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Gender Expansive Youth Disclosure and Mental Health: Clinical Implications of Gender Identity Disclosure

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Some health care providers work with gender expansive youth; preliminary evidence notes that many of these youth do not disclose their gender identity to all of their health care providers. No previous research focused on youth has explored gender identity disclosure to health care providers, nor linked youth disclosure to negative mental health outcomes (e.g., symptoms of depression). Data were drawn from the LGBTQ National Teen Survey to test the relationship between gender identity disclosure, symptoms of depression, and self-esteem among 13- to 17-year old ($n = 5,637$, $M_{\text{age}} = 15.6$) participants who identified as transgender boys, transgender girls, and nonbinary youth assigned female at birth (AFAB) or assigned male nonbinary youth assigned male at birth (AMAB). Transgender boys reported the highest symptoms of depression and the lowest levels of self-esteem in comparison with other groups. Among the full sample, 66.8% had not disclosed their gender identity health care providers—nonbinary AMAB youth were least likely to disclose (77.6%). Symptoms of depression were the highest and self-esteem was the lowest for transgender boys with mixed levels of disclosure. Transgender girls reported the lowest symptoms of depression—these youth had also disclosed their identities the most. Findings suggest that mixed disclosure to health care providers is problematic for gender expansive youth, especially transgender boys. Findings suggest a need to better prepare health professionals to understand not all gender expansive youth may feel comfortable disclosing their gender identities in medical contexts. Future research should explore gender affirmative health care as a protective factor for negative mental health outcomes.

Public Significance Statement

In our study, most transgender and nonbinary youth had not disclosed their gender identity to health care providers. Mixed levels of disclosure to health care providers was associated with higher depressive symptoms and lower self-esteem. These findings inform clinicians and policymakers of the need to improve gender-based clinical practices for transgender and nonbinary youth.

Keywords: gender identity, health care, nonbinary, transgender

Gender expansive (e.g., transgender, nonbinary) youth are consistently faced with the decision of whether or not to disclose their gender identity to people within their lives (Savin-Williams &

Dubé, 1998). As it relates to their health care, gender expansive youth must decide whether sharing their gender identity with their provider (e.g., pediatricians, therapists, social workers, psychologists) will provide them with gender identity-related support (e.g., potentially obtaining hormones or gender affirmation surgery). Consequently, these decisions to disclose or not to disclose may be linked to gender expansive mental health outcomes. A dearth of scholarship has explored gender expansive youth mental health (e.g., symptoms of depression) in terms of gender identity disclosure to health care providers. There is, however, limited literature that examines mental health outcomes as they exist among gender expansive subgroups (for an exception see Pflum, Testa, Balsam, Goldblum, & Bongar, 2015).

Gender Minority Stress

Scholarship focused on gender identity and mental health is oftentimes situated within the context of minority stress. The minority stress model (Meyer, 2003) was developed to focus on the potential negative life outcomes and adverse experiences that are associated with cisgender sexual minority individuals. Minority stress is explained as chronic stress associated with stigmati-

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zation, discrimination, and sociocultural pressures (Meyer, 2003) experienced by sexual minority and gender expansive people. Another model that explains the health of gender minorities, in particular, is the gender minority stress and resilience (GMSR) model (Hendricks & Testa, 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015). This model draws from Meyer's minority stress model (Meyer, 1995, 2003) and explores the ways in which external (i.e., distal) and internal (i.e., proximal) stressors related to gender expansive identity can impact the mental health and well-being of gender expansive people (Hendricks & Testa, 2012; Testa et al., 2017). Specifically, the GMSR model proposes that chronic stress can result from external processes such as gender minority-based victimization, rejection, discrimination, and identity nonaffirmation (Hendricks & Testa, 2012; Testa et al., 2015). Gender minority-based victimization involves any act (e.g., verbal, physical) committed against a gender minority individual due to their gender identity or expression. Gender minority-based rejection involves any form of rejection due to the gender identity of an individual. Gender minority-based discrimination involves the hardships of obtaining social services, employment, medical care, or legal representation attributable to a person's gender identity. Last, gender identity nonaffirmation describes the refusal of individuals or society to acknowledge an individual's true gender identity. Hendricks and Testa (2012) convey that these external (i.e., distal) experiences can contribute to internal (i.e., proximal) stress-induced experiences such as negative expectations, internalized transphobia, and nondisclosure of gender identity. Several studies have conveyed that internalized transphobia can be associated with poor coping skills (Mizock & Mueser, 2014) and may compound mental health issues (Breslow et al., 2015). Last, gender identity nondisclosure is the behavior of concealing one's true gender identity as a means of protection from discrimination and harassment (Hendricks & Testa, 2012; Testa et al., 2015, 2017).

Minority stress manifests as discrimination and victimization for many gender expansive youth. Relative to their cisgender peers, gender expansive youth report more discrimination, stigmatization, and victimization (i.e., bullying; Boza & Nicholson Perry, 2014; Goldblum et al., 2012), and are at a two- to threefold greater risk for symptoms of depression (Reisner et al., 2015), anxiety (Reisner et al., 2015), and suicidal ideation (Reisner et al., 2015; Testa et al., 2017). Given these findings, it seems that gender affirmative health care providers could have significant influence on the mental health outcomes among gender expansive youth (i.e., depression, self-esteem).

Gender Identity Disclosure

Gender expansive youth are now disclosing their gender identities more frequently and at younger ages, in part because of the accessibility and importance of social media in everyday life (Bethea & McCollum, 2013; Maguen, Shipherd, Harris, & Welch, 2007). Disclosing to health care providers is not always possible for gender expansive youth, and in some situations may put a youth in danger or at higher risk for rejection. After all, previous research finds that the decision not to disclose gender identity can create stressful experiences (Galupo, Krum, Hagen, Gonzalez, & Bauerband, 2014; Pachankis, Cochran, & Mays, 2015) such as: Anxiety about others learning of one's identity before one is ready to share, decisions concerning whom to disclose, and feeling

separated from one's true identity (Pachankis, 2007). Previous research has also suggested that situations in which gender expansive identity disclosure is received with positivity and support is associated with greater self-acceptance (Pachankis, 2007), self-confidence (Riggle, Rostosky, McCants, & Pascale-Hague, 2011), and better mental health outcomes (Strain & Shuff, 2011). These distinctions, however, do not ignore the fact that "coming out is a socially complex process that is mitigated by too many contextual factors to be understood linearly or moralistically" (Klein, Holtby, Cook, & Travers, 2015, p. 324).

Gender expansive individuals experience a combination of negative and positive feelings during the process of identity disclosure (Bethea & McCollum, 2013) which ultimately may lead to nondisclosure—including feeling obligated to disclose and being bothered by the unpredictability of the disclosure process. In positive experiences, individuals have reported a feeling of freedom after their gender identity disclosure. In one study, gender expansive individuals reported experiencing internal and/or external stressors when they felt an obligation to disclose their gender identity to their family and friends (Bethea & McCollum, 2013). Among these gender expansive individuals, one main reason for avoiding disclosure was due to the anticipation of social rejection. Gender expansive individuals reported that despite their preparedness to disclose, they were uncertain about the way in which the recipient would react (Bethea & McCollum, 2013).

