The colours of the rainbow: an exploratory quantitative analysis of identity affirmation among sexual and gender minority people of colour in North America

by

Ren Ho Mun Lo

B.E.S. (Planning), University of Waterloo, 2019

Dipl. (GIS), University of Waterloo, 2019

Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Public Health

in the

Master of Public Health Program

Faculty of Health Sciences

SIMON FRASER UNIVERSITY

Fall 2023

Declaration of Committee

Name:	**Ren Ho Mun Lo**
Degree:	**Master of Public Health**
Title:	**The colours of the rainbow: an exploratory quantitative analysis of identity affirmation among sexual and gender minority people of colour in North America**
Committee:	**Chair:** **Malcolm Steinberg** Associate Professor, Health Sciences
	Travis Salway Supervisor Assistant Professor, Health Sciences
	Vaibhav Saria Committee Member Assistant Professor, Gender, Sexuality, and Women's Studies
	João Bastos Examiner Associate Professor, Health Sciences

Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016

Abstract

Experiences of sexual orientation and gender identity and expression change efforts (SOGIECE) among sexual and gender minority people of colour (SGM-POC) have not been adequately described. A non-probabilistic cross-sectional sample of youth aged 15-29 in Canada and the United States (US) was recruited online during March-August 2022. 7,889 participants were recruited, including White (n=6,287), Asian (n=532), Black (n=207), Hispanic (n=168), Middle Eastern (n=36), and multi-racial (n=651) respondents. Prevalence of SOGIECE (70-85%) and pressure to be cisgender and/or heterosexual (81-90%) were high, with no significant differences between subgroups. Family events were the least reported safe setting in which to be out (0-16%), especially for Asian (p<0.001) and Black (p=0.011) respondents. SGM-POC reported family members as supportive less frequently than White respondents. Priests/religious leaders (6-16%) and other members of a religious group (11-17%) were the least reported source of support. These findings provide guidance for targeted public health efforts.

Keywords: sexual and gender minorities; youth; people of colour; sexual orientation and gender identity and expression change efforts; social networks; supportive environments

Acknowledgements

This journey would not have been possible without the guidance and support from my supervisor, Dr. Travis Salway, who has provided invaluable feedback, direction, inspiration, and mentorship for my research and academic career. For your kind and constant support, for providing me with this opportunity, for entertaining my grand ambitions of incorporating all my research questions, for every research assistantship and scholarship, and for every piece of encouragement: thank you. My experience working with Dr. Salway and the Reaffirm Collaborative team has shaped my perspective and growth as a budding researcher, and I will always be grateful for having had the opportunity to work with them.

Many thanks to Dr. Vaibhav Saria, who generously provided their knowledge and expertise as a member of my committee.

I would like to extend my thanks to Sarah Watt, Martha Gumprich, Andrés Delgado-Ron, and Thiyaana Jeyabalan, research team members at the Reaffirm Collaborative, for their support framing my research and providing statistical support.

To the youth and participants of the UnACoRN survey, thank you for sharing your stories and experiences and for doing so with honesty and bravery. I aimed to represent your experiences and insights in the best way I could and I hope that future researchers will continue to capture the details of what you shared in a way that honours your stories and journeys.

Finally, I am most grateful to my partner in life, Daksha Jadhav, for supporting me as a thought partner and editor throughout this journey. I would not be in this position today if not for their reassurance and unwavering belief in my academic potential.

Table of Contents

List of Tables

List of Figures

Chapter 1. Introduction

1.1. Objective and outline

The objective of this thesis is to explore the experiences of identity affirmation among sexual and gender minority people of colour (SGM-POC), ages 15 to 29 years old, in Canada and the United States (US). Identity affirmation is defined as recognizing and supporting the diverse gender and sexual identities expressed through social interactions (conversations, healthcare consultations, etc.) (King & Gamarel, 2021). Informal sexual orientation, gender identity, and gender expression change efforts (SOGIECE) exposure was examined alongside an assets-based approach investigating the settings, environments, and social networks in which SGM-POC feel safe and supported being out about their sexuality, gender identity, and/or gender expression. Data from the Understanding Affirming Communities, Relationships, and Networks (UnACoRN) study was analyzed for this purpose, with the goal of generating descriptive statistics and elucidating significant differences between SGM-POC subgroups and a SGM-White comparator group wherever possible.

In this first chapter, I present a brief overview of the thesis topic and share my positionality statements to provide context of my social position relative to this thesis work. Then, I will discuss the background, theoretical framework, and gaps in the literature underpinning the rationale of this research (Chapter 2). Next, I will present the results of my analysis in the format of a stand-alone research manuscript to be published in a peer-reviewed journal, including the research questions, methods, and discussion of findings (Chapter 3). Finally, to conclude, I will provide policy recommendations based on my findings and current events and discuss the future directions and knowledge translation efforts for my work moving forward (Chapter 4).

1.2. Positionality statement

Personal, interpersonal, and critical positionality statements are included below, following Smith's (2011) model of critical reflection, to examine the influence of subjectivity, professionalism, and power on the research at hand.

1.2.1. Personal positionality

I am a second-generation Canadian citizen by birthright, the child of upper-middle class Chinese immigrants who left Hong Kong in fear of a communist China takeover in 1994. My understanding of colonization is multi-faceted – British rule provided a free and democratic government for Hong Kong for many years, while simultaneously committing atrocities on other peoples. Colonization brought unprecedented prosperity to Hong Kong and afforded many opportunities to my parents, who grew up in low-income households, and allowed my family to immigrate to Canada. Almost three decades later, Hong Kong is no longer a functional democracy. I am not well-connected to my Cantonese culture, history, language, and community beyond my immediate family. Having grown up in Vancouver with the luxury of freedom, I am immensely grateful to live, work, and study as an uninvited guest on unceded Coast Salish territory, the traditional and ancestral lands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaɬ (Tsleil-Waututh) Nations.

As a non-binary person, I am blessed with an androgynous disposition that somewhat reduces misgendering in daily life. However, appearing androgynous also signals my identity as a gender minority, subsequently increasing my risk of experiencing transphobic violence. I am a sexual minority as well which, when combined with my gender identity/expression and racial identity, has led to unique intersectional experiences of violence and informal SOGIECE. My background and personal connection to this topic therefore informs this thesis research and interpretation of results.

1.2.2. Interpersonal positionality

My first experiences of informal SOGIECE were through cisheteronormative cultural values from my family and ethnic community. These values were driven and reinforced by the Roman Catholic faction of my local community, which I was introduced to by attending Catholic school. Coming to terms with my SGM identity was difficult, and the continuous coming out process to my family and ethnic community even more so, as I hold an expectation of rejection. These experiences are mirrored by my South Asian non-binary partner of seven years. Through my partner, I have been introduced to and have experienced a vibrant culture and ethnic community other than my own. This has

broadened my worldview and enhanced my appreciation for other cultures. However, we have similar strained relationships reconciling our SGM and POC identities – such that, at present, we continue to struggle to express ourselves. These lived experiences that I share with my SGM-POC partner, friends, and colleagues guide this thesis investigation.

1.2.3. Critical positionality

As a Chinese sexual and gender minority, I often find myself as the only SGM-POC in professional and academic spaces. The institution of academia has historically privileged Western, White, and White-passing individuals, leading to research that conflates minority groups and ignores intersectional experiences. Studies examining SGM are no different, where populations examined are overwhelmingly cisgender gay White men. Disproportionate power has also been given to those who are financially stable, a protective factor that has allowed me to pursue graduate studies. This financial support, coupled with my network of highly educated friends and colleagues, provides me with significant aid when I encounter barriers in my work.

1.3. MPH Competencies

The following Master of Public Health (MPH) concentration and foundational competencies have been identified and strengthened by research undertaken in this thesis:

<u>Concentration Competencies:</u>

- #2) Identify theories and frameworks that explain constructions of gender and sex, race and ethnicity, social class, and other markers of social location with attention to their intersections, historical and contemporary contexts, and relationships to health equity,

- #5) Engage in self-reflection and self-reflexivity about one's own social position relative to others and discuss implications of one's positionality for research and practice addressing health inequities.

Foundational Competencies:

- #1) Apply epidemiological methods to the breadth of settings and situations in public health practice,
- #2) Select quantitative and qualitative data collection methods appropriate for a given public health context,
- #3) Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate,
- #4) Interpret results of data analysis for public health research, policy or practice,
- #6) Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels.

Chapter 2. Background and Rationale

2.1. Background

2.1.1. A focus on sexual and gender minority people of colour

In this thesis, ‘sexual minorities’ and ‘gender minorities’ are used as broad terms to refer to individuals identifying as non-heterosexual (including gay, lesbian, queer, fluid, bi-, pan-, and a-sexual individuals) and/or non-cisgender (including those with a gender identity different from their sex assigned at birth and non-binary, genderfluid, genderqueer, third gender, and agender individuals) respectively. Throughout this work, the term sexual and gender minorities (SGM) is used to refer to people who are a sexual minority, gender minority, or both. Similarly, people of colour (POC) describe those with a racial identity other than White/Caucasian, as well as multi-racial individuals, irrespective of cultural or ethnic background. For the purpose of this thesis, self-selected racial identity was utilized with acknowledgement that race is a social construct that impacts how individuals experience society and health care (Smedley & Smedley, 2005). Finally, the term sexual and gender minority people of colour (SGM-POC) is used to denote individuals who are both POC *and* a sexual minority, gender minority, or both.[1] Note that these definitions may differ from similar terms used by other works cited herein, which may aggregate, exclude, or include subgroups depending on study limitations. Language is dynamic and this thesis reflects appropriate language, syntax, and semantics for the time of publishing, but may not encapsulate how individuals and/or communities speak of their experiences and identities over time. Thesis analyses and interpretation were likewise bound by the language used in the UnACoRN survey, conducted prior to thesis conception, which was incomplete and/or inaccurate in some areas (such as racial categories included for selection).

[1] While this thesis focuses on SGM-POC, Indigenous SGM are not included in the study sample analyzed. This is due to the unique ways in which Indigenous teachings represent gender and sexual diversity, which are fundamentally different from western notions and definitions (Pruden et al., 2021). Therefore the Indigenous data captured in the UnACoRN survey is being independently analyzed by the Two-Spirit Dry Lab, a research group led by Indigenous and settler scholars who focus exclusively on Indigenous data (Two-Spirit Dry Lab, n.d.).

SGM and POC possess stigmatized social identities that lead to the experience of stressors, such as actions perpetuated by others that are motivated by homophobia, transphobia, and racism, in daily life. In 2018, SGM and trans/non-binary individuals constituted an estimated 4% (~one million) and 0.24% (~75,000) of all Canadians older than 15 years of age, respectively (Statistics Canada, 2021). In the same population, Statistics Canada reported that 2.6% of racialized Canadians (including South Asian, Chinese, Black, Filipino, Latin American, and multi-racial groups) and 3.3% of non-racialized Canadians (Caucasian) identified as sexual minorities, with no comparable estimates for gender minorities (2023a). Escalating police-reported hate crimes in recent years are one example of the discrimination that SGM and POC experience in Canada: hate crimes motivated by race/ethnicity and sexual orientation both grew by 12% from 2021 to 2022 across the country (Statistics Canada, 2023b). The impacts of the stressors that SGM-POC face can uniquely impact them through experiences such as increased self-reported internalized stigma (Sarno et al., 2021), coerced sexual objectification of SGM-POC bodies, alcohol misuse (Souleymanov et al., 2020), and reduced acceptance in their racial/ethnic and 2SLGBTQ+ communities due to interconnected impacts of racism and homophobia/transphobia (Patel, 2019; Sadika et al., 2020).

Expectations of conformity set by Western society and White SGM are imposed on SGM-POC, alongside racism and ethnicism in dating and close relationships, lead to exclusion from SGM communities while heteronormative assumptions in POC communities lead to strained familial and community relationships for SGM-POC (Sadika et al., 2020). Additionally, linguistic limitations for SGM-POC present another challenge as POC's native language may not have the words to translate North American labels and concepts of sexual and gender diversity – potentially creating misconceptions and rejection of Western ideas by family and community members (Sadika et al., 2020). Language barriers also limit the adoption of SGM-affirming resources in ethnic communities, which further perpetuates cisheteronormative ideals. These interconnected systems ultimately uniquely disadvantage SGM-POC by limiting acceptance, social networks of support, and settings in which individuals feel safe.

2.1.2. Sexual orientation and gender identity and expression change efforts (SOGIECE) and SGM-POC

Sexual orientation and gender identity and expression change efforts (SOGIECE) encompass a wide range of practices that perpetuate cissexist and heterosexist norms that seek to repress, deny, or change a person's sexual orientation, gender identity, or gender expression (Centre for Gender and Sexual Health Equity, 2020). There is no ubiquitous form of SOGIECE: 'formal' SOGIECE occurs in formal settings, such as through enrollment into structured conversion therapy programs, while 'informal' SOGIECE occurs in unstructured environments (i.e. perpetuation of cisgender and heterosexual norms in casual conversation among family members or friends, social media content) (Centre for Gender and Sexual Health Equity, 2020; Kinitz et al., 2022). Exposure to SOGIECE is associated with a variety of negative mental and physical health outcomes, including emotional distress, suicidality, mental illness (i.e. depression and anxiety) (Goodyear et al., 2022; Ryan et al., 2020; Salway et al., 2020; Turban et al., 2020), and substance use (Ryan et al., 2020; Salway et al., 2020).

