

HARLEY CASWELL BSc (Hons)

EXPLORING MINORITY STRESS IN GENDER-DIVERSE
POPULATIONS

Section A: How does type and extent of social and legal transition relate to health, mental health and social wellbeing in transgender and gender diverse individuals?

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Section B: Exploring minority stress and intersectionality in adolescents attending a gender identity clinic in the United Kingdom.

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Summary of MRP Portfolio

Section A: This section is a systematic literature review of empirical research exploring type and extent of social and legal transitions and their relationship with mental health and social wellbeing. The review included thirteen quantitative and one qualitative study. Most studies were published within the last five years, all within the last nine, demonstrating the relevance and importance of research in transgender and gender-diverse populations. The review highlighted numerous methodological challenges to researching such a diverse population with varying experiences. Clinical, policy and research implications are discussed.

Section B: This section details a cross-sectional survey exploring gender identity-related minority stress and wellbeing in adolescents referred to a gender identity clinic in the UK. The internal consistency of an adapted measure of gender identity minority stress for adolescents is reviewed, with the measure demonstrating good internal consistency. On average, participants reported experience of 17 out of the 54 minority stressors assessed. The most commonly reported minority stressors related to negative expectations from others, internalised transphobia and transnegative communication from others. Statistical analyses found no significant differences in gender identity minority stress between minority and majority groups. Intersectionality is explored alongside clinical implications, limitations and future research.

Section C: Includes all appendices.

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Abstract

Aim: Transgender and gender-diverse (TGD) individuals may seek affirmation via social, legal and medical transitions. This review aims to explore how extent and type of social and legal transition relate to mental health and social wellbeing in TGD individuals. **Method:** A systematic literature search of three databases, and handsearching references, elicited fourteen studies. **Results:** Findings were mixed regarding whether social and/or legal transition or expressing one's identified gender full-time, part-time or never were associated with positive mental health and social wellbeing outcomes, or whether any differences existed at all. Research highlighted differences between communities' responses to TGD individuals. Expressing one's identified gender full-time and reporting lower levels of visual conformity to stereotypical binary genders was associated with greater discrimination. **Conclusions:** Findings should be interpreted with caution due to the varied measures of gender expression. Studies did not generally consider how participants wanted to express themselves and whether they wanted to be read as a binary gender. Degree of visual conformity to binary expectations is an important variable that was rarely measured that may have significant impact on mental health and social wellbeing outcomes. Future research should acknowledge this, particularly considering non-binary individuals. Numerous clinical, policy and research implications are discussed.

Keywords: transgender; transition; mental health; wellbeing; chosen name

Introduction

Gender Identity Development

In recent years a significant shift in Western culture's perception and understanding of gender has occurred. Historically, gender was believed to exist dichotomously (male/female; Fagot & Leinbach, 1985; Kohlberg, 1966). Now, gender is recognised as a spectrum between poles of femininity and masculinity (Ehrensaft, 2018). The World Health Organization (WHO; 2020) describes gender as socially constructed characteristics determined by sex, such as norms, roles and relationships, which differ across cultures and time. Whereas, gender *identity* refers to one's deeply felt, internal sense of gender that may or may not resemble one's birth-assigned sex (American Psychological Association [APA], 2015b). Table 1 provides definitions used in this review.

Various gender identity development theories exist, including social cognitive (Bussey & Bandura, 1999), psychoanalytic (Winnicott, 1960) and ecological (Bronfenbrenner, 1988). Ehrensaft (2012) suggests development of one's "true gender self" (p.341) is an interweaving web of nature, nurture, culture and time. Cognitive developmental researchers found stereotyped gender behaviours and preferences begin from a young age (Zosuls et al., 2009), with most children identifying with their assigned gender by age three or four (Reilly et al., 2019). During adolescence, there is a suggested intensification of expected conformity to gender roles (Hill & Lynch, 1983). However, not all individuals identify with their assigned gender; instead, identifying as the 'opposite' gender, or another identity across the gender spectrum (Ehrensaft, 2018).

Table 1*Definitions of Key Terminology*

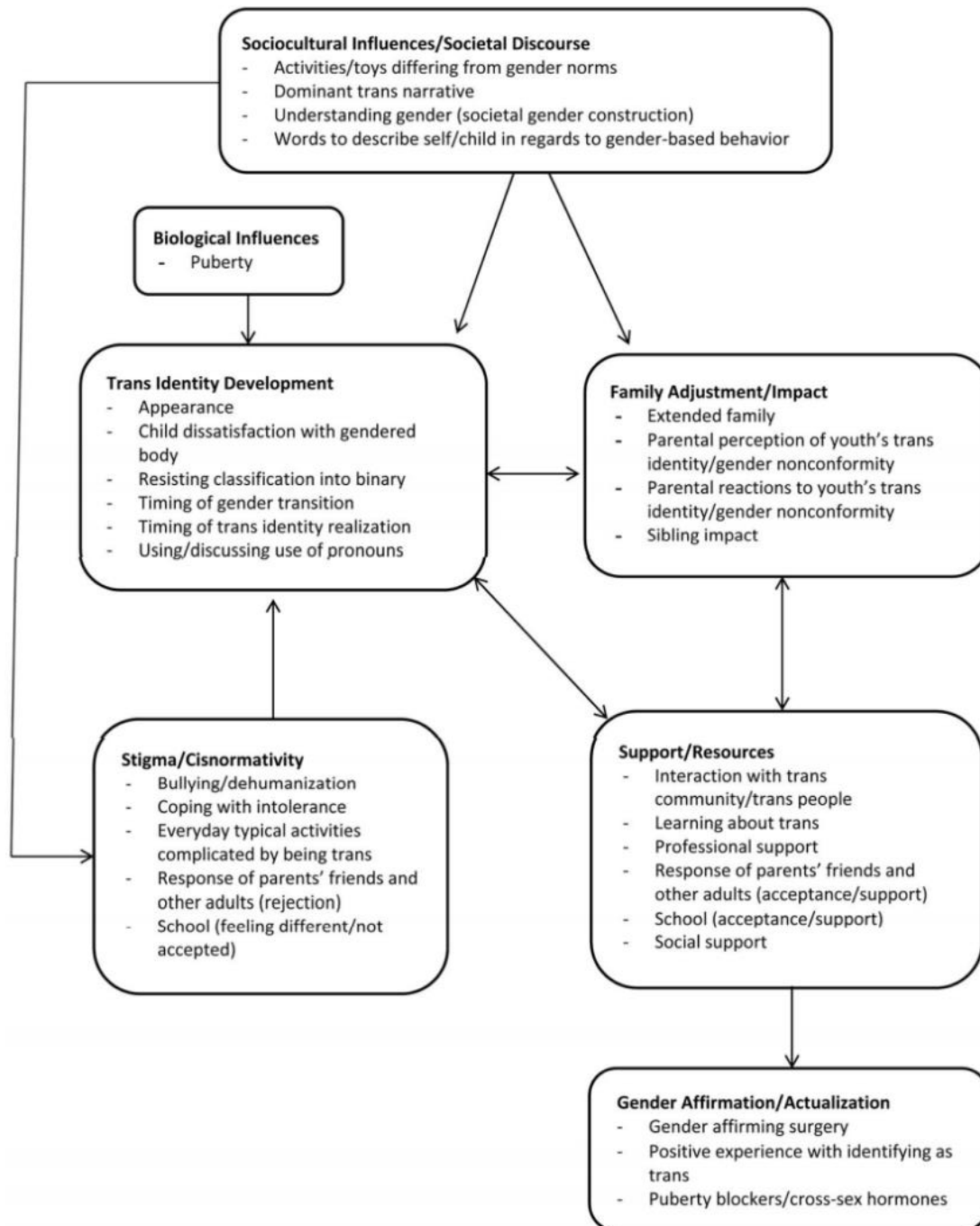
Term	Definition
Assigned gender	The gender assigned to someone at birth; typically, male or female (APA, 2015a).
Birth-assigned sex	Refers to the biology of a person, that typically defines a person as male or female (World Health Organization [WHO], 2002).
Cisgender	Describes a person whose gender identity and gender expression matches their assigned gender (APA, 2015b).
Gender	Refers to socially constructed characteristics determined by sex, such as norms, roles and relationships, which differ across cultures and time (WHO, 2020).
Genderfluid	When one experiences their gender as evolving and changing, rather than static (Gender Spectrum, 2019).
Genderqueer	A gender identity that exists outside the gender binary (APA & National Association of School Psychologists, 2015). Other terms include ‘non-binary’ and ‘genderfluid’.
Gender affirmation	An iterative, life-long process of being recognised and supported as one’s identified gender, gender expression and/or role (Sevelius, 2013).
Gender diversity	An umbrella term for gender identities that expand beyond the binary framework (A Gender Agenda, 2020).
Gender dysphoria	A diagnosis given to those experiencing distress due to incongruence between their gender identity and assigned gender (APA, 2015b).
Gender expression	Refers to one’s physical presentation and behaviours, reflecting gender identity or gender roles. Gender expression can differ from a person’s gender identity (APA, 2015b). Refers to social cues and signals reflecting information relating to one’s gender e.g. clothes, mannerisms, voice (Pfeffer, 2009).
Gender identity	One’s deeply felt, internal sense of being a boy, man, or male; a girl, woman, or female; or an alternative gender (e.g., genderqueer) that may or may not correspond to a person’s birth-assigned sex (APA, 2015b).
Transgender	An umbrella term used to describe various individuals whose gender identity does not match their birth-assigned sex (APA, 2015b). However, not all TGD individuals relate to this term as it insinuates a changing of gender, which is not an accurate reflection of the process for some (Billard, 2019).

Numerous models of transgender identity development exist (Bockting, 2014; Bockting & Coleman, 2007; Devor, 2004; Heistand & Levitt, 2005; Lewins, 1995; Morgan & Stevens, 2012), indicating various stages before fully integrating one’s gender identity. Many models adapted sexual identity development models, integrated sexuality and gender identity

or focused on binary transgender identities. Katz-Wise and colleagues (2017) proposed a conceptual framework with seven overarching themes (see Figure 1). This highlights the complex process of transgender and gender-diverse (TGD) identity formation, with themes interacting and influencing each other as opposed to linear development.

Figure 1

Conceptual Framework of TGD Youth's Identity Formation (Katz-Wise et al., 2017)



Gender Diversity, Mental Health and Wellbeing

Despite benefits of presenting as one's true gender (Mullen & Moane, 2013), research suggests TGD individuals have elevated risks of mental health difficulties, including anxiety, depression, suicidality and distress relating to stigma and discrimination (Bockting et al., 2013; Mak et al., 2020; Tebbe & Moradi, 2016). Research reports depression rates in TGD adults at 50%-70% - much higher than the general population (Reisner et al., 2016; Tebbe & Moradi, 2016). Grant et al. (2011) found a 41% lifetime suicide rate in their survey of over 7000 transgender adults, compared to only 9% in the general population and 10-20% in lesbian, gay and bisexual (LGB) adults (Paul et al., 2002; Salway et al., 2019). Nonetheless, suicide rates may vary across generations with changing societal perspectives towards TGD populations and increasing access to gender-affirming treatments. Although suicide rates vary among TGD populations (Haas et al., 2010), research suggests suicide attempt history is the strongest predictor of completed suicide across populations (Harris & Barraclough, 1997).

Research highlights clinical levels of internalising problems and self-harm in TGD children and youth (Arcelus et al., 2016; Wallien et al., 2007). A UK gender clinic for young people found mean levels of internalising problems in the clinical range after assessment (Skagerberg et al., 2013a), with 24% reporting self-harm and 10% attempting suicide prior to referral (Skagerberg et al., 2013b). However, Durwood et al. (2017) and Olson et al. (2016) found socially transitioned children in the US did not have elevated depression scores compared to siblings, matched controls or population averages when using parent- and self-report measures. Parent-report measures showed slightly elevated anxiety in transgender children compared to population averages. Durwood and colleagues (2017) concluded there are socially transitioned children who are doing well. Nonetheless, these findings must be considered within the family context: children who have socially transitioned at a young age may be more likely to have a supportive family. Furthermore, global differences exist

between gender-affirming practices and recommendations (Butler et al., 2018; Cohen-Kettenis et al., 2008; Spack, 2009); this may explain some cross-cultural differences. For instance, de Graaf et al. (2018) highlight differences in acceptance of homosexuality between Canada and The Netherlands, which could explain some differences in psychological functioning between these countries.

Minority Stress

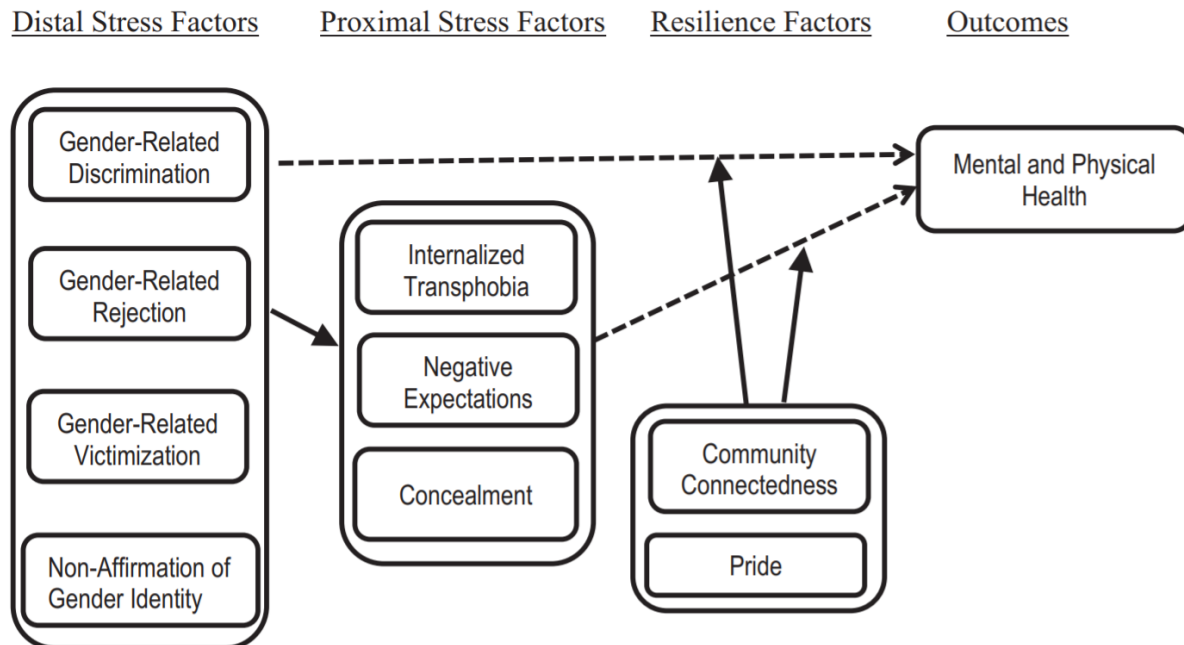
Despite findings demonstrating associations between gender diversity, mental health and wellbeing, gender identity alone is not a risk factor for such problems; it is the stigma associated with TGD identities that creates the risk (Eliason & Chinn, 2017). Minority stress refers to specific additional stressors associated with identifying as a stigmatised minority group (Link & Phelan, 2001). Meyer's (2003) minority stress model demonstrates how interactions between stressors, minority status, identity, social support and coping methods impact mental health.

Meyer's model has been adapted for TGD populations who experience additional, unique stressors (see Figure 2; Hendricks & Testa, 2012; Testa et al., 2015). For instance, TGD individuals are regularly judged against their ability to be read as cisgender, whether they are trying to be read as a specific gender or not (Teich, 2012). The model includes proximal stressors occurring at the individual level, and objective, distal stressors occurring at societal or structural levels. Resilience factors can buffer against the negative impacts of minority stress.

Research has shown TGD individuals are at risk of verbal harassment and physical violence (Bradford et al., 2013; Lombardi et al., 2002). Reported physical violence ranges from 43-60%, with sexual violence reported in 43-46% (Hendricks & Testa, 2012). Having experienced physical or sexual violence is associated with a four times higher likelihood of attempting suicide than those who have not experienced such violence (Testa et al., 2012).

Figure 2

Minority Stress Framework for Transgender and Gender Diverse Populations (Hendricks & Testa, 2012; Testa et al., 2015)



A recent review by Delozier and colleagues (2020) found TGD populations were much more likely to experience school-based peer victimisation, with victimisation predicting depression and suicidality. Reisner et al. (2015) found TGD youth were twice as likely to be maltreated by parents or caregivers compared to their cisgender peers, and may develop negative coping strategies, such as substance misuse.

TGD populations are at increased risk of homelessness. Grant et al. (2011) found TGD individuals were twice as likely to experience homelessness, with 20% of their sample attributing their homelessness to their TGD identity. TGD individuals can face further challenges accessing homeless shelters, which are often segregated by sex in the US (Mottet & Ohle, 2006). Quintana et al. (2010) suggests TGD individuals experience the highest rates of discrimination in homeless shelters out of all minority groups.

In comparison to distal stressors, much less research investigating proximal stressors exists (Delozier et al., 2020; Hendricks & Testa, 2012). TGD individuals may conceal their

identity, to protect against victimisation: Beemyn and Rankin (2011) found almost half of respondents reported concealment to avoid intimidation. However, this can cause additional stress and may result in internalised transphobia. Nonaffirmation from significant others has been associated with poorer mental health (Delozier et al., 2020). Hughto et al.'s (2015) critical review supports the minority stress model in TGD populations: they found stigma impacts TGD individuals at the individual, interpersonal and structural levels, with significant limiting of opportunities. Notably, most research relates to adult populations.

Gender Affirmation

Gender affirmation refers to the multidimensional process of presenting and being read as one's identified gender (Reisner et al., 2016). Previously, this concept was termed 'passing'. However, 'passing' has been criticised for perpetuating gendered stereotypes and binary genders (Games, 2020). Furthermore, not all TGD individuals identify as binary genders or wish to live unidentified as transgender (Billard, 2019). This rejection of 'passing' has been referred to as posttranssexualism, representing a more liberated and political movement (Gender Minorities Aotearoa, 2020; Stone et al., 1991).

Presenting as one's identified gender can pose difficulties, including lack of support from others and valued relationships ending (Meyer, 2003; Mullen & Moane, 2013). However, over time, it is linked with greater self-esteem and self-concept (Vaughan & Wachler, 2010), happiness and contentment with identity (Mullen and Moane, 2013), greater overall wellbeing, and reduced depression and anxiety symptoms compared to those not expressing their true gender (Strain & Shuff, 2010). It is suggested the greater convergence between one's identified gender and gender expression, the greater one's wellbeing and lesser risk of victimisation (Davis & Meier, 2014; Kattari & Hasche, 2015; van de Grift et al., 2016).

Gender affirmation involves four domains: psychological, social, legal and medical (Reisner et al., 2016). Table 2 describes the transitions individuals may take to affirm their gender. Notably, not all TGD individuals pursue all types of transition. For example, genderqueer individuals may be less likely to seek medical transition (Grant et al., 2011, Kuper et al., 2012), as transition within binary categories may not be applicable (Scheim & Bauer, 2015). Similarly, they may not choose a different name if their birth name is gender neutral or reflects their gender identity in some way (James et al., 2016).

Table 2

Description of types of transitions

Type of Transition	Description
Psychological	Refers to one's internal felt sense of gender identity and feeling that this is respected; resisting internalising stigma and/or transphobia (Reisner et al., 2016).
Social	Includes changing one's name, pronouns, hairstyle and clothing choice (Olson et al., 2016). It may also include practices such as chest binding (Grewal, 2017) or genital tucking (Conard, 2017). This transition is entirely reversible (Conard, 2017).
Legal	Involves changing name and/or gender on legal documents, such as passports, to align with one's identified gender. Also involves legally changing one's name (Scheim & Bauer, 2015).
Medical	Involves accessing physical interventions. This includes permanent hair removal, hormonal treatment (puberty-suppressing hormones, cross-sex hormones), genital and/or breast/chest surgery and vocal training or voice modification surgery (Coleman et al., 2012).

Sevelius et al. (2013) suggests TGD individuals with unfulfilled affirmation needs are at greater risk of mental health difficulties than those whose affirmation needs are met. In a sample of over 17 000 binary-identified TGD individuals, Lelutiu-Weinberger et al. (2020) looked at the combined effects of legal and medical affirmation and found affirmation was linked to lower odds of suicidal ideation and psychological distress as well as higher odds of accessing healthcare in the past year. Affirmation had a significant moderate protective effect against discrimination, highlighting its importance. Similarly, McLemore (2018) found misgendering or nonaffirmation was associated with poorer mental health outcomes.

Social transitions are typically the first step towards affirming one's gender, offering opportunity to explore one's gender identity in a reversible way (Coleman et al., 2012; Mullen & Moane, 2013). Some healthcare professionals consider a social transition mandatory prior to accessing medical interventions (Hill et al., 2010). However, many TGD individuals face difficulties within the social domain, such as, others refusing to use their chosen name in interpersonal or institutional settings and being prevented from dressing according to their gender identity (James et al., 2016; Lanham et al., 2019; McGuire et al., 2010). Research shows some schools and medical institutions require a legal name change prior to using TGD individuals' chosen name (Thaler et al., 2009). However, according to the 2015 US Transgender Survey, only 11% of TGD people had gender- and name-concordant legal and identity documents (IDs). Without these, many experience being denied access to healthcare, education and housing, with increased reported harassment and violence (James et al., 2016).