Scholarship finds that of the gender expansive individuals who seek treatment for health care and mental health-related issues, not all choose not to disclose their gender identity to health care providers, in part because of the anticipation of transphobic rejection (Rossman, Salamanca, & Macapagal, 2017). Other youth do not disclose because of the dangers associated with nonsupportive social networks (Mills-Koonce, Rehder, & McCurdy, 2018; Pflum et al., 2015); thus, disclosure simply may not be an option for some youth. Some studies have found that gender expansive individuals experience gender identity-based discrimination by health care providers (Buxton, 2006; Glynn & van den Berg, 2017; Hines, 2006; Lev, 2004; Wren, 2002), which may explain why some of these gender expansive youth continue to conceal their identities.

Disclosure to Health Care Providers

Previous studies note several themes with regard to negative experiences of gender identity disclosures to health care providers. Specifically, 21% of gender expansive patients described experiencing some form of discrimination that included microaggressions (Lambda Legal, 2010) or the outright refusal of treatment (Lambda Legal, 2010; Poteat, German, & Kerrigan, 2013; Rossman et al., 2017). In their study that explored gender expansive patient's reasons for nondisclosure to health care providers, Rossman and colleagues (2017) identified three main themes: Health care providers' factors in nondisclosure, patients' resistance to disclosure, and patients' beliefs regarding the connection between their gender identity and their health care needs (Rossman et al., 2017). Some gender expansive individuals have described the process of disclosure to a health care provider as a difficult experience (Rossman et al., 2017). If gender expansive youth are seeking puberty-blocking medication or hormones but doctors are not practicing gender affirmative care, then diagnostic miscommunication or misdiagnosis may result.

The Current Study

We sought to explore gender identity disclosure to health care providers as a means to understand whether there are connections between (non-)disclosure and symptoms of depression and self-esteem among gender expansive subgroups. No previous scholarship has examined the potential associations between disclosure to health care providers and negative mental health outcomes. The present study addresses three questions to build upon current gender expansive literature: (a) Do symptoms of depression and self-esteem differ by gender identity?; (b) Does gender identity disclosure to health care providers differ by gender expansive identity?; and (c) Do symptoms of depression and self-esteem differ by gender identity disclosure to health care providers?

Method

Study Design and Participant Recruitment

We utilized data from the LGBTQ National Teen Survey, which was specifically designed to advance the understanding of victimization, health behaviors, and family relationships of LGBTQ adolescents. Data were collected in partnership with the Human Rights Campaign (HRC) between April and December 2017. All respondents were English-speaking, identified as LGBTQ, 13–17 years of age, and resided in the United States at the time of the survey.

LGBTQ adolescents were invited to participate in an anonymous, online, self-report survey hosted by the survey website Qualtrics.com. The online survey platform prevented bots from taking the survey, and the authors employed multiple data cleaning measures such as the identification and deletion of mischievous responders (see Watson, Wheldon, & Puhl, 2019 for an overview of the survey process). Participants were recruited through social media, along with HRC's wide-reaching network of community partners. Specifically, the HRC posted Facebook messages and Twitter messages with a short message and link to the Qualtrics survey. Some advertisements also included photos of diverse young teens. HRC partner organizations (e.g., Youth Link, Trevor Project, Advocates for Youth) helped disseminate the survey link to their networks via e-mail or direct communication. For their participation, respondents were given the option to enter a drawing for one of 10 Amazon.com gift cards, and all participants were offered HRC wristbands. All study procedures were approved by the University of Connecticut Institutional Review Board protocol #16–809.

Sample

This project utilized data from a larger sample of 17,112 ($M = 15.57$, $SD = 1.27$) sexual and/or gender minority 13- to 17-year-old youth across the United States who completed the LGBTQ National Teen Survey. Overall, 5,637 (33%) teens indicated they were transgender. Additionally, 2,396 (14%) of the sample chose *nonbinary* as their gender identity. To categorize gender minority youth, we used a combination of the sex assigned at birth and current gender identity information (see Measures below). Only participants with valid responses on survey questions were included within our analysis ($n = 3624$).

Respondents represented diverse subgroups of LGBTQ adolescents from all 50 states across the United States. The ethnic/racial composition of our sample of 3,624 Gender expansive youth was 68% White ($n = 2461$), 3.1% Black ($n = 111$), 0.6% Native American ($n = 22$), 2.9% Asian American ($n = 106$), 8.1% Hispanic/Latino ($n = 294$), 15.5% bi/multiracial ($n = 560$), and 1.9% of participants ($n = 67$) indicated another race that was not listed.

Measures

The online survey created for this study assessed the following topics: sex, gender identity, gender identity disclosure (e.g., being “out” to various contexts), symptoms of depression, and levels of self-esteem.

Sex assigned at birth. Participants were asked, “What sex were you assigned at birth?” Response options were *male* and *female*.

Gender identity. Given the growing consideration for multiple gender identities (Carroll, Gilroy, & Ryan, 2002; Eyler, 2007; Hendricks & Testa, 2012; Saeed, Mughal, & Farooq, 2018) we asked participants to choose among several different gender identity options. Thus, participants were asked, “What is your current gender identity?”. Response options included *boy*, *girl*, *trans boy*, *trans girl*, *nonbinary*, *genderqueer/gender nonconforming*, and *different identity*, with a write-in response. For the purposes of this study, participants whose sex assigned at birth and gender identities were coincident were coded as cisgender. Youth who wrote in responses to this item were back-coded when appropriate (e.g., if a youth wrote in *trans* or *transgender* they were categorized with their respective gender identity category). Youth who reported a binary gender identity that was different from their sex assigned at birth were coded as transgender. Participants who identified a nonbinary gender identity were coded in respect to their sex assigned at birth: nonbinary assigned male at birth (AMAB) and nonbinary assigned female at birth (AFAB).

Degree of disclosure (outness). Studies indicate greater vulnerability for victimization when gender expansive youth are out (D’Augelli, Grossman, & Starks, 2008; Russell, Toomey, Ryan, & Diaz, 2014); therefore, identity disclosure to health care providers were assessed by a scale adapted from the Outness Inventory Scale (OIS; Mohr & Fassinger, 2000). Questions asked, “For each of the following groups, how many people currently do you think know of your transgender or non-binary identity?” Respondents were able to report the degree of outness to health care providers, which included: *none* (0), *a few* (1), *some* (2), *most* (3), and *all* (4). In addition, respondents could choose an option that indicated *Does not apply to me*. A total of 396 participants chose this option. The OIS has demonstrated good internal consistency and was positively correlated with identification among LGBT communities (Mohr & Fassinger, 2000). Though the original scale included 12 contexts of disclosure (i.e., family members/parents, siblings, grandparents and extended family, LGBTQ friends, non-LGBTQ friends, classmates, coworkers, teachers and adults at school, athletic coaches, religious community, new acquaintances, and doctors/other health care providers), this project included three contexts in particular: family members/parents, LGBTQ friends, and doctors and other health care providers.