The estimated prevalence of SOGIECE exposure is 2 to 34% among 2SLGBTQ+ individuals in Canada and the United States (Green et al., 2020; Mallory et al., 2019; Meanley et al., 2020; Ryan et al., 2020; Salway et al., 2020, 2023; Trans PULSE Canada, 2019; Turban et al., 2019, 2020). Prevalence estimates of SOGIECE exposure indicate that SGM-POC are more likely to experience SOGIECE than White SGM (Blosnich et al., 2020; Green et al., 2020; Salway et al., 2020; Turban et al., 2020). However, further POC subgroup analyses are limited, as POC participants have typically constituted a small proportion of study samples compared to white participants (Green et al., 2020; Meanley et al., 2020; Salway et al., 2020; Turban et al., 2020). For this reason, researchers have suggested that future studies disaggregate POC subgroups to further investigate the distribution of the inequitable exposure to these harmful practices (Salway et al., 2023). Additionally, current literature fails to capture the intersectional experiences of SOGIECE among SGM-POC especially in informal settings (Meanley et al., 2020), since SOGIECE occurs across religion, race, sexualities, and genders (Goodyear et al., 2022; Kinitz et al., 2022). Exploratory quantitative analyses in this area are vital to understand how, where, and with whom SOGIECE is perpetuated among SGM-POC.

2.1.3. Environments and social networks of support

Environments of support can be encapsulated by community climate, a concept that encompasses the overall messages that LGBTQ people receive in their social environments through interactions with religious, legal, economic, and social structures, which can positively or negatively affect daily life (Oswald et al., 2010). Supportive community climates can be built by improving LGBTQ-affirming resources and infrastructure, such as by having LGBTQ-accepting and affirming religious institutions, school supports, and public policies, thereby reducing environmental microaggressions experienced by SGM individuals (Oswald et al., 2010). Environments of support for SGM have a largely protective effect, including improved mental health (Paceley et al., 2020; Woodford et al., 2015), and reduced suicidality (Saewyc et al., 2020) and substance use (Hatzenbuehler et al., 2012; Watson et al., 2020) among SGM youth. Perceived community climate is a critical component that influences daily life among SGM-POC, and understanding where individuals feel safe and supported is important to highlight areas for further improvement.

Studies examined by a systematic review of social support among LGBTQ youth defined social support as “social, school, and family connectedness, support from peers, adults, advisors, and support groups” (McDonald, 2018). LGBTQ youth receiving social support experienced improved mental health outcomes, such as reductions in “symptoms of depression, suicidal ideation, drug use, shame, school avoidance, sexual orientation violence, and anxiety” (McDonald, 2018). The effect of social support from family, friends, and community is protective for SGM individuals, as found by a systematic review examining social and legal affirmation for transgender people (King & Gamarel, 2021). A cross-sectional study of LGBT Latino and non-Latino young adults in the US, conducted in 2015, found that support from family, friends, and community were strong predictors of positive outcomes, including life situation and self-esteem (Snapp et al., 2015). In a 2023 Canadian national cross-sectional study of LGB individuals using data from 2015 to 2016, community belonging, another type of social support, was found to moderate the relationship between marginalization and mental health (Dulai et al., 2023). Finally, support from family was found to be the most significant protective type of social support against suicidality among SGM youth in two studies: a 2013 prospective longitudinal study of LGBT youth (Mustanski & Liu, 2013) and a 2010 cross-sectional study of LGB youth analyzing data from 2000 (Padilla et al., 2010), both in the US.

Individuals seek social support from different sources depending on the type of support they need: one study found that, for everyday social support (i.e. recreational and social activities, talking about problems), both lesbian, gay, and bisexual (LGB) and heterosexual individuals relied on people other than family, who were often the same sexual orientation and race/ethnicity as the participants (Frost et al., 2016). This contrasted with major support (i.e. borrowing large sums of money), where heterosexual, lesbian, and bisexual women tended to rely on their families while gay and bisexual men relied on other LGB people (Frost et al., 2016). Crucially, racial minority LGBs received overall fewer dimensions of social support and providers of support than White LGBs (Frost et al., 2016). Further work in this area to evaluate which social networks support SGM-POC, by disaggregated group, is necessary to highlight gaps in social support that they receive and where support programming could be targeted.

2.2. Theoretical Framework

The minority stress theory has been utilized extensively to understand the experiences of marginalized populations, proposing that prejudice and social stressors from having one or more stigmatized social identities can lead to poor mental health outcomes (Brooks, 1981; Meyer, 2003). Distal and proximal stressors from the minority stress model apply to SGM in particular – distal stressors include objective external stressful events and conditions (i.e. discrimination), and proximal stressors refer to subjective and individual processes undertaken often in reaction to distal stressors (i.e. internalized homophobia, concealment of identity, expectations of rejection) (Meyer, 2003). While minority stress effectively describes mental health impacts among SGM, it has limited applicability for physical health outcomes. Diamond and Alley (2022) explain this gap in minority stress theory through the concept of social safety, which they define as “reliable social connection, social belongingness, social inclusion, social recognition and social protection, which are essential human needs at all stages of life”. They argue that the absence of social safety among stigmatized populations, including SGM, further explains the health disparities emergent in SGM populations (Diamond & Alley, 2022). Additionally, there is increasing evidence suggesting that the minority stress theory by itself fails to capture the complexity of experiences for those with multiple minority identities, such as SGM-POC, as it assumes uniformity of experiences across minority identities (Cyrus, 2017). To illustrate, when examining the differential experiences of the

gay community among Black versus White men who have sex with men (MSM), authors found that Black MSM experienced less positive engagement with the gay community than White MSM due to encounters of racism (Haile et al., 2014). A qualitative study of SGM Latinxs similarly found that the racism, heterosexism, and sexism dimensions of oppression work together with Latinx cultural values to shape their experiences of minority stress (Noyola et al., 2020). Exploring the impact of stigma-related stressors with an additive or multiplicative approach, for each identity held, has led to a lack of consistency among study findings for SGM-POC (Cyrus, 2017). This is likely due to the exclusion of how identities influence and impact each other – the foundational concept of intersectionality (Bowleg, 2012; Crenshaw, 1991; Cyrus, 2017; Sarno et al., 2021).

The intersectionality framework was developed to explain the unique interactions between identities such as race and gender – specifically to characterize how and why women of colour experience increased levels of violence (Crenshaw, 1991; Hill Collins, 1990). Crenshaw (1991) further elaborates that combinations of stigmatized social identities trigger systems of oppression in unique ways, leading to experiences of discrimination that cannot be attributed to each identity alone. A systematic review exploring intersectional microaggressions, subtle acts of discrimination occurring in every-day life due to a person's intersectional identities (Nadal et al., 2015), among SGM-POC in Canada revealed these complex dynamics: 1) POC who expressed a minoritized sexual or gender identity reported strained relationships and a lack of belonging with their family, racial, and ethnic communities, as a result of cultural norms, expectations, beliefs, and linguistic limitations that favoured cis- and hetero-sexist ideals; and 2) SGM who were racial minorities experienced exclusion, racism, and ethnicism in LGBTQ spaces and communities, due to cultural insensitivity and stereotyping within the LGBTQ community and expectations of conformity set by the dominant White LGBTQ group in society (Logie & Rwigema, 2014; Sadika et al., 2020). These unique intersectional minority stressors have been associated with increased internalized stigma (Sarno et al., 2021), substance use (Mereish et al., 2023), reduced access to economic opportunities (Brooks, 1981), and poor mental health (Mereish et al., 2022) among SGM-POC.

Intersectional minority stress examines how stressors, due to having multiple stigmatized identities, interact together in various environments to impact an individual's health outcomes. Research in this thesis will apply an intersectional minority stress lens

to examine SOGIECE stressors and forms of social support among SGM-POC, with the goal of understanding how stigmatized social identities interact and shape safe and supportive social networks.

2.3. Gaps in the Literature

Informal SOGIECE practices, driven by societal cis- and hetero-sexist norms that influence every-day interactions (Kinitz et al., 2022), include the intersectional minority stressors discussed previously that impact the acceptance of SGM-POC in their communities (Sadika et al., 2020). Although there has been a greater focus on SOGIECE practices in recent years, informal SOGIECE has so far been characterized through qualitative studies (Goodyear et al., 2022; Kinitz et al., 2022). Quantitative studies examining SOGIECE primarily focus on exposure to formal conversion therapy programs or services (Blais et al., 2022; Salway et al., 2020, 2021). SOGIECE studies to date have utilized a deficits-based approach, focusing on perceived weaknesses and characterizing health disparities among SGM, and have not described systems and networks of support among SGM-POC. Studies examining social networks and environments of support were limited in aggregating their racial groups in findings and did not often include gender minority individuals in their sample (McDonald, 2018). Finally, the majority of studies examining SGM affirmation and SOGIECE literature, especially those analyzing large national samples, have been conducted in the US while few have been undertaken in Canada. This gap in the literature fails to capture the unique social environment and experience of SGM in Canada, where there are more legal and policy protections (Rich et al., 2019) and potentially greater social acceptance for SGM (Poushter & Kent, 2020) compared to the US.

A salutogenic approach emphasizes factors that support the health and wellbeing of a population, and an assets-based approach focuses on building upon a population's strengths and increasing external community capacity. Research in this thesis seeks to fill the aforementioned gaps and utilize a quantitative, salutogenic, and assets-based approach to examine the prevalence of informal SOGIECE, explore the characteristics of those enacting informal SOGIECE, and summarize safe and supportive environments among SGM-POC.

Chapter 3. Manuscript

3.1. Structured Abstract

Objective: To examine experiences of informal sexual orientation and gender identity and expression change efforts (SOGIECE) among sexual and gender minority people of colour (SGM-POC).

Methods: A non-probabilistic cross-sectional sample of youth aged 15-29 in Canada and the United States (US) was recruited online during March-August 2022. 7,889 participants were recruited, including White (n=6,287), Asian (n=532), Black (n=207), Hispanic (n=168), Middle Eastern (n=36), and multi-racial (n=651) respondents. Prevalence estimates of lifetime experiences of SOGIECE, perceived settings of safety when being out, and social networks of support were compared between SGM-POC and white-SGM.

Results: Prevalence of SOGIECE (70-85%) and pressure to be cisgender and/or heterosexual (81-90%) were high, with no significant differences between groups. LGBTQ+ spaces were the most supportive settings across racial groups, and friends, online forums/chat groups, and partners were the most supportive social networks. SGM-POC reported family members as supportive less frequently than white respondents. Priests/religious leaders (6-16%) and other members of a religious group (11-17%) were the least reported source of support.

Conclusions: These findings provide guidance for targeted public health efforts.

3.2. Introduction

Sexual and gender minorities (SGM) and people of colour (POC) possess stigmatized social identities that lead to the experience of stressors, such homophobia, transphobia, and racism, in daily life. In 2018, SGM and trans/non-binary individuals constituted an estimated 4% (~one million) and 0.24% (~75,000) of all Canadians older than 15 years of age respectively (Statistics Canada, 2021). Escalating police-reported hate crimes in recent years are one example of the discrimination that SGM and POC experience: hate crimes motivated by race/ethnicity and sexual orientation both grew by

12% from 2021 to 2022 in Canada (Statistics Canada, 2023b). The impacts of the stressors that SGM-POC face can uniquely impact them through experiences such as increased self-reported internalized stigma (Sarno et al., 2021), coerced sexual objectification of SGM-POC bodies, alcohol misuse (Souleymanov et al., 2020), and reduced acceptance in their racial/ethnic and 2SLGBTQ+ communities due to interconnected impacts of racism and homophobia/transphobia (Patel, 2019; Sadika et al., 2020; Souleymanov et al., 2020).

Sexual orientation and gender identity and expression change efforts (SOGIECE) encompass a wide range of practices that perpetuate cissexist and heterosexist norms that seek to repress, deny, or change a person's sexual orientation, gender identity, or gender expression (Centre for Gender and Sexual Health Equity, 2020). There is no ubiquitous form of SOGIECE, as it can occur in formal settings (i.e. through conversion therapy programs) and in unstructured environments (i.e. perpetuation of cisgender and heterosexual norms in casual conversation among family members or friends) (Centre for Gender and Sexual Health Equity, 2020; Kinitz et al., 2022). Exposure to SOGIECE is associated with a variety of negative mental and physical health outcomes, including emotional distress, suicidality, mental illness (i.e. depression and anxiety) (Goodyear et al., 2022; Ryan et al., 2020; Salway et al., 2020; Turban et al., 2020), and substance use (Ryan et al., 2020; Salway et al., 2020).