Much research has focussed on medical transitions and their associated benefits. Costa and Colizzi's (2016) systematic review of 17 studies found cross-sex hormone treatment was associated with better mental health outcomes including depression, anxiety and quality of life. Furthermore, Defreyne et al.'s (2017) review of 29 studies found gender affirming surgery led to positive effects on quality of life and wellbeing. Meanwhile, less research has focussed on social and legal transitions, despite childhood social transitions being one of the most controversially debated topics in TGD healthcare (Coleman et al., 2012; Giordano, 2019; Steensma & Cohen-Kettenis, 2015; Wong et al., 2019).

Review Rationale and Aims

The impact of medical interventions has been regularly reviewed. However, much less research explores the implications of being successfully read correctly (Begun & Kattari, 2016), particularly in relation to legal and social transitions. Whilst legal affirmation is

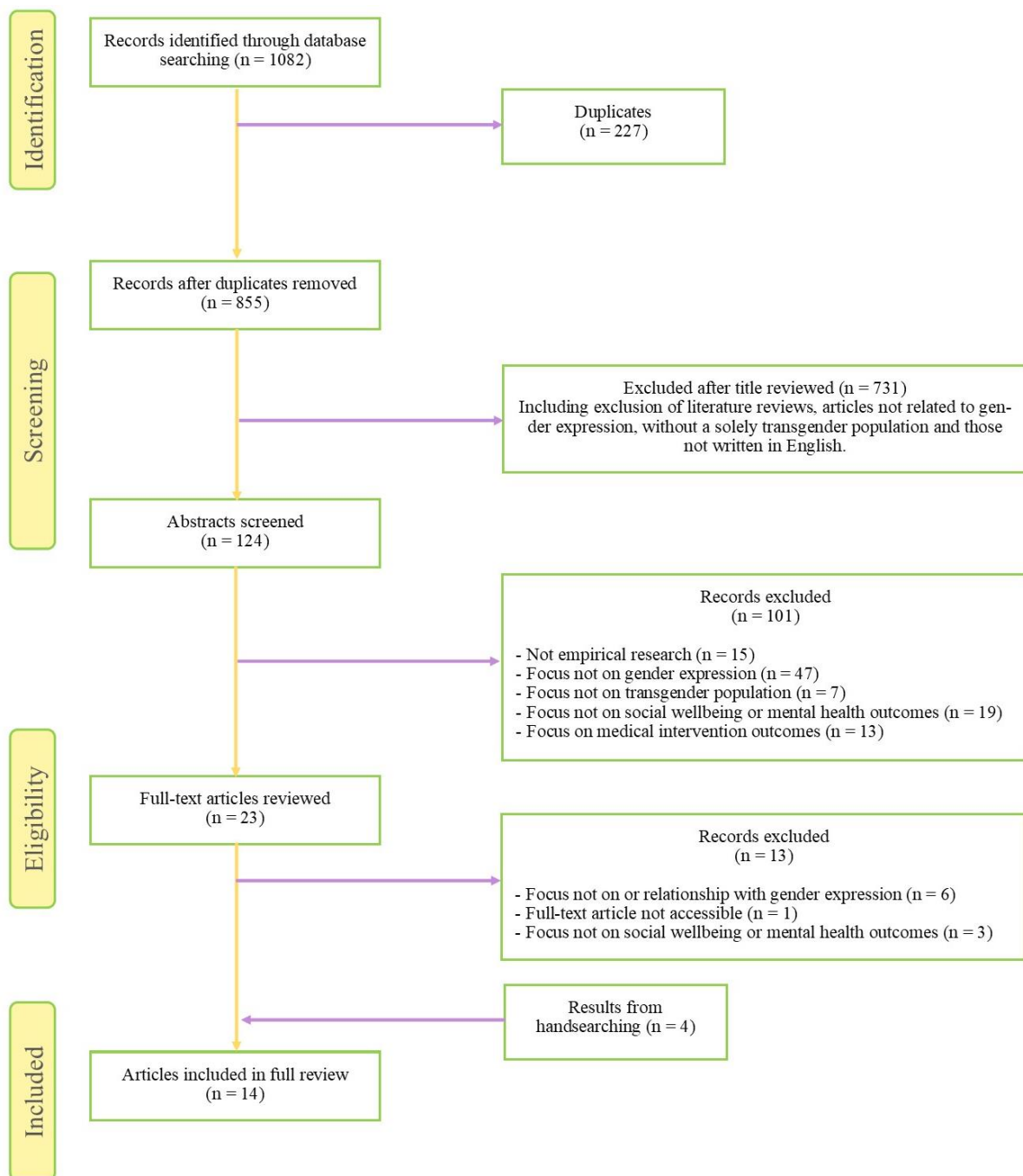
generally consistent across environments due to its permanence, social affirmation may be context-dependent. For example, individuals may present as their identified gender in some contexts and not others, for various reasons (Beemyn & Rankin, 2011). Given the links between minority stress, victimisation and mental health (Testa et al., 2015), both mental health and social wellbeing outcomes are important to consider. Hence, the aim of this review is to explore:

- The relationship between types of legal and social transition and mental health and social wellbeing;
- The relationship between extent of social and legal transitions and mental health and social wellbeing.

Method

Literature Search

A systematic search of three databases (Web of Science, PsycInfo and Medline), chosen because of their focus on social and behavioural sciences, was conducted on 23 July 2020. From reviewing commonly used terminology across time, numerous terms referring to gender identity were searched in the titles, reflecting the changing social environment: (“gender nonconform*” OR “gender non-conform*” OR “gender varian*” OR transgender OR transsexual OR “gender dysphoria” OR “gender identity”). Considering variation in how transitions are described, the following terms were used to search abstracts to capture a broad range of research: (“gender expression” OR outness OR pass* OR “visual conformity” OR concealment OR “gender affirmation” OR “identity disclosure”), as well as a variety of terms capturing mental health and social wellbeing: (violence OR “minority stress” OR discrimination OR social OR wellbeing OR “mental health” OR distress OR stigma OR prejudice OR depression OR anxiety).

Figure 3*Flow Chart Detailing Systematic Search Process*

The time period (1999-2020) was chosen because the UK government interdepartmental working group for transsexual people was established in 1999, which particularly investigated legal measures surrounding birth certificates. The establishment of

this group reflected the increased visibility of TGD populations. Handsearching took place until 11 February 2021. Figure 3 details a flow chart of screening and eligibility checks.

Table 3 displays inclusion and exclusion criteria. Studies measuring extent of transitions did not always explicitly report medical transition demographics; therefore, extent of transition was based on general visual gender expression rather than visual changes explicitly due to medical interventions. Considering proposals that TGD gender identity development commences during childhood (Katz-Wise et al. 2017), both children and adults were included.

Table 3

Study inclusion and exclusion criteria

Domain	Inclusion Criteria
Empiricism	Empirical research on primary or secondary data. Book chapters and reviews were excluded.
Population	Gender diverse populations. Studies were excluded if they focussed on minority sexuality <i>and</i> gender diverse populations rather than gender diverse populations specifically.
Exposure	Social and/or legal transitions, or extent of transition (e.g. part-time, full-time presenting as one's identified gender). Studies focussing on 'coming out' experiences or medical transitions were excluded. Studies were also excluded if social or legal transitions could not be separated from medical transitions.
Outcome	Mental health outcomes; social wellbeing outcomes (e.g. bullying, housing).

Review Structure

Studies were read in full, and results grouped based on measure of gender expression and outcome. Research was critically appraised using quality assessment tools. The well-established and extensively peer-reviewed Joanna Briggs Institute checklist was used to appraise the quantitative, cross-sectional studies (Moola et al., 2020; see Appendix A). The Critical Appraisal Skills Programme (CASP; 2018; see Appendix B) checklist was used for the qualitative study. The CASP is the most widely used appraisal tool for synthesising

qualitative health and social care research (Dalton et al., 2017; Hannes & Macaitis, 2012). Completed appraisals are provided in Appendices C and D. Though checklists can be useful tools to assist appraisal, the heterogeneity in variables measured and analysis makes it difficult to directly compare studies. In line with Booth et al.'s (2016) advice, checklists were used as guidance to appraise and compare studies, rather than calculate each study's score. Thematic analysis was conducted on the qualitative study related to this review question. This was due to varying subthemes identified within the qualitative study's coding which were relevant to this review's aims.

Review Findings

Overview of Studies and Structure

The search strategy identified 1082 studies. After reviewing titles for duplicates and irrelevant studies, 124 abstracts were screened. After screening the full-text of 23 articles, 10 articles remained (see Appendix E). Four additional articles were included from handsearching, resulting in 13 quantitative and one qualitative study (see Figure 3). Findings are grouped by type (i.e., social/legal) or extent (i.e., full-time/part-time transition) of transition and outcomes measured. Methodological considerations are referenced throughout. Appendix F details study participants' demographics.

Notably, most participants were White. Only one study included no White participants (Hill et al., 2018), two studies had mostly people of the global majority¹ (PGM; Pollitt et al., 2020; Russel et al., 2018) and Fontanari et al. (2020) had approximately half PGM. Various sexual orientations were reported, with no majority sexual orientation identified. Most research took place in the US ($n=7$), with two studies recruiting from the US

¹ 'People of the global majority' (PGM) is the term used throughout this report. At the time of writing, PGM is considered the most inclusive and empowering term to refer to the collective group of Black, Brown and Indigenous people. It is noted that this will likely change over time and in the future PGM may not be the most respectful term to refer to this diverse group of people. <https://www.rw-3.com/blog/talking-about-race-racism-navigating-terms-of-racial-identity>

and South America, another recruiting from Canada and one from Brazil. Two studies took place in Europe, and one did not report their location; however, the researcher was based in the US. Eight studies recruited adults, four recruited youth (aged approximately 16-24) and two recruited pre-pubescent children. Table 4 provides a summary of each study.

Table 4*Summary of studies*

Study	Authors (Year)	Title	Sample (number, location)	Purpose	Method of data collection (outcome measures)	Measure of gender expression	Key Findings
Quantitative							
1	Allen (2018)	The relationship of self-compassion and level of outness with emotional distress in transgender individuals.	234 transgender adults in the USA.	To explore the relationship of self-compassion and level of outness as correlates and predictors of emotional distress.	Cross-sectional online survey (SCS, DASS-21, adapted OI).	Degree of outness to different groups of people in their lives, adapted from a measure of outness of sexual orientation.	Higher levels of outness as transgender was associated with less emotional distress ($r = -.30, p > .01$), but did not predict emotional distress. Self-compassion was significantly and positively related to outness as transgender ($r = .32; p < .01$).
2	Bauer et al. (2015)	Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada.	380 transgender persons aged 16+ in Ontario, Canada.	To identify intervenable social factors associated with suicide risk reduction.	Cross-sectional online or paper-based survey (MOSSSS; ETS).	Social transition status (full-time, part-time, not); gender-concordant IDs.	Having at least one gender-concordant ID was associated with large reductions in suicidal ideation over the past year ($RR = 0.56, 95\% \text{ CI } [0.35, 0.90]$) and past year suicide attempts ($RR = 0.26, 95\% \text{ CI } [0.11, 0.62]$). This could prevent 90 cases of suicidal ideation for every 1000 trans people and 230 attempts per 1000 trans people with suicidal ideation. Social transition status was not associated with suicidality.
3	Begun & Kattari (2016)	Conforming for survival: Associations between transgender visual conformity/passing and homelessness experiences.	6456 transgender or GNC adults from the NTDS in the USA and South America.	To examine, relationships between homelessness experiences and visual conformity/passing.	Cross-sectional online or paper-based survey (newly developed survey capturing homelessness experiences).	Degree of visual conformity.	11.4% experienced homelessness due to their gender identity. An additional 16.3% sought temporary sleeping arrangements due to gender identity. Those who self-rated as less visually conforming were significantly less likely than those who rated themselves as somewhat conforming or conforming to seek access to shelters ($\chi^2(4) = 48.24, p < .001$), more likely to be denied access ($\chi^2(2) = 13.06, p < .01$) and more frequently thrown out of homeless shelters ($\chi^2(2) = 7.89, p < .05$). When accessing shelters, they were more likely to be harassed ($\chi^2(2) = 7.07, p < .05$) or physically assaulted ($\chi^2(2) = 6.78, p < .05$) and forced to live

						as their birth-assigned sex ($\chi^2(2) = 7.85, p < .05$) to remain in the shelter or feel safe ($\chi^2(2) = 13.46, p < .01$).	
						Results suggest that lower visual conformity/passing is positively associated with homelessness as well as negative experiences incurred while accessing shelters.	
4	Fontanari et al. (2020)	Gender affirmation is associated with transgender and gender nonbinary youth mental health improvement.	350 transgender and gender nonbinary Brazilian youth, aged 16-24.	To evaluate the impact of social, medical and legal gender affirmation on mental health.	Cross-sectional online survey (Deprivation Scale, OASIS, MDS, GDS, GPS).	Social (chosen name use; expressed identified gender [all the time, half the time or never]); legal (legal name change).	<p>Youth who preferred to be called by another name reported fewer depressive symptoms than those who did not, $F(1,177) = 3.89, p = 0.05, \eta^2 = 0.02$. Having their father use their chosen name was associated with less depressive symptoms, $F(2,79) = 4.22, p = 0.018, \eta^2 = 0.10$. Having their mother use their chosen name was associated with less anxiety, $F(2,107) = 4.86, p = 0.010, \eta^2 = 0.086$, and depressive symptoms $F(2,115) = 5.70, p = 0.004, \eta^2 = 0.093$.</p> <p>Youth who had legally changed their name reported lower anxiety, $F(1,112) = 6.25, p = 0.014, \eta^2 = 0.054$, and depressive symptoms, $F(1,116) = 4.78, p = 0.031, \eta^2 = 0.041$, than those who had not.</p> <p>Accessing multiple steps of gender affirmation (social, legal, and medical/surgical) was associated with fewer symptoms of depression $F(4,108) = 4.167, p = 0.004, \eta^2 = 0.140^1$, and anxiety $F(4,105) = 4.16, p = 0.004, \eta^2 = 0.144^1$. Furthermore, engaging in gender affirmation processes helped youth to develop a sense of pride and positivity about their gender identity and a feeling of being socially accepted.</p>
5	Gonzalez et al. (2012)	Agentic and communal personality traits: Their associations with depression and resilience among transgender women.	122 transgender women in the USA.	To examine differences in agency and communion personality traits with depression and resilience among transgender women living part-time and full-time in the female gender role.	Cross-sectional online survey (PAQ, RS, CES-D).	Part-time or full-time transition status.	<p>Transgender women living full-time in the female gender role reported higher levels of agentic and communal traits and acceptance of self and life compared to those living part-time in the female gender role.</p> <p>No significant differences in depression scores between those living full-time and part-time in the female gender role.</p> <p>No significant differences in personal competence (a construct of resilience).</p>

6	Hill et al. (2018)	Exploring transgender legal name change as a potential structural intervention for mitigating social determinants of health among transgender women of colour.	65 transgender women of colour in New York, USA.	To examine the effects of legal name change on socioeconomic factors, health care access and utilisation, and transgender-related victimization.	Cross-sectional 30-minute telephone survey (various items including BSI, RSES).	Legal name change or not.	After controlling for age, those who legally changed their name were significantly more likely to have a higher monthly income ($AOR = 5.36$, 95% CI [1.50, 19.13]) and stable housing ($AOR = 3.35$, 95% CI [1.09, 10.35]) than the pre-name change group. No significant differences for general health care utilization. A significantly greater percentage of the pre-name change group reported postponing medical care due to gender identity ($AOR = 5.88$, 95% CI [1.03, 33.40], Cramer's $V = 0.23$), using non-prescribed hormones ($AOR = 4.12$, 95% CI [1.28, 13.31], Cramer's $V = 0.31$) and experiencing verbal harassment by family and friends ($AOR = 4.86$, 95% CI [1.08, 21.89], Cramer's $V = .25$).
7	Kattari & Hasche (2015)	Differences across age groups in transgender and gender non-conforming people's experiences of health care discrimination, harassment, and victimization.	5885 transgender and gender non-conforming adults across the USA, Puerto Rico and Guam from the NTDS.	To examine experiences of discrimination, harassment, and victimization, considering insurance status, level of passing and time of transition.	Cross-sectional online survey (developed for this survey).	Degree of being read as transgender; living full-time or part-time as identified gender.	Participants with a lower level of passing had a higher likelihood of reporting discrimination than those with higher levels of passing ($OR = 1.09$, 95% CI [1.02, 1.16]). Participants living part-time as identified gender had a lower likelihood of reporting discrimination ($OR = 0.33$, 95% CI [0.25, 0.43]) and harassment ($OR = 0.96$, 95% CI [0.95, 0.96]) than those living full-time.
8	Peitzmeier et al. (2017)	Health impact of chest binding among transgender adults: A community-engaged, cross-sectional study.	1800 adults assigned female at birth.	To understand the prevalence and risk factors for negative health outcomes associated with chest binding.	Cross-sectional online survey (newly developed survey capturing experiences of chest binding and mental and physical health outcomes).	Social: chest-binding.	Self-reported mental health effects of binding were almost universally positive, with additional qualitative data reporting decreases in suicidality, anxiety and gender dysphoria, and increases in self-esteem, confidence and perceived safety in public. 97.2% reported at least one negative health outcome from binding.
9	Pollitt et al. (2020)	Predictors and mental health benefits of chosen name use among transgender youth.	129 transgender youth from three cities across the USA.	To examine characteristics associated with chosen name use, predictors of chosen name use and the association between chosen name use and mental health outcomes.	Cross-sectional survey (BDI-Y, PANSI, RSES, CASSS)	Social: chosen name use.	Chosen name use at home ($b = -0.52$, $SE = 0.18$, $p = .004$), school ($b = -0.47$, $SE = 0.18$, $p < .001$) or work ($b = -0.61$, $SE = 0.16$, $p < .001$) predicted fewer depressive symptoms. Chosen name use at home ($b = 0.45$, $SE = 0.17$, $p = .01$), school ($b = 0.35$, $SE = 0.16$, $p = .03$) or work ($b = 0.37$, $SE = 0.16$, $p = .02$) predicted greater self-esteem.

10	Russel et al. (2018)	Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behaviour among transgender youth.	129 transgender youth from three cities across the USA.	To examine the relationship between chosen name use and mental health among transgender youth.	Cross-sectional online survey (BDI-Y, SHBQ, CASSS).	Social: chosen name use.	Chosen name use in more contexts was associated with lower depression ($B = -5.37$, 95% CI [-8.20, -2.55]), 29% decrease in suicidal ideation, and 56% decrease in suicidal behaviour. These were lowest when chosen names could be used in all four contexts: home, school, work and with friends.
11	Scheim et al. (2020)	Gender-concordant identity documents and mental health among transgender adults in the USA: A cross-sectional study.	27 715 transgender adults in the USA	To examine the relationship between having gender-concordant identity documents and mental health.	Cross-sectional online survey (Kessler 6 Scale ²).	Legal (chosen name- and gender-concordant IDs); living full-time or part-time as identified gender.	Having all IDs gender- and chosen name-concordant was associated with lower prevalence of psychological distress ($B = 1.92$, 95% CI [-2.27, -1.56]), suicidal ideation ($APR = 0.78$, 95% CI [0.72, 0.85]), and suicidal planning ($APR = 0.75$, 95% CI [0.64, 0.87]). Only 10.7% of the sample had all concordant documents. Having some concordant ID compared to none was generally associated with smaller reductions in distress and suicidality. Gender-concordant ID was not associated with suicide attempts.
12	Sievert et al. (2020)	Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with gender dysphoria.	54 transgender children in Germany.	To examine the impact of socially transitioning on children's psychological functioning.	Cross-sectional questionnaire (German version of the CBCL, MFAD).	Social transition status (no; partial; almost complete; complete).	Social transition status was not significantly associated with psychological functioning or peer relations. Degree of social transition did not significantly predict internalising or externalising problems. Peer problems and worse family functioning were significantly associated with psychological functioning.
13	Witcomb et al. (2019)	Experiences and psychological wellbeing outcomes associated with bullying in treatment-seeking transgender and gender-diverse youth.	274 TGD youth in the UK.	To explore experiences of bullying in TGD youth attending a transgender health service.	Cross-sectional paper questionnaires completed at home (HADS, TBQ).	Social transition status.	Bullying was more commonly reported by those who were 'out' with their gender identity. It was not influenced by whether individuals had socially transitioned or not. Those who had socially transitioned were less likely to report gender-based bullying than their non-transitioned counterparts. Birth-assigned females were most at risk.

