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The Experiences of Transgender Providers of Gender-Affirming Care: Scrutiny, Stress, and Solidarity in Sociopolitically Turbulent Times

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Transgender (trans) people and providers of gender-affirming care (GAC) are being targeted in the current sociopolitical environment. The goal of this project was to gain insight into the experiences of those who share both of these targeted identities—that is, trans providers of GAC—who are currently providing care in states without GAC bans but doing so against the backdrop of antitrans sentiment and the fortification of GAC bans across the United States. Using a sample of 58 trans GAC mental health and medical providers, we analyzed their responses to closed- and open-ended survey responses about their professional and personal experiences. Providers described numerous changes to their professional roles and responsibilities, including increased patient demand. Providers also reported concerns about job security, both related to the care environment and to how their identities impacted their work. Such concerns were intensified by threats and harassment directed against themselves and their clinics and worries about how access to care, for themselves and their patients, would be impacted in the future. Finally, providers described the unique challenges and joys of providing GAC as a trans person. Trans providers are uniquely valuable members of the provider community, and institutions should work diligently to support these providers during a moment when their safety and ability to practice is in jeopardy, such as by offering support, protection, and job security. Cisgender professionals who work alongside trans GAC providers should commit to maintaining a safe and supportive workplace for their trans colleagues and to using their social position to advocate for policies and practices that will reduce the unequal burdens endured by trans providers of GAC.

Public Significance Statement

Trans providers of gender-affirming care experience unique challenges to the provision of such care in the current political environment, as well as unique joys. There is an urgent need to protect the providers who offer gender-affirming care—particularly trans providers who are targeted in both their roles as providers and as members of the trans community.

Keywords: gender-affirming care, state laws, transgender, providers, therapists

Gender-affirming care (GAC) refers to a wide range of treatments sought by transgender (trans) youth, adults, and their families, including psychosocial support as well as medical and surgical care. In recent years, many states have moved to restrict access to this care, particularly for trans minors (Abreu et al., 2022), whereas other states have adopted "shield" laws aimed at protecting access to this care (Arrayales & Redfield, 2026; Movement Advancement Project, 2025). Although GAC remains empirically supported, providers of GAC may face scrutiny and skepticism from individuals within and outside of their workplaces as they seek to defend access to this politicized form of care (Hughes et al., 2023). Such scrutiny has intensified in the past several years alongside the general rise in antitrans sentiment (Pew Research Center, 2025). The sociopolitical climate for trans people has continued to worsen, especially during the lead-up to the 2024 election, during which President Trump's campaign spent over 200 million dollars on antitrans ads, and trans people have experienced intensifying worries about their safety, well-being, and future (Goldberg & Sears, 2025a; O'Connor, 2025). This climate has only escalated since the election (Dawson & Kates, 2026). Thus, in the current climate, trans people and their providers are the focus of heightened attention (Vogel, 2025).

Insomuch as both providers of GAC and trans people are being targeted in the current sociopolitical climate, this study aimed to understand the experiences and perspectives of those with both

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identities—trans providers of GAC. Of interest was what it is like to be a trans person providing a highly scrutinized but essential form of care to members of one's own community amid the dual context of societal pressure and deep personal awareness of the importance of such care. Our goal was to uncover the nuances of their professional and personal experiences, with attention to issues of safety, visibility, and burden, during an increasingly volatile and sociopolitically uncertain time to be a provider of GAC in the United States.

The Legal Context of GAC

GAC commonly refers to health services that support a person in living in alignment with their gender identity when their gender identity differs from their sex assigned at birth (Coleman et al., 2022). This care may include talk therapy, puberty blockers, and hormones to promote the development of secondary sex characteristics that are consistent with a person's gender identity, and, in some cases, surgical interventions (Coleman et al., 2022). Such treatments are considered evidence-based and typically follow standardized practice protocols (Budge et al., 2024; Coleman et al., 2022). Access to GAC is supported by a consensus of medical associations in the United States (American Medical Association, 2021; GLAAD, 2024).

Despite the strong empirical evidence and professional support for GAC, there has been a dramatic rise in legislation targeting such care, especially among youth, in the United States. Such attacks on care must be contextualized in terms of the larger movement of antitrans legislation that has swept the country over the past 5 years. Since 2022, the number of antitrans bills has risen astronomically, with over 600 bills being considered each year in state legislatures in 2022, 2023, and 2024, and over 900 introduced in 2025 (Trans Legislation Tracker, 2025). By the end of 2025, 27 states and Puerto Rico had enacted some type of restriction on GAC for youth (Arrayales & Redfield, 2026; Trans Legislation Tracker, 2025).

In addition to state bans, mounting political pressures and threats (e.g., of violence, from community members; of loss of funding, from state officials) have led some gender clinics, including those at hospitals and medical schools, to close their doors, at least to youth patients, dating back to at least 2022 and continuing to the present (Rummler, 2022; Simmons-Duffin & Bolton, 2025). Threats to care have continued to escalate under the current presidential administration, which, after the completion of this study, issued multiple executive orders threatening to restrict all federal funding to institutions offering GAC care to youth as well as encouraging potential criminal prosecution against providers (Redfield, 2025). Pursuant to the executive order, the Federal Trade Commission solicited public comment about the possibility that providers of GAC to youth may be engaged in a form of fraud (Federal Trade Commission, 2025). In December 2025, the Department of Health and Human Services proposed a rule that would prevent institutions such as children's hospitals that provide any GAC to youth from being able to participate in the Medicare and Medicaid programs, alongside several other rules aimed at restricting or preventing access to GAC (Centers for Medicare and Medicaid Services, 2025; Konnoth, 2025). At the same time, the Department released a "declaration" alleging that GAC for minors does not meet professional standards (U.S. Department of Health and Human Services, 2025). Investigations into providers of GAC for youth under these various policies—and resulting litigation—have proliferated (Rummler, 2026). The cascading effect of the administration's campaign has led to temporary and ongoing shutdowns of care in dozens of hospitals, including in states where it is otherwise legal (Gaffney, 2026; Sharp, 2025).

Existing state-level restrictions on GAC vary widely but often criminalize health care professionals and sometimes parents, prohibit insurance coverage of such care, and prohibit state funding to facilities that provide such care (Kim et al., 2025). Such policies have created a chilling effect on GAC provision, contributed to targeted harassment of health care professionals and facilities, and led to organizational divestment of GAC due to concerns about risk (Kim et al., 2025). In turn, many providers in affected states have had to refer patients to nearby states that do not have such legislative restrictions. Providers in these states have been warned to prepare their institutions and clinical teams for increases in patients; prioritize care for those low on medication or experiencing high distress; use telehealth to facilitate equitable distribution of care; and form coalitions with clinics in the same geographic area to further reduce barriers for families (McNamara et al., 2023). Some people, of course, cannot travel for care due to practical and financial barriers, a reality that will undoubtedly contribute to delayed or foregone care, and potentially worse mental and physical health outcomes (Borah et al., 2023). But even for patients who are able to travel, continuity of care can be undermined by the costs associated with travel and time, inadequate insurance coverage, and growing waitlists at facilities in states without restrictive legislation (McNamara et al., 2023). It is important to acknowledge that telehealth, which allows for treatment to occur remotely using conferencing technology, does not remove the necessity of travel for patients and their families: Professional licensure often prohibits medical and behavioral health professionals from seeing patients who are not located in a state where they are licensed, although the specific restrictions vary based on both state of license and affected profession (Koumpias et al., 2024).