Depression. The measure for symptoms of depression was adapted from Kutcher's Adolescent Depression Scale. The 10-items used to measure symptoms of depression include regularity of "Low mood, sadness, feeling down," "Irritability," "Sleep difficulties," "Decreased interest in activities," "Feelings of worthlessness," "Feeling tired or having low energy," "Difficulty concentrating," "Loss of interest in previously enjoyed activities," "Feeling worried," as well as "Physical symptoms of worry" (i.e., headaches, nausea, restlessness). The rating scale included the time-frame (0) *hardly ever*, (1) *much of the time*, (2) *most of the time*, and (3) *all of the time*. The reported scores will represent the mean symptoms of depression. In the current sample, the coefficient alpha was .90.

Self-esteem. The measure for self-esteem was modified from the Rosenberg Self-Esteem Scale (Rosenberg, 1989). This modified 10-item scale asked participants to rate their agreement with statements such as "I feel that I am a person of worth, at least on an equal plane as others," "All in all, I am inclined to feel that I am a failure," "I am able to do things as well as most other people," and "I take a positive attitude towards myself." Respondents rated their agreement with positive or negative statements using a 4-point Likert scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *agree*, 4 = *strongly agree*). Higher scores reflected higher levels of self-esteem. The mean reported self-esteem scores give an estimate level of self-esteem. In the current sample, the Cronbach's alpha was .91.

Plan of Analysis

Analyses were conducted in SPSS v25. Data were analyzed for missing values and outliers—in this paper we used data from

participants who were not missing on all study variables. Across all variables, missingness ranged from 6.1% to 12.8%. Nearly all (92%) youth without full responses to every survey item had terminated the survey early; most of these early terminations only filled out the demographic portion of the survey. Our final sample ($N = 7050$) of LGBTQ and of gender expansive ($N = 3624$) youth is representative of those youth who provided valid responses on all study variables. We first used ANOVAs to distinguish whether or not cisgender youth differed from gender expansive youth in levels depression and self-esteem. We then used MANCOVAs, adjusted for age and two contexts of disclosure (i.e., out to family members/parents, out to LGBTQ friends), to model the association between disclosure to health care providers and depression/self-esteem.

Results

The sample demographics are reported in Table 1. On average, youth were 15.57 ($SD = 1.27$) years old. Nine hundred three (24.9%) youth were transgender boys, 122 (3.4%) transgender girls, 237 (6.5%) nonbinary AMAB, and 2,362 (65.2%) nonbinary AFAB youth. Additionally, 22.0% ($n = 2,335$) youth identified as cisgender males and 44.5% ($n = 4,715$) as cisgender girls. Table 1 displays the samples' demographic information by gender identity.

Our first research question involved determining whether there were differences in mental health outcomes (i.e., symptoms of depression and self-esteem) between cisgender and gender expansive youth. We found a difference in symptoms of depression, $F(1, 10,121) = 742.93, p = .001, \mu^2 = .068$, and self-esteem, $F(1, 10,121) = 808.83, p < .001, \mu^2 = .074$, when comparing cisgen-

Table 1
Sample Demographic Characteristics by Gender Identity

Characteristic	Full sample		Cisgender boy		Cisgender girl		Transgender boy		Transgender girl		Nonbinary AFAB		Nonbinary AMAB	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Sexual orientation														
Heterosexual	279	1.6	0	0.0	0	.0	157	10.5	31	16.8	74	2.1	17	3.6
Gay/Lesbian	6401	37.4	2875	70.5	2254	30.5	248	17.9	33	17.8	772	21.6	219	46.1
Bisexual	5970	34.9	1018	25	3569	48.3	388	27.6	56	30.3	836	23.4	103	21.7
Pansexual	2256	13.2	82	2.0	761	10.3	341	24.9	37	20.0	968	27.1	67	14.1
Queer	699	4.1	27	0.7	210	2.8	84	6.5	8	4.3	345	9.7	25	5.3
Asexual	725	4.2	28	0.7	278	3.8	80	5.6	8	4.3	315	8.8	16	3.4
Questioning	424	2.5	29	0.7	205	2.8	60	3.8	7	3.8	110	3.1	13	2.7
Other	358	2.1	20	0.5	119	1.6	46	3.1	5	2.7	153	4.3	15	3.2
Race/ethnicity														
White	10225	61.9	2279	58.2	4376	61.4	932	68.1	120	66.7	2254	64.7	264	58.8
Black	952	5.8	273	7.0	473	6.6	47	3.4	9	5.0	124	3.6	26	5.8
Hispanic/Latino	1877	11.4	556	14.2	828	11.6	115	8.4	13	7.2	316	9.1	49	10.9
Asian	677	4.1	182	4.6	324	4.5	36	2.6	8	4.4	110	3.2	17	3.8
Native American	95	0.6	24	0.6	29	0.4	13	1.0	1	0.6	21	0.6	7	1.6
Multiracial	2360	14.3	519	13.3	958	13.4	192	14.0	27	15.0	589	16.9	75	16.7
Other	342	2.1	83	2.1	144	2.0	33	2.4	2	1.1	69	2.0	11	2.4
Age														
13	1284	7.5	146	3.6	596	8.1	133	9.5	14	7.6	370	10.4	25	5.3
14	2542	14.9	394	9.7	1210	16.4	219	15.5	24	13.0	634	17.7	61	12.8
15	3594	21.0	841	20.6	1540	20.8	321	22.9	41	22.2	766	21.4	85	17.9
16	4481	26.2	1213	29.7	1885	25.5	350	24.9	51	27.6	853	23.9	129	27.2
17	5211	30.5	1485	36.4	2165	29.3	381	27.1	55	29.7	950	26.6	175	36.8

Note. AMAB = assigned male at birth; AFAB = assigned female at birth.

der youth to gender expansive youth. Tukey post hoc analyses indicated that symptoms of depression among gender expansive youth ($M = 16.003$, $SD = 7.30$) were higher ($p < .05$) compared to cisgender youth ($M = 11.91$, $SD = 7.25$). Similarly, the mean score for level of self-esteem among gender expansive youth ($M = 22.63$, $SD = 9.07$) was different, and consequently much lower ($p < .05$), than levels of self-esteem among cisgender youth ($M = 28.33$, $SD = 9.95$).