The estimated prevalence of SOGIECE exposure is 2 to 34% among 2SLGBTQ+ individuals in Canada and the United States (Green et al., 2020; Mallory et al., 2019; Meanley et al., 2020; Ryan et al., 2020; Salway et al., 2020, 2023; Trans PULSE Canada, 2019; Turban et al., 2019, 2020). Prevalence estimates of SOGIECE exposure indicate that SGM-POC are more likely to experience SOGIECE than White SGM (Green et al., 2020; Salway et al., 2020). However, further POC subgroup analyses are limited, as POC participants constitute a small proportion of study samples compared to white participants (Green et al., 2020; Meanley et al., 2020; Salway et al., 2020; Turban et al., 2020).

Informal SOGIECE practices, driven by societal cis- and hetero-sexist norms that influence every-day interactions (Kinitz et al., 2022), include intersectional minority stressors that impact the acceptance of SGM-POC in their communities (Sadika et al., 2020). Although there has been a greater focus on SOGIECE practices in recent years,

informal SOGIECE has so far been characterized through qualitative studies (Goodyear et al., 2022; Kinitz et al., 2022). Quantitative studies examining SOGIECE primarily focus on exposure to formal conversion therapy programs or services (Blais et al., 2022; Salway et al., 2020, 2021). SOGIECE studies to date have utilized a deficits-based approach and have not described systems and networks of support among SGM-POC. Studies examining social networks and environments of support were limited in aggregating their racial groups in findings and did not often include gender minority individuals in their sample (McDonald, 2018). This study seeks to fill this gap and utilize a quantitative and salutogenic approach to examine the prevalence of informal SOGIECE, explore the characteristics of those enacting informal SOGIECE, and summarize safe and supportive environments among SGM-POC.

3.3. Objectives and Research Questions (RQs)

The objectives of this quantitative study are to examine informal SOGIECE experiences among SGM-POC, and, using an assets-based approach, to investigate the environments and social networks in which SGM-POC feel safe and supported. Data from the Understanding Affirming Communities, Relationships, and Networks (UnACoRN) study will be analyzed to address the following RQs:

- What is the proportion of the SGM population that has ever experienced SOGIECE in their lifetime (lifetime prevalence)?
    a. How does this lifetime prevalence estimate differ between POC and White SGM respondents?
- Which environments do SGM feel safe and supported, when being out about their sexuality and gender identity/expression?
    a. How do the frequencies of safe and supportive environments differ between POC and White SGM respondents?
- Which social networks and groups support the gender identity, expression, and sexuality of SGM?

a. How do the frequencies of safe and supportive social networks and groups differ between POC and White SGM respondents?

3.4. Methods

3.4.1. Sample

The UnACoRN survey, a cross-sectional study that surveyed youth aged 15 to 29 in Canada and the United States (US), conducted recruitment from March 2022 to August 2022 using the non-probabilistic sampling method (Delgado-Ron et al., 2022). Respondents were eligible to participate if they were aged 15 to 29, living in Canada or US at the time of survey completion, and able to complete the survey in English or French. Recruitment occurred through a variety of online (Meta: 83.1% of sample recruited from this venue, Tiktok: 1.4%, Reddit: 3.2%, Pornhub: 1.31%) and in-person (allied organizations, bus advertisements, media interviews: recruitment estimates unavailable) channels (Delgado-Ron et al., 2022). Recruitment ads included a variety of topics non-specific to informal SOGIECE. Participants who completed the UnACoRN survey were offered the chance to enter a draw to win one of 15 $100 gift cards and a giant stuffed unicorn. During the UnACoRN survey development, the research team consulted with subject matter experts and SGM youth, combining novel measures with those from previously conducted surveys targeting SGM individuals. Further information about the UnACoRN study's recruitment strategy and questionnaire is described by Delgado-Ron and colleagues (2022). Indigenous respondents were excluded from analysis given the unique ways in which gender and sexual diversity are represented through Indigenous teachings and growing calls for Indigenous-disaggregated data (Pruden et al., 2021). Participants that did not identify as SGM (cisgender and heterosexual individuals) were excluded from analysis.

Out of 7,889 participants who provided racial, gender, and sexual orientation identity demographic information, 7,520 (95.3%) were from SGM populations and 1,602 (20.3%) identified as a POC. There were 5,691 Canadian residents and 2,164 US residents, excluding skipped responses. Since all questions asked in the survey contained either a "Prefer not to answer" option and/or were able to be skipped, sample totals for each measure vary depending on individual question response rate.

3.4.2. Measures

Exposure: SGM and POC

Participants' racial identity was used to determine POC and non-POC status, with six multi-selectable categories: White, Asian, Black, Hispanic, Pacific Islander, and an open-text option to self-describe. Manual recoding of open-text responses and separation of those selecting >1 racial identity yielded seven mutually exclusive categories: White, Asian, Black, Hispanic, Middle Eastern, Pacific Islander, and multi-racial. Since the number of Pacific Islander participants (n=8) was too low for statistical comparison, they were excluded from further analyses. The non-POC group comprised of participants who only selected the 'White' option. POC groups selected any other non-White option, including multi-racial participants, and are disaggregated into subgroups wherever possible for analysis. SGM participants consisted of those who reported a sexual minority (sexuality other than heterosexual/straight, excluding Indigiqueer respondents) and/or a gender minority identity (those with a gender identity that does not align with sex assigned at birth [i.e., 2-step gender modality method], trans experience [i.e., 1-step gender modality method], and/or differences in sex development [i.e., intersex]) (Kronk et al., 2022). Trans experience was measured by asking "Are you a person of trans experience, meaning your gender identity is different from the sex/gender you were assigned at birth?". Participants who did not answer the racial, sexual, or gender identity survey questions were excluded from analysis, as well as those who self-identified as cisgender and heterosexual.

Outcome: SOGIECE

Two measures were used to examine SOGIECE exposure: 1) experience of pressure to be cisgender or straight (cis-het pressure); and 2) experience of a person in a position of authority who tried to deny, suppress, or lead participant(s) to doubt their gender identity, gender expression, or sexuality (SOGIECE). Participants were exposed to cis-het pressure if they selected "Yes, pressure to be cisgender" and/or "Yes, pressure to be straight," were not exposed if they selected "No", and excluded if they skipped the question or chose not to answer. Participants were exposed to SOGIECE if they responded "Yes, sexuality", "Yes, gender identity", and/or "Yes, gender expression," were not exposed if they selected "No", and excluded if they skipped the question or chose not to answer. Prevalence was also examined by stratifying participants by sex

assigned at birth, given that SOGIECE targeting gender minorities seek to make them conform with their gender/sex assigned at birth (Ashley, 2022). Participants who were exposed to cis-het pressure and/or SOGIECE were asked “From whom?” this exposure originated from. Perpetuators of cis-het pressure and SOGIECE were identified for analysis based on the responses to these questions, excluding self-described perpetuators and skipped or prefer not to answer responses (see full list of response options in Appendix A).

Outcome: Environments and Social Networks of Support

Environments of support were measured by asking respondents where they felt safe, or know they would be safe, being out about their sexuality or gender identity and expression. Response options were multi-selectable and all were utilized for analysis, excluding “Two-Spirit or Indiqueer communities” (specific to Indigenous respondents), self-described spaces, skipped, and prefer not to answer options (see Appendix A).

There were two questions measuring social networks of support, one for sexual minorities and another for gender minorities, and “Yes”, “No”, and “Not Applicable” could be selected for each individual response option. These questions asked “Who has supported your [gender identity or expression / sexuality]? Support can come in many forms. For example, it can be explicit or implicit, can be shown through words or actions. Please answer based on what support looks like for *you*.” Response options were identical for both questions (see Appendix A). All options were utilized for analysis, excluding “Other”, skipped, and prefer not to answer responses.

3.4.3. Analysis

Descriptive analyses were conducted for all RQs. R (version 4.2.2) and R Studio were used to conduct all statistical analyses in this study. Prevalence estimates and 95% confidence intervals (CI) for SOGIECE and cis-het pressure were calculated using the exact method and the R epitools package (Aragon et al., 2022). The chi-square test with the Bonferroni correction was used to determine statistical significance for all pairwise comparisons between racial groups, with the White group as the comparison group ($p<0.05$ considered statistically significant). The Bonferroni correction was employed to mitigate the risk of Type I error from the utilization of multiple chi-square

tests, which may arise from comparing multiple individual racial groups to the comparison group, by conservatively adjusting the p-value (Armstrong, 2014).

Ethical approval for this study was obtained from the Simon Fraser University Research Ethics Board.

3.5. Results

3.5.1. Sample demographics

UnACoRN respondents selected into six broad racial categories: White (n=6,287), Asian (n=532), Black (n=207), Hispanic (n=168), Middle Eastern (n=36), and multi-racial (n=651). Among these groups, most respondents were SGM (White: n=6,013, Asian: n=486, Black: n=191, Hispanic: n=161, Middle Eastern: n=35, multi-racial: n=628). In the overall sample of 7,889 participants, 93.7% were sexual minorities (n=7,394) and 68.3% were gender minorities (n=5,385). The sample mean age was 18.8 years, the median age was 17 years, and the interquartile range was 5 years. Demographics of the sample are further described by racial group in Table 3.1.

Table 3.1. Demographics of 2022 survey participants in US and Canada, who provided racial, gender, and sexual orientation identity information.

		White N=6287	**Asian** N=532	**Black** N=207	**Hispanic** N=168	**Middle eastern** N=36	**Multi-racial** N=651
*Gender identity**	Man	1492 (23.7%)	128 (24.1%)	48 (23.2%)	44 (26.2%)	8 (22.2%)	171 (26.3%)
	Woman	2424 (38.6%)	238 (44.7%)	83 (40.1%)	52 (31.0%)	18 (50.0%)	234 (35.9%)
	Agender	529 (8.4%)	45 (8.5%)	14 (6.8%)	10 (6.0%)	2 (5.6%)	57 (8.8%)
	Genderfluid	883 (14.0%)	64 (12.0%)	30 (14.5%)	29 (17.3%)	7 (19.4%)	105 (16.1%)
	Genderqueer	882 (14.0%)	56 (10.5%)	23 (11.1%)	19 (11.3%)	2 (5.6%)	91 (14.0%)
	Nonbinary	2019 (32.1%)	142 (26.7%)	59 (28.5%)	54 (32.1%)	10 (27.8%)	209 (32.1%)
	Third gender	44 (0.7%)	3 (0.6%)	3 (1.4%)	0 (0%)	0 (0%)	4 (0.6%)
*Trans experience***	Yes	3100 (49.4%)	184 (34.6%)	90 (43.5%)	80 (47.6%)	12 (33.3%)	350 (53.9%)
	No	2429 (38.7%)	277 (52.1%)	91 (44.0%)	56 (33.3%)	22 (61.1%)	227 (35.0%)
	Not sure	747 (11.9%)	71 (13.3%)	26 (12.6%)	32 (19.0%)	2 (5.6%)	72 (11.1%)

		White N=6287	**Asian** N=532	**Black** N=207	**Hispanic** N=168	**Middle eastern** N=36	**Multi-racial** N=651
*Sexual orientation identity**	Gay	780 (12.4%)	84 (15.8%)	20 (9.7%)	21 (12.5%)	6 (16.7%)	92 (14.1%)
	Lesbian	1033 (16.4%)	69 (13.0%)	30 (14.5%)	14 (8.3%)	12 (33.3%)	98 (15.1%)
	Bisexual	2124 (33.8%)	182 (34.2%)	55 (26.6%)	65 (38.7%)	10 (27.8%)	255 (39.2%)
	Pansexual	1183 (18.8%)	82 (15.4%)	42 (20.3%)	40 (23.8%)	7 (19.4%)	132 (20.3%)
	Asexual	1234 (19.6%)	100 (18.8%)	28 (13.5%)	26 (15.5%)	6 (16.7%)	117 (18.0%)
	Queer	1875 (29.8%)	141 (26.5%)	42 (20.3%)	41 (24.4%)	9 (25.0%)	181 (27.8%)
	Heterosexual / straight	589 (9.4%)	70 (13.2%)	27 (13.0%)	15 (8.9%)	4 (11.1%)	59 (9.1%)
	Fluid	536 (8.5%)	36 (6.8%)	14 (6.8%)	11 (6.5%)	4 (11.1%)	58 (8.9%)
Age, In years	Mean	18.9	18.5	17.9	18	19.5	18.1
	Median	17	17	17	16	18	17
	Interquartile range	5.0	5.0	4.0	3.0	7.0	3.0
Age at coming out to others	Gender identity (mean age, % out)	15.8, 90.9%	15.8, 91.1%	15.6, 85.8%	15.3, 94.0%	16.8, 88.9%	14.9, 92.7%
	Sexuality (mean age, % out)	14.4, 94.7%	14.9, 92.0%	14.9, 87.2%	14.4, 94.8%	15.2, 94.1%	13.5, 95.1%
Country of residence	Canada	4600 (73.4%)	460 (86.8%)	133 (64.3%)	84 (50.0%)	34 (94.4%)	380 (58.6%)
	US	1666 (26.6%)	70 (13.2%)	73 (35.3%)	84 (50.0%)	2 (5.6%)	269 (41.4%)
Self-perceived economic status	Not enough to to live/for necessities	134 (3.4%)	7 (2.4%)	3 (2.6%)	4 (3.9%)	0 (0.0%)	12 (3.2%)
	Just enough to live/for necessities	674 (17.2%)	30 (10.1%)	26 (22.4%)	19 (18.6%)	5 (22.7%)	53 (14.0%)
	Enough	1306 (33.3%)	89 (30.0%)	47 (40.5%)	45 (44.1%)	8 (36.4%)	143 (37.8%)
	We only have to worry about money for fun or extras	1292 (32.9%)	126 (42.4%)	30 (25.9%)	25 (24.5%)	3 (13.6%)	117 (31.0%)
	We never have to worry about money	521 (13.3%)	45 (15.2%)	10 (8.6%)	9 (8.8%)	6 (27.3%)	53 (14.0%)

* Answers are not mutually exclusive

** 1 step gender modality method, measured by the question: “Are you a person of trans experience, meaning your gender identity is different from the sex/gender you were assigned at birth?”

