Transiness Report (2026)

SAFEGUARDING FAILURES AFFECTING TRANSITIONED WOMEN

A Systems Analysis of Sexual and Domestic Violence Service Design

February 2026

Liora Wren

Foreword

I know the weight of not knowing where to turn. I have navigated these systems myself. Sometimes with disclosure, sometimes without, and have sat with the disorienting question of where safety might be found. I have left services that felt unsafe and spent years believing that meant the failure was mine.

This report emerges from that recognition.

It translates lived reality into systems language and documents safeguarding failures affecting transitioned women with procedural clarity. This labour should not have been necessary. The responsibility to identify and remedy systemic risk belongs to the institutions charged with protecting survivors. Yet when systems render harm administratively invisible, those most exposed to risk are often left to make that harm legible.

The analysis that follows is deliberately evidence-based. It demonstrates how routing survivors according to birth classification rather than safeguarding context produces therapeutic mismatch, predictable disengagement, and outcomes that contradict the trauma-informed principles services publicly uphold.

Beneath this procedural analysis is a simple truth: when a survivor cannot safely navigate the services intended to support them, or encounters dynamics that mirror the conditions of their abuse, the safeguarding system has failed.

This report does not engage in metaphysical debates about gender. It is a systems analysis grounded in survivor reality. Its findings indicate that service models structured around birth-sex routing are not merely inadequate but risk falling short of statutory safeguarding duties under the Care Act 2014 and established clinical standards.

This failure should not have required documentation to become visible. But visibility is the first condition of accountability.

<div align="right">Liora Wren</div>

CONTENTS

Overview

This document identifies systemic safeguarding failures affecting transitioned women with medically complete or clinically stable transitions who experience sexual or domestic violence.

The issue is not under-provisioning, nor disagreement about identity. It is a service design and referral mismatch that produces predictable disengagement from protection.

This report is part of a series of actions under Domain 4: Safeguarding and Protection Services of the Transiness Manifesto 2026.

Population focus:

- Transitioned women whose transition is medically complete or clinically stable
- Living stably in their affirmed gender
- Often non-disclosing ("stealth") in crisis contexts
- Presenting with trauma patterns consistent with abuse directed at women

This focus is deliberate: predictive mismatch and harm are most pronounced in this group.

Methodological note: This report cites research using "transgender" as an umbrella category while focusing specifically on transitioned women with medically stable transitions. Community-based transition data indicates that approximately 97% of trans people living in role either have physically transitioned, are currently transitioning, or intend to transition. This means that research findings on "transgender individuals" are directly applicable to the population examined here: transitioned women who interact with services as women, not as abstract identity categories.

Executive Summary

This report details systemic safeguarding failures in the UK affecting transitioned women who experience sexual or domestic violence. It identifies a critical service design mismatch where referral pathways prioritise administrative categories over the actual psychological and clinical needs of survivors.

Sexual violence and domestic violence services exist because of specific expertise: understanding how abuse operates, how power imbalances function, and how institutional responses can either interrupt or compound harm. Yet in their response to transitioned women following the April 2025 Supreme Court ruling, many services are structurally reproducing the dynamics of abuse they exist to address.

Abuse operates through:

- Someone else defining your reality
- Loss of agency and control
- Being told "this isn't about you"
- Exclusion justified as "for the greater good"

- Being expected to endure harm quietly

When services treat the Supreme Court ruling as mandating categorical exclusion or birth-sex routing, they replicate these same dynamics at the institutional level:

- Reclassifying transitioned women against their lived experience
- Forced categorisation without survivor consent
- Institutional responses framed as "we have no choice" rather than active decisions
- Individual harm rationalised through appeal to collective safety
- Survivors required to accept therapeutic mismatch or categorical exclusion without complaint

This is not about individual practitioners' intentions. It is about institutional design that mirrors the mechanisms of abuse itself. When services whose core expertise is recognising abuse dynamics implement policies that reproduce those dynamics at the institutional level, this represents a fundamental failure of safeguarding practice.

Scale of Need

Population Estimate: Approximately 52,600 trans women aged 16 and over in the UK.

Elevated Risk: Evidence consistently shows transgender women experience substantially higher rates of intimate partner violence (IPV) and sexual violence compared to cisgender women.

Annual Flow: In a typical year, an estimated 5,400-12,000 transitioned women in the UK experience IPV, and approximately 5,700 experience sexual IPV specifically (based on 10.8% past-year prevalence applied to ~52,600 population).

Systemic Absence: Despite this scale, there is a near-absence of transitioned women in recorded service uptake (near-zero to <1%), against an expected baseline of 0.8-0.9% in a functioning system, indicating that the majority of survivors remain administratively invisible.

Why Current Systems Fail

The primary barriers to protection are the use of natal sex as a default classification for onward referrals, and operational opacity for those seeking help. This creates a predictable **predictive failure** because natal sex does not reliably determine:

- **Perpetrator Dynamics:** Abuse often involves male partners using tactics typical of male-on-female violence
- **Gender-Targeted Abuse:** Survivors face specific tactics like hormone withholding, forced misgendering, and threats of "outing" that generic services are not trained to recognise
- **Therapeutic Match:** Routing survivors to male-centred services creates a profound mismatch that often leads to immediate disengagement

Operational Opacity: Most UK sexual and domestic violence services do not provide clear, up-front information on how transitioned women are supported. Survivors are

therefore forced to "test" services through disclosure during moments of acute crisis, exposing them to rejection and re-traumatisation before safety is secured.

Anticipated Harm: Research demonstrates that 20-23% of transgender people avoid healthcare due to anticipated discrimination, with discrimination experiences associated with up to 20-fold increased likelihood of care postponement. This healthcare avoidance pattern transfers directly to safeguarding contexts where transitioned women must decide whether to seek help.

The Double Bind

For transitioned women seeking safety, every option carries predictable harm:

- Contact women's services → risk categorical exclusion confirming "there is no help for people like me"
- Contact men's services → accept profound therapeutic mismatch
- Disclose proactively → absorb re-traumatisation risk and possible service degradation
- Don't disclose → risk inappropriate routing if natal sex is later discovered
- Don't seek help → remain in danger

This is not a gap in service provision. It is a systematically rigged situation where there are no safe moves.

Policy Non-Compliance

Current natal-sex routing practices are fundamentally at odds with existing UK frameworks:

- **Care Act 2014:** Mandates individual assessment and the promotion of psychological wellbeing, both of which are undermined by categorical misclassification
- **NICE Guidelines (NG76):** Require trauma-informed, person-centred care; birth-sex routing is structurally incompatible with these standards

Population Scale and Evidence Base

UK Population Estimate

Based on 2021-2022 Census data, the number of transgender women aged 16 and over in the UK is estimated at 45,000–60,000, with a midpoint of approximately 52,600.