Next, we tested whether these differences held across groups of gender expansive youth. Within-group differences were found when comparing gender expansive symptoms of depression, $F(3, 3142) = 15.10$, $p < .001$, $\mu^2 = .014$, and self-esteem, $F(3, 3142) = 16.28$, $p < .001$, $\mu^2 = .015$. Specifically, Tukey post hoc analyses indicated that symptoms of depression among transgender boys were higher ($M = 16.97$, $SD = 7.51$, $p < .05$) compared with all other gender expansive subgroups (see Table 2). Additionally, there were differences in depressive symptoms between nonbinary AFAB youth ($M = 16.06$, $SD = 7.09$) and all other subgroups ($p < .05$), as well as between nonbinary AMAB youth ($M = 13.43$, $SD = 7.37$) and transgender boys ($M = 16.97$, $SD = 7.51$) and nonbinary AFAB youth ($M = 16.06$, $SD = 7.10$) at the $p < .001$ level.

Transgender boys reported lower levels of self-esteem ($M = 21.73$, $SD = 9.21$), compared with transgender girls ($M = 25.24$, $SD = 10.28$, $p < .05$) and nonbinary AMAB youth ($M = 26.31$, $SD = 9.70$, $p < .001$). Nonbinary AFAB youth ($M = 22.45$, $SD = 8.77$) also reported lower self-esteem than transgender girls ($M = 25.24$, $SD = 10.28$, $p < .05$) and nonbinary AMAB youth ($M = 26.31$, $SD = 9.70$, $p < .001$).

Our second research question asked whether disclosure of gender identity to health professionals differed between subgroups of gender expansive youth. Table 3 presents these findings. We found that disclosure to health care providers significantly differed by gender identity, $F(3, 3142) = 44.50$, $p < .001$, $\mu^2 = .041$. Tukey Post hoc comparisons indicated that transgender girls ($M = 1.35$,

$SD = 1.61$) disclosed their gender expansive identity to health care professionals more often than nonbinary AMAB ($M = .44$, $SD = .65$) and AFAB ($M = .65$, $SD = 1.23$) youth, while only disclosing marginally more than transgender boys ($M = 1.22$, $SD = 1.52$). Specifically, transgender girls disclosed most, and nonbinary AMAB youth disclosed their gender identities least to health care providers.

Our third research goal was to examine the correlation between gender identity disclosure to health care providers and mental health symptoms (depression, self-esteem) among gender expansive youth. These results are presented in Figure 1. There was a significant difference between disclosure and depressive symptoms as determined by a MANCOVA (adjusted for age, disclosure to family members/parents, and LGBTQ friends), $F(4, 3142) = 2.87$, $p < .05$, $\mu^2 = .004$. Similarly, differences in self-esteem and disclosure were also significant, $F(4, 3142) = 6.07$, $p < .001$, $\mu^2 = .008$. Tukey post hoc tests revealed that gender expansive symptoms of depression were statistically higher ($p < .05$) for disclosure to “A few” health care providers ($M = 16.71$, $SD = 7.01$) when compared with disclosure to “All” health care providers ($M = 15.13$, $SD = 7.68$). Symptoms of depression were highest among gender expansive youth who disclosed to “Some” health care providers ($M = 16.94$, $SD = 7.66$), and symptoms of depression were significantly lowest for youth who had disclosed to “All” or “Most” of their health care providers ($M = 15.13$, $SD = 7.68$; $M = 15.48$, $SD = 7.68$, respectively) when compared with “Some.” Results were similar for self-esteem and disclosure: Tukey post hoc analyses indicated self-esteem was statistically significantly higher ($p < .01$) for disclosure to “All” health care providers ($M = 24.29$, $SD = 10.28$) compared with disclosure to “None” ($M = 22.35$, $SD = 8.81$) and “A few” ($M = 21.78$, $SD = 8.77$).

Discussion

Gender expansive adolescents represent a unique and distinctly heterogeneous population of youth within the United States who are not well understood by health care providers or the scientific community. Our scholarship continues to bridge the gap between research and clinical practice for gender expansive youth. Before exploring within-group differences among gender expansive youth, we compared symptoms of depression and levels of self-esteem between gender expansive and cisgender youth. We found that gender expansive youth faced differences in mental health across measures of symptoms of depression and self-esteem when compared to cisgender youth. These findings are supported by previous research that also conveys the existence of greater mental health disparities between gender expansive and cisgender youth (Benotsch et al., 2013; Cochran & Cauce, 2006; Day, Fish, Perez-Brumer, Hatzenbuehler, & Russell, 2017; Hughes & Eliason, 2002; Lombardi, 2011; Nemoto, Operario, Keatley, Han, & Soma, 2004; Nuttbrock et al., 2014; Peacock, Andrinopoulos, & Hembly, 2015; Reisner et al., 2015; Reisner & Murchison, 2016; Santos et al., 2014; Wolf & Dew, 2012). These findings enhance our growing knowledge of negative mental health outcomes faced by gender expansive youth by utilizing large-scale population comparisons. The significant risks highlighted in these findings underscore the need for further attention to gender affirmative health care protocols for doctors, nurses, and therapists alike.

Table 2
Mean Levels of Symptoms of Depression and Self-Esteem by Gender Identity

Outcome gender subgroup	N	M	SD
Depression			
Cisgender boy	2133	10.07*	6.92
Cisgender girl	4470	12.76*	7.23
Transgender boy	885	16.97*	7.51
Transgender girl	118	13.58*	7.85
Nonbinary AFAB	2350	16.06*	7.10
Nonbinary AMAB	243	13.43*	7.37
Total	10199	13.35	7.53
Self-esteem			
Cisgender boy	2133	30.89*	10.35
Cisgender girl	4470	27.10*	9.48
Transgender boy	885	21.73*	9.48
Transgender girl	118	25.24*	10.28
Nonbinary AFAB	2350	22.45*	8.77
Nonbinary AMAB	243	26.31*	9.70
Total	10199	26.32	10.01

Note. AMAB = assigned male at birth; AFAB = assigned female at birth.

* Significant at the .05 level.

Table 3
Sample Disclosure Level by Gender Identity

Gender identity	Disclosure to healthcare providers												
	None		A few		Some		Most		All		Total		
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	<i>M</i>	<i>SD</i>
Transgender boy	463	51.3 _a	137	15.2 _{ab}	65	7.2 _a	105	11.6 _{abc}	133	14.7 _{ab}	903	1.23	1.52
Transgender girl	65	53.3 _b	14	11.5 _b	7	5.7	14	11.5 _c	22	18.0 _b	122	1.30	1.61
Nonbinary AFAB	1709	72.4 _{ab}	266	11.3 _a	95	4.0 _a	124	5.2 _{ab}	168	7.1 _a	2362	.56	1.19
Nonbinary AMAB	184	77.6 _{ab}	15	6.3 _a	12	5.1	10	4.2 _a	16	6.8 _a	237	.64	1.22
Total	2421	66.8	432	11.9	179	4.9	253	7.0	339	9.4	3624	.80	1.34

Note. Each subscript letter (_{a,b,c}) denotes where column (e.g., none) proportions significantly differ from each other at the $p < .05$ level. AMAB = assigned male at birth; AFAB = assigned female at birth.

