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Parental Perceptions of Emotional and Behavioral Difficulties Among Prepubertal Gender-Nonconforming Children

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Abstract

The purpose of this study was to better understand parents' perceptions of how, if at all, their transgender and gender-nonconforming (TGNC) children exhibited common childhood emotional and behavioral concerns in relation to gender nonconformity/gender dysphoria (GD), and to identify ways in which evidence-based interventions (EBI) targeting emotional and behavioral concerns could be adapted to best serve TGNC children. Qualitative data were gathered from a targeted focus group activity with 40 parents (25 mothers, 15 fathers) of 24 TGNC children ages 4–11 years old. Parents of TGNC children described how 4 prespecified domains of emotional and behavioral problems (i.e., oppositional behavior, anger, sadness, and fears/worries) are *characterized* in the context of gender-nonconformity/GD. Parents also identified *precipitants* of these problems. Overall study findings indicate there is a role for EBI adaptation as parents identified many different examples of emotional and behavioral challenges emerging in unique and nuanced ways in TGNC children.

Keywords

gender-nonconforming children; transgender children; gender diverse children; qualitative research; focus group

Transgender and gender-nonconforming (TGNC) youth have diverse gender identities or expressions that do not conform to culturally defined norms associated with their assigned

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sex at birth (Adelson, 2012, & the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI)). Many, but not all, TGNC youth experience gender dysphoria (GD), the distress due to incongruence between assigned sex at birth and their sense of self as male, female, or an alternate gender (American Psychiatric Association, 2013). Increasing awareness of gender diversity, coupled with shifting paradigms away from pathologizing transgender individuals (Drescher, 2010) toward affirming their identities (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Hidalgo et al., 2013), may contribute to growing numbers of TGNC youth seeking care in the United States (D. Chen et al., 2016; M. Chen, Fuqua, & Eugster, 2016) and abroad (Wood et al., 2013).

Multiple guidelines outline clinical management of TGNC adolescents (Coleman et al., 2012; Hembree et al., 2009). However, there is no consensus on a clinical approach to care for prepubertal TGNC children beyond general agreement that attempts to actively steer a child's gender identity/expression toward conformity with assigned sex at birth is neither clinically sound nor ethical. There is also little understanding of the nature of psychopathology among TGNC children, which tends to be conceptualized in one of two primary ways: (1) Gender nonconformity/GD is unrelated to co-occurring psychiatric symptoms (vs. secondary to co-occurring psychopathology; Ristori & Steensma, 2016); and (2) co-occurring psychiatric symptoms (e.g., depression, anxiety, oppositionality) emerge secondary to gender nonconformity/GD due to invalidating social and cultural responses to the child's gender identity or expression (e.g., restrictions on gender expression, bullying; Hidalgo et al., 2013).

Scientific evidence documenting health and well-being in TGNC children is sparse, but historically, studies suggest they may be at risk for psychopathology. One Dutch study found that 52% of prepubertal children with *DSM-IV* gender identity disorder ($N = 120$) met criteria for at least one additional psychiatric condition, with 37% and 23% meeting criteria for internalizing and externalizing disorders, respectively (Wallien, Swaab, & Cohen-Kettenis, 2007). Additional studies comparing Dutch and Canadian children found that 26% to 44% of 4- to 5-year-old TGNC children ($N = 158$) and about 62% of 6- to 11-year-old TGNC children ($N = 308$) experienced total problem behaviors at the clinical range, per parent report (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003). Based on teacher report, 32.7% of TGNC children under the age of 12 years ($N = 554$) experienced total problem behaviors in the clinical range (Steensma et al., 2014).

More recent studies suggest that psychopathology may not be as common among transgender children living in their affirmed gender role. Two studies (Durwood, McLaughlin, & Olson, 2017; Olson, Durwood, DeMeules, & McLaughlin, 2016) examined psychopathology in transgender children who identify as the gender "opposite" of that implied by their assigned sex at birth and have "socially transitioned" to living in their affirmed gender. Compared to age- and gender-matched controls and their own cisgender siblings, transgender children did not differ on parent-reported depression and had only marginally higher anxiety symptoms that fell below the preclinical range (Olson et al., 2016). Based on self-report, transgender children also did not differ from control groups or from national averages on measures of depression or anxiety (Durwood et al., 2017). These recent, positive findings regarding the emotional health and well-being of a subset of TGNC

children encourage investigation into ways in which outcomes for more TGNC children can be improved.