3.5.2. SOGIECE and cis-het pressure

Prevalence

Among all SGM participants, prevalence of SOGIECE exposure was 70.6% (n=4049/5737, 95% CI: 69.4%-71.8%). Middle Eastern respondents had the highest SOGIECE prevalence at 85.2% (n=23/27, 95% CI: 66.3%-95.8%), while White respondents had the lowest at 69.8% (n=1395/3228, 95% CI: 68.5%-71.1%) below the Asian (71.0%, n=247/348, 95% CI: 65.9%-75.7%), Black (76.4%, n=110/144, 95% CI: 68.6%-83.1%), Hispanic (76.9%, n=93/121, 95% CI: 68.3%-84.0%), and multi-racial groups (73.6%, n=345/469, 95% CI: 69.3%-77.5%). Prevalence of exposure to cis-het pressure for all SGM participants was higher than SOGIECE at 84.9% (n=5000/5891, 95% CI: 83.9%-85.8%). These prevalence estimates were highest among Hispanic participants at 90.3% (n=112/124, 95% CI: 83.7%-94.9%) and lowest among Black participants at 81.4% (n=118/145, 95% CI: 74.1%-87.4%), below Asian (87.4%, n=320/366, 95% CI: 83.6%-90.6%), Middle Eastern (85.2%, n=23/27, 95% CI: 66.3%-95.8%), White (84.5%, n=4012/4747, 95% CI: 83.5%-85.5%), and multi-racial (86.4%, n=412/477, 95% CI: 83.0%-89.3%) groups. Pairwise comparison analyses of SOGIECE and cis-het pressure prevalence yielded no significant differences between racial groups for both measures.

Stratifying the sample by sex assigned at birth and racial group (n>20) found that prevalence estimates differed between those assigned male (AMAB) versus assigned female (AFAB) at birth. SOGIECE exposure prevalence for AMAB and AFAB participants overall was 55.1% (n=407/739, 95% CI: 51.4%-58.7%) and 72.6% (n=3557/4900, 95% CI: 71.3%-73.8%) respectively. AFAB participants (86.2%, n=4328/5021, 95% CI: 85.2%-87.1%) had a higher prevalence of cis-het pressure exposure than AMAB participants (75.2%, n=578/769, 95% CI: 72.0%-78.2%) as well. Prevalence estimates by racial group and sex assigned at birth are available in Appendix B.1. for both SOGIECE and cis-het pressure.

Perpetuators

The most reported perpetuator of SOGIECE and cis-het pressure were parents or other primary caregivers, ranging from 84.9%-95.5% and 74.7%-94.8% for each measure respectively. The least reported perpetuators of SOGIECE were sports

coaches (1.9%-13.6%), while counsellors (3.5%-13%) and therapists (3.5%-17.4%) were the least reported for cis-het pressure. A detailed breakdown of the reported perpetuators by racial group is available in Table 3.2 below.

Table 3.2. Reported perpetuators of SOGIECE and pressure to be cisgender/straight among SGM survey participants in Canada and the US, 2022.

		White N=6287	**Asian** N=532	**Black** N=207	**Hispanic** N=168	**Middle eastern** N=36	**Multi-racial** N=651
Reported perpetuators of SOGIECE	Counsellor	327 (10.4%)	8** (3.3%)	7 (6.6%)	6 (6.5%)	6 (27.3%)	30 (8.8%)
	Healthcare provider	330 (10.4%)	14 (5.8%)	11 (10.4%)	8 (8.6%)	5 (22.7%)	43 (12.6%)
	Parent or other primary caregiver	2684 (84.9%)	228** (94.2%)	101 (95.3%)	83 (89.2%)	21 (95.5%)	304 (89.1%)
	Priests or other religious leaders	805 (25.5%)	60 (24.8%)	26 (24.5%)	22 (23.7%)	5 (22.7%)	89 (26.1%)
	Sports coaches	185 (5.9%)	8 (3.3%)	2 (1.9%)	6 (6.5%)	3 (13.6%)	20 (5.9%)
	Teachers or professors	650 (20.6%)	35 (14.5%)	21 (19.8%)	15 (16.1%)	5 (22.7%)	73 (21.4%)
	Total answered	3161	242	106	93	22	341
Reported perpetuators of cis-het pressure	Counsellors	363 (9.2%)	11* (3.5%)	10 (8.7%)	7 (6.3%)	3 (13.0%)	33 (8.1%)
	Friends	1132 (28.7%)	85 (27.0%)	27 (23.5%)	27 (24.3%)	7 (30.4%)	115 (28.1%)
	Healthcare providers	630 (16.1%)	42 (13.3%)	18 (15.7%)	13 (11.7%)	5 (21.7%)	71 (17.3%)
	Online forum/chat groups	995 (25.2%)	49** (15.6%)	20 (17.4%)	15 (13.5%)	4 (17.4%)	116 (28.3%)
	Other family members	2414 (61.1%)	176 (55.9%)	67 (58.3%)	63 (56.8%)	16 (69.6%)	243 (59.3%)
	Other members of a religious group/ congregation	1491 (37.8%)	88** (27.9%)	47 (40.9%)	36 (32.4%)	13 (56.5%)	150 (36.6%)
	Parent or other primary caregiver	2950 (74.7%)	286**** (90.8%)	109**** (94.8%)	96 (86.5%)	20 (87.0%)	325 (79.3%)
	People I'm dating/ partner/spouse	635 (16.1%)	38 (12.1%)	11 (9.6%)	12 (10.8%)	2 (8.7%)	70 (17.1%)
	Priests or other religious leaders	1452 (36.8%)	87 (27.6%)	55 (47.8%)	40 (36.0%)	10 (43.5%)	153 (37.3%)
	Siblings	839 (21.3%)	66 (21.0%)	29 (25.2%)	23 (20.7%)	8 (34.8%)	93 (22.7%)
	Sports coaches or teammates	590 (14.9%)	28 (8.9%)	7 (6.1%)	18 (16.2%)	6 (26.1%)	67 (16.3%)
	Teachers or professors	1098 (27.8%)	70 (22.2%)	25 (21.7%)	27 (24.3%)	4 (17.4%)	118 (28.8%)

		White N=6287	Asian N=532	Black N=207	Hispanic N=168	Middle eastern N=36	Multi-racial N=651
	Therapists	358 (9.1%)	11* (3.5%)	7 (6.1%)	12 (10.8%)	4 (17.4%)	32 (7.8%)
	Websites	1167 (29.6%)	66* (21.0%)	20 (17.4%)	19 (17.1%)	4 (17.4%)	139 (33.9%)
	Total answered	3949	315	115	111	23	410

* adjusted $p \leq 0.05$ significant difference from comparison group (White)
** adjusted $p \leq 0.01$
**** adjusted $p \leq 0.0001$

Pairwise comparisons between racial groups determined that more Asian respondents than White respondents reported parents or other primary caregivers as perpetuators for SOGIECE (p=0.003), and more Black and Asian respondents than White respondents reported cis-het pressure from parents/primary caregivers (p<0.0001). Asian participants reported several groups less frequently than White participants as perpetuators of cis-het pressure: online forum/chat groups (p=0.0025), priests or other religious leaders (p=0.021), other members of a religious group/congregation (p=0.01), counsellors (p=0.013), therapists (p=0.016), and websites (p=0.023). No other comparisons were significantly different between racial groups for SOGIECE and cis-het pressure.

3.5.3. Environments of support

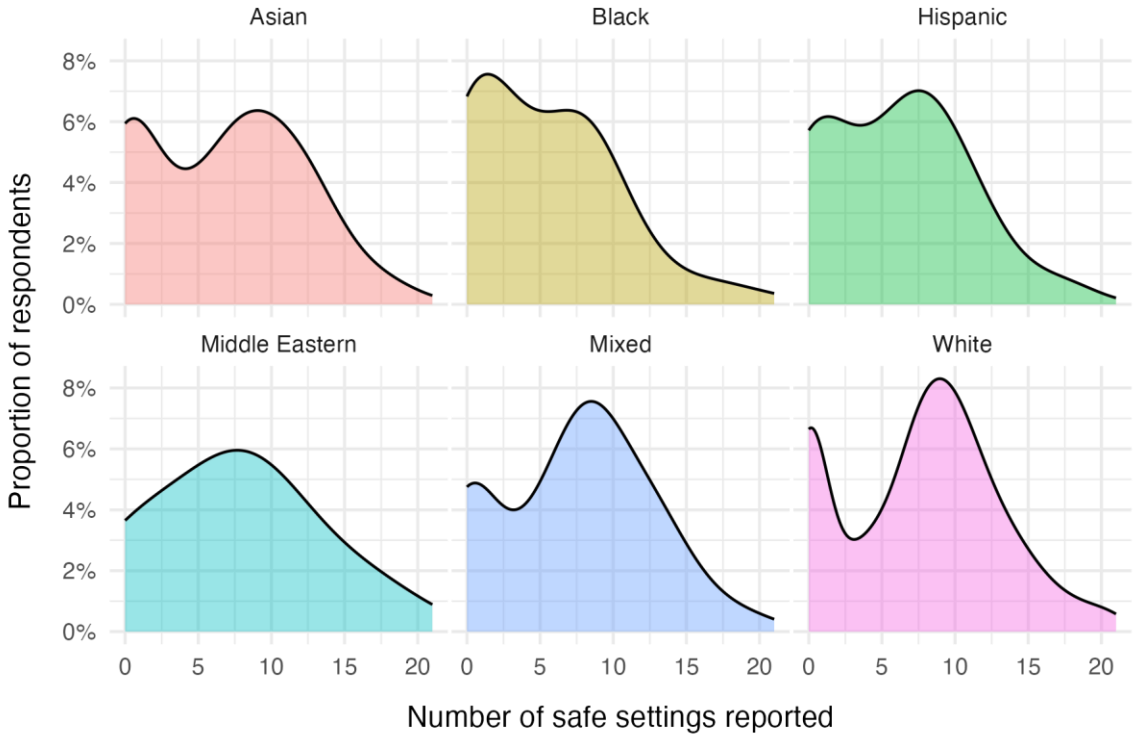
The most frequently reported settings of safety when being out for participants sexuality, gender identity, and/or gender expression were LGBTQIA+ communities, including queer (62.0%-73.3%), gay or lesbian (47.9%-63.3%), and bisexual (49.0%-63.6%) community settings. The least reported settings of safety were family events (0%-16.8%), religious setting such as a church, synagogue, or mosque (1.4%-3.7%), and international travel (4.7%-12.1%). A smooth density plot illustrating the number of supportive settings reported by proportion of each racial group is available in Figure 3.1 below. With a maximum of 21 settings that could be selected, most respondents selected 0 to 10 safe settings and proportions of respondents tapered substantially for >10 selected settings. A detailed breakdown of the reported settings of safety by racial group is available in Table 3.3 below.

Table 3.3. Reported settings of safety when being out for sexuality, gender identity, and/or gender expression among SGM survey participants in Canada and the US, 2022.

