Generational Differences in Internalized Transnegativity and Psychological Distress Among Feminine Spectrum Transgender People

Kasey B. Jackman, PhD, RN, PMHNP-BC,¹ Curtis Dolezal, PhD,² and Walter O. Bockting, PhD^{1,2}

Abstract

Purpose: This study examined internalized transnegativity and psychological distress in two age groups of transgender individuals who identified their gender identity on the feminine spectrum (rather than congruent with their male sex assigned at birth). Due to greater visibility and acceptance of gender diversity in the United States, we hypothesized that internalized transnegativity would be lower in the younger compared with the older group, and that the younger generation would, therefore, report lower levels of psychological distress than the older generation.

Methods: The study sample consisted of trans-feminine individuals ($N=440$) who completed a online survey of the U.S. transgender population and comprised a younger group aged 18–24 years ($n=133$) and an older group aged 40 years and older ($n=307$). Internalized transnegativity was assessed using the Transgender Identity Survey, and psychological distress was assessed with the Brief Symptom Inventory 18. We used regression and mediation analysis to examine differences between the two groups.

Results: Contrary to our expectations, the older group reported significantly lower levels of both internalized transnegativity and psychological distress compared with the younger group. Internalized transnegativity partially mediated the relationship between age group and psychological distress.

Conclusion: Despite greater visibility of transgender people and increasing acceptance of gender diversity in the United States, the younger trans-feminine individuals reported more psychological distress than the older trans-feminine individuals, which was, in part, related to internalized transnegativity. Trans-feminine individuals may benefit from culturally sensitive and clinically competent mental health services to alleviate internalized transnegativity and psychological distress.

Keywords: gender dysphoria, internalized transnegativity, minority stress, resilience, transgender

Introduction

TRANSGENDER PEOPLE ON the feminine spectrum are individuals who identify to varying degrees as female or as an alternative gender that differs from the male sex they were assigned at birth. They include individuals who describe their gender identity as female, (transgender or transsexual) woman, gender nonconforming, nonbinary, or genderqueer. For the purposes of this article, we use the term “trans-feminine people” to refer to this group of individuals.

Estimates of the size of the transgender population vary widely depending on the method of measuring transgender identity, the operational definition of transgender identity

used by the researchers, and the geographic location.^{1,2} Data from a probability sample of 19 U.S. states and Guam indicated that 0.53% of the U.S. population identifies as transgender.³ The sex ratio of trans-feminine compared with trans-masculine adults is traditionally understood to be weighted toward trans-feminine individuals among adults (e.g., 1.66:1⁴), whereas among adolescents, the ratio is equal or an even higher proportion is trans-masculine youth.⁵

Transgender individuals are affected disproportionately by mental health concerns compared with their nontransgender counterparts. Transgender people are at higher risk for anxiety, depression, suicidality, and nonsuicidal self-injury compared with cisgender peers.^{6–8} In a large online sample

¹School of Nursing, Program for the Study of LGBT Health, Columbia University, New York, New York.

²Division of Gender, Sexuality, and Health, New York State Psychiatric Institute/Columbia University Department of Psychiatry, New York, New York.

of the U.S. transgender population, rates of depression were high and significantly higher among trans-feminine (49%) than among trans-masculine individuals (37%).⁸

The minority stress model, originally applied to lesbian, gay, and bisexual populations, delineates processes that occur along a continuum from distal to proximal and confer added stress related to being a member of a stigmatized minority group.⁹ Distal minority stress processes include prejudice events such as discrimination or victimization. These processes are considered objective stressors because they can be observed by others and do not depend solely on an individual's perception and self-report. Proximal minority stress processes include expectations of rejection, concealment of one's minority identity, and internalized homophobia.⁹ These minority stress processes are posited to affect health negatively. Coping and social support, on an individual or community level, are theorized to moderate the negative impact of stress on health and thus promote resilience.⁹ Meyer's minority stress model was adapted for transgender and gender nonconforming populations by Hendricks and Testa.¹⁰ In this adaptation, internalized transnegativity, analogous to internalized homophobia, is included as a proximal minority stressor affecting mental health negatively.¹⁰ Bockting et al.^{11,12} defined internalized transnegativity as discomfort with one's own transgender identity as a result of internalizing society's normative gender expectations.

