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Traumatic stress and resilience among transgender and gender diverse youth

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Key Words: traumatic stress, minority stress, social stress, discrimination, stigma, marginalization, transphobia, childhood abuse, social stress, adverse childhood experience, resilience, coping

Key Points (3-5 bulleted sentences indicating the main takeaways/defining elements of the article)

1. Traumatic stress during childhood elicits neurobiological, behavioral, and psychosocial impacts across the lifespan.
2. Transgender and gender diverse (TGD) youth face higher rates of abuse and traumatic stress as compared to their cisgender peers.
3. Traumatic stressors facing TGD youth include both discrete experiences of abuse and recurrent socially-embedded forms of stigma, discrimination, and marginalization.
4. TGD youth encounter traumatic stressors across multiple social settings, including at school, at home, and in community settings.
5. Clinicians can help TGD youth build resilience by bolstering existing strengths, helping youth heal from trauma, and facilitating connections to supportive activities, peers, role models.

Synopsis (100 words or less)

Traumatic stress increases the risk for mental health conditions and adversely impacts health, academic performance, and coping. Transgender and gender diverse (TGD) youth experience higher rates of both abuse and maltreatment and interpersonal and community-embedded discrimination than their cisgender peers. Neurobiological stress responses and social stress theory provide useful frameworks for understanding the effects of discrimination, stigma, and rejection. Despite facing higher rates of interpersonal trauma, TGD youth are quite resilient when able to access supports and affirming trauma-informed services. Clinicians play an important role in identifying and addressing traumatic stress impacting TGD youth and bolstering resilience.

Introduction

Childhood trauma is a significant public health problem with lasting consequences. Traumatic stress increases the risk for virtually all mental health conditions and adversely impacts health, academic performance, and coping.¹ The Substance Abuse and Mental Health Services Administration (SAMHSA) defines “trauma” as an experience of physical, emotional, or life-threatening harm with lasting effects on health and wellbeing.² The terms “toxic stress” and “traumatic stress” refer to stress that overwhelms an individual’s support systems, buffering relationships, and coping strategies.³ A traumatic experience may present as a single event, like a physical assault, or a chronic exposure, such as maltreatment in a school setting or family rejection. Transgender and gender diverse (TGD) youth often experience both acute and chronic traumatic stressors related to identity-based marginalization and discrimination. Ongoing interpersonal trauma is more likely to cause post-traumatic stress disorder (PTSD) and is associated with more severe forms of PTSD than non-interpersonal trauma.⁴

Transgender and gender diverse youth face the gamut of common childhood stressors and additionally face higher rates of interpersonal and community-embedded trauma as compared to their cisgender peers. Neurobiological models of chronic stress and social stress theory provide useful frameworks for conceptualizing how experiences of discrimination, stigma, and rejection across social settings affect mental health. Despite the higher rates of interpersonal traumas facing TGD youth, TGD youth are often quite resilient, particularly when able to access social supports, skill building, and affirming trauma-informed services. Clinicians who identify and address traumatic stress affecting TGD youth patients, while also providing guidance for improving social relationships and supportive activities, can have a profoundly positive impact on mental health.

Neurobiological underpinning of toxic stress

In youth who experience chronic social stress, including family rejection, discrimination, stigma, and/or rejection, physiological stress response mechanisms become dysregulated. During an acute stress response, changes in neurotransmitters, hormones, and immune mediators, promote adaptation and stability, a process known as allostasis. These time-limited responses are generally protective and helpful to an individual under duress. Chronic activation of stress response systems, however, leads to lasting mental and physical changes that may be damaging to organ systems. Underlying neuroendocrine systems are unable to achieve allostasis when stressors do not remit. As stress builds, an individual exceeds their innate capacity to cope, leading to allostatic overload.⁵ Multiple neuroendocrine systems are implicated in the “wear and tear” in the body and brain associated with chronic childhood stress.⁶ This model of allostasis (achievement of stability via stress activation) versus allostatic overload (pathophysiological changes resulting from overuse) helps explain familiar clinical presentations among youth with trauma histories.

Two key neurobiological systems are known to be affected by toxic stress: (1) the hypothalamic-pituitary-adrenal (HPA) system, which involves glucocorticoids, and (2) the sympathetic adrenomedullary system, which centers on adrenaline (epinephrine and norepinephrine). Areas of the brain implicated in post-traumatic stress symptoms—specifically the hippocampus, amygdala, and prefrontal cortex—are especially sensitive to stress hormones.⁶ The amygdala, a region that encodes emotional memories and informs emotional responses,⁷ may become hyperresponsive to threats, leading to hypervigilance and a heightened fear response in the absence of true danger—also referred to as altered fear conditioning.^{8,9} Neuroimaging studies have also demonstrated decreased hippocampal volume and abnormal hippocampus functioning in PTSD.¹⁰ Damage to the hippocampus, which helps encode emotional, episodic, and spatial memories, contributes to symptoms of memory impairment and mood regulation seen in PTSD.¹¹ Lastly, alterations in the shape and/or volume of multiple regions of the prefrontal cortex, in particular the medial prefrontal cortex, help explain the diminished extinction of fear response and an inability to downregulate amygdala activation.^{12,13} Stress-related changes in the prefrontal cortex also impact circadian rhythms and memory more generally.⁶

Psychosocial impacts of identity-related toxic stress

Childhood trauma is associated with lasting health effects across the lifespan. Studies have linked childhood trauma to poor physical health,^{14–17} greater psychological stress,^{15,18} increased risk for psychopathology,^{15,16,19–22} and increased risk of substance use.¹⁵ Early studies on childhood trauma centered on “childhood adversity,” as characterized by the Adverse Childhood Experience (ACE) study.¹⁵ In the ACE study, investigators retrospectively examined adult health outcomes in association with exposure to childhood maltreatment (physical, emotional, and sexual abuse), physical and emotional neglect, and household challenges. Household dysfunction included parental interpersonal violence, a family member with mental illness or substance use, a family member in prison, or parental separation/divorce. The ACE study found a strong direct correlation between the number of ACEs and poor health outcomes. Experiences of early adversity tended to cluster, and data showed a dose-response relationship between the number of ACEs and adult health outcomes. For example, participants reporting 4 or more adverse childhood experiences had a 4 to 12 times increased risk for alcoholism, drug abuse, depression, and suicide attempts as compared to those who reported no ACEs.¹⁵

Subsequent studies have added peer rejection, peer victimization, community violence exposure, and socioeconomic status to the ever-growing list of adverse childhood experiences²³ and emphasized that ACEs all occur within a social context. Historical definitions of adverse childhood experiences may fail to capture the nuance and pervasiveness of social stress experienced by TGD youth. This expanded definition better captures the experiences of many

TGD youth, who are repeatedly exposed to peer and family rejection and victimization at higher rates than their cisgender peers.²⁴

Risk factors for the development of PTSD following a traumatic event can be divided into factors before, during, and after the event. Risk factors prior to a traumatic event include younger age (when an individual has limited self-regulatory capacity); female sex; lower education level or intelligence; family history of depression, anxiety, or PTSD; history of mental health disorder, temperament, genetic, and/or neurobiological factors such as stress reactivity; and a prior individual history of trauma.²⁵ Risk factors during the event include the level of exposure, intensity of the experience, perception of the event, and whether the trauma is interpersonal and/or intentional. Risk factors after the event include limited social support, limited access to resources/services, ongoing stress, and limited coping skills. Critically, almost none of the risk factors for developing PTSD are within the individual's control. TGD youth often face numerous risk factors for PTSD while experiencing more limited social support and reduced access to resources and services. They are also more likely to have experienced prior traumatic events and to face ongoing stressors and instability than cisgender youth.

