; terminology used in the study) scored higher on measures targeting weight and shape concerns and body dissatisfaction than cis women, while female-to-male (FtM) participants scored higher on the same dimensions than cis men. Among Italian participants, Bandini et al. (2013) found that both MtF and FtM participants expressed higher levels of body uneasiness than cis men and women.

The majority of research on correlates of body dissatisfaction has similarly focused on cis men and women and has found that body dissatisfaction relates to several mental health, social, and physical concerns including decreased self-esteem (Davidson & McCabe, 2005), depression

(Noles, Cash, & Winstead, 1985; Olivardia et al., 2004), and social anxiety (Davidson & McCabe, 2005). In a known study that did explore psychological correlates of poor body image in trans persons, depression and self-esteem were positively correlated with poor body image in MtF individuals, though findings were not consistent for FtM individuals (Vocks et al., 2009).

Body dissatisfaction also relates to maladaptive health behaviors. In cis women, positive body image is often tied to low body weight and a thin frame, and thus, body dissatisfaction has been connected to disordered eating behaviors such as food restriction and bingeing and purging behaviors (Cash & Deagle III, 1998). Although cis men are also at risk for body dissatisfaction, they tend to prioritize muscularity over slimness (Olivardia et al., 2004; Parent, 2013), and engage in unhealthy behaviors such as illegal steroid use and excessive exercise, occasionally to the point of dependence (Parent & Moradi, 2011). The limited research with trans persons has provided similar evidence that poor body image may relate to disordered eating behaviors and mental health concerns (Vocks, et al., 2009), suggesting the value of exploring best practice in managing body dissatisfaction in a clinical setting for trans persons.

Objectification Theory and Predictors of Body Dissatisfaction

Much of the recent research on body dissatisfaction has focused on factors associated with objectification theory. Objectification theory acknowledges gender socialization and sociocultural standards of beauty as primary contributors to positive or negative body image, and thus, is appropriate to use with a population for whom gender and gender expression can be an area of confusion or discomfort. Fredrickson and Roberts (1997) developed the theory as a way to explain why women, in particular, struggle with body dissatisfaction and disordered eating patterns. They argued that self-objectification is the idea that experiences of the male gaze, or of being viewed as objects of consumption by men, and sexual objectification both on a personal

and cultural level, as well as exposure to cultural standards of beauty or attractiveness lead to internalization of the idea that women exist as objects of consumption (Fredrickson & Roberts, 1997; Sevelius, 2013). It is now recognized that men also can experience self-objectification, and that self-objectification contributes to body surveillance, body shame, and beliefs that if one does not fit within the cultural ideal of beauty then she or he is worth less as a person (Engeln-Maddox, Miller & Doyle, 2011; Fredrickson & Roberts, 1997; Parent & Moradi, 2011).

Objectification theory was historically applied to the experiences of heterosexual cis women with more recent research on heterosexual cis men and sexual minorities. Research has found that, in cis women, experiences of sexual objectification and exposure to thin-ideal media images may predict internalization of the thin-idea, and self-objectification, which in turn, predicts body dissatisfaction, surveillance, and shame (Grabe, Ward & Hyde, 2008; Harper & Tiggemann, 2008; Moradi et al., 2005). Research on cis men is mixed, but many studies do support applicability of objectification theory to cis men, finding that in cis men internalization of media ideals and self-objectification contribute to body dissatisfaction and a drive for muscularity (Daniel & Bridges 2010; Daniel et al., 2014). Martins, Tiggemann, and Kirkbride (2007) found that gay men who are exposed to appearance-focused messages of gay subculture and the male gaze are also at risk for long-term self-objectification, and an increased risk of resulting body dissatisfaction (). Lesbian women and heterosexual cis women also report similar numbers of objectifying experiences, and both groups revealed a relationship between experience of sexualized gaze and self-objectification (Hill & Fisher, 2008). Velez, Breslow, Brewster, Cox Jr., and Foster (2016) recently explored objectification theory in context of the experiences of trans men, finding that internalization of cultural standards of attractiveness was related to body

dissatisfaction; viewed in light of the rest of the above findings, this finding suggests that objectification can occur regardless of one's sexuality or gender.