Recent evidence supports the relationship between minority stress processes and negative mental health outcomes among transgender and gender nonconforming people, since experiences of discrimination and expectations of rejection have been found to be associated with psychological distress.^{8,13,14} Evidence has also been found for the protective role of family support and pride in one's transgender identity,⁸ and support from transgender peers and transgender community connectedness have been shown to buffer the negative effect of stigma on mental health,¹⁴⁻¹⁶ although support from the transgender community might be more beneficial for trans-feminine spectrum people than for trans-masculine spectrum people.¹⁵

With increasing visibility of transgender and gender nonconforming people in the media and in society in the United States, acceptance of gender diversity appears to have increased.¹⁷ Transgender women, in particular, have become more visible in the media and are more likely to be represented positively.^{18,19} Public awareness and familiarity with transgender issues are higher than in the past, although nuances of diversity and fluidity of gender identity among transgender and gender nonconforming people may be less well understood.²⁰⁻²² To explore if changes in visibility and attitudes have had a positive impact on health and well-being, we set out to compare younger and older trans-feminine individuals in terms of internalized transnegativity and mental health. We expected younger participants to report lower levels of psychological distress due to having come of age in a climate that is less stigmatizing of gender diversity than older participants. We also expected this difference to be due, at least in part, to lower levels of internalized transnegativity among the younger generation.

Methods

This study is a secondary analysis of data collected as part of a larger study of the U.S. transgender population conducted

by the senior author during his tenure at the University of Minnesota Medical School. The study was approved by the University of Minnesota Medical School's Institutional Review Board, Human Subjects Committee.⁸

Participants

A diverse sample of individuals who self-identified as transgender, were 18 years of age or older, and who were living in the United States were recruited online through transgender community web sites and messages posted to online mailing lists, journals, and forums.²³ Banners displayed revolving texts such as "A diverse community requires distinctive support," "Transgender health survey," and "TGStudy: Click here to get started." To confirm eligibility, validity, and uniqueness, a computerized de-duplication, cross-validation protocol compared each participant's e-mail and IP address, user name, password, date of birth and age, zip code, and scale completion time with other participants' responses to identify participants who submitted more than one survey or who provided invalid data.²⁴ Surveys from a total of 1229 participants were complete and deemed valid.

From this larger sample, we selected responses of trans-feminine participants in two age groups: aged 18-24 years ($n=133$) and aged 40 years or older ($n=307$), for a total sample size of $N=440$. The age groups were determined based on the age distribution in our sample. We were interested in comparing two age groups, youth versus midlife and beyond, rather than examining the effects of age as a continuous variable. Of the younger group, 37.9% identified as transsexual, 16.7% as crossdresser, 15.9% as drag queen or female impersonator, and 29.5% as another transgender identity (such as bigender, genderqueer, or two-spirit). Of the older group, 39.1% identified as transsexual, 37.2% as crossdresser, 3.0% as drag queen or female impersonator, and 20.7% as another transgender identity. In the younger group, 36.0% had been living primarily in the female gender role for a mean duration of 2.4 years [standard deviation (SD)=2.1, median=1.6 years]. In the older group, 43.9% had been living primarily in the female gender role for a mean duration of 6.0 years (SD =6.7, median=4.0 years). In the younger group, 64.6% reported feeling strongly to very strongly like a woman, whereas in the older group 72.2% reported feeling strongly to very strongly like a woman. In addition, 39.4% of the younger group and 60.5% of the older group reported ever having taken feminizing hormones.