Our community-based transition data indicates that approximately 97% of trans people living in role either have physically transitioned, are currently transitioning, or intend to transition. Of these, 45% have undergone both hormone therapy and surgery, 26% use hormone therapy alone, and 25% are actively awaiting treatment, with only 2.8% who are not seeking physical transition. This means that the overwhelming majority of transitioned women are medically transitioning or intend to, and therefore interact with services as transitioned women rather than abstract identity categories.

Violence Prevalence

Evidence from systematic reviews and comparative studies consistently shows transgender women experience substantially elevated rates of intimate partner violence and sexual violence compared with cisgender women.

Key Evidence:

Systematic review and meta-analysis (2020, 85 studies, 49,966 transgender participants):

- Median lifetime prevalence of physical IPV was 37.5%, lifetime sexual IPV was 25.0%
- **Past-year sexual IPV prevalence: 10.8%**
- Compared with cisgender individuals, transgender individuals were 1.7 times more likely to experience any IPV, 2.2 times more likely to experience physical IPV, and 2.5 times more likely to experience sexual IPV

United States (2023 California Violence Experiences Survey): Compared with cisgender women, transgender women had 6.7 times greater risk of past-year physical violence (any form), and 3.2 times greater risk of past-year intimate partner violence (any form).

San Francisco Bay Area cohort (2016-2017, 629 transgender women): The prevalence of lifetime sexual intimate partner violence was 36%. Sexual IPV was significantly associated with polysubstance use, depression, PTSD, suicidality, homelessness, and discrimination.

Population-level comparison:

When comparing the past-year sexual IPV prevalence among transgender individuals (10.8%) with past-year sexual assault prevalence among adult women in England & Wales (~2.4-2.6% from Crime Survey data), transgender individuals experience approximately **4.1-4.5 times higher prevalence**.

This is distinct from the 2.5× figure cited in the systematic review, which represents study-internal comparisons. The 4.1-4.5× multiplier reflects population-level crime survey data and provides the basis for calculating expected service demand.

Applying conservative UK population estimates:

- ~5,400-12,000 transitioned women experience some form of intimate partner violence annually
- ~5,700 transitioned women experience sexual intimate partner violence annually (52,600 × 10.8%)

The direction and magnitude of effect are consistent across studies and jurisdictions: transgender women experience sexual and violent victimisation at substantially elevated rates.

Expected Service Utilisation in a Functioning System

Safeguarding systems exist to respond to risk, not population proportion. When a group faces substantially elevated exposure to harm, services must scale accordingly. Where they do not, exclusion becomes not accidental but predictable and systemic.

Step 1: Population proportion

UK adult trans women: ~52,600

UK adult female population: ~27 million

Raw population proportion: 52,600 ÷ 27,000,000 = 0.195% (~0.2%)

Step 2: Risk-weighted service demand

From the evidence above, transitioned women experience past-year sexual IPV at rates 4.1-4.5 times higher than cisgender women in England & Wales (10.8% vs 2.4-2.6%).

Expected service utilisation = population proportion × risk multiplier

0.2% × 4.1 = 0.82%

0.2% × 4.5 = 0.90%

Expected service utilisation: ~0.8-0.9%

This means that in a fully functioning, non-exclusionary safeguarding system, transitioned women should constitute approximately 0.8-0.9% of sexual violence service users.

Service Uptake Gap

Despite this scale of risk, UK safeguarding systems do not routinely capture, monitor, or commission service pathways capable of meeting the needs of transitioned women. Audit findings across sexual and domestic violence services consistently demonstrate near-zero to <1% representation of transitioned women, despite risk-weighted expectations of approximately 0.8-0.9% service utilisation.

When observed uptake ranges from near-zero to <1%, against an expected baseline of 0.8-0.9%, this indicates that approximately 0-90% of transitioned women survivors are

failing to reach specialist support. At services where representation is genuinely near-zero, this exclusion rate approaches 100%.

This represents a systemic mismatch between safeguarding need and service accessibility.

Absence from services must not be interpreted as absence of harm. Instead, it reflects structural access failure, anticipatory avoidance, and predictable disengagement arising from systems that do not reliably provide safe, navigable, and dignity-preserving pathways for transitioned women.

Trauma and Discrimination

A community-based study of 412 transgender adults in Massachusetts found that 44.4% met criteria for probable PTSD, approximately 6.5 times higher than the 6.8% general population rate.

Critically, the magnitude of association between discrimination experiences and PTSD symptoms ($\beta=0.25$) was comparable to childhood abuse ($\beta=0.29$) and exceeded intimate partner violence ($\beta=0.18$) as a predictor. This elevated PTSD prevalence occurred regardless of prior trauma history: discrimination experiences were independently associated with PTSD symptoms even after statistically adjusting for childhood abuse and intimate partner violence.

The number of domains attributed to discrimination was independently associated with higher PTSD symptoms ($\beta=0.05$), suggesting that experiencing discrimination across multiple contexts (gender identity, appearance, sexual orientation, etc.) compounds trauma burden. For transitioned women navigating multiple systems, this cumulative discrimination effect becomes highly relevant to safeguarding access.

Help-Seeking Barriers

Despite elevated risk, help-seeking and disclosure are low among transgender survivors of sexual violence, with substantial reliance on informal rather than formal support systems.

Key findings:

- In a U.S. national survey of 15,198 transgender IPV survivors, only a minority sought help from survivor agencies
- In another U.S. sample, 84% of transgender IPV survivors had sought some help, but primarily from friends (77%), followed by mental health providers (40%) and family (30%). Police, hotlines, and shelters were rarely used
- UK-specific evidence: 40% of transgender people in Britain report trouble accessing healthcare due to gender identity, and 32% have experienced unequal treatment by healthcare staff

Healthcare avoidance as a predictive mechanism: In the 2015 U.S. Transgender Survey, approximately 20–23% of transgender adults reported avoiding needed healthcare because they anticipated disrespect, mistreatment, or discrimination from providers. Among transgender-feminine individuals, 26% delayed preventive care due

to fear of discrimination. Those with discrimination experiences were up to 20 times more likely to postpone care.

Delaying care "because of fear of discrimination" was strongly linked to poorer general health, current depression (3.08 greater odds), past-year suicide attempts (3.81 greater odds), and suicidal ideation (2.93 greater odds) among transgender adults.

In safeguarding terms: Absence from services does not indicate absence of need. Non-engagement is a recognised signal of service mismatch or perceived unsafety, not resolution. For transitioned women specifically, this avoidance pattern represents a rational response to systems that have demonstrated unreliability or harm.

The Data Gap: Monitoring Failure of Transitioned Women

In the UK, there is no routine, linked data capturing:

- Prevalence of SV/DV experienced by transitioned women
- Access to SARCs and onward SV/DV services by transitioned women
- Completion, dropout, or disengagement rates for transitioned women
- Outcomes following referral or exclusion of transitioned women

This creates a predictable blind spot. Elevated risk is known from international evidence and service-user accounts. Disengagement following inappropriate routing is observed. But harm to transitioned women remains administratively invisible.