Challenges Faced by GAC Providers

Prior research has identified challenges facing GAC providers in states that have introduced or passed legislation related to the provision of GAC, including institutional pressures, concerns about legal action, career worries, and safety concerns (Gupta et al., 2023; Gzesh et al., 2024). This work has found that GAC providers who serve youth in particular face challenges in providing quality care amid its politicization (Gzesh et al., 2024; Shirin et al., 2025).

Other studies have examined the experiences of GAC providers in states without restrictive legislation. This work has found that providers in these states, who work at some of the country's most established hospitals, have been attacked, particularly online, as a result of the visibility of these facilities combined with the current national sociopolitical landscape vis-à-vis GAC (Human Rights Campaign, 2022). Such online harassment has led employers and individuals to safeguard their privacy and safety by removing online resources, websites, and provider descriptions, installing security systems at work and at home, and hiring attorneys (Hughes et al., 2023). A 2023 study of 117 providers of GAC to adolescents found that 70% of providers reported that they or their clinic had experienced threats related to their provision of such care—most

commonly social media posts (44%) or phone calls (38%), with almost one quarter reporting threatening emails and 21% reporting that protesters had come to their clinic (Hughes et al., 2023). These threats contributed to a heavier workload (e.g., it took time to respond to threats and to develop system changes to improve security) and poorer well-being. Other work indicates that GAC providers endure additional stresses related to remaining compliant with institution and state regulations, retaliation from local or state authorities, and legal consequences (Garcia Gutiérrez et al., 2024; Gupta et al., 2023).

There is evidence that providers in states seen as safe havens for GAC have seen increased patient demand and intensifying scrutiny due to the national politicization of such care, particularly for youth (Goldberg & Redfield, 2025; Hughes et al., 2023; Redfield et al., 2023). Such providers may face significant tension and strain due to the complexity of accommodating an influx of new patients as well as the demands of dealing with heightened levels of national scrutiny and increased intrusions on their privacy (e.g., attacks on social media). Anecdotal evidence (e.g., news reports) suggests that medical and mental health providers of GAC are experiencing heightened stress amid the national attacks on such care, leading some to make changes in their professional focus or career path (Garcia Gutiérrez et al., 2024).

Challenges Faced by Trans Providers

There is emerging evidence, then, that GAC providers are experiencing greater levels of stress, even in legislatively unaffected states. Those who are trans themselves may be exposed to heightened scrutiny for their engagement in this work (Shipman & Martin, 2019; Westafer et al., 2022). For example, parents of trans youth—who may approach treatment with caution and fear, and are sometimes misinformed or confused about the risks and benefits of such care (Abreu et al., 2022; Heffernan et al., 2024)—may be wary, suspicious, or skeptical of trans providers of GAC. Furthermore, the limited work on trans medical providers and therapists suggests that they encounter unique challenges in the workplace, including a lack of support and understanding from colleagues and challenges with patients (Dimant et al., 2019; Goates et al., 2024; Shipman & Martin, 2019; Westafer et al., 2022). A study of 36 trans physicians and medical students found that two thirds of participants had witnessed colleagues disparage trans people, highlighting the additional strains that trans providers often endure in professional settings (Dimant et al., 2019). The reality of transphobia during their education and training may lead some trans providers to seek out subspecialties they believe will be more inclusive and affirming—including GAC (Dimant et al., 2019; Goates et al., 2024), although notably, such care may be performed within larger institutions or settings that are less than affirming (Streeter et al., 2025).

Particularly relevant to the current study, some trans providers feel a unique obligation to the trans community and are highly conscious of their visibility and representation as trans health providers. This can create stress as they juggle the emotional exhaustion associated with being "out" as trans providers on top of the regular duties of providing medical care (Westafer et al., 2022). Trans providers bear the burden of visibility insomuch as they are often treated within professional settings as the default point of contact and expertise for trans issues, regardless of training, scope of practice, or current workload. Such visibility often translates into disproportionate referrals for trans clients, assumptions of expertise on all topics related to trans health specifically or lesbian, gay, bisexual, trans, and queer (LGBTQ+) health more generally, and requests to educate others on these topics (Dimant et al., 2019). They may also experience isolation due to the strain associated with being the only trans provider, or only visible trans provider, in a given care setting or community (Elad, 2022). Despite this, trans providers, especially therapists, are uniquely prepared to model resilience and offer authentic support and strategies for navigating minority stress to their trans clients (Goates et al., 2024). Writing from the perspective of a trans nonbinary therapist, Elad (2022, p. 185) observes the unique positionality, roles, and importance of trans therapists vis-à-vis trans clients:

> Because of the unique cultural and sociopolitical aspects of trans health care worldwide, in which trans communities are simultaneously politicized as identities and medicalized as a means of control, trans people are often dependent on providers. Mental health providers play a significant role as they are often required to 'assess' trans people before they are granted access to many forms of medical and social transition. Thus, trans mental health providers are often engaged in political activism. They lead transformations of workplaces and workplace ethics, and often occupy the position of role model due to their trans identity.

Elad (2022) goes on to describe both the unique joys of being a trans provider of trans patients (e.g., supporting trans clients' journey of self-realization) as well as the challenges (e.g., feeling trapped and not recognized for expertise unrelated to trans issues; experiencing heightened surveillance by supervisors, creating anxiety and fear of job loss). Trans providers may be especially vulnerable to harm and discrimination in their workplace environment, "which puts an additional burden on them as staff, risking unpleasant experiences of burnout and trauma when working with trans clients who navigate similar experiences" (Elad, 2022, p. 186).

As trans people, trans providers necessarily face and must navigate antitrans rhetoric. Recent work, for example, has documented associations between the number of antitrans bills passed and trans people's fears surrounding safety (Schanzle et al., 2023) and between concerns about the eradication of trans rights and trans people's symptoms of depression and anxiety (Restar et al., 2024). Thus, both objective threat and appraisal of potential threat may translate into poorer well-being. Trans providers may also be personally affected by threats to GAC as they may access or plan to access such care themselves.

Theoretical Perspective

Both trans people and providers of GAC are impacted by structural stigma—that is, societal laws, policies, and norms that inflict harm on and impact the well-being of marginalized communities (Hatzenbuehler, 2016). Laws that restrict access to GAC, insurance companies that exclude GAC coverage, as well as the hostile sociopolitical climate surrounding GAC, constitute sources of structural stigma (Clark et al., 2025). A great deal of research has demonstrated that trans people are impacted by the introduction and passage of oppressive laws and policies that restrict their rights, including their access to GAC, insomuch as such laws are associated with increased stigma and experiences of

discrimination, decreased psychological safety, unhealthy coping, and poorer well-being (Abreu et al., 2022; Dhanani & Totton, 2023; Horne et al., 2022).

Gender minority stress theory, as conceptualized by Hendricks and Testa (2012), building on the work of Meyer (2003), details the processes whereby which exposure to and experiences with structural stigma contribute to poorer mental health outcomes for trans people—but also underscores the role of support and affirmation in mitigating the impact of gender minority stress on psychological outcomes (Testa et al., 2015). Group resiliency processes, such as participating in activism and advocacy, and being a positive role model, may also facilitate trans people's well-being and offset the corrosive effects of gender minority stress on mental health (Matsuno & Israel, 2018). Trans providers of GAC navigate intersecting and complex systems of structural stigma, insomuch as they are providing affirming services to members of their own community amid broader sociopolitical and legislative attacks that target them as both (a) trans people and (b) providers of GAC. Thus, they experience a "double targeting" of their personal and professional identities, at the same time that they are experiencing the professional strains of accommodating influxes of patients from states without bans (Borah et al., 2023).