Instruments

Internalized transnegativity was measured with the 26-item Transgender Identity Survey.¹² This instrument was developed using exploratory and confirmatory factor analyses with diverse online and offline samples of transgender people across the United States. It assesses internalized transnegativity along several dimensions, including pride, shame, and alienation from transgender peers.¹² Participants were asked how they felt in the last 3 months about being transgender by indicating their agreement with such statements as "Being transgender makes me feel like a freak" and "I am proud to be a transgender person." Response options were on a 7-point Likert scale ranging from 1=Strongly Disagree to 7=Strongly Agree. Scores were computed so that higher scores indicate greater levels of internalized transnegativity; a total scale

score was calculated as the mean of the 26 items. Internal consistency reliability of this scale was 0.94 (Cronbach's alpha); test-retest reliability was 0.93 ($n = 18$).¹²

Psychological distress was assessed with the 18-item short-form of the Brief Symptom Inventory (BSI-18).²⁵ This instrument assesses symptoms of depression, anxiety, and somatization. Participants were asked how much a particular symptom distressed or bothered them during the last 7 days: 1 = not at all, 2 = a little bit, 3 = moderately, 4 = quite a bit, and 5 = extremely. Examples of items are "Feeling hopeless about the future" (depression), "Feeling tense or keyed up" (anxiety), and "Nausea or upset stomach" (somatization). We used the total scale score, the Global Severity Index (GSI), as our measure of psychological distress; higher scores indicate greater psychological distress. Internal consistency reliability of the GSI was 0.94 (Cronbach's alpha); test-retest reliability was 0.72 ($n = 20$).⁸

Enacted stigma was assessed by 10 items that asked participants whether they had experienced various forms of discrimination because of their transgender identity or gender presentation.²⁶ Examples of items are "Have you ever been verbally abused or harassed and thought it was because of your transgender identity or gender presentation?" and "Have you ever been denied or lost housing and thought it was because of your transgender identity or presentation?" Response options were "yes" or "no." Internal consistency reliability for this scale was 0.74 (Cronbach's alpha); test-retest reliability was 0.79 ($n = 20$).⁸

Gender dysphoria (i.e., distress due to incongruence between one's gender identity and sex or gender role assigned at birth) was assessed by a single item asking participants "How comfortable are you currently with the sex you were assigned at birth?" Response options were on a 7-point Likert scale ranging from 1 = very uncomfortable to 7 = very comfortable. The item was reverse scored so that higher scores indicate greater gender dysphoria. While gender dysphoria can be measured in different ways, and use of a single item measure has limitations, this item has been used in past analyses to represent this construct.⁸ Test-retest reliability was 0.85 ($n = 20$).⁸

Procedure

The larger study that provided the data for this secondary analysis was designed to reach self-identified transgender adults via the Internet and survey them about their experience of gender and their sexual health.²³ After clicking on a banner advertisement or link, participants landed on the study website that explained the project's purpose and procedures. After confirming eligibility and providing informed consent online, participants completed the survey at their own pace and convenience. The entire survey, which included the domains of demographics, gender identity and expression, sexual orientation and behavior, stigma and internalized transnegativity, social support, mental health, and substance use, took 50–60 minutes to complete. Participants were offered a \$30 online gift certificate to compensate them for their time and effort.

Statistical analysis

First, we compared the younger and older groups on each of our variables of interest using independent *t*-tests. Second, we

used multiple regression to examine differences between the two age groups in psychological distress and internalized transnegativity while controlling for significant differences between the groups in race/ethnicity and sexual orientation. We also included enacted stigma and gender dysphoria in these models because, in addition to age, we expected these also to be related to our outcomes. We did not control for differences in education and income, as these differences can be attributed, at least in part, to age. Finally, we used the approach recommended by MacKinnon et al.'s²⁷ to test whether internalized transnegativity partially mediated the relationship between age group and psychological distress. According to this approach, a variable *M* is declared a mediator only if both the test of the regression coefficient of the explanatory factor *X* on the mediator and the test of the coefficient of the mediator on the outcome variable *Y* controlling for *X* are both significant at level $\alpha = 0.05$, two-tailed. This approach was found to achieve a better balance of Type I error and statistical power than alternative approaches MacKinnon et al. reviewed.²⁷ In the mediation analysis, we again controlled for the significant differences between age groups in race/ethnicity, sexual orientation, as well as for gender dysphoria because of its association with our variables of interest.