TGD youth face both discrete episodes of maltreatment and abuse *and* socially-embedded discrimination, stigma, and marginalization across community settings. Minority social stress theory explains that both the direct negative consequences of social stressors and the internal experience of anti-transgender discrimination and messaging influence psychological processes.²⁶ Social stress impacts youths' perception of the external world, fosters concealment of identity, and worsens self-image.²⁶ Recurrent exposures to traumatic experiences and marginalization compound over time to lower self-image, impede self-efficacy, and decrease health-promoting behaviors. Data clearly show an increased risk for substance use, depression, stress, shame, and loneliness among TGD youth.^{27,28} For TGD youth of color, gender minority status intersects with racial-ethnic identity to potentiate social stress. Intersectional framework explains that TGD youth of color experience profound inequities across community, school, and legal, and social welfare settings due to compounding marginalization on the basis of both race/ethnicity *and* gender identity and expression.

Clinically, providers often observe internalizing symptoms related to anxiety, depression, and/or PTSD, and, in some youth, externalizing symptoms like irritability or reactivity. TGD youth experience disproportionate rates of depression and anxiety disorders as compared to cisgender heterosexual peers.²⁹⁻³¹ LGBTQ individuals also carry a risk of PTSD 1.6 to 3.9 times higher than their cisgender heterosexual peers.²⁴ Relatedly, the rates of non-suicidal self-injury, suicidal ideation, planning, and suicide attempts are higher among TGD compared to their cisgender peers.³¹ Depression and victimization are significantly associated with higher odds of suicidal ideation among both transgender youth³² and transgender adults.³³ A staggering 45% of LGBQ

youth in the national 2021 Youth Risk Behavior Survey (YRBS) reported seriously considering attempting suicide within the last year, while 22% reported an actual attempt in the past year.³⁴

Rates of disordered eating are also higher among LGBTQ individuals than cisgender heterosexual counterparts,³⁵ with disordered eating behaviors often beginning in childhood or adolescence as with the general U.S. population.³⁶ LGBTQ children aged 9 to 10 years old in the Adolescent Brain Cognitive Development Study were more likely to have full or subthreshold binge eating disorder compared to their cisgender heterosexual peers.³⁷ Though relatively limited, data on TGD youth and young adults show elevated rates of self-reported eating disorders and, specifically, elevated rates of compensatory behaviors like fasting, vomiting, and laxative pill use.^{36,38} Increased rates of disordered eating behaviors among TGD youth stem from traumatic experiences, discrimination, gender dysphoria, and body dissatisfaction.^{35,36,38,39} Eating disorders are associated with more severe psychiatric symptoms and risk behaviors in early adulthood,³⁹ presenting additional complex challenges for TGD youth with trauma.

As with cisgender youth, TGD youth with trauma histories are more likely to engage in substance use than peers who have not experienced childhood trauma.^{40,41} Among a large national sample, TGD adolescents had increased odds of alcohol use, marijuana use, and illicit drug use over the last year compared to cisgender peers. Experiences of bullying and harassment were associated with increased risk of substance use.⁴² Another large cross-sectional analysis conducted among diverse California middle and high school students similarly found elevated rates of heavy alcohol, cigarette, marijuana, illicit drug, and polysubstance use when comparing TGD youth to cisgender peers (2.4 to 5 times the odds, depending on the substance). Both recent use (in the last 30 days) and lifetime use were elevated. Not surprisingly, TGD youth were at greater risk for substance use at an earlier age than cisgender peers. Victimization partially mediated the relationship between TGD identity and substance use.⁴⁰ Both adolescent PTSD⁴¹ and depression^{43,44} have bidirectional, reciprocal effects with substance use, wherein the presence of one increases risk for the other. Adolescents may utilize substances to mitigate PTSD or depression symptoms, while simultaneously exacerbating underlying symptoms in the long-term. Furthermore, substance use also increases the risk of victimization^{45,46} and decreases response to treatment of PTSD⁴⁵ and depression.^{43,44}

Physical health impacts

Minority stress, discrimination, trauma, victimization, and stigma all influence the general health and wellbeing of LGBTQ people. LGBTQ people experience worse health and more disabilities than their cisgender heterosexual peers, with TGD individuals experiencing the greatest differences in overall health.⁴⁷ In addition to minority stress associated with their LGBTQ identities, Black, Native American, and other people of color experience racism and intergenerational and historical trauma, which further compounds poor health outcomes.⁴⁷ People

who experience multiple traumatic events, especially during childhood, are more likely to have a greater burden of persistent somatic symptoms like fatigue, dizziness, headaches, gastrointestinal symptoms, and pain.⁴⁸⁻⁵⁰

Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis is one of the lasting effects of childhood adversity, maltreatment, and LGBTQ-related structural stigma.⁵¹⁻⁵⁶ HPA axis dysregulation and stress-related disorders are associated with increased inflammatory factors, decreased anti-inflammatory factors, and altered immune responsiveness affecting overall physical health.^{57,58} PTSD is also associated with metabolic and autoimmune disorders as well as increased risk for cardiovascular disease.⁵⁹ The autonomic nervous system can be under- or over-modulated in PTSD, contributing to a range of gastrointestinal, cardiac, and pulmonary complaints.⁴⁹ Neurological symptoms such as gait disturbances, psychogenic nonepileptic seizures, and visual symptoms may also be present. In children and adolescents, traumatic stress has also been associated with catatonia, pseudo-neurological symptoms, and altered arousal states.⁴⁹

The increased vulnerability to somatic symptoms is potentially related to alterations to physiological responses and perception of bodily sensations following traumatic events.^{48,60} Individuals experiencing interpersonal trauma or multiple traumatic events are more likely to report more severe somatic symptoms.⁴⁸ A sense of threat, a common experience for LGBTQ youth, is associated with somatic symptoms.⁵⁰ Treatment for PTSD has been shown to improve somatic symptoms.⁴⁹