Without outcome-sensitive monitoring, safeguarding systems misinterpret silence as success and cannot correct design failures that disproportionately affect transitioned women.

What Should Be Monitored

To detect system-generated harm rather than misinterpret absence as safety, monitoring must track:

- Pathway completion rates from SARC to specialist follow-up services, stratified by whether transgender identity was disclosed at initial presentation
- Time-to-dropout following initial crisis intervention, identifying whether disengagement clusters after inappropriate routing
- Referral acceptance versus completion rates across different service models, revealing where therapeutic mismatch predicts withdrawal
- Re-attendance patterns indicating unresolved need following initial service contact
- Healthcare avoidance behaviours and their relationship to service design features
- Re-victimisation rates among those who disengaged from mismatched services

Without these measures, safeguarding systems cannot distinguish between:

- Survivors successfully supported through appropriate pathways
- Survivors who withdrew because no appropriate pathway existed
- Survivors who never presented because they anticipated categorical exclusion

Statistical invisibility is not evidence of safety. It is evidence of system failure to track what matters.

Given the scale—thousands of transitioned women experiencing violence annually—the near-absence from recorded service uptake represents a profound system-design failure, not low need.

Improving Data Infrastructure

Current census data provides only crude population estimates. To gain sufficient insight into safeguarding need and system performance, data collection must improve substantially.

Census enhancement: Including questions related to medical transition status would enable:

- More accurate population estimates of transitioned women by region
- Identification of geographical locations where the service gap is highest
- Targeted commissioning based on local population need
- Monitoring of whether service provision scales appropriately to demand

Service-level monitoring: Beyond population data, services must track the outcome measures identified earlier: pathway completion, dropout timing, re-attendance patterns, and healthcare avoidance behaviours.

Without both population-level and service-level data infrastructure, safeguarding systems cannot detect their own failures or correct design flaws that disproportionately affect transitioned women.

How Institutional Design Replicates Abuse Dynamics

Sexual violence and domestic violence services exist because of specific expertise: understanding how abuse operates, how power imbalances function, and how institutional responses can either interrupt or compound harm. This expertise is encoded in trauma-informed practice frameworks, safeguarding training, and therapeutic models designed around survivor agency and safety.

Yet when services treat the Supreme Court ruling as mandating categorical exclusion or birth-sex routing, they create structural conditions that mirror the mechanisms of abuse itself.

This is not a claim about individual practitioners' intentions or beliefs. It is an observation about institutional design: when services implement policies based on rigid natal-sex classification, they structurally reproduce the power-over dynamics they are trained to recognise and interrupt.

The Parallel Dynamics

These are not superficial parallels. They represent the same power-over dynamics that safeguarding services exist to address, now reproduced at the institutional level.

Contradiction 1: Agency and Autonomy

Core trauma-informed principle: Survivors must retain agency over identity, disclosure, and engagement. Loss of control is a defining feature of abuse and its psychological aftermath. Recovery depends on restoration of autonomy.

Observed institutional practice: Transitioned women are reclassified against their lived reality, routed based on sex-at-birth regardless of current context, or excluded from collective support settings irrespective of personal history, risk profile, or trauma presentation.

Safeguarding impact: This replicates coercive dynamics by overriding self-definition at the point of crisis, removing survivor choice about how they are categorised and where they are routed, and enforcing classification without consent or meaningful input.

The result is institutional re-enactment of control rather than restoration of agency. Where abuse strips autonomy, safeguarding systems should restore it, yet natal-sex routing removes it again.

Contradiction 2: Barrier Reduction

Core trauma-informed principle: Services must reduce barriers to access and anticipate avoidance behaviours arising from fear of rejection, humiliation, or misrecognition. Absence from services is recognised as a potential signal of system failure, not resolution of need.

Observed institutional practice: Ambiguous or exclusionary policies cause transitioned women to self-exclude before contact. Evidence of near-zero service uptake despite thousands experiencing violence annually reflects not low need but rational avoidance under perceived risk.

Safeguarding impact: Disengagement is not accidental but foreseeable. When services implement policies known to deter disclosure and help-seeking, safeguarding responsibility is not discharged. The system has created the conditions for non-engagement.

Contradiction 3: Proportionality Over Formalism

Core trauma-informed principle: Formal neutrality must not override proportionality or lived vulnerability. Safeguarding requires context-sensitive risk assessment, not categorical classification.

Observed institutional practice: The Supreme Court ruling is treated as mandating universal sex-based sorting, despite no such operational requirement existing.

The April 2025 Supreme Court ruling clarified the interpretation of the term "sex" in the Equality Act. It did not:

- Create new exclusion powers
- Mandate categorical exclusion
- Prescribe service models
- Alter existing safeguarding duties under the Care Act 2014 or NICE guidance
- Remove proportionality requirements for single-sex service exceptions

Importantly, the ruling does not eliminate the possibility of pluralistic service models. Services like Edinburgh Rape Crisis Centre demonstrate that it remains entirely possible to offer parallel recovery spaces that reflect diverse safety needs—including women-only spaces for those without transitioned history, women-only spaces inclusive of transitioned women, and mixed-gender groups. Rather than enforcing a single classification model, such approaches preserve survivor autonomy, prevent forced disclosure, avoid administrative misclassification, and maintain safety across diverse survivor needs. This represents best-practice trauma-informed service architecture and proves that categorical exclusion is a choice, not a legal necessity.

Safeguarding impact: Treating legal permission as legal obligation transforms ambiguity into categorical exclusion, privileging administrative simplicity over survivor safety. Neutral framing ("we're just following the law") obscures the active institutional choice to interpret permission as obligation, displacing responsibility while producing disproportionate harm to an already-marginalised group.

Contradiction 4: Risk Resolution Not Relocation

Core trauma-informed principle: Safeguarding must reduce risk, not relocate it. Services are trained to recognise when institutional responses push vulnerability elsewhere rather than resolving it.

Observed institutional practice: By excluding transitioned women from women's services without providing equivalent alternatives, services displace risk onto:

- Isolation and lack of support networks
- Informal or unregulated support spaces

- No support at all, with survivors remaining in dangerous situations

Safeguarding impact: This increases vulnerability rather than mitigating it, directly contradicting core safeguarding objectives. The harm is not eliminated—it is rendered invisible to the system that should be monitoring and responding to it.

Contradiction 5: Survivor Safety Over Institutional Safety

Core trauma-informed principle: Safeguarding decisions must be survivor-centred, not driven by reputational, political, or organisational fear. Services are trained to recognise when institutional risk management overrides individual need.