Within-group differences of symptoms of depression and levels of self-esteem were also meaningful when comparing these measures among gender identity subgroups. Specifically, transgender boys reported the highest symptoms of depression and the lowest levels of self-esteem, and transgender girls reported the lowest symptoms of depression when compared with all other gender expansive subgroups. These findings are consistent with previous studies that identified transgender boys as exhibiting more negative mental health outcomes among gender expansive youth (Veale, Watson, Peter, & Saewyc, 2017).

Our review of gender identity disclosure to health care providers among gender expansive youth also indicated subgroup and age-related trends. Among our sample, two thirds of gender expansive youth had not disclosed their gender identity to health care providers, and less than one-tenth had disclosed to all of their health care providers. Nondisclosure to health care providers was highest among nonbinary AMAB youth, with nonbinary AFAB youth close behind. Transgender boys reported highest levels of mixed gender identity disclosure (out to some, but not all) to health care providers when compared to gender expansive subgroups, and transgender girls had the highest levels of overall disclosure to health care providers.

Nondisclosure among nonbinary youth has been identified as problematic (Veale et al., 2017). Considering the GMSR model (Hendricks & Testa, 2012; Testa et al., 2015), higher levels of foregoing gender identity disclosure to health care providers and

notably worse mental health outcomes among nonbinary youth may be attributable to the compounded stress and stigma of not conforming to traditional (Western) binary gender role categories (Skidmore, Linsenmeier, & Bailey, 2006; Veale et al., 2017). This is not to say that some gender expansive youth do not benefit from concealing their gender identity within their social environments. For some youth, their safety may be compromised after disclosing their identity. For these youth, to conceal is to remain safe.

Age-Related Comparisons: Gender Identity Disclosure

When we separated disclosure to health care providers by age, we found that younger adolescents (13- and 14-year olds) had disclosed their gender identities to fewer health care providers than their older gender expansive peers. These findings may indicate that an increased level of maturity, confidence, and/or positive life experiences relative to gender expansive age are necessary for increased disclosure to health care providers. Our findings suggest that older gender expansive youth disclosed more to health care providers than their younger-aged peers. One caveat within these findings was among transgender girls' disclosure to health care providers compared to other gender expansive subgroups. Transgender girls exhibit the highest levels of disclosure to health care providers, and they are the only subgroup to display decreasing rates of full disclosure when disclosure is isolated by age. This suggests that transgender girls are disclosing less to health care

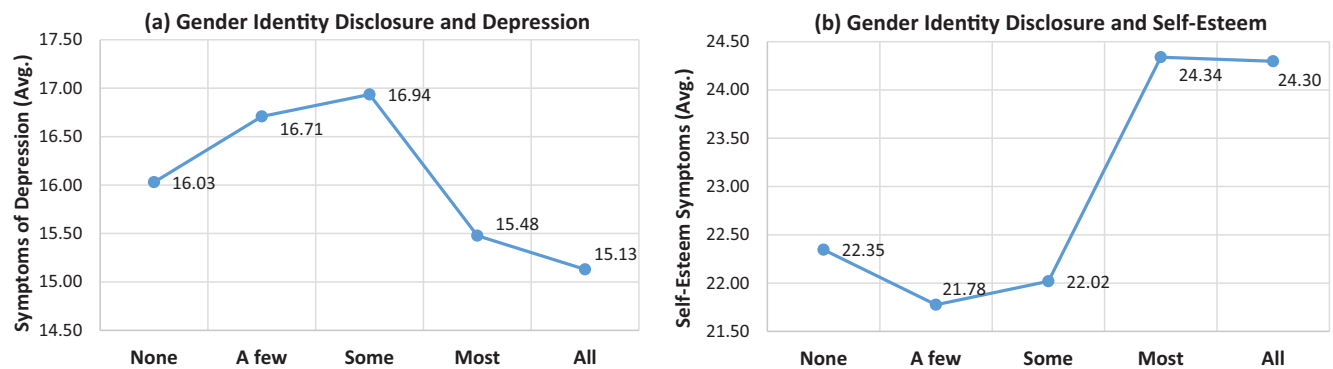


Figure 1. Associations between gender identity disclosure to health care professionals and symptoms of depression (a) and self-esteem (b) among gender expansive youth. See the online article for the color version of this figure.

providers as they get older. This evidence is supported by previous research that suggests that transgender youth, particularly transgender girls, experience increased anxiety and distress as they age (Edwards-Leeper, Feldman, Lash, Shumer, & Tishelman, 2017), and thus may become less apt to disclose their gender identity. Further research is needed to explore the possibility of increased negative life experiences among transgender girls as they get older.

As we examined gender identity disclosure to health care providers and symptoms of depression among gender expansive youth, we found that symptoms of depression were highest for mixed disclosure (out to some, but not all), whereas symptoms of depression were lowest for disclosure to all health care providers. This suggests a negative relationship between disclosure and symptoms of depression. Similarly, self-esteem was highest for gender expansive youth who disclosed to all, and was lowest for those who had only disclosed their gender identity to a mixed number of health care providers. Thus, gender identity disclosure and levels of self-esteem exhibited a positive relationship.

These findings are noteworthy on two fronts: First, while gender identity disclosure among sexual and gender expansive youth has been suggested to contribute to negative mental health outcomes because of stigmatization and discrimination, the management of multiple gender identities for the purpose of selective concealment (GMSR model, Testa et al., 2015) may be compounding gender expansive-related stress (Riggle, Rostosky, Black, & Rosenkrantz, 2017; Skidmore et al., 2006). Second, the highest symptoms of depression are found among mixed disclosure of gender identity (out to some, but not all) when compared with lower symptoms for nondisclosure and lowest symptoms for disclosure to all health care providers. These findings highlight the need for research that examines gender expansive-related stress due to mixed disclosure to health care providers.

Previous research and theory (GMSR model) suggests that factors related to gender identity concealment may compound negative mental health outcomes (Breslow et al., 2015; Hendricks & Testa, 2012; Mizock & Mueser, 2014; Riggle et al., 2017; Testa et al., 2015, 2017). The findings reported here suggest that mixed disclosure to health care providers is specifically related to higher symptoms of depression and lower levels of self-esteem; future research should more fully explore gender expansive identity disclosure and its relationship to gender expansive stress.

Gender identity disclosure among gender expansive youth is a process that has no clearly defined protocol to protect against victimization, harassment, or discrimination. It seems, however, that there are positive attributes to understanding disclosure to health care providers. For transgender girls, who exhibit the highest rates of disclosure, sharing their gender identity to health care providers may be a successful means of coping with the inherent stress of social pressures on gender expansive youth. For nonbinary youth (particularly nonbinary AMAB) where the prevalence of nondisclosure is the highest among gender subgroups, nondisclosure may be a logical strategy to avoiding increased stigmatization and victimization within a binary gender society. Transgender boys, however, who are exhibiting the highest symptoms of depression and the lowest levels of self-esteem, seem to be faring the worst with mixed disclosure to health care providers. Our findings suggest that being out to some, but not to all can be problematic for gender expansive youth.

