



Advancing Research on Minority Stress and Resilience in Trans Children and Adolescents in the 21st Century

Russell B. Toomey 

The University of Arizona

ABSTRACT—*Transgender and nonbinary children and adolescents bear a disproportionate level of poor health, and adverse developmental and academic outcomes compared to their cisgender peers. In this article, I review evidence from recent research on minority stress and resilience among trans youth and advocate for two additional domains to be included when studying the experiences of trans youth from a minority stress perspective. I describe the variability across sexual-minority and gender-minority youth in experiences of minority stress across and within contexts. I advocate for explicit attention in minority stress models with gender-minority youth to the domains of (a) intrapersonal and interpersonal gender dysphoria, and (b) access and use of affirmative and comprehensive health care.*

KEYWORDS—*health disparities; minority stress; transgender*

Throughout the 21st century, transgender and nonbinary children and adolescents (hereafter referred to collectively as trans youth) have been front and center in U.S. federal, state, and local school board policy debates (Walch et al., 2021). The goal of these political debates is often to limit the spaces that trans youth occupy while living authentically (e.g., restroom access), constrain their access to affirmative services and supports (e.g., affirmative medical care), and curb their ability to have legal documents that align with and affirm their identity (e.g., correcting one's assigned sex at birth on birth certificates). For

example, in 2020 and 2021, legislators in 25 U.S. states introduced bills that seek to limit or exclude trans youth from school-based sports (American Civil Liberties Union, 2021). Research on same-sex marriage policy debates and youth well-being (Hatzenbuehler, Shen, Vandewater, & Russell, 2019) suggests that the political debate about these legislative actions contributes to maladjustment among trans youth and their families.

Alongside these political debates, research is clear that trans youth disproportionately experience the burden of poor health outcomes, including suicidality, depression, self-harm, and eating disorders (for a review, see Connolly, Zervos, Barone, Johnson, & Joseph, 2016; Hughes, Blakely, & Nikolavsky, 2021). For example, between 30% and 50% of trans adolescents (ages 13–19) in the United States report having attempted suicide in their lifetime compared to 10% to 18% of youth who are not transgender (a population frequently referred to with the adjective *cisgender*; Toomey, Syvertsen, & Shramko, 2018). Research also suggests that high school-aged trans adolescents are less likely to receive preventative health measures than their cisgender peers (Rider, McMorris, Gower, Coleman, & Eisenberg, 2018). While many of the studies of this population have been conducted with adolescents, emerging evidence finds similar mental health burdens among trans children (ages 3–9; for a review, see Weiselberg, Shadianloo, & Fisher, 2019).

In this article, I briefly review and discuss the limitations of the application of minority stress models (e.g., Goldbach & Gibbs, 2017; Hendricks & Testa, 2012; Meyer, 2003) when applied to trans youth. Then I advocate for two overarching domains that are missing from minority stress models and that are unique and salient to trans children and adolescents. I assert that researchers need to develop valid and reliable measures of these constructs so they can be included in empirical studies of trans youth's health disparities in addition to the well-established minority stress constructs that are frequently used.

I focus on studies from the United States and on adolescents (rather than children) because of the dearth of research about trans people from other countries and on trans children.

Russell B. Toomey, The University of Arizona.

Correspondence concerning this article should be addressed to Russell B. Toomey, Norton School of Family and Consumer Sciences, The University of Arizona, 650 N. Park Ave., Tucson, AZ 85721-0078; e-mail: toomey@arizona.edu.

© 2021 The Authors

Child Development Perspectives © 2021 Society for Research in Child Development.

DOI: 10.1111/cdep.12405

However, the model I propose will attend to the growing body of research focused on the experiences of trans children, as well as the developmental nuances across these portions of the lifespan (Olson & Gülgöz, 2018). Finally, much of the literature has focused on the experiences of binary-identified trans youth (i.e., transfeminine or transmasculine youth). Since nonbinary youth represent a large portion of the trans youth community (Chavanduka, Gamarel, Todd, & Stephenson, 2020; Diamond, 2020), research and conceptual models must include nonbinary experiences. This is particularly warranted since nonbinary adolescents (ages 13–25) experience unique challenges and risks, such as disclosing gender identity to others at lower levels than binary-identified trans youth (Fisher, Fried, Desmond, Macapagal, & Mustanski, 2018), and experiencing higher levels of compromised mental health (Toomey et al., 2018; Veale, Watson, Peter, & Saewyc, 2017).