Observed institutional practice: Policies are justified defensively ("we have no choice," "we must protect ourselves legally") rather than evidentially ("this demonstrably reduces harm to survivors"). Authority is invoked to suppress ethical scrutiny. The Supreme Court ruling is used as a shield against having to make difficult, context-sensitive decisions.

Services claiming "we have no choice" are making active institutional choices disguised as passive legal compliance. The ruling provided legal clarity about terminology. Services chose to interpret that clarity as permission for categorical exclusion, despite existing obligations requiring individual assessment and trauma-informed care.

Safeguarding impact: Institutional risk management is substituted for survivor protection, undermining trust and re-traumatising those seeking help. When services prioritise their own legal or reputational safety over the safety of those they exist to serve, they have inverted their fundamental purpose.

The Safeguarding Conclusion

Services cannot credibly claim trauma-informed, survivor-centred safeguarding while implementing policies that:

- Remove agency at the point of crisis
- Predictably deter access among those most vulnerable
- Misapply legal authority to avoid proportionate assessment
- Structurally reproduce power-over dynamics

The disadvantage experienced by transitioned women is not an unintended side-effect of necessary legal compliance. **It is a foreseeable outcome of institutional choices** made in response to a ruling that created no new operational obligations and explicitly left room for pluralistic service models.

When services whose core expertise is recognising abuse dynamics implement policies that reproduce those dynamics at the institutional level, this represents a fundamental failure of safeguarding practice—not merely inadequate provision, but active contradiction of the principles these services exist to uphold.

[Note: This concept of institutional dynamics mirroring abuse dynamics is central to understanding systemic failure. It will be referenced throughout the document when examining specific pathway failures.]

The Predictive Failure of Natal Sex Routing

The fundamental problem with using natal sex as a routing mechanism is that **it does not reliably predict the safeguarding context** that determines what kind of support a survivor needs.

Natal sex does not reliably predict:

1. The perpetrator dynamics encountered

- Example: Intimate partner violence from male partners using coercive control tactics typical of male-on-female abuse
- Classification by natal sex assumes perpetrator type, but transitioned women living stably in their affirmed gender overwhelmingly experience abuse from male perpetrators

2. The social context of abuse

- Example: Threats of exposure/outing used as leverage; abuse occurring in contexts where the survivor is perceived and targeted as a woman
- The abuse is gendered, but in ways specific to transitioned women's experiences of living as women

3. Barriers to exit

- Example: Fear of misgendering or categorical exclusion from women's refuges; belief that "no one else would want me"; prior service rejection creating learned helplessness
- Standard safety planning doesn't account for barriers specific to transitioned women like documentation mismatches or fear of service exclusion

4. The trauma presentation

- Example: Hyper-vigilance about being "read" as trans intersecting with PTSD hyper-arousal; avoidance of situations that require disclosure
- Trauma is shaped by lived experience as a woman, compounded by minority stress

5. The psychological meaning of the abuse

- Example: Gender-affirming violence that targets femininity; attacks perceived as punishment for transition
- The abuse explicitly targets the survivor's womanhood

Example of Predictive Failure

A transitioned woman experiencing coercive control by a male intimate partner presents to SARC following sexual assault. Natal sex routing might direct her to:

Option A: A service for male survivors, designed around assumptions of same-sex assault or female perpetrators → **therapeutic mismatch** even though the service technically accepts her

Option B: A women's service that categorically excludes her → **complete service absence**

Option C: A service that accepts her but cannot hold the intersection of intimate partner violence, gendered targeting, and disclosure risks → **engagement failure**

In each scenario, natal sex classification has failed as a predictive tool. It routed based on administrative category rather than actual safeguarding context.

Abuse Tactics Targeting Transitioned Women: Why Generic Services Fail.

Transitioned women experiencing domestic or sexual violence face specific coercive control tactics that target their gender identity and transition. These tactics are distinct, recognisable, and frequently misunderstood or minimised by services not designed to address them.

Documented Abuse Tactics

Identity-based control and erasure:

- Forcing survivor to present in wrong gender (e.g., requiring masculine presentation, refusing to use correct name/pronouns)
- Shaming for expressing gender (mocking femininity, ridiculing appearance, comparing negatively to cisgender women)
- Preventing or sabotaging transition (hiding documents, refusing to support name changes, blocking access to healthcare)
- Forcing participation in conversion therapy or threatening to do so

Medical and bodily control:

- Withholding, hiding, or destroying hormone medications
- Threatening to disclose medical history without consent
- Criticising surgery scars, body parts, or physical characteristics associated with transition
- Controlling access to transition-related healthcare appointments

Social and sexual exploitation:

- Objectifying or fetishising based on trans status
- Threatening to "out" survivor to family, employers, or community
- Isolating from LGBTQ+ friends and support networks specifically
- Using transphobic insults or slurs as routine degradation

Legal and immigration coercion:

- Threatening deportation (particularly for transitioned women whose documentation doesn't match current gender presentation)
- Weaponising legal gender recognition processes
- Threatening to involve authorities in ways that would force disclosure
- Exploiting documentation mismatches to create dependency

Why This Matters for Services

1. They are not recognised by services designed for cisgender populations

A service trained to recognise economic control, isolation, and physical violence may not identify:

- Hormone withholding as medical abuse
- Forced misgendering as psychological control
- Threatened outing as coercive leverage
- Prevention of transition as long-term entrapment strategy

This is therapeutic mismatch at the assessment stage: the abuse isn't recognised as abuse.

2. They demonstrate that the abuse is targeting the survivor as a woman

These tactics only make sense if the perpetrator recognises and is weaponising the survivor's gender identity. Forcing someone to present in the "wrong" gender, shaming feminine expression, threatening outing: these are attacks on her womanhood, not attacks that would occur if she were perceived as male.

Birth-sex classification cannot capture this dynamic. The abuse is gendered, but in ways specific to transitioned women's experiences.

3. They create barriers to exit that generic services cannot address

Standard safety planning asks: "Do you have somewhere safe to go? Can you access your documents? Do you have financial independence?"

For transitioned women, additional barriers include:

- Will the refuge/shelter support me as a woman, or will I face the same misgendering I'm escaping?
- If my documents still show birth name/gender, will I be denied access or outed?
- If my hormones are in the perpetrator's possession, where do I get emergency prescription replacement?
- If I'm threatened with outing to my employer, can I maintain income if I leave?

Services that don't understand these barriers cannot create effective safety plans.

4. They require specific knowledge to safety-plan around

Effective intervention for these abuse tactics requires understanding:

- How to secure emergency hormone replacement when medications are withheld
- How documentation mismatches create vulnerability and how to address them
- How outing threats function differently from other forms of reputation harm
- How isolation from LGBTQ+ community compounds other forms of isolation
- How conversion therapy threats intersect with family and religious coercion

Generic DV training does not cover this. Services need either:

- Expertise specific to transitioned women integrated into their model, OR
- Explicit partnership with specialist services

Neither option is enabled by natal-sex routing.