14	Kuvalanka et al. (2014)	Child, Family, and Community Transformations: Findings from Interviews with Mothers of Transgender Girls.	5 mothers of transgender daughters in the USA.	To understand the experiences of parents with transgender and gender-nonconforming children and how this may be impacted by different contexts.	Cross-sectional 1:1 telephone interviews.	Social transition status.	All parents reported changes in their child's demeanour and wellbeing (e.g. happiness, confidence, outgoingness) after socially transitioning. There were also reports of decreased feelings of anger and thoughts of self-harm. Challenges and benefits of communities (towns, schools, religions) were described.
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Note. SCS = Self-Compassion Scale (Neff, 2003); DASS-21 = Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995); OI = Outness Inventory (Mohr & Fassinger, 2000); MOSSSS = Medical Outcomes Study Social Support Scale (Sherbourne & Stewart, 1991); ETS = Experiences of Transphobia Scale (Marcellin et al., 2013); RR = risk ratio; GNC = gender non-conforming; NTDS = National Transgender Discrimination Survey; OASIS = Overall Anxiety Severity and Impairment Scale (Campbell-Sills et al., 2009); MDS – Modified Depression Scale (Dunn et al., 2012); GDS = Gender Distress Scale (Bauer et al., 2017a); GPS = Gender Positivity Scale (Bauer et al., 2017b); PAQ = Personal Attributes Questionnaire (Spence & Helmreich, 1979); RS = Resilience Scale (Wagnild & Young, 1993); CES-D = Centre for Epidemiology Studies Depression Scale (Radloff, 1977); BSI = Brief Symptom Inventory (Derogatis & Spencer, 1993); RSES = Rosenberg Self-Esteem Sale (Rosenberg, 1965); AOR = adjusted odds ratio; OR = odds ratio; BDI-Y = Beck Depression Inventory for Youth (Beck, 2001); PANSI = Positive and Negative Suicide Ideation Inventory (Osman et al., 1998); SHBQ = Self-Harm Behaviour Questionnaire (Gutierrez & Osman, 2008); CASSS = Child and Adolescent social Support Scale (Demaray & Malecki, 2002); APR = adjusted prevalence ratio; CBCL = Child Behaviour Checklist (Döpfner et al., 1998); MFAD = McMaster's Family Assessment Device (Epstein et al., 1983); FTM = female-to-male; TGD = transgender and gender-diverse; HADS = Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983); TBQ = Transgender Bullying Questionnaire

¹ η^2 : small = 0.01; medium = 0.06; large = 0.14

² Kessler et al. (2002)

Social Transition

Five quantitative studies and one qualitative study reviewed relationships between social transitions and mental health and social wellbeing. Two studies measured whether participants had socially transitioned or not; others looked at specific aspects of social transitions: chosen name use ($n=3$); chest-binding ($n=1$).

Of the quantitative studies, all explored mental health outcomes (anxiety, $n=3$; depressive symptoms, $n=5$; suicidality, $n=2$; self-esteem, $n=2$) and two explored social wellbeing (safety in public, $n=1$; bullying, $n=1$). The qualitative study reviewed both mental health and social wellbeing (see Table 5 for thematic analysis).

Relationship with Mental Health

Despite the negative health outcomes, Peitzmeier et al. (2017) found chest-binding was associated with positive impacts on mental health, including self-esteem, suicidality and anxiety in their sample of 1800 adults. Similarly, all five mothers of transgender children in Kuvalanka et al.'s (2014) study recalled improvements in their daughters' self-esteem, happiness and outgoingness following their social transition. Although participants were interviewed at one time-point, they reflected upon their child's entire transition. This suggests changes in wellbeing and mental health may have occurred because of social affirmation. One mother reported significant decline in their daughter's mental health, which she attributed to bullying, social isolation and her daughter commencing male puberty. It is difficult to know how common these experiences are given the small sample of five children.

Sievert et al. (2020) found greater rates of internalising and externalising problems in their sample of 54 German children with gender dysphoria compared to age-equivalent German norms. Social transition status was not found to be associated with psychological functioning and did not predict this. However, participants in this study reached clinical threshold to access a gender identity clinic; hence, this could explain differences in the

psychological functioning in this research compared to other published studies (e.g. Durwood et al., 2017; Olson et al., 2016).

Regarding chosen name-use, Fontanari et al. (2020) found a small, but significant effect size with Brazilian TGD youth preferring to be called by another name reporting significantly fewer depressive symptoms than TGD youth who did not prefer to be called by another name. Having their father use their chosen name had a small effect size for depressive symptoms; having their mother use their chosen name had a medium effect size for anxiety and depressive symptoms. Greater gender positivity was significantly associated with mothers of TGD youth using their chosen name.

This has been replicated in US TGD youth: chosen name use in more contexts was associated with less reported depressive symptoms, 29% reduction in suicidal ideation and 56% reduction in suicidal behaviour, with the least of these reported when chosen name was used across home, school, work and with friends (Russel et al., 2018). Findings were consistent even when controlling for social support and personal characteristics. Similarly, Pollitt et al. (2020) reported chosen name use across home, school or work settings predicted large reductions in suicidality and depressive symptoms and small improvements in self-esteem when controlling for parental support and outness to family.

When reviewing data location and sample demographics, it seems both Pollitt et al. (2020) and Russel et al. (2018) analysed the same 129 participants. Whilst they use different analyses, control for different confounding variables and use different measures for suicidality, it is questionable how much additional weight Pollitt et al. (2020) brings to support the associations between chosen name use and mental health outcomes, given they are likely reporting on the same individuals.

Relationship with Social Wellbeing

Through chest-binding, TGD individuals felt safer in public (Peitzmeier et al., 2017). However, Witcomb et al. (2019) found 86.5% of TGD youth had experienced bullying, mainly in school, with socially transitioned youth being no more likely to report experiencing bullying than non-transitioned TGD youth. Homophobic and transphobic bullying were most frequently reported, with this type of bullying significantly more frequently reported in socially transitioned youth than non-transitioned youth ($\chi^2 = 7.97, p < .01$). However, the research did not differentiate between specific transphobic or homophobic bullying. Of socially-transitioned youth, birth-assigned females were more likely to report bullying than birth-assigned males.

Mothers of transgender daughters reported mixed experiences of socially transitioning upon their daughter and families' social wellbeing. For instance, some experienced rejection, neglect or discrimination from their daughter's school, religious group or local community, which sometimes resulted in families moving to new, more liberal and accepting communities. One mother reported her daughter experienced bullying and isolation from peers because of her social transition. In comparison, others shared acceptance from peers and recalled supportive schools and local communities (Kovalanka et al., 2014). It seems the response from social communities varied depending on the beliefs of others in that environment.

Table 5*Thematic analysis of Kivalanka et al. (2014)*

Theme	Subtheme	Examples
Impact on mental health		<i>“she hated herself, she wanted to just kill herself.... She was so out of control”</i> (Anne)
Positive impact on wellbeing	Happiness	<i>“a much happier child since she’s transitioned She just carries herself differently, with a confidence.”</i> (Christine) <i>“I have never in my life seen a happier kid.”</i> (Nora)
	Outgoing	<i>“She’s just a whole new person ... she was just trying to be invisible before”</i> (Christine) <i>“she’s just so outgoing ... and [after transition] she immediately started doing [well at] school and participating”</i> (Lauren)
Impact on community acceptance	Local community	<i>“We lived in a ... very, very conservative area—more conservative than I even knew And Nicole was, you know ... getting the message, not from us, but from those around her that it wasn’t okay to be herself.”</i> (Anne) <i>“Her family had also recently moved to a more affirming community, where she no longer was isolated for being transgender and where her gender identity was outwardly celebrated.”</i> (Anne) <i>“We have support at school, we have support in our community.”</i> (Christine)
	School	<i>“[Superintendent] said that he wasn’t comfortable with me making them [staff] be a part of this ‘deception’”</i> (Lauren) <i>“they required Emma to use the nurse’s bathroom rather than the girls’ bathroom. Lauren felt this restriction kept Emma “segregated” and was “a reminder to her [Emma] all the time” that she was not fully accepted”</i> (Study authors regarding Emma’s daughter) <i>“the staff had been advised to distance themselves from Jennifer’s family and “this situation”.”</i> (Study authors regarding Jennifer’s daughter) <i>“‘Our lawyers have advised us not to speak with you’.”</i> (Nicole) <i>“we don’t have a gender-neutral bathroom.” So, Nicole would have to go and dress female and go to the boys’ bathroom”</i> (Anne)
	Religion	<i>“We also found a Unitarian Universalist church. We’ve never gone to church that much before, but we found this community, and Nicole’s been able to stand up in front of that community, and ... tell them who she is. And, you know, just say, “This is who I am and thank you for accepting me” and have the whole church stand up and cheer for her. So, she’s been very, very affirmed in who she is, and it’s a completely different experience”</i> (Anne)

Legal Transition

Four quantitative studies explored the relationship between legal transitions and their impact on mental health (suicidality, $n=2$; depression, $n=1$; anxiety, $n=1$; psychological distress, $n=1$). One explored social wellbeing. Legal transitions included name change ($n=2$) and gender- or name-concordant IDs ($n=2$).

Relationship with Mental Health

Fontanari et al. (2020) found lower anxiety and depressive symptoms reported in TGD youth who had legally changed their name ($n=33$), than those who were in the process of doing so, or had not started this process ($n=179$). Although Hill et al. (2018) found no significant differences in depression and anxiety between transwomen of colour who had ($n=28$) and had not ($n=37$) changed their name, all participants in the pre-name change group had already initiated this process. Convenience sampling from a name-change project likely leads to bias in Hill et al.'s sample and may represent TGD individuals who are more proactive in their transition or able to access the means to change their name.

Scheim et al. (2020) reviewed rates of name- and identified gender-concordant IDs in over 27 000 TGD adults. The small percentage of participants with all concordant documents (10.7% weighted percentage) reported the least psychological distress. Those with all or some concordant IDs reported less suicidality than those with no concordant IDs. The large sample size in this study suggests reliability of the findings. However, given the cross-sectional nature, cause and effect cannot be determined: perhaps psychological distress inhibits individuals from changing their IDs, or a third unspecified factor affects the relationship.

Bauer et al. (2015) found similar results: having at least one gender-concordant ID was associated with lower suicidal ideation, (risk ratio $[RR] = 0.56$), and suicide attempts ($RR = 0.26$) in the past year. They estimated that access to gender-concordant IDs had the potential to prevent 90 TGD individuals per 1000 experiencing suicidal ideation. Of those

experiencing suicidal ideation, they estimated a further 230 suicide attempts could be prevented. Although Bauer et al. (2015) controlled for various confounding variables, including childhood trauma and major physical and mental health diagnoses, they were not able to isolate the effects of each intervenable factor investigated. Therefore, other intervenable factors, such as parental support, may have assisted access to legal document changes.

Relationship with Social Wellbeing

Hill et al. (2018) was the only study to explore the relationship between legal transitions and social wellbeing, assessing housing stability, employment, income and harassment from friends and family. They found women in the post-name change group were significantly more likely to have stable housing and higher monthly incomes. Whilst causality cannot be inferred due to the cross-sectional nature, there is suggestion that legal name change may be associated with socioeconomic benefits to individuals. This is particularly important for this sample of transgender women of colour who may experience minority stress due to their gender identity and ethnicity.

Extent of Transition

Seven studies explored relationships between extent of transition and mental health and social wellbeing. Extent of transition was measured in numerous ways: expressing identified gender full-time or part-time ($n=5$); level of visual conformity/being read as identified gender ($n=2$), affirmation domains accessed ($n=1$) and outness to different groups ($n=1$). Mental health outcomes explored included: emotional/psychological distress ($n=2$); suicidality ($n=2$); depressive symptoms ($n=2$); anxiety ($n=1$) and personal competence ($n=1$). One study explored homeless experiences and one explored discrimination and harassment.

Relationship with Mental Health

Fontanari and colleagues (2020) found higher rates of reported depressive symptoms in youth who never expressed their true gender identity ($n=56$), compared to those who expressed theirs half ($n=135$) or all the time ($n=158$). Allen (2018) found the more ‘out’ individuals were, the less emotional distress they reported. Although, ‘outness’ on its own did not predict emotional distress, it was a predictor when considered alongside self-compassion. Hence, self-compassion may be considered more of a predictor of emotional distress than ‘outness’.

Gonzalez and colleagues (2012) compared TGD women living full-time ($n=72$) or part-time ($n=41$) in the female gender role and found no significant differences in reported depression. However, women living in the female role full-time had significantly greater scores for agency and communion and acceptance of self and life. Similarly, Bauer et al. (2015) found social transition status (full-time; part-time; never) was not associated with suicidality in their sample of 380 TGD adults, though statistical power was not high. Therefore, research evidence is equivocal regarding significant differences in mental health outcomes between those presenting as their identified gender full-time, part-time or never.

Fontanari et al. (2020) reviewed each type of transition (legal, social, medical) and found accessing more domains was associated with less anxiety and depressive symptoms, even when controlling for socioeconomic status. However, groups were not mutually exclusive; hence, outcomes could not be attributed solely to that transition type. Youth who accessed all three types of transition reported the least anxiety and depression. Although Scheim et al. (2020) collected data regarding whether participants lived as their true gender part-time or full-time, these groups were not used in their analysis.

Relationship with Social Wellbeing

Kattari and Hasche (2015) found lower reported rates of discrimination and harassment in transgender and gender nonconforming (GNC) participants living part-time as their identified gender compared to those living full-time. The researchers also reviewed “level of passing” (i.e. presenting and being read as one’s identified gender) on a five-point Likert scale. They observed individuals with a lower self-reported “level of passing” reported higher rates of discrimination ($OR = 1.09$, 95% CI [1.02, 1.16]). Perhaps discrimination prevalence could relate to “level of passing” rather than time spent expressing one’s true gender. Due to the self-report nature of individuals’ “level of passing”, the validity of this variable is questionable. Furthermore, it suggests participants aim to be read as a binary gender; yet we know this is not the case for everyone, particularly those who identify as GNC.

Begun and Kattari (2016) reviewed TGD homelessness experiences depending on how visually conforming the individuals rated themselves. Those who rated themselves as less visually conforming were significantly less likely than those who rated themselves as somewhat conforming or conforming to seek access to shelters. Furthermore, they were significantly more likely to be denied access and more frequently thrown out of homeless shelters. If they did access shelters, they were more likely to be harassed or physically assaulted by other residents or staff and forced to live as their birth-assigned sex to remain in the shelter or to feel safe. Nonetheless, this single-item measure of visual conformity minimises the multifaceted nature of visual conformity/being read correctly.

Discussion

This review aimed to synthesise the current empirical literature exploring social and legal transitions, and extent of transitions, and their relationships with mental health and

social wellbeing. Findings will be discussed in relation to review aims and the minority stress framework, followed by clinical, policy and research implications.

Relationship between legal and social transitions and mental health and social wellbeing

Findings were mixed when considering the relationship between social transitions and mental health. Two studies found no associations; meanwhile, five found positive associations. This raises questions about the role of social affirmation in mental health. Nonetheless, using individuals' chosen name could be an immediate, risk-free way of affirming their gender, perhaps protecting against elevated levels of psychological distress and decreased wellbeing (Fontanari et al., 2020; Lelutiu-Weinberger et al., 2020; Pollitt et al., 2020; Strain & Shuff, 2010).

Three studies reviewed social transitions and social wellbeing. Whilst participants reported feeling safer in public, research found no differences in likelihood of experiencing bullying between those who had and had not socially transitioned. Research demonstrates *perceived* safety of public and community spaces impacts TGD individuals experience: places may be perceived as unsafe due to prior experiences of minority stress (Linander et al., 2019; Perry & Dyck, 2013). Varying confounding factors may impact studies results. For example, participants' degree of visual-conformity in a binary-driven society may influence minority stress experiences and subsequently mental health and social wellbeing (Teich, 2012).

Legal name change and concordant IDs was unanimously associated with positive wellbeing and decreased psychological distress. This supports research highlighting the role of structural interventions, such as legal affirmation, to wellbeing and healthcare-usage. In fact, Lelutiu-Weinberger et al. (2020) found affirmation mitigated the association between discrimination and past-year suicidal ideation.

One study reviewed legal transitions and social wellbeing, finding differences between those who had and had not accessed legal transitions. This highlights a lack of research in this area. Although the cross-sectional nature means cause and effect cannot be inferred, it may be that legal affirmation made it feel easier and safer for participants to access employment, housing and healthcare. This can have secondary impacts on mental health also.

Relationship between extent of transition and mental health and social wellbeing

Seven studies reviewed extent of transitions. Findings for mental health outcomes were equivocal: some reported greater levels of psychological distress in those not presenting as their true gender; others reported no differences. Gonzalez et al. (2012) suggest mental health difficulties may be more associated with minority stress than gender dysphoria. This is important considering the limited research exploring domains of social and legal transitions and minority stress. Within this review, two studies specifically reviewed minority stress in relation to harassment and discrimination, with both highlighting relationships between degree of visual conformity to binary genders and frequency of discrimination. This suggests findings may reflect degree of visual conformity rather than time spent expressing one's identified gender. Thus, mental health and wellbeing may be associated with communities' responses rather than solely individuals gender expression. However, given the limited research on this topic, it is difficult to draw conclusions.

Minority Stress Framework

Findings from this review support many aspects of Testa et al.'s (2015) TGD minority stress framework and their impact on mental health, including gender-related discrimination, rejection and victimisation and internalised transphobia. Notably, this review provides considerable support for Testa and colleagues addition of 'nonaffirmation of gender identity', with many studies reporting associations between nonaffirmation and mental health

outcomes. Additionally, findings indicate transition, including types of transition accessed and time spent presenting as one's identified gender, may also be influencing minority stress and mental health. Katz-Wise and colleagues' (2017) include transition within their model of TGD identity formation. Considering obstacles and cultural differences in approaches to transition, identity formation may form the context for the minority stress framework, having potentially both positive and negative impacts on mental health. Degree of visual conformity was also highlighted as an additional aspect for consideration. Further research is required to determine how stage of gender identity formation, degree of visual conformity and individuals' preference to conform to binary genders fits within the minority stress framework.

The review demonstrated a limited, but growing, evidence base for associations between transition and mental health, and social affirmation and mental health. Transition and affirmation may be separate, additional resilience factors to be included within the minority stress model, protecting against mental health difficulties. Further research is required to determine this, particularly given the close relationship between some aspects of transition and affirmation: for instance, choosing a preferred name (social transition) versus others using one's preferred name (social affirmation). Finally, given the studies included in this review, it may be beneficial to include social wellbeing as an outcome to the model, particularly feeling safe in public and housing stability.

Limitations

Most studies included White participants from America, limiting applicability to other ethnicities, countries and cultures given cross-cultural differences in psychological functioning and affirmation practices (de Graaf et al., 2018; de Vries et al., 2016; Spack, 2009). The social and cultural environment, particularly acceptance of TGD populations, likely impacts wellbeing (de Graaf et al., 2018). Only one study specifically examined the

experiences of PGM, and two others had majority PGM. The racially homogenous nature of study samples hinders validity. This may partly reflect convenience sampling involving internet-based samples (Gosling et al., 2004).

Although there are benefits to online surveys, such as increasing the participant pool, minimising social desirability bias and increasing access to underrepresented groups (Allen, 2018; Begun & Kattari, 2016; Gosling et al., 2004), it simultaneously excludes participants without internet access. Fontanari et al. (2020) was one of two studies to comment on this. Their study took place in Brazil where it may be more common to be without internet access compared to other Western nations (Navarro, 2020).

All studies were cross-sectional in nature, which limits ability to draw causal conclusions, instead only demonstrating associations between variables. Furthermore, the variables measured may fluctuate over time; for example, mental health and wellbeing can fluctuate at different timepoints depending on external wider contexts and individuals' circumstances.

In some ways, this review was limited by the heterogeneity of variables measured, particularly how gender expression was measured. Some research measured time individuals presented as their identified gender; for others, it involved types of transition or how they considered others read them. Measuring gender expression or transition using a quantitative approach is somewhat reductionist: it struggles to capture the multifaceted experiences of gender expression and identity. Many studies used singular items regarding time spent living as one's identified gender, or how visually conforming an individual was. Often, measurement was simplified and did not reflect the complexities of transitions. For example, expressing as one's true gender in some contexts but not others (Witcomb et al., 2019). Arguably, some aspects of transitions are easier to implement: growing/cutting one's hair may be more accessible than asking others to use one's preferred name; however, both are

regarded as social transitions. Lindqvist et al. (2020) reviewed options for measuring gender identity and expression, highlighting numerous difficulties, including gender norms varying across time and context. They recommend researchers identify gender norms specific to their research context and use these to develop questions regarding gender expression.

Although this review focused on social and legal transitions, and excluded studies primarily focussing on effects of medical transitions, it was not always possible to separate medical, social and legal transitions for all studies. To some extent, this limits grouping of studies and ability to isolate the relationships of outcomes and particular transitions, impacting validity. Only two studies considered medical transitions as confounds. Despite its irrelevance to some studies, due to age or measurement of specific transitions (e.g., chest-binding), it is surprising how few studies considered this confound.

The range of confounds identified and controlled for in each study were vast, varying from demographic characteristics including age and birth-assigned sex, to socio-economic factors (see Appendix D). Only two studies considered time elapsed since transitioning, and two considered degree of visual conformity or how individuals were read by others. Research did not explore whether TGD individuals desired to be read in certain ways: differences may exist between TGD individuals wishing to live unidentified as male or female and experiencing nonaffirmation, compared to those who wish to be read as non-binary or multiple gender identities. Nonetheless, this review has highlighted the complexities of conducting research with a diverse population, the nuances in terminology and how the research itself may be designed on outdated assumptions and be inadvertently perpetuating obsolete and/or insensitive beliefs.