Distinct stressors facing TGD youth

The true prevalence of traumatic stress among TGD youth is difficult to accurately estimate, as childhood trauma is often under-reported due to stigma and shame.⁶¹ Exposure to trauma is quite common in the general U.S. population, with 58% of youth reporting exposure to assault or bullying, sexual victimization, maltreatment by caretaker, property victimization, or witnessing victimization in the past year.²³ The prevalence of childhood trauma is even higher among LGBTQ youth.⁶² In a recent cross-sectional study of lifetime exposure to ACEs in LGBTQ youth, 58% reported emotional neglect, 56% reported abuse, and 41% reported living with a family member with mental illness.⁶³ As with the foundational ACE Study,¹⁵ ACEs tended to cluster, with 43% of LGBTQ youth reporting four or more ACEs by age 18.⁶³ TGD youth report higher rates of maltreatment and ACE scores than cisgender LGBTQ youth.⁶³ Numerous studies have shown an association between childhood gender nonconformity and an increased risk of childhood abuse.^{64,65} In one study, greater gender nonconformity before 11 years of age was associated with greater exposure to childhood abuse and higher rates of PTSD.²⁴

Family rejection represents a common form of childhood trauma facing TGD youth.⁶⁶ Parental rejection behaviors increase risk for substance use, depression, and suicidality among TGD youth.⁶⁶⁻⁶⁸ In addition to the direct mental health impacts, family rejection contributes to disproportionate rates of child welfare contact and out-of-home placements for TGD youth.⁶⁹ TGD youth additionally face disproportionate rates of homelessness, with family rejection and maltreatment being the leading cause.⁷⁰⁻⁷² Family conflict, adversarial relationships, and a lack of parent-child closeness are also linked to higher drug use and initiation.⁷³⁻⁷⁶

LGBTQ youth are also more likely than cisgender heterosexual youth to face bullying and victimization from peers.⁷⁷ In a recent national assessment conducted by the Centers for Disease Control and Prevention (CDC), almost 25% of LGBQ students reported bullying at school within the last year, and 30% reported online bullying.³⁴ One in five LGBQ students reported ever being forced to have sex, with female students experiencing disproportionate risk compared to male students.³⁴ In the 2021 National School Climate Survey, 76% of LGBTQ students reported verbal harassment based on identity in the past year.⁷⁸ Bullying continues through college and is associated with increased stress, anxiety, and depression, and lower self-esteem.^{79,80} Unsurprisingly, LGBTQ youth who experience bullying and victimization in school settings report lower self esteem and higher levels of depression.⁷⁸

In addition to experiences of bullying and harassment by peers, LGBTQ students experience many other forms of school-based discrimination, including exclusion from school spaces and activities, hearing homophobic and transphobic comments from teachers or staff, and being encouraged to ignore perpetrators and/or to change their own behavior in order to avoid victimization. Over two-thirds of LGBTQ students report feeling unsafe in school due to factors related to gender or sexual orientation, with 32% missing at least one day of school in the past month as a result. Victimization is itself also associated with an increased risk of school discipline directed towards the *LGBTQ student*.⁷⁸ Bullying and harsher discipline in school settings increase rates of school dropout among LGBTQ youth.⁸¹ These experiences of discrimination are associated with symptoms of PTSD in TGD individuals, even when adjusting for previous traumatic experiences.⁸²

The rise of anti-transgender bills around the U.S. further marginalizes TGD youth, who already face high rates of victimization and discrimination in home and school settings. Public restriction or loss of civil rights among the LGBTQ community contributes to feelings of stigma, hopelessness, internalized homophobia, and poor self-image.^{83,84} Overall, young LGBTQ Americans experience greater impacts of discrimination on their psychological wellbeing than previous generations.⁸⁵ TGD youth frequently follow news about transgender rights, with 85% reporting they follow the news closely. Over 85% of TGD youth surveyed nationally reported worsened mental wellbeing as a result of exposure to debate about anti-transgender state laws.⁸⁶

These data align with prior analyses of the effects of political climate on LGBTQ youths' mental health. In the late 2000s, LGB youth living in states that banned same-sex marriage had higher rates of suicide attempts than LGB counterparts in states that legalized same-sex marriage.⁸⁷ Data among LGB adults similarly showed higher rates of psychiatric disorders and psychological distress among those living in states that banned same-sex marriage before it was federally recognized,⁸⁸ as well as those living in states that do not protect LGBTQ people from employment discrimination or hate crimes.⁸⁹

High rates of abuse and maltreatment, family rejection, and pervasive sociopolitical stress compound to increase psychiatric symptoms, risk behaviors, and maladaptive coping—including substance use and self-harm—among TGD youth. Homelessness, bullying, social stigma, and family rejection are specifically associated with an elevated risk of suicide.^{66,90} Additional chapters in this Special Issue detail the roles of school and family environments in the mental wellbeing of TGD youth.

Resilience and protective factors for TGD youth

Providers can support the mental wellbeing of TGD youth by recognizing and promoting recovery from trauma and by helping youth build resilience. According to the American Psychological Association (APA), resilience commonly refers to “the process by which people adapt well in the face of trauma, stressors, and adversity.”⁹¹ Multiple factors contribute to resilience among TGD youth, including individual coping strategies, interpersonal communication and support, access to resources, and school and community connectedness. Resilience factors can exist at the *individual* level (e.g., self-efficacy skills, strategies for managing stress in helpful ways, social skills, ability to define one's identity), at the *relationship* level (e.g., receiving encouragement and support from others, positive parent-child attachment, family cohesion), and at the *community* level (e.g., reliable support from social networks, engagement in positive extracurricular and community-based activities). Some resilience factors are essentially internal characteristics and skills, while others focus on the social support systems around the youth.

Literature on PTSD delineates a set of protective factors that help prevent the development of clinical PTSD following a traumatic event. Protective factors include: supportive relationships, networks of support, and access to support groups, services, and resources; the response of others to the traumatic event (especially important for children and adolescents); adaptive coping strategies; strong system of meaning or faith; and opportunities for expression and mastery, stability, and hope or optimism.^{25,92} As with PTSD risk factors, many of these protective factors are outside of the control of the individual. Yet, providers who work with TGD youth can often impact the youth's social environment through direct family education and communication,

connections to other supportive spaces or resources (e.g., online or in-person youth groups or activities), and safety, interpersonal, and communication skill building.