MINORITY STRESS THEORIES SPECIFIC TO SEXUAL- AND GENDER-MINORITY POPULATIONS

Research elucidating health disparities between trans and cisgender youth has been conducted primarily through the lens of Meyer's (2003) minority stress model (National Academies of Sciences, Engineering, and Medicine, 2020). According to this model, health disparities experienced by *sexual-minority adult populations* stem from chronic and unique minority stressors related to underlying oppressive structures, such as heteronormativity, that privilege heterosexual/straight identities while restricting access to resources for others (e.g., those who identify as gay, lesbian, bisexual, queer). Meyer's model posits the unique role of minority stressors in predicting health disparities *above and beyond* stressors encountered by the general population (e.g., financial stress).

Meyer put forward two distinct types of minority stress processes that explain health disparities among sexual-minority populations: (a) *distal* minority stress (e.g., minority stress that is experienced as overt stress in a variety of contexts, such as discrimination, victimization, and harassment), and (b) *proximal* minority stress (e.g., expectations and anticipation of distal minority stress that lead to anticipating rejection and discrimination, such as hypervigilance, and internalization of prejudiced attitudes about one's own minority group). General stress, along with distal and proximal minority stress, all uniquely predict compromised mental and behavioral health outcomes. Meyer proposed that characteristics of minority identity (e.g., prominence of identity) and coping and social support may moderate the associations between stress and outcomes, providing avenues for resilience.

The minority stress model (Meyer, 2003) has been applied for nearly two decades in developmental science to sexual- and gender-minority populations with little adaptation to include gender-minority-specific stress and resilience processes (National Academies of Sciences, Engineering, and Medicine,

2020). This homogenous application of the model to overlapping yet distinct populations is likely an artifact of developmental scientists' and psychologists' historical conflation of sexuality, gender, and sex in research studies; also responsible are sampling methods that resulted in analytic samples of "LGBT" youth (compared to heterosexual youth), rather than subsamples of sexual minorities (compared to heterosexual youth) or gender minorities (compared to cisgender youth; see Fassinger & Arsenneau, 2007; Galupo, Henise, & Mercer, 2016; Hyde, Bigler, Joel, Tate, & van Anders, 2019). This latter sampling and analytic error also ignores the presence of intersectional identities (e.g., an adolescent may identify as both trans and queer), intersections that likely have important implications for risk and resilience (Galupo et al., 2016).

In 2012, Hendricks and Testa published an adaptation of Meyer's (2003) model for use with trans populations, but the focus remained on trans adults. This adaptation emphasized how stress related to gender minority status—rather than gender variance itself—accounted for trans health disparities (Hendricks & Testa, 2012). The adaptation was necessary given the historic pathological view of gender identities and expressions that do not conform to binary gender norms or ideologies (Hyde et al., 2019). Yet their adaptation did not attend to or include minority stress processes that may be unique to trans populations and distinct from sexuality-specific-related stressors.

Finally, and perhaps most critical to my focus on child and adolescent development, Meyer's (2003) model was formulated based on studies of adults, without attention to the implications of the salience and uniqueness of varying developmental experiences and needs. Goldbach and Gibbs (2017) responded to calls in the literature (e.g., Institute of Medicine, 2011) to address the unique developmental needs of sexual-minority youth via their developmentally informed minority stress model. In their model (Goldbach & Gibbs, 2017), they include developmental processes absent in Meyer's original formulation, such as the salience of identity development, a critical focus on social contexts of stress and coping in adolescence—and the lack of autonomy and control over minority stressors in adolescent contexts (e.g., schools, family), and the changing nature of coping and resilience during adolescence. These advances in the theoretical model were necessary for developmentally informed research on the unique experiences of sexual-minority adolescents. Yet this model does not consider the unique experiences of trans youth.

Relatedly, while most sexual minorities become aware of and disclose their sexual identities during adolescence (Martos, Nezhad, & Meyer, 2015), many trans youth apparently now disclose or express their gender identities in early childhood (e.g., Olson, Key, & Eaton, 2015). The validity of trans youth's identities is frequently questioned because of trans youth's developmental positionality, particularly in early childhood (see Yong, 2019). Yet research on predominately White trans children (ages 6–11) suggests that these youth are not confused about their gender identity and follow developmental patterns of gender

development similar to cisgender peers (Olson et al., 2015). Thus, since minority stress perspectives were originally developed for adults, we must consider developmental nuances in childhood and adolescence that may alter the use of minority stress models in understanding health disparities.