Clinical Implications

Despite much research offering associations rather than causality, arguably TGD individuals may experience benefits if they are supported to use their preferred name,

reducing felt sense of marginalisation and promoting social wellbeing. Scholars, activists and TGD individuals agree that using chosen names and correct pronouns is the most supportive way to interact with TGD individuals and affirm their identity (Coolhart & MacKnight, 2015; Grossman & D'Augelli, 2006; Hill et al., 2018; Sausa, 2005). This is especially important for mental health clinicians (Russel et al., 2018).

Allen (2018) suggests practitioners should focus on instilling hope in TGD individuals to create positive expectations. However, this must be carefully balanced with the likelihood of experiencing minority stress. Given the mixed findings regarding presenting as one's true gender and harassment and discrimination, services need to be accessible for TGD populations and barriers to accessing services, and domains of transition, should be eliminated (Fontanari et al., 2020). Some TGD individuals may choose to present as their birth-assigned sex to reduce discrimination and victimisation. However, this may not be possible for individuals living full-time as their identified gender; hence, it is unacceptable for TGD individuals to feel forced to choose to present inauthentically to feel safe accessing healthcare. Non-judgemental and anti-discriminatory staff is a significant part of ensuring services are accessible. Systemic implementation of gender diversity training and competencies is one way to work towards eliminating interpersonal and structural discrimination (Kattari & Hasche, 2015; Lelutiu-Weinberger et al., 2020). Begun and Kattari (2016) highlight the further need to eradicate the socially-constructed notion of gender binaries and the notion that all TGD individuals wish to be read as a binary gender. Instead, they promote the spectrum of gender identities.

Policy Implications

Systemic interventions are crucial in promoting individual agency, which has been associated with fewer depressive symptoms and greater resilience. They foster a different political culture and have been associated with positive health environments, ameliorating

health disparities among minority groups (Auerbach et al., 2011; Gonzalez et al., 2012).

Implications from findings of the reviewed studies are considered here alongside current policy.

Name change is a key component of gender expression. Whilst anyone can use a different name, some organisations require legal documentation before using one's preferred name (Gov.uk, n.d.). However, legally changing one's name has various barriers which need reducing: in the UK, these include knowledge of the process, cost, and consent for under 18s (Gov.uk, n.d.; Teich, 2012). All parties with parental responsibility must agree to name changes for under 18s (Gov.uk, n.d.); however, many TGD individuals experience a lack of support from family members, particularly around preferred name use (Fontanari et al., 2020; Pollitt et al., 2020). Considering legal name change is associated with decreased psychological distress (Scheim et al., 2020), being unable to access legal name change procedures may lead to elevated mental distress in TGD individuals. Furthermore, not having concordant IDs has been linked with verbal harassment, denied access to services and assault (James et al., 2016). By making legal name change more accessible (e.g. reducing costs), TGD populations may experience less distress, as well as benefits in accessing healthcare and securing employment, given the significant role IDs play in employment processes. Finally, Hill and colleagues (2018) suggest legal name change may help legitimise TGD identities to individuals' friends and family. Hence, making legal name change easier could be a preventative structural intervention, reducing the health and economic disparities between TGD and cisgender populations (Bauer et al., 2015; Hill et al., 2018), promoting psychological health and social wellbeing, as well as pride and positivity associated with gender identity (Fontanari et al., 2020).

A similar, difficult procedure involves gender changes on legal documents. In the UK, TGD individuals must have particular documents to acquire gender-concordant passports

(HM Passport Office, 2013). Gender identity changes have become a high-profile, controversial topic in the UK (Roberts, 2020; Topping, 2020), with multiple barriers preventing access to required documentation. Furthermore, UK passports can only be male or female, as the Courts ruled against a non-binary gender marker (*Elan-Cane v. The Secretary of State for the Home Department*, 2020). This creates additional barriers and discrimination for non-binary individuals in the UK. Whereas, other countries offer non-binary gender markers (Sarrubba, 2020) and have eliminated further additional documentation barriers to access legal name and gender changes (TGEU, 2013). By making this process more accessible, and accessible to individuals of all gender identities, TGD individuals experience legal affirmation, which is associated with better mental health outcomes (Bauer et al., 2015; Scheim et al., 2020).

Structural systems, such as electronic medical records, tend to rely on cis-normative systems, perpetuating binary thinking in relation to gender identity. Geist et al. (2020) suggests clinicians and healthcare systems should advocate for system changes, including providing space for preferred names. By focussing less on birth-assigned sex, services may affirm individuals' identity, reduce discrimination and promote safety: for instance, granting access to accommodation based on gender identity as opposed to birth-assigned sex (Begun & Kattari, 2016).

Institutions, like schools and colleges, could operate more flexibly when assigning names and genders to IDs (Russel et al., 2018), as this is associated with better mental health outcomes (Fontanari et al., 2020; Pollitt et al., 2020; Russel et al., 2018). Under the Equality Act (2010), schools should support name and gender changes on school systems, and when applying for exams (VWV, 2016). Furthermore, it is paramount schools and workplaces allow TGD individuals to dress according to their gender identity (Government Equalities Office, 2018; The Intercom Trust, 2015), providing further opportunity to affirm gender

identity, rather than discriminating against this. Policy procedures should not prevent TGD individuals' expressing their true gender.

Research Implications

Given the cross-sectional nature of studies included in this review, longitudinal research is needed to determine cause and effect of mental health experiences and social wellbeing, and how this may or may not be impacted by transition type and/or stage. Bauer et al. (2015) highlight the benefits of using past year suicidality rather than lifetime prevalence: predictors of recent and lifetime suicidality differ widely, with past year measures enabling analysis of recent or current risk. Nonetheless, this does not eliminate the issue of temporality with cross-sectional research.

Most research recruited adults; within these samples, a wide age range existed. This can limit generalisability of findings, as participants belong to different generations and consequently have varying experiences of society and discrimination. This is demonstrated in a recent UK survey which found young adults were the most accepting of transgender identities compared to older age groups (Smith, 2020). By researching specific age groups, results may be more valid for generalising to similar aged TGD populations. Nonetheless, participants' experiences may also differ depending on their age of transition (Begun & Kattari, 2016; Kattari & Hasche, 2015) and the associated political climate, as demonstrated by Bronfenbrenner's ecological theory of development (Bronfenbrenner, 1988). Furthermore, differences in mental health may exist depending on how much time has elapsed since individuals' transitions.

Some studies explored the experiences of youth (typically aged 16-24). This developmental stage is associated with identity formation, independence and freedom to make one's own choices (Erikson, 1963; 1968) and is associated with increased risk to psychological wellbeing (Geist et al., 2020). Erikson suggested identity formation begins

much younger than 16; hence, exploring experiences of identity formation throughout childhood and into adulthood may provide useful insights as TGD individuals explore and express their identity (Durwood et al., 2017). This is particularly important given TGD children and youth have similar, but different, needs to adults (Geist et al., 2020).

Furthermore, it is possible outcomes in childhood may be associated with wider factors, such as familial support and protection from stigma and discrimination, rather than age at transition. Nonetheless, earlier social transition does not necessarily provide protection from later life mental health difficulties (Durwood et al., 2017). Hence, a systems approach (Bronfenbrenner, 1988) is needed to consider contextual factors (Geist et al., 2020).

Replication is recommended to identify relationship moderators and mediators, such as the extent to which social support can buffer hostile experiences (Greytak et al., 2013). Preliminary evidence suggests attending a school with a Gender and Sexuality Alliance is associated with better educational, psychological and social outcomes (Heck et al., 2013; Toomey et al., 2011). Qualitatively exploring which available support and interventions individuals find most useful may help to improve the type of support offered to TGD individuals (Geist et al., 2020).

As shown in Appendix F, participants ethnicity across studies was predominantly White. By recruiting more heterogeneous samples, findings may be more externally valid and generalisable to TGD populations. Although some under-represented groups may be small and difficult to access, studies demonstrated ability to access 'hidden' populations through recruiting via LGB and transgender organisations online and using respondent-driven sampling (Bauer et al., 2015; Fontanari et al., 2020).

Differences seem to exist between children from North America compared to Europe. However, this difference may be somewhat explained by inclusion criteria, with some studies recruiting from gender identity clinics and some recruiting community samples. Perhaps

children accessing a gender identity clinic may be more likely to experience emotional and behavioural difficulties, compared to community samples. Therefore, future research may wish to consider where participants are recruited from, particularly when comparing findings between studies. Similar comparisons cannot yet be drawn with adult populations due to a lack of published research exploring this in populations outside of America and Canada, highlighting a further need for research globally.

Research must take intersectionality into consideration (Kattari & Hasche, 2015) as minority experiences may not be attributed to gender identity alone. Determining whether minority stress experiences are due to gender diversity or another minority identity is incredibly difficult and may not be possible. However, this should be considered within research planning and analysis. There are currently competing hypotheses which require further exploration regarding whether identifying with multiple minority groups has an additive effect on minority stress, or whether identifying with multiple minority categories creates a novel experience which cannot be divided into its components (Meyer, 2010; Parent et al., 2013).

Generational influences alter society's understanding and definitions of gender identity and other research variables such as victimisation, discrimination and harassment (Kattari & Hasche, 2015). This could lead to under- or over-reporting experiences. Future research may wish to consider defining terminology to promote shared understandings amongst participants.

Incidentally, many studies measured transition extent and stage using binary questions. Whilst this type of data collection may lend itself to quantitative methodologies, it is reductionist in its approach and does not account for the variability and nuances in experiences (Pollitt et al., 2020). For example, individuals may express their true gender in some settings but not others, and transitioning may be a gradual process that is context-

dependent (Witcomb et al., 2019). Typically, research would not deem binary age categories of ‘old’ and ‘young’ acceptable; yet research often measures gender in this way (Lindqvist et al., 2020). Some studies explored all TGD identities, and some focussed on specific binary identities (see Appendix F). With gender considered to be a spectrum (Ehrensaft, 2018), it is recommended research explores non-binary individuals’ experiences (Olson et al., 2016). Little is known about the experiences of non-binary individuals. Whilst this population may not necessarily seek medical interventions, they may benefit from psychosocial support and gender affirmation (Lacefield et al., 2015; Vincent, 2019). Furthermore, research highlighted degree of visual conformity being a confounding factor which may link to minority stress experiences, which thus impact mental health. Future research should consider measuring desire to visually conform and degree of visual conformity.

Finally, as is common in qualitative research, it is advisable for quantitative researchers to examine their social identity and associated assumptions (Ryan & Golden, 2006), as this may influence the way data is collected and measured. For instance, Begun and Kattari (2016) and Kattari and Hasche (2015) measured visual conformity and ability to ‘pass’; yet this is not all TGD individuals’ goals and is based on assumptions which perpetuate outdated binary gender stereotypes and assumptions (Billard, 2019; Games, 2020).

Conclusions

This review has synthesised research findings of thirteen quantitative and one qualitative study exploring type and extent of social and legal transitions, demonstrating the multidimensional nature of transitions. Most studies were published within the last five years, all within the last nine, demonstrating the relevance and importance of research in TGD populations. Many studies reported positive associations between social and legal transitions and mental and social wellbeing, and highlighted the importance of removing barriers to transition. Notably, studies predominantly took place in America, where a consistent gender-

affirmative stance is taken (Spack, 2009). Findings support the TGD minority stress framework and suggest additional aspects to be considered within the model, namely identity formation, transition, affirmation and social wellbeing outcomes.

There are clear methodological limitations when researching the varied nature of gender expression and transitions in such a diverse population. Future research should include non-binary participants and consider preference and degree of visual conformity to gender binaries. It should aim to expand on these cross-sectional findings by using longitudinal designs to consider causality. Furthermore, intersectionality must be considered, given that many TGD individuals identify with multiple stigmatised groups.

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HARLEY CASWELL BSc (Hons)

Section B: Exploring minority stress and intersectionality in adolescents
attending a gender identity clinic in the United Kingdom.

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Abstract

Background and aims: Little is known about gender identity minority stress in gender diverse adolescents. This study aimed to adapt an adolescent minority stress measure to identify gender identity minority stressors (ASI-GD) experienced by adolescents referred to the UK gender identity clinic. Additional identities of ethnicity, sexual orientation and neurodiversity were considered. **Method:** Forty-five adolescents completed online questionnaires regarding gender identity minority stress, wellbeing and sociodemographics. **Results:** All 54 minority stressors were endorsed ($M = 16.8$; $SD = 8.2$). The ASI-GD had good internal consistency. Minority stress was negatively associated with wellbeing but this did not reach significance. Ten percent of participants identified as people of the global majority; 71% as LGB+ and 38% as autistic. No significant differences in gender identity minority stress existed between minority and majority identities for ethnicity, sexual orientation or neurodiversity. Despite a small, positive relationship between wellbeing and number of minority identities endorsed, this did not reach significance. **Conclusions:** The most commonly reported minority stressors related to negative expectations from others, internalised transphobia and transnegative communication. Non-significant findings warrant further investigation due to lack of statistical power. Clinical implications are discussed including application to the minority stress framework, intersectionality and directions for future research.

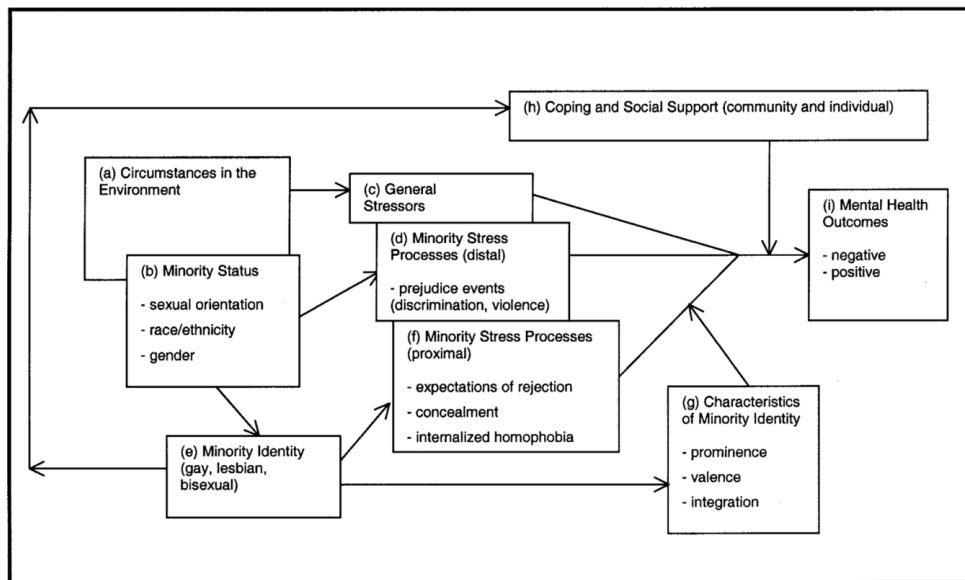
Key words: ethnicity, sexuality, autism, transgender, wellbeing

Introduction

Minority stress refers to the unique, chronic stigma, discrimination and prejudice created by the social environment experienced by those belonging to stigmatised minority groups (Brooks, 1981; Meyer, 1995; 2003). Examples of stigmatised identities include sexual orientation, gender identity and ethnicity (Hendricks & Testa, 2012; Meyer, 2010; Williams & Williams-Morris, 2000). Minority stress has been extensively researched in lesbian, gay and bisexual (LGB) populations to understand the increased prevalence of mental health problems (Cochran & Mays, 1994; D'Augelli & Hershberger, 1993; Meyer, 1995; Waldo, 1999). Meyer's (2003) framework suggests the experiences of identifying with a minority group (e.g., stigma, prejudice) are stressful and can lead to mental health difficulties. Meyer specifically highlighted the role of distal and proximal minority stressors. Distal stressors create overt stress for LGB individuals which subsequently impacts their mental health. Proximal stressors lead to distress from negative expectations of others and the effort of identity concealment, further effecting LGB individuals' mental health (see Figure 1). An additional process highlighted the effects of coping and social support which built resilience to minority stress. Meyer suggested this occurred through the union of members of a minority group developing a within-group, leading to group solidarity and cohesion, protecting against the adverse effects of minority stress on mental health. Meyer further explained members of the within group likely compared themselves with each other, as opposed to the dominant culture, therefore offering validation, and creating a positive view of themselves which can somewhat counteract stigma. The framework was born from numerous social psychological theories highlighting intergroup processes and comparison to others, which impact understanding and organisation of one's experiences and self-definition (Pettigrew, 1967; Stryker & Statham, 1985; Tajfel & Turner, 1986; Turner, 1999).

Figure 1

Minority stress process in LGB populations (Meyer, 2003)



Gender Identity Minority Stress

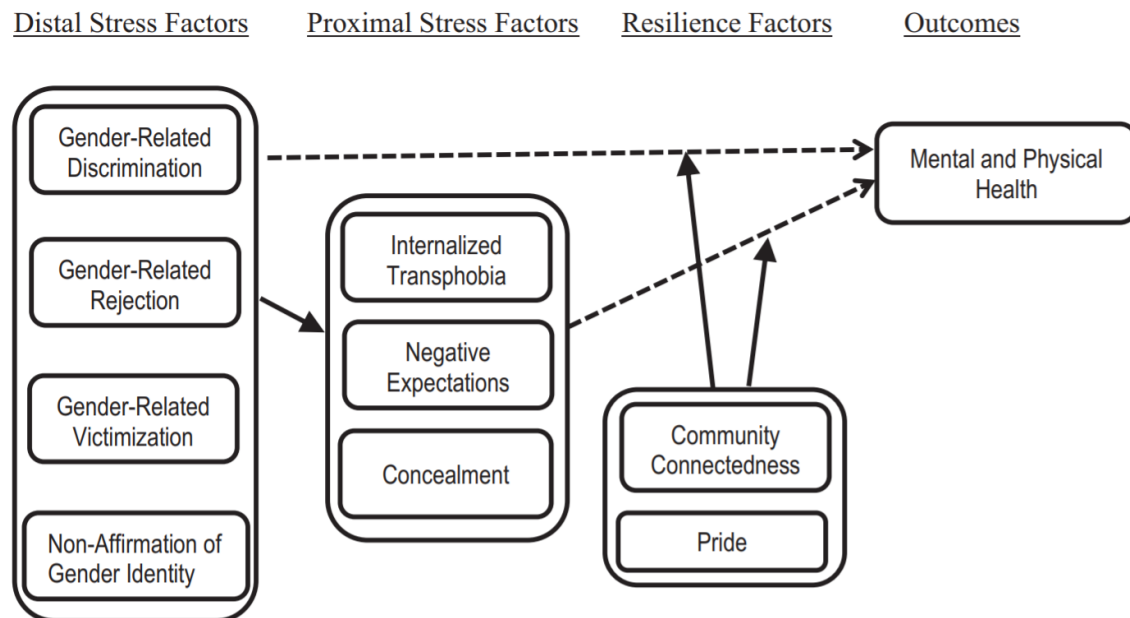
Gender diverse populations are a stigmatised minority group with a greater prevalence of psychological distress compared to the general population and populations with diverse sexual orientations (Bockting et al., 2013; Budge et al., 2013; Carmel et al., 2014; Grant et al., 2010). Diverse sexual orientations are referred to as LGB+ in this report to capture the broad spectrum of sexual orientations (Human Rights Campaign, 2020). Compared to cisgender peers, Reisner et al. (2015) found gender diverse adolescents experienced a two to three times increased risk for anxiety, depression and suicidality. Research in an adolescent gender identity development service (GIDS) in the United Kingdom (UK) identified bullying, low mood and self-harm as the most commonly reported difficulties for gender diverse adolescents, with bullying reported by 47% of participants (Holt et al., 2016). Nonetheless, gender identity alone is not a risk factor for such problems; it is the stigma associated with transgender and gender diverse identities that creates the risk (Eliason & Chinn, 2017). Research suggests the psychological wellbeing of gender diverse populations is exacerbated and mediated by social factors such as peer relations and minority stress (de Graaf et al.,

2017; de Vries et al., 2016; Hendricks & Testa, 2012; Lombardi, 2009; Shiffman et al., 2016; Testa et al., 2015). Additional risks for gender diverse populations include so-called ‘conversion therapy’, aiming to change individuals’ gender identity. A recent UK study found 14% of gender diverse participants had been offered conversion therapy. Of those, 61% had received conversion therapy with nearly half of those being forced to undergo conversion therapy (Asquith et al., 2021)

After noting similarities between LGB+ populations and gender diverse populations, Testa et al. (2015) modified Meyer’s minority stress model to capture the unique experiences of gender diverse individuals (see Figure 2). Both models include distal stressors, which are observable acts of discrimination, and proximal stressors, relating to anticipation and expectation of distal stressors. Resilience factors are highlighted as protective mechanisms against minority stress. In comparison to identity concealment for LGB+ individuals, Testa and colleagues noted identity concealment may not be a choice for some gender diverse individuals as it may for LGB+ individuals depending on physical characteristics (e.g. height) and stage of transition. An additional distal stressor was included: nonaffirmation. Nonaffirmation describes incidents when one’s identified gender is not affirmed by others. For example, being referred to with incorrect pronouns. Through confirmatory factory analysis, recent research identified gender dysphoria as an additional proximal stressor (Lindley & Galupo, 2020), as gender dysphoria was being triggered by distal stressors, correlated with other proximal stressors and was associated with negative health outcomes.