Results

Due to the age difference between the groups, we expected differences in education and income. On the whole, educational level was high while income level was low. Of the younger group, 78.5% reported at least some college at the time of the survey, whereas of the older group, 91.5% completed at least some college. Median annual income (annual household income divided by the number of people living in the household) was \$17,500 for the younger group and \$27,500 for the older group. In addition, the two groups differed in race/ethnicity, with a smaller majority (74.4%, $n = 99$) of the younger versus the older age group (88.9%, $n = 273$) identifying as white ($X^2(1) = 14.9$, $P < 0.001$). The two groups also differed in terms of sexual orientation ($P < 0.001$). Of the younger participants, 37.9% were primarily attracted to men, 21.2% to women, and 40.9% were attracted to both. Of the older participants, 18.2% were primarily attracted to men, 47.6% to women, and 34.2% were attracted to both.

Bivariate comparisons showed no significant differences between the younger and older groups in gender dysphoria and enacted stigma (Table 1). However, the younger participants reported higher levels of internalized transnegativity ($P < 0.05$) and higher levels of psychological distress ($P < 0.001$) than the older participants. In multivariate analysis, when controlling for race/ethnicity, sexual orientation, enacted stigma, and gender dysphoria, the younger group had significantly higher levels of psychological distress and internalized transnegativity than the older group (Table 2). In addition, enacted stigma was positively associated with psychological distress ($P < 0.001$), and gender dysphoria was negatively associated with internalized transnegativity ($P < 0.001$).

To examine whether the difference in psychological distress between the groups is, at least in part, due to a difference in internalized transnegativity, we conducted a mediation analysis using the approach advocated by MacKinnon et al.²⁷ First, the relationship between age and internalized transnegativity

TABLE 1. BIVARIATE COMPARISONS BETWEEN YOUNGER AND OLDER TRANS-FEMININE INDIVIDUALS ($N=440$)

	<i>Younger (n=133)</i>		<i>Older (n=307)</i>		T	df	P
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>			
Gender dysphoria	3.93	2.07	4.00	2.02	0.34	436	0.737
Enacted stigma	1.89	1.92	1.61	1.82	1.36	401	0.176
Internalized transnegativity	3.68	1.09	3.45	0.89	2.09	210	0.038
Psychological distress	20.28	15.36	13.80	12.06	3.98	163	<0.001

SD, standard deviation.

was tested, while controlling for race/ethnicity, sexual orientation, and gender dysphoria, which was shown to be significant ($P<0.05$; Table 3). Second, the relationship between internalized transnegativity and psychological distress was tested, while controlling for race/ethnicity, sexual orientation, gender dysphoria, and age, which was shown to be significant ($P<0.001$; Table 4). Together, these analyses showed that internalized transnegativity partially mediates the relationship between age and psychological distress. The indirect effect via internalized transnegativity reduced the coefficient of the relationship between age and psychological distress by 13%.

Discussion

This study examined differences between younger and older trans-feminine individuals in internalized transnegativity and mental health. We hypothesized that younger participants would report less psychological distress and lower levels of internalized transnegativity, which we attributed to having come of age in a climate with greater visibility of transgender and gender nonconforming people and growing acceptance of gender diversity. Contrary to our expectations, the younger participants reported both more psychological distress and more internalized transnegativity than the older participants. Age norms for the BSI (a longer version of the measure used here) vary across samples. One study found lower levels of distress among older people,²⁸ while other studies found no differences by age on the subscales used in our analyses²⁹ or found higher levels of distress among older participants.³⁰ Therefore, it is unlikely that the difference we found is primarily due to a general aging effect. However, our findings may point toward a maturation effect among trans-feminine people, whereby older individuals have developed coping skills and social support

systems that increased their resilience in response to stigma and minority stress related to being transgender. This interpretation is consistent with the findings of Nuttbrock et al.³¹ that gender-related abuse is more closely related to psychological distress among younger transgender women compared with older transgender women. To better understand how trans-feminine people may develop resilience over time, the trajectory of stigma, minority stress, and mental health will need to be studied longitudinally.³²