Rossmann and colleagues (2017) suggested that anticipated stigma is implicit in the disclosure process and may impact how patients interpret providers' reactions. Levitt and Ippolito (2014) found that owing to environmental limitations (i.e., discrimination, risk of harm), gender expansive individuals significantly compromise their life choices to maintain their friendships, safety, and social standing within their communities. This scholarship is an important exploration into the lived experiences of gender expansive youth, who may eventually seek the services of a health care provider for therapy, puberty suppression, or hormone treatments and may benefit from understanding the mental health outcomes associated with gender identity disclosure.

Implications

More than 15 years ago, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a policy with the aim to make health care providers aware of the LGBTQ-specific issues in substance use and mental health treatment (Craft & Mulvey, 2001). This policy underscored the need for health care providers to understand the within-group differences, as well as the theoretically driven mechanisms and moderators of gender expansive mental health outcomes (Stevens, 2012). Our work was conducted in the spirit of better informing recommendations for clinical training and practice toward improved gender expansive health care models.

Additionally, there is a noticeable lack of quantitative data exploring gender expansive experiences prior to 2010, because most large-scale survey measures pursue specific male–female binary parameters for gender identification (Westbrook & Saperstein, 2015). The limited studies that test gender-identity disparities note important differences. In a recent analysis of gender expansive health-related behaviors, researchers found that gender expansive individuals are at an elevated risk for negative mental health outcomes, with a threefold risk of symptoms of depression and psychiatric disorders (Day et al., 2017; Reiser et al., 2015).

Gender affirmative health care relationships within the lives of gender expansive youth may significantly benefit those who are struggling with symptoms of depression and low self-esteem, and who are attempting to manage the stress of gender identity disclosure. Recent studies have demonstrated that positive role models (i.e., teachers, school counselors) may benefit gender expansive youth (Dessel et al., 2017; Heck, Flentje, & Cochran, 2013; Heck et al., 2014; Snapp, Watson, Russell, Diaz, & Ryan, 2015), so why too couldn't doctors and clinicians be considered as proponents for positively impacting the lives of gender expansive youth? Gender affirmative support by doctors and therapists may help to ensure a protective effect between gender expansive stress and negative mental health outcomes (i.e., symptoms of depression, low self-esteem).

The framework within which gender expansive youth mental health disparities exist requires vigilance and understanding. Rossmann and colleagues (2017) stated that a significant barrier to patient disclosure was health care providers simply not asking about their gender identity. The modification of health care paperwork to include questions about gender identity status has been underscored as a clear and present need by the Institute of Medicine (Cahill & Makadon, 2014; Graham et al., 2011; Rossmann et al., 2017) and the World Provider Association for Transgender

Health (Deutsch et al., 2013; Rossman et al., 2017) as a means to bridge the gap between clinical knowledge and practice. Additionally, considering the effectiveness of family based treatment for adolescent symptoms of depression (Wills, Vaccaro, & McNamara, 1992), it is important to understand and account for the ways in which family support can influence the modification of gender affirmative health care. The question of how a gender affirmative health care system can protect against the negative effects of victimization and internalized transphobia on gender expansive youth has yet to be answered. Based on the nondisclosure rates of gender expansive youth to health care providers, stakeholders should continue to invest in fostering an environment inclusive of gender affirmative care.

Limitations

There are multiple factors that make accurate sampling a challenging endeavor when studying gender expansive youth populations. Population-level research within the United States oftentimes lacks reliable data on gender identity. This survey sought to include as many gender expansive respondents as possible. However, owing to the recruitment of participants using social media means for a web-based survey, gender expansive individuals with specific characteristics (e.g., Internet access, stable housing, and time) may have disproportionately participated in this survey. Thus, our survey measures and means may not reach homeless or transient populations of gender expansive youth—this sample may not completely represent the full-lived experiences of gender expansive youth within the United States. Additionally, by utilizing methods of online advertising to gain survey participants, we may have disproportionately attracted responses from specific ethnoracial backgrounds.

There are many variables that may impact gender expansive mental health, and it is important to consider the possibility that certain aspects of self-esteem and depressive symptoms may not be completely due to gender expansive identity. Specifically, gender expansive youth who exhibit high self-esteem may not be exhibiting these symptoms solely due to being out to their health care providers. It is certainly possible that gender expansive youth who have supportive relationships with family and friends have the protective factors to ensure higher levels of self-esteem. Conversely, if gender expansive youth have been taught positive coping mechanisms, then they may be more apt to be able to manage gender minority stress and negative life experiences that can contribute to symptoms of depression. A gender expansive young person's depressive symptoms may not be as a result of the degree to which they are out to their health care provider.

Our measure of disclosure to health care providers did not specify the type of health care provider or ask whether or not youth have multiple health care providers. Though we utilized a question from a validated and widely used scale on disclosure, the wording of this question is a limitation (e.g., an inability to assess whether youth have providers and how many) and should be explored further in subsequent research. Last, youth may have different reasons for disclosure to certain types of health care providers (e.g., primary care physician, mental health counselor, nurse)—future research should disentangle the specific types health care providers to which gender expansive youth may disclose their identities. Last, we found some small effect sizes in our ANOVA

and MANCOVA analyses. Specifically, some effect sizes between disclosure to health care providers and symptoms of depression and self-esteem among gender expansive youth were weak. Though this indicates that there are other factors contributing to the mental health status of gender expansive youth, this study is the first in-depth analysis on disclosure to health care providers and negative mental health outcomes.

Conclusion

Although gender expansive youth face high levels of discrimination, stigmatization, and victimization (Boza & Nicholson Perry, 2014; Goldblum et al., 2012), and are at an increased risk for symptoms of depression (Reisner et al., 2015), anxiety (Reisner et al., 2015), and suicidal ideation (Testa et al., 2017) relative to their cisgender peers (Nuttbrock et al., 2014), it is important to consider the protective and exposure factors that are created by gender expansive identity disclosure to health care providers. In addressing these concerns, Glynn and van den Berg (2017) called for the modification of the health care system to include gender expansive-specific needs. It behooves the clinical and research community to explore the contributing factors (negative and positive) that may influence mental health outcomes of gender expansive youth. It is therefore prudent for health care providers to work toward an understanding of gender affirmative treatment to ensure positive outcomes for these youth. Gender expansive youth systematically vary by multiple psychosocial factors (e.g., gender identity, disclosure, and mental health) and should thus be understood by their unique lived experiences, with greater consideration paid to the quality of gender affirming support from health care providers.