Additional Possible Predictors of Body Dissatisfaction in Trans Persons

Beyond the predictors of body dissatisfaction that have been explored in cis persons, there are additional factors that may be important to consider in conceptualizing body dissatisfaction in trans persons. One factor may relate to the desire or need to pass, or publicly appear as one's identified gender. The ability to pass can have implications with regards to safety and gender congruence, or the connection one feels between their gender identity and gender affirmation by others (Maurer, Pleck, & Rane, 2001). Gender affirming experiences, in which one is recognized as his or her identified gender, help trans persons to feel affirmed in their gender and understand that others experience them as that gender (Sevelius, 2013). Trans women in particular have reported that passing is easier when one has a naturally slight body type or is generally "smaller" (Sevelius, 2013). Striving for a stereotypically masculine or feminine body type may contribute to one's ability to pass and be affirmed in their gender by others. This also means, though, that those who experience objectifying events consistent with their gender (for example, when a trans woman is "cat called") could consider these to be gender-affirming experiences that may contribute to feelings of gender congruence (Sevelius, 2013). Thus, whereas sexual objectifying experiences have been found to relate to body dissatisfaction in cis persons, this may not be the case for trans persons.

Not all trans persons place an emphasis on passing; however, Roen (2001) suggests that among those who do there is often a need to pass for safety's sake. If an individual were "found out," he or she may be at risk for stigma and/or verbal, physical, or sexual assault (Sevelius, 2013). Stotzer (2009) found that trans persons are at high risk of assault from both strangers and

known individuals, and those who transgress gender norms more visibly, or fail to pass, may be at even greater risk for violence and micro-aggression (Brown, 2010). This threat to both physical and emotional safety puts trans persons in a position where they *must* internalize body ideals and physically conform to the body ideals of their identified gender in order to feel safe, potentially increasing the likelihood of body dissatisfaction.

Another factor to consider is gender expression and, thus, physical gender role adherence. Individuals generally fall somewhere on the spectrum of more masculine to feminine gender expression and stereotypical gender role adherence; the extent to which one identifies with more masculine or feminine norms may influence likelihood of struggling with body dissatisfaction. Lakkis et al. (1999) proposed the “femininity hypothesis” (p. 3) to suggest that, regardless of gender, those who identify with hegemonic feminine traits will be more at risk for body dissatisfaction. Though empirical research on the role of gender identity expression on body image is minimal, Jackson, Sullivan, and Rostker (1988) found that feminine-identified women expressed more body image concern than androgynous women. Similar results were found in a study of sexual and gender minority men and women (Cella, Iannaccone, & Cotrufo, 2013). As McCabe and Ricciardelli (2003) pointed out, this “may indicate that it is not gender that shapes the body image...” (p. 680) but the gender expression and role with which one identifies.

The Present Study

The present study attempted to add to the emerging research with trans individuals and extend knowledge by exploring predictors of body dissatisfaction among trans men and women who are living as their identified gender based on the male-female binary. People who may identify as non-binary or who otherwise transgress male and female gender identities were not included, as little is known about the non-binary body ideal at this time. Specifically, we used

hierarchical regression to test the predictive value of both predictors associated with objectification theory, (internalization of cultural standards of attractiveness, self-objectification, sexual objectification experiences, and perceived pressure from media portrayals of the body ideal) and additional trans specific predictors of gender identity expression, experience of gender-based violence, and whether one had undergone affirming medical procedures. Analysis for women and men were completed separately.

Among men, we hypothesized that internalization of cultural standards of attractiveness, self-objectification, and exposure to media portrayals of the body ideal would predict higher body shame and drive for muscularity. Among women, we expected that internalization of cultural standards of attractiveness, self-objectification, and exposure to media portrayals of the body ideal would predict higher body shame and pursuit of the thin ideal. Given qualitative findings that sexual objectification experiences may be affirming for trans men and women (Sevelius, 2013), we hypothesized that sexually objectifying experiences would not predict body dissatisfaction among trans women or trans men. We also predicted that for both genders, the additional variables of endorsing a feminine gender expression, having not undergone medical transition, and having experienced gender related violence would add significant predictive value beyond the variables associated with objectification theory.

We were also interested in gender differences. We hypothesized that trans women would express higher levels of body shame and pursuit of the thin ideal than trans men, who would conversely express higher levels of drive for muscularity. Consistent with past research (Jauk, 2013), trans women were expected to report more gender-based abuse, than trans men. However, in light of findings that suggest that trans men and women both experience distress as a result of gender-based violence (Testa et al., 2012), it was not expected that report of more

gender-based abuse would predict body dissatisfaction differently for trans men and trans women.

Methods

Participants

In order to be eligible for participation in the present study, participants had to self-identify as a trans man or trans woman, report living as their identified gender full-time for at least six months, be currently living in the United States, and be at least 18 years of age.