Although transgender people may come out at any age, younger individuals may be at earlier stages of gender affirmation or transition than older individuals, which could, in part, explain the higher levels of psychological distress found among the younger group in our sample. Indeed, fewer of the younger participants were living primarily in the female gender role and for a shorter average period of time compared to participants in the older group. In addition, given the evidence supporting an association between hormone therapy and improved mental health among transgender people,^{33,34} the higher percentage of older participants in our sample who had taken feminizing hormones may have contributed to the difference between the age groups in psychological distress, although not all transgender individuals need or desire hormones to affirm their gender identity. We did, however, attempt to take these factors into account by controlling for participants' level of gender dysphoria in our analyses, limitations in its measurement notwithstanding. Thus, we think it is unlikely that the difference found in psychological distress between the younger and older group is primarily due to stage of gender affirmation or transition. Rather, the lower level of psychological distress in the older group may indicate the development of resilience as part of a broader process of transgender identity development across the lifespan.^{35–38}

TABLE 2. MULTIVARIATE ANALYSIS OF PREDICTORS OF PSYCHOLOGICAL DISTRESS AND INTERNALIZED TRANSNEGATIVITY ($N=440$)

	<i>Psychological distress</i>			<i>Internalized transnegativity</i>		
	<i>B</i>	<i>SE</i>	<i>P</i>	<i>B</i>	<i>SE</i>	<i>P</i>
Race/ethnicity (White vs. all other ^a)	−1.84	1.85	0.319	−0.03	0.13	0.805
Sexual orientation	0.24	0.35	0.497	−0.02	0.03	0.361
Gender dysphoria	−0.53	0.33	0.101	−0.11	0.02	<0.001
Enacted stigma	1.72	0.37	<0.001	0.02	0.03	0.393
Age	−6.31	1.50	<0.001	−0.24	0.11	0.027

^aAll other includes African American, Latina, Asian-Pacific Islander, multirace, and other races.
SE, standard error.

TABLE 3. REGRESSION OF AGE ON INTERNALIZED TRANSNEGATIVITY, CONTROLLING FOR RACE/ETHNICITY, SEXUAL ORIENTATION, AND GENDER DYSPHORIA (FIRST STEP OF MEDIATION ANALYSIS) ($N = 440$)

	<i>Internalized transnegativity</i>		
	<i>B</i>	<i>SE</i>	<i>p</i>
Race/ethnicity	−0.02	0.13	0.902
Sexual orientation	−0.03	0.02	0.229
Gender dysphoria	−0.11	0.02	<0.001
Age	−0.21	0.10	0.042

$R^2 = 0.074$, $F(4) = 8.45$, $SE = 0.93$, $P < 0.001$.

We found that the higher level of psychological distress among the younger compared with the older trans-feminine individuals in our sample was due, in part, to different levels of internalized transnegativity. To date, clinical research and care has focused primarily on gender dysphoria and on gender-affirming medical interventions, such as hormone therapy and surgery, which aim to reduce dysphoria.^{33,34} The emerging evidence on the impact of enacted and felt stigma^{8,13,14} and, with our study, the impact of internalized transnegativity on psychological distress points to the need to also address these minority stress processes through clinical and support services aimed to improve mental health and facilitate resilience. While effective at reducing gender dysphoria, gender-affirming medical interventions may have less of an effect on internalized transnegativity. Interventions to optimize the mental health of trans-feminine individuals should go beyond reducing gender dysphoria to also address internalized transnegativity and other minority stress processes and their negative impact on mental health.

Even though this study points to a meaningful association between internalized transnegativity and psychological distress, we acknowledge that internalized transnegativity remains a complex construct. Although our measure of internalized transnegativity was grounded in self-reflections of a clinical sample of transgender individuals, review by an expert panel, and development and testing using large samples of transgender people from across the United States, further testing of the construct validity of this measure is recommended.¹²

TABLE 4. REGRESSION OF AGE ON PSYCHOLOGICAL DISTRESS, CONTROLLING FOR RACE/ETHNICITY, SEXUAL ORIENTATION, GENDER DYSPHORIA, AND INTERNALIZED TRANSNEGATIVITY (SECOND STEP OF MEDIATION ANALYSIS) ($N = 440$)

	<i>Psychological distress</i>		
	<i>B</i>	<i>SE</i>	<i>P</i>
Race/ethnicity	−2.62	1.85	0.157
Sexual orientation	0.01	0.34	0.976
Gender dysphoria	−0.38	0.33	0.244
Internalized transnegativity	3.72	0.71	<0.001
Age	−5.26	1.50	0.001

$R^2 = 0.131$, $F(5) = 11.54$, $SE = 12.61$, $P < 0.001$.