Figure 2

Minority Stress Framework for Transgender and Gender Diverse Populations (Testa et al., 2015)



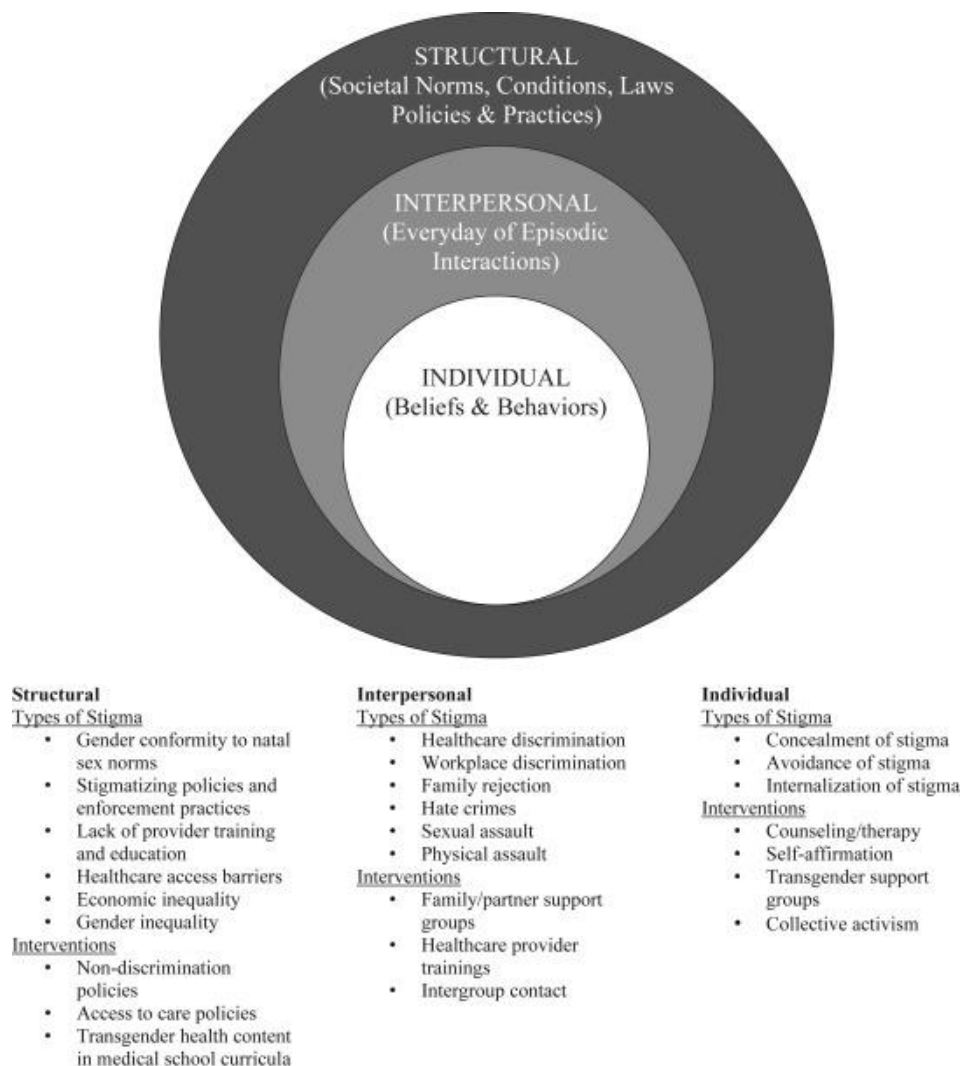
Research supports the minority stress perspective for adult (Rood et al., 2016; Testa et al., 2015) and adolescent gender diverse populations (Chodzen et al., 2019; Delozier et al., 2020). Chodzen and colleagues (2019) found various distal and proximal stressors predicted major depressive disorder and generalised anxiety disorder in clinically referred gender diverse youth. Delozier et al.'s (2020) topical review of empirical research highlights the mechanisms underlying health disparities for gender diverse adolescents using the minority stress framework. They conclude that reducing proximal and distal stressors and increasing resilience are recommended to improve psychosocial and physical health outcomes in gender diverse adolescents. Adolescence is pinpointed as a critical period given the developmental role of identity formation and increased peer influence and vulnerability (Delozier et al., 2020; Steinberg & Monahan, 2007). Furthermore, adolescents may lack power to escape environments where stigma and discrimination may be high, such as families and schools (Geist et al., 2020). However, limited research exists with adolescents compared to adults,

particularly for proximal stressors, with most research to date taking place in America; hence, it is unknown whether this applies to gender diverse populations in the UK. Furthermore, many studies explore singular path models rather than considering multiple stressors.

Figure 3

Social-ecological model of stigma & stigma interventions for gender diverse populations

(Hughto et al., 2015)



Hughto et al.'s (2015) critical review of empirical literature states stigma experienced by American gender diverse populations occurs at multiple levels: individual, interpersonal and structural, limiting opportunities for gender diverse individuals (see Figure 3). This adds to Testa et al.'s (2015) minority stress model as it demonstrates the importance of considering

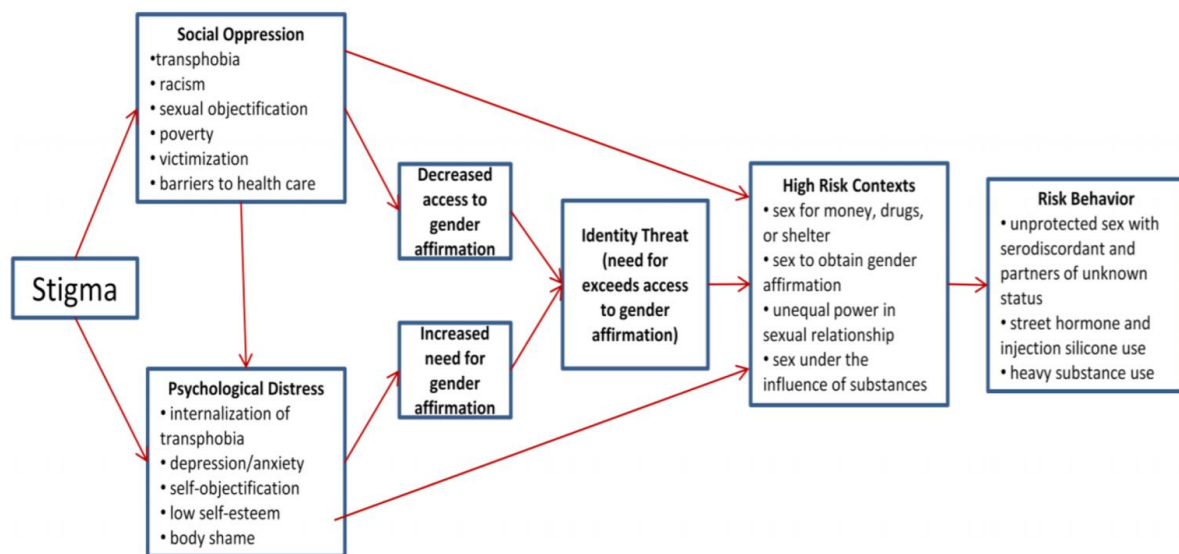
the contexts individuals are situated within, rather than considering minority stress from an individual perspective alone. Nonetheless, the review highlights the scarcity of research explaining the relationship between stigma, health and mental health outcomes.

Hughto et al. (2015) suggest potential interventions at each level. Arguably, each level of intervention incorporates affirmation. This is supported by research indicating affirmation reduces distress and associated mental health difficulties in adults (Glynn et al., 2016), youth (Fontanari et al., 2020), and children (Kovalanka et al., 2014; Olson et al., 2016). For example, using preferred names has been associated with reduced suicidality and depression (Bauer et al., 2015; Russel et al., 2018). Sevelius' (2013) gender affirmation model developed with transwomen of colour also forefronts the role of affirmation and the risky means of obtaining affirmation (see Figure 4).

Across Europe, Bränström and Pachankis (2021) reported structural stigma was associated with lower life satisfaction for gender diverse individuals. They found identity concealment explained this association, with greater concealment in countries with higher rates of structural stigma. However, they acknowledged concealment may also protect against discrimination, thus positively impacting life satisfaction. Notably, the UK had one of the lowest levels of reported structural stigma.

Figure 4

Gender affirmation model (Sevelius, 2013)



Multiple Minority Identities

So far, minority identities have been considered in their singular form; however, many individuals identify with multiple minority identities. For instance, identifying as gender diverse and LGB+, or gender diverse and a person of colour. Meyer (2010) refers to identifying with two minority identities as double jeopardy, a phrase first introduced to consider the impact of racism and sexism (Beale, 1979). Researchers proposed individuals identifying with multiple minority identities are at increased risk of minority stress compared to those identifying with only one (Jaspal, 2015). This is supported by research demonstrating an additive effect of multiple minority identities on health and psychological wellbeing in adults (Krieger et al., 2008; Szymanski & Gupta, 2009; Szymanski & Sung, 2010). However, others report no differences between double and single minority identities for mental health outcomes and alcohol and substance misuse in adults (Balsam et al., 2015; Harris, 2017) or mixed findings (Hayes et al., 2011). Within gender diverse populations, Allen (2018) found no differences in emotional distress between White participants and PGM. Nonetheless, they found those identifying as heterosexual experienced less emotional

distress than LGB+ participants. Chiang and colleagues (2016) compared the mental health of New Zealand high-school students based on various minority identities: ethnicity, sexual orientation and gender identity. They found double minority participants reported poorer mental health than straight, cisgender, people of the global majority² (PGM), but better mental health than White, LGB+ participants. Those identifying in all majority groups reported the lowest risk for mental health difficulties. They concluded that any minority identity increases mental health risks, but dual minority does not further elevate risk. However, gender diverse and LGB+ participants were amalgamated into one group; thus, their findings are questionable as some participants within the amalgamated group may already identify as dual minority (gender diverse and LGB+) or triple minority (gender diverse, LGB+ and PGM).

Higher rates of poor mental and physical health are not consistently reported among multiple minority groups such as LGB+ and gender diverse PGM, suggesting the presence of protective factors (Cyrus, 2017). It is suggested belonging to one minority group may in fact help build resilience to minority stress associated with other identities (Meyer, 2010). For example, those identifying as PGM may develop psychological resilience through community support and cultural beliefs, values and traditions (Sanders & Munford, 2015; Yu et al., 2016), which may somewhat negate the impact of minority stress.

An intersectional approach suggests multiple minority identities are not mutually exclusive (Parent et al., 2013) and instead stigmatised social identities overlap and are interdependent (Cyrus, 2017). Intersectionality has its roots in Black feminist thought in the 20th century. The term ‘intersectionality’ was introduced by Black feminist author, Kimberle

² ‘People of the global majority’ (PGM) is the term used throughout this report. At the time of writing, PGM is considered the most inclusive and empowering term to refer to the collective group of Black, Brown and Indigenous people. It is noted that this will likely change over time and in the future PGM may not be the most respectful term to refer to this diverse group of people. <https://www.rw-3.com/blog/talking-about-race-racism-navigating-terms-of-racial-identity>

Crenshaw, in 1989 when considering the intersection of race and sex for Black women. In the 1970s, the Third World Women's Alliance brought attention to triple jeopardy – specifically, racism, imperialism and sexism (Women of Colour Resource Centre, n.d.). Intersectionality was developed as a framework, highlighting the combined effects of multiple minority identities, in addition to effects from the fusion of these identities (Crenshaw, 1991). Hence, intersectional approaches propose a complex interplay of identities rather than a simple additive effect (Hayes et al., 2011; Shadick et al., 2015). For instance, Fox et al. (2020) found Black gender diverse and LGB+ participants reported less depressive symptomatology and self-harm than White, heterosexual, cisgender participants, concluding that multiple minority identity was not associated with greater psychopathology.

Multiple Minority Identities in Gender Diverse Samples

Research collating population-based surveys across the United States (US) using the Behavioral Risk Factor Surveillance System (BRFSS) reports 85% of transgender adults identified as heterosexual (Meyer et al., 2017). Meanwhile, the US 2015 Transgender Survey (USTS) found only 15% of gender diverse adults identified as straight/heterosexual, with 79% identifying as LGB+ (James et al., 2016). This is similar to other US-based research which found 14%-23% of gender diverse samples identified as straight (Kuper et al., 2012; Russel et al., 2018). The higher observed rates of heterosexuality in gender diverse adults in Meyer and colleagues' (2017) study may reflect the random digit dialling techniques used to obtain participants, with gender diverse participants being a subgroup of the study's participants. In comparison, James and colleagues (2016) used outreach techniques to recruit hard to reach groups of gender diverse participants specifically.

Most research estimating the sexual orientation of gender diverse populations is based on adult samples in the US. One study reports data from a 2015 state-wide, representative sample of US adolescents and found similar rates of transgender adolescents identifying as

heterosexual or LGB+ (40% and 41%, respectively) with an additional 19% questioning their sexual orientation (Walls et al., 2019). Another state-wide representative sample conducted in 2006 found that of the 17 transgender adolescents, 29% identified as heterosexual, 41% as homosexual or bisexual and 29% as unsure (Almeida et al., 2009).

Data from the UK found less than 10% of new referrals for children and young people to the GIDS were from PGM (de Graaf et al., 2020). Although this is comparable to rates in other UK clinical samples of gender diverse youth (Witcomb et al., 2019), it is an under-representation of PGM when compared to national adolescent populations and those seen in CAMHS (de Graaf et al., 2020). Therefore, it is likely not representative of the overall gender diverse adolescent population. Whilst 82% of respondents to the USTS identified as White (James et al., 2016), the BRFSS estimated 55% of transgender individuals identify as non-Hispanic, White compared to 66% in the general population (Flores et al., 2016).

Autism is increasingly considered an identity-based minority whereby autistic individuals are exposed to additional social stress and stigma, which is associated with poorer mental health (Botha & Frost, 2018, 2020). Research in Finland found 26% of adolescents referred to a gender identity clinic were diagnosed with autism (Kaltiala-Heino et al., 2015). In the Netherlands, 7.5% of referrals to a child and adolescent gender clinic had gender dysphoria and autism, based on standardised diagnostic assessments (de Vries et al., 2010). Similar rates were found in a US-based adult gender clinic with an autism screening instrument (Pasterski et al., 2014). Research in a non-clinical UK sample found 14% of gender diverse adults had received an autism diagnosis compared to 4% of cisgender participants. A further 28% of gender diverse participants reached the threshold of the autism screener, indicating suspected autism, whilst none of the cisgender participants scores warranted further autism investigation (Stagg & Vincent, 2019). Similarly, in the UK GIDS, 54.2% of adolescents scored in the mild-moderate and severe range of an autism screening

tool (Skagerberg et al., 2015). Such high rates of autism traits identified by screeners are greater than that seen in neurotypical populations, but less than those formally diagnosed with autism (van der Miesen et al., 2018). Glidden et al.'s (2016) systematic review supports the high prevalence of autism in gender diverse populations. Currently, there is no prevailing understanding of the co-occurrence of autism and gender diversity (Glidden et al., 2016). Given the high co-occurrence rates, it is important to understand how these multiple minority identities may be related to psychological functioning.

Research with Adolescents

Despite adolescence being a critical period for identity development (Erikson, 1963; 1968), there is a dearth of research with gender diverse adolescents. For instance, there are currently no figures in the UK estimating the size of the adolescent gender diverse population (Government Equalities Office, 2018). Although research exploring minority stress in gender diverse adolescents exists, there is currently no standardised measure of minority stress solely exploring gender identity minority stress alone. Schrage et al. (2018) critiqued the adolescent minority stress field for frequently creating their own minority stress measures, which lack psychometric properties and reliability. In fact, all current published measures of gender identity minority stress have either been developed for adult populations or conflate minority stress associated with sexuality and gender identity.

Notably, there is limited research reporting sexual orientation of gender diverse populations in adolescents and youth. In the US, the Youth Risk Behaviour Survey (YRBS) is completed biannually by most middle and high schools. In 2017, an additional question was piloted regarding gender diversity. Although this has been used to report adolescent transgender and LGB+ population sizes, there is no published data on the sexual orientation of transgender respondents. Similarly, in the UK there is no published data on the sexual orientation of gender diverse adolescent populations. Further exploration of gender diverse

adolescents in the UK is warranted to understand the size and demographics of this population.

Rationale and Aims

There are clear links between minority stress and psychological wellbeing in gender diverse populations. However, at present, there is an absence of research exploring gender identity-related minority stress in the UK, particularly in adolescents. This is reflected in the limited, published measures of gender identity minority stress in adolescents. Given adolescence is a critical developmental period for identity formation as well as increased vulnerability, it is important to understand the experience of minority stress for gender diverse adolescents and to research this in a standardised way. Exploring intersectionality within clinically referred gender diverse adolescents in the UK will provide insight into the heterogeneity that exists. This will contribute towards further understanding gender identity minority stress and wellbeing, and differences between minoritised groups and multiple minority identities. This may inform clinical practice for working with gender diverse adolescents. Alongside adapting a measure for gender identity-related minority stress, the following hypotheses were identified:

A. Gender identity minority stress will be negatively associated with wellbeing.

B. Identification as LGB+, PGM or autistic will significantly predict gender identity minority stress.

Given the opposing ideologies of Meyer's (2010) hypothesis regarding the additive effect of identifying with multiple minority groups and the mutually inclusive intersection of minority identities that may foster resilience to minority stress (Hayes et al., 2011; Shadick et al., 2015; Testa et al., 2015), a final hypothesis was developed:

C. Minority identities (i.e. LGB+, PGM or autistic) that significantly predict gender identity minority stress (as identified by hypothesis B) will moderate the relationship between minority stress related to gender diversity and wellbeing.

Method

Design

A cross-sectional design was used, with participants completing online questionnaires, yielding quantitative data. There were no aims to determine causality.

Participants

The GIDS support young people presenting with difficulties associated with their gender identity, up until their 18th birthday (GIDS, n.d.). Eligible participants were identified by clinicians at the GIDS teams across the UK, based on the following inclusion criteria: aged 11-18 inclusive, having adequate understanding of written or spoken English and clinical appropriateness. Two-hundred and eighty-four participants were invited to take part in the research. Of those, 49 consented to the research (17.3%). Four participants were excluded due to missing questionnaires, resulting in a total of 45 participants.

Measures

Sociodemographics

Participants were instructed to select as many gender identities as relevant from a list, with an option to add identities not listed. Additional questions regarding other minority identities were collected, including sexual orientation, ethnicity, disability, and religion. For autism, participants were asked if they thought they had autism and then, if they had been formally diagnosed with autism. These two groups were then collapsed into one category because whether or not participants had been formally diagnosed, believing they had autism would likely affect their identity and associated minority stress experiences.

Wellbeing

The World Health Organization-Five Wellbeing Index (WHO-5; WHO, 1998) is a five-item self-report measure of wellbeing over the past two weeks. Agreement with statements (e.g. *I have felt cheerful and in good spirits*) is measured on a six-point Likert scale ranging from 0 (*at no time*) to 5 (*all the time*), creating a total score. Higher scores indicate greater wellbeing. This measure has demonstrated good reliability and validity, both as a screening tool for depression and an outcome in clinical trials (Winther Topp et al., 2015). It is suitable for use with children and adolescents, with good internal consistency ($\alpha = 0.85$; Allgaier et al., 2012). Cronbach's alpha for this study was .71.

Minority Stress

As there are no adolescent minority stress measures measuring gender identity minority stress alone, the Sexual Minority Adolescent Stress Inventory (SMASI; Schrage et al., 2018) was adapted for this study. The SMASI measures minority stress associated with identifying as lesbian, gay, bisexual, transgender or queer (LGBTQ). It comprises 64 statements (e.g. *My parents are sad that I am LGBTQ*), with a 'yes' or 'no' option. An additional question determines whether this was in the last 30 days. This produces a lifetime score and 30-day score, each between 0 and 64. Through exploratory factor analysis, 11 subscales were identified, reflecting various minority stressors: Identity Management, Negative Expectancies, Negative Disclosure Experiences, Family Rejection, Internalized Homonegativity, Homonegative Communication, Homonegative Climate, Social Marginalization, Intersectionality and Religion. One 10-item subscale (Work) is optional dependent on whether respondents have employment experience. The SMASI has demonstrated excellent internal consistency (overall $\alpha = 0.98$; subscale α range = 0.75–0.96) and test-retest reliability (overall $r > 0.99$; subscale r range = 0.89–0.99; Schrage et al., 2018). Further investigation of the SMASI confirms its measurement of proximal and distal

minoritised sexual orientation stressors, rather than general adolescent stressors (Goldbach et al., 2017).