AN ADAPTED MODEL OF GENDER MINORITY STRESS FOR TRANS YOUTH

Building on the original minority stress model (Meyer, 2003) and the more recently adapted models (e.g., Goldbach & Gibbs, 2017; Hendricks & Testa, 2012), I advocate for a developmentally informed model of gender minority stress among children and adolescents that addresses disparities experienced by trans youth (see Figure 1). This new model features two additional domains that should be measured and included as contributors to the well-being of trans youth: (a) a new minority stress category focused on dysphoria stemming from both anatomical-gender discrepancies and lack of interpersonal affirmation of gender identity (e.g., correct name, pronoun use), and (b) a contextual focus on access to and use of affirmative health care (including physical and mental health services). To address the heightened disparities that burden trans existence, a newly adapted model with trans-specific domains is necessary to frame developmental research—above and beyond models and constructs that have been well-validated among sexual-minority populations. Application in research must consider developmental nuances (e.g., cognitive, social, physical, and psychosocial developments) in all parts of the minority stress model. For example, how does autonomy granting (e.g., caregiver practices that support adolescents' competence in and ability for decision making) affect health outcomes among trans youth differently than cisgender youth, and how does developmental access to autonomy granting affect trans children differently than it does trans adolescents?

The proposed model of gender minority stress for trans youth operates under the same basic condition to explain the existence of disparities posited by all prior minority stress models: Disparities experienced by trans populations are a result of cisnormativity and transphobia (Figure 1, box A). Cisnormativity refers to the social norms and expectations that all individuals conform to the sex/gender binary, and involves the following assertions: sex = gender; sex/gender is biologically determined, stable, and unchangeable across the lifespan; and only two discrete and nonoverlapping categories of sex/gender exist: male and female (Baril & Trevenen, 2014). Because sex/gender is one of the most salient categories humans use to categorize, label, and sort, cisnormativity is embedded in the most basic experiences across the lifespan (Hyde et al., 2019). Social science is not immune to systems of oppression, so a cisnormative lens also permeates developmental science (e.g., McGuire, Kavalanka, Catalpa, & Toomey, 2016); for example, such a lens is used when the validity of assertions by trans youth about their identities is

questioned or when a focus on a binary system of sex/gender excludes trans youth.

Cisnormativity permeates the individual, their contexts, and their relationships throughout life (Figure 1, box B). In their developmental model of minority stress among sexual-minority youth, Goldbach and Gibbs (2017) explain that minority stress occurs within several key developmental contexts (e.g., schools, families). Research is clear that trans youth experience many distal minority stressors across contexts (e.g., family, school, peers; Figure 1, box C), and that stress is encountered differently within and across these contexts (e.g., peers vs. family; Ross-Reed, Reno, Peñalosa, Green, & FitzGerald, 2019). Limited research also documents that trans youth (ages 15–24) experience numerous proximal minority stressors and that these experiences are associated with disparate health outcomes (e.g., internalized transphobia; Chavanduka et al., 2020; Figure 1, box D). A review of the research on distal and minority stressors is beyond the scope of this article, but based on findings from the studies reviewed in the following sections, two additional domains of minority stress specific to trans youth are necessary to more comprehensively understand risk and resilience, as well as pathways for prevention and intervention. Next, I discuss these two domains: gender dysphoria, and access to and use of affirmative health care.

Intrapersonal and Interpersonal Anatomical/Gender Dysphoria

Gender dysphoria (sometimes referred to as anatomical dysphoria) is the experience of distress related to the incongruence of one's assigned sex/gender at birth with one's actual gender identity and expression (Galupo, Pulice-Farrow, & Lindley, 2020). While gender dysphoria is typically conceptualized as the emotional distress caused by the incongruence between one's actual gender identity and expression and one's physical anatomy (what I term *intrapersonal gender dysphoria*), gender dysphoria can also result from the experience of nonaffirmation of gender identity across contexts (what I term *interpersonal gender dysphoria*; e.g., gender dysphoria resulting from the refusal of other people or contexts to affirm a trans person's existence). Emerging research suggests that gender dysphoria strongly predicts health and well-being among trans youth (McGuire et al., 2020; Weiselberg et al., 2019), yet neither Meyer's (2003) model nor Hendricks and Testa's (2012) adapted model includes this construct as a unique domain of minority stress.