Settings of safety	White N=6287	Asian N=532	Black N=207	Hispanic N=168	Middle eastern N=36	Multi-racial N=651
Applying for a job	662 (11.3%)	49 (10.1%)	14 (7.3%)	15 (9.3%)	4 (12.1%)	59 (10.0%)
Arts based groups (e.g., choir, band, theatre)	3189 (54.3%)	235 (48.5%)	78** (40.6%)	69 (42.9%)	15 (45.5%)	328 (55.4%)
Asexual communities	3382 (57.55%)	250 (51.6%)	81*** (42.2%)	76 (47.2%)	19 (57.6%)	329 (55.6%)
Bisexual communities	3684 (62.69%)	281 (58.0%)	94** (49.0%)	90 (55.9%)	21 (63.6%)	364 (61.5%)
Family events	985 (16.8%)	25**** (5.2%)	14* (7.3%)	19 (11.8%)	0 (0.0%)	92 (15.5%)
Gay or lesbian communities	3722 (63.3%)	282 (58.1%)	92*** (47.9%)	86 (53.4%)	20 (60.6%)	360 (60.8%)
Going for a walk outside	1760 (30.0%)	122 (25.2%)	29*** (15.1%)	27* (16.8%)	9 (27.3%)	162 (27.4%)
Going to a school, class, or university	2281 (38.8%)	198 (40.8%)	64 (33.3%)	51 (31.7%)	12 (36.4%)	240 (40.5%)
Gym, pool, or sports	599 (10.2%)	45 (9.3%)	13 (6.8%)	7 (4.4%)	3 (9.1%)	57 (9.6%)
Health care spaces and services (clinics, doctors offices, hospitals, emergency room, etc.)	1610 (27.4%)	115 (23.7%)	33* (17.2%)	29 (18.0%)	8 (24.2%)	146 (24.7%)
International travel	422 (7.2%)	29 (6.0%)	9 (4.7%)	9 (5.6%)	4 (12.1%)	36 (6.1%)
Intersex communities	2825 (48.1%)	213 (43.9%)	57**** (29.7%)	61 (37.9%)	16 (48.5%)	277 (46.8%)
Mental healthcare	2652 (45.1%)	178** (36.7%)	51**** (26.6%)	54 (33.5%)	14 (42.4%)	265 (44.8%)
Non-binary communities	3807 (64.8%)	275* (56.7%)	90**** (46.9%)	88 (54.7%)	21 (63.6%)	377 (63.7%)
Party or social gathering	1993 (33.9%)	131* (27.0%)	38*** (19.8%)	31** (19.3%)	11 (33.3%)	207 (35.0%)
Public transportation	789 (13.4%)	59 (12.2%)	15 (7.8%)	12 (7.5%)	7 (21.2%)	79 (13.3%)
Queer communities	4303 (73.2%)	325 (67.0%)	119* (62.0%)	104 (64.6%)	24 (72.7%)	434 (73.3%)
Religious setting such as a church, synagogue, or mosque	218 (3.7%)	7 (1.4%)	4 (2.1%)	3 (1.9%)	1 (3.0%)	22 (3.7%)
Trans communities	3786 (64.4%)	272** (56.1%)	89**** (46.4%)	87 (54.0%)	21 (63.6%)	382 (64.5%)
Travel within the country where you live	1749 (29.8%)	123 (25.4%)	21**** (11.0%)	27* (16.8%)	11 (33.3%)	142 (24.0%)
Workplace gatherings	763 (12.98%)	48 (9.9%)	12 (6.3%)	7* (4.4%)	3 (9.1%)	67 (11.3%)
Total answered	5877	485	192	161	33	592

* adjusted p≤0.05 significant difference from comparison group (White)
** adjusted p≤0.01
*** adjusted p≤0.001
**** adjusted p≤0.0001

Figure 3.1. Number of safe settings reported by proportion of respondents in each racial group among 2022 UnACoRN survey participants.



Pairwise comparisons between racial groups found that Black, Asian, and Hispanic respondents reported significantly fewer settings as safe than White respondents. Black participants less frequently reported 14 settings as safe (as compared with White participants): LGBTQIA+ communities (trans, non-binary, intersex (p<0.0001), gay or lesbian (p=0.0003), asexual (p=0.0005), bisexual (p=0.002) and queer (p=0.01) communities), travel within the country where they live, mental healthcare (p<0.0001), going for a walk outside (p=0.0002), party or social gatherings (p=0.0009), arts based groups (p=0.004), family events (p=0.01), and healthcare spaces and services (p=0.03). Asian respondents less frequently reported 5 settings as safe (as compared with White participants): trans (p=0.004) and non-binary (p=0.007) communities, family events (p<0.0001), mental healthcare (p=0.006), and party or social gatherings (p=0.035). Finally, Hispanic respondents less frequently reported 4 settings as safe (as compared with White participants): party or social gatherings (p=0.002),

travel within the country where you live (p=0.007), going for a walk outside (p=0.006), and workplace gatherings (p=0.03).

3.5.4. Social networks of support

The most frequently reported social networks of support for gender identity and/or gender expression were friends (97%-100%), online forums or chat groups (89%-98%), and people the participants were dating, partners, and spouses (89%-96%). The least reported networks of support for gender identity and/or gender expression were priests or other religious leaders (6%-16%) and other members of a religious group (11%-17%). Siblings (54%-79%) were reported as being more supportive for gender identity and/or gender expression than parents or other primary caregivers (28%-57%) and other family members (33%-53%).

The most frequently reported supportive networks for sexuality were friends (93%-100%), online forums or chat groups (87%-96%), people the participants were dating, partners, and spouses (86%-96%), and counsellors or therapists (78-91%). The least reported supportive networks for sexuality were priests or other religious leaders (12%-19%) and other members of a religious group (15%-21%). Siblings (65%-86%) were again reported as being more supportive for sexuality than parents or other primary caregivers (31%-72%) and other family members (37%-64%).

A detailed breakdown of the reported social networks of support, for both gender identity and/or sexuality, by racial group is available in Table 3.4 below.

Table 3.4. Reported social networks of support for sexuality, gender identity, and/or gender expression among SGM survey participants in Canada and the US, 2022 (responded yes/total).

	Networks of support	White N=6287	Asian N=532	Black N=207	Hispanic N=168	Multi-racial N=651
Gender identity and/or gender expression	Counsellors	1506/1848 (81%)	88/101 (87%)	36/47 (77%)	34/43 (79%)	164/202 (81%)
	Friends	3178/3251 (98%)	210/211 (100%)	90/93 (97%)	81/83 (98%)	336/345 (97%)
	Healthcare providers	1249/1746 (72%)	52/87 (60%)	30/47 (64%)	27/38 (71%)	144/195 (74%)
	Online forum/chat groups	2442/2602 (94%)	162/165 (98%)	68/76 (89%)	57/63 (90%)	267/282 (95%)

	Networks of support	White N=6287	Asian N=532	Black N=207	Hispanic N=168	Multi-racial N=651
	Other family members	1130/2234 (51%)	43/120* (36%)	19/57 (33%)	27/54 (50%)	125/235 (53%)
	Other members of a religious group/ congregation	195/1138 (17%)	10/58 (17%)	7/51 (14%)	4/35 (11%)	15/136 (11%)
	Parent(s) / primary caregiver(s)	1528/2696 (57%)	46/162**** (28%)	22/79**** (28%)	25/67* (37%)	145/283 (51%)
	People I'm dating / partner / spouse	2050/2200 (93%)	109/113 (96%)	47/53 (89%)	62/65 (95%)	195/222 (88%)
	Priests or other religious leaders	147/1069 (14%)	9/57 (16%)	3/49 (6%)	3/32 (9%)	11/132 (8%)
	Siblings	1885/2392 (79%)	91/130 (70%)	32/59*** (54%)	47/61 (77%)	182/239 (76%)
	Sports coaches or teammates	408/881 (46%)	23/39 (59%)	10/24 (42%)	5/21 (24%)	50/110 (45%)
	Teachers or professors	1871/2275 (82%)	124/136 (91%)	48/61 (79%)	43/58 (74%)	211/247 (85%)
	Therapists	1825/2064 (88%)	87/99 (88%)	36/46 (78%)	41/49 (84%)	181/206 (88%)
Sexuality	Counsellors	1877/2184 (86%)	136/152 (89%)	43/55 (78%)	38/47 (81%)	185/219 (84%)
	Friends	4267/4346 (98%)	333/334 (100%)	111/119** (93%)	105/107 (98%)	434/438 (99%)
	Healthcare providers	1603/2023 (79%)	79/112 (71%)	38/57 (67%)	31/39 (79%)	168/212 (79%)
	Online forum/chat groups	2983/3178 (94%)	228/238 (96%)	85/98 (87%)	68/74 (92%)	316/334 (95%)
	Other family members	1781/2946 (60%)	70/174**** (40%)	30/82*** (37%)	38/63 (60%)	187/291 (64%)
	Other members of a religious group/ congregation	237/1431 (17%)	19/89 (21%)	10/63 (16%)	8/43 (19%)	23/156 (15%)
	Parent(s) / primary caregiver(s)	2692/3717 (72%)	93/236**** (39%)	33/106**** (31%)	50/90** (56%)	249/364 (68%)
	People I'm dating / partner / spouse	2788/2940 (95%)	172/180 (96%)	57/66 (86%)	80/84 (95%)	264/283 (93%)
	Priests or other religious leaders	180/1377 (13%)	10/82 (12%)	8/60 (13%)	8/42 (19%)	23/142 (16%)
	Siblings	2816/3266 (86%)	164/208* (79%)	55/85**** (65%)	71/84 (85%)	268/313 (86%)
	Sports coaches or teammates	608/1086 (56%)	31/60 (52%)	11/31 (35%)	10/23 (43%)	71/120 (59%)
	Teachers or professors	2063/2472 (83%)	159/181 (88%)	52/71 (73%)	42/59 (71%)	214/249 (86%)
	Therapists	2332/2558 (91%)	127/141 (90%)	45/55 (82%)	49/54 (91%)	218/240 (91%)

* adjusted p≤0.05 significant difference from comparison group (White)
** adjusted p≤0.01
*** adjusted p≤0.001
**** adjusted p≤0.0001

Pairwise comparisons between racial groups determined that fewer Asian, Black (p<0.0001), and Hispanic (p=0.02) than White respondents reported parents or other primary caregivers as supportive for gender identity and/or gender expression and sexuality (Asian and Black: p<0.0001 for both measures, Hispanic: p=0.02 for gender identity/expression and p=0.007 for sexuality). Fewer Black (p<0.0001) and Asian (p=0.04) participants than White participants reported siblings as supportive for sexuality, while fewer Black participants than White participants reported siblings as supportive for gender identity and/or gender expression (p=0.0001). Finally, fewer Black and Asian (p<0.0001) respondents than White respondents reported other family members as supportive for sexuality, and fewer Asian respondents than White respondents reported other family members as supportive for gender identity and/or gender expression (p=0.02).

3.6. Discussion

This study examined the informal SOGIECE experiences of SGM youth, as well as, where, and with whom, they feel safe and supported, by racial identity in Canada and the US. The sample for this exploratory, quantitative analysis skewed younger in the eligible participant age range (median: 17 years). Results therefore shed light on the experiences of SGM youth who were early in their identity formation stages of self-concept, self-identity, and social identity (Bishop et al., 2020). This study sample overrepresented White participants (79.8% of the sample), consistent with other quantitative studies of this scale (Green et al., 2020; Meanley et al., 2020; Salway et al., 2020; Turban et al., 2020). Despite this, the sample successfully captured the intersectional experiences of a diverse cohort, owing to the large sample size, with sufficient statistical power to assess the experiences of six out of seven independent racial categories.

Among all racial groups, prevalence estimates for informal SOGIECE (70.6%) and cis-het pressure (84.9%) exposure were very high despite a young sample that has mostly come out to others about their gender identity or sexuality. With no significant differences between racial groups, exposure to SOGIECE and cis-het pressure was ubiquitous throughout our sample. This is a steep increase compared to formal SOGIECE prevalence estimates in previous studies, which ranged from 2 to 34% in Canada and the US (Green et al., 2020; Mallory et al., 2019; Meanley et al., 2020; Ryan

et al., 2020; Salway et al., 2020, 2023; Trans PULSE Canada, 2019; Turban et al., 2019, 2020), and is likely due to our utilization of abstract informal SOGIECE measures that do not have a strict inclusion criteria. Formal SOGIECE measures also vary in study definitions, leading to a wide range of prevalence estimates, but generally focus specifically on conversion therapy. Overall, our findings demonstrate that informal SOGIECE in social contexts indeed extends beyond formal SOGIECE and conversion therapy programs.

Prevalence of SOGIECE was found to be greater among AFAB participants as compared to AMAB participants (72.6% vs. 55.1%) as was pressure to be cis-het (86.2% vs. 75.2%). This result contrasts findings from a systematic review examining lifetime prevalence of experiencing formal conversion therapy practices among AFAB and AMAB individuals, in which prevalence was higher among people AMAB (Salway et al., 2023). However our findings align with authors examining sexual and gender identity-based microaggressions, in which AFAB youth were more likely to experience microaggressions than AMAB youth (Kiekens et al., 2022). Similar to the conclusion drawn by Kiekens et al (2022), the differences between formal and informal SOGIECE may be explained by the influence of sexism in everyday life, which is more often experienced by cisgender women than cisgender men (Lewis, 2018). The stigmatization of femininity among AMAB individuals, while experienced less daily, may have greater penalties for violating gender norms than people assigned female at birth, leading to higher prevalence of conversion practices (Salway et al., 2023).

Nevertheless, the majority of SGM youth surveyed have experienced pressure to deny, change, or suppress aspects of their gender identity, sexuality, and/or gender expression and/or to be cisgender or straight. Many of these youth experienced this pressure from parents or other primary caregivers, religious leaders, or other members of a religious group, consistent with previous qualitative research (Kinitz et al., 2022). Our finding that Black (cis-het pressure) and Asian (cis-het pressure and SOGIECE) respondents reported parents or other primary caregivers more often as perpetuators than White respondents is similar to previous studies examining ethnic differences in parental rejection (Richter et al., 2017). This may be attributable to differences in socio-cultural pressures (i.e. dissonance between the predominant Western culture of the North American LGBTQ+ population and the culture of one’s family of origin, linguistic limitations, and cisheteronormative expectations in POC communities) experienced by

Black and Asian SGM youth (Jackson et al., 2020; McDonald, 2018; Richter et al., 2017; Sadika et al., 2020). Future research focusing on the experiences of SGM-POC could shed more light on this topic.