A total of 234 participants were included in analysis; 140 identified as trans men or men, and 94 identified as trans women or women. Of the 613 trans men and women who started the survey, 258 were eliminated for not meeting the criteria of either age or living full-time as their identified gender and 34 were removed for either identifying as non-binary or for not meeting the time requirements of six months of living as their identified gender; 88 participants dropped out prior to completing the full set of surveys. Participants' ages ranged from 18 to 66 ($M = 26.65$, $SD = 8.66$). A majority of the participants identified as Caucasian ($n = 191$, 81.52%), 9.82% ($n = 23$) identified as Biracial, 3.42% ($n = 8$) as Asian/Pacific Islander, 2.99% ($n = 7$) as Latino/Hispanic, and 0.85% ($n = 2$) identified as African American/Black. Participants endorsed diversity in sexual orientation, with 18.10% ($n = 42$) identifying as bisexual, 17.67% ($n = 41$) as heterosexual 15.94% ($n = 37$) as gay, 13.36% ($n = 31$) as Pansexual, 12.50% ($n = 29$) as Other, Asexual, or Questioning, 12.07% ($n = 28$) as Queer, and 10.34% ($n = 24$) as lesbian.

A vast majority of the participants ($n = 212$, 90.60%) of participants had undergone some type of medical treatment, with the majority ($n = 210$, 89.74%) currently using hormone therapy. Furthermore, 18.80% ($n = 44$) participants reported at least one experience of gender related physical abuse, 11.11% ($n = 26$) identified at least one experience of gender related

sexual abuse, and 51.23% ($n = 51.3$) reported at least one experience of gender related verbal abuse. Further demographic information regarding history of abuse and extent to which one has undergone medical interventions to aid transition are available in Table 1.

Measures

Participants were asked to complete the following measures or questions: a demographics questionnaire; questions regarding experiences of trans-related violence; the Interpersonal Sexual Objectification Scale (ISOS; Kozee, Tylka, Augustus-Horvath, & Denchik, 2007), which was expanded to include questions regarding participants' attitudes towards the sexual objectification experiences (Baggett, 2010); the Self Objectification Questionnaire (SOQ; Noll & Fredrickson, 1998) for trans women; the Male Assessment of Self-Objectification (MASO; Daniel, Bridges, & Martens, 2014) for trans men; the Sociocultural Attitudes Towards Appearance Questionnaire-4 (Schaefer et al., 2015); the Bem Sex Role Inventory (BSRI; Bem, 1981); the Body Shape Questionnaire form 8C (BSQ-8C; Evans & Dolan, 1983); the Drive for Muscularity Scale (DMS; McCreary & Sasse, 2000); and the Body Shame subscale of the Objectified Body Consciousness Scale (OBCS-BS; McKinley & Hyde, 1996).

Demographics: Demographic information included age, sex assigned at birth, identified gender, at what age they became aware that their identified gender did not match their sex assigned at birth, race/ethnicity, sexual orientation, highest level of education achieved, employment status, and income. Participants were asked to provide information regarding in what ways they have undergone the transition process, to what extent passing was important to them, and their perception of their ability to pass.

Experience of transgender related violence: Per previous studies (e.g. Testa et al., 2012), experience of trans-related violence was assessed through single questions asking participants

about experience of physical violence, sexual violence, and verbal harassment. Participants were asked whether they have been physically abused, how many incidents of physical abuse they have experienced, how many of these incidents were related to their gender identity, who the perpetrators were, and the date of the most recent abusive event. Similar questions were asked regarding sexual and verbal abuse.

Sexual objectification experiences and attitudes: Sexual objectification experiences were assessed utilizing the Body Evaluations subscale of the Interpersonal Sexual Objectification Scale (ISOS; Kozee et al., 2007), an 11-item measure that asks participants to respond to questions regarding to what extent they had different sexually objectifying experiences such as being cat-called. The measure utilizes a 5-point Likert scale ranging from 1 (never) to 5 (almost always). Reliability and validity of the ISOS have been established in adult women ($\alpha = .92$; Kozee et al., 2007) and men ($\alpha = .90$; Engeln-Maddox et al., 2011). Internal consistency reliability in the present study was similar ($\alpha = .91$). Three-week test-retest reliability suggested stability of the measure in a sample of women ($r = .90$; Kozee et al., 2007).