In studies of trans youth, intrapersonal gender dysphoria is often a sampling characteristic rather than an observed and measured construct; that is, samples have often been recruited at gender clinics that serve trans youth who present with gender dysphoria (Jones, Bouman, Haycraft, & Arcelus, 2019). As such, intrapersonal gender dysphoria is often the target of interventions (social, medical, psychological) that aim to reduce psychopathology among trans populations, yet gender dysphoria is rarely evaluated empirically in studies (Jones et al., 2019).

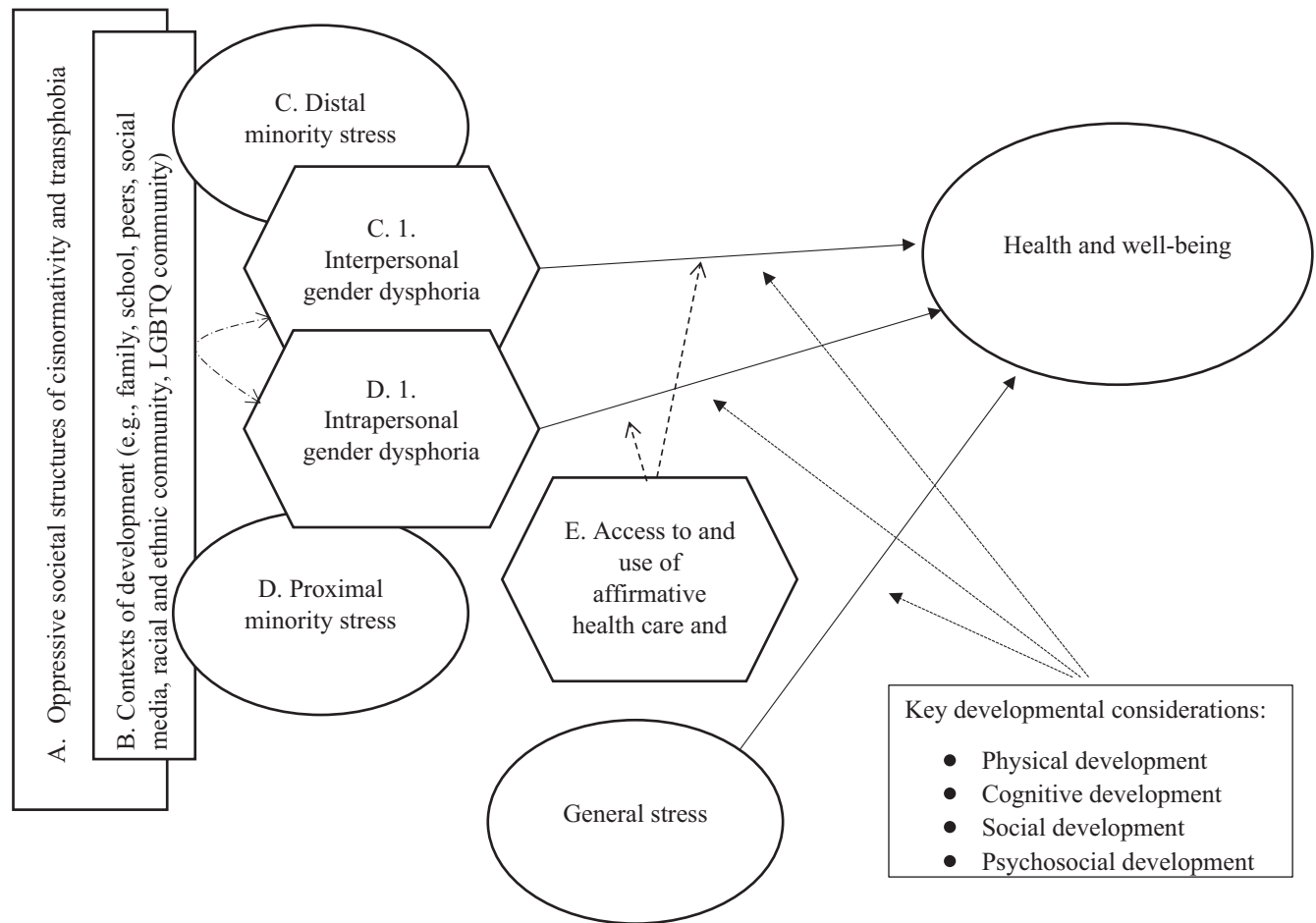


Figure 1. Proposed and adapted developmentally informed model of gender-minority stress among children and adolescents.