Religious spaces, leaders, and members were consistently the least supportive environment and social networks for our sample across all racial groups. The most often reported settings of safety when being out were LGBTQ+ communities, while friends, online forums/chatgroups, and partners were the most reported supportive social networks. This echoes the importance of “chosen” families, as SGM youth across racial subgroups in our sample proactively and successfully seek out supportive social networks and have more dimensions of support.

Support from friends and online networks have been found to be reliable for everyday support (such as companionship, emotional, and informational support), and are less reliable for major types of support (such as borrowing large sums of money, caregiving when sick) (Frost et al., 2016). A provider of major support can be family members, which varied across our sample, with Black, Asian, and Hispanic groups reporting significantly less support from one or more family member groups than White respondents. This finding is consistent with previous studies, where racial/ethnic sexual minorities reported receiving fewer dimensions of support than White sexual minorities (Frost et al., 2016). Furthermore, Black and Asian respondents reported some or all LGBTQ+ communities as safe less often, echoing findings of racism experienced by SGM-POC in LGBTQ+ settings (Jackson et al., 2020; Patel, 2019; Sadika et al., 2020; Souleymanov et al., 2020).

Finally, healthcare providers, counsellors, and therapists were consistently reported as supportive for SGM youth across racial groups and were the least reported perpetuators of SOGIECE/cis-het pressure. However, mental healthcare settings (26.6%-45.1%) and general healthcare services/settings (17.2%-27.4%) were less often reported as supportive, indicating that there may be some differences between accessing psychiatric and general healthcare services compared to experiences with the providers themselves. Further research in this area could examine how policies or broader public health initiatives can fill the niche of support that SGM youth do not receive, and whether the support received can replace or compensate for a lack of support in other dimensions.

3.7. Strengths and Limitations

3.7.1. Strengths

To our knowledge at time of publication, the present study is the first to quantitatively examine informal SOGIECE and characterize its perpetuators among young SGM in Canada and the US. Furthermore, the UnACoRN survey recruited a sizable sample that allowed for the generation of racially disaggregated descriptive statistics and analyses across racial groups, which has so far been limited in previous studies. Our utilization of an assets-based approach builds on existing literature to describe environments and social networks of support, thereby redirecting focus away from individual SGM/SGM-POC health disparities and instead, highlighting areas in which further education/interventions could be targeted. Finally, we utilized the intersectional minority stress framework to holistically examine SGM participants' experiences, without using an additive or multiplicative approach, which allowed us to fulsomely understand the interactions of various dimensions of identities across settings and their resultant experiences.

3.7.2. Limitations

Our sample constitutes a non-probabilistic subset of the total population of youth in Canada and the US. US participants were underrepresented in our sample, reducing generalizability to US residents. Participant racial identities in the sample were not representative of the demographic distribution in Canada and the US, the design of the demographic categories resulted in the conflation of various racial groups, and we over-sampled participants younger than 20 years old as well as White self-identifying participants. As a result, our findings are skewed and limit generalizability of each racial subgroup to the overall population. There was a lack of specificity in the survey question design regarding what actions and environments qualify as safe and supportive. Subsequently, individuals offering strategies to survive by remaining 'stealth' or 'in the closet' are not captured as a safe or supportive environment or action. This further introduces variability in this study's results, reducing applicability to the broader SGM population. Questions regarding environments of support and perpetuators of SOGIECE and cis-het pressure did not include a 'Not Applicable' option for each response. This

may have led to non-differential misclassification of responses, over-representing unsupportive environments and non-perpetuators of SOGIECE and cis-het pressure.

3.8. Public Health Implications

Given that 70.6% of SGM youth have experienced informal SOGIECE and 84.9% have experienced cis-het pressure according to our 2022 sample, a likely underestimate as 2SLGBTQ+ rights have become further politicized since data collection in Canada and the US, we recommend the following actions in collaboration with multiple levels of government, SGM youth, and community organizations. First, we recommend a focus on building capacity among communities in Canada and the US by sharing educational material, dispelling myths, and supporting community members to create more SGM-affirming environments and expanding social support for youth. Secondly, we recommend further expanding SGM-affirming services for SGM youth, including financial and affirming healthcare support to reduce the burden of reduced social support among SGM-POC specifically. Finally, the creation of culturally specific education, programming, and services for SGM-POC is imperative to improve social connections, support, and participation for this population within the LGBTQ+ community. Recommendations for anti-trans/school-based policies and healthcare providers are described in more detail in Chapter 4.1.

Chapter 4. Conclusion

4.1. Recommendations

4.1.1. Anti-trans and school-based policies

Since 2020, there has been a surge in legislative efforts “seeking to deny [SGM people] access to basic healthcare, legal recognition, education, bathrooms, athletics, or the right to openly exist in public schools” in the US (Trans Legislation Tracker, n.d.). These bills have targeted gender minorities: some examples of passed bills include ones that have banned gender-affirming care, imposed harsh penalties for gender-affirming care providers, blocked teachers from using student’s preferred pronouns, and banned books promoting “gender fluidity or gender pronouns” (Trans Legislation Tracker, n.d.). This trend has surfaced in Canada in 2023. Bill 137 in Saskatchewan requires parental permission for school staff to use students’ chosen name and pronouns that align with their gender identity, forcing “gender diverse youth under the age of 16 to either remain closeted at school or to accept being outed to their parents” (Egale, 2023; Latimer, 2023). New Brunswick has rolled back protections for SGM youth in schools in Policy 713, similarly requiring parental consent for teachers to use the chosen name and pronouns of a child under the age of 16 (Ibrahim, 2023).

The anti-trans policies being passed in Canada and the US are institutional mechanisms that actively enforce the repression and denial of SGM peoples’ gender identity and gender expression – the very definition of SOGIECE. While Canada has criminalized formal conversion therapy practices (Bill C-4), Bill 137 and Policy 713 are examples of informal and unstructured SOGIECE practices that do not fall under the Bill C-4 ban. My findings that: 1) experiences of informal SOGIECE and cis-het pressure are highly prevalent and ubiquitous among SGM youth; 2) parents and primary caregivers were reported most often as perpetuators of informal SOGIECE and cis-het pressure, especially among Asian and Black SGM; 3) family events were reported as one of the least safe settings to be out; and 4) parents and primary caregivers were not often reported as a supportive social group for SGM participants’ gender identity/expression, especially for Asian, Black, and Hispanic SGM; all provide evidence that parents, primary caregivers, and family settings are not safe or supportive for many SGM youth. It

is clear that school-based anti-trans policies, that require or force gender minority youth to be outed to their family, will put gender minority children at risk for harm.

Based on results from this thesis, the following recommendations are presented for policy makers and other authorities. All provisions requiring parental permission for school staff to use students' chosen name and pronouns should be removed from policies, to prevent escalating informal SOGIECE experiences among SGM youth to more formal practices like conversion therapy. While anti-trans policies such as these will continue to be proposed due to the rising visibility and politicization of SGM identity, considerations of anti-trans policies in legislative bodies should include a comprehensive consultation and review process with experts, researchers, representation from the SGM community, and healthcare providers, with examination of scientific evidence. The wellbeing and safety of SGM youth should be prioritized in every step of the decision-making process.

4.1.2. Healthcare providers

Recommendations for beyond those discussed in Chapter 3 are presented below for healthcare providers and researchers. Findings from this thesis suggest that healthcare practitioners, including mental healthcare providers, therapists, and counsellors, are often safe and supportive social networks for SGM youth. Further work in this area to enhance culturally informed care offerings for SGM-POC, such as by providing services in a wider variety of languages, would help to improve healthcare access and identity affirmation among SGM-POC (Dhanaua, 2023). I also found that healthcare settings were less often reported safe and supportive for SGM youth than experiences with healthcare practitioners themselves. Recommendations to improve healthcare practices include providing gender diverse options in intake forms, providing continuing education for staff on care for SGM patients, and training staff to use appropriate language to refer to patients (Bass & Nagy, 2023).

4.1.3. Population-based studies for SGM-POC

The differences in racial subgroups that were uncovered by my analyses illustrates the importance of examining racially disaggregated data wherever possible. The following recommendations were formulated from learnings in this study and are

presented for researchers below. While this study utilized a minimal list of racial categories, future population-based studies could include a wider set of racial categories with clear definitions to guide participants and produce more accurate results (such as those released by the Canadian Institute for Health Information (2022)). Utilizing the most appropriate terminology for analysis is also an important focus, understanding the social constructs of culture, ethnicity, and race (Smedley & Smedley, 2005) and using the best fitting construct for the research question in mind.

SGM-POC, especially in Canada, are an understudied population in scientific research. As such, a continued focus on SGM-POC would provide much-needed background and evidence to develop context-specific interventions for these communities, to better support SGM-POC individuals. An emphasis on representative sampling of participants to the national population distribution of racial groups, for future population-based studies, would better capture the breadth of experience among SGM in Western contexts as well. Population-based studies should avoid centering Whiteness in their samples and reflect on how Western and colonial approaches to sampling limit the reach and utility of the study. Strategies include designing the study or recruitment practices in collaboration with community groups and ensuring targeted outreach to POC communities by exploring recruitment and incentive strategies, to allow for more diversity within the sample.

4.2. Knowledge Translation

Findings from this thesis will be shared through a variety of avenues. Preliminary findings were presented to a local seminar series, the BC Centre for Disease Control (BCCDC) Work-in-Progress seminar, on June 16, 2023. Study findings will also be disseminated at an international conference, the 2023 American Public Health Association Annual Meeting and Expo, where an abstract was accepted for oral presentation. Data visualizations may be further designed and published for thesis results in an online data dashboard, which was partially completed in 2023 (Lo, 2023/2023). Finally, a manuscript describing the study findings will be prepared and submitted to an academic journal once the thesis is completed.

4.3. Conclusion

This thesis reinforces the understanding that SGM-POC experience varying levels of support from their social networks and environments that they interact with, further dispelling the notion of a homogenous SGM population. Given the escalating public discourse and policies targeting LGBTQ+ people in Canada and the US, it is imperative that we prioritize the wellbeing of SGM and utilize an intersectional approach to develop interventions. Efforts must be made to create safe and supportive environments and social networks, to allow SGM to thrive into the future.

References

Aragon, T., Fay, M., Wollschlaeger, D., & Omidpanah, A. (2022). *Epidemiology Tools*. https://cran.r-project.org/web/packages/epitools/epitools.pdf

Armstrong, R. A. (2014). When to use the Bonferroni correction. *Ophthalmic and Physiological Optics*, *34*(5), 502–508. https://doi.org/10.1111/opo.12131

Ashley, F. (2022). *Banning transgender conversion practices: A legal and policy analysis*. UBC Press.

Bass, B., & Nagy, H. (2023). Cultural Competence in the Care of LGBTQ Patients. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK563176/

Bishop, M. D., Fish, J. N., Hammack, P. L., & Russell, S. T. (2020). Sexual identity development milestones in three generations of sexual minority people: A national probability sample. *Developmental Psychology*, *56*(11), 2177–2193. https://doi.org/10.1037/dev0001105

Blais, M., Cannas Aghedu, F., Ashley, F., Samoilenko, M., Chamberland, L., & Côté, I. (2022). Sexual orientation and gender identity and expression conversion exposure and their correlates among LGBTQI2+ persons in Québec, Canada. *PLOS ONE*, *17*(4), e0265580. https://doi.org/10.1371/journal.pone.0265580

Blosnich, J. R., Henderson, E. R., Coulter, R. W. S., Goldbach, J. T., & Meyer, I. H. (2020). Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016–2018. *American Journal of Public Health*, *110*(7), 1024–1030. https://doi.org/10.2105/AJPH.2020.305637

Bowleg, L. (2012). The Problem With the Phrase Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health. *American Journal of Public Health*, *102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.

Canadian Institute for Health Information. (2022, March 17). *Race-based and Indigenous identity data*. https://www.cihi.ca/en/race-based-and-indigenous-identity-data

Centre for Gender and Sexual Health Equity. (2020). *Ending conversion therapy in Canada: Survivors, community leaders, researchers, and allies address the current and future states of sexual orientation and gender identity and expression change efforts*. http://www.cgshe.ca/press/2020/02/canadian-conversion-therapy-survivors-call-for-actions-report/

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

Cyrus, K. (2017). Multiple minorities as multiply marginalized: Applying the minority stress theory to LGBTQ people of color. *Journal of Gay & Lesbian Mental Health*, *21*(3), 194–202. https://doi.org/10.1080/19359705.2017.1320739

Delgado-Ron, J. A., Jeyabalan, T., Watt, S., Black, S., Gumprich, M., & Salway, T. (2022). Sampling sexual and gender minority youth in Canada and the US: Lessons in cost-effectiveness from the UnACoRN internet-based survey (Preprint). *Journal of Medical Internet Research*. https://doi.org/10.2196/44175

Dhanaua, G. (2023). *Redressing Disparities in Mental Health Services to Better Serve 2S/LGBTQ+ BIPOC*. Simon Fraser University.