For many TGD youth, mental health challenges emerge in childhood or adolescence, as gender expression and roles play a larger role in peer socialization. Caregiver attachment and security are foundational to trust and interpersonal relationships throughout the lifespan and highly protective for transgender youth. TGD youth with strong early attachments are often better equipped to buffer socially-embedded discrimination and adversity. Importantly, prepubescent TGD children supported in their gender identity by parents exhibit comparable rates of depression as matched cisgender peers and only slightly higher anxiety scores.⁹³

Regardless of age, parental support and engagement are highly meaningful for TGD youths' wellbeing. Studies have consistently shown that parental support and engagement lower the risk of alcohol and drug use in general adolescent populations^{94–96} and for LGB adolescents.^{97–99} In particular, parental trust, warmth, and involvement decrease tobacco, alcohol, and marijuana use.¹⁰⁰ Research conducted over two decades by the Family Acceptance Project has demonstrated that LGBTQ youth who experience more acceptance and support from their parents display lower rates of depression and suicidality and higher self esteem.^{66,101} Parental behaviors impact youths' social support, self-worth, and overall health. Specific supportive family behaviors are associated with improved mental wellbeing, including advocating for the youth when mistreated by others, seeking supportive community spaces for the youth, and supporting the youth's gender expression.⁶⁶ The Family Acceptance Project provides a number of helpful free guides and handouts for use with families of TGD youth.^{101,102}

Peer, community, and school connectedness present additional key targets for bolstering resilience among TGD youth. Positive social support or sense of belonging improves self esteem, lowers rates of psychological symptoms, and decreases unhealthy adolescent behaviors like substance use and high numbers of sexual partners. LGBTQ youth who report acceptance from peers regarding their identity also tend to use substances less than peers who do not experience identity acceptance from peers.¹⁰³ Meanwhile, positive relationships with teachers and school staff improve feelings of safety at school,¹⁰⁴ ease the burden of navigating structural barriers at school,¹⁰⁴ and reduce absenteeism among TGD youth.¹⁰⁵ Participation in Gay-Straight Alliance (GSA) student groups, which offer interpersonal support and educational, advocacy, and/or recreational activities to LGBTQ students and their allies, is associated with better psychological wellbeing and more social connectedness among LGBTQ students.¹⁰⁶ In fact, the presence of a GSA group on a school campus is associated with better overall student wellbeing¹⁰⁷ and lower rates of risk behaviors among students—including substance use and high numbers of sexual partners.¹⁰⁸

Implications for clinical care

Trauma-Informed Care (TIC), as defined by SAMHSA, is a systems-based approach designed to create safe environments that are responsive to the signs and symptoms of trauma. A trauma-informed approach does the following: “(1) *realizes* the widespread impact of trauma and understands potential paths for recovery, (2) *recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system, (3) *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and (4) *resists* re-traumatization.”² Within health care settings, trauma-informed principles and practices support patients, families, and professionals through trust, collaboration, safety, and empowerment.² TIC is of particular relevance to TGD youth, who have often experienced a multitude of traumatic stressors and barriers when presenting to care settings.

In addition to TIC, the *gender affirmative framework* is another key guiding set of principles for providing high-quality care to TGD youth and their families. TIC and gender affirming care guide both systems of care and individual providers in creating safe, supportive environments for TGD youth.¹⁰⁹ At its core, gender affirmative framework contends that gender presentations are diverse and vary across cultures and over time and that no gender identity or expression is pathological. Gender is informed by biology, development, socialization, culture, and context. For some youth, gender is evolving and/or fluid, and for some youth gender is non-binary. As discussed herein, clinical symptoms and risk-taking behaviors result from TGD youth’s experiences in society and by cultural reactions to their gender identities and presentations.^{110–113} Providers who adopt gender affirmative framework engage in the following best practices: (1) approaching LGBTQ identities as natural, normal variations of human sexuality and gender; (2) acquiring and utilizing accurate knowledge to effectively provide mental health care to LGBTQ clients; (3) addressing and counteracting anti-LGBTQ attitudes, stigma, and minority stress; and (4) providing support and promoting resilience and pride.^{114–116} SAMHSA further encourages providers to consistently use affirming language (including names and pronouns), support LGBTQ peer support, and ensure that services are responsive to the needs of TGD individuals.¹¹⁷

Gender affirming care is associated with reduced symptoms of depression, suicidal ideation, and suicide attempts.^{118–120} The specific act of using pronouns and chosen names has also been shown to reduce depressive symptoms and suicidal behaviors.¹¹⁹ Importantly, greater symptom reduction was directly associated with the use of pronouns and chosen name in a greater number of contexts.¹¹⁹ When providers assist families in adopting accepting behaviors, TGD youths’ self esteem, social support, and health are all likely to improve.⁶⁶ The improvements in depression and suicidal ideation observed with gender affirming care are lasting and significant. Over a one-year follow-up period, gender affirming care was associated with a 60% lower odds of moderate or severe depression and a 73% lower odds of suicidality.¹²⁰ Beyond improvements in depressive symptoms and suicidality, studies demonstrate that gender affirming care is also associated with

improvements in psychosocial functioning, physical health, quality of life, and general wellbeing.¹²¹⁻¹²³

Conclusions

Transgender and gender diverse (TGD) youth experience higher rates of abuse, assault, and maltreatment than their cisgender peers. Some TGD youth further experience traumatic stress associated with identity rejection by family, peers, communities, and the broader public,¹⁰⁹ which often presents as pervasive interpersonal and community-based discrimination, rejection, and marginalization. Providers working with TGD youth and their families can improve mental wellbeing by addressing underlying trauma symptoms while bolstering individual skills, family and peer supports, and school and community connectedness.