However, research does suggest that receiving affirming treatment reduces compromised mental health outcomes among trans youth (for a review, see Weiselberg et al., 2019). Thus, gender dysphoria distress is likely also reduced and is the mechanism to explain reductions in adverse mental health outcomes. New measurement tools offer opportunities to directly examine intrapersonal gender dysphoria distress among adolescents (McGuire et al., 2020), yet measures must be validated to assess this construct among trans children. Given the preponderance of evidence to suggest that intrapersonal gender dysphoria is a central and key construct associated with distress among trans youth, I advocate for including this construct in minority stress models (Figure 1, box D1).

Intrapersonal gender dysphoria is a key stressor that is often neglected in studies that examine health disparities among trans populations (Johnson, Leibowitz, Chavez, & Herbert, 2019). Emerging research suggests that using one's chosen name and pronouns is associated with large reductions in compromised mental health outcomes (e.g., Pollitt, Ioverno, Russell, Li, & Grossman, 2021). Yet trans children and adolescents experience contexts and interpersonal relationships that do not affirm their

gender, including others' refusal to use their chosen name or pronouns, lack of access to bathrooms or other facilities that correspond to their gender identity, and restrictions on appearance (e.g., clothing, hair style; Kosciw, Clark, Truong, & Zongrone, 2020).

When youth are supported in their gender identities, mental health disparities, particularly among trans *children*, decline significantly (Olson, Durwood, DeMeules, & McLaughlin, 2016). Beyond the direct association between distress related to interpersonal gender dysphoria and health outcomes (Figure 1, box C1), interpersonal gender dysphoria is likely reciprocally associated with intrapersonal gender dysphoria. But research has not yet examined these complex relationships. Given the unique nature of gender dysphoria to trans youth (compared to the experiences of sexual-minority youth), interpersonal and intrapersonal experiences of gender dysphoria must be measured empirically and must be included in studies of minority stress and resilience of trans youth, above and beyond other forms of minority stress that have traditionally been included in models (e.g., school-based victimization; Kosciw et al., 2020).

Access to and Use of Affirmative Health Care

Access to and use of affirmative and comprehensive health care are critical for trans youth, yet this context has not been included explicitly in any of the adaptations of the minority stress model. Because of society's cisnormative view that sex = gender, any deviation of one's gender identity or expression that violates cisnormative expectations has resulted historically in a diagnosis of gender identity disorder, which was recently updated in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) to gender dysphoria (Hyde et al., 2019). Thus, trans people—including children and adolescents—have been and continue to be medically and clinically pathologized just because of their asserted gender identities and expressions. Furthermore, health care settings often lack competent and affirmative providers, which creates substantial barriers to receiving affirmative services (Rider et al., 2018).

Pediatricians and other health professionals (e.g., psychologists, social workers) are often the first context in which caregivers seek guidance regarding their young child's gender identity or expression (Weiselberg et al., 2019). To be clear, while physical interventions to affirm trans youth's gender identity and expression do not begin until puberty or near the beginning of adolescence (Hodax, Wagner, Sackett-Taylor, Rafferty, & Forcier, 2020), health professionals often fill a critical role in educating caregivers about gender, and these professionals can also help young children with social transition (e.g., changing name, pronouns, appearance; Weiselberg et al., 2019). Trans youth and their caregivers often need the assistance of competent and affirmative providers to help guide decisions about the use of medical interventions, such as pubertal suppression, an intervention with numerous benefits for trans youth (e.g., Edwards-Leeper & Spack, 2012).