Gzesh et al. (2024) introduced a conceptual model of moral distress experienced by pediatric GAC providers, where moral distress is defined as the "uncertainty, conflict, and/or constraints that challenge clinical providers to act within their professional ethics and guidelines" (p. 2). Gzesh et al. (2024) model outlines the complex interplay of societal and institutional pressures (e.g., legislative and workplace constraints on providing GAC), individual coping, and resilience-building processes that shape provider experiences—but also underscores the powerful role of shared identities between patients and providers in shaping both patient and provider experiences (see also: Goates et al., 2024). Gzesh et al. note that "though the topic is under-researched and as yet does not include TGD identities, existing literature suggests that provider-patient gender concordance can positively impact patient outcomes," and suggest that shared trans identities between patient and provider may facilitate relatability, trust, empathy, and comfort through "a unique bridge of understanding" (p. 6). Trans providers may indeed serve as role models for trans patients, "modeling success and acceptance and potentially fostering hope and confidence" (p. 6); yet Gzesh et al. (2024) model of provider experiences does not fully address how shared identities with clients may also create stress and burnout for trans providers, amid the heightened pressures they face to represent well-being, keep their emotions in check, and model positivity and resilience in the face of sociopolitical unrest and perceived danger.

Research Questions

The current study sought to understand the experiences of trans providers of GAC in states without bans, during a sociopolitically turbulent time when both trans people at large and GAC specifically were, and continue to be, under attack. But beyond understanding the challenges and stressors they faced, we sought to understand trans providers' experiences of joy, resiliency, and determination, insomuch as they occupy a very specific positionality characterized by dialectics of power and vulnerability.

Our research questions centered on how trans GAC providers were "meeting the moment" personally and professionally: That is, how they were being affected by the national and state legislative and sociopolitical climate surrounding trans rights and GAC. In the context of the current environment, we asked the following research questions:

Research Question 1: What professional changes and challenges are trans GAC providers experiencing in states without bans?

Research Question 2: How have recent changes in the social and political environment surrounding GAC affected trans GAC providers in their personal and professional lives?

Research Question 3: How does being a trans GAC provider affect the experience of providing GAC?

Method

Sample

Our sample consists of 58 GAC providers who themselves identify as trans or nonbinary. Participants were 38.9 years old on average ($SD = 7.94$; range = 26–61). In terms of race and ethnicity, most participants were White only ($n = 52$); just three were Latino/a/x, one was American Indian or Alaska native, one was Middle Eastern, and one was multiracial. All participants identified as LGBQ+. Half were married, and almost half were parents. Participants were located in 11 states, with the largest numbers in Massachusetts, Minnesota, California, New York, and Oregon. Participants were in a range of professional roles; 47 (81%) said that their employers provided therapy or counseling, and 32 (55%) said that their employers provided hormone therapy. For detailed demographics, see Table 1.

Data Collection

Data, collected in late 2024 (September–December 2024), were drawn from an online survey focused on the experiences of GAC providers. Potential participants were informed that the survey was "open to anyone who provides gender affirming care (physician, nurse, physician assistant, therapist, psychologist, etc.)" and "designed primarily to address the experiences of individuals providing such care in 'safe states' (i.e., states that have not passed legislation limiting such care)." The survey was developed by Abbie E. Goldberg in collaboration with public policy and law scholars and individuals who engaged in clinical practice with trans populations. It was constructed using the Qualtrics software application.

Two separate focus groups, each with four GAC providers in states without bans, helped to inform the development of the survey. Focus groups were conducted during the summer of 2024. About half of the focus group participants were mental health providers, and about half were medical providers. Discussions focused on the experiences of providing GAC in states without bans, as well as, more specifically: changes in the experience of providing care over the past few years; experiences of (non)support from employers; workplace climate; attacks from the broader public;

Table 1
Demographics for Trans Providers of GAC (N = 58)

Variable	*n*	%
Gender		
Nonbinary	31	54
Trans men	13	23
Trans women	4	7
Something else (e.g., nonbinary and trans masc; two spirit and trans masc)	10	16
Transition[a]		
Changed my legal name or gender marker	35	60
Hormone therapy	37	64
Gender affirming surgery, any kind	32	55
Other types of gender affirming treatments or interventions (e.g., voice, hair)	20	35
Sexual orientation		
Queer	37	64
Bisexual	6	10
Lesbian	4	9
Pansexual	4	7
Gay	3	5
Something else	3	5
Marital status[a]		
Married	29	50
Partnered but not married	15	26
Single	9	16
Divorced	3	3
Polyamorous	11	19
Parental status		
Children under 18	19	33
Children over 18	3	5
Both	2	3
No children	34	59
Provider type		
Mental health care, social worker	25	43
Mental health care, psychologist	3	5
Mental health care, other (e.g., licensed mental health counselor)	10	18
Medical care, physician	8	14
Medical care, physician's assistant	2	3
Medical care, nurse practitioner	7	12
Medical care, registered nurse	3	5
Type of practice		
Medical school/University hospital	12	21
Free standing health clinic	11	19
Free standing individual therapy practice	13	23
Free standing group therapy practice	10	17
University college counseling center	5	8
Private hospital	3	5
Something else (e.g., public hospital, primary care)	4	7
Practice setting		
Urban	29	50
Suburban	11	19
Rural	3	5
Something else (e.g., college town, multiple areas)	15	26
Practice environment with respect to GAC		
Very affirming	22	38
Somewhat affirming	27	47
Neutral	4	7
Somewhat hostile	5	8
Very hostile	0	0
Ages seen/client population		
Adults only	8	14
Youth only	3	5
Both	47	81
Funding received by clinic/employer		
Government funding	18	31
Public funding	18	31
Private donations	16	28
Something else (e.g., college-funded health services; all patients are self-pay)	26	45

Note. GAC = gender affirming care.
[a] Participants could select more than one response, so percentages may add up to > 100%.

advocacy; future plans related to their career; how their identities impacted their response to the politicization and provision of care; mental and physical health; and the upcoming 2024 Presidential election and associated stress. Focus group participants were invited to offer feedback on the survey, which was also informed by the literature, news articles, and the insights of the research team and associated scholars.

The anonymous survey was pilot tested for ease of use and functionality by four members of the target population before survey launch. Feedback was also sought from scholars and practitioners. The suggestions of both groups led to minor changes in the survey. For example, several terms were clarified, definitions of key constructs were provided, and several follow-up questions were added (e.g., to allow participants to provide explanations about their workplace context and client population). The finalized survey was approved by the Human Subjects Board at Clark University and disseminated widely via professional and personal contacts and listservs, with cautionary advice not to post on public social media out of concerns for data integrity.

The data collected for this article are anonymous. We, the researchers, have no access to information about participants' identities. We did not ask for identifying information (e.g., birth dates), nor did participants report it.

Closed- and Open-Ended Questions

We analyzed responses to a number of closed- and open-ended questions for our analysis. Closed-ended questions centered on employment setting, type of care provided, client population, and climate surrounding the provision of GAC. Closed-ended questions also addressed changes in professional role, responsibility, and experiences since the introduction of antitrans legislation; perceptions of employer support and job security; job satisfaction; and experiences of being targeted, threatened, or attacked. Open-ended questions requested elaboration on items they endorsed (e.g., closed-ended questions related to job security and experiences of being targeted). Additional open-ended questions included the following: (a) How do you seek to talk to and counsel youth, adults, and families during this period of intensifying antitrans sentiment? (b) Is your approach different from what it was a few years ago? How? (c) Do you have other identities that make providing GAC more stressful or complicated? Explain. How does this impact you/your professional role, visibility, and stress? (d) What would you tell a student hoping to enter this field as a GAC provider?