References

1. Bethell CD, Newacheck P, Hawes E, Halfon N. Adverse childhood experiences: assessing the impact on health and school engagement and the mitigating role of resilience. *Health Aff (Millwood)*. 2014;33(12):2106-2115. doi:10.1377/HLTHAFF.2014.0914
2. SAMHSA. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. 2014.
3. McEwen BS. Neurobiological and Systemic Effects of Chronic Stress. *Chronic Stress (Thousand Oaks, Calif)*. 2017;1. doi:10.1177/2470547017692328
4. Yoo Y, Park HJ, Park S, et al. Interpersonal trauma moderates the relationship between personality factors and suicidality of individuals with posttraumatic stress disorder. *PLoS One*. 2018;13(1):e0191198. doi:10.1371/JOURNAL.PONE.0191198
5. Guidi J, Lucente M, Sonino N, Fava GA. Allostatic Load and Its Impact on Health: A Systematic Review. *Psychother Psychosom*. 2021;90(1):11-27. doi:10.1159/000510696
6. McEwen BS, Morrison JH. The brain on stress: vulnerability and plasticity of the prefrontal cortex over the life course. *Neuron*. 2013;79(1):16-29. doi:10.1016/J.NEURON.2013.06.028
7. Davis M, Whalen PJ. The amygdala: vigilance and emotion. *Mol Psychiatry*. 2001;6(1):13-34. doi:10.1038/SJ.MP.4000812
8. Orr SP, Metzger LJ, Lasko NB, Macklin ML, Peri T, Pitman RK. De novo conditioning in trauma-exposed individuals with and without posttraumatic stress disorder. *J Abnorm Psychol*. 2000;109(2):290-298. doi:10.1037/0021-843X.109.2.290
9. Peri T, Ben-Shakhar G, Orr SP, Shalev AY. Psychophysiological assessment of aversive conditioning in posttraumatic stress disorder. *Biol Psychiatry*. 2000;47(6):512-519. doi:10.1016/S0006-3223(99)00144-4
10. Shin LM, Rauch SL, Pitman RK. Amygdala, medial prefrontal cortex, and hippocampal function in PTSD. *Ann N Y Acad Sci*. 2006;1071:67-79. doi:10.1196/ANNALS.1364.007
11. Yehuda R. Linking the neuroendocrinology of post-traumatic stress disorder with recent neuroanatomic findings. *Semin Clin Neuropsychiatry*. 1999;4(4):256-265. doi:10.153/SCNP00400256
12. Morgan MA, Romanski LM, LeDoux JE. Extinction of emotional learning: contribution of medial prefrontal cortex. *Neurosci Lett*. 1993;163(1):109-113. doi:10.1016/0304-3940(93)90241-C
13. Quirk GJ, Russo GK, Barron JL, Lebron K. The role of ventromedial prefrontal cortex in the recovery of extinguished fear. *J Neurosci*. 2000;20(16):6225-6231. doi:10.1523/JNEUROSCI.20-16-06225.2000
14. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174-186. doi:10.1007/s00406-005-0624-4
15. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258. <http://www.ncbi.nlm.nih.gov/pubmed/9635069>. Accessed April 2, 2018.
16. Min MO, Minnes S, Kim H, Singer LT. Pathways linking childhood maltreatment and

- adult physical health. *Child Abuse Negl.* 2013;37(6):361-373.
doi:10.1016/j.chiabu.2012.09.008
17. Springer KW, Sheridan J, Kuo D, Carnes M. The Long-term Health Outcomes of Childhood Abuse: An Overview and a Call to Action. *J Gen Intern Med.* 2003;18(10):864-870. doi:10.1046/j.1525-1497.2003.20918.x
 18. D'andrea W, Ford J, Stolbach B, Spinazzola J, Van Der Kolk BA. Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis. *Am J Orthopsychiatry.* 2012;82(2):187-200. doi:10.1111/j.1939-0025.2012.01154.x
 19. Afifi TO, Boman J, Fleisher W, Sareen J. The relationship between child abuse, parental divorce, and lifetime mental disorders and suicidality in a nationally representative adult sample. *Child Abuse Negl.* 2009;33(3):139-147. doi:10.1016/j.chiabu.2008.12.009
 20. Duncan RD, Saunders BE, Kilpatrick DG, Hanson RF, Resnick HS. Childhood physical assault as a risk factor for PTSD, depression, and substance abuse: findings from a national survey. *Am J Orthopsychiatry.* 1996;66(3):437-448.
<http://www.ncbi.nlm.nih.gov/pubmed/8827267>. Accessed April 2, 2018.
 21. Edwards VJ, Holden GW, Felitti VJ, Anda RF. Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. *Am J Psychiatry.* 2003;160(8):1453-1460.
doi:10.1176/appi.ajp.160.8.1453
 22. Heim C, Newport DJ, Mletzko T, Miller AH, Nemeroff CB. The link between childhood trauma and depression: insights from HPA axis studies in humans. *Psychoneuroendocrinology.* 2008;33(6):693-710. doi:10.1016/j.psyneuen.2008.03.008
 23. Finkelhor D, Turner HA, Shattuck A, Hamby SL. Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth: An Update. *JAMA Pediatr.* 2013;167(7):614-621. doi:10.1001/JAMAPEDIATRICS.2013.42
 24. Roberts AL, Rosario M, Corliss HL, Koenen KC, Austin SB. Elevated risk of posttraumatic stress in sexual minority Youths: Mediation by childhood abuse and gender nonconformity. *Am J Public Health.* 2012;102(8):1587-1593.
doi:10.2105/AJPH.2011.300530
 25. Sayed S, Iacoviello BM, Charney DS. Risk Factors for the Development of Psychopathology Following Trauma. *Curr Psychiatry Rep.* 2015;17(8):1-7.
doi:10.1007/S11920-015-0612-Y/METRICS
 26. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav.* 1995;36(1):38-56. doi:10.2307/2137286
 27. Scheer JR, Edwards KM, Helminen EC, Watson RJ. Victimization Typologies Among a Large National Sample of Sexual and Gender Minority Adolescents.
<https://home.liebertpub.com/lgbt>. 2021;8(8):507-518. doi:10.1089/LGBT.2021.0024
 28. Scheer JR, Antebi-Gruszka N. A Psychosocial Risk Model of Potentially Traumatic Events And Sexual Risk Behavior Among LGBTQ Individuals.
<https://doi.org/10.1080/1529973220191597815>. 2019;20(5):603-618.
doi:10.1080/15299732.2019.1597815
 29. Wallien MSC, Van Goozen SHM, Cohen-Kettenis PT. Physiological correlates of anxiety in children with gender identity disorder. *Eur Child Adolesc Psychiatry.* 2007;16(5):309-315. doi:10.1007/S00787-007-0602-7

30. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *J Abnorm Child Psychol*. 2003;31(1):41-53. doi:10.1023/A:1021769215342
31. Atteberry-Ash B, Kattari SK, Harner V, et al. Differential Experiences of Mental Health among Transgender and Gender-Diverse Youth in Colorado. *Behav Sci (Basel)*. 2021;11(4). doi:10.3390/BS11040048
32. Perez-Brumer A, Day JK, Russell ST, Hatzenbuehler ML. Prevalence and Correlates of Suicidal Ideation Among Transgender Youth in California: Findings From a Representative, Population-Based Sample of High School Students. *J Am Acad Child Adolesc Psychiatry*. 2017;56(9):739. doi:10.1016/J.JAAC.2017.06.010
33. Sutter M, Perrin PB. Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *J Couns Psychol*. 2016;63(1):98-105. doi:10.1037/COU0000126
34. Centers for Disease Control and Prevention (CDC). The Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021. https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm. Published 2023.
35. Nagata JM, Ganson KT, Austin SB. Emerging Trends in Eating Disorders among Sexual and Gender Minorities. *Curr Opin Psychiatry*. 2020;33(6):562. doi:10.1097/YCO.0000000000000645
36. McClain Z, Peebles R. Body Image and Eating Disorders Among Lesbian, Gay, Bisexual, and Transgender Youth. *Pediatr Clin North Am*. 2016;63(6):1079. doi:10.1016/J.PCL.2016.07.008
37. Schvey NA, Pearlman AT, Klein DA, Murphy MA, Gray JC. Obesity and Eating Disorder Disparities Among Sexual and Gender Minority Youth. *JAMA Pediatr*. 2021;175(4):412-415. doi:10.1001/JAMAPEDIATRICS.2020.5152
38. Guss CE, Williams DN, Reisner SL, Austin SB, Katz-Wise SL. Disordered Weight Management Behaviors, Nonprescription Steroid Use, and Weight Perception in Transgender Youth. *J Adolesc Health*. 2017;60(1):17-22. doi:10.1016/J.JADOHEALTH.2016.08.027
39. Micali N, Solmi F, Horton NJ, et al. Adolescent Eating Disorders Predict Psychiatric, High-Risk Behaviors and Weight Outcomes in Young Adulthood. *J Am Acad Child Adolesc Psychiatry*. 2015;54(8):652-659.e1. doi:10.1016/J.JAAC.2015.05.009
40. Day JK, Fish JN, Perez-Brumer A, Hatzenbuehler ML, Russell ST. Transgender Youth Substance Use Disparities: Results From a Population-Based Sample. *J Adolesc Health*. 2017;61(6):729-735. doi:10.1016/J.JADOHEALTH.2017.06.024
41. Simmons S, Suárez L. Substance Abuse and Trauma. *Child Adolesc Psychiatr Clin N Am*. 2016;25(4):723-734. doi:10.1016/J.CHC.2016.05.006
42. Reisner SL, Greytak EA, Parsons JT, Ybarra ML. Gender minority social stress in adolescence: disparities in adolescent bullying and substance use by gender identity. *J Sex Res*. 2015;52(3):243-256. doi:10.1080/00224499.2014.886321
43. Goldstein BI, Shamseddeen W, Spirito A, et al. Substance use and the treatment of resistant depression in adolescents. *J Am Acad Child Adolesc Psychiatry*. 2009;48(12):1182-1192. doi:10.1097/CHI.0B013E3181BEF6E8
44. SAMHSA. *Key Substance Use and Mental Health Indicators in the United States: Results*

- from the 2018 National Survey on Drug Use and Health. HHS Public. Rockville: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2019. <https://www.samhsa.gov/data/>.
45. NCTSN. Making the connection: trauma and substance abuse. www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf. Published 2008.
 46. Kingston S, Raghavan C. The relationship of sexual abuse, early initiation of substance use, and adolescent trauma to PTSD. *J Trauma Stress*. 2009;22(1):65-68. doi:10.1002/JTS.20381
 47. NASEM. *Understanding the Well-Being of LGBTQI+ Populations*. Washington, DC: The National Academies Press; 2020.
 48. Barends H, van der Wouden JC, Claassen - van Dessel N, Twisk JWR, van der Horst HE, Dekker J. Potentially traumatic events, social support and burden of persistent somatic symptoms: A longitudinal study. *J Psychosom Res*. 2022;159. doi:10.1016/J.JPSYCHORES.2022.110945
 49. Gupta MA. Review of somatic symptoms in post-traumatic stress disorder. <http://dx.doi.org/10.3109/095402612012736367>. 2013;25(1):86-99. doi:10.3109/09540261.2012.736367
 50. Jowett S, Shevlin M, Hyland P, Karatzias T. Posttraumatic Stress Disorder and Persistent Somatic Symptoms during the COVID-19 Pandemic: The Role of Sense of Threat. *Psychosom Med*. 2021;83(4):338-344. doi:10.1097/PSY.0000000000000890
 51. Gerritsen L, Milaneschi Y, Vinkers CH, et al. HPA axis genes, and their interaction with childhood maltreatment, are related to cortisol levels and stress-related phenotypes. *Neuropsychopharmacology*. 2017;42(12):2446-2455. doi:10.1038/npp.2017.118
 52. Hatzenbuehler ML, McLaughlin KA. Structural Stigma and Hypothalamic-Pituitary-Adrenocortical Axis Reactivity in Lesbian, Gay, and Bisexual Young Adults. *Ann Behav Med*. 2014;47(1):39. doi:10.1007/S12160-013-9556-9
 53. Heim C, Shugart M, Craighead WE, Nemeroff CB. Neurobiological and psychiatric consequences of child abuse and neglect. *Dev Psychobiol*. 2010;52(7):671-690. doi:10.1002/dev.20494
 54. Mijas M, Blukacz M, Koziara K, et al. Dysregulated by stigma: Cortisol responses to repeated psychosocial stress in gay and heterosexual men. *Psychoneuroendocrinology*. 2021;131:105325. doi:10.1016/J.PSYNEUEN.2021.105325
 55. Tarullo AR, Gunnar MR. Child maltreatment and the developing HPA axis. *Horm Behav*. 2006;50(4):632-639. doi:10.1016/j.yhbeh.2006.06.010
 56. Van Voorhees E, Scarpa A. Effects of Child Maltreatment on the Hypothalamic-Pituitary-Adrenal Axis. *Trauma, Violence, Abus*. 2004;5(4):333-352. doi:10.1177/1524838004269486
 57. Silverman MN, Sternberg EM. Glucocorticoid regulation of inflammation and its functional correlates: From HPA axis to glucocorticoid receptor dysfunction. *Ann N Y Acad Sci*. 2012;1261(1):55-63. doi:10.1111/j.1749-6632.2012.06633.x
 58. Sun Y, Qu Y, Zhu J. The Relationship Between Inflammation and Post-traumatic Stress Disorder. *Front Psychiatry*. 2021;12:1385. doi:10.3389/FPSYT.2021.707543/BIBTEX
 59. Katrinli S, Oliveira NCS, Felger JC, Michopoulos V, Smith AK. The role of the immune system in posttraumatic stress disorder. *Transl Psychiatry* 2022 121. 2022;12(1):1-14. doi:10.1038/s41398-022-02094-7