Participants were also asked to respond to how they felt about the sexual objectification experiences. In her dissertation, Baggett (2010) modified the ISOS to include these questions in order to explore whether sexual objectifying experiences are always considered negative. She developed 11-items to match the item of the original ISOS, and asked clients to rate how they felt about the objectification on a scale ranging from 1 (It bothers/offends me a lot) to 5 (I enjoy it a lot). In her study of 184 women and 179 men, internal consistency for this scale modification was good ($\alpha = .84$ for women and $\alpha = .91$ for men; Baggett, 2010), and internal consistency reliability was similar in the present study ($\alpha = .90$).

Self-Objectification: The self-objectification questionnaire (SOQ; Noll & Fredrickson, 1998) and Male Assessment of Self-Objectification (MASO; Daniel, Bridges, & Martens, 2014) were used to assess self-objectification. The SOQ consists of 10-items that ask participants to rank order body attributes on the extent to which attributes have the greatest impact on their physical self-concept. Participants give each attribute a ranking, ranging from 0 (least impact) to 9 (greatest impact). Five items each address appearance-based concerns (e.g. “weight”) and competence-based concerns (e.g. “physical fitness level”) (Noll & Fredrickson, 1998). Due to the scoring of this measure, Cronbach’s alphas are unavailable. Validity of the scale has been supported through significant positive correlations with scales addressing appearance anxiety and body dissatisfaction (Noll & Fredrickson, 1998).

The MASO (Daniel et al., 2014) was developed as a companion to the SOQ after it was determined that the SOQ may not fully encompass the male experience. The MASO uses objectification theory as its theoretical basis, but puts an emphasis on performance-based objectification, or the fact that men are often judged by what their bodies can do. The measure consists of 20 items and asks users to respond to questions regarding to what extent certain body attributes (“height”) or competencies (“flexibility”) are important to them. The measure uses a 7-point Likert scale ranging from 0 (not important at all) to 6 (very important). The MASO is scored by subtracting the competency-based score from the appearance-based score; higher scores on the MASO indicate higher levels of self-objectification. The MASO was developed and normed over the course of three studies utilizing a total of almost 350 participants. Internal consistency reliability was good ($\alpha = .88$ for the appearance based subscale and $\alpha = .89$ for the competency based subscale). Internal consistency for the present study was $\alpha = .81$. Validity

was established through positive correlations with the drive for muscularity, body surveillance, body shame, and self-objectification as measured by the SOQ (Noll & Fredrickson, 1988).

Cultural standards of attractiveness: The Sociocultural Attitudes Towards Appearance Questionnaire-4 (SATAQ-4; Schaefer et al., 2015) measures the extent to which one has incorporated “specific values [of body size and shape] to the extent to which they become guiding principles” (Thompson et al., 2004, p. 294). It consists of four subscales used in this study, measuring internalization of cultural standards of attractiveness (thinness and muscularity), familial pressure, and media pressure to fit into cultural standards of beauty. Items are scored on a 5-point Likert scale ranging from 1 (definitely disagree) to 5 (definitely agree). Example questions include “I think a lot about having very little body fat” (SATAQ-4 Internalization-Thinness); “I spend a lot of time doing things to look more muscular” (SATAQ-4 Internalization-Muscularity); “I feel pressure from the media to decrease my level of body fat” (SATAQ-4 Pressures-Media); and “I feel pressure from family members to improve my appearance” (SATAQ-4 Pressures-Family).

The measure was initially normed across four samples of US women ($N = 859$, three samples of international women ($N = 362$), and a sample of US college-aged men ($N = 271$) (Schaefer et al., 2015). Internal consistency reliability for all subscales were good and ranged from $\alpha = .75$ (Internalization-Thinness) to $\alpha = .95$ (Pressures-Media). Validity of the scale was established through significant positive correlations with scales assessing disordered eating, body dissatisfaction, and self-esteem.

Gender Expression: The BSRI (Bem, 1974, 1981) is one of the most widely used measures to assess masculinity and femininity (Fernández & Coello, 2010). Per previous research exploring body dissatisfaction and gender roles and expression (Cella et al., 2013;

Jackson et al., 1998) the BSRI was utilized to examine how much one aligns with masculine, feminine, or “neutral” gender expression and role. The BSRI (Bem, 1974; Bem, 1981) is a 60-item measure that asks participants the degree to which they view themselves on several characteristics. Characteristics include, “Makes decisions easily,” and “Analytical” (Bem, 1974; Bem, 1981). Participants are asked to give each characteristic a score ranging from 1 (never or almost never true) to 7 (always or almost always true). The BSRI (Bem, 1974; Bem, 1981) has adequate internal consistency reliability, reported at .86 and .80 for the masculine and feminine scales, respectively; test-retest reliability over a 1-month period was .90. Internal consistency for the present study was $\alpha = .86$ for both subscales.

