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High Internalized Transphobia and Low Gender Identity Pride Are Associated with Depression Symptoms among Transgender and Gender-Diverse Youth

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Disclosure

The authors confirm that all listed authors have contributed to this manuscript and have reviewed the final draft.

Conflicts of Interest

The authors have no conflicts of interests or financial disclosures to report relevant to the present analysis/manuscript.

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Abstract

Purpose: Prior studies have identified a significant relationship between internalized transphobia and poor mental health among transgender and gender-diverse (TGD) adults; however, this relationship has not been extensively examined among youth. Further, little research has sought to explore protective factors, such as identity pride, and their influence on this relationship. We examined the association between internalized transphobia and depression and anxiety symptoms among TGD youth and explored the moderating role of gender identity pride on these associations.

Methods: Participants were 315 TGD youth ages 12–20 years ($M = 16$; $SD = 1.89$) seeking gender-affirming hormone treatment at one of four major pediatric hospitals across the U.S. At the time of enrollment, participants were naïve to gender-affirming hormone treatment. Participants self-reported mental health, internalized transphobia, and identity pride. Multiple regression models were used with depression and anxiety symptoms as outcomes, and age, designated sex at birth, and perceived parental support included as covariates.

Results: Greater internalized transphobia was associated with greater depressive symptoms, and gender identity pride moderated this relationship, such that greater gender identity pride was associated with fewer depressive symptoms. Greater internalized transphobia was significantly associated with greater anxiety symptoms; no moderation effect was observed for this relationship.

Conclusions: Gender identity pride influenced mental health symptoms for youth experiencing internalized transphobia and represents a potential key protective factor. These results support efforts to further develop, test, and implement clinical interventions to bolster identity pride for TGD youth.

Keywords

transgender; non-binary; adolescents and young adults; internalized transphobia; gender identity pride; mental health

Transgender and gender-diverse (TGD) individuals are those whose gender identity is not congruent with their designated sex at birth and may include those who identify as non-binary, agender, and other identities outside of a male-female gender binary¹. A growing literature has observed that TGD individuals experience higher rates of mental health problems (e.g., depression, anxiety) compared to their cisgender peers (i.e., those whose gender identity is congruent with their designated sex at birth)^{1,2} and their cisgender sexual minority peers (i.e., cisgender lesbian, gay, bisexual individuals)³. These mental health disparities are present by adolescence and highlight the importance of identifying factors that impact healthy development in TGD youth², including mental health symptoms and protective factors.

Disparities in mental health outcomes among TGD youth compared to their cisgender peers are speculated to stem from chronic, pervasive stress associated with their minoritized

identity (i.e., gender minority stress)⁴⁻⁷. The Gender Minority Stress (GMS) Model, based on the Minority Stress framework⁸, posits that the cumulative effects of proximal (e.g., internalized stigma and shame)⁹ and distal stressors (e.g., policies that promote discrimination, lack of community resources)^{1,4} contribute to negative mental health outcomes among TGD individuals. The GMS model also includes factors that may ameliorate the substantial toll of minority stress on mental health outcomes in youth (e.g., identity pride, community connectedness)⁵. Moreover, this framework has continued to be expanded upon to include more expansive models of transgender resilience, such as the Transgender Resilience Intervention Model (TRIM), with implications and guidelines for intervention and policy efforts to address minority stress and strengthen sources of resilience¹⁰. More recently, in their model, Coyne and colleagues (2020)¹¹ presented an adapted Gender Minority Stress framework that accounts for additional resilience factors that may buffer the effects of stressors (see figure 1).

Internalized transphobia is a stress process in which an individual experiences discomfort with their own transgender identity as a result of internalizing society's negative attitudes toward TGD people (e.g., anti-transgender legislation and policies, family/peer rejection)^{12,13}. Research has linked experiencing distal stressors, such as non-affirmation and anti-transgender bias, to the development of greater internalized transphobia; moreover, researchers found that such minority stressors were both directly and indirectly (via internalized transphobia) linked to greater severity of post-traumatic stress¹⁴. Internalized transphobia has also been found to increase the risk of having a diagnosis of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) among TGD youth¹⁵.

Gender identity pride, a source of internal resilience for TGD youth, has begun to be explored as a potential buffer against the impact of chronic minority stress^{10,16}. Gender identity pride within a Western socio-cultural context has been conceptualized as feelings of positive regard related to one's identity as part of the gender minority community¹⁶. Findings from burgeoning research suggest that gender identity pride may buffer against internalized stigma and shame related to belonging to a gender minority group^{16,17}. More recently, outpatient, camp-based, and telehealth interventions focused on improving self-esteem and identity pride for TGD youth have been developed and evaluated¹⁸⁻²¹. These efforts have identified important facets for treatment, including positive identity development, use of narrative methods, positive social support and community building, and reducing internalized transnegativity¹⁹⁻²². However, to date, few studies have quantitatively investigated the relationship between internalized transphobia and gender identity pride among TGD youth and whether identity pride serves as a protective factor in mitigating or buffering against negative outcomes^{16,23}. The current study aims to contribute to the literature supporting these ongoing efforts.

The present study explored two potential mechanisms of mental health risk and resilience among TGD youth. First, we examined whether internalized transphobia is associated with depression and anxiety symptoms in a sample of TGD youth. We then examined how gender identity pride may moderate associations between internalized transphobia and symptoms of depression and anxiety. We hypothesized that internalized transphobia would

be associated with greater depression and anxiety (Hypothesis 1) and that gender identity pride would moderate these associations such that the internalized transphobia—depression/anxiety association would be strongest at low levels of gender identity pride (Hypothesis 2).

Methods

Participants and recruitment

The Trans Youth Care Study is an ongoing, multisite, observational study of TGD initiating medical treatment with gender-affirming hormones (i.e., testosterone or estrogen)^{24,25}. The study's aims include the longitudinal tracking of gender-affirming treatment outcomes, mental health, and overall well-being of TGD youth. Participants were recruited from four pediatric gender clinics located in major metropolitan areas of the U.S., reflecting demographics from the western, midwestern, and northeastern areas of the country (i.e., Los Angeles, San Francisco, Chicago, and Boston). Eligibility criteria include: (1) presence of gender dysphoria as determined by a clinician; (2) appropriateness and readiness to initiate gender-affirming hormones (GAH) (i.e., estrogen or testosterone) as determined by the clinical team; (3) age 20 years or younger; (4) English proficiency; and (5) psychiatrically and cognitively able to give informed consent/assent for participation. Data were collected by a computer-assisted survey instrument from youth only. While the Trans Youth Care study recruited two cohorts (i.e., GAH cohort and gonadotropin-releasing hormone agonist [GnRHa] cohort), the present study used only the GAH cohort baseline survey data, which were collected prior to participants initiating GAH. Exploring the mental health of these youth prior to treatment was indicated so as not to have effects of treatment confound our findings, given that youth generally report improved mental health after accessing hormone treatment²⁶. The GnRHa cohort is comprised of younger youth accessing puberty-blocking hormones for which key variables in the current analysis were not available (i.e., gender minority stress and resilience scale); thus, they were not included in the present study. A detailed description of the Trans Youth Care Study methods and data on the full cohort are published elsewhere²⁴. Researchers received institutional review board approval from all study sites. Consent and assent were obtained for all participants; parental permission was obtained for minors.

Initial findings on the baseline characteristics of the study have been previously published²⁵. Participants were 315 youth ages 12–20 ($M = 16.01$; $SD = 1.87$). The baseline survey initially included 316 individuals; however, one participant was ultimately excluded for not meeting inclusion criteria.

Demographics.

Participants self-reported age in years, race/ethnicity, and designated sex at birth. The sample identified as White non-Hispanic/Latinx (58.7%), White Hispanic/Latinx (7.9%), non-White Hispanic/Latinx (15.9%), Multiracial (10.2%), Black/African American (3.5%), Asian/Pacific Islander (3.2%) and Other (0.6%); see Table 1. Participants were transmasculine/male (60.3%), transfeminine/female (33.7%), non-binary (3.8%), genderqueer/gender fluid (1.3%) and other (1%). These responses were recoded into three

categories: transmasculine/male (60.3%), transfeminine/female (33.7%), and non-binary (6.0%).

Perceived parental support.

General parental support was assessed using four items adapted from the Family subscale of the Multidimensional Scale of Perceived Social Support (MSPSS)^{27,28} (i.e., statements changed “family” to “parent”). Examples of items include: “My parent or parents really try to help me” and “I get the emotional help and support I need from my parent or parents”. The items are rated on a 5-point Likert scale (1=strongly disagree to 5=strongly agree) with higher scores indicating greater perceived parental support.

Mental health.

The Revised-Children’s Manifest Anxiety Scale (RCMAS-2)²⁹ assessed anxiety with a 49-item “yes”/ “no” response scale. “Yes” responses were summed and converted into *T*-scores (>60 = clinically significant) reflecting a Total Anxiety score.

The 21-item Beck Depression Inventory-II (BDI-II)³⁰ is a self-report measure of depressive symptoms (e.g., sadness, loss of interest, worthlessness) over the previous two weeks scored on a 0–3 scale. For example, for “Sadness”, respondents choose from 0 = “I do not feel sad” to 3 = “I am so sad or unhappy that I can’t stand it.” Scores were summed and compared to standardized cutoffs reflecting minimal (0–13), mild (14–19), moderate (20–28), and severe depression (29–63).

Gender Minority Stress and Resilience.

The Gender Minority Stress and Resilience Measure for Adolescents (GMSR-A) is a self-report measure assessing social stigma and psychosocial resilience associated with gender minority identity⁷ adapted for adolescents³¹. The GMSR-A is comprised of nine subscales (i.e., internalized transphobia, non-affirmation, non-disclosure, negative expectations, gender identity pride, community connectedness). Two subscales were used in the current study: internalized transphobia (e.g., “When I think about my gender identity or expression, I feel unhappy”, “I feel that my gender identity or expression is embarrassing”) and gender identity pride (“I am proud to be a person whose gender identity is different from my sex assigned at birth”, “I have no problem talking about my gender identity and gender history to almost anyone”). All subscales were rated on a 5-point Likert scale (1=strongly disagree to 5=strongly agree). Subscale items were summed with higher scores indicating greater minority stress or resilience, respectively.

Data Analyses

Data analyses were conducted using SPSS 28.0³². Correlation analyses were performed to examine relationships between predictor and outcome variables for the total sample. Age, designated sex at birth, and perceived parental support were included as covariates based on prior analytic findings indicating significant associations with the outcomes of interest²⁵. In addition, after accounting for significant outliers ($n = 2$), ANOVAs did not identify any significant mean differences on predictor or outcome variables based on racial/ethnic groups or clinic location. Additional key covariates were included in the initial models,

including race/ethnicity and location, but were statistically non-significant and not included in the final models to retain statistical power. Two initial univariate regression models examined the role of internalized transphobia as a predictor of anxiety and depression with age, designated sex at birth (dummy coded 0 for designated male at birth and 1 for designated female at birth), and perceived parental support entered as covariates in step 1 and internalized transphobia added in step 2. Two univariate regression models were performed using the PROCESS macro.³³ Model 1 (simple moderation) examined the moderating role of gender identity pride on the relationship between internalized transphobia and each mental health outcome (i.e., anxiety, depression) independently, with age, designated sex at birth, and perceived parental support included as covariates in Step 1, internalized transphobia and gender identity pride added as covariates in step 2, and an interaction term for internalized transphobia x gender identity pride added in step 3. The PROCESS macro utilizes bootstrapping that non-parametrically re-samples the dataset 5,000 times. Bootstrapping is considered robust for managing skewness and missing data, stringent in avoiding Type 1 error, and statistically more powerful than traditional analytical approaches³⁴. The significant interactions were further interpreted using a simple slopes analysis in which we observed the effect of internalized transphobia for high levels of identity pride (one SD above the mean), the main effect of internalized transphobia (for mean-centered levels of identity pride), and low levels of identity pride (one SD below the mean)³⁵. Missing data were addressed using individual mean imputation, which can reduce bias introduced by excluding cases with missing data, when a case contains a majority of responses and calculating missing responses is needed to create composite scales³⁶. Models included participants who had complete data ($n = 304$ for depression and $n = 303$ for anxiety outcomes).

Results

Bivariate correlations found that age was positively associated with anxiety ($\rho = .117$, $p < .05$) and gender identity pride ($\rho = .130$, $p < .05$; i.e., older age was associated with higher levels of anxiety and higher gender identity pride) while being designated female at birth was associated with lower levels of gender identity pride ($\rho = -.178$, $p < .01$). Greater perceived parental support was significantly associated with younger age ($\rho = -.252$, $p < .01$), lower internalized transphobia ($\rho = -.135$, $p < .05$), lower anxiety ($\rho = -.209$, $p < .01$), and lower depression ($\rho = -.259$, $p < .01$). Higher levels of depression and anxiety were associated with greater internalized transphobia ($\rho = .436$ and $\rho = .427$, $p < .01$, respectively) and lower levels of gender identity pride ($\rho = -.186$ and $\rho = -.172$, $p < .01$, respectively). Finally, greater internalized transphobia was associated with lower levels of gender identity pride ($\rho = -.367$, $p < .01$). See Table 2.

Hypothesis 1.

We hypothesized that internalized transphobia would be associated with greater depression and anxiety. Consistent with this hypothesis, internalized transphobia was significantly associated with greater depression, $b = .53$ [95% CI .37–.69], $p < .01$, and anxiety, $b = .47$ [95% CI .15–.79], $p < .01$. Further, internalized transphobia was significantly associated with greater anxiety when gender identity pride was added as a moderator to the model, $b = .52$

[95% CI .37–.67], $p < .01$. Based on bivariate analysis and consistent with prior literature, age, designated sex at birth, and perceived parental support were retained as covariates in all models. Only lower perceived parental support was associated with greater depression and anxiety across all steps of the regression models ($p < .05$). See Table 3.

Hypothesis 2.

We hypothesized that gender identity pride would moderate associations between internalized transphobia and mental health outcomes. The second hypothesis was partially supported with a significant interaction observed for the model with depression as the outcome but not for the model with anxiety as the outcome. As noted above, simple slopes for the associations between internalized transphobia and mental health outcomes were examined at low (-1.0 standard deviation [SD]), mean or average, and high ($+1.0$ standard deviation [SD]) levels of gender identity pride. Gender identity pride significantly moderated the association between internalized transphobia and depression at all levels; specifically, at low levels ($b = .68$, $p < .01$), average levels ($b = .53$, $p < .01$), and at high levels ($b = .38$, $p < .01$). The strongest moderation effects were observed at the lowest levels of identity pride, $R^2 = .01$, $F(1, 298) = 4.72$, $p = .03$ suggesting that youth with the highest levels of internalized transphobia and lowest levels of gender identity pride reported the highest levels of depressive symptoms. Figure 2 displays the simple slopes. Moderation was not observed in the model examining anxiety as the outcome. See Table 3 for significant main and interaction effects.

Discussion

Internalized transphobia contributes significantly to poorer mental health among TGD individuals^{5,16}. Prior research has identified internalized transphobia as a significant, intervenable factor in addressing high rates of negative mental health among TGD individuals³⁷. The present study found that greater internalized transphobia was significantly associated with greater anxiety and depressive symptoms^{16,38}, extending prior findings to a larger sample of TGD youth²³ and highlighting internalized transphobia as an important target for mental health intervention. In partial support of our hypothesis, we found that gender identity pride moderated the relationship between internalized transphobia and depressive symptoms. This association was present for all levels of gender identity pride; however, the strongest effects were observed at the lowest level of identity pride. More specifically, youth with high internalized transphobia and low identity pride endorsed greater depressive symptoms. These results provide additional evidence to support interventions aimed at improving gender identity pride as a factor in reducing depressive symptoms among TGD youth with internalized transphobia. Contrary to our hypothesis, we did not observe a similar moderating effect of gender identity pride on the relationship between internalized transphobia and anxiety for TGD youth.

As noted, previous studies have explored the moderating role of gender identity pride on the relationship between internalized transphobia and mental health among TGD adults^{7,16,39}. However, this study is among the first to examine these relationships in TGD youth. According to prior research with other minoritized communities, pride in one's

identity supports positive mental health and promotes healthy behaviors⁴⁰. Burgeoning clinical research indicates that such minority stressors, like internalized transphobia, can be addressed through gender-affirmative therapy with youth and families⁴¹; specifically, as a component of interventions to address internalized stigma and transphobia^{10,42}. For instance, a brief online cognitive-behavioral therapy intervention for LGBTQ+ youth that focused on addressing multiple minority stressors, including stigma and discrimination, and promoting resilience (i.e., reflective coping, adaptive stress appraisal) was found to significantly reduce depression and increase use of positive coping strategies^{10,42}.

Our findings suggest that among TGD youth with internalized transphobia, low gender identity pride is associated with greater depressive symptoms. When assessing mental health among TGD youth, screening for any or all of these domains may be useful when assessing the need for or specificity of a mental health referral. If youth have high levels of internalized transphobia, a helpful referral would be to a gender-affirming psychotherapist who may employ established interventions that aim to reduce depressive symptomology by targeting underlying internalized transphobia through cognitive restructuring⁴³. In addition, evidence has found that increasing a sense of identity pride in peer support groups may also improve mental health outcomes, particularly for ethnically/racially minoritized TGD youth^{19–21}. While these constructs are considered distinct yet associated experiences, one may assess these potential targets for intervention independently, using tools like the GMSR-A measure³¹. While the GMSR-A has been validated for youth ages 12 and older, it would be beneficial to validate with younger youth, and potentially examine factors, such as internalized transphobia and gender identity pride, with youth prior to pubertal development⁴⁴. Our findings provide further support for the importance of targeting identity-related constructs to increase TGD youths' resilience and to ameliorate depressive symptoms¹⁰ above and beyond the influence of perceived parental support, a covariate in our analyses. We observed that perceived parental support in our sample continued to be a significant predictor for mental health outcomes. Parental support may reflect a potential protective factor as well for these youth, which is supported by prior findings in the literature⁴⁵. For instance, parental involvement in building positive identity development has been associated with positive youth development, including psychological adjustment and better mental health⁴⁶. Future research is warranted to further explore the influence of parental support on the development of identity pride, which will likely have significant implications for the ongoing development and evaluation of family-based interventions⁴⁷.

As noted, gender identity pride did not moderate the positive relationship between internalized transphobia and anxiety symptoms. Future research should explore other potential influences on the relationship between internalized transphobia and anxiety. For instance, anxiety may be uniquely associated with specific elements of gender minority stress not tested here (e.g., non-disclosure, perception of anti-transgender policies and legislation, and negative expectations for the future)^{15,48}. Though anxiety and depression often co-occur, anxiety may also be associated with positive experiences, including the “coming out” process, and may not necessarily be associated with greater internalized transphobia.

Limitations and Future Directions

The data for the current analyses were cross-sectional in nature, which limited our efforts to infer directionality of results; however, with ongoing data collection, future Trans Youth Care Study research should examine these relationships longitudinally. Further, subgroup differences by gender identity, while pertinent for future analyses, were outside of the current scope of this study and limited by small subgroup sizes. Future investigations are needed to examine subgroups within the community of TGD youth, specifically racially diverse and transfeminine communities, to see if our findings are consistent or differ, as well as to identify predictors of risk or resilience to best tailor treatment approaches. Given the sample size, we were unable to observe any differences by racial/ethnic group or by geographic location. Thus, our current analysis was unable to examine differences across multiple marginalized identities in considering other demographic characteristics that may also influence identity pride (e.g., sexual orientation; race/ethnicity). Therefore, this remains an important area for future research. These efforts can further the development of appropriate interventions that can lessen the impact of internalized transphobia and augment identity pride, particularly among youth who hold multiple marginalized identities¹⁹.

Finally, the youth in our sample live in major metropolitan areas within parts of the U.S. that are considered more liberal, inclusive, and supportive for TGD individuals. It should be noted that living in more supportive geographic locations does not completely protect youth from the impact of discrimination and harmful policies occurring on a national level against TGD youth and their families. These findings may not be generalizable to other areas of the country where there is greater stress and discrimination present for TGD youth^{49,50} highlighting the need to understand and address the mental health needs of youth in these areas.

These results contribute to a dearth of literature specifically examining the role of potential protective factors, like gender identity pride, on the relationship between internalized transphobia and negative mental health. Our findings contribute to this literature and provide further support for behavioral interventions designed to bolster identity pride, a correlate of depressive symptoms in our study^{17,41}. While important, gender identity pride represents only one aspect of strength and resilience for TGD youth. Thus, future research is encouraged to examine whether specific kinds of protective factors, including gender identity pride, community connectedness, and/or positive coping skills, uniquely contribute to well-being and improved mental health. Future research should also consider longitudinal analyses that examine processes and mechanisms by which forms of minority stress and resilience influence pathways of mental health within a population that continue to experience significant marginalization and stigmatization.

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Implications and Contributions:

Gender identity pride moderated the relationship between internalized transphobia and depressive symptoms. These findings support the ongoing development and evaluation of interventions to mitigate the impact of internalized transphobia by bolstering gender identity pride.

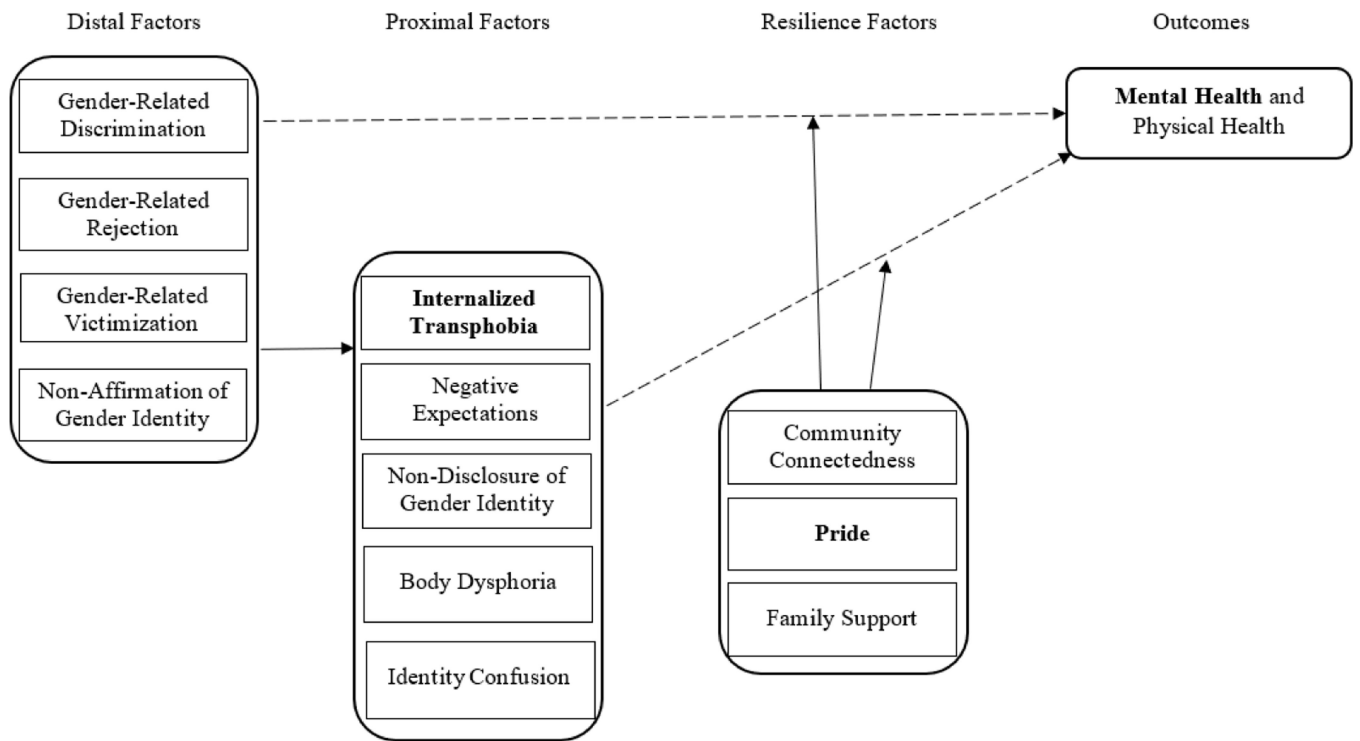


Figure 1. Adapted gender minority stress and resilience factors model from Coyne et al. (2020). Bolded factors are the focus of the present analysis.

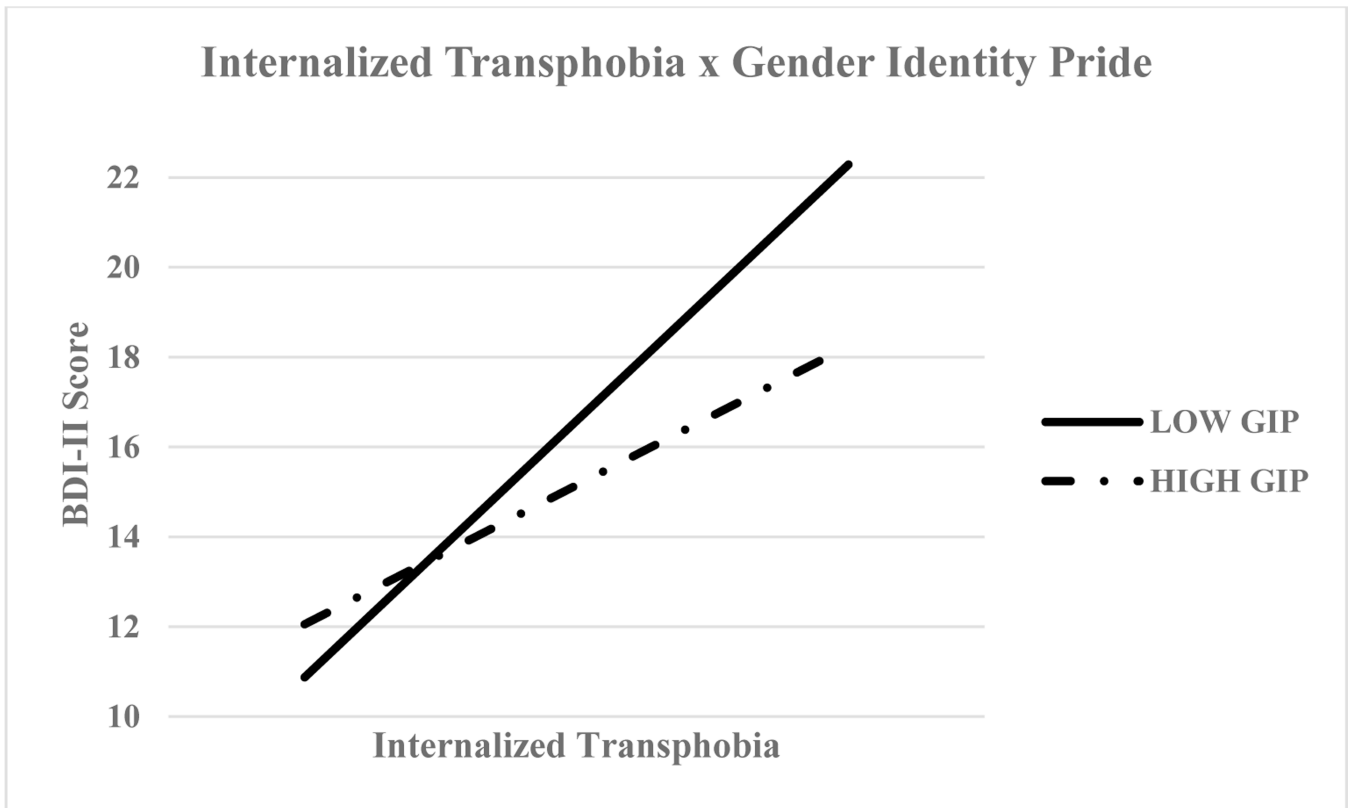


Figure 2. Moderating effect of gender-identity pride on the association between internalized transphobia and depressive symptoms ($p = .03$).
Note: GIP = Gender Identity Pride

Table 1.

Participant characteristics (N = 315).

Variable	Frequency - Number (%)
Age (Mean = 16.01; SD = 1.87)	
12	6 (1.9)
13	23 (7.3)
14	38 (12.1)
15	67 (21.3)
16	55 (17.5)
17	51 (16.2)
18	48 (15.2)
19	15 (4.8)
20	12 (3.8)
Gender Identity*	
Transmasculine/male	190 (60.3)
Transfeminine/female	106 (33.6)
Non-Binary	12 (3.8)
Genderqueer/gender fluid	4 (1.3)
Other	3 (1.0)
Sex Assigned at Birth	
Male	111 (35.2)
Female	204 (64.8)
Race/Ethnicity	
White	185 (58.7)
Non-white Hispanic/Latinx	50 (15.9)
White Hispanic/Latinx	25 (7.9)
Black/African American	11 (3.5)
Multiracial	32 (10.2)
Asian/Pacific Islander	10 (3.2)
Other/Unknown	2 (0.6)
Beck Depression Inventory (BDI)	

Variable	Frequency - Number (%)
Minimal	129 (48.1)
Mild	48 (17.9)
Moderate	50 (18.7)
Severe	41 (15.3)
	<i>M (SD)</i>
Revised-Children's Manifest Anxiety Scale (RCMAS-2)	60.03 (11.48)
Total T-score (range = 29–81)	
Gender Minority Stress and Resilience - select scales	
Internalized Transphobia (range = 0–32)	13.27 (8.48)
Gender Identity Pride (range = 0–32)	8.06

* One participant indicated that their designated sex at birth and gender identity were aligned at baseline and met eligibility criteria for the study.

Table 2.

Correlation table.

	1.	2.	3.	4.	5.	6.	7.
1. Age	---						
2. Designated Sex at Birth	-.101	---					
3. MSPSS-Family Scale	-.252 **	.047	---				
4. BDI-II	.087	-.039	-.259 **	---			
5. RCMAS Total Score	.117 *	.037	-.209 **	.706 **	---		
6. IT	.082	.056	-.135 *	.436 **	.417 **	---	
7. GIP	.130 *	-.178 **	.067	-.186 **	-.172 **	-.367 **	---

* p < .05

** p < .01

Note: MSPSS – Multidimensional Scale of Perceived Social Support. BDI-II – Beck Depression Inventory, Second Edition. RCMAS – Revised Children’s Manifest Anxiety Scale. IT – Internalized Transphobia subscale. GIP – Gender Identity Pride subscale.

Table 3.

Regression analysis main and interaction effects.

Variable	B	SE	p	LLCI-ULCI	Adjusted R ²	R ² Change (Interaction)
BDI-II Total Score (n=302)						
<i>Step 1</i>						
					.04	
- Age	.02	.38	.95			
- Designated Sex at Birth	-1.31	1.42	.36			
- Perceived Parental Support	-.66	.19	<.01			
<i>Step 2</i>						
					.20	
- Age	-.04	.35	.91			
- Designated Sex at Birth	-2.05	1.32	.12			
- Perceived Parental Support	-.49	.18	<.01			
- Internalized Transphobia (IT)	.53	.08	<.01			
- Gender Identity Pride (GIP)	-.12	.09	.18			
<i>Step 3</i>						
					.22	.01
- Age	-.06	.35	.87	-.75--.63		
- Designated Sex at Birth	-1.79	1.31	.17	-4.38--.80		
- Perceived Parental Support	-.50	.17	<.01	-.84--.15		
- IT	.52	.08	<.01	.36--.67		
- GIP	-.09	.09	.30	-.26--.08		
- IT x GIP	-.02	.01	.03	-.04--.00		
RCMAS Total T-Score (n=301)						
<i>Step 1</i>						
					.04	
- Age	.42	.36	.25			
- Designated Sex at Birth	1.80	1.36	.19			
- Perceived Parental Support	-.54	.18	<.01			

Variable	B	SE	p	LLCI-ULCI	Adjusted R ²	R ² Change (Interaction)
<i>Step 2</i>						
.18						
- Age	.29	.34	.40			
- Designated Sex at Birth	1.41	1.28	.27			
- Perceived Parental Support	-.38	.17	.03			
- Internalized Transphobia (IT)	.50	.08	< .01			
- Gender Identity Pride (GIP)	-.01	.08	.89			
<i>Step 3</i>						
.19						
.00						
- Age	.29	.34	.39	-.38-.96		
- Designated Sex at Birth	1.38	1.28	.28	-1.15-3.90		
- Perceived Parental Support	-.38	.17	.03	-.71--.04		
- IT	.50	.08	< .01	.35-.66		
- GIP	-.02	.08	.86	-.18-.15		
- IT x GIP	.00	.01	.75	-.01-.02		

Bolded p values indicate significance.