References

- Benotsch, E. G., Zimmerman, R., Cathers, L., McNulty, S., Pierce, J., Heck, T., . . . Snipes, D. (2013). Non-medical use of prescription drugs, polysubstance use, and mental health in transgender adults. *Drug and Alcohol Dependence, 132*, 391–394. <http://dx.doi.org/10.1016/j.drugalcdep.2013.02.027>
- Bethea, M., & McCollum, E. (2013). The disclosure experiences of male-to-female transgender individuals: A systems theory perspective. *Journal of Couple & Relationship Therapy, 12*, 89–112. <http://dx.doi.org/10.1080/15332691.2013.779094>
- Boza, C., & Nicholson Perry, K. (2014). Gender-related victimization, perceived social support, and predictors of depression among transgender Australians. *International Journal of Transgenderism, 15*, 35–52. <http://dx.doi.org/10.1080/15532739.2014.890558>
- Breslow, A. S., Brewster, M. E., Velez, B. L., Wong, S., Geiger, E., & Soderstrom, B. (2015). Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 2*, 253–265. <http://dx.doi.org/10.1037/sgd0000117>
- Buxton, A. P. (2006). When a spouse comes out: Impact on the heterosexual partner. *Sexual Addiction & Compulsivity, 13*, 317–332. <http://dx.doi.org/10.1080/10720160600897599>
- Cahill, S., & Makadon, H. (2014). Sexual orientation and gender identity data collection in clinical settings and in electronic health records: A key to ending LGBT health disparities. *LGBT Health, 1*, 34–41. <http://dx.doi.org/10.1089/lgbt.2013.0001>
- Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development, 80*, 131–139. <http://dx.doi.org/10.1002/j.1556-6678.2002.tb00175.x>

- Cochran, B. N., & Cauce, A. M. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment, 30*, 135–146. <http://dx.doi.org/10.1016/j.jsat.2005.11.009>
- Craft, E. M., & Mulvey, K. P. (2001). Addressing lesbian, gay, bisexual, and transgender issues from the inside: One federal agency's approach. *American Journal of Public Health, 91*, 889–891. <http://dx.doi.org/10.2105/AJPH.91.6.889>
- D'Augelli, A., Grossman, A., & Starks, M. (2008). Gender atypicality and sexual orientation development among lesbian, gay, and bisexual youth: Prevalence, sex differences, and parental responses. *Journal of Gay & Lesbian Mental Health, 12*, 121–143.
- Day, J. K., Fish, J. N., Perez-Brumer, A., Hatzenbuehler, M. L., & Russell, S. T. (2017). Transgender youth substance use disparities: Results from a population-based sample. *Journal of Adolescent Health, 61*, 729–735. <http://dx.doi.org/10.1016/j.jadohealth.2017.06.024>
- Dessel, A. B., Kulick, A., Wernick, L. J., & Sullivan, D. (2017). The importance of teacher support: Differential impacts by gender and sexuality. *Journal of Adolescence, 56*, 136–144. <http://dx.doi.org/10.1016/j.adolescence.2017.02.002>
- Deutsch, M. B., Green, J., Keatley, J., Mayer, G., Hastings, J., Hall, A. M., . . . the World Professional Association for Transgender Health EMR Working Group. (2013). Electronic medical records and the transgender patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group. *Journal of the American Medical Informatics Association, 20*, 700–703. <http://dx.doi.org/10.1136/amiajnl-2012-001472>
- Edwards-Leeper, L., Feldman, H. A., Lash, B. R., Shumer, D. E., & Tishelman, A. C. (2017). Psychological profile of the first sample of transgender youth presenting for medical intervention in a U.S. pediatric gender center. *Psychology of Sexual Orientation and Gender Diversity, 4*, 374–382. <http://dx.doi.org/10.1037/sgd0000239>
- Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey, & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15–32). Binghamton, NY: Haworth Press.
- Galupo, M. P., Krum, T. E., Hagen, D. B., Gonzalez, K. A., & Bauerband, L. A. (2014). Disclosure of transgender identity and status in the context of friendship. *Journal of LGBT Issues in Counseling, 8*, 25–42. <http://dx.doi.org/10.1080/15538605.2014.853638>
- Glynn, T. R., & van den Berg, J. J. (2017). A systematic review of interventions to reduce problematic substance use among transgender individuals: A call to action. *Transgender Health, 2*, 45–59. <http://dx.doi.org/10.1089/trgh.2016.0037>
- Goldblum, P., Testa, R. J., Pflum, S., Hendricks, M. L., Bradford, J., & Bongar, B. (2012). The relationship between gender-based victimization and suicide attempts in transgender people. *Professional Psychology: Research and Practice, 43*, 468–475. <http://dx.doi.org/10.1037/a0029605>
- Graham, R., Berkowitz, B., Blum, R., Bockting, W., Bradford, J., de Vries, B., & Makadon, H. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: Institute of Medicine.
- Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Offsetting risks: High school gay-straight alliances and lesbian, gay, bisexual, and transgender (LGBT) youth. *Psychology of Sexual Orientation and Diversity, 1*, 81–90. <http://dx.doi.org/10.1037/2329-0382.1.S.81>
- Heck, N. C., Livingston, N. A., Flentje, A., Oost, K., Stewart, B. T., & Cochran, B. N. (2014). Reducing risk for illicit drug use and prescription drug misuse: High school gay-straight alliances and lesbian, gay, bisexual, and transgender youth. *Addictive Behaviors, 39*, 824–828. <http://dx.doi.org/10.1016/j.addbeh.2014.01.007>
- 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. <http://dx.doi.org/10.1037/a0029597>
- Hines, S. (2006). Intimate transitions: Transgender practices of partnering and parenting. *Sociology, 40*, 353–371. <http://dx.doi.org/10.1177/0038038506062037>
- Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*, 263–298. <http://dx.doi.org/10.1023/A:1013669705086>
- Klein, K., Holtby, A., Cook, K., & Travers, R. (2015). Complicating the coming out narrative: Becoming oneself in a heterosexist and cissexist world. *Journal of Homosexuality, 62*, 297–326. <http://dx.doi.org/10.1080/00918369.2014.970829>
- Legal, L. (2010). *When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV*. New York, NY: Lambda Legal.
- Lev, A. (2004). *Transgender emergence therapeutic guidelines for working with gender-variant people and their families* (Haworth marriage and the family). New York, NY: Haworth Clinical Practice Press/Routledge.
- Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: The experience of transgender identity development. *Journal of Homosexuality, 61*, 1727–1758. <http://dx.doi.org/10.1080/00918369.2014.951262>
- Lombardi, E. (2011). Transgender health: A review and guidance for future research—Proceedings from the Summer Institute at the Center for Research on Health and Sexual Orientation, University of Pittsburgh. *International Journal of Transgenderism, 12*, 211–229. <http://dx.doi.org/10.1080/15532739.2010.544232>
- Maguen, S., Shipherd, J. C., Harris, H. N., & Welch, L. P. (2007). Prevalence and predictors of disclosure of transgender identity. *International Journal of Sexual Health, 19*, 3–13. http://dx.doi.org/10.1300/J514v19n01_02
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*, 38–56. <http://dx.doi.org/10.2307/2137286>
- 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. <http://dx.doi.org/10.1037/0033-2909.129.5.674>
- Mills-Koonce, W. R., Rehder, P. D., & McCurdy, A. L. (2018). The significance of parenting and parent-child relationships for sexual and gender minority adolescents. *Journal of Research on Adolescence, 28*, 637–649. <http://dx.doi.org/10.1111/jora.12404>
- Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 1*, 146–158. <http://dx.doi.org/10.1037/sgd0000029>
- Mohr, J., & Fassinger, R. (2000). Measuring dimensions of lesbian and gay male experience. *Measurement and Evaluation in Counseling and Development, 33*, 66–90. <http://dx.doi.org/10.1080/07481756.2000.12068999>
- Nemoto, T., Operario, D., Keatley, J., Han, L., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health, 94*, 1193–1199. <http://dx.doi.org/10.2105/AJPH.94.7.1193>
- Nuttbrock, L., Bockting, W., Rosenblum, A., Hwang, S., Mason, M., Macri, M., & Becker, J. (2014). Gender abuse, depressive symptoms, and substance use among transgender women: A 3-year prospective study. *American Journal of Public Health, 104*, 2199–2206. <http://dx.doi.org/10.2105/AJPH.2014.302106>
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin, 133*, 328. <http://dx.doi.org/10.1037/0033-2909.133.2.328>
- Pachankis, J. E., Cochran, S. D., & Mays, V. M. (2015). The mental health of sexual minority adults in and out of the closet: A population-based study. *Journal of Consulting and Clinical Psychology, 83*, 890–901. <http://dx.doi.org/10.1037/ccp0000047>
- Peacock, E., Andrinopoulos, K., & Hembling, J. (2015). Binge drinking among men who have sex with men and transgender women in San Salvador: Correlates and sexual health implications. *Journal of Urban Health, 92*, 701–716. <http://dx.doi.org/10.1007/s11524-014-9930-3>