Body dissatisfaction: Body dissatisfaction was measured using the Body Shape Questionnaire form 8C (BSQ-8C; Evans & Dolan, 1993), the Drive for Muscularity Scale (DMS; McCreary & Sasse, 2000), and the Body Shame subscale of the Objectified Body Consciousness Scale (OBCS-BS; McKinley & Hyde, 1996).

The BSQ-8C (Evans & Dolan, 1998) is the shortened version of the 34-item Body Shape Questionnaire developed by Cooper, Taylor, Cooper and Fairburn (1987) and has been determined to be the most favorable version of several other short forms of the measure (Pook, Tuschen-Caffier, & Brähler, 2008). The BSQ-8C consists of 8 items that address concern about weight gain and strive to achieve a desired shape. Items are scored on a 6-point Likert scale ranging from 1 (never) to 6 (always). Sample items include, “Have you been afraid that you might become fat (or fatter).” and “Have you imagined cutting off fleshy areas of your body?” Internal consistency reliability of the measure is good ($\alpha = .92$ for both women and men; Welch, Lagerström & Ghaderi, 2012), and for the present study was $\alpha = .90$. Convergent validity of the

measure was established through significant positive correlations with measures assessing disordered attitudes towards food and eating (Welch et al., 2012).

The DMS (McCreary & Sasse, 2005) is a 15-item measure that assesses preoccupation with increasing muscularity. Items are scored on a 6-point Likert scale ranging from 1 (always) to 6 (never) and include “I think about taking anabolic steroids” and “I think that my weight training schedule interferes with other aspects of my life.” (McCreary & Sasse, 2005). Internal consistency was .84 for boys and .78 for girls (McCreary & Sasse, 2005), and was .94 in the present study. Validity was established through positive correlations with measures assessing participants’ desires to gain weight and frequency of engaging in weight training, and through non-significant or negative relationships with scales assessing drive for thinness (McCreary & Sasse, 2005).

The Body Shame subscale of the Objectified Body Consciousness Scale (OBCS-BS; McKinley & Hyde, 1996) assesses the extent to which persons feel shame about their body. The subscale consists of 8 items scored on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Items include “When I’m not the size I think I should be, I feel ashamed.” and “When I can’t control my weight, I feel like something must be wrong with me.” (McKinley & Hyde, 1996). Internal consistency was sufficient in women ($\alpha = .84$; McKinley & Hyde, 1996) and men ($\alpha = .72$; Daniel & Bridges, 2010) and was .86 in the present study. Validity has been established through positive correlations with the Body Surveillance subscale of the OBCS and negative correlations with a measure assessing body esteem (McKinley & Hyde, 1996).

Procedures

After obtaining approval from the Institutional Review Board (IRB) at the researchers home institution, participants were recruited via snowball sampling and social media advertising,

largely via the social media site, Reddit. Recruitment information stated that the study was meant to explore body dissatisfaction in trans men and women, with hopes of informing treatment, that participant involvement was voluntary and anonymous, and that participants would be able to discontinue their involvement at any time. The recruitment message provided a link to the online self-report survey provided via SurveyMonkey, which had participants give consent before starting the study. As participation incentive, for each completed survey researchers donated \$1 (up to \$500) to each participant's choice of either the Transgender Law Center, the National Center for Transgender Equality, or Camp Aranu'tiq. Upon completion, participants received a statement thanking them for their participation and were directed to a separate survey allowing them to pick their charity to receive the donation.

Results

To test the hypotheses, six separate hierarchical regressions were used to explore the predictive value of the test variables for men and women across the three outcome variables. All assumptions were met. An a priori power analysis was run and suggested that 210 total participants were needed with equal numbers of trans men and women. Given that despite considerable recruitment efforts, 110 participants were not achieved for trans women, Adjusted R^2 is provided, which is often used as an alternative to R^2 when sample size is small (Tabachnic & Fidell, 2007); those results should be reviewed with caution. Given the large number of statistical tests run, a Bonferonni adjustment was used and a p -value of .017 was deemed necessary to find significance (Tabachnic & Fidell, 2007).

For each regression, the variables consistent with objectification theory including self-objectification, experience of sexually objectifying experiences, and each subscale associated with cultural standards of attractiveness, were entered at the first step. Experience of gender

related abuse, whether one had undergone medical interventions for transition, and the extent to which one ascribed to gendered norms were included in step two. Regression statistics for each test are available in Table 2 and Table 3.