Data Cleaning and Preparation

A total of 155 surveys were started, and 22 were not included because they were either incomplete ($n = 12$) or completed by providers in states that had passed legislation restricting GAC ($n = 13$). Our final sample was 133. More than two thirds completed the survey before the November 2024 election. From this total *N* of 133, we observed that 58 (44%) were trans. In turn, analysis of the full data revealed that trans providers reported experiences that were uniquely nuanced by their gender identity. Amid a dearth of research on trans providers in general and trans providers of GAC specifically, we chose to focus specifically on this population in a mixed-methods investigation that prioritized qualitative data and analysis. It is those 58 individuals who make up the analytical sample.

Data Analysis

We conducted a subanalysis of a larger data set, focusing on trans providers who participated in a broader study of the experiences of GAC care providers in states without bans, examining their responses to survey questions that were asked of the full sample. A mixed-methods approach was well-suited to this study, given the limited research on the topic and our desire to present basic descriptive data on trans providers' experiences while simultaneously drawing on relevant open-ended questions to nuance and provide meaning to the quantitative items (Goldberg & Allen, 2015; Poth, 2025). Furthermore, the open-ended responses enabled us to explore emergent phenomena not captured by the closed-ended items, ultimately resulting in a deeper and more meaningful understanding of our participants' experiences.

Descriptive statistics (*M*s, *SD*s) were calculated for variables of interest. Our primary analysis was qualitative. Responses to the open-ended survey portions ranged from one sentence to almost one page of text, with most respondents providing responses of two to five sentences. We used qualitative content analysis (Krippendorff, 2019) to examine such responses. Content analysis is a standard method for examining open-ended responses to survey questions, enabling new insights through the process of systematically identifying, coding, and categorizing primary patterns in the data. Through careful exploration and classification of qualitative data, we established a coding system consisting of primary themes and subthemes to organize the data.

Our analysis focused on participants' responses to the open-ended questions described earlier, which centered on trans providers' experiences as trans people, providers of GAC, and the intersection of these experiences. Abbie E. Goldberg first read all open-ended responses to gain familiarity with the data, including overarching themes in responses (Goldberg & Allen, 2015). Then, via line-by-line coding, Abbie E. Goldberg labeled phrases relevant to the primary domains of interest (e.g., accommodating patient demand; managing visibility). Although all open-ended questions were explored collectively and in relation to each other, some were more closely tied to certain research questions than others, thereby generating more data than others vis-à-vis each research question. These codes were abstracted under larger categories and subcategories (e.g., providing GAC in a safe state; providing GAC as a trans person), which were positioned in relation to each other such that connective links were established to meaningfully capture participants' responses. A coding scheme was produced and reapplied, such that all data were recoded according to the scheme (Goldberg & Allen, 2015).

Afterward, a student research assistant served as an auditor and analyzed a random selection of open-ended responses, reading one out of five respondents' data, as a basic "check" on primary themes, to strengthen the credibility of the analysis. Minor discrepancies were discussed and reconciled with Abbie E. Goldberg, which led her to make minor modifications in the scheme. Then, Elizabeth R. Boskey and Elana Redfield provided further feedback about the finalized coding structure, resulting in rearranging several sections for cohesion and flow. Both the coding process and our final coding scheme were informed by our knowledge of the literature, the national sociopolitical and legislative landscape, our theoretical perspectives, and our own reflexive and collaborative processing of what, and how, the participants were sharing about their experiences as trans providers of GAC. As a research team diverse in professional role and training, discipline, gender identity, and geographic location, we drew upon our differences to enable a deeper and more critical analytic process. Specifically, we treated differences in perspective and interpretation as opportunities for reflection, reengagement with the data, and refinement of codes and themes. In turn, we aimed to center participants' accounts, rather than privileging any single author's particular interpretations or analytic lens.

Of note is that in presenting our findings, we do not provide demographic details alongside quotes out of a desire to anonymize the data as fully as possible, given participants' particularly vulnerable status as trans GAC providers.

Results

We first address changes in participants' professional demands amid state bans in other states, followed by a discussion of their feelings of job security and employer support. Then, we examine how the broader attacks on GAC were impacting participants not only professionally but also personally, and how they were coping with the associated stress. We turn then to the unique challenges they faced as trans providers of GAC. Finally, we discuss how participants were meeting the current sociopolitical moment in their work with patients, and their perspectives on the unique challenges and joys of providing GAC. Threaded throughout the discussion of these topics are themes of safety, vulnerability, adaptation, and resilience.

Changes in Professional Demands Amid the Expansion of Legislative Bans on GAC

Participants' responses indicated that they were often grappling with changes to the nature of care provision, due to the confluence of an increasingly hostile atmosphere surrounding GAC, state bans on GAC, and an increased demand for care in their states. Specifically, even though GAC was "safe" in their states, which they were grateful for, many described changes in health insurance coverage for GAC that had created new barriers to care for the patients they served. In addition, many participants detailed how patient demand had risen dramatically due to care bans around the country (Table 2). Notably, those who were surveyed post-November 4 (31%) emphasized that their concerns about being able to keep up with patient demand had intensified since Trump's reelection ("Will we get more patients traveling to us from out of

Table 2
Changes in Professional Demands Amid the Expansion of Legislative Bans on GAC

Type of change	*n*	%
Changes in demand		
Increase in demand for GAC for adults[a]	37	64
• "The therapy practice where I work is explicitly trans and queer affirming in its name and branding. We have had continuous increase in demand for services in the last several years."		
• "In the past few years I have seen an increase in demand for gender affirming care, particularly for adults who are moving from states that were imposing bans on medical interventions for gender dysphoria."		
• "Many of my clients and people I work with have relocated from out of state due to hostility."		
Increase in demand for GAC for youth	31	53
• "There has been an increased need of services for trans youth due to social policy stigma and distress related to antitrans rhetoric and harassment from others while out in public."		
Increases in staff working in GAC	14	24
Increases in scope/types of GAC provided	8	14
Worked with grassroots/advocacy to facilitate/coordinate access to GAC	14	24
Changes in job responsibility (including larger caseload and increased administrative work)	8	14
• "We are incredibly short staffed . . . my patient caseload has increased substantially as I'm covering for providers who have left our clinic due to the stressors of the job."		
• "[I am now] organizing flying patients to our state for care."		
Less time spent on things I enjoy (e.g., research)	25	43
Changes in insurance		
Recent issues or changes with coverage (e.g., more denials, lack of coverage, more requirements)	30	52
• "Coverage is mandated for insurance plans sold in the state. We get rejections form out of state insurance. Most of the insurance companies eventually pay but make the providers and patients jump through multiple hoops to obtain approval. Some programs also attach copays or deductibles which make the care unaffordable for patients."		
• "I'm seeing more patients report that their insurance specifically excludes gender affirming care, usually an out-of-state-based spouse's or parent's insurance. And some are forced to private pay for all care to hide it from a hostile, usually religious based, employer or parent."		

Note. GAC = gender affirming care.
[a] Participants were asked whether they had experienced any of the changes listed (yes/no). Quotes from their responses to related open-ended questions are used for illustrative purposes.

state? We can hardly keep up with demand now"; "I worry that our community will not be able to support the influx of people needing gender-affirming care").

A few participants offered the perspective that although challenges existed, access to GAC had improved in the years since they personally transitioned or started practicing, and several also noted that their state's coverage was better than that of many other states. Said one:

> Access to gender affirming care has evolved considerably since I started my practice. In [state], these changes have largely been for the better, though I know this is not the case in many parts of the country. When I was first transitioning in the early aughts, the idea that any aspect of medicalized transition could be covered by insurance would have been inconceivable to me. I will say that I see an increasing number of clients exhibiting anxieties that the care they need will cease to become available depending upon the vagaries of political administrations.