Diamond, L. M., & Alley, J. (2022). Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse populations. *Neuroscience & Biobehavioral Reviews*, *138*, 104720. https://doi.org/10.1016/j.neubiorev.2022.104720

Dulai, J. J. S., Salway, T., & Ablona, A. (2023). Strong community belonging moderates poor mental health in lesbian, gay, and bisexual individuals living in Canada: An intersectional analysis of a national population-based survey. *Canadian Journal of Public Health*. https://doi.org/10.17269/s41997-023-00794-1

Egale. (2023, October 20). *UR Pride Centre for Sexuality and Gender Diversity v. Government of Saskatchewan et al.* Egale. https://egale.ca/awareness/sask-legal-case/

Frost, D. M., Meyer, I. H., & Schwartz, S. (2016). Social support networks among diverse sexual minority populations. *American Journal of Orthopsychiatry*, *86*(1), 91–102. https://doi.org/10.1037/ort0000117

Goodyear, T., Kinitz, D. J., Dromer, E., Gesink, D., Ferlatte, O., Knight, R., & Salway, T. (2022). “They Want You to Kill Your Inner Queer but Somehow Leave the Human Alive”: Delineating the Impacts of Sexual Orientation and Gender Identity and Expression Change Efforts. *The Journal of Sex Research*, *59*(5), 599–609. https://doi.org/10.1080/00224499.2021.1910616

Green, A. E., Price-Feeney, M., Dorison, S. H., & Pick, C. J. (2020). Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018. *American Journal of Public Health*, *110*(8), 1221–1227. https://doi.org/10.2105/AJPH.2020.305701

Haile, R., Rowell-Cunsolo, T. L., Parker, E. A., Padilla, M. B., & Hansen, N. B. (2014). An Empirical Test of Racial/Ethnic Differences in Perceived Racism and Affiliation with the Gay Community: Implications for HIV Risk: A Test of Racial Differences in Racism. *Journal of Social Issues*, *70*(2), 342–359. https://doi.org/10.1111/josi.12063

Hatzenbuehler, M. L., Pachankis, J. E., & Wolff, J. (2012). Religious Climate and Health Risk Behaviors in Sexual Minority Youths: A Population-Based Study. *American Journal of Public Health*, *102*(4), 657–663. https://doi.org/10.2105/AJPH.2011.300517

Hill Collins, P. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Unwin Hyman.

Ibrahim, H. (2023, August 23). N.B. digs in on rules for teachers and name, pronoun use of LGBTQ students. *CBC News*. https://www.cbc.ca/news/canada/new-brunswick/policy-713-education-changes-1.6944879

Jackson, S. D., Mohr, J. J., Sarno, E. L., Kindahl, A. M., & Jones, I. L. (2020). Intersectional experiences, stigma-related stress, and psychological health among Black LGBQ individuals. *Journal of Consulting and Clinical Psychology*, *88*(5), 416–428. https://doi.org/10.1037/ccp0000489

Kiekens, W. J., Kaufman, T. M. L., & Baams, L. (2022). Sexual and Gender Identity-Based Microaggressions: Differences by Sexual and Gender Identity, and Sex Assigned at Birth Among Dutch Youth. *Journal of Interpersonal Violence*, *37*(21–22), NP21293–NP21319. https://doi.org/10.1177/08862605211056729

King, W. M., & Gamarel, K. E. (2021). A Scoping Review Examining Social and Legal Gender Affirmation and Health Among Transgender Populations. *Transgender Health*, *6*(1), 5–22. https://doi.org/10.1089/trgh.2020.0025

Kinitz, D. J., Goodyear, T., Dromer, E., Gesink, D., Ferlatte, O., Knight, R., & Salway, T. (2022). “Conversion Therapy” Experiences in Their Social Contexts: A Qualitative Study of Sexual Orientation and Gender Identity and Expression Change Efforts in Canada. *The Canadian Journal of Psychiatry*, *67*(6), 441–451. https://doi.org/10.1177/07067437211030498

Kronk, C. A., Everhart, A. R., Ashley, F., Thompson, H. M., Schall, T. E., Goetz, T. G., Hiatt, L., Derrick, Z., Queen, R., Ram, A., Guthman, E. M., Danforth, O. M., Lett, E., Potter, E., Sun, S. D., Marshall, Z., & Karnoski, R. (2022). Transgender data collection in the electronic health record: Current concepts and issues. *Journal of the American Medical Informatics Association*, *29*(2), 271–284. https://doi.org/10.1093/jamia/ocab136

Latimer, K. (2023, October 21). Sask.’s new law creates complications for support staff, gender-diverse students: Mental health experts. *CBC News*. https://www.cbc.ca/news/canada/saskatchewan/sask-support-workers-students-bill-137-1.7003848

Lewis, J. A. (2018). From modern sexism to gender microaggressions: Understanding contemporary forms of sexism and their influence on diverse women. In C. B. Travis, J. W. White, A. Rutherford, W. S. Williams, S. L. Cook, & K. F. Wyche (Eds.), *APA handbook of the psychology of women: History, theory, and battlegrounds (Vol. 1).* (pp. 381–397). American Psychological Association. https://doi.org/10.1037/0000059-019

Lo, R. H. Mu. (2023). *HSCI893-Dashboard* [R]. https://github.com/rhmlo/HSCI893-Dashboard (Original work published 2023)

Logie, C. H., & Rwigema, M.-J. (2014). "The Normative Idea of Queer is a White Person": Understanding Perceptions of White Privilege Among Lesbian, Bisexual, and Queer Women of Color in Toronto, Canada. *Journal of Lesbian Studies*, *18*(2), 174–191. https://doi.org/10.1080/10894160.2014.849165

Mallory, C., Brown, T., & Conron, K. (2019). *Conversion therapy and LGBT youth: Update*. The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf

McDonald, K. (2018). Social Support and Mental Health in LGBTQ Adolescents: A review of the literature. *Issues in Mental Health Nursing*, *39*(1), 16–29. https://doi.org/10.1080/01612840.2017.1398283

Meanley, S. P., Stall, R. D., Dakwar, O., Egan, J. E., Friedman, M. R., Haberlen, S. A., Okafor, C., Teplin, L. A., & Plankey, M. W. (2020). Characterizing Experiences of Conversion Therapy Among Middle-Aged and Older Men Who Have Sex with Men from the Multicenter AIDS Cohort Study (MACS). *Sexuality Research and Social Policy*, *17*(2), 334–342. https://doi.org/10.1007/s13178-019-00396-y

Mereish, E. H., Fish, J. N., & Watson, R. J. (2023). Intersectional Minority Stress and Alcohol, Tobacco, and Cannabis Use Among Sexual and Gender Minority Adolescents of Color: Moderating Role of Family Support. *LGBT Health*, *10*(1), 18–25. https://doi.org/10.1089/lgbt.2021.0430

Mereish, E. H., Parra, L. A., Watson, R. J., & Fish, J. N. (2022). Subtle and Intersectional Minority Stress and Depressive Symptoms among Sexual and Gender Minority Adolescents of Color: Mediating Role of Self-Esteem and Sense of Mastery. *Prevention Science : The Official Journal of the Society for Prevention Research*, *23*(1), 142–153. https://doi.org/10.1007/s11121-021-01294-9

Meyer, I. H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mustanski, B., & Liu, R. T. (2013). A Longitudinal Study of Predictors of Suicide Attempts Among Lesbian, Gay, Bisexual, and Transgender Youth. *Archives of Sexual Behavior*, *42*(3), 437–448. https://doi.org/10.1007/s10508-012-0013-9

Nadal, K. L., Davidoff, K. C., Davis, L. S., Wong, Y., Marshall, D., & McKenzie, V. (2015). A qualitative approach to intersectional microaggressions: Understanding influences of race, ethnicity, gender, sexuality, and religion. *Qualitative Psychology*, *2*(2), 147–163. https://doi.org/10.1037/qup0000026

Noyola, N., Sánchez, M., & Cardemil, E. V. (2020). Minority stress and coping among sexual diverse Latinxs. *Journal of Latinx Psychology*, *8*(1), 58–82. https://doi.org/10.1037/lat0000143

Oswald, R. F., Cuthbertson, C., Lazarevic, V., & Goldberg, A. E. (2010). New Developments in the Field: Measuring Community Climate. *Journal of GLBT Family Studies*, *6*(2), 214–228. https://doi.org/10.1080/15504281003709230

Paceley, M. S., Fish, J. N., Thomas, M. M. C., & Goffnett, J. (2020). The Impact of Community Size, Community Climate, and Victimization on the Physical and Mental Health of SGM Youth. *Youth & Society*, *52*(3), 427–448. https://doi.org/10.1177/0044118X19856141

Padilla, Y. C., Crisp, C., & Rew, D. L. (2010). Parental Acceptance and Illegal Drug Use among Gay, Lesbian, and Bisexual Adolescents: Results from a National Survey. *Social Work*, *55*(3), 265–275. https://doi.org/10.1093/sw/55.3.265

Patel, S. (2019). “Brown girls can’t be gay”: Racism experienced by queer South Asian women in the Toronto LGBTQ community. *Journal of Lesbian Studies*, *23*(3), 410–423. https://doi.org/10.1080/10894160.2019.1585174

Poushter, J., & Kent, N. (2020). *The Global Divide on Homosexuality Persists*. Pew Research Centre. https://www.pewresearch.org/global/2020/06/25/global-divide-on-homosexuality-persists/

Pruden, H., Salway, T., Consolacion, T., Leung, J., Ablona, A., & Stillwagon, R. (2021). Drivers of Sexual Health Knowledge for Two-Spirit, Gay, Bi and/or Indigenous Men Who Have Sex with Men (gbMSM). *Journal of AIDS and HIV Research*, *11*, 93.

Rich, A., Salway, T., Rostomyan, M., Khounsarian, F., & Zhang, S. (2019). *Structural stigma for sexual and gender minorities in North America: A policy analysis.* 2019 American Public Health Association Conference, Philadelphia, PA.

Richter, B. E. J., Lindahl, K. M., & Malik, N. M. (2017). Examining ethnic differences in parental rejection of LGB youth sexual identity. *Journal of Family Psychology*, *31*(2), 244–249. https://doi.org/10.1037/fam0000235

Ryan, C., Toomey, R. B., Diaz, R. M., & Russell, S. T. (2020). Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment. *Journal of Homosexuality*, *67*(2), 159–173. https://doi.org/10.1080/00918369.2018.1538407

Sadika, B., Wiebe, E., Morrison, M. A., & Morrison, T. G. (2020). Intersectional Microaggressions and Social Support for LGBTQ Persons of Color: A Systematic Review of the Canadian-Based Empirical Literature. *Journal of GLBT Family Studies*, *16*(2), 111–147. https://doi.org/10.1080/1550428X.2020.1724125

Saewyc, E. M., Li, G., Gower, A. L., Watson, R. J., Erickson, D., Corliss, H. L., & Eisenberg, M. E. (2020). The link between LGBTQ-supportive communities, progressive political climate, and suicidality among sexual minority adolescents in Canada. *Preventive Medicine*, *139*, 106191. https://doi.org/10.1016/j.ypmed.2020.106191

Salway, T., Ferlatte, O., Gesink, D., & Lachowsky, N. J. (2020). Prevalence of Exposure to Sexual Orientation Change Efforts and Associated Sociodemographic Characteristics and Psychosocial Health Outcomes among Canadian Sexual Minority Men. *The Canadian Journal of Psychiatry*, *65*(7), 502–509. https://doi.org/10.1177/0706743720902629

Salway, T., Juwono, S., Klassen, B., Ferlatte, O., Ablona, A., Pruden, H., Morgan, J., Kwag, M., Card, K., Knight, R., & Lachowsky, N. J. (2021). Experiences with sexual orientation and gender identity conversion therapy practices among sexual minority men in Canada, 2019–2020. *PLOS ONE*, *16*(6), e0252539. https://doi.org/10.1371/journal.pone.0252539

Salway, T., Kinitz, D. J., Kia, H., Ashley, F., Giustini, D., Tiwana, A., Archibald, R., Mallakzadeh, A., Dromer, E., Ferlatte, O., Goodyear, T., & Abramovich, A. (2023). A systematic review of the prevalence of lifetime experience with 'conversion' practices among sexual and gender minority populations. *PLOS ONE*, *18*(10), e0291768. https://doi.org/10.1371/journal.pone.0291768

Sarno, E. L., Swann, G., Newcomb, M. E., & Whitton, S. W. (2021). Intersectional minority stress and identity conflict among sexual and gender minority people of color assigned female at birth. *Cultural Diversity and Ethnic Minority Psychology*, *27*(3), 408–417. https://doi.org/10.1037/cdp0000412

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist*, *60*(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16