Studies of services that provide access to affirmative legal/social transition (e.g., name changes) and medical transition (e.g., puberty blockers) for trans youth demonstrate that disparities dissipate when these services are used (Johnson et al., 2019; Russell, Pollitt, Li, & Grossman, 2018). Yet affirmative interventions (e.g., pubertal suppression) are typically provided only by practitioners who are already competent and affirmative. Alternatively, other paradigms focus on "watchful waiting" (i.e., wait-and-see ideologies) or discourage transition altogether (for a review, see Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016); indeed, these practices may be viewed as stressors from a minority stress perspective since they often invalidate the identities, desires, and experiences of trans youth. Ultimately, access to and use of affirmative health care and practices for trans youth likely moderate the associations between all forms of distal and proximal minority stress, highlighting this construct as a key mechanism for intervention and prevention (Figure 1, box C1).

Central to affirmative health care access and use is the role of decision making. This developmental skill has just begun to be

included in studies examining the role of affirmative therapies for trans youth ages 14–18 (Clark, Marshall, & Saewyc, 2020). Legal requirements vary across the globe regarding when adolescents can provide their own consent for medical treatment, and youth differ developmentally in their abilities to understand risks, weigh risks and benefits, and consent to treatment protocols. However, emerging research suggests that families must be included in efforts to comprehensively understand access to and use of health care for trans youth (Clark et al., 2020).

The Role of Family

Family relationships are critical for trans children and adolescents. Family members' reactions to learning that a child is trans include behaviors that range from acceptance and support to ambivalence to resistance and rejection (for a review, see Abreu, Rosenkrantz, Ryser-Oatman, Rostovsky, & Riggle, 2019). Emerging research shows that trans children ages 3–12 who are supported in their social transitions by their caregivers (e.g., referred to by their chosen name and pronouns) do not experience health outcomes that are disparate from their cisgender peers (Olson et al., 2016). However, we lack population-level data to understand how common family rejection and acceptance are among trans youth.

Families play a critical role in gatekeeping access to resources and support that are affirmative to trans youth in other contexts (e.g., health care, school), particularly among young children who lack the agency and autonomy to navigate and access this information, support, or care independently. All trans youth must receive the permission and consent of their caregivers for the most basic to the most complicated of gender expression needs (e.g., purchasing clothing that conveys one's authentic gender to the world, changing the sex marker on a birth certificate). Developmentally informed research is needed to understand the reciprocal and dynamic nature of autonomy granting, support seeking, and identity development within families with a trans child, and how developmental opportunities or barriers moderate the associations between minority stressors and well-being (Figure 1, box F).

CONCLUDING THOUGHTS

The number of trans youth who have disclosed their identities and expressions to others at younger ages has increased exponentially over the past decade. Given the heightened attention in society to these children and adolescents, developmental research must move past a homogeneous application of the minority stress framework developed for sexual-minority populations to understand the unique experiences of trans youth. Specifically, research that examines the well-being of trans youth should measure and include the two domains I have presented in this article (i.e., intrapersonal and interpersonal gender dysphoria, and affirmative health care access and use), in addition to more generalized minority stress experiences

(i.e., discrimination, internalized transnegativity), to predict more accurately and ultimately prevent compromised health outcomes. The study of trans youth offers much to the developmental sciences: Most significantly, developmental researchers can learn from studies of trans youth about the importance of affirming children's and adolescents' stated identities and experiences, as well as the need to support their individual autonomy to live authentically and thrive. The model I have presented provides avenues for further exploration and continued advancement toward reducing disparity.