Employer (Non)Support and Employment (Un)Certainty

Amid the increased stressors related to providing GAC, and their status as a trans provider of GAC, another area of interest was how supported participants felt by their employer, and how secure they felt in their jobs. The majority felt at least somewhat supported, although most also voiced at least some uncertainty about their job security. Over one quarter were considering leaving their jobs, and almost one in 10 had pursued jobs outside of GAC. Half voiced concerns about financial stability (e.g., if they lost their jobs; Table 3).

Participants who articulated feeling less than fully supported sometimes highlighted discrepancies between their employer (e.g., hospital) versus their department or team. Said one, "My department is very supportive; the hospital is overall much less responsive. Despite harassment in our public facilities [and] bomb and death threats, there has been little effective follow up." To some, ambivalent or mixed support at work seemed to reflect organizational discomfort with the politicized nature of the GAC services they provided. For example, although one provider felt that their status in a safe state meant that "there are likely low chances of me losing my job," they did not feel fully supported at work, where their employer "made efforts to make our LGBTQ+ services less visible and talk less about issues facing our community."

Others articulated ambivalent support or affirmation for them as trans people, noting that their colleagues and institutions did not seem to fully understand the importance of respecting and affirming their gender identity across systems and settings. As one participant shared, "There is emphatically intended support in my workplace, with varying follow through. For example, I often have to advocate to my director to appropriately train new staff, as I was constantly getting misgendered. I developed an onboarding

Table 3
Job/Employment Support, Uncertainty, and Future Plans

Item	*n*	%
Level of perceived support from current employer		
Very supported	30	52
Somewhat supported	13	22
Ambivalent/Mixed	6	10
Not very supported	3	5
Not at all supported	1	2
I am my own boss/employer	5	9
Concerns about current job security		
Very worried	3	5
Somewhat worried	5	9
Mixed/Unsure	11	19
Not very worried	17	29
Not at all worried	21	36
Missing	1	2
Concerned about financial stability (e.g., if I lose my job)	29	50
Considered leaving my current job	16	28
Pursued job opportunities that do not involve providing gender affirming care	5	9

curriculum for trans competence in medical settings that was questionably implemented." Another participant shared that one of their supervisors "does not take interest in [trans] folks—no one in the research center has ever used my they/them pronouns. Do I think they will fire me? No. But do they care if I leave? No. Would they prefer me not be there? Probably." A few participants had already made job changes to escape less than affirming workplace environments. One participant said:

> I am very careful about where I work, and how much work I will have to do to advocate for simple things like using my correct pronouns. When I was interviewing for jobs three years ago, my references let me know that all of the jobs but one misgendered me. I took the one job that did not, despite the pay being $40,000/year less.

Participants who felt less than fully confident about their job security often pointed to the existing legislative and political landscape, which was expected to continue to impact funding, health insurance coverage, and the overall climate vis-à-vis GAC. One participant said, "I am concerned that there will be an executive order discontinuing federal funding for [GAC]. Many of our payments come from Medicare and out clinic struggles financially as is. My concern that we would close or be unable to continue to offer [care] if this occurs." Concerns about job security and employability were often amplified by worries that their trans identity could be seen as a liability. One participant shared:

> I generally feel secure in my job but sometimes wonder how a national ban on gender affirming care, or a state ban, would impact my job security. As a provider who is visibly trans, I also sometimes worry about the impact of societal views of [GAC] on prospective clients' initial impressions of me, such as whether they would contact me for services.

Several participants indicated that discrimination by clients because of their trans identity had impacted their overall caseload, which contributed to productivity concerns or worries about potential scrutiny from their employer. As one participant shared, "I'm a trans woman and have faced a great deal of harassment and discrimination and rejection from clients and sometimes other providers," leading to concerns about "my viability as an employee."

Effects on Professional and Personal Lives: Increased Worries, Delays in Care, and Shifts in Coping

The changing climate surrounding GAC was associated with both professional and personal impacts. One particularly urgent impact was the need to navigate threats and attacks against their organizations or employers as well as against themselves. Over one quarter (n = 15, 26%) reported that their employer or workplace had received threats related to their provision of GAC, with one fifth (n = 12, 21%) noting that their employer or workplace had increased security in their buildings over the past few years. The most common types of threats were verbal threats online (31%) and by phone (26%), with 19% having been verbally threatened in person (Table 4). One participant detailed the variety of threats that they received, including "bomb threats, death threats, threats to my clients and families, threats to my job and career, harassed in workplace bathrooms as well as public bathrooms, harassed in large city functions both verbally and physically." Another provider shared the range of experiences and worries they experienced as a trans provider of GAC, stating, "I have received anonymous and religious hate mail delivered to my clinic setting," and articulating concern that an "anti-trans person [would] pretend to be a patient and end up harming myself and/or my staff."

Alongside these experiences of threats and harassment, providers also experienced heightened worries about the legislative environment, for both their patients and themselves. Specifically, most (n = 51; 88%) endorsed increased worries about their patients' well-being. Two thirds (n = 38; 66%) endorsed increased worries about their family's well-being. Almost half (n = 28;

Table 4
Threats and Harassment Experiences as a Gender Affirming Care Provider

Type of threat	n	%	Examples
Verbally threatened or attacked *online*, including social media[a]	18	31	"I've lost count of the number times I've been accused of horrible things, threatened with physical violence, and been the recipient of harmful rhetoric online." "I've had a few emails through my website from folks calling me a child predator because I provide gender affirming care to youth."
Verbally threatened or attacked *by phone,* including text messages	15	26	"[I have received phone calls] with death threats from parents of ADULTS that I have treated."
Verbally threatened or attacked *in person*	11	19	"I've been yelled at, misgendered, mocked, laughed at, stared at, and called all sorts of things by clients, family members, and other people out in the community." "I have been verbally harassed and threatened in person but I believe these instances were about my personal trans identity rather than my work in trans-affirming care." "I've had parents accuse me of pushing an agenda with their minor child and yell at me and threaten to sue me."
Legal action has been taken against me	5	9	"I was reported to the [state] board of medical practice for investigation because my trans identity was a 'mental illness' and I was 'influencing children.'"
Self or family targeted or attacked in any other way	5	9	"[There have been] comments online by others about both me and my family/kids."
Home, car, or physical property has been targeted or harmed	1	2	"My car has been visibly damaged (keyed and cracked windshield)."

[a] Participants were asked whether they had experienced any of the changes listed (yes/no). Quotes from their responses to related open-ended questions are used for illustrative purposes.

48%) endorsed increased tension in their relationships with family, underscoring the far-reaching effects of strain surrounding the provision of GAC. One third ($n = 19$; 33%) endorsed increasing tensions in their relationships with community members (e.g., neighbors).

In addition to impacting their emotional and family lives, almost one third of participants ($n = 18$; 31%) stated that current legislative attacks had caused them to delay, or otherwise interfered with, their own GAC. Most explained that they were delaying top surgery or changes in gender marker. One participant shared: "There are longer wait times to schedule top surgery. Many folks who have been planning to have top surgery are not moving forward with it due to the changing political climate out of fear of a lack of access at some point." Another participant said, "I am waiting to change my gender marker to X for fear of vulnerability and retaliation if I'm legally documented as nonbinary." Participants who were not delaying any care generally explained that this was because GAC was protected in their state, they were not currently seeking any GAC, or they had already done all of the surgeries or medical interventions they planned to pursue. Some did express some concern about ongoing access to hormone therapy ("I've been doing this for a long time, I just really need maintenance at this point").