Within the adaptation (Adolescent Stress Inventory – Gender Diversity [ASI-GD]), references to ‘sexual orientation’ and ‘LGBTQ’ were replaced with ‘gender identity’ and ‘gender diverse’, as suggested by service-users (e.g. *I hate being gender diverse; A religious leader tried to change my gender identity*). The optional Work subscale was removed due to the age of participants. Fifty-four statements relating to distal and proximal gender identity minority stressors remained. Due to the limited published research exploring gender identity-related minority stress in adolescents in the UK, the lifetime Total Score was used rather than the 30-day score, to obtain an initial understanding of minority stress in this population. Scores ranged from 0-54; higher scores indicated greater exposure to minority stressors. Cronbach’s alpha for the Total Score for this study was .88, reflecting good internal consistency, demonstrating that items on the ASI-GD are measuring the same construct.

Stakeholder Involvement

The GIDS clinicians and research team were consulted in planning the research, generating multiple viewpoints and feedback. When adapting the minority stress measure, various minority stress questionnaires were considered with the research team for suitability. After choosing the SMASI, the adapted version was again reviewed by the GIDS staff for feedback. Questionnaires used in the study were reviewed by adolescent GIDS service-users to assess suitability. Feedback was sought regarding the most appropriate terminology: ‘gender diverse’ was their preferred term and is used throughout.

Procedure

Identified participants’ records were checked by a research assistant to ensure participants had previously consented to being contacted for research purposes. Eligible participants were emailed an invitation to participate (see Appendix G). This included a

Qualtrics weblink containing an information sheet detailing the research (see Appendix H) and a consent form (see Appendix I). Participants could contact the researchers with questions prior to consenting to participate. After giving electronic informed consent, participants were invited to complete the questionnaires online (see Appendix J). Participants were able to take breaks before completing the questionnaires and could return to the webpage later. An option was available to complete questionnaires via telephone or videocall. No participants requested this.

Ethical Considerations

Ethical approval was given by the Health Research Authority and the Tavistock and Portman NHS Foundation Trust Research and Development Department. Participants aged 16 and over gave informed consent. Participants under 16 gave informed assent alongside parental consent. To maintain confidentiality, participants were allocated codes, ensuring their responses were separate from their identifying information. Participants' wellbeing was of utmost importance: participants were advised to contact the GIDS should they experience distress associated with completing this research. Participants were reminded they could withdraw from the study at any point without giving a reason.

Data Analysis

SPSS (version 24) was used to perform analyses. The association between minority stress and wellbeing was explored using correlation (hypothesis A). Linear regression and multiple regression were planned to explore predictors of minority stress (hypothesis B). Interaction effects would determine whether significant predictors of minority stress moderated the relationship between minority stress and wellbeing (hypothesis C). Power calculations using G*Power identified a minimum of 77 participants were required to achieve a medium effect size for the moderation analysis (Faul et al., 2009). Unfortunately, due to the COVID-19 pandemic and associated additional stress for clinicians and adolescents invited to

participate (see page 5), recruitment did not meet the minimum number of participants required. Alternative analyses were planned to investigate the research questions. Hypotheses B and C were adapted as follows:

B. Significant differences in gender identity minority stress will exist between sexual identities;

C. Significant differences in gender identity minority stress will exist between ethnic identities;

D. Significant differences in gender identity minority stress will exist between autism identities;

E. Number of minority identities will be significantly associated with wellbeing;

F. Number of minority identities will be significantly associated with gender identity minority stress.

Despite homoscedasticity assumptions being met, Shapiro-Wilk tests and graphical representations of the data indicated data was not normally distributed. Groups were considerably unequal except for the autism groups. Considering this, and the relatively small overall sample size, non-parametric tests were used (Campbell, 2001). Mann Whitney U tests were used to investigate hypotheses B-D. Participants reporting 'don't know/unsure' or 'prefer not to say' were excluded from these analyses. Spearman's correlation was used for hypotheses E and F, with participants coded by number of minority groups identified with. Participants reporting only identifying as a minority gender identity were coded as '1' and those identifying with two minority identities as '2'. Only one participant identified with more than three minority identities; thus, those identifying with three or more minority identities were collapsed into one group and coded as '3'.

Researcher Reflexivity

Despite calls for quantitative researchers to engage in reflexivity throughout the research process, this occurs much less frequently than in qualitative research (Aronowitz et al., 2015; Ryan & Golden, 2006). Nonetheless, quantitative researchers can be equally embedded within their research, with their identities influencing the questions they seek to answer, the methods they use and the explanations they support (Ryan & Golden, 2006).

Reflexivity felt particularly important within this research considering the research focussed on minority stress and the lead researcher belonged to mostly majority groups: the lead researcher was a cisgender, straight, White, able-bodied, middle-class female. It is possible the lead researcher's experience of minority stress associated with gender influenced their interest in this topic. Through using Jacobson and Mustafa's (2019) social identity map to aid reflexivity (see Appendix K), power differentials were explored and appropriate terminology for minority groups considered. It was hoped this approach would somewhat help to disrupt top-down approaches and power relations embedded between the researcher and participants, particularly given the remote nature of the research (Rice et al., 2019).

Results

Demographics

Table 1 displays the sample's reported gender identities. Participants were prompted to select all applicable gender identities ($M = 1.8$, $SD = 0.9$, range = 1-5). The mean age of the sample was 16 years and 10 months ($SD = 1.2$, range = 11 years and 6 months-18 years and 2 months), 95% confidence interval (CI) [16 years and 5 months, 17 years and 2 months]. Ninety-seven percent of the sample had socially transitioned, with 84% of the total sample presenting full-time as their identified gender and 13% presenting part-time. The mean age of socially transitioning was 12 years and six months, 95% CI [11 years and 8 months, 13 years and 3 months]. The sample's self-reported ethnicity, sexual orientation and neurodiversity is

displayed in Table 2 alongside gender identity minority stress scores (see Appendix L for additional demographics).

Table 1

Gender Identities of the Sample

Gender identity	Total N (%)
Transgender	29 (64.4)
Non-binary	10 (22.2)
Male	28 (62.2)
Female	6 (13.3)
Agender	2 (4.4)
Questioning	3 (6.7)
Genderqueer	1 (2.2)
Genderfluid	1 (2.2)
Femme	1 (2.2)

Table 2

Minority Characteristics and Gender Identity Minority Stress (ASI-GD) and Wellbeing

(WHO-5) Scores

	Total N (%)	ASI-GD	WHO-5
		Median (IQR)	Median (IQR)
Sexual orientation			
Heterosexual or straight	6 (13.3)	12.5 (11)	11 (6)
LGB+	31 (68.8)	15 (12)	9 (7)
Don't know/unsure	7 (15.6)	14 (20)	6 (7)
Prefer not to say	1 (2.2)	-	-
Ethnicity			
White	40 (88.9)	14 (12)	9 (6)
PGM	5 (11.1)	20 (17)	9 (15)
Neurodiversity			
Thinks they have an ASC/diagnosed with an ASC	17 (37.8)	14 (14)	13 (5)
Do not think they have an ASC	17 (37.8)	18 (15)	8 (5)
Don't know	10 (22.2)	13 (9)	9 (8)
Prefer not to say	1 (2.2)	-	-
Minority Identities			
1	9 (20)	14 (17)	9 (6)
2	20 (44.4)	14 (11)	8.5 (5)
3	15 (33.3)	17 (13)	13 (5)
4	1 (2.2)	30*	9*

Note. LGB+ = lesbian, gay, bisexual and other sexual identities other than straight; PGM = people of the global majority; ASC = autism spectrum condition; ASI-GD = Adolescent Stress Inventory – Gender Diversity; WHO-5 = World Health Organization-Five Wellbeing Index; IQR = interquartile range

* Only one participant identified with four minority identities.

Minority Stress and Wellbeing

The mean wellbeing score was 10.0 ($SD = 3.9$; range = 3-19). All minority stressors were endorsed by at least 4.4% of the sample ($M = 16.8$; $SD = 8.2$; range: 5-34). The most commonly reported minority stressors were: 'I hear other gender diverse people use words like "tranny" or "HeShe."' (86.7%); 'There are times when I do not want to be gender diverse' (84.4%); 'I have heard negative messages about being gender diverse from religious people' (84.4%); 'I expect people to reject me when they find out that I am gender diverse' (68.9%); 'I have heard a family member make negative comments about gender diverse people' (66.7%); 'I was "outed" about my gender identity by someone other than my family without my permission' (60%) and 'I felt unsafe or threatened in school because I am gender diverse' (53.3%). The least endorsed stressors were: 'I believe it is wrong for me to be gender diverse because of my religion' (4.4%); 'A religious leader has encouraged me to reconsider my gender identity' (6.7%); 'A religious leader tried to change my gender identity' (6.7%) 'I hope that being gender diverse is just a phase for me' (6.7%); 'I have had to move or change where I live because I am gender diverse' (6.7%). Appendix M presents frequencies of all minority stressors.

Hypothesis A: Relationship Between Gender Identity Minority Stress and Wellbeing

Although there was a small negative correlation between gender identity minority stress and wellbeing, this did not reach significance ($r_s = -.19$, $N = 45$, $p = .11$, 95% bias corrected and accelerated bootstrap CI [-.46, .09]).

Hypothesis B: Differences in Gender Identity Minority Stress Between Sexual Identities

Seventy-one percent of the sample identified as LGB+. There was no statistically significant difference in minority stress experiences between gender diverse participants identifying as heterosexual/straight and those identifying as LGB+, $U = 120.00$, 95% CI: [-11, 3], $n_1 = 6$, $n_2 = 31$, $z = 1.12$, $p = .28$, $r = .17$ (small effect), two-tailed.

Hypothesis C: Differences in Gender Identity Minority Stress Between Ethnic Identities

Eleven percent of the sample identified as PGM. There was no statistically significant difference in minority stress experiences between gender diverse participants identifying as White and those identifying as PGM, $U = 141.50$, 95% CI: [-16, 2], $n_1 = 40$, $n_2 = 5$, $z = 1.50$, $p = .14$, $r = .22$ (small effect), two-tailed.

Hypothesis D: Differences in Gender Identity Minority Stress Between Autism

Identities

Over a third of the sample identified as being autistic, with 27.3% of the total sample being formally diagnosed with autism. There was no statistically significant difference in minority stress experiences between gender diverse participants identifying as having autism and those not identifying as having autism, $U = 141.50$, 95% CI: [-5, 7], $n_1 = 17$, $n_2 = 17$, $z = -.10$, $p = .92$, $r = -.02$, two-tailed.

Hypothesis E: Relationship Between Number of Minority Identities and Wellbeing

Table 2 shows how many minority identities were endorsed by participants. As only one participant identified with four minority identities, groups identifying with three and four minorities were collapsed into one group for the purposes of this analysis. A small, positive association existed between wellbeing and number of minority identities, explaining 7% of the variation in wellbeing scores. However, this did not reach significance ($r = .27$, $N = 45$, $p = .069$, two-tailed).

Hypothesis F: Relationship Between Number of Minority Identities and Gender

Identity Minority Stress

Again, participants identifying with three or four minority identities were collapsed into one group. The association between gender identity minority stress and number of minority identities was non-significant ($r = .18$, $N = 45$, $p = .23$, two-tailed).

Discussion

This study aimed to explore gender identity minority stress in the context of additional minority identities of ethnicity, sexual orientation and neurodiversity. Original hypotheses planned to determine predictors and moderators of gender identity minority stress. These hypotheses were adapted due to the limited sample size, by comparing gender identity minority stress levels among majority and minority groups for sexual orientation, ethnicity and neurodiversity. Finally, associations between number of minority identities and wellbeing and minority stress were explored. Alongside this, internal consistency for the ASI-GD, an adapted measure of gender identity minority stress was reviewed. Findings will be discussed below, alongside clinical and research implications.

The ASI-GD demonstrated good internal consistency for the overall total minority stress score. This minority stress measure is the first of its kind for use with adolescents, with a specific focus on gender identity. All minority stressors were endorsed by at least 4.4% of participants, with participants on average endorsing approximately a third of all gender identity minority stressors. The most commonly reported minority stressors related to negative expectations from others, internalised transphobia and transnegative communication from others, including family, religious leaders and other gender diverse adolescents. This reflects both distal and proximal stressors. The least commonly endorsed stressors related to internalised transphobia and nonaffirmation by religious leaders encouraging participants to reconsider or change their gender identity. The vast range of proximal and distal stressors endorsed supports Hughto et al.'s (2015) model of the varying levels of gender identity minority stress at both the individual and interpersonal level (see Figure 3), highlighting the need to consider individuals' contexts. Structural level stressors were not assessed within this study and are thus an area for future research. Furthermore, the frequency each stressor was experienced by every participant was not collected.

The reports of gender identity minority stress in this sample support Testa et al.'s (2015) gender minority stress framework, particularly the inclusion of nonaffirmation as a distal stressor. Commonly experienced minority stressors from this sample related to transnegative communication from others. Transnegative communication is a distal stressor not currently explicitly included in the framework. Although some transnegative communication may be identified as gender-related discrimination or victimisation, transnegative communication is broader than this, as it includes comments not directly about the individual, which may contribute towards internalised transphobia. Hence, it is proposed transnegative communication is included as an additional distal stressor to capture the broader scope of negative comments.

This was the first study to report on the sexual orientation of gender diverse adolescents in the UK. Most of the sample identified as LGB+; the most common sexual orientation was bisexual. This is a stark contrast to previous US population-based findings that 85% of transgender adults identified as heterosexual (Meyer et al., 2017). However, it is similar to research in the US specifically recruiting transgender adults only (James et al., 2016; Kuper et al., 2012; Russel et al., 2018). There is limited published research reporting sexual orientation amongst gender diverse adolescents as studies often include both LGB+ and gender diverse participants without providing a breakdown of sexual orientation between LGB+ and gender diverse participants, instead grouping them together (e.g. Shields et al., 2013). Two small-scale published studies reporting sexual orientation of adolescent transgender populations in the US found 41% of participants identified as LGB+ (Almeida et al., 2009; Walls et al., 2019). The proportion of participants in this study identifying as LGB+ (71.1%) is much greater than current published adolescent research. The incidence of identifying as LGB+ in this sample is more reflective of the 2015 USTS (James et al., 2016), which found approximately 70% of respondents identified as LGB+.

There are several possible reasons for this pattern of diverse sexual orientation identities. It could reflect a changing social environment that is more accepting of diversity, with LGB+ populations more willing and able to visibly self-identify and more public support for policies against discrimination (National Academies of Sciences, Engineering, and Medicine, 2020). Alongside this, diverse sexualities are increasingly represented in television shows (Damshenas, 2021). However, it cannot be ruled out that dual minority adolescents were more likely to participate in the research because of the study's title and aims. Due to the limited published data, it is difficult to draw strong conclusions from this small sample. Nonetheless, it seems to indicate a greater proportion of LGB+ adolescents amongst gender diverse adolescents in the UK. However, this research took place with adolescents referred to a gender identity clinic and thus does not necessarily represent the general UK gender diverse adolescent population.

Eleven percent of the sample identified as an ethnicity other than White. Whilst this is unlikely to be representative of the entire adolescent gender diverse population, it is similar to previous ethnicity data published from the GIDS (de Graaf et al., 2020), making this sample representative of the ethnicities of the GIDS' population.

Neurodiversity was also considered as a minority identity. Participants were asked if they thought they had autism and if they had been formally diagnosed with autism. Participants reporting either of those were incorporated into one group because whether or not they had been formally diagnosed, believing they had autism would likely affect their identity and associated minority stress experiences. Over a third of the sample had either been diagnosed with autism or thought they had autism. This is consistent with current UK trends identifying traits of autism in clinical and non-clinical gender diverse populations (Skagerberg et al., 2015; Stagg & Vincent, 2019). Of the total sample, 27% had been formally diagnosed with autism. This is similar to rates of diagnosed autism in adolescents

attending a gender clinic in Finland (Kaltiala-Heino et al., 2015), but much higher than rates in the Netherlands (de Vries et al., 2010).

In line with hypothesis A, there was a negative association between gender identity minority stress and wellbeing. However, this did not reach significance. This may be due to the limited sample size; hence, it warrants further investigation with a greater sample size to determine if there is a consistent negative relationship between these variables. It is possible the relationship between gender identity minority stress and wellbeing is mediated through additional variables such as social support and resilience (Meyer, 2003; Testa et al., 2015).

Hypotheses B-D explored differences in gender identity minority stress between majority and minority groups. The analysis showed no significant differences between participants identifying as straight and LGB+, those identifying as White and non-White/PGM and those who did and did not identify as having autism. This suggests identifying with multiple minorities may not increase risk of gender identity minority stress. This could be due to the resilience built from identifying with multiple minority groups and previous experience of identity embracement. For instance, gender diverse PGM may have experience of embracing their ethnicity and have strong cultural community connections, thus affirming their identity, and perhaps reducing vulnerability to internalised transphobia or need to conceal their gender identity.

Most participants identified as dual or triple minority, with one participant identifying with all four minorities. Just 20% of the sample identified with only one minority - gender identity. Hypothesis E explored the relationship between number of minority identities identified with and wellbeing. Despite a small, positive relationship between these factors, it did not quite reach significance, perhaps reflecting the complex interrelation of multiple minority identities and the capacity to build resilience associated with these identities. It also highlights the complexity of separating minority identities into their unique experiences.

Similarly, there was no significant association between number of minorities identified with and gender identity minority stress (hypothesis F), further highlighting the complexity of multiple minority identities. This research has put individuals with multiple minority identities at the forefront; furthering our understanding of intersecting identities is key. Although historically intersectional research has focussed on experiences of Black females, it now involves the study of how various social categories are mutually shaped and interrelated (Rice et al., 2019).

Given the proportion of adolescents identifying with multiple minority identities, and the interaction of these identities, which are unlikely to be mutually exclusive, it is proposed the minority stress framework should reflect these interwoven aspects of identity. Whilst there is not currently conclusive evidence for bi/directional processes, mediators or moderators to be included in the framework, individuals' identity could be included in some way. For example, encapsulating the model to demonstrate consideration of individuals' context and additional aspects of their identity, in the same way Hughto et al.'s (2015) model considers wider structural contexts.

Limitations

The research took place during the COVID-19 pandemic, representing a unique period of limited social interaction due to global lockdowns and schools closing (Singh et al., 2020). The global context generated various obstacles to the research and likely impacted adolescents' experience of minority stress and wellbeing. Whilst it may have reduced some minority stressors at school and in public, research suggests rates of cyberbullying increased during the pandemic (Lobe et al., 2020). Similarly, some adolescents may have benefitted in some ways from staying home and socialising online, whilst for others this may have had a detrimental impact. Hence, the global context may have impacted participants' current experiences of minority stress and wellbeing. Whilst the minority stress measure obtained

lifetime prevalence of minority stressors, the wellbeing index reviewed the past two weeks. Therefore, the global context may have had more of an impact on wellbeing scores than minority stress scores. Although the lifetime score gave an indication of baseline gender identity minority stress levels in this population, the 30-day score, may have derived different results, which may have been more reflective of the context the research was taking place i.e. the global pandemic.

The study was limited by the small sample size, likely due to additional strains placed upon clinicians identifying participants due to the COVID-19 pandemic, in addition to the UK political climate relating to treatment at the GIDS (Bell v. Tavistock, 2020). This prevented some of the original hypotheses from being explored. Nonetheless, the adapted hypotheses generated pertinent findings when considering intersectionality and the proposed additive effect of minority stress.

Whilst the ASI-GD demonstrated good internal consistency, further exploration of its psychometric properties is required to assess validity and reliability. Notably, three questions on the ASI-GD assessed intersectionality from the perspective of gender identity and ethnicity. Although this is a small proportion of the overall 54 items, it may somewhat explain findings relating to ethnicity and minority stress.

This research focused on gender identity minority stress within the context of three additional minority identities. However, numerous additional minority identities exist, with varying impacts of each minority on individuals' lives. Therefore, this research is limited by only considering minority stress associated with one minority identity as opposed to all the minority identities considered within the research (i.e. sexual orientation, ethnicity, neurodiversity). This highlights the considerable challenges when researching specific minority identities, as these cannot necessarily be disentangled from other aspects of individuals' identities. Furthermore, the research had a somewhat individual focus, which

limits understanding of intersectional features of social settings, contexts and structures (Cortina et al., 2012). Analyses in this study were further constrained by non-parametric tests, reducing the power of results. Researching intersectionality through quantitative methods limits consideration of power and privilege – elements that are critical to intersectionality theory (Else-Quest & Hyde, 2016). Finally, quantitative methods tend to favour identifying differences as opposed to similarities between groups (Toro & Yoshikawa, 2016).

Clinical Implications

This is the first study in the UK to report on gender diverse adolescents' minority stress experiences. The findings provide a snapshot of the lives of gender diverse adolescents in the UK and the stressors they experience. Given that all stressors were endorsed to some degree demonstrates the social climate gender diverse adolescents are living in, be it at home, school, with friends or in religious or cultural communities. Considering that stressors reflecting internalised transphobia and negative expectations of others were commonly reported by participants, it is not surprising that gender diverse populations avoid or refrain from accessing physical and mental health services (Clark et al., 2018; Shipherd et al., 2010). Therefore, it is of paramount importance for all services to be anti-discriminatory in their approach to increase access to services for gender diverse populations and reduce health disparities.