A better understanding of the nature of common childhood emotional and behavioral concerns among TGNC children has implications for treatment planning. Existing efficacious treatments have been developed for the general population of children experiencing internalizing and externalizing disorders. Cognitive-behavioral therapy (CBT) for anxiety (O’Neil, Brodman, Cohen, Edmunds, & Kendall, 2012) and depression (Curry, 2001) focus on helping youth understand the relationship between their thoughts, emotions, and behaviors, evaluate whether dysfunctional thought patterns are exacerbating symptoms, and if so, engage in cognitive restructuring to reframe their thoughts in a more accurate way. Specific to CBT for anxiety, exposure to anxiety-provoking stimuli are a crucial component of treatment. Psychosocial treatments for conditions characterized by anger, oppositionality, and attentional concerns share components of parent management training (Webster-Stratton, 2005) and problem-solving skills training (Lochman, Wells, & Lenhart, 2008), whereby parents are provided instruction on altering negative parent-child interaction patterns while children are taught to define interpersonal problems, identify and evaluate alternative solutions, and implement the “best” solution.

The validity and effectiveness of these treatment approaches with TGNC children is unclear (Byrne et al., 2012). Understanding the nature of emotional and behavioral problems in this population is necessary to determine whether evidence-based interventions (EBI) are appropriate for TGNC children for whom environmental stressors (e.g., family rejection, transphobia) may directly precipitate symptomatology. For instance, existing EBI may not be appropriately tailored to meet the specific needs of TGNC children, like accounting for the ways in which symptoms develop or manifest. To address this gap, we conducted a series of focus groups (FGs) with parents of ethnically diverse prepubertal TGNC children. We aimed to understand parental perceptions of childhood emotional and behavioral concerns in relation to gender-nonconformity/GD, in an effort to identify whether EBI need to be adapted to best serve these children.

Method

Participants

Between July 2015 and March 2016, clinicians introduced a mixed-methods research study to parents of prepubertal TGNC children presenting for care to a subspecialty gender clinic in a pediatric hospital in the Midwestern U.S. They were told that the study aimed to better understand the clinical needs of prepubertal TGNC children and their families. Parents were also told that participation would include two study visits—one comprising a diagnostic interview and several measures related to child and parent psychosocial functioning and a second consisting of a focus group with other parents of TGNC children. Parents interested in more information gave permission to be contacted by phone by the research team to assess eligibility (i.e., English fluency, child in Tanner stage 1 pubertal development) and secure enrollment. The study was approved by the hospital’s institutional review board, and parents provided written consent prior to participation.

The research team called the parents of the 38 TGNC children expressing interest in the study. Two parents were not interested after learning more about the study protocol, four did not respond to phone calls to determine eligibility, and two were unable to be scheduled. Thus, we enrolled parents of 30 prepubertal TGNC children. Data for this study were gathered from a targeted FG activity conducted from December 2015 to March 2016. Forty parents of 24 TGNC children ages 4–11 years (see Table 1 for demographics) each attended one of five scheduled FGs. Parents of the remaining 6 TGNC children completed the first study visit, but were unable to attend a scheduled FG. Children varied by assigned sex at birth and degree of social gender transition, with the following resulting characteristics: (1) 7 gender-nonconforming boys (i.e., assigned males living as male), (2) 2 gender-nonconforming girls (i.e., assigned females living as female), (3) 8 transgender girls (i.e., assigned males living as female), and (4) 7 transgender boys (i.e., assigned females living as male). See Table 2 for child diagnostic characteristics.