REFERENCES

- Abreu, R. L., Rosenkrantz, D. E., Ryser-Oatman, J. T., Rostovsky, S. S., & Riggle, E. D. (2019). Parental reactions to transgender and gender diverse children: A literature review. *Journal of GLBT Family Studies, 15*, 461–485. <https://doi.org/10.1080/1550428X.2019.1656132>
- American Civil Liberties Union. (2021, February 26). *Legislation affecting LGBT rights across the country*. Retrieved from <https://www.acLU.org/legislation-affecting-lgbt-rights-across-country>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Baril, A., & Trevenen, K. (2014). Exploring ableism and cisnormativity in the conceptualization of identity and sexuality 'disorders'. *Annual Review of Critical Psychology, 11*, 389–416. Retrieved from <https://thediscourseunit.files.wordpress.com/2016/05/22-exploring.pdf>
- Chavanduka, T. M. D., Gamarel, K. E., Todd, K. P., & Stephenson, R. (2020). Responses to the gender minority stress and resilience scales among transgender and nonbinary youth. *Journal of LGBT Youth, 18*, 135–154. <https://doi.org/10.1080/19361653.2020.1719257>
- Clark, B. A., Marshall, S. K., & Saewyc, E. M. (2020). Hormone therapy decision-making processes: Transgender youth and parents. *Journal of Adolescence, 79*, 136–147. <https://doi.org/10.1016/j.adolescence.2019.12.016>
- Connolly, M. D., Zervos, M. J., Barone, II., C. J., Johnson, C. C., & Joseph, C. L. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health, 59*, 489–495. <https://doi.org/10.1016/j.jadohealth.2016.06.012>
- Diamond, L. M. (2020). Gender fluidity and nonbinary gender identities among children and adolescents. *Child Development Perspectives, 14*, 110–115. <https://doi.org/10.1111/cdep.12366>
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity, 3*, 165–172. <https://doi.org/10.1037/sgd0000167>
- Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. *Journal of Homosexuality, 59*, 321–336. <https://doi.org/10.1080/00918369.2012.653302>
- Fassinger, R. E., & Arseneau, J. R. (2007). "I'd rather get wet than be under that umbrella": Differentiating the experiences and identities of lesbian, gay, bisexual, and transgender people. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 19–49). Washington, DC: American Psychological Association. <https://doi.org/10.1037/11482-001>
- Fisher, C. B., Fried, A. L., Desmond, M., Macapagal, K., & Mustanski, B. (2018). Perceived barriers to HIV prevention services for transgender youth. *LGBT Health, 5*, 350–358. <https://doi.org/10.1089/lgbt.2017.0098>
- Galupo, M. P., Henise, S. B., & Mercer, N. L. (2016). "The labels don't work very well": Transgender individuals' conceptualizations of sexual orientation and sexual identity. *International Journal of Transgenderism, 17*, 93–104. <https://doi.org/10.1080/15532739.2016.1189373>
- Galupo, M. P., Pulice-Farrow, L., & Lindley, L. (2020). "Every time I get gendered male, I feel a pain in my chest": Understanding the social context for gender dysphoria. *Stigma and Health, 5*, 199–208. <https://doi.org/10.1037/sah0000189>
- Goldbach, J. T., & Gibbs, J. J. (2017). A developmentally informed adaptation of minority stress for sexual minority adolescents. *Journal of Adolescence, 55*, 36–50. <https://doi.org/10.1016/j.adolescence.2016.12.007>
- Hatzenbuehler, M. L., Shen, Y., Vandewater, E. A., & Russell, S. T. (2019). Proposition 8 and homophobic bullying in California. *Pediatrics, 143*, e20182116. <https://doi.org/10.1542/peds.2018-2116>
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*, 460–467. <https://doi.org/10.1037/a0029597>
- Hodax, J. K., Wagner, J., Sackett-Taylor, A. C., Rafferty, J., & Forcier, M. (2020). Medical options for care of gender diverse and transgender youth. *Journal of Pediatric and Adolescent Gynecology, 33*, 3–9. <https://doi.org/10.1016/j.jpjag.2019.05.010>
- Hughes, M., Blakely, S., & Nikolavsky, D. (2021). The current state of transgender care. In D. Nikolavsky & S. A. Blakely (Eds.), *Urological care for the transgender patient* (pp. 3–6). Cham, Switzerland: Springer. https://doi.org/10.1007/978-3-030-18533-6_1
- Hyde, J. S., Bigler, R. S., Joel, D., Tate, C. C., & van Anders, S. M. (2019). The future of sex and gender in psychology: Five challenges to the gender binary. *American Psychologist, 74*, 171–193. <https://doi.org/10.1037/amp0000307>
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13128>
- Johnson, B., Leibowitz, S., Chavez, A., & Herbert, S. E. (2019). Risk versus resiliency: Addressing depression in lesbian, gay, bisexual, and transgender youth. *Child and Adolescent Psychiatric Clinics, 28*, 509–521. <https://doi.org/10.1016/j.chc.2019.02.016>
- Jones, B. A., Bouman, W. P., Haycraft, E., & Arcelus, J. (2019). The Gender Congruence and Life Satisfaction Scale (GCLS): Development and validation of a scale to measure outcomes from transgender health services. *International Journal of Transgenderism, 20*, 63–80. <https://doi.org/10.1080/15532739.2018.1453425>
- Kosciw, J. G., Clark, C. M., Truong, N. L., & Zongrone, A. D. (2020). *The 2019 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools*. New York, NY: GLSEN. Retrieved from <https://www.glsen.org/sites/default/files/2020-11/NSCS19-111820.pdf>
- Martos, A. J., Nezhad, S., & Meyer, I. H. (2015). Variations in sexual identity milestones among lesbians, gay men, and bisexuals.