The Safeguarding Conclusion

The existence of these gender-targeted abuse tactics proves that the safeguarding need is determined by lived gender and social positioning, not by administrative categories assigned at birth.

To address these abuse tactics, services must:

- Recognise them as abuse in assessment and risk evaluation frameworks
- Understand the specific barriers they create to leaving and staying safe
- Know how to safety-plan around them (e.g., emergency hormone access, documentation strategies, outing risk management)
- Connect with specialist resources where additional expertise is needed
- Create environments where disclosure is safe if the survivor chooses to disclose these specific tactics

None of this is enabled by classification systems that route based on birth sex rather than actual abuse context.

Institutional Betrayal

Unlike other high-risk survivor groups, transitioned women are not met with specialist or protected pathways. Instead, exclusion from women's sexual abuse services results in routinised reclassification into men's provision, despite clear evidence of gender-specific vulnerability and perpetrator dynamics.

When transitioned women are rejected from women's services, Survivors UK often becomes the only national service that will accept them. This creates not only a service model fundamentally mismatched to the abuse contexts, coercive tactics, and trauma presentations that transitioned women experience, but one that actively amplifies harm. This amplification is compounded by the absence of peers, removing access to shared gendered context, mutual recognition, and the relational safety that survivor spaces are specifically designed to provide.

This routing failure is not neutral. It mirrors well-documented patterns of domestic abuse experienced by transitioned women, including misgendering, reclassification, denial of vulnerability, forced disclosure, enforced dependence on unsafe or inappropriate environments, and isolation from peers. In both interpersonal and institutional contexts, harm is produced not through overt violence alone, but through systematic invalidation of physical and social reality, lived experience, and risk.

In safeguarding terms, this constitutes institutional betrayal (Smith & Freyd, 2014). Institutional betrayal has been defined within betrayal-trauma theory as wrongdoing perpetrated by an institution upon individuals who depend on that institution for protection. Within this framework, avoidance and silence are understood as protective responses when the betraying institution cannot be confronted safely.

In practice, this represents abandonment concealed within procedural compliance. Exclusion is reframed as referral, misclassification as neutrality, and silence as lack of demand. This is not effective service provision, but the displacement of safeguarding responsibility away from women's services and onto survivors themselves, who are required to absorb additional harm in order to access any support at all.

Pathway Failure in Practice

A transitioned woman experiencing intimate partner violence from a male partner presents to SARC following sexual assault. She has lived stably in her affirmed gender for six years, is employed, and has not disclosed her transition history in any professional or social context during that time.

Under natal-sex routing:

- She is referred to services for male survivors
- These services are designed around assumptions of same-sex assault or female perpetrators
- Staff are not trained to recognise hormone withholding, forced misgendering, or threatened outing as abuse tactics
- Group support settings are inappropriate to her psychological context
- She disengages after initial assessment
- Her perpetrator is never held accountable
- She remains in danger
- **The system records this as a completed SARC attendance and counts it as successful intervention**
- **The failure is invisible to all monitoring systems**

The Navigability Crisis and Disclosure Trap

From a survivor's perspective, it is often impossible to determine before contact whether a service will:

- Support her as a woman
- Conditionally accept her with therapeutic mismatch
- Re-route her based on natal sex
- Exclude her categorically

Review of major sexual and domestic violence providers in the UK reveals a profound information deficit: even services that publish inclusion statements rarely provide clear, operational guidance about how transitioned women are supported in practice.

What Survivors Cannot Determine in Advance

- Whether they will be accepted as women without qualification
- Whether acceptance depends on disclosure, and what documentation might be required
- Whether they will be re-routed to services designed for male survivors
- What therapeutic model will be applied to their situation
- Whether group-based support will include them, and how

The Impossible Calculus

A survivor experiencing intimate partner violence from a male partner, who lives stably as a woman and has not disclosed her history in years, faces an impossible calculus:

- **Contact women's services** → risk categorical exclusion and confirmation that "there is no help for people like me"
- **Contact men's services** → accept profound therapeutic mismatch (services designed for same-sex assault or female perpetrators)
- **Disclose proactively** → absorb re-traumatisation risk and possible service degradation
- **Don't disclose** → risk being routed inappropriately if natal sex is later discovered
- **Don't seek help** → remain in danger

This is not a gap in service provision: it is a gap in accessible information that makes existing services functionally unavailable.

When services exist but cannot be safely navigated, the safeguarding system has failed its most basic function: being accessible at the point of need.

This operational opacity reproduces abuse dynamics at the institutional level—survivors face the same uncertainty, loss of control, and forced adaptation they experience in abusive relationships.

The Disclosure Trap

For those living stably in their affirmed gender, often non-disclosing in most contexts ("stealth"), disclosure in crisis situations carries multiple risks:

Immediate safety risk: In DV contexts, disclosure to systems that might involve perpetrator contact creates outing risk

Re-traumatisation: Among those who experienced childhood gender identity-related healthcare discrimination, 51% reported two or more distinct forms of discrimination—requiring disclosure re-activates prior trauma

Service quality degradation: Studies show 32% of transgender people have experienced unequal treatment by healthcare staff, making disclosure a predictor of worse care rather than better matching for transitioned women

Institutional exposure: Disclosure in formal systems creates documentation that can be involuntarily revealed

Psychological harm: In crisis, being required to explain, justify, or negotiate one's existence adds trauma to trauma

Why "Just Ask" or "Just tell" Doesn't Work

Some might argue survivors should simply contact services and ask about their policies, or disclose their history upfront to ensure appropriate routing. This fundamentally misunderstands safeguarding contexts and trauma responses.

1. Disclosure in crisis contexts is traumagenic

Evidence shows discrimination experiences produce PTSD symptoms through the same mechanisms as direct violence: avoidance of stimuli, hyper-vigilance, and physiological stress responses. Asking survivors to disclose in order to access appropriate care introduces a new traumatic stressor at the point where they are seeking relief from existing trauma.

2. Asking reveals identity before safety is confirmed

The act of asking "do you accept trans women?" discloses identity to an unknown service whose response cannot be predicted, creating exposure risk before protection is secured.

For someone who is non-disclosing in most life contexts, this represents a forced revelation to a stranger, during crisis, with no guarantee of acceptance. If the response is negative, the survivor has now disclosed to a service that will not help and must begin the process again elsewhere, carrying the additional burden of fresh rejection.

3. Prior discrimination predicts avoidance

Healthcare avoidance data shows that those most in need of services—those with prior negative experiences—are least able to overcome this information barrier. Requiring inquiry or disclosure to access appropriate services reinforces the very avoidance pattern that keeps survivors from seeking help.

4. Acute crisis impairs capacity for navigation

Someone who has just experienced sexual assault or is fleeing immediate violence does not have the cognitive or emotional capacity to conduct service research, make disclosure decisions, and manage rejection risk.