A proportion of adolescents reported hearing negative views about gender diverse people, with some reporting that religious figures had encouraged them to reconsider their gender identity or tried to change their gender identity. Whilst in some ways this is surprising, it is not as uncommon as perhaps it is believed to be (Asquith et al., 2021). Half of recipients of conversion therapy in a recent UK study were under the age of 12 when it commenced, and three-quarters were under the age of 24. The majority of recipients cited religious belief as a key contributory factor, with religious leaders being most likely to offer

and practice conversion therapy. It was noted that recipients reported severe physical and sexual violence during conversion therapy, with those undergoing conversion therapy being much more likely to report severe mental health difficulties and suicidality (Asquith et al., 2021). Although the UK government set out its aim to end the practice of conversion therapy (Government Equalities Office, 2018), it will take some time for this to be implemented.

Although only a small proportion of participants in this study endorsed such minority stressors, this may reflect accepting/supportive systems surrounding young people accessing a gender clinic. In contrast, there may be young people who have not felt supported to access gender identity services who are at risk of nonaffirmation by significant others, including religious figures offering conversion therapy. Nonetheless, findings indicate the risk exists for some young people and thus children and adolescents at risk need to be identified and safeguarded against these potentially incredibly violent acts by people with significant power.

Nonaffirmation by significant others, particularly those who may be perceived as being in a position of power, creates considerable risk for young people. As an attempt to have their gender identity affirmed, they may seek alternative affirmative methods associated with greater risk. For instance, engaging in sexual activity to affirm their gender or using hormones obtained through non-medical routes (Sevelius, 2013). This highlights a role for clinicians and services to engage with community groups, be it schools, local communities, or religious groups, to offer education around gender diversity, stigma and discrimination. It is hoped that increasing societies' knowledge of gender diversity may begin to create a shift in prejudice and discrimination, helping to affirm gender diverse individuals' identity, therefore reducing the likelihood of obtaining affirmation through high risk means. The ASI-GD may prove helpful during assessment of gender diverse adolescents to aid conversations about gender identity minority stress and the variety of experiences. It may also be used as an audit tool within services to determine frequency data for different stressors.

Considering the large proportion of participants identifying as LGB+, it is recommended that sexual orientation is incorporated within the assessment process of young people exploring their gender identity. It is recommended clinicians hold in mind that expectations about gender diverse young people at the GIDS being heterosexual may not be an accurate representation of this population. Hence, multiple aspects of young people's identity must be considered, alongside the varying minority stressors and associated stigma they may experience. Given they may be identifying with multiple minoritised groups, they may be particularly sensitive to structural discrimination within services, further highlighting the need for services to be anti-discriminatory.

Future Research

Replicating this research with a larger sample would help strengthen the tentative conclusions drawn from this sample. Doing so when the pandemic has subsided would provide insight into whether the relationships alter with the global context. Furthermore, fulfilling the original hypotheses with a larger sample will help build the knowledge base regarding minority stress and multiple minority identities for gender diverse adolescents, as there is currently scarce published literature regarding this. In addition to dichotomous responses to each stressor, it would be valuable to capture estimates of the frequency individuals have experienced each stressor. This will help determine how often adolescents may be experiencing these stressors and highlight priorities for intervention.

The promising, preliminary properties of the ASI-GD support further investigation with a larger sample to ensure adequate reliability and validity. Factor analysis should be completed to determine the relevance of the subscales identified in the original measure. Future research may wish to also consider structural level minority stressors.

Given the high proportion of adolescents identifying with multiple minority identities, this research has highlighted the difficulties trying to compare experiences between groups,

as those experiences may be influenced by other minority identities. To further expand our understanding of minority stress, future research may wish to gather information on minority stress experiences associated with all minority identities, rather than those associated with gender identity alone. Moreover, experiences may be affected by additional factors, such as geographical location and the general liberalness of different communities. Exploring these additional factors will develop the field's understanding of minority stress and the hypothesis regarding an additive effect of minority stress versus intersectionality (Allen, 2018; Cyrus, 2017). To further explore the processes contributing to the adverse effects of minority stress on gender diverse adolescents' mental health, it would be useful for future research to assess the distress associated with minority stressors and its relationship with mental health. Furthermore, social identity theory (Tajfel et al., 1979) may be used to explore the proposed protective effects of within-group identity for members of the gender diverse group.

Furthermore, measuring protective factors, such as social support and community connectedness, are important to determine how they may mediate the psychological and physical impacts of identifying with minority groups (Cyrus, 2017). Qualitatively exploring the experiences of those with multiple minority identities would provide insight into the nuanced intersection of these identities, recognising similarities and differences, with qualitative research creating space for various experiences and complexities of underrepresented groups (Marecek et al., 1997; Toro & Yoshikawa, 2016). For instance, the similarities and differences between PGM and LGB+ gender diverse adolescents, given that sexual orientation and gender identity are often included within the same community (i.e. LGBTQIA+ community).

Conclusions

This is the first study to explore the prevalence of gender identity minority stress in clinically referred gender diverse adolescents in the UK. A wide range of stressors were

reported, typically associated with negative expectations from others, internalised transphobia and transnegative communication. The reporting of religious figures encouraging adolescents to change their gender identity or trying to change their identity highlights the importance of considering religious involvement during risk assessments.

This research is the first to present data on sexual orientation for gender diverse adolescents in the UK. The majority of participants identified as LGB+. Given the limited research reporting the sexual orientation of gender diverse adolescents, it cannot be determined if this is typical for this population. Adult prevalence samples vary with some studies reporting majority heterosexual samples and some reporting majority LGB+ identities.

The non-significant findings warrant further investigation as they may reflect a lack of statistical power within the analyses rather than the interrelation of multiple minority identities. Future research should explore gender identity minority stress with larger samples and consider protective factors for wellbeing, perhaps associated with identification with additional minority identities.

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Section C: Appendices

Appendix A

Joanna Briggs Institute Checklist

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Appendix B

Critical Appraisal Skills Programme Checklist

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Appendix C

Completed Joanna Briggs Institute Checklist

This has been removed from the electronic copy.

Appendix D

Completed Critical Appraisal Skills Programme Checklist

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Appendix E

Studies included in the review

Allen, C. D. (2018). *The relationship of self-compassion and level of outness with emotional distress in transgender individuals*. [Doctoral dissertation, Oklahoma State University]. Dissertation Abstracts International: Section B: The Sciences and Engineering.

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Appendix F

Demographic characteristics of study participants

Study	Gender Identity <i>n</i> (%)	Birth-assigned sex (M:F)	Extent of gender expression <i>n</i> (%)	Ethnicity <i>n</i> (%)	Sexual orientation <i>n</i> (%)
Allen (2017)	MTF= 96 (41) FTM= 64 (27.4) Male = 13 (5.6) Female = 20 (8.5) Intersex = 1 (0.4) Agender = 4 (1.6) Androgynous = 1 (0.4) Demigirl = 1 (0.4) Gender fluid = 9 (3.6) Gender queer = 4 (1.6) Neuter = 1 (0.4) Non-binary = 9 (3.6)	133:101	Planned to take steps to transition = 213 (91) No plans = 21 (9)	Caucasian = 190 (81.5) Bi-racial = 18 (7.7) Multi-racial = 8 (3.4) Hispanic = 6 (2.6) Native American = 6 (2.6) Asian American = 3 (1.3) Black or African American = 2 (0.9)	Heterosexual = 39 (16.7) Queer = 36 (15.4) Lesbian = 36 (15.4) Bisexual = 18 (7.7) Asexual = 17 (7.3) Questioning = 16 (6.8) Gay = 11 (4.7) Other = 37 (15.8)
Bauer et al. (2015)*	FTM = 52.6% MTF = 47.4% Primarily fluid or third gender identity = 17.7% Primarily masculine or feminine identity = 82.3%	NR	Social transition: Full-time = 53.3% Part-time = 26.9% Not living as identified gender = 19.8%	Aboriginal = 6.6% Non-aboriginal white = 77.3% Non-Aboriginal racialised = 16.1%	Lesbian, gay, bisexual or MSM/WSW = 66.7% Straight = 33.3%
Begun & Kattari (2016)	Female/woman = 2608 (40.5) Male/man = 1687 (26.2) Chose own term not listed = 864 (13.4)	3870: 2566	Somewhat conforming/visually conforming = 4976 (77.6) Not conforming = 1436 (22.4) Living part-time as authentic gender = 1275 (19.8)	White = 4872 (75.5) Black = 290 (4.5) American Indian/Alaskan Native = 75 (1.2) Latino/a = 294 (4.6) Asian/Pacific Islander = 137 (2.1) Middle Eastern = 45 (0.7) Biracial/multiracial = 743 (11.5)	Gay/Lesbian/same-gender = 1326 (20.8) Bisexual = 1473 (23.1) Queer = 1270 (19.9) Heterosexual = 1341 (21.1) Asexual = 260 (4.1) Other = 698 (11)
Fontanari et al. (2020)	Transgender boys = 14 (42.6) Transgender girls = 85 (24.3) Gender non-binary = 116 (33.1)	NR	Express true gender in day-to-day life: All the time = 158 (48.7)	White = 155 (58.3) Non-white= 111 (41.7)	NR

			Half the time = 135 (36.4) Never = 56 (15)		
Gonzalez et al. (2012)	Transgender women = 122 (100)	NR	Full-time present as a woman = 72 (64) Part-time present as a woman = 41 (36)	Caucasian = 102 (83.6) Asian American = 8 (6.6) African American = 3 (2.5) Latina/Hispanic = 6 (4.9) Native American = 3 (2.5)	Heterosexual/straight = 35 (29.7) Bisexual = 50 (42.4) Homosexual/gay = 33 (27.9)
Hill et al. (2018)	Transgender women = 65 (100)	NR	NR	Black/African American = 34 (52.3) Pacific Islander = 5 (7.7) Hispanic/Latino = 30 (46.2)	Attracted to: Men only = 43 (67.2) Mostly men = 11 (17.2) Both men and women equally = 6 (9.4) Mostly women = 3 (4.7) Women only = 1 (1.6)
Kattari & Hasche (2015)	Male/man 1525 (26) Female/woman = 2423 (41.3) Part-time = 1163 (19.8) Not listed = 757 (12.9)	NR	NR	White = 4465 (75.9) Black = 245 (4.2) American Indian = 73 (1.2) Latino = 192 (3.3) Asian/Pacific Islander = 125 (2.1) Middle Eastern = 5 (0.1) Multiracial = 780 (13.3)	Gay/lesbian = 1203 (20.7) Bisexual = 1355 (23.3) Queer = 1162 (20) Heterosexual = 1217 (20.9) Asexual = 240 (4.1) Other = 646 (11.1)
Kuvalanka et al. (2014)	Girls = 5 (100)	5:0	Socially transitioned = 5 (100)	White/Caucasian = 4 (80) Black/African American = 9 (10)	NR
Peitzmeier et al. (2017)	Transgender = 1431 (79.5) Male/masculine = 1227 (68.1) Genderqueer/ bigender = 616 (34.2) Agender = 608 (33.8) Feminine = 230 (12.8) Masculine female = 118 (6.6) Cisgender = 31 (1.7) Intersex = 24 (1.3) Other = 10 (0.6)	NR	Had already had top surgery 236 (13.1) Planning on getting top surgery 1197 (66.6) Not planning on getting top surgery 232 (12.9) Unsure 131 (7.3)	NR	NR
Pollitt et al. (2020)	Transwoman 28 (37.8) Transman 28 (37.8) Different gender–assigned sex male 5 (6.8)	NR	NR	White = 18 (24) Asian 6 (8) Black = 28 (33) Multiracial = 21 (28) Not reported = 5 (7)	Lesbian/gay = 17 (23) Bisexual = 22 (30) Questioning = 125 (9) Heterosexual = 17 (23) Different sexual identity = 9 (12)

	Different gender–assigned sex female 13 (17.6)				
Russel et al. (2018)	MTF = 38% (28) FTM = 38% (28) MTDG = 7% (5) FTDG = 17% (13)	NR	NR	White = 18 (24) Asian 6 (8) Black = 28 (33) Multiracial = 21 (28) Not reported = 5 (7)	Lesbian/gay = 17 (23) Bisexual = 22 (30) Questioning = 125 (9) Heterosexual = 17 (23) Different = 9 (12)
Scheim et al. (2020)**	Transgender woman = 7948 Transgender man = 7235 Non-binary, assigned female = 5800 Non-binary, assigned male = 1303	8538:13 748	Medical transition: Not needed = 1974 Not begun = 7539 Hormones or non-genital surgery, or both = 11 185 Genital surgery = 1501	Alaska Native or American Indian = 277) Asian or Pacific islander = 624 Biracial, multiracial, or not listed = 1212 Black or African American = 657 Latinx or Hispanic = 1202 White, Middle Eastern, or north African = 18 314	NR
Sievert et al. (2020)	NR	29:25	No social transition = 30% Undergone social transition in at least one area of life = 70% Undergone a complete social transition = 39%	NR	NR
Witcomb et al. (2019)	Men = 164 (59.9) Women = 77 (28.1) Partly both = 8 (2.9) Neither = 6 (2.2) Other = 8 (2.9) Did not know = 4 (1.5) No response = 7 (2.6)	95:179	Social transition = 157 (57.3)	White British = 263 (96)	NR

Note. M – male; F = female; MTF = male-to-female; FTM = female-to-male; MTDG = male to different gender; FTDG = female to different gender; NR = Not reported; MSM/WSW = men who have sex with men/women who have sex with women.

* = Weighted background characteristics of trans people in Ontario, Canada

** = Weighted to the age and race distribution of the USA from the American Community Survey

Appendix G

Email invite sent to participants

Hello,

[included if email sent to caregivers and young people] We are emailing you about some online research which we would like to invite young people attending GIDS to take part in. The information for young people is below:

[included if email only sent to caregivers] We are emailing you about some online research which we would like to invite you to share with the young person in your care. The information is below:

We are emailing to invite you to take part in some online research. We are asking young people attending GIDS about their wellbeing and any stress they may experience associated with their gender identity (minority stress). We'd like to know how this relationship might change based on other aspects of identity such as sexuality or ethnicity.]

The research is anonymous and should take about 30 minutes to complete online. If you're interested in taking part, please click the link below which will take you to a webpage explaining the research in more detail. If you decide to take part, you will then be directed to the consent form and questionnaires.

[\[weblink & QR code\]](#)

If you decide to take part, you will need to enter the following **participant ID** when asked: **XXXX**.

If you are under the age of 16, your parent/carer will also need to sign the consent form for you to take part, though they won't need to see how you respond to the questionnaires.

This research is entirely separate from your care at GIDS. Your clinician will not know whether you have or haven't taken part.

If you have any questions about the research, please contact the lead researcher, [name] ([email address](#)).

[Name]

Lead researcher; Trainee Clinical Psychologist

[\[email address\]](#)

Co-researcher: [Name] (Clinical Psychologist, GIDS; [email address](#))

Academic supervisor: [Name] (Senior Research Lecturer at Canterbury Christ Church University; [email address](#))

Appendix H

Information sheets

YOUNG PERSON INFORMATION SHEET

Project Title: Exploring minority stress and intersectionality in adolescents attending a gender identity clinic in the United Kingdom.

Lead Researcher: [Name] (Trainee Clinical Psychologist; email address)

Co-researcher: [Name] (Clinical Psychologist, GIDS; email address)

Academic supervisor: [Name] (Senior Research Lecturer at Canterbury Christ Church University; email address)

We would like to invite you to take part in a research study being conducted at the Gender Identity Development Service (GIDS). Before you decide if you would like to take part, you need to understand why the research is being done and what it would involve for you. If anything is not clear or if you would like more information, please contact us (details above).

What is the purpose of the study?

Research has shown that some young people experiencing difficulties with their gender identity development experience stress related to this (e.g. bullying). This is called 'minority stress' and refers to the stresses experienced by someone who is part of a minority group e.g. part of the LGBTQ* community. People can also experience minority stress related to other minority identities e.g. sexuality, ethnicity. This study aims to explore young people's minority stress and wellbeing, and how this might be affected by other minority identities.

Who are you looking for to take part?

We are looking for young people aged 11-18 inclusive to participate in the study.

Do I have to take part?

Your participation is entirely voluntary, and you do not have to agree to take part. If you do decide to take part and then change your mind, you are free to do so at any time without giving a reason. If you are under the age of 16, both you and your parent/caregiver must both provide consent to take part in this study.

Where can I find out more about how my information is used?

You can find out more about how we use your information at www.hra.nhs.uk/information-about-patients/ or by asking one of the research team (details above).

What will happen if I agree to take part?

After reading this information, you will be invited to complete an informed consent sheet, which means that you are happy to take part in the study and fully understand the research. You will then be asked to complete some personal information e.g. your age and birth-assigned gender. You will also be asked to complete two questionnaires. One is about your wellbeing (the WHO Wellbeing Index) and the other explores your experiences of minority stressors associated with gender identity development difficulties (e.g. bullying) called the SMASI (Sexual Minority Adolescent Stress Inventory). This measure is aimed at LGBTQ* groups, including gender diverse populations, and we have adapted it so the focus is on gender diversity. The questionnaires will take approximately 30 minutes to complete.

We will not make any identifying or personal information public. Your participation will be anonymous.

Questionnaires can be completed online. If you would prefer, these questionnaires can be completed over the phone or via Zoom with the lead researcher [name]. For this to happen,

please respond to the email invite to let us know that you would like to be contacted by the lead researcher.

How will we use information about you?

All the information we collect will be anonymous. We will keep all information about you safe and secure. Confidentiality will only be broken if you report considerable risk of harm to yourself, to others or from others. We will write our reports in a way that no-one can work out that you took part in the study. The anonymous data collected for this research may be used in future research projects at the GIDS. No personal data such as your name will be stored with this data.

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason. We will then remove your data from the study.

What are the risks and disadvantages of taking part?

There is a small risk that you may become upset or distressed by the questions on the questionnaires. No other risks have been identified.

What if I am unhappy or if there is a problem?

If any problems arise whilst completing the questionnaires, consider contacting the lead researcher (email address) or the GIDS (phone number; email address).

Complaints:

If you have a concern about any aspect of this study, you should speak with the lead researcher [name]. Alternatively, you can contact the Salomons Centre for Applied Psychology at Canterbury Christ Church University in which the research is partnered with (Research Director: [email address]).

Distress:

If you experience distress whilst completing a questionnaire, you are invited to take a break, or stop completing the questionnaire altogether. You may withdraw from the study if you wish. You are encouraged to let the GIDS know by contacting them on [phone number] or emailing them [email address]. Please let the researcher know or contact the lead researcher or co-workers. Your wellbeing is of great importance to us.

Will my data be kept confidential?

All information obtained during the study will be kept confidential and if the data is published, no one will be able to identify it is you. All data will be anonymous. Confidentiality will only be broken if you report considerable risk of harm to yourself, to others or from others.

Can I see the information you hold?

Under the General Data Protection Regulation (GDPR) 2018 you are entitled to request access to the personal data we hold. Data collected in this study may be held for up to 20 years.

Will the use of my data meet GDPR rules?

In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

What will happen to my data at the end of the study?

The data taken for the study will be stored and may be used in further research studies that have been approved by the appropriate Ethics Committee. The data will be kept for a period of 20 years after which it will be archived.

Has this study been approved?

The study has been reviewed and approved by the NOCLOR review board and has received NHS Ethical approval.

What if I want to ask questions not included in this information sheet?

Please raise any further questions you may have with the lead researcher or co-worker(s) on this study; they will be happy to answer any additional questions you may have.

Thank you for taking the time to read this information sheet and considering taking part in this study.

IRAS ID: [IRAS ID]
22/10/2020 (version 6)

If you are aged 16 and over, please skip to the next section to begin the questionnaires.

PARENT/CARER INFORMATION SHEET

Project Title: Exploring minority stress and intersectionality in adolescents attending a gender identity clinic in the United Kingdom.

Lead Researcher: [name] (Trainee Clinical Psychologist; email address)

Co-researcher: [name] (Clinical Psychologist, GIDS; email address)

Academic supervisor: [name] (Senior Research Lecturer at Canterbury Christ Church University; email address)

We would like to invite you to take part in a research study being conducted at the Gender Identity Development Service (GIDS) as part of the Tavistock and Portman NHS Foundation Trust. This research is being undertaken as part of a doctoral training programme and is sponsored by Canterbury Christ Church University. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. If anything is not clear or if you would like more information, please contact us (details above).

What is the purpose of the study?

Research has shown that some young people experiencing difficulties with their gender identity development experience stress associated with this (e.g. bullying). This is called 'minority stress' and refers to the stresses experienced by someone who is part of a minority group e.g. part of the LGBTQ* community. People can also experience minority stress related to other minority identities e.g. sexuality, ethnicity. This study aims to explore young people's minority stress and wellbeing, and how this might be affected by other minority identities.

Who are you looking for to take part?

We are looking for young people aged 11-18 inclusive to participate in the study.

Do I have to take part?

Your child's participation is entirely voluntary, and you do not have to agree to allow them to take part. If you do consent to their participation, you will be asked to sign a consent form. Both the young person and their parent/caregiver must both provide consent for the young person to take part in this study.