- Pflum, S. R., Testa, R. J., Balsam, K. F., Goldblum, P. B., & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 2*, 281–286. <http://dx.doi.org/10.1037/sgd0000122>
- Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine, 84*, 22–29. <http://dx.doi.org/10.1016/j.socscimed.2013.02.019>
- Reisner, S. L., & Murchison, G. R. (2016). A global research synthesis of HIV and STI biobehavioural risks in female-to-male transgender adults. *Global Public Health, 11*, 866–887. <http://dx.doi.org/10.1080/17441692.2015.1134613>
- Reisner, S. L., Pardo, S. T., Gamarel, K. E., White Hughto, J. M., Pardee, D. J., & Keo-Meier, C. L. (2015). Substance use to cope with stigma in healthcare among U.S. female-to-male trans masculine adults. *LGBT Health, 2*, 324–332. <http://dx.doi.org/10.1089/lgbt.2015.0001>
- Riggle, E. D., Rostosky, S. S., Black, W. W., & Rosenkrantz, D. E. (2017). Outness, concealment, and authenticity: Associations with LGB individuals' psychological distress and well-being. *Psychology of Sexual Orientation and Gender Diversity, 4*, 54–62. <http://dx.doi.org/10.1037/sgd0000202>
- Riggle, E. D., Rostosky, S. S., McCants, L. E., & Pascale-Hague, D. (2011). The positive aspects of a transgender self-identification. *Psychology and Sexuality, 2*, 147–158. <http://dx.doi.org/10.1080/19419899.2010.534490>
- Rosenberg, M. (1989). *Society and the adolescent self-image* (rev. ed.). Middletown, CT: Wesleyan University Press.
- Rossmann, K., Salamanca, P., & Macapagal, K. (2017). A qualitative study examining young adults' experiences of disclosure and nondisclosure of LGBTQ identity to health care providers. *Journal of Homosexuality, 64*, 1390–1410. <http://dx.doi.org/10.1080/00918369.2017.1321379>
- Russell, S. T., Toomey, R. B., Ryan, C., & Diaz, R. M. (2014). Being out at school: The implications for school victimization and young adult adjustment. *American Journal of Orthopsychiatry, 84*, 635–643. <http://dx.doi.org/10.1037/ort0000037>
- Saeed, A., Mughal, U., & Farooq, S. (2018). It's complicated: Sociocultural factors and the disclosure decision of transgender individuals in Pakistan. *Journal of Homosexuality, 65*, 1051–1070.
- Santos, G. M., Rapues, J., Wilson, E. C., Macias, O., Packer, T., Colfax, G., & Raymond, H. F. (2014). Alcohol and substance use among transgender women in San Francisco: Prevalence and association with human immunodeficiency virus infection. *Drug and Alcohol Review, 33*, 287–295. <http://dx.doi.org/10.1111/dar.12116>
- Savin-Williams, R. C., & Dubé, E. M. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *Family Relations, 47*, 7–13. <http://dx.doi.org/10.2307/584845>
- Skidmore, W. C., Linsenmeier, J. A., & Bailey, J. M. (2006). Gender nonconformity and psychological distress in lesbians and gay men. *Archives of Sexual Behavior, 35*, 685–697. <http://dx.doi.org/10.1007/s10508-006-9108-5>
- Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations, 64*, 420–430. <http://dx.doi.org/10.1111/fare.12124>
- Stevens, S. (2012). Meeting the substance abuse treatment needs of lesbian, bisexual and transgender women: Implications from research to practice. *Substance Abuse and Rehabilitation, 3*, 27–36. <http://dx.doi.org/10.2147/SAR.S26430>
- Strain, J. D., & Shuff, I. M. (2011). Psychological well-being and level of outness in a population of male-to-female transsexual women attending a national transgender conference. *International Journal of Transgenderism, 12*, 230–240. <http://dx.doi.org/10.1080/15532739.2010.544231>
- Testa, R., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*, 65–77. <http://dx.doi.org/10.1037/sgd0000081>
- Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*, 125–136. <http://dx.doi.org/10.1037/abn0000234>
- 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. <http://dx.doi.org/10.1016/j.jadohealth.2016.09.014>
- Watson, R. J., Wheldon, C., & Puhl, R. M. (2019). Evidence of diverse identities in a large national sample of sexual and gender minority adolescents. *Journal of Research on Adolescence*. Advance online publication. <http://dx.doi.org/10.1111/jora.12488>
- Westbrook, L., & Saperstein, A. (2015). New categories are not enough: Rethinking the measurement of sex and gender in social surveys. *Gender & Society, 29*, 534–560. <http://dx.doi.org/10.1177/0891243215584758>
- Wills, T. A., Vaccaro, D., & McNamara, G. (1992). The role of life events, family support, and competence in adolescent substance use: A test of vulnerability and protective factors. *American Journal of Community Psychology, 20*, 349–374. <http://dx.doi.org/10.1007/BF00937914>
- Wolf, E. C., & Dew, B. J. (2012). Understanding risk factors contributing to substance use among MTF transgender persons. *Journal of LGBT Issues in Counseling, 6*, 237–256. <http://dx.doi.org/10.1080/15538605.2012.727743>
- Wren, B. (2002). 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemmas in parenting a transgendered adolescent. *Clinical Child Psychology and Psychiatry, 7*, 377–397.

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