Evidence on the role of peer and community support in ameliorating the negative impact of stigma on mental health,^{15,16} combined with the finding of our study that the older generation may have developed resilience during the course of their identity development, suggest that intergenerational mentoring could potentially benefit trans-feminine youth and young adults. Older trans-feminine individuals could share their wisdom and skills, and provide support to the younger generation in coping with prejudice, discrimination, and internalized transnegativity.

Limitations

This study is limited by the use of data collected from a nonprobability sample of participants recruited via the Internet. Nevertheless, this recruitment and sampling approach was effective at reaching a large, national sample of a marginalized population, and did allow us to access participants living in geographically remote areas. Unfortunately, the online sample was limited in the representation of ethnic and racial diversity; future studies should strive to improve on this and advance our understanding of how gender and ethnic/racial minority identities intersect, for example in relationship to the development of resilience.

The cross-sectional nature of the data precluded any conclusions about causal relationships among the constructs examined. Since we did not ascertain the level of internalized transnegativity and psychological distress among the older group at a younger age, we are not able to disentangle age and cohort effects. Our study is also limited by the use of a single-item measure of gender dysphoria to control for the impact of gender-affirming interventions on participants' level of psychological distress. Longitudinal studies are needed to better understand the development of transgender identity and resilience across the lifespan. Although we aimed to compare youth (aged 18–24 years) to participants at midlife and older (aged ≥ 40 years), future research could explore differences in the mechanisms of how internalized transnegativity contributes to psychological distress *within* different age groups. In addition, given ongoing changes in the social climate and access to healthcare due to policy changes^{39,40} implications for clinical practice should be drawn with caution and based on the most recent data available.

Although our sample consisted of individuals with a wide variety of transgender identities, including people who identify as transsexual, crossdresser, drag queen, female impersonator, and other transgender identities such as bigender, genderqueer, and two-spirit,²³ grouping all of these individuals together may have obscured differences between identity subgroups. For example, data from the National Transgender Discrimination Survey⁴¹ indicated that cross-dressers are half as likely to report a suicide attempt in their lifetime compared with individuals with other transgender identities. In another online study, with a diverse gender and sexual minority sample, transgender women reported the highest levels of psychological distress compared with transgender men, genderqueer/nonbinary identified individuals, and cis-gender sexual minority peers.⁴² Due to the limited sample size in our study, we were not able to examine differences between identity subgroups, but it is possible that internalized transnegativity as well as psychological distress may also differ between subgroups of trans-feminine people.

Conclusion

Increased visibility in popular culture and media does not necessarily mean increased well-being for transgender and gender nonconforming people. Societal perceptions of gender as a binary system continue to put transgender individuals at risk for prejudice and discrimination, as well as for internalizing binary concepts of gender which might ultimately not reflect their particular identity and experience. Interventions and policies are needed to reduce social stigma attached to nonconformity in gender identity and expression. In addition, the potential negative effects of internalized stigma should be assessed and addressed through clinical interventions designed to promote resilience and optimize health outcomes. Understanding the impact of internalized transnegativity on mental health and addressing it therapeutically may lead to improved psychosocial adjustment and health for trans-feminine spectrum people. Future research using a life course perspective could illuminate how challenges and vulnerabilities related to transgender identity development may accumulate and resolve over time.

Acknowledgments

The larger study that provided the data for this secondary analysis was funded by grants from the National Institutes of Health (R01-DA015269 and R01-HD05759, Walter Bockting, PI). We thank our transgender community advisory board members for their collaboration and enduring support. At the time of the present study, Kasey Jackman was a predoctoral fellow on the training grant Comparative and Cost-Effectiveness Research Training for Nurse Scientists (NINR T32NR013454, Patricia Stone, PI). This study was made possible through support from the Jonas Center for Nursing and Veterans Healthcare.