The analyses showed that among trans men, with the BSQ-8 (Evans & Dolan, 1998) as the outcome variable, the step one predictors contributed significantly to the regression model $F(6,133) = 11.99, p < .001, R^2 = .35$. Of the predictor variables, internalization of the thin ideal was the strongest predictor of drive for a body ideal ($\beta = .27, p = .001$) followed by pressure from the media ($\beta = .16, p < .001$); other predictors were not significant. The addition of the step two predictors did not significantly account for any added variance: $F(4,129) = 7.42, p = .582$. Similarly, with the DMS (McCreary & Sasse, 2000) as the outcome variable, the step one predictors again contributed significantly to the regression model $F(6,133) = 21.94, p < .001, R^2 = .50$. Internalization of the muscular ideal was the only significant predictor ($\beta = -.71, p < .001$). The addition of the step two variables added no significant variance $F(4,129) = 15.19, p = .019$. Results were similar with the OBCS-BS as the outcome variable. The step one model was again statistically significant $F(6,133) = 16.33, p < .001, R^2 = .42$, with pressure from the media acting as the strongest predictor of body shame ($\beta = .34, p = .002$) followed by internalization of the muscular ideal ($\beta = .22, p = .002$) and internalization of the thin ideal ($\beta = .20, p = .011$). The step two variables again added no significant variance $F(4,129) = 9.98, p = .61$.

Among trans women, with the BSQ-8 as the outcome variable, the step one predictors contributed significantly to the regression model $F(6,87) = 12.58, p < .001, \text{Adj. } R^2 = .43$. Again, internalization of the thin ideal was the strongest predictor ($\beta = .46, p < .001$), followed by pressure from the media ($\beta = .35, p < .001$). The other predictors were not significant, nor was the addition of the step two variables, $F(4,83) = 8.67, p = .108$. Unsurprisingly, with the

DMS as the outcome variable, the step one predictors did not significantly contribute to the regression model $F(6,87) = 2.17, p = .054, \text{Adj. } R^2 = .07$. The step two variables did not add any significant variance $F(4,83) = 1.30, p = .976$. Finally, the step one model significantly predicted body shame as measured by the OBCS-BS $F(6,87) = 8.07, p < .001, \text{Adj. } R^2 = .31$. Media pressure, internalization of the thin ideal, and pressure from family were the only significant predictors ($\beta = .32, p = .001, \beta = .30, p < .002$, and $\beta = .23, p = .009$, respectively). The step two variables did add significant variance $F(4,84) = 7.83, p = .001$. In particular, having undergone some medical intervention to transition ($\beta = -.25, p < .004$), and experience of gender related abuse ($\beta = .20, p = .015$) were significant predictors among the step two variables.

To test gender differences, a series of t-tests were used to compare men and women on the three outcome variables. Contrary to our hypothesis that trans women would endorse greater levels of body dissatisfaction than trans men, trans men and trans women did not differ on either the BSQ, $t(232) = .53, p = .063$, or the OBCS-BS, $t(232) = -.344, p = .481$. There was a significant difference between trans men ($M = 4.02, SD = .96$) and trans women ($M = 5.68, SD = .08$) on the DMS, with men endorsing a stronger drive for muscularity; $t(232) = -13.95, p < .001$. Moreover, as suggested by the regression findings, experience of gender related violence appeared to predict body shame among trans women ($\beta = .20, p = .015$), but not among trans men ($\beta = -.07, p = .326$).

Discussion

The results of the present study provided partial support for our hypotheses. Measures that are used frequently in exploring self-objectification in cisgender populations, including internalization of the thin ideal, internalization of the muscular ideal, and pressure from the media, all significantly related to body dissatisfaction amongst both trans men and trans women.

This suggests that trans men and women are susceptible to media portrayals of the ideal body and internalize sociocultural messages that idealize thinness and muscularity, which may then contribute to dissatisfaction with their own bodies. These findings were consistent with what has been reliably found in studies with cis men and women (Grabe et al., 2008; Harper & Tiggemann, 2008; Martins et al., 2007); however, and interestingly, trans men seemed susceptible to internalized standards of thinness in addition to muscularity, which is not as consistent with the belief that cis men prioritize muscularity over thinness. Also of note in the present study, and consistent with past findings that cis women generally prioritize thinness over muscularity (Moradi et al., 2005), was the finding that trans women reported a lower drive for muscularity than trans men; this drive was not influenced by media, internalization of body ideals, or any of the other variables consistent with objectification theory.