60. Atanasova K, Lotter T, Reindl W, Lis S. Multidimensional Assessment of Interoceptive Abilities, Emotion Processing and the Role of Early Life Stress in Inflammatory Bowel Diseases. *Front psychiatry*. 2021;12. doi:10.3389/FPSYT.2021.680878
61. Giovannoni J. Definitional issues in child maltreatment. In: Cicchetti D, Carlson V, eds. *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*. New York: Cambridge University Press; 1989:3-37.
62. Elze DE. The Lives of Lesbian, Gay, Bisexual, and Transgender People: A Trauma-Informed and Human Rights Perspective. *Trauma Hum Rights*. 2019:179-206. doi:10.1007/978-3-030-16395-2_8
63. Craig SL, Austin A, Levenson J, Leung VWY, Eaton AD, D'Souza SA. Frequencies and patterns of adverse childhood events in LGBTQ+ youth. *Child Abuse Negl*. 2020;107. doi:10.1016/J.CHIABU.2020.104623
64. Warren AS, Goldsmith KA, Rimes KA. Childhood gender-typed behaviour, sexual orientation, childhood abuse and post-traumatic stress disorder: a prospective birth-cohort study. *Int Rev Psychiatry*. 2022;34(3-4):360-375. doi:10.1080/09540261.2022.2064211
65. Bos H, de Haas S, Kuyper L. Lesbian, Gay, and Bisexual Adults: Childhood Gender Nonconformity, Childhood Trauma, and Sexual Victimization. <https://doi.org/10.1177/0886260516641285>. 2016;34(3):496-515. doi:10.1177/0886260516641285
66. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family Acceptance in Adolescence and the Health of LGBT Young Adults. *J Child Adolesc Psychiatr Nurs*. 2010;23(4):205-213. doi:10.1111/J.1744-6171.2010.00246.X
67. Grossman AH, D'Augelli AR. Transgender youth: invisible and vulnerable. *J Homosex*. 2006;51(1):111-128. doi:10.1300/J082V51N01_06
68. Main M, Goldwyn R. Predicting rejection of her infant from mother's representation of her own experience: Implications for the abused-abusing intergenerational cycle. *Child Abuse Negl*. 1984;8(2):203-217. doi:10.1016/0145-2134(84)90009-7
69. Irvine A, Canfield A. The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming and Transgender Youth Within the Child Welfare to Juvenile Justice Crossover Population. *Soc Policy Law*. 2016;24(2):243-261. <http://digitalcommons.wcl.american.edu/jgsplhttp://digitalcommons.wcl.american.edu/jgspl/vol24/iss2/2>. Accessed April 16, 2023.
70. Whitbeck LB, Chen X, Hoyt DR, Tyler KA, Johnson KD. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *J Sex Res*. 2004;41(4):329-342. doi:10.1080/00224490409552240
71. Rew L, Whittaker TA, Taylor-Seehafer MA, Smith LR. Sexual health risks and protective resources in gay, lesbian, bisexual, and heterosexual homeless youth. *J Spec Pediatr Nurs*. 2005;10(1):11-19. doi:10.1111/J.1088-145X.2005.00003.X
72. Durso LE, Gates GJ. *Serving Our Youth: Findings from a National Survey of Services Providers Working with Lesbian, Gay, Bisexual and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless*. Los Angeles, CA; 2012.
73. Norem-Hebeisen A, Johnson DW, Anderson D, Johnson R. Predictors and concomitants of changes in drug use patterns among teenagers. *J Soc Psychol*. 1984;124(1ST Half):43-50. doi:10.1080/00224545.1984.9924535
74. Brook JS, Lukoff IF, Whiteman M. Initiation into adolescent marijuana use. *J Genet*

- Psychol.* 1980;137(1st Half):133-142. doi:10.1080/00221325.1980.10532808
75. Kandel DB, Kessler RC, Margulies RZ. Antecedents of adolescent initiation into stages of drug use: A developmental analysis. *J Youth Adolesc.* 1978;7(1):13-40. doi:10.1007/BF01538684
 76. Guo J, Hill KG, Hawkins JD, Catalano RF, Abbott RD. A developmental analysis of sociodemographic, family, and peer effects on adolescent illicit drug initiation. *J Am Acad Child Adolesc Psychiatry.* 2002;41(7):838-845. doi:10.1097/00004583-200207000-00017
 77. Moyano N, Sánchez-Fuentes M del M. Homophobic bullying at schools: A systematic review of research, prevalence, school-related predictors and consequences. *Aggress Violent Behav.* 2020;53:101441. doi:10.1016/J.AVB.2020.101441
 78. Kosciw JG, Clark CM, Menard L. *The 2021 National School Climate Survey: The Experiences of LGBTQ+ Youth in Our Nation's Schools.* New York; 2022.
 79. Seelman KL, Woodford MR, Nicolazzo Z. Victimization and Microaggressions Targeting LGBTQ College Students: Gender Identity As a Moderator of Psychological Distress. <https://doi.org/10.1080/1531320420161263816>. 2016;26(1-2):112-125. doi:10.1080/15313204.2016.1263816
 80. Moran TE, Chen CYC, Tryon GS. Bully victimization, depression, and the role of protective factors among college LGBTQ students. *J Community Psychol.* 2018;46(7):871-884. doi:10.1002/JCOP.21978
 81. Kosciw JG, Greytak EA, Giga NM, Villenas C, Danischewski DJ. *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools.* New York; 2015.
 82. Reisner SL, Hughto JMW, Gamarel KE, Keuroghlian AS, Mizock L, Pachankis JE. Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. *J Couns Psychol.* 2016;63(5):509-519. doi:10.1037/COU0000143
 83. Woodford MR, Pacey MS, Kulick A, Hong JS. The LGBQ Social Climate Matters: Policies, Protests, and Placards and Psychological Well-Being Among LGBQ Emerging Adults. *J Gay Lesbian Soc Serv.* 2015;27(1):116-141. doi:10.1080/10538720.2015.990334
 84. Bauermeister JA. How Statewide LGB Policies Go From “Under Our Skin” to “Into Our Hearts”: Fatherhood Aspirations and Psychological Well-Being Among Emerging Adult Sexual Minority Men. *J Youth Adolesc.* 2014;43(8):1295. doi:10.1007/S10964-013-0059-6
 85. Gruberg S, Mahowald L, Halpin J. The State of the LGBTQ Community in 2020 - Center for American Progress. <https://www.americanprogress.org/issues/lgbtq-rights/reports/2020/10/06/491052/state-lgbtq-community-2020/>. Published 2020. Accessed May 30, 2021.
 86. The Trevor Project. *Issues Impacting LGBTQ Youth.*; 2022. https://www.thetrevorproject.org/wp-content/uploads/2022/01/TrevorProject_Public1.pdf.
 87. Raifman J, Moscoe E, Austin SB, McConnell M. Difference-in-Differences Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts. *JAMA Pediatr.* 2017;171(4):350-356. doi:10.1001/JAMAPEDIATRICS.2016.4529
 88. Scales Rostosky S, B Riggles ED, Horne SG, Miller AD. Marriage Amendments and Psychological Distress in Lesbian, Gay, and Bisexual (LGB) Adults. 2009.