Disclaimer

The data used for this secondary analysis were collected for a study conducted by WOB during his tenure at the University of Minnesota Medical School. This analysis was presented as a poster at the Eastern Nursing Research Society Annual Scientific Sessions in Washington, DC in 2015. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Jonas Center for Nursing and Veterans Healthcare.

Author Disclosure Statement

No competing financial interests exist.

References

1. Collin L, Reisner SL, Tangpricha V, Goodman M: Prevalence of transgender depends on the "case" definition: A systematic review. *J Sex Med* 2016;13:613–626.
2. Deutsch MB: Making it count: Improving estimates of the size of transgender and gender nonconforming populations. *LGBT Health* 2016;3:181–185.
3. Meyer IH, Brown TN, Herman JL, et al.: Demographic characteristics and health status of transgender adults in select US regions: Behavioral Risk Factor Surveillance System, 2014. *Am J Public Health* 2017;107:582–589.
4. Dhejne C, Öberg K, Arver S, Landén M: An analysis of all applications for sex reassignment surgery in Sweden,

- 1960–2010: Prevalence, incidence, and regrets. *Arch Sex Behav* 2014;43:1535–1545.
5. Aitken M, Steensma TD, Blanchard R, et al.: Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *J Sex Med* 2015;12:756–763.
6. Marshall E, Claes L, Bouman WP, et al.: Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *Int Rev Psychiatry* 2016;28:58–69.
7. Jackman K, Honig J, Bockting W: Nonsuicidal self-injury among lesbian, gay, bisexual and transgender populations: An integrative review. *J Clin Nurs* 2016;25:3438–3453.
8. Bockting WO, Miner MH, Swinburne Romine RE, et al.: Stigma, mental health, and resilience in an online sample of the US transgender population. *Am J Public Health* 2013; 103:943–951.
9. Meyer IH: Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol Bull* 2003;129:674–697.
10. Hendricks ML, Testa RJ: A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Prof Psychol Res Pract* 2012;43:460–467.
11. Bockting WO: Transgender identity, sexuality, and coming out: Implications for HIV risk and prevention. Proceedings of the NIDA-sponsored satellite sessions in association with the XIV International AIDS Conference, Barcelona, Spain, July 7–11, 2002, pp 163–172. Bethesda, MD: National Institute on Drug Abuse, U.S. Department of Health and Human Services, National Institutes of Health, 2003.
12. Robinson B, Berg D, Bockting W, et al.: Internalized transphobia as a health hazard: Development of the Transgender Identity Scale. XVIII Harry Benjamin International Gender Dysphoria Symposium, Ghent, Belgium, 2003.
13. Rood BA, Reisner SL, Surace FI, et al.: Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health* 2016;1:151–164.
14. Tebbe EA, Moradi B: Suicide risk in trans populations: An application of minority stress theory. *J Couns Psychol* 2016;63:520–533.
15. Pflum SR, Testa RJ, Balsam KF, et al.: Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychol Sex Orientat Gend Divers* 2015;2:281–286.
16. Nuttbrock L, Bockting W, Rosenblum A, et al.: Transgender community involvement and the psychological impact of abuse among transgender women. *Psychol Sex Orientat Gend Divers* 2015;2:386–390.
17. Miller H: Best of 2015: Transgender visibility continues to break down barriers. Human Rights Campaign, 2015. Available at www.hrc.org/blog/best-of-2015-transgender-visibility-continues-to-break-down-barriers Accessed July 18, 2017.
18. Rodriguez H: *We Can't Let Increased Transgender Visibility Lead to More Vulnerability*. New York: The Guardian, 2015. Available at www.theguardian.com/commentisfree/2015/aug/21/transgender-visibility-vulnerability Accessed November 16, 2016.
19. Capuzza JC, Spencer LG: Regressing, progressing, or transgressing on the small screen? Transgender characters on U.S. scripted television series. *Comm Q* 2016;65:214–230.
20. Kuper LE, Nussbaum R, Mustanski B: Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *J Sex Res* 2012; 49:244–254.