Interestingly, in all but one of the regressions, none of the trans-specific predictors including experience of gender related violence, having undergone medical transition, or conformity to gender role norms were found to be significant predictors of body dissatisfaction. The one exception to this was found among trans women whose results suggested that experiencing gender related violence predicted greater body dissatisfaction, while having undergone at least some form of medical transition predicted lower levels of body dissatisfaction.

Effects of Gender Related Violence

The finding that trans women who have experienced gender related violence would report higher levels of body dissatisfaction was consistent with the research hypotheses and based on qualitative support that one may feel the need to “pass” or fit within a gendered body ideal in order to stay safe (Sevelius, 2013). However, it is interesting that these results were not consistent for trans men. A possible explanation for this could relate to a shift in power for one

transitioning from female to male. Although one is gaining a disenfranchised identity as “trans,” there also may be an increase in power if that person is able to pass as male, which could limit the effect of gender-related violence on one’s body image; of course, further study on this would be beneficial.

Effects of Medical Transition

Regarding the effect that having undergone medical transition may have on body image, the findings of the present study suggest that either the physiological or the psychological effects of starting the medical transition may serve as a protective factor for trans women. Findings of a recent study support the benefit of starting the medical transition, as researchers have observed reduced odds of depression and anxiety, and an increase in quality of life among trans women who have started the medical transition process (White Hughto & Reisner, 2016). These findings are interesting considering that the most frequent form of medical-transition endorsed by participants, hormone therapy, tends to result in increased body fat among trans women (Unger, 2016). Perhaps the benefits of other changes associated with hormone use, including the psychological impact of making a concrete step towards transition, breast growth and decreased facial and body hair, outweigh the effect of increased body fat; though, it is also possible that the increase in body fat may result in a “softer” or more feminine appearance, which may be desirable. However, this finding is somewhat inconsistent with the finding from the present study that trans women experience the drive for thinness similarly to cis women, suggesting that certain aspects of one’s physical body may be prioritized more. Amongst trans women, for example, although they may still experience a desire to be thin, other changes associated with hormone therapy may be experienced as more valuable.

Interestingly, hormone therapy in trans men is often associated with decreased body fat and increased muscularity and strength (Van Caenegem et al., 2015), which, as the present study suggests, are desirable effects for trans men. However, the findings of the present study did not suggest that having undergone a medical transition was a protective factor for trans men's body satisfaction. There is little in the existing research to suggest why this may be the case, and such findings will require further study

Limitations

Of primary concern in the present study was the low sample size given the number of predictors and statistical tests used; the results of the study should be considered in light of this limitation. Another limitation of the study is the lower number of trans women represented as well as the lack of participants from diverse backgrounds. The sample in the present study was predominately white and employed, which is not representative of the national average for trans men and women. A recent report (James et al., 2016) puts the unemployment rate for trans workers at 15%, three times the national average, and Flores, Brown, & Herman (2016) estimated that 45% of trans men and women identify as a race other than white.

Racial differences in particular may have implications for the present study as not only do body ideals differ across cultures, but so do body variables that contribute to positive or negative body image. African American and Latina women are more likely than European American women to eschew the thin ideal, particularly when they also report a strong ethnic identity (Schooler & Daniels, 2014; Webb, Warren-Findlow, Chou, & Adams, 2013). Moreover, Choate (2005) has summarized research suggesting that African American women, in particular, experience body image resilience. She suggests that this resilience stems from factors such as receiving empowering messages from family, supportive peer relationships, and African

American women's unique placement outside of the dominant culture which allows them to challenge body ideals based on this culture (Choate, 2005). Additionally, some scholars have argued that for African-American women, hair and skin tone play an equally important role as physique when considering body image (Awad et al., 2015; Capodilupo, 2015).

While these factors may lead some to believe that trans people of color may be less likely to endorse body dissatisfaction, Sevelius (2013) suggested that holding multiple minority identities may increase the risk for trans women to adhere to stereotypical standards of beauty. Multiple minority identities may introduce greater levels of minority stress, and trans individuals may experience an even greater urgency to reduce some of this stress by adhering strongly to standards of beauty in the hopes that one may be able to pass as cisgender. Furthermore, often trans people of color experience greater levels of poverty, and Sevelius (2013) sums up these complicating factors, stating: "those with the highest need for gender affirmation and the lowest access will be at the highest risk for negative health outcomes" (p. 678).