Acute trauma produces well-documented effects on decision-making capacity, information processing, and emotional regulation. Safeguarding systems are designed to reduce cognitive load during crisis, not increase it.

5. It only works once, and failure creates compounding harm

If a survivor contacts a service, discloses, and is rejected or experiences poor treatment, she now has additional discrimination experience that makes future help-seeking even less likely. The evidence shows cumulative discrimination experiences compound PTSD symptoms.

6. Disclosure acts as administrative coercion

Transitioned women often approach services in acute crisis, frequently immediately following sexual assault or enduring ongoing domestic violence. In these contexts, institutions hold decisive power: they control access to safety, clinical care, advocacy, and specialist protection.

When compliance with disclosure is made the gateway to potential support, access to protection becomes conditional. Survivors are required to submit to procedures that they know, from prior experience and available evidence, are likely to expose them to harm, exclusion, or service degradation. Non-compliance predictably results in misrouting, rejection, or denial of care.

This recreates conditions of vulnerability and power asymmetry that closely mirror the dynamics of coercive control in abusive relationships. A safeguarding system predicated on coerced disclosure has inverted its ethical foundation.

The Double Bind

Feminist scholars Eve Kosofsky Sedgwick and Marilyn Frye identified the "double bind" as a hallmark of oppression: situations where all available options expose one to penalty, censure, or deprivation. This is precisely the situation transitioned women face when seeking safety—a systematically rigged situation where there are no safe moves.

Compounding Vulnerabilities

Safeguarding risk is compounded by vulnerabilities commonly observed in transitioned women affected by birth-sex misrouting. These vulnerabilities arise from the interaction between social positioning, lived experience, and institutional response—not from birth classification itself.

Vulnerability 1: Cumulative Trauma and Institutional Betrayal

Transitioned women often situate abusive experiences in a broader context of victimisation where their gender identity is inseparable from other facets of identity, and these compounded traumas shape future help-seeking decisions.

Evidence shows experiencing discrimination across multiple domains (gender identity, appearance, sexual orientation, race, age, disability, housing) independently predicts elevated PTSD symptoms even after controlling for direct violence exposure.

When safeguarding systems add institutional discrimination through misclassification or exclusion, they become part of this cumulative harm pathway rather than an interruption of it.

Vulnerability 2: Increased Entrapment Risk

Some perpetrators treat boundaries as less serious and harm as more permissible, a dynamic exacerbated by:

- Weak or inconsistent institutional protection (e.g., services that exclude or provide substandard care)
- Social messages that transitioned women are less deserving of safety
- Prior experiences of being told "you're not really a woman" functioning as implicit permission for abuse
- Longitudinal evidence showing physical violence and housing discrimination increasing despite targeted interventions

Entrapment risk increases through:

- Categorical exclusion from women's refuges or support services
- Belief that "no one else would want me" rooted in prior romantic/social rejection
- Fear that disclosure will result in service refusal, increasing dependency on abusive partner
- Previous experience of institutional failure creating learned helplessness about seeking help

Additional entrapment through abuse tactics targeting transitioned women:

- Hormone medication withholding creates medical dependency
- Threatened outing to employers creates economic dependency
- Documentation mismatches create barriers to accessing refuge accommodation

- Isolation from LGBTQ+ community removes culturally competent support networks

Vulnerability 3: Normalisation of Harm

Chronic invalidation across systems normalises abusive treatment:

- If institutional systems routinely misgender, misclassify, or dismiss, abusive dynamics may not register as exceptional
- Hypervigilance about "causing problems" or being "too demanding" can suppress recognition of danger
- Prior discrimination in healthcare, employment, or housing creates expectation that harm is normal
- Longitudinal studies show 83% of transgender women report verbal harassment and 56% physical harassment, creating baseline expectation that mistreatment is inevitable

These vulnerabilities arise from institutional design and social positioning, not from birth classification. Natal sex routing fails to account for these risks because it classifies by administrative category rather than actual vulnerability context.

Data Weaponisation and The Misuse of "Accuracy"

Following the April 2025 Supreme Court ruling, sexual violence services across England have increasingly adopted data collection practices that function as gatekeeping mechanisms rather than safeguarding tools.

Audit of English sexual violence services identified a consistent two-step harm sequence:

Step 1: Forced disclosure through bureaucratic requirement

Services require information about "sex assigned at birth," "biological sex," or gender history through:

- Intake forms
- Equality monitoring
- Staff discretion policies
- Single-sex service eligibility criteria

Step 2: Use of disclosed information to exclude or degrade service

Once disclosed or discovered, this information is used to:

- Categorically exclude from women's services
- Re-route to services designed for male survivors
- Offer conditional support
- Reject referrals entirely

This creates the disclosure trap: survivors must choose between concealment (with ongoing fear of discovery) or disclosure (with predictable adverse consequences). Both outcomes constitute safeguarding harm.

The "Accuracy" Misdirection

The concept of "accuracy" in relation to natal sex enjoys deployment without examination of its operational consequences. Focus shifts from who a person is and what happened to them to how they must be administratively categorised.

This obscures the accuracy question safeguarding systems should actually ask:

Does our classification system predict who needs what kind of support, from whom, and under what circumstances?

The evidence demonstrates that natal sex classification does not reliably predict safeguarding context for transitioned women. Using it as a routing mechanism is predictively inaccurate, even if the data itself is administratively "correct."

Birth-sex data is not data collection in service of safeguarding. It is **data weaponisation:** information extracted under vulnerability, used to justify harm, while rendering that harm administratively invisible.

Birth-sex data extraction produces **data vandalism,** forcing people into categories that contradict lived reality and sabotage appropriate care matching. When "accurate" data

collection requires survivors to disclose information that is risky, that predictably leads to exclusion, the rational response is non-participation or non-disclosure.

Services that require disclosure as a condition of access, then use that disclosure to exclude, have constructed a system that functions as institutional violence.

Required System Changes

Effective safeguarding requires moving beyond natal sex classification as the controlling factor in routing and service design. Given the scale of need—thousands of transitioned women experiencing violence annually in the UK—the current approach constitutes a systemic failure to protect.

The following changes are not aspirational improvements. **They are minimum requirements for compliance with existing statutory duties** under the Care Act 2014 and clinical standards under NICE guidance NG76. Services currently practising natal-sex routing of transitioned women are not merely suboptimal—they are non-compliant with frameworks already in force.