doi:10.1037/a0013609

89. Hatzenbuehler ML, Keyes KM, Hasin DS. State-Level Policies and Psychiatric Morbidity In Lesbian, Gay, and Bisexual Populations. *Am J Public Health*. 2009;99(12):2275. doi:10.2105/AJPH.2008.153510
90. Ream G, Peters A. Working With Suicidal and Homeless LGBTQ+ Youth in the Context of Family Rejection. *J Heal Serv Psychol* 2021 471. 2021;47(1):41-50. doi:10.1007/S42843-021-00029-2
91. APA Dictionary of Psychology. <https://dictionary.apa.org/>. Published 2023. Accessed April 15, 2023.
92. Campodonico C, Berry K, Haddock G, Varese F. Protective Factors Associated With Post-traumatic Outcomes in Individuals With Experiences of Psychosis. *Front Psychiatry*. 2021;12:2164. doi:10.3389/FPSYT.2021.735870/BIBTEX
93. Olson KR, Durwood L, Demeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016;137(3):20153223. doi:10.1542/PEDS.2015-3223/81409
94. Resnick MD, Bearman PS, Blum RW, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997;278(10):823-832. doi:10.1001/JAMA.278.10.823
95. Bukstein OG, Bernet W, Arnold V, et al. Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *J Am Acad Child Adolesc Psychiatry*. 2005;44(6):609-621. doi:10.1097/01.CHI.0000159135.33706.37
96. Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychol Bull*. 1992;112(1):64-105. doi:10.1037/0033-2909.112.1.64
97. Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39(5):662-668. doi:10.1016/J.JADOHEALTH.2006.04.024
98. Needham BL, Austin EL. Sexual orientation, parental support, and health during the transition to young adulthood. *J Youth Adolesc*. 2010;39(10):1189-1198. doi:10.1007/S10964-010-9533-6
99. Ryan C, Huebner D, Diaz RM, Sanchez J. Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. *Pediatrics*. 2009;123(1):346-352. doi:10.1542/PEDS.2007-3524
100. Hundleby JD, Mercer GW. Family and Friends as Social Environments and Their Relationship to Young Adolescents' Use of Alcohol, Tobacco, and Marijuana. *J Marriage Fam*. 1987;49(1):151. doi:10.2307/352679
101. Ryan C. *Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.; 2009.
102. Ryan C. *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children*. San Francisco: Family Acceptance Project, San Francisco State University.; 2009.
103. Rosario M, Schrimshaw EW, Hunter J. Disclosure of Sexual Orientation and Subsequent Substance Use and Abuse Among Lesbian, Gay, and Bisexual Youths: Critical Role of Disclosure Reactions. *Psychol Addict Behav*. 2009;23(1):175. doi:10.1037/A0014284

104. McGuire JK, Anderson CR, Toomey RB, Russell ST. School climate for transgender youth: a mixed method investigation of student experiences and school responses. *J Youth Adolesc.* 2010;39(10):1175-1188. doi:10.1007/S10964-010-9540-7
105. Greytak EA, Kosciw JG, Boesen MJ. Putting the “T” in “Resource”: The Benefits of LGBT-Related School Resources for Transgender Youth. <https://doi.org/10.1080/193616532012718522>. 2013;10(1-2):45-63. doi:10.1080/19361653.2012.718522
106. Herdt G, Russell ST, Sweat J, Marzullo M. Sexual Inequality, Youth Empowerment, and the GSA: A Community Study in California. *Sex Inequalities Soc Justice*. December 2006:233-251. doi:10.1525/CALIFORNIA/9780520246140.003.0011
107. Ioverno S, Baiocco R, Belser AB, Grossman AH, Russell ST. The protective role of gay-straight alliances for lesbian, gay, bisexual and questioning students: A prospective analysis. *Psychol Sex Orientat Gend Divers.* 2016;3(4):397-406. doi:10.1037/SGD0000193
108. Poteat VP, Sinclair KO, Digiovanni CD, Koenig BW, Russell ST. Gay–Straight Alliances Are Associated With Student Health: A Multischool Comparison of LGBTQ and Heterosexual Youth. *J Res Adolesc.* 2013;23(2):319-330. doi:10.1111/J.1532-7795.2012.00832.X
109. Clarke M, Farnan A, Barba A, Giovanni K, Brymer M, Julian J. *Gender-Affirming Care Is Trauma-Informed Care*. Los Angeles, CA; 2022.
110. Hidalgo MA, Ehrensaft D, Tishelman AC, et al. The Gender Affirmative Model: What We Know and What We Aim to Learn. *Hum Dev.* 2013;56(5):285-290. doi:10.1159/000355235
111. 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(5):460-467. doi:10.1037/A0029597
112. Ehrensaft D. *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes*. New York: The Experiment Publishing; 2016. <https://theexperimentpublishing.com/catalogs/spring-2016/gender-creative-child/>. Accessed April 15, 2023.
113. Keo-Meier C, Ehrensaft D. *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children*. Washington, DC: American Psychological Association (APA); 2018.
114. Moradi B, Budge SL. Engaging in LGBQ+ affirmative psychotherapies with all clients: Defining themes and practices. *J Clin Psychol.* 2018;74(11):2028-2042. doi:10.1002/JCLP.22687
115. Pepping CA, Lyons A, Morris EMJ. Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. *Psychotherapy (Chic).* 2018;55(1):52-62. doi:10.1037/PST0000149
116. Pachankis JE. The Scientific Pursuit of Sexual and Gender Minority Mental Health Treatments: Toward Evidence-Based Affirmative Practice. *Am Psychol.* 2018;73(9):1207. doi:10.1037/AMP0000357
117. Levenson JS, Craig SL, Austin A. Trauma-informed and affirmative mental health practices with LGBTQ+ clients. *Psychol Serv.* 2023;20(Suppl 1). doi:10.1037/SER0000540

118. van Bergen DD, Dumon E, Parra LA, et al. "I Don't Feel at Home in This World" Sexual and Gender Minority Emerging Adults' Self-Perceived Links Between Their Suicidal Thoughts and Sexual Orientation or Gender Identity. *Can J Psychiatry*. January 2023. doi:10.1177/07067437221147420/ASSET/IMAGES/LARGE/10.1177_07067437221147420-FIG3.JPEG
119. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *J Adolesc Health*. 2018;63(4):503-505. doi:10.1016/J.JADOHEALTH.2018.02.003
120. Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Netw Open*. 2022;5(2):e220978-e220978. doi:10.1001/JAMANETWORKOPEN.2022.0978
121. Allen LR, Watson LB, Egan AM, Moser CN. Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clin Pract Pediatr Psychol*. 2019;7(3):302-311. doi:10.1037/PPP0000288
122. Achille C, Taggart T, Eaton NR, et al. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *Int J Pediatr Endocrinol*. 2020;2020(1). doi:10.1186/S13633-020-00078-2
123. White Hughto JM, Reisner SL. A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals. *Transgender Heal*. 2016;1(1):21-31. doi:10.1089/TRGH.2015.0008