Further Directions

A clear area for further research, given the limitations expressed previously, is to prioritize recruitment of trans persons of color and explore how ethnic identity and culturally informed body ideals may influence body image among this population. Additionally, further research should explore the symptomatic implications of body dissatisfaction in terms of how it may influence or complicate disordered eating patterns, other unhealthy practices such as steroid use or inappropriate hormone use, and mental health among trans persons. Ultimately, though, the goal of the present research was to elucidate possible factors that may need to be addressed in treatment for body dissatisfaction in trans men and women. Thus, as we further explore the

relationship between trans persons and their bodies, interventions may become more focused, and studies testing treatment of body dissatisfaction in trans persons should be prioritized.

Clinical Implications

Although much of the findings from the present study are consistent with what we know of body dissatisfaction in cisgender populations, there are several clinical implications for trans clients. Given the finding of the present study that trans men and women endorse similar levels of body dissatisfactions, clinicians should assess body image concerns in trans men as well as trans women. There may be an assumption that trans men do not struggle with these concerns due to their male identity, but the findings of the present study suggest that this is not the case, and that trans men are equally at risk for not only trying to adhere to the muscular ideal, but also the thin ideal. Thus, whereas cis men may be more likely to use unsafe strategies such as steroids or over-exercise, trans men may be at risk of both these muscle-building strategies as well as body weight reducing strategies such as calorie restriction or binge/purge behaviors.

Additionally, relevant was the observed relationship between media exposure to the thin ideal and body dissatisfaction, and how this relationship may be complicated by social media exposure. Social media has become an invaluable resource for transgender individuals, particularly adolescents, who are using the internet to learn about and form their own identities as trans individuals, make social connections with similar people, and receive validation in their identities (Fox & Ralston, 2016; Miller, 2017). The dark side of positive effects of social media exposure is that there also may be higher exposure to the thin or muscular ideal through ads or even targeted pages trying to “teach” trans people how to get the bodies they want based on a culturally influenced perception of what the body ideal should be. In a recent meta-analysis with cis female participants, researchers have found that higher levels of social media exposure have

been related to an internalization of the thin ideal (Mingoia, Hutchinson, Wilson, & Gleaves, 2017). It is becoming increasingly important for clinicians to have discussions about media and social media consumption with their trans clients and how to balance the helpful effects of these outlets with the harmful effects.

Conclusion

Although the research on body dissatisfaction in trans men and women is in its infancy, the present study provided support for the continued development of this line of inquiry. Findings of the present study suggested that trans men and women's perception of their bodies are influenced by many of the same factors affecting cisgender men and women including media pressure and sociocultural standards of beauty. Factors related to having undergone medical transition or experience of gender related violence may also have an effect on one's body esteem. In terms of future steps, more focus needs to be placed on how body dissatisfaction may contribute to the mental health concerns for trans men and women as well as how clinicians can most effectively work with trans clients presenting with body concerns. The present study provides empirical support for the need for clinicians to have conversations about body image and for the need for researchers to continue exploring this issue in their research.

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Table 1

Full Sample Characteristics for Experienced Abuse and Medical Transition (N = 234)

Variable	n	%
Type of Abuse		
Verbal	70	29.9
Physical	3	1.3
Sexual	2	.9
Verbal & Physical	28	12
Verbal & Sexual	11	4.7
Physical & Sexual	3	1.3
All	10	4.3
None	107	45.7
Medical Transition Method		
Hormone Blockers	84	35.9
Hormone Therapy	210	89.7
Surgery to change primary sex characteristics	68	29.1
Other Surgery (facial feminization, etc.)	62	26.5
None	22	9.4

Table 2

Hierarchical Regression Analysis for Trans Men

Outcome Variable		R	R ²	R ² Δ
BSQ-8	Step 1	.59	.35*	.35
	Step 2	.60	.37	.01
DMS	Step 1	.71	.50*	.50
	Step 2	.74	.54	.04
OBBS-BS	Step 1	.65	.42*	.42
	Step 2	.66	.44	.01

Note. * $p < .017$

Table 3

Hierarchical Regression Analysis for Trans Women

Outcome Variable		<i>R</i>	<i>Adj. R</i> ²	<i>R</i> ² Δ
BSQ-8	Step 1	.68	.47*	.47
	Step 2	.72	.51	.05
DMS	Step 1	.36	.07	.13
	Step 2	.37	.03	.01
OBCS-BS	Step 1	.60	.31*	.36
	Step 2	.70	.42*	.13

Note. * $p < .017$