Smith, E. (2011). Teaching critical reflection. *Teaching in Higher Education*, *16*(2), 211–223. https://doi.org/10.1080/13562517.2010.515022

Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social Support Networks for LGBT Young Adults: Low Cost Strategies for Positive Adjustment. *Family Relations*, *64*(3), 420–430. https://doi.org/10.1111/fare.12124

Souleymanov, R., Brennan, D. J., George, C., Utama, R., & Ceranto, A. (2020). Experiences of racism, sexual objectification and alcohol use among gay and bisexual men of colour. *Ethnicity & Health*, *25*(4), 525–541. https://doi.org/10.1080/13557858.2018.1439895

Statistics Canada. (2021, June 15). *A statistical portrait of Canada's diverse LGBTQ2+ communities*. https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm

Statistics Canada. (2023a, April 19). *Ethnocultural diversity among lesbian, gay and bisexual people in Canada: An overview of educational and economic outcomes*. https://www150.statcan.gc.ca/n1/pub/89-28-0001/2022001/article/00005-eng.htm

Statistics Canada. (2023b, July 27). *Police-reported hate crimes, by detailed motivation, Canada, 2020 to 2022*. https://www150.statcan.gc.ca/n1/daily-quotidien/230727/t006b-eng.htm

Trans Legislation Tracker. (n.d.). *Learn | U.S. anti-trans legislation history*. Retrieved October 31, 2023, from https://translegislation.com/learn

Trans PULSE Canada. (2019, December 20). *Trans PULSE Canada quickstat #1—Conversion therapy*. https://transpulsecanada.ca/results/quickstat-1-conversion-therapy/

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, *77*(1), 68. https://doi.org/10.1001/jamapsychiatry.2019.2285

Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological Attempts to Change a Person's Gender Identity From Transgender to Cisgender: Estimated Prevalence Across US States, 2015. *American Journal of Public Health*, *109*(10), 1452–1454. https://doi.org/10.2105/AJPH.2019.305237

Two-Spirit Dry Lab. (n.d.). *Two-Spirit Dry Lab*. Two-Spirit Dry Lab. Retrieved March 9, 2023, from https://twospiritdrylab.ca/

Watson, R. J., Park, M., Taylor, A. B., Fish, J. N., Corliss, H. L., Eisenberg, M. E., & Saewyc, E. M. (2020). Associations Between Community-Level LGBTQ-Supportive Factors and Substance Use Among Sexual Minority Adolescents. *LGBT Health*, *7*(2), 82–89. https://doi.org/10.1089/lgbt.2019.0205

Woodford, M. R., Paceley, M. S., Kulick, A., & Hong, J. S. (2015). The LGBQ Social Climate Matters: Policies, Protests, and Placards and Psychological Well-Being Among LGBQ Emerging Adults. *Journal of Gay & Lesbian Social Services*, *27*(1), 116–141. https://doi.org/10.1080/10538720.2015.990334

Appendix A. UnACoRN Survey Questions

Table A.1. Questions asked to participants about their demographic information in the 2022 UnACoRN survey.

Question	Answer Options
1. How old are you?	Open ended
2. What country do you live in?	a) Canada b) United States of America
If 2a: 3. What are the first three (3) characters of your postal code?	Open ended
If 2b: 4. What are the first five (5) digits of your zip code?	Open ended
5) What cultural backgrounds best describe you and your family? Choose all that apply.	a) Indigenous to Turtle Island/North America (First Nations, Métis, Inuk) b) African c) European d) East Asian[1] e) South Asian[2] f) Southeast Asian[3] g) Pacific Islander [4] g) Hispanic or Latinx[5] h) Middle Eastern[6] i) I prefer to describe my background as_____ j) Prefer not to answer 1 E.g., China, Mongolia, North Korea, South Korea, Japan, Hong Kong, Taiwan, Macau 2 E.g., Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka 3 E.g., Brunei, Burma (Myanmar), Cambodia, Timor-Leste, Indonesia, Laos, Malaysia, the Philippines, Singapore, Thailand, Vietnam 4 E.g., Hawaii, Samoa, Guam, Fiji, Tonga, or Marshal Islands 5 E.g., Latin, Central and South America 6 E.g., West Central Asian and Middle Eastern
6) What race(s) would you identify yourself as? Check all that apply.	a) Indigenous b) Asian c) Black d) White e) Hispanic e) Pacific Islander f) Don't know g) I prefer to describe my race as_____ h) Prefer not to answer

If Q5=a OR Q6=b 7. Do you identify as?	a) First Nations b) Métis c) Inuk d) Indigenous to areas outside of Turtle Island (for example: e) Aboriginal, Torres Strait, etc.) f) None g) Prefer not to answer
8. Do you identify as Two-Spirit?	a) Yes b) No
9. What is your household income (Dollars per year)?	a) Less than $20,000 b) $20,000 to $34,999 c) $35,000 to $49,999 d) $50,000 to $74,999 e) $75,000 to $99,999 f) Over $100,000 g) I don't know h) Prefer not to answer
10. How much money does your household have?	a) Not enough to live/for necessities b) Just enough to live/for necessities c) Enough d) We only have to worry about money for fun or extras e) We never have to worry about money f) Prefer not to answer

Table A.2. Questions asked to participants about their gender identity, gender expression, and sex assigned at birth in the 2022 UnACoRN survey.

Question	Answer Options
1. What sex/gender were you assigned at birth (i.e., the sex on your original birth certificate)?	a) Male b) Female
2. Are you a person of trans experience, meaning your gender identity is different from the sex/gender you were assigned at birth?	a) Yes b) No c) Not sure
3. Were you born with a variation in your physical sexual characteristics (sometimes called being intersex or having a difference in sex development)? You can answer regardless of when you found out about it (e.g., at birth or later), and without having an official diagnosis.	a) Yes b) No c) Not sure d) Prefer not to answer
4. How would you describe your current gender identity? Check all that apply	a) Man b) Woman c) Non-binary d) Genderfluid e) Genderqueer f) Third Gender g) Agender h) Detrans/Detransitioner i) Unsure/questioning/undecided h) None of the above. I prefer to self-describe my gender identity as:
5. How old were you when you first came out about your gender identity to any other person?	Open ended
6. How would you describe your gender expression or presentation? By "gender expression" we mean how you dress, act and speak. [Unsure, not at all, very little, somewhat, very much; prefer not to answer] [Scale response]	a) Feminine b) Masculine c) Androgynous (e.g., presenting/dressing both femininely and masculinely at the same time.) d) Fluidity between expressions

Table A.3. Questions asked to participants about their sexuality in the 2022 UnACoRN survey.

Question	Answer Options
1. How would you describe your sexuality? Check all that apply	a) Gay b) Lesbian c) Bisexual d) Pansexual e) Asexual f) Queer g) Indigiqueer h) Heterosexual/straight i) Fluid j) Unsure/questioning/undecided k) None of the above. I would prefer to self-describe my sexuality as:
2. How would you describe your sexual attraction? (Check all that apply)	a) I am attracted to girls/women b) I am attracted to boys/men c) I am attracted to people with non-binary identities d) I am attracted to people of all gender identities e) Gender does not affect my attraction to others f) I feel no sexual attraction
3. Have you told anyone about your sexuality (meaning who you are sexually attracted to or have sex with)?	a) Yes b) No c) Prefer not to answer
4. How old were you when you first came out about your sexuality to any other person?	Open ended

Table A.4. SOGIECE survey questions asked in the 2022 UnACoRN survey.

Question	Answer Options
1. Where do you feel safe, or know you would be safe, being out about your sexuality or gender identity and expression? (Check all that apply)	a) Family events b) Applying for a job c) Going to a school, class, or university d) Health care spaces and services (clinics, doctors offices, hospitals, emergency room, etc.) e) Mental healthcare f) Gym, pool, or sports g) Arts based groups (e.g., choir, band, theatre) h) Travel within the country where you live i) International travel j) Party or social gathering k) Religious setting such as a church, synagogue, or mosque l) Gay or lesbian communities m) Queer communities n) Two-Spirit or Indigiqueer communities o) Bisexual communities p) Non-binary communities q) Trans communities r) Intersex communities s) Asexual communities t) Workplace gatherings u) Public transportation v) Going for a walk outside w) None of the above x) Other... y) Prefer not to say
2. Have you ever experienced pressure to be cisgender or straight? (Check all that apply)	a) Yes, pressure to be cisgender b) Yes, pressure to be straight c) No d) Prefer not to answer
If Q2=a OR b 3. From whom? (Check all that apply)	a) Parent(s) or other primary caregiver(s) b) Siblings c) Other family members d) Friends e) People I'm dating / partner / spouse f) Priests or other religious leaders g) Other members of a religious group/congregation h) Healthcare providers i) Therapists j) Counsellors k) Teachers l) Sports coaches or teammates m) Websites n) Online forum/chat groups o) Other … p) Prefer not to answer

4. Has any person in a position of authority (e.g., parent, caregiver, counselor, healthcare provider, community/religious leader, etc.) ever tried to deny, suppress, change or lead you to doubt your gender identity, gender expression or sexuality? (Check all that apply)	a) Yes, sexuality (e.g., lesbian, gay, bisexual) b) Yes, gender identity (e.g., identity that differs from gender assigned at birth) c) Yes, gender expression (e.g., person's clothing, hairstyle, makeup) d) No e) Prefer not to answer
If Q4=a, b, OR c 5. Who tried to deny, suppress, change or lead you to doubt your gender identity, gender expression or sexuality? (Check all that apply)	a) Parent or caregiver b) Counselor c) Healthcare provider d) Community/religious leader e) A coach f) Teammates g) Prefer not to answer
6. What are some of the ways others have tried to deny, suppress, influence, or change your gender identity, gender expression, or sexuality? They told me to: (Check all that apply)	a) Read certain books b) Go to religious service c) Date someone of a specific gender d) Be friends with people of a particular sex/gender e) Be friends with members of a particular sexuality f) Move or express my body a certain way g) Move / change locations h) Change my tone or pitch of voice i) Go to particular school (religious, boarding) j) Limit sleepovers k) Not participate in certain activities (sports, extracurricular) l) Participate in certain activities (sports, extracurricular) m) Limit drug use n) Other [please specify] o) Prefer not to answer
All non-cis participants: 7. Who has supported your gender identity or expression? Support can come in many forms. For example, it can be explicit or implicit, can be shown through words or actions. Please answer based on what support looks like for *you*. Matrix: Yes, no, not applicable	a) Parent(s)/primary caregiver(s) b) Siblings c) Other family members d) Friends e) People I'm dating/partner/spouse f) Priests or other religious leaders g) Other members of a religious group/congregation h) Healthcare providers i) Therapists j) Counsellors k) Teacher l) Sports coaches or teammates m) Other n) Prefer not to answer

All sexual minority respondents: 8. Who has supported your sexuality? Support can come in many forms. For example, it can be explicit or implicit, can be shown through words or actions. Please answer based on what support looks like for *you*. Matrix: Yes, no, not applicable	a) Parent(s)/primary caregiver(s) b) Siblings c) Other family members d) Friends e) People I'm dating/partner/spouse f) Priests or other religious leaders g) Other members of a religious group/congregation h) Healthcare providers i) Therapists j) Counsellors k) Teacher l) Sports coaches or teammates m) Other n) Prefer not to answer

Appendix B. Chapter 3 supplementary data table

Table B.1. Prevalence of SOGIECE and cis-het pressure exposure by racial group and sex assigned at birth among 2022 UnACoRN survey participants.

	Racial Identity	Assigned female at birth	Assigned male at birth
SOGIECE prevalence	White	72.2% n=2855/3955 (95% CI: 70.8%-73.6%)	52.1% n=308/591 (95% CI: 48.0%-56.2%)
	Asian	71.8% n=209/291 (95% CI: 66.3%-76.9%)	63.3% n=31/49 (95% CI: 48.3%-76.6%)
	Black	76.3% n=90/118 (95% CI: 67.6%-83.6%)	73.9% n=17/23 (95% CI: 51.6%-89.8%)
	Multi-racial	74.0% n=302/408 (95% CI: 69.5%-78.2%)	66.7% n=36/54 (95% CI: 52.5%-78.9%)
	Total	72.6% n=3557/4900 (95% CI: 71.3%-73.8%)	55.1% n=407/739 (95% CI: 51.4%-58.7%)
Cis-het pressure prevalence	White	86.1% n=3487/4051 (95% CI: 85.0%-87.1%)	73.2% n=451/616 (95% CI: 69.5%-76.7%)
	Asian	88.0% n=271/308 (95% CI: 83.8%-91.4%)	84.3% n=43/51 (95% CI: 71.4%-93.0%)
	Black	82.4% n=98/119 (95% CI: 74.3%-88.7%)	73.9% n=17/23 (95% CI: 51.6%-89.8%)
	Multi-racial	85.9% n=354/412 (95% CI: 82.2%-89.1%)	87.5% n=49/56 (95% CI: 75.9%-94.8%)
	Total	86.2% n=4328/5021 (95% CI: 85.2%-87.1%)	75.2% n=578/769 (95% CI: 72.0%-78.2%)