- Sexuality Research and Social Policy*, 12, 24–33. <https://doi.org/10.1007/s13178-014-0167-4>
- McGuire, J. K., Berg, D., Catalpa, J. M., Morrow, Q. J., Fish, J. N., Nic Rider, G., . . . Spencer, K. (2020). Utrecht Gender Dysphoria Scale—Gender Spectrum (UGDS-GS): Construct validity among transgender, nonbinary, and LGBQ samples. *International Journal of Transgender Health*, 21, 194–208. <https://doi.org/10.1080/26895269.2020.1723460>
- McGuire, J. K., Kivalanka, K. A., Catalpa, J. M., & Toomey, R. B. (2016). Transfamily theory: How the presence of trans* family members informs gender development in families. *Journal of Family Theory & Review*, 8, 60–73. <https://doi.org/10.1111/jftr.12125>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674–697. <https://doi.org/10.1037/0033-2909.129.5.674>
- National Academies of Sciences, Engineering, and Medicine. (2020). *Understanding the well-being of LGBTQI+ populations*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25877>
- Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137, e20153223. <https://doi.org/10.1542/peds.2015-3223>
- Olson, K. R., & Gülgöz, S. (2018). Early findings from the TransYouth Project: Gender development in transgender children. *Child Development Perspectives*, 12, 93–97. <https://doi.org/10.1111/cdep.12268>
- Olson, K. R., Key, A. C., & Eaton, N. R. (2015). Gender cognition in transgender children. *Psychological Science*, 26, 467–474. <https://doi.org/10.1177/0956797614568156>
- Pollitt, A. M., Ioverno, S., Russell, S. T., Li, G., & Grossman, A. H. (2021). Predictors and mental health benefits of chosen name use among transgender youth. *Youth & Society*, 53, 320–341. <https://doi.org/10.1177/0044118X19855898>
- Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics*, 141, e20171683. <https://doi.org/10.1542/peds.2017-1683>
- Ross-Reed, D. E., Reno, J., Peñaloza, L., Green, D., & FitzGerald, C. (2019). Family, school, and peer support are associated with rates of violence victimization and self-harm among gender minority and cisgender youth. *Journal of Adolescent Health*, 65, 776–783. <https://doi.org/10.1016/j.jadohealth.2019.07.013>
- Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *Journal of Adolescent Health*, 63, 503–505. <https://doi.org/10.1016/j.jadohealth.2018.02.003>
- Toomey, R. B., Syvertsen, A. K., & Shramko, M. (2018). Transgender adolescent suicide behavior. *Pediatrics*, 142, e20174218. <https://doi.org/10.1542/peds.2017-4218>
- Veale, J. F., Watson, R. J., Peter, T., & Saewyc, E. M. (2017). Mental health disparities among Canadian transgender youth. *Journal of Adolescent Health*, 60, 44–49. <https://doi.org/10.1016/j.jadohealth.2016.09.014>
- Walch, A., Davidge-Pitts, C., Safer, J. D., Lopez, X., Tangpricha, V., & Iwamoto, S. J. (2021). Proper care of transgender and gender diverse persons in the setting of proposed discrimination: A policy perspective. *The Journal of Clinical Endocrinology & Metabolism*, 106, 305–308. <https://doi.org/10.1210/clinem/dgaa816>
- Weiselberg, E. C., Shadianloo, S., & Fisher, M. (2019). Overview of care for transgender children and youth. *Current Problems in Pediatric and Adolescent Health Care*, 49, 100682. <https://doi.org/10.1016/j.cppeds.2019.100682>
- Yong, E. (2019, January 19). Young trans children know who they are. *The Atlantic*. Retrieved from <https://www.theatlantic.com/science/archive/2019/01/young-trans-children-know-who-they-are/580366/>