Providers reported making a variety of changes aimed to improve their coping abilities or to decrease their personal and professional vulnerability amid the current legislative context and sociopolitical environment (Table 5). Such efforts included a range of activities, from increasing advocacy and opportunities for personal connection to trying to decrease online visibility and access to personal information. Providers also reported both positive changes in personal health behaviors, such as increased exercise and medication and engagement in therapy, and negative changes, such as increased use of alcohol and substances.

The Intersection of Identities: Additional Challenges as a Trans Provider

Participants were asked whether they had other identities that made providing GAC more stressful or complicated. All agreed that being trans made providing GAC more complex. Participants detailed how this led to additional sources of stress related to their status as trans GAC providers (Table 6). Specifically, additional complexities specific to being a trans provider included *suspicion and doubt* from their professional community, including colleagues, clients, and their families, and the public at large. Trans providers worried they were assumed to be *less credible and biased*, even potentially "pushing" care on others, because they were trans. As one participant shared, "I think that knowing that I am nonbinary makes some parents discount my expertise, training, years of experience … and just see me as personally biased, no matter what I do or how much I help their children." In counterpoint to the suspicion that some experienced as trans providers, others experienced *a pressure to be "out" and "visible,"* with a few noting that they felt a particular obligation to do so, given their own privilege (e.g., as White; as cis passing). Participants also spoke to the expectation of *being a "trans representative,"* which made their role as a GAC provider more complicated. They worried that others saw them as the representative of all trans people and also felt pressure to be knowledgeable about all issues facing their community. Said one, "Being transgender has meant having that professional spotlight on me. Cisgender people expect me to have all the answers and represent transness as a whole."

Table 5
Responding to the Changing Environment for GAC Care: Actions and Coping

Response	*n*	%
Coping		
Made efforts to spend time with and get support from family and friends	41	71
Set boundaries between work and home (e.g., not checking email at home, taking weekends off)	34	59
Exercise and meditation	30	52
Started therapy	11	19
Increased therapy (e.g., in time, number, or type)	19	33
Sought other medical care	16	28
Increased use of alcohol or other substances	19	33
Advocacy		
Engaged in more advocacy work on behalf of trans youth/Adults	29	50
Engaged in less advocacy work on behalf of trans youth/Adults	4	7
Visibility		
I have sought to become more visible as a provider of GAC	32	55
I have sought to become less visible as a provider of GAC	9	16
Privacy and safety		
Removed (or hired services to remove) private information about me or my family on the internet	22	38
Made efforts to decrease my visibility online (e.g., only use first name in social media; get off social media)	24	41
Changed my methods of communication with other colleagues (e.g., private messaging service, use of nonemployer email address) to preserve privacy	11	18
Installed security system/s in my home	6	10
Other steps		
Other steps to improve my health/well-being, protect myself/my family, or shift my professional role/focus: • Reduced work hours • Started new psychiatric medications • Moved to Northeast	13	22

Note. GAC = gender affirming care.

Table 6
Unique Challenges Associated With Being a Trans GAC Provider

Theme	Quotes/examples
Suspicion and doubt	"[I feel] doubted more by the academic/medical community, as if my support for this care is only personal/subjective and not medical/academic/objective." "I gave a talk not too long ago and I was asked by someone—one of the attendees—if I was transgender, and the reason I bring this up is because the attendee could not wrap their mind around that this is standard of care. They thought it only was an interest of people with a certain socio-political opinion, it wasn't something that everybody needs to know. I just want to kind of put it out there. That's the elephant in the room."
Credibility as professionals	"Colleagues and client parents often question my education and training background." "I often am not referred clients as much as the cis providers who work with trans youth because parents don't want their kids working with an openly trans therapist."
Pressure to be "out" and "visible"	"Many of us have always wanted to become less visible as a transgender person and pass as a cis-gender individual. That's the dream for many transgender individuals. The fact that passing also increases my personal safety is just a bonus." "While I do not identify 'as' trans, it is part of my history. It is not my self-description of who I am. This alone is stressful in interactions with a larger gender diverse and clinical communities that increasingly push for everyone to be 'out and proud' as a marker of health or adjustment. This view pigeon-holes people into . . . being 'the trans person' before being the person. It is challenging to balance these external pressures and my life and not be squashed in the middle. I feel expected to announce my medical history in every setting."
Pressure of being a "trans representative"	"Being a mental health provider who is openly trans is very rewarding but also stressful and complicated at times. I often feel like I am representing all trans people or all gender affirming providers when I move outside of my professional circle." "I think I'm the only trans PCP/in-person hormone prescriber in my state, so I feel like there's pressure to be a model provider/person."
Dangers of overidentification with trans clients	"I listen and provide support. It's very stressful for me too as a trans woman who has dedicated her life to access to gender affirming care, so there's a lot of commiserating." "It is hard to know what to do . . . . I am trans and sometimes I worry that my own feelings or opinions will get in the way of being able to make space for my clients' needs in session."
Risk of emotional exhaustion/burnout	"I often think about working less hours/shorter shifts because the days are long and often emotionally draining. I have specifically sought out spaces for queer/trans providers to have support as we support our patients. This has been helpful."
Concerns about vulnerability to attack	"I have felt very vulnerable to attacks from the right, and afraid that I would be personally targeted because of my transness."
Transness as an aid to providing authentic care	"As a trans physician, I am right there with my patients when they express fear and anxiety about anti-trans legislation; I tell them I'm not going anywhere." "The work is politicized, and that is part of what we engage with in the exam room. I love being trans and supporting trans and gender diverse college students in accessing medical care. They often tell me that knowing we share some aspects of identity is helpful and supportive. I think we do often connect in solidarity and I work very hard to re-frame transness as another normal part of human variation."

Note. GAC = gender affirming care.

Another participant said, "There is an assumption that patients automatically get better care from trans-identified therapists in my workplace [so] I get more referrals than I can take and have to work harder to find them additional connections." A few participants discussed being pushed to take on more clients than they felt comfortable with, because of their trans identity.

Several participants spoke to the potential *dangers of overidentification* with their trans clients. They discussed the difficulty of providing services to clients who were going through shared challenges, which for some led to vicarious trauma. As one participant said, "It's difficult sometimes to support clients with the same things I am worrying about." Such vicarious trauma contributed to the *emotional exhaustion and burnout* that some participants endured. As one participant said, "I feel exhausted much of the time and also feel compelled to keep going. I often want to stop working completely or go into another area of my field entirely that requires nothing of controversy in the scope of practice. The increase of needs feels crushing."

Finally, participants articulated *concerns about vulnerability to attack*, including online. Some noted that worries about being targeted extended to their physical safety, with a few sharing that they had begun to take actions such as wearing bulletproof vests, purchasing guns, or carrying mace or other self-protection tools. This, in some ways, was the most acute concern of those experiencing the double-edged sword of being a trans GAC provider, whereby being out allowed "people in my community to feel seen, but causes other to remain suspicious of my therapy offerings," and potentially left them vulnerable to harassment or violence.

In some cases, participants described how being trans had served to enhance, rather than simply complicate (which they were specifically asked about), the provision of care. They saw their training as trans-affirming providers, and their personal trans experience, as aiding them in *providing authentic and meaningful care,* including the process of establishing trust and rapport. As one shared, "Being trans in the exam room for my trans patients is a blessing; it can make trust easier and we can cut through the BS." Some participants actively named their own identity with their clients and saw this as supporting and enhancing their work—both by communicating solidarity, but also offering perspective on what it means to be a trans elder and role model.

In addition to identifying their gender as an aspect of their identity that made providing GAC more complex, 22 individuals indicated

that various disabilities made care more complex, and six individuals indicated that being a person of color made care more complex. Highlighting the ways in which their disabilities complicated their work, participants often shared that one or more invisible disabilities (e.g., chronic illness, autoimmune issues) had impacted their emotional and physical capabilities as a provider. One participant shared:

> I was diagnosed with fibromyalgia last year, and told it was likely due to the increased stress in a variety of places in my life. Having a condition that will suddenly make me unable to work has definitely stressed and compromised what I feel I can offer my clients in my life, and it's been difficult to feel like the consistent and trustworthy person in trans people's lives [while] navigating this illness.

The complexities of being a trans provider of color were varied. One participant shared, "At work, sometimes I wonder if people feel more uncomfortable that I am nonbinary or that I am BIPOC. Both are there and come up, often." Another participant said, "It feels extra hard seeing other Black people in poor health, hard living situations, poor access to health care, etc."

Meeting the Current Sociopolitical Moment: Centering Safety and Support as a Provider

At the time they were surveyed, in 2024, participants were witnessing a continued and rapid increase in legislation targeting providers of GAC, as well as the accompanying gear-up to the 2024 election—which was, as discussed, marked by repeated, hostile rhetoric regarding trans people and gender-affirming health care. Participants expressed concerns about how these stresses affected both their clients and themselves. In turn, because of the emerging reality of greater legal obstructions to care and increasing worries about future access to care, many participants had shifted in their approach to care and how they counseled trans clients. They described taking more care to acknowledge and validate the harms of antitrans rhetoric, as well as to express solidarity with their patients as members of the trans community. Many said that they no longer provided "blanket assurances" regarding the future (e.g., guaranteeing continued access to care) amid the current political landscape and were more likely to acknowledge uncertainty. They also provided more practical guidance (e.g., how to protect personal information) as well as exploring options for maintaining continuity of care amid legislative shifts. One participant shared, "I validate their concerns, provide factual information about what is going on, and assist with developing a plan to access care if [GAC] is banned where they live." Toward this end, participants often noted an increased emphasis on safety and self-protection in their work with clients ("I've started keeping pepper spray in my office to provide to clients"; "I'm supporting folks in obtaining all needed documentation if they need to move").

Participants spent much more time discussing community support and resources in the service of hope, connection, and resilience. They emphasized mutual aid and developing relationships with others, encouraging their clients to "identify who their allies are" and to "lean on community" and also sharing "stories of hope, resilience, and resistance." One participant said, "I focus on helping them find resources for support, … encourage their involvement in advocacy work, promote the building strengthening of ties with others in the trans and larger queer community, … and work with them to build and fortify their sense of self-efficacy and personal value." Another participant said, "I name my identity and try to offer safe spaces, and … talk about how advocacy is important for those who can/have the privilege." One participant, a therapist, offered this account of how they sought to support their adult clients:

> I provide empathetic listening to everyone. I offer support and assist people to redirect their fear-based energy toward things they have some control over. I work with folks to learn and use self-soothing skills and to engage in self-care. I help many stop doom-scrolling and using social media or obsessing on news feeds. I support people exploring reality-based options they can consider should they need/want to move away. I help normalize the effects of discrimination and chronic stress as well as intersectional and minority stress. I work to enable people to stay connected, to increase connections, and to resist the reactions of isolating as they become more fearful. I also help normalize with helping people step back and understand broader views of history and behaviors of humans to attack marginalized or weaker groups and people to gain 'power.'

Indeed, faced with the seemingly unprecedented nature of the current attacks on themselves and their clients, participants also drew on historical perspectives to offer hope and perspective, and to "affirm the strength that queer folks have always had in the face of adversity," as well as to "contextualize [the current struggle] as part of a much larger fight for human rights that prior generations have been engaged in for centuries, and that will continue long after we are gone." As one participant said, "I offer solidarity as a trans-identified clinician as well as advocacy from within my professional role. I also make use of perspective as someone who is not young either chronologically or in transness to support folks in recognizing trans resilience across historical periods of waxing and waning hostility from larger systems."

Recognizing their risk for emotional exhaustion and burnout, some participants' shift in approach encompassed greater attention to their own limits in terms of time and capacity, recognizing the need to get "solid" in their own identities and support systems to be effective and skillful with their clients without "incurring vicarious trauma." As one participant said, "I am trans and occupy both sides of the provider/client relationship. I work harder now to balance my own needs, so I can continue to do my job."

The Challenges and Joys of Providing GAC

Participants were asked what advice they would give to a student potentially entering the field of GAC, which provided an opportunity to surface their perspectives on the challenges and joys of the profession, and whether and how entering the field at the current time was ultimately "worth it."

Many participants were equal parts cautious and enthusiastic, largely framing the care as both challenging and rewarding, thus acknowledging the duality of providing it. They discussed the meaningfulness of their career, while simultaneously emphasizing the high level of stress associated with the profession, as well as the need for self-care and boundaries. One participant characterized their job as "life-giving and full of colleagues who will contribute to joy and solidarity … and it can be scary and … hopeless at times to hear about the transphobia and bigotry clients/patients

experience." Another shared, "This work is equally rewarding and demanding. It will crush you weekly and then you'll feel so accomplished the next day."

Some participants focused more exclusively on the meaningfulness of the work, emphasizing positive impacts they have observed in their clients, finding joy in getting to witness "the happy moments when someone finally feels affirmed . . . [and] the relief and improvement of dysphoria after [treatment]," and voicing gratitude for being able to play a role in actively supporting clients in their journey: "One of the greatest joys I have is being able to include questions to youth such as 'what brings you euphoria' vs. just dysphoria, and including joy and celebration in our work, especially given there may be few spaces available for this joy." They recognized that they played a crucial role in their clients' lives, serving as role models they did not have ("It is a privilege that I am able to provide them with care I wasn't able to receive when I was younger, and I want trans youth to see me and know that they can do whatever they want to in life, that they matter, and that I am there for them"). Only a few focused solely on the challenges of the job. As one said, "It's harder than you think it will be. Not the medicine; that part is fine. But the increased scrutiny of pediatric gender medicine is so, so hard."

Many participants underscored the need for boundaries and self-care, as well as the importance of doing this work in community with others, to build social support and be able to turn to trusted mentors and colleagues. Such sources of connection were viewed as crucial ingredients to avoiding burnout. One provider, for example, emphasized the need to "be sure to care for oneself well, stay connected to community, and allow [one's] self to pay attention to capacity; it is hard and scary work in the current climate and we can only provide good gender affirming care if we are caring for ourselves well."

A few participants emphasized the need for self-protection in the profession of being a GAC provider, stressing the need for liability insurance as well as caution and care in selecting where to live and practice. They highlighted the benefits of practicing multiple types of care to avoid being "pigeonholed" and to ensure other professional opportunities, should the need arise. A few participants, too, emphasized the unique challenges that trans providers engaged in GAC must face, and offered cautionary guidance in line with that reality. As one participant stated, "This is healthcare that kids and families need and deserve access to. If you are trans and queer and providing this care, be prepared to have thick skin and be targeted based on your identity."