What will happen if I agree to take part?

After reading this information sheet, you will be invited to complete an informed consent sheet, which means that you are happy for your child to take part in the study and fully

understand the terms of their participation. There is nothing else for you to complete for this research.

Your child will also read a similar information sheet to this and will be invited to complete an informed consent sheet. They will be asked to complete some demographic information e.g. age, the SMASI and the WHO Wellbeing Index. The SMASI (Sexual Minority Adolescent Stress Inventory) is a questionnaire exploring experiences of minority stressors associated with gender identity development difficulties (e.g. bullying). This measure is aimed at LGBTQ* groups, including gender diverse populations, and we have adapted it so the focus is on gender diversity.

We will not make any identifying or personal information public. You and your child's participation will be anonymous.

Questionnaires can be completed online. If you would prefer, these questionnaires can be completed over the phone or via Zoom with the lead researcher [name]. For this to happen, please respond to the email invite to let us know that you would like to be contacted by the lead researcher.

How will we use information about you?

All participation is anonymous. We will keep all information safe and secure. Confidentiality will only be broken if your child reports considerable risk of harm to themselves, to others or from others. We will write our reports in a way that no-one can work out that your child took part in the study. The anonymous data collected for this research may be used in future research projects at the GIDS. No personal data such as yours or your child's name will be stored with this data.

Where can I find out more about how my information is used?

You can find out more about how we use your information at www.hra.nhs.uk/information-about-patients/ or by asking one of the research team (details above).

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason. We will then remove your data from the study.

What are the risks and disadvantages of taking part?

There is a small risk that your child may become upset or distressed by the questions on the questionnaires. No other risks have been identified.

What if I am unhappy or if there is a problem?

If any problems arise whilst completing the questionnaires, consider contacting the lead researcher [email address] or the GIDS [phone number; email address]

Complaints:

Any complaints you have about this study will be fully investigated. If you have a concern about any aspect of this study, you should speak with the lead researcher [name]. Alternatively, you can contact the Salomons Centre for Applied Psychology at Canterbury Christ Church University in which the research is partnered with (Research Director: [email address]).

Distress:

If your child experiences distress whilst completing a questionnaire, they are invited to take a break, or stop completing the questionnaire altogether. They may withdraw from the study if they wish. You are encouraged to speak to a member of the team at the GIDS to offer your child some support. Please let the GIDS know by contacting them on [phone number] or emailing them [email address]. Yours and your child's wellbeing are of great importance to us.

Harm:

In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for legal action for compensation against the Tavistock and Portman NHS Foundation Trust but you may have to pay your legal costs. For research carried out at the Tavistock and Portman NHS Foundation Trust, participants would be in the same position as if public liability insurance had been taken out.

Will my data be kept confidential?

All information obtained during the study will be kept confidential and if the data is published it will not be identifiable as yours or your child's. All data will be anonymous. Confidentiality will only be broken if your child reports considerable risk of harm to themselves, to others or from others.

Can I see the information you hold?

Under the General Data Protection Regulation (GDPR) 2018 you are entitled to request access to the personal data we hold. Data collected in this study may be held for up to 20 years.

Will the use of my data meet GDPR rules?

In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

What will happen to my data at the end of the study?

The data taken for the study will be stored and may be used in further research studies that have been approved by the appropriate Ethics Committee. The data will be kept for a period of 20 years after which it will be archived.

Has this study been approved?

The study has been reviewed and approved by the NOCLOR review board and has received NHS Ethical approval.

What if I want to ask questions not included in this information sheet?

Please raise any further questions you may have with the lead researcher or co-worker(s) on this study; they will be happy to answer any additional questions you may have.

Where are the contact details?

Contact details are at the beginning of this document.

Thank you for taking the time to read this information sheet and considering taking part in this study.

Appendix I

Consent forms

Exploring minority stress and intersectionality in adolescents attending a gender identity clinic in the United Kingdom

CONSENT FORM - YOUNG PERSON

I confirm that I have read and understand the information sheet dated 22/10/2020 (Version 6) for the above study and have had the opportunity to ask questions.

Yes

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

Yes

I give permission that data used as part of the protocol of this study may be used in further research studies that have been approved by the appropriate Ethics Committee.

Yes

I understand that confidentiality will only be broken if I report considerable risk of harm to myself, to others or from others.

Yes

If you would like to be sent a summary of the study's findings, please provide your email address below (please note, this is not mandatory)

Full name:

Date:

Participant ID:
(stated in email invitation)

If you are aged 16 and over, please skip to the next section to begin the questionnaires.

Exploring minority stress and intersectionality in adolescents attending a gender identity clinic in the United Kingdom

CONSENT FORM - PARENT/CARER

I confirm that I have read and understand the information sheet dated 22/10/2020 (Version 6) for the above study and have had the opportunity to ask questions.

Yes

I give permission that data used as part of the protocol of this study may be used in further research studies that have been approved by the appropriate Ethics Committee.

Yes

I agree that my child can participate in this study.

Yes

If you would like to be sent a summary of the study's findings, please provide your email address below (please note, this is not mandatory)

Full name:

Date:

Appendix J

Questionnaires

Sociodemographic Questions

Instructions: Please complete all the following information as accurately as possible.

How old are you? ___ years and ___ months

What gender were you assigned at birth?

Male Female Intersex Other

How would you describe your gender identity? (please select all that apply)

Transgender Non-binary Male
 Female Agender Questioning

Other (please state) _____

Prefer not to say

How would you describe your sexuality?

- Heterosexual or straight Gay or lesbian Bisexual Pansexual
 Other (please state) _____
 Don't know/unsure
 Prefer not to say

Please tick a box below which best fits your ethnic origin:

- | | |
|--|--|
| <input type="checkbox"/> White – British | <input type="checkbox"/> Black or Black British – Caribbean |
| <input type="checkbox"/> White – Irish | <input type="checkbox"/> Black or Black British – African |
| <input type="checkbox"/> White – Northern Irish | <input type="checkbox"/> Black or Black British – Somali |
| <input type="checkbox"/> White – English | <input type="checkbox"/> Black or Black British – Mixed |
| <input type="checkbox"/> White – Scottish | <input type="checkbox"/> Black or Black British – Nigerian |
| <input type="checkbox"/> White – Welsh | <input type="checkbox"/> Black or Black British – British |
| <input type="checkbox"/> White – Cornish | <input type="checkbox"/> Black or Black British – Any other background |
| <input type="checkbox"/> White – Cypriot | |
| <input type="checkbox"/> White – Greek | <input type="checkbox"/> Mixed – White & Black Caribbean |
| <input type="checkbox"/> White – Greek Cypriot | <input type="checkbox"/> Mixed – White & Black African |
| <input type="checkbox"/> White – Turkish | <input type="checkbox"/> Mixed – White & Asian |
| <input type="checkbox"/> White – Turkish Cypriot | <input type="checkbox"/> Mixed – Black and Asian |
| <input type="checkbox"/> White – Italian | <input type="checkbox"/> Mixed – Black and Chinese |
| <input type="checkbox"/> White – Irish Traveller | <input type="checkbox"/> Mixed – Black and White |
| <input type="checkbox"/> White – Gypsy / Romany | <input type="checkbox"/> Mixed – Chinese and White |
| <input type="checkbox"/> White – Kosovan | <input type="checkbox"/> Mixed – Asian and Chinese |
| <input type="checkbox"/> White – Polish | <input type="checkbox"/> Mixed – Any other mixed background |
| <input type="checkbox"/> White – All Republics of former USSR | |
| <input type="checkbox"/> White – Albanian | <input type="checkbox"/> Other Ethnic Groups – Chinese |
| <input type="checkbox"/> White – Bosnian | <input type="checkbox"/> Other Ethnic Groups – Vietnamese |
| <input type="checkbox"/> White – Croatian | <input type="checkbox"/> Other Ethnic Groups – Japanese |
| <input type="checkbox"/> White – Serbian | <input type="checkbox"/> Other Ethnic Groups – Filipino |
| <input type="checkbox"/> White – Other Republics of former Yugoslavia | <input type="checkbox"/> Other Ethnic Groups – Malaysian |
| <input type="checkbox"/> White – Mixed White | <input type="checkbox"/> Other Ethnic Groups – Arab |
| <input type="checkbox"/> White – Other European | <input type="checkbox"/> Other Ethnic Groups – North African |
| <input type="checkbox"/> White – Any other background | <input type="checkbox"/> Other Ethnic Groups – Other Middle East |
| | <input type="checkbox"/> Other Ethnic Groups – Israeli |
| <input type="checkbox"/> Asian or Asian British – Indian | <input type="checkbox"/> Other Ethnic Groups – Iranian |
| <input type="checkbox"/> Asian or Asian British – Pakistani | <input type="checkbox"/> Other Ethnic Groups – Kurdish |
| <input type="checkbox"/> Asian or Asian British – Bangladeshi | <input type="checkbox"/> Other Ethnic Groups – Moroccan |
| <input type="checkbox"/> Asian or Asian British – Mixed Asian | <input type="checkbox"/> Other Ethnic Groups – Latin America |
| <input type="checkbox"/> Asian or Asian British – Punjabi | <input type="checkbox"/> Other Ethnic Groups – South / Central America |
| <input type="checkbox"/> Asian or Asian British – Kashmiri | <input type="checkbox"/> Other Ethnic Groups – Maur / Seyc / Mald / St Helen |
| <input type="checkbox"/> Asian or Asian British – East African Asian | <input type="checkbox"/> Other Ethnic Groups – Any other Group |
| <input type="checkbox"/> Asian or Asian British – Sri Lanka | |
| <input type="checkbox"/> Asian or Asian British – Tamil | <input type="checkbox"/> I am unable to choose |
| <input type="checkbox"/> Asian or Asian British – Sinhalese | <input type="checkbox"/> I do not wish to disclose my ethnic origin |
| <input type="checkbox"/> Asian or Asian British – British | |
| <input type="checkbox"/> Asian or Asian British – Caribbean Asian | |
| <input type="checkbox"/> Asian or Asian British – Any other background | |

Have you socially transitioned?

- Yes, living full-time as identified gender
- Yes, living part-time as identified gender
- No

At what age did you socially transition? ___ years and ___ months

Do you think you have an autism spectrum condition? (e.g. autism, Asperger syndrome)

- Yes No Don't know Prefer not to say

Have you formally been given a diagnosis of an autism spectrum condition?

- Yes No Don't know Prefer not to say

Do you consider yourself to have a disability?

- Yes No Don't know Prefer not to say

What type of area do you live in?

- City/town (urban) Countryside/village (rural) Don't know
- Prefer not to say

If you are religious, what is your religion?

- Christian Muslim Hindu Buddhist
- Jewish Sikh No religion
- Other (please state) _____
- Prefer not to say

WHO (Five) Well-Being Index

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3.

Over the last two weeks:	All the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1. I have felt cheerful and in good spirits	5	4	3	2	1	0
2. I have felt calm and relaxed	5	4	3	2	1	0
3. I have felt active and rigorous	5	4	3	2	1	0

4. I woke up feeling fresh and rested	5	4	3	2	1	0
5. My daily life has been filled with things that interest me	5	4	3	2	1	0

Measure of Minority Stress in Gender Diverse Adolescents*

*adapted from the Sexual Minority Adolescent Stress Inventory (Schrager, Goldbach & Mamey, 2018)

We'd like to understand more about stress experienced by gender diverse youth. This survey includes statements that reflect thoughts, feelings and experiences that may be happening to you now or have happened sometime in the past. Some questions and statements have different instructions so please read each of these instructions carefully. There are no right or wrong answers.

Below are statements that reflect different types of stressful thoughts or events that you may have experienced. Please read each statement and answer "Yes" if it has ever happened to you in the past, or "No" if it hasn't.

You should select the one option that best represents your experience for each statement. We are aware that different people will use different words when thinking about their gender, such as 'gender diversity', 'trans', 'genderqueer' etc. Here, we have used the term 'gender diverse'.

		Yes	No
1	I am questioning how to label my gender identity		
2	I am having trouble accepting that I am gender diverse		
3	I feel pressured to label myself		
4	I am concerned that if I am gender diverse, I will have a worse life than if I lived as my birth-assigned gender		
5	A family member told other family members that I am gender diverse without my permission		
6	A family member told me not to tell other family members that I am gender diverse		
7	I have to lie to my family about being gender diverse		
8	I think I will lose friends if I come out as gender diverse		
9	I expect people to reject me when they find out that I am gender diverse		
10	If I tell my family about my gender expression, it will cause problems within my family		
11	A family member asked me about my gender identity before I wanted to talk about it		
12	I was forced to tell someone about my gender identity because someone saw me expressing my gender identity when I didn't want them to		
13	I was "outed" about my gender identity by someone other than my family without my permission		
14	There are times when I do not want to be gender diverse		
15	If I could, I would live as my birth-assigned gender		
16	I hate being gender diverse		
17	I think it is wrong for me to be gender diverse		
18	I hope that being gender diverse is just a phase for me		

19	I think negatively about other gender diverse people who act “too masculine/feminine”.		
20	I am uncomfortable with being gender diverse		
21	I have heard a family member make negative comments about gender diverse people		
22	My family does not want to talk to me about being gender diverse		
23	Someone who lives with me has told me they disapprove of me being gender diverse		
24	I feel as though I am a disappointment to my family because I am gender diverse		
25	My family has told me that being gender diverse is just a phase		
26	My parents are uncomfortable with gender diverse people		
27	My mother (or female caregiver) does not accept me as gender diverse		
28	My father (or male caregiver) does not accept me as gender diverse		
29	My parents are sad that I am gender diverse		
30	My family tries to make me live as my birth-assigned gender		
31	I felt unsafe or threatened in school because I am gender diverse		
32	Other youth refuse to do school activities with me because I am gender diverse		
33	I have seen other gender diverse youth treated badly at my school		
34	It's hard to be gender diverse at my school		
35	Other students make fun of me for being gender diverse		
36	I have seen other gender diverse youth treated badly in the neighbourhood where I live		
37	I have felt unsafe or threatened in the neighbourhood where I live because I am gender diverse		
38	I have had to move or change where I live because I am gender diverse		
39	I have felt isolated or alone in the neighbourhood where I live because I am gender diverse		
40	Other people in the neighbourhood where I live make fun of me for being gender diverse		
41	I have been physically assaulted in the neighbourhood where I live because I am gender diverse		
42	My friends make jokes about gender diverse people that upset me		
43	Other youth refuse to hang out with me because I am gender diverse		
44	Other people who are in my racial/ethnic community judge me for being gender diverse		
45	I have heard negative comments from others in my racial/ethnic community about being gender diverse		
46	I feel as though I don't fit in my racial/ethnic community because I am gender diverse		
47	As a gender diverse person in my racial/ethnic community, I feel like I am a minority within a minority		
48	I hear other gender diverse people use words like "tranny" or "HeShe."		
49	My family is part of a religion that has transphobic beliefs.		
50	I have heard negative messages about being gender diverse from religious people		
51	I would not be accepted as gender diverse in my family's religion		
52	I believe it is wrong for me to be gender diverse because of my religion		
53	A religious leader has encouraged me to reconsider my gender identity		

54	A religious leader tried to change my gender identity		
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Appendix K

Social identity map

This has been removed from the electronic copy.

Appendix L

Sample characteristics

	Total N (%)
Gender identity	
Transgender	29 (64.4)
Non-binary	10 (22.2)
Male	28 (62.2)
Female	6 (13.3)
Agender	2 (4.4)
Questioning	3 (6.7)
Genderqueer	1 (2.2)
Genderfluid	1 (2.2)
Femme	1 (2.2)
Birth-assigned sex	
Male	11 (24.4)
Female	33 (73.3)
Other	1 (2.2)
Social transition	
Living full-time as identified gender	38 (84.4)
Living part-time as identified gender	6 (13.3)
Not socially transitioned	1 (2.2)
Sexual orientation	
Heterosexual or straight	6 (13.3)
Gay or lesbian	8 (17.8)
Bisexual	16 (35.6)
Pansexual	2 (4.4)
Queer	3 (6.7)
Asexual	2 (4.4)
Unlabelled	1 (2.2)
Don't know/unsure	7 (15.6)
Prefer not to say	1 (2.2)
Ethnicity	
White - British	34 (75.6)
White - Northern Irish	1 (2.2)
White - Greek	2 (4.4)
White - Other European	3 (6.7)
Black or Black British - Caribbean	1 (2.2)
Black or Black British - Mixed	2 (4.4)
Asian or Asian British - Indian	1 (2.2)
Mixed White and Black - Caribbean	1 (2.2)
Neurodiversity	
Thinks they have an ASC	17 (37.8)
Don't think they have an ASC	17 (37.8)
Don't know	10 (22.2)
Prefer not to say	1 (2.2)

Diagnosed with an ASC	12 (27.3)
Not diagnosed with an ASC	30 (68.2)
Prefer not to say	2 (4.5)
Missing	1 (2.2)
Disability	
Yes	12 (26.7)
No	22 (48.9)
Prefer not to say	1 (2.2)
Missing	10 (22.2)
Location	
Rural	15 (33.3)
Urban	29 (64.4)
Missing	1 (2.2)
Religion	
Christian	5 (11.1)
Jewish	1 (2.2)
Pagan	1 (2.2)
No religion	36 (80)
Prefer not to say	2 (4.4)

Note. ASC = autism spectrum condition

Appendix M

Minority stress frequencies

Minority Stressor	Frequency (%)
I hear other gender diverse people use words like "tranny" or "HeShe."	39 (86.7)
There are times when I do not want to be gender diverse	38 (84.4)
I have heard negative messages about being gender diverse from religious people	38 (84.4)
I expect people to reject me when they find out that I am gender diverse	31 (68.9)
I have heard a family member make negative comments about gender diverse people	30 (66.7)
I was "outed" about my gender identity by someone other than my family without my permission	27 (60.0)
I felt unsafe or threatened in school because I am gender diverse	24 (53.3)
I have seen other gender diverse youth treated badly at my school	23 (51.1)
I have heard negative comments from others in my racial/ethnic community about being gender diverse	23 (51.1)
I am concerned that if I am gender diverse, I will have a worse life than if I lived as my birth-assigned gender	22 (48.9)
It's hard to be gender diverse at my school	22 (48.9)
I feel as though I am a disappointment to my family because I am gender diverse	21 (46.7)
I am uncomfortable with being gender diverse	21 (46.7)
I have felt isolated or alone in the neighbourhood where I live because I am gender diverse	21 (46.7)
A family member told other family members that I am gender diverse without my permission	20 (44.4)
My family has told me that being gender diverse is just a phase	20 (44.4)

I think I will lose friends if I come out as gender diverse	16 (35.6)
I hate being gender diverse	15 (33.3)
I have felt unsafe or threatened in the neighbourhood where I live because I am gender diverse	15 (33.3)
My family does not want to talk to me about being gender diverse	14 (31.1)
Other students make fun of me for being gender diverse	14 (31.1)
If I could, I would live as my birth-assigned gender	13 (28.9)
I am questioning how to label my gender identity	13 (28.9)
If I tell my family about my gender expression, it will cause problems within my family	12 (26.7)
My friends make jokes about gender diverse people that upset me	12 (26.7)
Other people who are in my racial/ethnic community judge me for being gender diverse	12 (26.7)
I feel pressured to label myself	11 (24.4)
A family member told me not to tell other family members that I am gender diverse	11 (24.4)
I am having trouble accepting that I am gender diverse	10 (22.2)
My parents are sad that I am gender diverse	10 (22.2)
Other youth refuse to do school activities with me because I am gender diverse	10 (22.2)
A family member asked me about my gender identity before I wanted to talk about it	9 (20.0)
I was forced to tell someone about my gender identity because someone saw me expressing my gender identity when I didn't want them to	9 (20.0)
My parents are uncomfortable with gender diverse people	9 (20.0)
I have seen other gender diverse youth treated badly in the neighbourhood where I live	9 (20.0)
Someone who lives with me has told me they disapprove of me being gender diverse	8 (17.8)
My father (or male caregiver) does not accept me as gender diverse	8 (17.8)
Other youth refuse to hang out with me because I am gender diverse	8 (17.8)
As a gender diverse person in my racial/ethnic community, I feel like I am a minority within a minority	8 (17.8)
My mother (or female caregiver) does not accept me as gender diverse	7 (15.6)
I have to lie to my family about being gender diverse	6 (13.3)
I think it is wrong for me to be gender diverse	6 (13.3)
I feel as though I don't fit in my racial/ethnic community because I am gender diverse	6 (13.3)
My family is part of a religion that has transphobic beliefs.	6 (13.3)
My family tries to make me live as my birth-assigned gender	5 (11.1)
I have been physically assaulted in the neighbourhood where I live because I am gender diverse	5 (11.1)

I think negatively about other gender diverse people who act “too masculine/feminine”.	4 (8.9)
I would not be accepted as gender diverse in my family's religion	4 (8.9)
I hope that being gender diverse is just a phase for me	3 (6.7)
I have had to move or change where I live because I am gender diverse	3 (6.7)
A religious leader has encouraged me to reconsider my gender identity	3 (6.7)
A religious leader tried to change my gender identity	3 (6.7)
I believe it is wrong for me to be gender diverse because of my religion	2 (4.4)