1. Mandatory Transparency

Requirement: All sexual violence and domestic abuse services must publish clear, specific operational guidance stating:

- Whether transitioned women are supported appropriately without qualification
- What, if any, documentation or disclosure is required for access
- What therapeutic model will be applied to their situation
- Whether group-based support includes transitioned women and under what framework
- How confidentiality of gender history is maintained within the service

This information must be:

- Findable: Available on websites, in national directories, on helpline scripts, and in materials provided by referring agencies (police, hospitals, GPs)
- Specific: Not vague statements of "welcoming all" or "inclusive environment" but operational detail about who is served and how
- Consistent: Not dependent on which staff member answers the phone or which branch is contacted
- Up-front: Accessible before any disclosure or contact is required, allowing survivors to make informed decisions about engagement

Evidence basis: Uncertainty functions as a safeguarding barrier. When survivors cannot determine service appropriateness in advance, those with prior discrimination experiences will avoid engagement entirely.

2. Context-Based Routing

Requirement: Pathway decision tools ask: "What perpetrator dynamics are present? What coercive tactics were used? What barriers to exit exist?", not "What was assigned sex at birth?"

Risk assessment frameworks evaluate actual vulnerability (e.g., isolation, economic dependency, threat of exposure) rather than historical categorical routing.

Evidence basis: Natal sex does not predict the therapeutic context, perpetrator dynamics, or trauma presentation for transitioned women living stably in their affirmed gender. Routing tools must match on actual safeguarding context.

3. Therapeutic Match Requirements

Requirement: Commissioning guidance explicitly requires demonstration of pathway options for survivors whose birth-sex classification does not match their current vulnerability context.

Service specifications include capacity to support survivors who live stably in their gender and face gendered abuse patterns regardless of natal sex.

Evidence basis: Therapeutic mismatch predicts disengagement. With thousands of transitioned women experiencing violence annually, services must be capable of holding their actual safeguarding context.

4. Outcome-Sensitive Monitoring

Requirement:

- SARCs are required to confirm onward referral acceptance and engagement, not just make referrals
- Follow-up contact protocols identify non-engagement early and offer alternative pathways
- Monitoring includes healthcare avoidance behaviours as an outcome metric, recognising that absence from services may signal system failure

Evidence basis: Disengagement after initial crisis contact indicates pathway failure. Systems must track whether survivors complete pathways to safety, not merely whether they attended initial appointments.

5. Disclosure-Optional Protocols

Requirement:

- Services develop "disclosure-optional" protocols where survivors can access appropriate support without explaining personal history
- Risk assessment tools do not require birth-sex disclosure as mandatory field when it's not clinically relevant to immediate care
- Alternative routing pathways exist that match on presentation rather than categorical classification

Evidence basis: Requiring disclosure to access appropriate care creates a barrier that some survivors cannot overcome, leading to no engagement rather than matched support.

The Test of a Safeguarding System

Can someone experiencing acute danger identify and access appropriate support without requiring explanation, negotiation, advocacy, or testing of eligibility during crisis?

If the answer is no, the system has failed, regardless of whether services technically exist.

Current state: For transitioned women, the answer is demonstrably no. Services may exist, but they are not accessibly signposted in ways that allow safe navigation during crisis.

The current approach produces predictable stratification:

- Those able to absorb additional trauma burden through disclosure and advocacy may eventually access appropriate care, but only after accepting re-traumatisation as the price of entry
- Those who cannot do so—often those with prior trauma or discrimination experiences, those in acute crisis, those who are non-disclosing in most life contexts—will disengage or never present

This is precisely backwards from a safeguarding perspective: the system should be most accessible to those most vulnerable, but instead it is most accessible to those with the greatest psychological resources to navigate barriers.

A safeguarding system is not adequate if it can only be accessed by those with sufficient psychological resources to absorb additional trauma as the price of entry. **The test is whether protection is accessible to those most vulnerable, at the point of need, without requiring heroic navigation or acceptance of further harm.**

Natal-sex routing fails this test because it creates a system where appropriate services may exist but cannot be safely identified, accessed, or trusted by those who need them.

The Politics of Refusal

As legal scholar Florence Ashley (2023) observes, "A politics of refusal challenges the state's authority and legitimacy in doling out recognition."

When sexual violence services:

- Cannot be safely navigated by those who need them most
- Reproduce the dynamics of abuse they exist to interrupt
- Interpret absence from services as evidence of success rather than system failure
- Require survivors to absorb additional trauma as the price of protection

...they have forfeited the trust necessary for voluntary engagement.

There is no legal requirement to disclose sex or gender in most contexts. There is no obligation to participate in 'monitoring' that requires self-harm as the price of protection.

Safeguarding systems rely on voluntary engagement, informed consent, and survivor agency. Where access to protection is made conditional on compliance with procedures that are known to cause harm, that voluntariness collapses. What appears administratively neutral becomes structurally coercive.

Conclusion

With thousands of transitioned women experiencing violence annually in the UK, and near-absence from recorded service uptake, the gap between need and provision represents a profound system failure.

When the evidence demonstrates that classification practices fail on their own terms and produce foreseeable harm at scale, the duty to change is not contingent on agreement about identity—it is a fundamental safeguarding obligation.

Existing frameworks already require this change:

- The Care Act 2014 mandates individual assessment and promotion of psychological wellbeing
- NICE guidelines require trauma-informed, person-centred pathways

Natal-sex routing of transitioned women violates both: it substitutes categorical assumption for individual assessment and prevents trauma-informed care matching.

The duty to change is not merely ethical—it is already encoded in statute and clinical guidance.

Systems that persist with natal-sex routing are choosing administrative convenience over survivor safety. This constitutes institutional failure, measurable through disengagement, dropout, and re-victimisation among those who attempted to access help.

This report documents not merely inadequate provision but multidimensional institutional failure—the kind that requires not reform but reconstitution around principles of survivor agency, trauma-informed care, and recognition that administrative categories must serve protection, not substitute for it.

References

Prevalence of Violence and Victimisation

Arayasirikul, S., Chantharat, T., Chen, Y. H., Jin, H., & Wilson, E. C. (2022). A global cautionary tale: discrimination and violence against trans women worsen despite investments in public resources and improvements in health insurance access and utilization of health care. *International Journal for Equity in Health, 21*(1), Article 32. https://doi.org/10.1186/s12939-022-01632-5

Closson, K., Abramovich, A., Bauer, G., Brotto, L., Ciotoli, F., Colpitts, E., Dollard, M., Forster, S., Gahagan, J., Giblon, R., Greenspan, N. R., Heck, C. J., Jabbari, S., Jackson, R., Kidd, S., McClelland, A., Nussbaum, N., Ross, L. E., Scheim, A. I., ... & Worthington, C. (2024). Physical, sexual, and intimate partner violence among transgender and gender-diverse individuals. *JAMA Network Open, 7*(3), e243325. https://doi.org/10.1001/jamanetworkopen.2024.3325

Hindes, S., Fileborn, B., Kirkman, M., Bauer, G. R., Browne, K., & Lyons, A. (2025). LGBTQ+ adult sexual violence critical scoping review: Insights into victimization and perpetration. *Trauma, Violence, & Abuse*, 26(1), 171–187. https://doi.org/10.1177/15248380241311928