21. Diamond LM, Butterworth M: Questioning gender and sexual identity: Dynamic links over time. *Sex Roles* 2008;59: 365–376.
22. Diamond LM, Pardo ST, Butterworth MR: Transgender experience and identity. In: *Handbook of Identity Theory and Research*. Edited by Schwartz SJ, Luyckx K, Vignoles VL. New York: Springer-Verlag New York, 2011, pp 629–647.
23. Rosser BRS, Oakes JM, Bockting WO, Miner M: Capturing the social demographics of hidden sexual minorities: An internet study of the transgender population in the United States. *Sex Res Soc Policy* 2007;4:50–64.
24. Miner MH, Bockting WO, Romine RS, Raman S: Conducting Internet research with the transgender population: Reaching broad samples and collecting valid data. *Soc Sci Comput Rev* 2012;30:202–211.
25. Derogatis LR, Savitz KL: The SCL-90-R and Brief Symptom Inventory (BSI) in primary care. In: *Handbook of Psychological Assessment in Primary Care Settings*. Edited by Maruish ME. Mahwah, NJ: Lawrence Erlbaum Associates Publishers, 2000, pp 297–334.
26. Clements-Nolle K, Marx R, Katz M: Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *J Homosex* 2006;51: 53–69.
27. MacKinnon DP, Lockwood CM, Hoffman JM, et al.: A comparison of methods to test mediation and other intervening variable effects. *Psychol Methods* 2002;7:83–104.
28. Francis VM, Rajan P, Turner N: British community norms for the Brief Symptom Inventory. *Br J Clin Psychol* 1990; 29:115–116.
29. Ryan C: British outpatient norms for the Brief Symptom Inventory. *Psychol Psychother* 2007;80:183–191.
30. Hale WD, Cochran CD, Hedgepeth BE: Norms for the elderly on the Brief Symptom Inventory. *J Consult Clin Psychol* 1984;52:321–322.
31. Nuttbrock L, Hwang S, Bockting W, et al.: Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *J Sex Res* 2010;47:12–23.
32. Bockting W, Coleman E, Deutsch MB, et al.: Adult development and quality of life of transgender and gender non-conforming people. *Curr Opin Endocrinol Diabetes Obes* 2016;23:188–197.
33. Fisher AD, Castellini G, Ristori J, et al.: Cross-sex hormone treatment and psychobiological changes in transsexual persons: Two-year follow-up data. *J Clin Endocrinol Metab* 2016;101:4260–4269.
34. Costa R, Colizzi M: The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: A systematic review. *Neuropsychiatr Dis Treat* 2016;12: 1953–1966.
35. Bockting W, Coleman E: Developmental stages of the transgender coming-out process: Toward an integrated identity. In: *Principles of Transgender Medicine and Surgery*. Edited by Ettner R, Monstrey S, Eyler AE. Binghamton, NY: The Haworth Press, Inc., 2007, pp 185–208.
36. Bockting W, Coleman E: Developmental stages of the transgender coming-out process: Toward an integrated identity. In: *Principles of Transgender Medicine and Surgery, 2nd ed*. Edited by Ettner R, Monstrey S, Coleman E. New York: Routledge, 2016, pp 137–158.
37. Lev AI: *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families*. Binghamton, NY: The Haworth Clinical Practice Press, 2004.
38. Lewins FW: *Transsexualism in Society: A Sociology of Male-to-Female Transsexuals*. South Melbourne: Macmillan Education Australia, 1995.
39. Baker KE: The future of transgender coverage. *New Engl J Med* 2017;376:1801–1804.
40. Williams D, Medlock M: Health effects of dramatic societal events-ramifications of the recent presidential election. *New Engl J Med* 2017;376:2295–2299.
41. Grant JM, Mottet L, Tanis JE, et al.: *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
42. Warren JC, Smalley KB, Barefoot KN: Psychological well-being among transgender and genderqueer individuals. *Int J Transgend* 2016;17:114–123.

Address correspondence to:
 Kasey B. Jackman, PhD, RN, PMHNP-BC
 School of Nursing
 Program for the Study of LGBT Health
 Columbia University
 560 West 168th Street
 New York, NY 10032

 E-mail: ke2105@cumc.columbia.edu