Discussion

During the period of time during which we recruited participants for the current study, and continuing up until today, GAC has continued to endure extensive political discourse, legislation, executive decree, and litigation. In June 2025, the Supreme Court upheld Tennessee's GAC ban, signaling that similar bans may endure, at least in the near term (Riedel, 2025). In addition, through a series of executive orders (EOs), the Trump administration has sought to eliminate access to GAC for people under age 19 (EO 14187), to revoke legal recognition of trans people across the federal government (EO 14168), and to remove trans people's access to various areas of civil society, including public accommodations (EOs 14148, 14168), accurate health information (EOs 14319, 14168), sports (EO 14201), safe schools (EO 14190), and ability to serve in the military (EO 14185). These orders, as well as health regulations both proposed (2025-13271 (90 FR 32352) and enacted (2025–11606 (90 FR 27074)), are having a chilling effect on access to GAC, particularly for young people (Simmons-Duffin & Bolton, 2025). This is true even in states where GAC remains legal, with many youth gender clinics choosing to shut down rather than risk the loss of government funding—including the potential loss of Medicare and Medicaid payments, a substantial portion of hospital revenue (Chen, 2025).

As participants attested, this a difficult time to exist in the world as both a trans person and as a provider of GAC. Trans GAC providers voiced extensive concerns about not only their patients' well-being but their own, and that of their families. Although providers who participated in this study were located in states that had not yet banned GAC, they perceived that possibility as an ongoing threat that affected their ability to care for themselves and their patients in a variety of different ways, underscoring how structural stigma can encompass proposed or threatened legislation in addition to enacted legislation (Dhanani & Totton, 2023; Goldberg et al., 2024). Indeed, simply living as a trans person amid legislative uncertainty can be highly stressful for trans people (Goldberg & Sears, 2025a; Tebbe et al., 2022). The current study suggests that the effects of this uncertainty for trans providers of GAC are compounded, leading some to take actions such as prioritizing boundaries and self-care, increasing their own therapy, and seeking out support. Significantly, these strategies have been named as useful in enhancing agency and well-being by LGBTQ+ people facing legislative uncertainty in prior research (Goldberg et al., 2024) and may be important in reducing the impact of gender minority stress associated with sociopolitical and legislative oppression (Testa et al., 2015). Significantly, too, participants described how engaging in advocacy and being a positive role model for their clients and patients were valuable and resiliency-promoting aspects of their professional role, helping to offset the many challenging aspects of the job (e.g., public scrutiny, employment uncertainty, safety concerns) that undermined their well-being (Matsuno & Israel, 2018).

GAC is evidence-based care, with its benefits to those who need it strongly supported for both youth and adults (Coleman et al., 2022). However, for providers, it may be quite difficult to separate the *provision* of such care from the *politics* surrounding it. Our data demonstrate that for our respondents, these difficulties were accompanied and perhaps offset by the rewards of being involved in GAC. The trans providers in our study generally described the provision of GAC as highly meaningful, as measured by the positive outcomes they saw in their clients.

Yet providers were also acutely aware of their patients' fears regarding access to care, and often shared those concerns, possibly increasing emotional burden (Elad, 2022; Goldberg & Sears, 2025a). Some voiced an awareness of the potential for vicarious trauma and took steps to guard against the potential for emotional reactivity, burnout, and exhaustion, the risk of which is heightened in the presence of shared trauma or fears (Tosone et al., 2012).

Trans providers of GAC, then, are uniquely positioned to both offer profound compassion, trust, and relatability to their trans clients but also face unique risks to their emotional and physical safety due to the multiple ways that their personal and professional identities are under attack (Gzesh et al., 2024) as well as the daily

strain of navigating lack of understanding, misgendering, and questioning of their credibility from colleagues and supervisors (Dimant et al., 2019; Westafer et al., 2022). Although trans providers of GAC care are uniquely positioned to advocate for policies that would improve the lives of their patients, there is a risk that their voices may not be listened to as readily as the voices of their cisgender colleagues due to a perception of potential bias through their shared community identity. Cisgender colleagues can at times help to both amplify the voices and expertise of trans providers as well as to advocate from a safer social position.

As access to GAC continues to narrow, trans providers who are still able to offer such care are likely to face increasing patient volume and consequently higher levels of stress and burnout, with patients from states that prohibit care already relocating to states where it remains available (Abreu et al., 2022; Goldberg & Sears, 2025b; Lopez et al., 2025). Attempts by the federal government to undermine the provision of GAC have the potential to increase demand on trans providers while also reducing their job security and sense of personal safety. Some states are attempting to mitigate these concerns through laws that shield providers of GAC from legal liability or obligations imposed in ban states—although notably, these will not necessarily reduce demand on providers already facing burdens in protective states. Although the outcome of such efforts remains to be seen, our work shows that, due to the politicization of GAC, trans providers of GAC are experiencing stressors that could be alleviated via protective interventions. For example, providers could benefit from various types of support and flexibility in their professional practice that could help delink concerns about job and financial security from the rapidly evolving federal and state policy landscape surrounding GAC.

Limitations, Implications, and Conclusions

Building on the limitations of the current study, future research should include racially diverse samples of trans GAC providers and be longitudinal, examining how both personal and professional experiences shift and evolve over time. In particular, future work should continue to evaluate how trans providers of GAC contend with the evolving challenges in the contemporary GAC environment, including whether and how they seek alternative or supplementary professional pursuits, make changes to their living situation (e.g., moving out of state or out of the country), or seek out additional or alternative supports and resources to facilitate coping. Future work might explore how experiences of risk, visibility, vulnerability, and occupational stress vary across diverse legal and workplace contexts. Longitudinal studies can help to identify how sustained exposure to sociopolitical and institutional volatility affects providers' well-being, career trajectories, and retention within the field of GAC. In addition, now that multiple states have enacted "shield" laws to protect providers of GAC and families of trans youth (Arrayales & Redfield, 2026), future research could explore the effect of these laws, and whether providers in states with "shield" laws experience different outcomes than providers in states without them.

GAC remains well-supported by the evidence, and research with trans adults shows that access to GAC has improved their well-being (Bhatt et al., 2022; van Leerdam et al., 2023). In turn, institutions that provide health care have an obligation to continue to support employees who provide GAC—a medically necessary form of health care. Trans providers of GAC should be valued for their professional contributions but also recognized as potential targets of scrutiny, derision, and harassment, with care and consideration given to their safety and well-being. Indeed, the risks that trans providers face are compounded by concerns about job stability and financial security amid the broader sociopolitical context in which GAC has become increasingly politicized.

Cisgender professionals who work alongside trans GAC providers should commit to maintaining safe and supportive workplaces. This may require attention to unique stressors, such as those identified by our participants, and may involve intervening in moments of bias, publicly affirming the legitimacy of GAC in professional settings, and leveraging their social position to support policies that protect trans providers' safety and job security. Cisgender professionals can also help advocate for changes to workplace policies and procedures that aim to offset the impact and harms caused by broader legislative shifts.

Ultimately, there is also a need for institutional support. Providers should be reassured that being trans, providing GAC, and/or demonstrating a commitment to following evidence-based medicine will not jeopardize their professional standing or job stability. Protecting the well-being of trans providers should be understood as a baseline equitable practice. This requires, in turn, institutional commitment to gender affirmation for staff, including the ability to change names, pronouns, and other identifiers across systems, coverage of GAC, and clear ways to address misgendering and harassment. It may also require investment in physical safety and digital privacy for all providers. By adhering to robust supportive internal policies, protective practices, and affirming public-facing messaging, institutions can leverage their resources to offset rather than reproduce the burdens of visibility and risk that trans providers currently face.

Our research demonstrates that trans providers of GAC experience unique stressors due to the intersection between their individual identities and social position and the work that they perform. They also experience unique joys in doing work that allows them to leverage their expertise in support of their own communities. Even as attacks on GAC occur at the national level, state policymakers and institutions should continue to value the knowledge and expertise of trans providers as part of the work of enabling the continuation of this evidence-based care. Cisgender providers, institutions, and state governments should also look for ways to support the ongoing work and well-being of trans providers in this difficult sociopolitical moment.

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