Peitzmeier, S. M., Malik, M., Kattari, S. K., Marrow, E., Stephenson, R., Agénor, M., & Reisner, S. L. (2020). Intimate partner violence in transgender populations: Systematic review and meta-analysis of prevalence and correlates. *American Journal of Public Health, 110*(9), e1–e14. https://doi.org/10.2105/AJPH.2020.305774

Santos, G. M., Makofane, K., Arreola, S., Do, T., & Ayala, G. (2025). Prevalence and correlates of sexual intimate partner violence among trans women in the San Francisco Bay Area. *Frontiers in Global Women's Health, 6*, Article 1524148. https://doi.org/10.3389/fgwh.2025.1524148

Trujillo-Guablocho, J., Quispe, E., Mera-Mamián, A. Y., Valencia-Aguirre, M., & Borja-Alvarez, T. (2025). Intimate partner violence in lesbian, gay, transgender, men who have sex with men, women who have sex with women, and bisexual people: A systematic review and meta-analysis of prevalence. *Interacciones, 6*(1), e459. https://doi.org/10.24016/2025.v6.459

Valentine, S. E., Marques, L., Wang, S., & Shipherd, J. C. (2017). Disparities in exposure to intimate partner violence among transgender/gender nonconforming and sexual minority primary care patients. *LGBT Health, 4*(4), 260–267. https://doi.org/10.1089/lgbt.2016.0113

PTSD, Discrimination, and Mental Health

Reisner, S. L., White Hughto, J. M., Gamarel, K. E., Keuroghlian, A. S., Mizock, L., & Pachankis, J. E. (2016). Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. *Journal of Counseling Psychology, 63*(5), 509–519. https://doi.org/10.1037/cou0000143

Valentine, S. E., Fleischmann, E. C., Graves, T. A., Shipherd, J. C., & Marques, L. (2024). The associations between gender minority stressors and PTSD symptom severity among trauma-exposed transgender and gender diverse adults. *Journal of Trauma & Dissociation, 25*(1), 95–111. https://doi.org/10.1080/15299732.2023.2234985

Valentine, S. E., Marques, L., Gamarel, K. E., Kaysen, D., Safren, S. A., & Shipherd, J. C. (2023). Considerations and complexities of accurate PTSD assessment among transgender and gender diverse adults. *Psychological Assessment, 35*(5), 397–410. https://doi.org/10.1037/pas0001219

Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review, 66*, 24–38. https://doi.org/10.1016/j.cpr.2018.03.003

Help-Seeking, Disclosure, and Service Barriers

Buckley, C., Ryan, G., & Bogen, K. W. (2025). Barriers and facilitators of help-seeking for LGBTQ+ survivors of sexual violence: A systematic review. *Trauma, Violence, & Abuse, 26*(1), 83–100. https://doi.org/10.1177/15248380251355902

Donovan, C., & Barnes, R. (2019). Help-seeking among lesbian, gay, bisexual and/or transgender victims/survivors of domestic violence and abuse: The impacts of cisgendered heteronormativity and invisibility. *Journal of Sociology, 56*(4), 554–570. https://doi.org/10.1177/1440783319851139

Kurdyla, V., Messinger, A. M., & Karkoski, A. (2019). Transgender intimate partner violence and help-seeking patterns. *Journal of Interpersonal Violence, 37*(7–8), NP5026–NP5053. https://doi.org/10.1177/0886260519880171

Messinger, A. M., Bauer, G. R., Catalano, D. C. J., Kattari, S. K., Brown, C., Ogden, S. N., & Bostwick, W. B. (2021). Intimate partner violence help-seeking in the U.S. transgender survey. *Journal of Homosexuality, 69*(12), 2139–2168. https://doi.org/10.1080/00918369.2021.1901506

Rymer, S., & Cartei, V. (2015). Supporting transgender survivors of sexual violence: Learning from users' experiences. *Critical and Radical Social Work, 3*(1), 155–164. https://doi.org/10.1332/204986015X14234119997616

Whitton, S. W., Dyar, C., Mustanski, B., & Newcomb, M. E. (2023). Disclosure and help-seeking experiences of sexual and gender minority victims of intimate partner violence: A mixed-methods study. *Journal of Interpersonal Violence, 39*(5–6), 1189–1216. https://doi.org/10.1177/08862605231207618

Healthcare Avoidance and Discrimination

Drabish, K., & Theeke, L. (2021). Health impact of stigma, discrimination, prejudice, and bias experienced by transgender people: A systematic review of quantitative studies. *Issues in Mental Health Nursing, 43*(2), 111–118. https://doi.org/10.1080/01612840.2021.1961330

Ferreira, I., Pereira, S., & Querido, A. (2023). Trans person: Discrimination and barriers associated with health care. *European Psychiatry, 66*(S1), S871. https://doi.org/10.1192/j.eurpsy.2023.1831

Glick, J. L., Theall, K. P., Andrinopoulos, K. M., & Kendall, C. (2018). The role of discrimination in care postponement among trans-feminine individuals in the U.S. National Transgender Discrimination Survey. *LGBT Health, 5*(3), 171–179. https://doi.org/10.1089/lgbt.2017.0102

Kcomt, L. (2019). Profound health-care discrimination experienced by transgender people: Rapid systematic review. *Social Work in Health Care, 58*(2), 201–219. https://doi.org/10.1080/00981389.2018.1532941

Levine, S., Adams, K., Berona, J., Zakai, O., Leitner, J. B., Macapagal, K., & Mustanski, B. (2022). Associations between healthcare experiences, mental health outcomes, and substance use among transgender adults. *The Journal of the American Board of Family Medicine, 35*(1), 81–91. https://doi.org/10.3122/jabfm.2022.01.210224

Seelman, K. L., Colón-Diaz, M. J. P., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health, 2*(1), 17–28. https://doi.org/10.1089/trgh.2016.0024

Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. American Psychologist, 69(6), 575–587. https://doi.org/10.1037/a0037564

UK Context and Population Estimates

Guyan, K. (2026). Trans-exclusionary data activism in the UK. *Journal of Gender Studies*. https://doi.org/10.1080/09589236.2025.2611975

National Records of Scotland. (2023). *Scotland's Census 2022 – Rounded population estimates*. https://www.scotlandscensus.gov.uk/

Northern Ireland Statistics and Research Agency. (2022). *Census 2021 population and household estimates for Northern Ireland*. https://www.nisra.gov.uk/

Office for National Statistics. (2023). *Gender identity, England and Wales: Census 2021*. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/genderidentity/bulletins/genderidentityenglandandwales/census2021

Stonewall. (2018). *LGBT in Britain – Trans report*. https://www.stonewall.org.uk/lgbt-britain-trans-report

Additional Supporting Evidence

Crime Survey for England and Wales. (2023). *Sexual offences prevalence and victim characteristics*. Office for National Statistics. https://www.ons.gov.uk/

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf