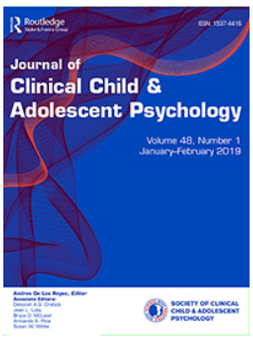

Routledge
Taylor & Francis Group

Journal of Clinical Child & Adolescent Psychology

ISSN: 1537-4416 (Print) 1537-4424 (Online) Journal homepage: https://www.tandfonline.com/loi/hcap20

Future Directions in Affirmative Psychological Interventions with Transgender Children and Adolescents

Leigh A. Spivey & Laura Edwards-Leeper

To cite this article: Leigh A. Spivey & Laura Edwards-Leeper (2019) Future Directions in Affirmative Psychological Interventions with Transgender Children and Adolescents, Journal of Clinical Child & Adolescent Psychology, 48:2, 343-356, DOI: 10.1080/15374416.2018.1534207

To link to this article: https://doi.org/10.1080/15374416.2018.1534207

Journal of Clinical Child & Adolescent Psychology, 48(2), 343–356, 2019

ISSN: 1537-4416 print/1537-4424 online
DOI: https://doi.org/10.1080/15374416.2018.1534207

Routledge
Taylor & Francis Group

Check for updates

FUTURE DIRECTIONS

Future Directions in Affirmative Psychological Interventions with Transgender Children and Adolescents

Leigh A. Spivey
Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill

Laura Edwards-Leeper
School of Graduate Psychology, Pacific University

Transgender children and adolescents experience a gender identity that is incongruent with their sex assigned at birth, often resulting in gender dysphoria. Emerging literature has explored the etiology of transgender identities, documented transgender youths' risk for psychopathology, and evaluated whether social and medical gender transition processes are appropriate and effective for transgender youth. However, there is a dearth of empirical data on gender-affirmative *psychological* interventions designed to reduce the forms of psychological distress experienced by many transgender youths. This is surprising given the elevated rates of psychological distress among transgender youth and the broad recommendation for psychotherapy for youth going through a gender transition. To identify future directions in psychological interventions for transgender youth, we first review key background information on transgender youths' identity development and the role of psychological support in affirmative care. Next, we present future directions in this literature, which emphasizes the need for theory-driven empirical research that incorporates the developmental context of transgender youth to understand the mechanisms underlying group-specific psychological distress. Finally, we lay out the application of these future directions by exploring 3 domains relevant to transgender youth's psychological distress: gender dysphoria, parent and peer interactions, and co-occurring psychopathology. Within each domain, we review extant empirical research, present the current state of affirmative psychological interventions, and discuss implications for future directions. Future research on affirmative psychological care for transgender youth is urgently needed and must focus on clearly articulating which youth could benefit from psychological interventions and why those interventions might be effective.

Transgender and gender nonconforming identities are increasingly visible in our society in ways that both celebrate gender diversity and recognize the unique challenges faced by this population. A recent review of the literature since 2011 suggests that 0.17% to 1.3% of adolescents and young adults may identify as transgender (Connolly, Zervos, Barone, Johnson, & Joseph, 2016). Although the base of empirical research on the experiences of transgender and gender nonconforming children and adolescents is rapidly expanding, many questions remain as to how to best support these youth. As research on the mental and physical well-being of this population gains momentum, we must prioritize advancing the field of psychological interventions in the direction of affirmative and empirically based treatment approaches. Moreover, we must think critically to address the limitations in the current empirical literature, which stem from inadequate theoretical foundations, oversimplification of a diverse population, and subpar research methodologies.

Correspondence should be addressed to Leigh A. Spivey, Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill, 235 E. Cameron Avenue, Chapel Hill, NC 27599. E-mail: laspivey@unc.edu

Terminology

The term *transgender* refers to individuals whose gender identity does not align, by societal expectations,

with their sex assigned at birth. Gender identity and sex assigned at birth are highly related yet distinct constructs: Gender identity refers to individuals' internal, cognitive awareness of themselves as female, male, or some other gender, and sex refers to whether an individual was assigned female or male at birth based on physical characteristics such as external genitalia, sex chromosomes, or sex hormones (American Psychological Association [APA], 2015). More broadly, gender nonconformity refers to gender expressions or identities that do not adhere to societal stereotypes for one's sex assigned at birth. The phrase "transgender and gender nonconforming" (TGNC) is increasingly used to refer to the population of gender diverse individuals to be broadly inclusive of diverse gender identities and expressions. However, empirical research has not yet clarified the clinically relevant differences between youth who specifically identify as transgender and those who fall under the broader umbrella of gender nonconforming (which may include transgender youth). Although we focus specifically on the experiences of transgender youth in this article, it is likely that the research and clinical implications discussed will also bear relevance to the broader population of gender nonconforming youth.

Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) includes a diagnosis labeled *gender dysphoria*. The diagnosis of gender dysphoria is intended to acknowledge the psychological distress and associated impairment that is experienced by some transgender people due to the incongruence between their gender identity and sex assigned at birth. The inclusion of gender dysphoria in the *DSM-5* remains controversial. Although retaining the diagnosis in the *DSM-5* may facilitate access to care and assist with communication between providers, it may also contribute to the continued stigmatization of transgender identities (Davy, 2015; Drescher, 2014).

The Need for Psychological Interventions

Transgender youth appear to experience disproportionately high rates of psychological distress relative to cisgender youth. Transgender youth may be at higher risk for depression, anxiety disorders, and suicidal thoughts and behaviors (e.g., Aitken, VanderLaan, Wasserman, Stojanovski, & Zucker, 2016; Clements-Nolle, Marx, & Katz, 2006; Connolly et al., 2016; Millet, Longworth, & Arcelus, 2017), though these risks may be lower for youth who are supported in their gender transition process (e.g., de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Durwood, McLaughlin, & Olson, 2017). Almost half of youth who present to specialized multidisciplinary clinics that treat transgender youth have psychiatric diagnoses other than gender dysphoria (Spack et al., 2012). In addition to seeking psychotherapy to address general psychological concerns related to the impact of stigma, harassment, and isolation experienced by many, transgender individuals may specifically access mental health care to support their gender transition process. Current standards of care and guidelines for transgender individuals suggest that mental health care providers are an important source of support and require mental health assessment for adolescents seeking gender-affirmative medical interventions (APA, 2015; Coleman et al., 2012; Hembree et al., 2017). Consistent with the standards of care, some specialized multidisciplinary clinics that provide treatment for transgender youth recommend or require their patients to have ongoing contact with a mental health provider for the duration of their medical transition (Chen et al., 2016; Edwards-Leeper & Spack, 2012).

To date, little empirical research has been published on effective psychological interventions developed specifically for transgender youth, which is a problem that Zucker (2008, p. 359) described as an "empirical black hole in the treatment literature" for transgender youth. Indeed, although both World Professional Association for Transgender Health (WPATH) and the Endocrine Society state that qualified mental health professionals should be involved in providing care for transgender youth (Coleman et al., 2012; Hembree et al., 2017), there are currently no empirically supported psychological interventions to meet the needs of this population. There is an expanding literature demonstrating the beneficial effects of medical interventions—such as pubertal suppression or gender-affirmative hormone therapy—on transgender youths' psychological well-being. The dearth of research on psychological interventions for transgender youth designed to target identity-related psychological distress likely stems from the heterogeneity within the population. Some, but not all, TGNC youth may meet the *DSM-5* diagnostic criteria for gender dysphoria (American Psychiatric Association, 2013), which includes psychological distress associated with an incongruence between one's gender identity and sex assigned at birth. Some, but not all, transgender youth may experience significant interpersonal difficulties with family or peers related to their gender identity, and some, but not all, transgender youth may experience psychopathology that is related to life stressors associated with their minority identity.

Thus, the purpose of this article is to identify future directions in affirmative psychological interventions

with transgender youth. Affirmative psychological interventions with transgender youth children and adolescents can be conceptualized as encompassing interventions that aim to support gender transition processes when it is clear that this is in the adolescent's best interest, reduce distress or impairment directly associated with gender dysphoria, and treat distress stemming from—or exacerbated by—identity-related stressors. As we present future directions in this area, we highlight critical developmental considerations that distinguish care for transgender youth from that of adults. We then demonstrate the application of these future directions by examining three domains that are likely relevant to affirmative psychological interventions with transgender youth: gender dysphoria, family and peers, and co-occurring psychopathology.

It is important to acknowledge that some providers believe that mental health services should not be involved in the care of transgender youth, a perspective that likely stems from the historical "gatekeeper" model that positioned mental health care providers in the role of limiting transgender individuals' access to affirmative care (e.g., Olson-Kennedy, 2016). In addition, not all TGNC youth experience significant psychological distress; for those who do, this distress may or may not be related to their gender identity (APA, 2015). Psychological distress that is unrelated to, and not impacted by, transgender youths' identity can likely be treated effectively using existing evidence-based interventions without modification. However, it is crucial that forthcoming research take into consideration factors related both to youths' minority identity and to their developmental status to develop effective interventions for those youth who *do* experience identity-related psychological distress.

BACKGROUND

Developmental Considerations

The timing of the emergence of a transgender identity or gender dysphoria in childhood or adolescence may be relevant to conceptualizing affirmative psychological interventions. A careful examination of gender identity development among transgender youth may elucidate unique developmental factors that could contribute to or protect against psychological distress. Here, we briefly review existing research on the development and disclosure of transgender identities in childhood and adolescence.

There is a small literature on gender identity development among transgender youth. Developmental theory suggests that children's gender identity is established between the ages of 3 and 5 (Kohlberg, 1966). However, this early research did not account for factors that may interfere with the recognition or affirmation of gender diverse identities. Thus, it is unclear whether transgender children also establish their gender identity at this age. Recent research has indicated that transgender children who are affirmed in their gender identity show a similar trajectory across gender identity development milestones relative to cisgender children. Prepubertal transgender children express a preference toward their affirmed gender rather than their sex assigned at birth when given a test that looked at implicit preference of gender; this is similar for same-gender peers rather than same-sex peers (Olson, Key, & Eaton, 2015). Similarly, socially transitioned 3- to 5-year-old transgender children (i.e., children living in their affirmed gender role) do not differ from their cisgender siblings or unrelated cisgender matched controls in their understanding of gender consistency, gender preferences, gender stereotypes, similarity to other members of their gender, or their gender identity and expression (Fast & Olson, 2017). Of interest, transgender children may be less likely to believe that their own gender, or the gender of others, is stable across time (Fast & Olson, 2017). Moreover, transgender children's responses to an implicit behavioral measure of gender identity—measuring the strength of one's cognitive associations between the self and male/female constructs—indicate that they have a strong implicit awareness of their affirmed gender identity (Olson, Key, et al., 2015).

There is variability in the developmental timing of transgender youth's recognition of their gender identity, disclosure of their identity to others, and expression of their gender identity. According to retrospective reports from TGNC adult participants in a national survey, a majority "felt different" in childhood (60%) or early adolescence (21%; James et al., 2016). However, fewer TGNC participants in this study came to think of themselves as transgender in childhood (26%) and early adolescence (28%), and only a small minority disclosed their identity to others (5% in childhood, 10% in early adolescence). These data may be limited by cohort effects, as the adult participants in this study likely experienced a different degree of societal acceptability for transgender identities in their childhood and adolescence compared to present-day youth. Moreover, though these data are retrospective rather than longitudinal, which limits the authors' ability to examine trends in within-person developmental processes, they indicate that there may be significant periods of time between transgender youth's first recognition of their identity and their disclosure to others. Similarly, data from children and adolescents presenting to a gender clinic indicate that, on average, there was a 9-year delay between youth's recognition of their gender

identity and disclosure of their identity to their family (Olson, Schrager, Belzer, Simons, & Clark, 2015).

Extant research and experience from experts in the field suggest that a portion of transgender youth recognize their identity in childhood ("early onset") and others do so at or after the onset of puberty ("late onset"; e.g., Edwards-Leeper & Spack, 2012). Moreover, not all prepubertal children who identify or express a gender that differs from their sex assigned at birth will continue to do so in adolescence or adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008). Developmental factors such as age of identity recognition and persistence of early onset gender dysphoria into adolescence are important to consider, as they may impact transgender youths' experiences with minority stress, their developmental capabilities to cope with identity-related stress, and internal or environmental factors that may impact gender-affirmative care (e.g., parent support for medical interventions in the absence of a longstanding history of gender dysphoria). One longitudinal study found that transgender youth who presented for gender-affirmative care in childhood were more likely to return for gender-affirmative medical interventions in adolescence if they were younger at their initial assessment, experienced more severe gender dysphoria in childhood, and had socially-transitioned in their gender role and expression in childhood (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). Further empirical research on the nuances of these identity development processes would likely directly inform affirmative psychological interventions, as transgender youths' psychological needs may vary as a function of their developmental status and gender history.

In summary, there is considerable variability in when transgender youth recognize and disclose their identity in childhood or adolescence, and some youth who express a transgender identity in childhood may cease to do so at the pubertal transition. Studies that suggest a majority of transgender children will not have gender dysphoria that persists from childhood to adulthood have been critiqued extensively (e.g., Newhook et al., 2018; Olson, 2016). The common critiques about these statistics include whether study samples included children who were not "truly" transgender—thus, unduly inflated the desistence rate—or the use of medical intervention (e.g., hormones and/or surgery) as the outcome variable typically used to measure persistence, which we now know is not feasible and/or desirable for all transgender individuals (Chen, Edwards-Leeper, Stancin, & Tishelman, 2018; Olson, 2016). At the same time, it is clear from these studies, as well as from anecdotal clinical reports, that many gender diverse young children either do not continue to experience significant distress associated with gender dysphoria or do not ultimately identify as transgender in later adolescence or adulthood. For these children, gender nonconformity, or even identification with a gender different from what one was assigned at birth, is simply one aspect of their gender identity development. Recent perspectives suggest that this issue is not about identity development but rather that studying the persistence/desistence of gender dysphoria from childhood through adolescence and adulthood is crucial for informing clinical interventions to support the development of TGNC youth (Steensma & Cohen-Kettenis, 2018). Future research should seek to understand which transgender children will continue to experience clinically significant distress associated with gender dysphoria in adolescence and adulthood to provide guidance on early medical intervention options, such as the decision to block pubertal development that could exacerbate distress among some transgender youth. The need for a nuanced, individualized approach when working with this diverse patient population is becoming increasingly clear.

Guidelines on the Role of Mental Health Care Providers

The WPATH and the Endocrine Society have each published standards of care or practice guidelines regarding the care of transgender individuals that detail the role of mental health professionals working with transgender youth (WPATH SOC Version 7; Coleman et al., 2012; Hembree et al., 2017). The descriptions of recommended psychological interventions with transgender youth in the WPATH SOC7 are broad in nature. For example, they suggest that mental health care providers work with families to increase support for youth and educate and advocate for transgender youth in their community. Regarding individual therapy, the WPATH SOC7 states that "psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties" (Coleman et al., 2012, p. 175), though there are currently no empirically supported treatments that have been demonstrated to be effective in accomplishing these goals with transgender youth. Finally, the WPATH SOC7 states that mental health professionals can support transgender youth in their transition process by understanding that gender is not a binary construct, supporting clients as they plan and execute their gender transition, and by maintaining a therapeutic relationship with transgender youth throughout their gender transition process (Coleman et al., 2012). Beyond suggesting basic therapeutic support during a transitional period, the WPATH SOC7 does not provide specific guidelines for interventions that target the unique stressors experienced by transgender youth.

The Endocrine Society is largely in agreement with the WPATH SOC7 in their description of the role of mental health professionals. Regarding the treatment of children and adolescents, the Endocrine Society guidelines state that

qualified mental health professionals should be involved in diagnosing gender dysphoria, assisting families with decision making about social transitions prior to puberty, and conducting a comprehensive psychosocial assessment prior to gender-affirmative hormone treatment (e.g., assessing coexisting psychopathology, capacity to consent to treatment, social support). Further, the Endocrine Society suggests that transgender adolescents could benefit from the support of mental health professionals throughout their gender transition process (Hembree et al., 2017).

Approaches to Psychological Care

There are differing perspectives on the best clinical approach to working with transgender children, which are primarily divided on whether it is appropriate to support social transitions prior to puberty (APA, 2015). However, there is a growing consensus for what is known as the affirmative care approach, in which providers affirm transgender youth's gender identity and expression and, when appropriate and in the best interest of the youth, support transition steps (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Hidalgo et al., 2013). Edwards-Leeper et al. (2016) explained the complexities of this approach in depth, emphasizing that affirmative care of transgender youth requires a nuanced understanding of each individual child's unique gender identity development and how it fits within the other contexts of the child's life. Specifically, an appreciation for the child's developmental level, family dynamics, peer influences, and co-occurring mental health complexities is critical to providing care that is both individualized and affirming. The affirmative care approach advances the field by emphasizing the complexity of psychological care for transgender youth and by urging providers to consider how to balance providing affirmative care within the constraints of youths' developmental context (Edwards-Leeper et al., 2016).

FUTURE DIRECTIONS

The mental health needs of transgender youth are distinguished from those of transgender adults primarily due to their developmental context. Childhood and adolescence are unique periods in which typical developmental processes, identity development and exploration, and the onset of minority identity-related stressors may interact and impact transgender youths' psychological functioning. Transgender youth experience a multitude of complexities that are likely not as salient for transgender adults, such as the increased peer pressure and desire to "belong" socially, the shift from dependence to autonomy in relationships with parents, and the discomfort with physical, emotional, and cognitive changes of puberty. Thus, we offer an initial perspective on incorporating the developmental context into future research on affirmative psychological interventions with transgender youth.

In approaching this task, it is crucial to highlight that the population of transgender children and adolescents is not defined by shared psychopathology, and thus it would be impossible to identify *one* specific evidence-based psychological intervention that could address transgender youths' psychological distress. A more realistic goal is to develop a foundation for evidence-based practice to provide affirmative psychological interventions with transgender youth. Important to note, this evidence-based practice must be theory driven to target the unique processes that lead to transgender youths' psychological distress while avoiding overpathologizing a vulnerable and stigmatized group. Conceivably, future research could eventually focus on developing an adaptive intervention for the care of transgender youth, which could provide structure for individualizing care of this heterogeneous population (e.g., Almirall & Chronis-Tuscano, 2016). Yet first, substantial empirical research is needed to elucidate *which* youth are at risk for *which* forms of distress and *why*.

The theoretical foundations for future evidence-based practice could be drawn from minority stress theory and the developmental psychopathology approach. Minority stress theory provides a theoretical framework for understanding why transgender youth might be at higher risk for psychological distress relative to their cisgender peers, and similarly why affirmative psychological intervention may be necessary and beneficial. Specifically, minority stress theory suggests that mental and physical health disparities that have been observed among sexual and gender minority individuals can be attributed to unique, identity-related stressors (e.g., Hendricks & Testa, 2012; Meyer, 2003). Minority stress includes proximal stressors, such as expectations of rejection and internalized stigma, and distal stressors, such as societal stigma and discrimination. Proximal minority stressors and psychological processes, such as emotion dysregulation and maladaptive coping, are theorized to mediate the relationship between distal minority stressors and psychopathology (Hatzenbuehler, 2009). For transgender youth, minority stress experiences may include gender-based harassment, internalized stigma related to their gender identity, or fears of rejection that may lead youth to conceal their transgender identity from family or peers. Minority stress is chronic, and evidence suggests that it can have a significant detrimental effect on the mental and physical well-being of sexual and gender minority individuals (e.g., Lick, Durso, & Johnson, 2013).

However, additional theoretical perspectives are needed to understand the complex ways in which minority stress experiences may interact with developmental processes to contribute to psychological distress for transgender youth. For example, how does minority stress interfere with or disrupt typical developmental processes? What is the impact of the developmental timing of minority stress experiences (e.g., family rejection in childhood compared

to adolescence)? The developmental psychopathology perspective is one theoretical approach that could offer incremental value above and beyond minority stress theory in addressing these questions. The developmental psychopathology approach has been defined by Kerig (2012) as "the study of developmental processes that contribute to, or protect against psychopathology" (p. 17). This perspective seeks to understand the individual as a whole, including both risk and resilience mechanisms. Another key is that risk and resilience processes are studied in the context of developmental capabilities, which means that youth are not conceptualized as "little adults" (e.g., Cicchetti & Rogosch, 2002). This point is highly relevant for affirmative interventions with transgender youth, as guidelines for treatment in adults do not necessarily extend to youth given differences in their cognitive and emotional development.

Future directions in affirmative psychological interventions with transgender youth must place greater emphasis on the developmental processes and context that distinguish transgender youth from transgender adults. For example, transgender adolescents face a number of identity-related stressors and changes, such as gender-based harassment and social and/or medical gender transition processes, during a period in which they also experienced heightened sensitivity to social feedback (e.g., Prinstein & Giletta, 2016). One way to do this is to integrate developmental theories, such as the developmental psychopathology approach, with minority stress theory when studying risk and resilience processes among transgender youth. Important to note, theoretical frameworks that integrate minority stress theory with developmental perspectives would highlight that there are normative developmental processes for transgender youth that lead to healthy psychosocial adjustment. But, for some transgender youth, these processes are disrupted by minority stress, and over time these disruptions may result in psychopathology.

An advantage of the developmental psychopathology approach is that it also provides a platform for integrating across various domains (e.g., biological, social) to understand the mechanisms by which transgender youth develop an increased risk for psychopathology. Boyce and Ellis (2005) suggested that early life experiences with adversity can lead to high stress reactivity later in life through a developed biological sensitivity to context. In the case of transgender youth, it is possible that early life minority stressors may set them on a different biological trajectory that contributes to maladaptive physiological responses to stress in adulthood. Minority stress theory suggests that transgender youth will likely face distal identity-related stressors throughout their lives, and thus how transgender youth respond and cope with stressors is highly relevant to their risk for developing psychopathology over their lifetime. Future research is needed to determine how early minority stress experiences impact transgender youths' biological stress reactivity and, second, how stress reactivity interacts with experiences of stigma or discrimination later in life to contribute to risk for psychopathology.

TARGET AREAS FOR AFFIRMATIVE PSYCHOLOGICAL INTERVENTION

To present future directions in affirmative psychological interventions with transgender youth, we describe several common forms of psychological distress experienced by transgender youth, critically examine empirical research that explores why transgender youth experience this distress, and discuss implications for affirmative psychological interventions. Crucially, future research must focus on identifying *mechanisms* that contribute to the development of psychological distress among transgender youth, including those related to minority stress, developmental factors, and the interaction between the two, to develop effective psychological interventions.

Gender Dysphoria

Gender Dysphoria is Distressing

Psychological interventions to reduce the distress associated with gender dysphoria have been remarkably understudied to date (e.g., physical discomfort, social misperception).[1] By definition in the *DSM-5*, gender dysphoria is a distressing experience for transgender youth, and in fact many youths take steps to reduce the incongruence and alleviate that distress (i.e., by socially or medically transitioning). Dysphoria often stems from two sources: distress about one's physical body being incongruent with one's identity, and/or distress related to others not perceiving their gender correctly (e.g., being misgendered). Both aspects of gender dysphoria are critically relevant to the period of adolescence, in which transgender youth may experience an exacerbation of physical distress from pubertal development as well as increasing distress about their social presentation due to adolescents' heightened sensitivity to social interactions (Prinstein & Giletta, 2016). Thus, although it is critical for health care providers to recognize that transgender identities are not pathological, we must also not minimize the distress associated with gender dysphoria.

uture research on gender dysphoria should devote increased attention to the severity of distress and impairment for transgender individuals, as well as the source of the distress (e.g., dysphoria related to one's body and/or dysphoria related to

[1] This refers to reductions in the distress associated with gender dysphoria and should not be misconstrued to suggest that psychological interventions for gender dysphoria could be used to encourage individuals to identify with their sex assigned at birth.

being misgendered). Future research is needed to develop measures that accurately assess the degree and source of distress and impairment associated with gender dysphoria, which could be used to investigate the impact of gender dysphoria on other developmental processes.

Gender Dysphoria in the Context of Development

Transgender youth face unique stressors at the onset of puberty due to unwanted impending physical changes that may increase their awareness of the incongruence between their sex assigned at birth and their gender identity, which may lead to an increase in the severity of gender dysphoria as they transition into adolescence (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). There are many other developmental tasks occurring during this period, and the developmental psychopathology approach would suggest considering the ways in which gender dysphoria may disrupt other developmental processes as well as how developmental processes may disrupt gender identity development. The ways in which gender dysphoria and developmental processes interact are particularly important to consider as many transgender youth must wait to begin irreversible gender-affirmative medical interventions—currently the only intervention shown to reduce gender dysphoria—until midadolescence or adulthood due to age recommendations by WPATH or the Endocrine Society (Coleman et al., 2012; Hembree et al., 2017), financial limitations, limited access to care, or a lack of support from their legal guardians. Little empirical research has explored the transactional effects of gender dysphoria on child and adolescent development. Examining such transactional processes could inform a more comprehensive understanding of transgender youths' psychosocial adjustment, as well as factors influencing gender identity development and access to gender-affirmative mental and physical health care.

Clinical Interventions for Gender Dysphoria

The current treatment protocol recommended by the WPATH SOC7 for gender dysphoria in transgender youth is supporting a transition to the individual's affirmed gender through social changes and gender-affirmative medical interventions, when desired and appropriate. A cohort of 55 transgender youths with histories of long-standing and persistent gender dysphoria was prospectively followed over the course of their gender transition process, which included puberty suppression using gonadotropin-releasing hormone analogues, gender-affirmative hormone therapy, and gender-affirmation surgeries (de Vries et al., 2014). Results from this longitudinal study indicated that the severity of gender dysphoria did not decline for transgender youth until after they began hormone therapy and received gender-affirmation surgeries; puberty suppression was not associated with improvements in gender dysphoria. However, de Vries and colleagues' study did not assess transgender youths' gender dysphoria after beginning hormone therapy yet before gender-affirmation surgery, which makes it difficult to tease apart the relative contributions of each transition step. Moreover, the clinical protocol used by de Vries and colleagues does not consider adolescents eligible for pubertal suppression until the age of 12, which for many may be well past the onset of puberty. This limitation could partially account for the lack of observed improvement in gender dysphoria after beginning pubertal suppression.

Social transition, puberty suppression, and gender-affirmative hormone therapy appear to have a positive impact on transgender individuals' broader psychological functioning. Prepubertal transgender children who have socially transitioned, presumably with support and affirmation from their caregivers, are no more depressed and only slightly more anxious than their siblings or cisgender matched controls (Olson, Durwood, DeMeules, & McLaughlin, 2016). It is important to note, however, that Olson et al. (2016) presented cross-sectional data and did not assess children's psychological function before and after their social transition, nor did they include a comparison group of transgender children who had *not* socially transitioned. Thus, it remains unclear whether social transition in childhood improved or supported transgender children's psychosocial adjustment, or whether preexisting healthy psychosocial functioning in some way facilitated children's social transition (e.g., enhancing ability to communicate desire for gender transition with caregivers). Similarly, in de Vries et al. (2014) longitudinal study, transgender youths' psychological functioning—as measured by their global functioning, internalizing symptoms, and externalizing symptoms—improved over the course of treatment, which included both medical and significant mental health involvement.

Although there are no psychological interventions that have been specifically designed and tested to support youth through a gender transition, the affirmative care approach provides several specific suggestions for helping transgender youth plan and navigate their gender transition process (Edwards-Leeper, 2017; Edwards-Leeper et al., 2016). For prepubertal transgender children, this may involve supporting children as they explore their gender identity and expression, recognizing that their gender may change over time, and assisting the child and family as they enact a social transition in whatever manner feels most comfortable and safe. For transgender adolescents, the suggestions are very similar and are supplemented by providing additional support and psychoeducation regarding gender-affirmative medical interventions. Future empirical research is needed to further clarify how psychologists can most effectively support transgender youth in exploring their gender identity and navigating a gender transition.

Parent, Family, and Peer Interactions

Peer Victimization

Transgender youth appear to have elevated peer relation problems and are more likely to be victimized by their peers compared to cisgender youth. In a large survey of TGNC adults, 76% of participants retrospectively reported that they were bullied or harassed by peers in school (Grant et al., 2011). Problems with peer relationships are associated with higher internalizing and externalizing symptoms among transgender adolescents (de Vries, Steensma, Cohen-Kettenis, VanderLaan, & Zucker, 2016), and victimization or peer relations problems may mediate transgender youths' elevated levels of substance use and suicidal thoughts and behaviors (Aitken et al., 2016; Reisner, Greytak, Parsons, & Ybarra, 2014). Finally, victimization experiences related to one's transgender identity in childhood and adolescence appear to have lasting psychological consequences. Transgender adults who report being victimized in school based on their gender identity are approximately four times more likely to attempt suicide compared to transgender adults who were not victimized in their youth (Goldblum et al., 2012).

Impact of Parent and Family Support

Parent and family support is a crucial protective factor for lesbian, gay, bisexual, transgender, queer, and questioning youth. Family acceptance of a youth's sexual orientation, gender identity, or gender expression is associated with greater child well-being and lower psychological distress (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In the U.S. Transgender Survey, 60% of participants reported that their immediate family was supportive of their gender identity and expression, and family support was associated with lower risk for homelessness, suicide attempts, and serious psychological distress (James et al., 2016). Parent support is associated with higher life satisfaction, lower perceived burdensomeness, and lower depressive symptoms among transgender adolescents presenting to gender clinics for gender-affirmative medical interventions (Simons, Schrager, Clark, Belzer, & Olson, 2013).

Impact of Parent and Family Rejection

Consistent with minority stress theory, a growing body of evidence suggests that gender identity-based family rejection may be a risk factor for psychological distress among transgender youth. Parents of transgender youth may have difficulty affirming their child's gender identity or expression for a variety of reasons, such as their own beliefs about gender or concerns for how their child will be perceived by others (Rahilly, 2015). This may lead parents of transgender youth to engage in rejecting behaviors, such as refusing to use their child's affirmed name or pronouns, discouraging behaviors or gender expressions consistent with their child's gender identity, or forcing the child or adolescent out of the family home. Transgender youth appear to experience high rates of parental rejection compared to cisgender youth. In a sample of 55 transgender adolescents, more than half of participants who reported that their mothers and fathers were aware of their transgender identity also reported that their parent had a negative or very negative reaction to their coming out (Grossman, D'Augelli, Howell, & Hubbard, 2005). Although some parents' reactions to their child's transgender identity became more positive over time in this study, 44%–50% of parents continued to react very negatively toward their child several years after they first learned of their identity.

Rejection experiences from parents and family can have a profound negative effect on transgender youth's psychological functioning. Transgender adults who experience high levels of family rejection are 3 times more likely to attempt suicide at some point in their life (Klein & Golub, 2016). This is consistent with the broader literature on adolescents that indicates that perceptions of low parental support are associated with suicide attempts (Miller, Esposito-Smythers, & Leichtweis, 2015). Further research is needed to determine whether there is a unique detrimental effect associated with gender identity-based parent rejection compared to rejection that is not directly tied to transgender identities. If the same mechanisms underlie the connections between transgender identity-based rejection and other forms of parental rejection with negative psychosocial outcomes, then established psychosocial interventions for improving parent–child interactions may be sufficient for transgender youth and their parents. However, if the developmental mechanisms that confer risk are unique to transgender identity-based parental rejection, then interventions would need to be modified to target the relevant mechanisms.

Clinical Interventions for Parents and Families of Transgender Youth

Several interventions for parents and families of transgender youth have been described in the literature, yet to date none have been tested empirically. Malpas (2011) presented a multidimensional treatment approach to working with transgender youth and their families that involves parent education, individual child therapy, parent coaching, family therapy, and a multifamily parent support group. The parent-focused components of Malpas's intervention include providing psychoeducation on transgender identity development, empowering parents to be an advocate and source of support for their child, promoting positive and adaptive parent–child interactions, and fostering community support for parents. Menvielle and Rodnan (2011) presented a similar approach for a multifamily parent support group for parents of transgender youth. Although they did not target specific areas for intervention, Menvielle and Rodnan described parents in their group benefitting from general

psychoeducation related to their child's identity, coping with stress associated with disclosing their child's identity to others, processing their grief reaction, and receiving social support from other parents of transgender youth. These programs appear to be beneficial for the families of transgender youth by anecdotal report, yet it is difficult to assess their effectiveness without quantitative data measuring changes in treatment targets. Future studies that test the effectiveness of such interventions with parents and families would enhance the growing body of literature on affirmative psychological treatment for transgender by empirically evaluating how the family environment impacts transgender youth's well-being.

It is clear that the parent and family environment is crucial to promoting well-being among transgender youth, yet the specific mechanisms by which this occurs remain understudied. Future research on parent and family interventions for transgender youth should focus on identifying ways to promote family acceptance, reduce rejecting behaviors, and enhance the parent–child relationship to promote resiliency in the context of chronic minority stress. Research on resiliency indicates that designing interventions to improve parenting strategies and parent responses to children's experiences with adversity can promote resiliency and reduce the impact of that adversity on later psychological distress (Masten, 2001). This is particularly relevant for transgender youth who need their parents to support and affirm their identity and to advocate for them in various settings, such as in school or health care (Grossman & D'Augelli, 2006). Consistent with developmental psychopathology, promoting resiliency in childhood and adolescence may positively impact on transgender individuals' ability to cope with gender-related stressors experienced later in life (e.g., Ong, Bergeman, Bisconti, & Wallace, 2006).

Co-Occurring Psychopathology

In addition to affirming gender identity development, psychologists can support transgender youth by treating co-occurring psychological concerns. Important to note, some forms of co-occurring psychopathology may be related to minority stress experiences (e.g., internalizing symptoms, suicidality), and other forms may instead co-occur with gender dysphoria at a greater rate than expected (e.g., autism spectrum disorder [ASD], attention deficit/hyperactivity disorder) and may be unrelated to the youth's gender dysphoria. The former may carry implications for developing affirmative interventions that are sensitive to gender diversity, whereas the latter may have significant implications for transgender youths' gender transition process. Of course, *both* forms may co-occur within an individual, and, moreover, transgender youth may experience psychopathology that is unrelated to their membership in a stigmatized minority group. This is a noteworthy avenue for future directions in this literature. Future research on affirmative psychological interventions should aim to (a) enhance our understanding of the etiology of the various forms of psychological distress experienced by transgender youth, (b) examine the implications of how these forms of distress co-occur or interact within an individual, and (c) inform clinical approaches to assessing the nuances of psychological distress among transgender youth (e.g., whether, or in what way, it was related to minority stress). Effective psychological interventions would be contingent on effective case conceptualization, for example, understanding the ways in which identity-related stress may interact with other psychological processes to trigger, maintain, or exacerbate psychopathology (e.g., Hatzenbuehler's, 2009, psychological mediation framework).

Depression, Self-Injury, and Suicidal Thoughts and Behaviors

One of the most consistent findings related to transgender youths' psychological well-being is their significantly elevated rate of suicidal thoughts and behaviors. Rates of lifetime suicidal behaviors may range from 28.5% to 40.0% based on retrospective self-reports from transgender adults (Clements-Nolle et al., 2006; Goldblum et al., 2012; James et al., 2016). Based on self-report data from community and gender-referred samples of transgender youth, rates of suicidal thoughts may range from 45% to 51% and rates of suicidal behaviors may range from 26% to 30% (Grossman & D'Augelli, 2007; Olson, Schrager, et al., 2015). The heightened risk for suicidal thoughts and behaviors appears to extend from childhood through adulthood (e.g., Aitken et al., 2016; Marshall, Claes, Bouman, Witcomb, & Arcelus, 2016). Children referred to specialized clinics for gender-identity-related issues are more likely to endorse suicidal ideation and self-injurious behaviors than both nonreferred cisgender children and sibling comparison groups (Aitken et al., 2016). Although transgender children endorse higher frequencies of suicidal thoughts and behaviors compared to cisgender children broadly, the frequency of their suicidal thoughts and behaviors is significantly lower than clinically referred cisgender children (Aitken et al., 2016). This suggests that although transgender children are at higher risk than children in general, their suicide risk may not be higher than that of cisgender children with other forms of psychopathology.

Consistent with minority stress theory, identity-related stressors such as gender-based discrimination, victimization, and family rejection appear to be associated with higher risk for suicidal thoughts and behaviors among transgender youth (e.g., Clements-Nolle et al., 2006; Goldblum et al., 2012; Klein & Golub, 2016). In one population-based study, the elevated rate of suicidal

ideation among transgender adolescents compared to cisgender youth was partially mediated by elevated levels of school-based victimization and depressive symptoms (Perez-Brumer, Day, Russell, & Hatzenbuehler, 2017). Similarly, compared to transgender adolescents without a suicide attempt history, transgender adolescents who reported attempting suicide in their lifetime reported more frequent verbal and physical abuse from their parents in childhood, lower satisfaction with their weight, and more negative beliefs about how others evaluated their body or appearance, and they were more likely to endorse negative attitudes about their transgender identity (i.e., internalized stigma; Grossman & D'Augelli, 2007). Finally, co-occurring psychopathology, including depression (Tebbe & Moradi, 2016) and substance abuse (Clements-Nolle et al., 2006), have been identified as mediators or risk factors for elevated suicide risk among transgender individuals; these forms of co-occurring psychopathology are likely best characterized as secondary to minority stress experiences.

However, the lifetime prevalence of or risk factors for suicidal thoughts and behaviors does not help us understand *when* transgender individuals are most at risk. If the elevated risk for suicide is in some way identity related as is commonly hypothesized, then it would be more informative to examine the onset and frequency of suicidal thoughts and behaviors in relation to gender identity development (e.g., awareness/disclosure of identity, transition steps, victimization experiences). Research that explicitly links suicidal thoughts and behaviors to developmental processes would be particularly useful in identifying opportunities for early intervention and prevention efforts.

Anxiety Disorders

Transgender individuals may have a higher prevalence of anxiety disorders compared to cisgender individuals. A review of the literature on transgender youth and adults found high rates of a variety of anxiety disorders, including social phobia, panic disorder, specific phobias, and obsessive-compulsive disorder (Millet et al., 2017). However, Millet and colleagues noted that the studies that they reviewed primarily included transgender individuals seeking gender-affirmative medical interventions, which limits the generalizability of the results as these individuals were likely experiencing significant distress compared to the broader population of transgender individuals. Transgender youth who are supported in their gender identities may experience fewer anxious symptoms: Prepubertal children who have socially transitioned report only slightly elevated anxiety symptoms compared to a normative sample of children (Olson et al., 2016). However, as discussed previously, the cross-sectional data presented by Olson and colleagues preclude any assumption about the causal relationship between childhood social transition and anxiety symptoms. In a chart review of children assigned male at birth who were referred to specialized gender clinics, the prevalence of separation anxiety disorder was higher than national estimates for boys (i.e., sex-matched sample) but was not significantly different than estimates for girls (i.e., gender-matched sample; VanderLaan et al., 2017).

Other Co-Occurring Disorders

Several other forms of psychopathology appear to co-occur with gender dysphoria at a higher rate than expected, though the underlying developmental mechanisms for these connections are not well understood currently. ASD appears to be more prevalent among transgender youth compared to cisgender youth (Glidden, Bouman, & Jones, 2016). In one study, 7.8% of youth presenting to a specialized clinic in the Netherlands for the treatment of gender dysphoria met diagnostic criteria for ASD (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010). Of note, de Vries and colleagues found that the incidence of ASD was much higher among children and adolescents who were diagnosed with gender identity disorder not otherwise specified (17%) compared to those who met full criteria for gender identity disorder (4.7%). In another study, the prevalence of gender dysphoria in children and adolescents with various neurodevelopmental disorders was estimated using responses to a single item that asked whether a participant "wishes to be the opposite sex" (Strang et al., 2014). Strang and colleagues found that, compared to nonreferred controls, youth with ASD were 7.59 times more likely to endorse the gender dysphoria item, and youth with attention deficit/hyperactivity disorder were 6.64 times more likely to endorse the item. Important to note, psychological support may be particularly important for transgender youth with co-occurring ASD as they plan and engage in gender transition processes, as cognitive and interpersonal characteristics associated with ASD may pose additional challenges for youth in transition (Strang et al., 2016).

Clinical Interventions for Co-Occurring Psychopathology

It is important to reiterate that the population of transgender youth is heterogeneous, and many transgender youths may not experience co-occurring psychopathology. For some transgender youth, co-occurring psychopathology may be related to minority stress, and for others it may be unrelated to their gender identity or expression. Finally, for some transgender youth, psychopathology may be attributed to a combination of minority stress and other factors unrelated to their minority identity. Thus, it is clear that no single psychological intervention will be effective in treating the various forms of psychopathology that may be more prevalent in this population. Nevertheless, it is critical that

we develop evidence-based practices to treat co-occurring psychopathology in transgender youth using theory-driven hypotheses and methodology. To do this, future research must emphasize accurate assessment of the source of a transgender child or adolescent's psychopathology (i.e., whether and/or how it relates to their minority identity). The result of this informs future directions in affirmative intervention research that either capitalizes on existing evidence-based treatments or that suggests a need for the development of novel intervention approaches.

The proximal stressors identified in minority stress theory that are hypothesized to contribute to co-occurring psychopathology align well with cognitive approaches to psychological intervention. For example, internalized stigma are negative beliefs about the self related to one's identity, and expectations of rejection or hypervigilance involve potentially inaccurate interpretations of situations. In one qualitative study of transgender adults, participants reported that they frequently expected rejection in their environment related to their gender identity or expression and that expecting rejection was associated with feelings of fear, anxiety, anger, and depression (Rood et al., 2016). Thus, it follows that psychological interventions that aim to treat co-occurring psychopathology related to minority stress should include proximal stress processes as treatment targets.

Although still in its early stages, emerging research on affirmative cognitive behavioral therapy (CBT) holds promise for the treatment of depression and anxiety related to minority stress experiences. Craig and Austin (2016) developed a CBT-based intervention for sexual and gender minority youth, which focuses on teaching coping skills for identity-related stressors, challenging maladaptive cognitions and threat appraisals, and enhancing social support. The authors tested the feasibility of implementing their intervention in a group therapy setting with sexual and gender minority youth (N = 30) over a 2-day retreat. Depressive symptoms significantly declined from pre- to postintervention, and this reduction in symptoms was maintained through a 3-month follow-up (Craig & Austin, 2016). However, although this was a *statistically* significant decline in symptoms, the mean symptom level postintervention and at follow-up remained in the "moderate" range and thus did not represent a clinically significant reduction in symptoms. Craig and Austin also found significant changes in their proposed mechanisms—reflective coping and threat appraisals—in the hypothesized directions from baseline to follow-up. Although these initial results are promising, the intervention was not compared to a control CBT group to determine whether the affirmative modifications provided added value to the intervention. Moreover, the intervention was not implemented using a more standard weekly session format; it is unclear whether the adolescents interacted with one another outside of sessions during the 2-day retreat, which could confound the findings due to the possible influence of social support.

SUMMARY AND CONCLUSIONS

Implications for Affirmative Psychological Interventions

The purpose of this article was to explore future directions in affirmative psychological interventions with transgender youth. To date, psychological interventions designed to ameliorate the various forms of psychological distress unique to the experiences of transgender youth have been surprisingly understudied. Yet, expert opinions, the WPATH SOC7, and data demonstrating high rates of psychosocial difficulties suggest that some portion of transgender youth could benefit from psychological interventions. Thus, future research should work to identify *which* transgender youth could benefit from such interventions and *why* these interventions would be effective. Affirmative psychological interventions have the potential to strengthen existing resiliency and lessen transgender individual's psychological distress over the course of development, which could save transgender individuals' time and financial resources and reduce health disparities associated with chronic stress and psychological distress.

To date, there are no affirmative psychological interventions with clearly articulated treatment targets and rationales that have been empirically tested for effectiveness with transgender youth. One exception is Craig and Austin's (2016) CBT intervention, previously described. However, randomized controlled trials are needed to determine its effectiveness with transgender youth above and beyond unmodified CBT for adolescent depression. Data from such studies would be useful in determining whether interventions that are tailored to address the unique experiences of transgender youth that have been shown to contribute to their elevated risk for psychological distress provide incremental benefit above and beyond established empirically-supported treatments.

Clearly, more research is needed on the specific risk factors and mechanisms that contribute to psychological distress among transgender youth, particularly with regard to gender dysphoria, negative parent and peer interactions, and co-occurring psychopathology. Moreover, there is a substantial need for research that explores the transactional relationships between these forms of psychological distress and normative developmental processes.

Limitations of the Existing Literature

Research on affirmative psychological interventions for transgender youth is somewhat limited by the state of the theory in this area, which underemphasize developmental processes and mechanisms leading to negative psychosocial outcomes. Minority stress theory provides a strong theoretical basis for beginning to conceptualize why transgender youth may experience disproportionate rates of psychopathology compared to cisgender youth (Hendricks & Testa, 2012; Meyer, 2003). However, additional theoretical perspectives, such as the developmental psychopathology approach, must also be considered to develop a comprehensive understanding of how to intervene on the various forms of psychological distress experienced by transgender youth.

A second limitation that must be addressed to advance research on affirmative psychological interventions with transgender youth stems from variability in how the population of interest is defined. Gender minority youth are referred to in numerous ways: transgender, gender dysphoric, gender nonconforming, gender diverse, gender variant, and so on. To some extent, this variability reflects increasing awareness of the diversity within the population of gender minority youth. To successfully develop effective affirmative psychological interventions, however, it is critical that we identify *who* is at risk for specific forms of psychological distress. Some TGNC youth may experience more severe gender dysphoria—such as children whose gender dysphoria persists into puberty—and would likely benefit from early medical interventions to support their gender transition. Similarly, some TGNC youth may be at greater risk for minority stress exposure and would likely benefit from affirmative psychological interventions that target the specific mechanisms linking minority stress and psychological distress. Last, though there will likely be an ongoing debate about whether to include gender dysphoria in the *DSM*, current research and clinical practice will continue to rely on this diagnosis to identify the population and evaluate eligibility for gender-affirmative medical interventions. Future research could explore individual differences related to the severity of youths' distress and impairment from gender dysphoria, systematically evaluate the characteristics of the subset of TGNC youth that meet diagnostic criteria for gender dysphoria, and examine the utility of the diagnosis in treatment planning for medical interventions.

Finally, research thus far on affirmative psychological interventions for transgender youth has been largely limited by inadequate research methodologies. For a comparatively new and emerging literature, it is understandable that many studies have relied on small convenience samples and cross-sectional designs. However, these limitations must be addressed to advance our understanding of affirmative psychological interventions for transgender youth. Future research should prioritize using longitudinal methodology to study risk and resiliency factors that impact the development of psychological distress among transgender youth. Data from longitudinal studies would be beneficial to the development of affirmative psychological interventions for transgender youth, as they could clarify how certain risk mechanisms—such as expectations of rejection or internalized stigma—develop within person over time. In addition to longitudinal methodologies, studies that use a matched-control design comparing developmental processes in transgender children to gender-matched cisgender children, siblings, clinic-referred, or community controls would be useful in understanding how minority stress experiences or gender dysphoria disrupt typical developmental processes.

Conclusion

In sum, despite extensive evidence that transgender youth experience various forms of psychological distress related to their minority identity, there is currently very little empirical data that can directly inform evidence-based practice with transgender youth. Future research on affirmative psychological interventions must be driven by theory that accounts for the interactions between developmental processes and minority stress experiences. We hope that clearly articulating why transgender youth experience disproportionate rates of psychological distress relative to cisgender youth, as well as what psychological interventions are effective in reducing distress and impairment, will ultimately lessen societal stigma toward gender diversity and enhance transgender youths' mental and physical well-being.

FUNDING

This material is based on work supported by the National Science Foundation Graduate Research Fellowship Program under Grant No. 1256065. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the National Science Foundation.

ORCID

Leigh A. Spivey http://orcid.org/0000-0002-5152-3157

REFERENCES

Aitken, M., VanderLaan, D. P., Wasserman, L., Stojanovski, S., & Zucker, K. J. (2016). Self-harm and suicidality in children referred for gender dysphoria. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*, 513–520. doi:10.1016/j.jac.2016.04001

Almirall, D., & Chronis-Tuscano, A. (2016). Adaptive interventions in child and adolescent mental health. *Journal of Clinical Child & Adolescent Psychology*, *45*, 383–395. doi:10.1080/15374416.2016.1152555

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*, 832–864. doi:10.1037/a0039906

Boyce, W. T., & Ellis, B. J. (2005). Biological sensitivity to context: An evolutionary-developmental theory of the origins and functions of stress reactivity. *Development and Psychopathology*, *17*, 271–301. doi:10.1017/S0954579405050145

Chen, D., Edwards-Leeper, L., Stancin, T., & Tishelman, A. (2018). Advancing the practice of pediatric psychology with transgender youth: State of the science, ongoing controversies, and future directions. *Clinical Practice in Pediatric Psychology*, *6*(1), 73. doi:10.1037/cpp0000229

Chen, D., Hidalgo, M. A., Leibowitz, S., Leininger, J., Simons, L., Finlayson, C., & Garofalo, R. (2016). Multidisciplinary care for gender-diverse youth: A narrative review and unique model of gender-affirming care. *Transgender Health*, *1*(1), 117–123. doi:10.1089/trgh.2016.0009

Cicchetti, D., & Rogosch, F. A. (2002). A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology*, *70*(1), 6–20. doi:10.1037//0022-006X.70.1.6

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons. *Journal of Homosexuality*, *51*, 53–69. doi:10.1300/J082v51n03_04

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender and gender-nonconforming people, version 7. *International Journal of Transgenderism*, *13*, 165–232. doi:10.1080/15532739.2011.700873

Connolly, M. D., Zervos, M. J., Barone, C. J., Johnson, C. C., & Joseph, C. L. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health*, *59*(5), 489–495. doi:10.1016/j.jadohealth.2016.06.012

Craig, S. L., & Austin, A. (2016). The AFFIRM open pilot feasibility study: A brief affirmative cognitive behavioral coping skills group intervention for sexual and gender minority youth. *Children and Youth Services Review*, *64*, 136–144. doi:10.1016/j.childyouth.2016.02.022

Davy, Z. (2015). The DSM-5 and the politics of diagnosing transpeople. *Archives of Sexual Behavior*, *44*(5), 1165–1176. doi:10.1007/s10508-015-0573-6

de Vries, A. C., Steensma, T. D., Cohen-Kettenis, P. T., VanderLaan, D. P., & Zucker, K. J. (2016). Poor peer relations predict parent- and self-reported behavioral and emotional problems of adolescents with gender dysphoria: A cross-national, cross-clinic comparative analysis. *European Child & Adolescent Psychiatry*, *25*(6), 579–588. doi:10.1007/s00787-015-0764-7

de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, *40*(8), 930–936. doi:10.1007/s10803-010-0935-9

de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, *8*(8), 2276–2283. doi:10.1111/j.1743-6109.2010.01943x

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*, 696–704. doi:10.1542/peds.2013-2958

Drescher, J. (2014). Controversies in gender diagnoses. *LGBT Health*, *1*(1), 10–14. doi:10.1089/lgbt.2013.1500

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, *44*, 34–45. doi:10.1037/0012-1649.44.1.34

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, *56*(2), 116–123. doi:10.1016/j.jaac.2016.10.016

Edwards-Leeper, L. (2017). Affirmative care of TGNC children and adolescents. In A. Singh & L. M. Dickey (Eds.), *Affirming counseling and psychological practice with transgender and gender nonconforming clients* (pp. 119–141). Washington, DC: American Psychological Association.

Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*, *3*, 165–172. doi:10.1037/sgd0000167

Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. *Journal of Homosexuality*, *59*(3), 321–336. doi:10.1080/00918369.2012.653302

Fast, A. A., & Olson, K. R. (2017). Gender development in transgender preschool children. *Child Development*. doi:10.1111/cdev.12758

Glidden, D., Bouman, W. P., & Jones, B. A. (2016). Gender dysphoria and autism spectrum disorder: A systematic review of the literature. *Sexual Medicine Review*, *4*(1), 3–14. doi:10.1016/j.sxmr.2015.10.003

Goldblum, P., Testa, R. J., Pflum, S., Hendricks, M. L., Bradford, J., & Bongar, B. (2012). The relationship between gender-based victimization and suicide attempts in transgender people. *Professional Psychology: Research and Practice*, *43*, 468–475. doi:10.1037/a0029605

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Grossman, A. H., & D'Augelli, A. R. (2006). Transgender youth. *Journal of Homosexuality*, *51*, 111–128. doi:10.1300/J082v51n01_06

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behaviors*, *37*, 527–537. doi:10.1521/suli.2007.37.5.527

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2005). Parents' reactions to transgender youths' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services*, *18*(1), 3–16. doi:10.1300/J041v18n01_02

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, *135*(5), 707–730. doi:10.1037/a0016441

Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., … T'Sjoen, G. G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An endocrine society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, *102*(11), 3869–3903. doi:10.1210/jc.2017-01658

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, *43*, 460–467. doi:10.1037/a0029597

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., … Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development*, *56*(5), 285–290. doi:10.1159/000355235

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. Retrieved from http://www.ustranssurvey.org/report

Kerig, P. K. (2012). The developmental psychopathology approach. In P. K. Kerig, A. Ludlow, & C. Wenar (Eds.), *Developmental psychopathology: From infancy through adolescence* (6th ed., pp.1–33). Maidenhead, UK: McGraw-Hill.

Klein, A., & Golub, S. A. (2016). Family rejection as a predictor of suicide attempts and substance misuse among transgender and gender nonconforming adults. *LGBT Health*, *3*(3), 193–199. doi:10.1089/lgbt.2015.0111

Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82–173). Stanford, CA: Stanford University Press.

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science*, *8*(5), 521–548. doi:10.1177/1745691613497965

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*, *50*, 453–470. doi:10.1111/j.1545-5300.2011.01371

Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *International Review of Psychiatry*, *28*, 58–69. doi:10.3109/0954261.2015.1073143

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*, 227–238. doi:10.1037/0003-066X.56.3.227

Menvielle, E. J., & Rodnan, L. A. (2011). A therapeutic group for parents of transgender adolescents. *Child and Adolescent Psychiatric Clinics*, *20*(4), 733–743. doi:10.1016/j.chc.2011.08.002

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. doi:10.1037/0033-2909.129.5.674

Miller, A. B., Esposito-Smythers, C., & Leichtweis, R. N. (2015). Role of social support in adolescent suicidal ideation and suicide attempts. *Journal of Adolescent Health*, *56*(3), 286–292. doi:10.1016/j.jadohealth.2014.10.265

Millet, N., Longworth, J., & Arcelus, J. (2017). Prevalence of anxiety symptoms and disorders in the transgender population: A systematic review of the literature. *International Journal of Transgenderism*, *18*, 27–38. doi:10.1080/15532739.2016.1258353

Newhook, J. T., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., … Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, *19*(2), 212–224. doi:10.1080/15532739.2018.1456390

Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *Journal of Adolescent Health*, *57*, 374–380. doi:10.1016/j.jadohealth.2015.04.027

Olson, K. R. (2016). Prepubescent transgender children: What we do and do not know. *Journal of the American Academy of Child & Adolescent Psychiatry*, *55*(3), 155–156. doi:10.1016/j.jaac.2015.11.015

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, *137*(3), 1–8. doi:10.1542/peds.2015-3223

Olson, K. R., Key, A. C., & Eaton, N. R. (2015). Gender cognition in transgender children. *Psychological Science*, *26*(4), 467–474. doi:10.1177/0956797614568156

Olson-Kennedy, J. (2016). Mental health disparities among transgender youth: Rethinking the role of professionals. *JAMA Pediatrics*, *170*(5), 423–424. doi:10.1001/jamapediatrics.2016.0155

Ong, A. D., Bergeman, C. S., Bisconti, T. L., & Wallace, K. A. (2006). Psychological resilience, positive emotions, and successful adaptation to stress in later life. *Journal of Personality and Social Psychology*, *91*, 730–749. doi:10.1037/0022-3514.91.4.730

Perez-Brumer, A., Day, J. K., Russell, S. T., & Hatzenbuehler, M. L. (2017). Prevalence and correlates of suicidal ideation among transgender youth in California: Findings from a representative, population-based sample of high school students. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(9), 739–746. doi:10.1016/j.jaac.2017.06.010

Prinstein, M. J., & Giletta, M. (2016). Peer relations and developmental psychopathology. In D. Cicchetti (Ed.), *Developmental Psychopathology* (Vol. 1, 3rd ed., pp. 527–579). Hoboken, NJ: Wiley.

Rahilly, E. P. (2015). The gender binary meets the gender-variant child: Parents' negotiations with childhood gender variance. *Gender & Society*, *29*(3), 338–361. doi:10.1177/0891243214563069

Reisner, S. L., Greytak, E. A., Parsons, J. T., & Ybarra, M. L. (2014). Gender minority social stress in adolescence: Disparities in adolescent bullying and substance use by gender identity. *The Journal of Sex Research*, *52*(3), 243–256. doi:10.1080/00224499.2014.886321

Rood, B. A., Reisner, S. L., Surace, F. I., Puckett, J. A., Maroney, M. R., & Pantalone, D. W. (2016). Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health*, *1*(1), 151–164. doi:10.1089/trgh.2016.0012

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. doi:10.1111/j.1744-61712010.00246.x

Simons, L., Schrager, S. M., Clark, L., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *Journal of Adolescent Health*, *53*(6), 791–793. doi:10.1016/j.jadohealth.2013.07.019

Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leiboweitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*, *129*(3), 418–425. doi:10.1542/peds.2011-0907

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, *16*(4), 499–516. doi:10.1177/1359104510378303

Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on "A critical commentary on follow-up studies and "desistence" theories about transgender and gender non-conforming children.". *International Journal of Transgenderism*, *19*(2), 225–230. doi:10.1080/15532739.2018.1468292

Steensma, T. D., McGuire, J. K., Kreukels, B. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(6), 582–590. doi:10.1016/j.jaac.2013.03.016

Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., … Luong-Tran, C. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior*, *43*(8), 1525–1533. doi:10.1007/s10508-014-0285-3

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., … Pleak, R. R. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child & Adolescent Psychology*, 1–11. doi:10.1080/15374416.2016.1228462

Tebbe, E. A., & Moradi, B. (2016). Suicide risk in trans populations: An application of minority stress theory. *Journal of Counseling Psychology*, *63*(5), 520–533. doi:10.1037/cou0000152

VanderLaan, D. P., Santarossa, A., Nabbijohn, A. N., Wood, H., Owen-Anderson, A., & Zucker, K. J. (2017). Separation anxiety among birth-assigned male children in a specialty gender identity service. *European Child & Adolescent Psychiatry.* doi:10.1007/s00787-017-1018-7

Wallien, M. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*, 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Zucker, K. J. (2008). Children with gender identity disorder: Is there a best practice? *Neuropsychiatrie De l'Enfance Et De l'Adolescence*, *56*(6), 358–364. doi:10.1016/j.neurenf.2008.05.010