Targeted Focus Group Activity

All FGs were co-facilitated by two licensed clinical psychologists with expertise in transgender health and qualitative data collection (DC, an Asian American cisgender female, and MAH, a Latino cisgender male) who followed a scripted protocol (see supplemental materials for FG guide). Each FG was 2 hours, involved 6–12 participants, and consisted of three segments: (1) discussion about unique experiences parenting a TGNC child, (2) a targeted “free listing” activity asking parents’ opinions about common challenges that arise in TGNC children and what has challenged them as a parent of a TGNC child, and (3) discussion about programing to address challenges faced by TGNC children and their parents.

The current study is based on data obtained from the segment two targeted FG activity. Prior to data collection, we utilized the *DSM-5* to identify features of the most common emotional/behavioral problems experienced by prepubertal children in general: (1) oppositional behavior, (2) anger, (3) inattention, (4) sadness, and (5) fears/worries. Parents provided written responses regarding the ways in which their child’s gender nonconformity/GD appeared related to these five problem areas. To elicit responses to each problem area, we employed a “free listing” activity (Bernard, 1995; Colucci, 2007). Parents commented on sheets of newsprint hung around the room, each titled with a different problem area. Comments were in response to the following probe: How, if at all, is this problem area related to your child’s gender nonconformity? Parents worked independently. We assigned each participant a uniquely colored marker to match written data with each participant during analysis. Those presenting with a co-parent were intentionally assigned to start at newsprint located across the room from one another. Participants rotated in a clockwise fashion in 3-minute intervals until every participant had completed all sheets. We then provided the group with 5 minutes to review all sheets and add additional comments.

Qualitative Data Analysis

We utilized a directed approach to content analysis (Hsieh & Shannon, 2005), the goal of which is to expand understanding of an existing phenomenon (i.e., common childhood emotional/behavioral problems) to an understudied population where these phenomena are

less understood (i.e., prepubertal TGNC children). This approach was consistent with a primary aim of our study: to explore how, if at all, parents reported that their TGNC children exhibited common childhood emotional and behavioral problems in relation to gender nonconformity/GD. Parental responses within each domain were analyzed to identify any resulting themes. We employed a multiphasic, interrater coding process to establish reliability by combining pair and small group analysis with an external reviewer who possessed subject matter expertise (Miles & Huberman, 1994). The first two authors served as primary analysts. First, each analyst coded the FG data independently to identify themes within each domain. Once completed, to reduce independent rater bias, primary analysts met to establish consensus and resolve discrepancies. Once interrater consensus was established, and as an additional method of reducing bias, the coding pair established theoretical consistency by repeating the consensus-building process for data obtained in the first two FGs with the external coder who provided feedback.

Using Dedoose software (SocioCultural Research Consultants, Los Angeles, CA) we conducted comparative (i.e., cross-case) analyses according to differences by parent race/ethnicity, by gender, and by parent gender versus child sex (Miles & Huberman, 1994). True to the iterative nature of qualitative inquiry, we repeated our analytic phases until all available data were coded at least once and until novel codes no longer emerged from our data analysis (i.e., saturation). No unresolved coding discrepancies emerged throughout our analysis.

Results

Parents of TGNC children described how four prespecified domains of emotional/behavioral problems appeared related to gender nonconformity/GD, including oppositional behavior, anger, sadness, and fears/worries. We identified two ways in which parents described these problems—some provided a *characterization* of these problems while others provided potential *precipitants* of these problems. Results were organized according to the four domains of problem areas, with parents' characterizations of problems and their perceived precipitants highlighted when present. We have included any relevant cross-case analysis within each section (see Table 3 for themes, subthemes, and application frequencies). Of note, while we did query about ways in which a child's problems with attention appear related to gender identity or expression, parental responses reflected problems related to motivation and interest rather than difficulties in attention and concentration. Thus, these findings are not elaborated further.

Characterizations and Precipitants of Oppositional Behavior

Half of the participants reported that their children exhibited oppositionality related to gender nonconformity, and they characterized these behaviors and highlighted perceived precipitants. Oppositionality was characterized in two ways: (1) "taking advantage" of parental guilt to get something for themselves or to get out of trouble, and (2) attempting to assert dominance in situations in which they perceived having little control. With respect to the first theme, two parents shared difficulty disciplining their children due to guilt related to gender ("I ... let him get away with things ... because of challenges he may face"—S116a,

mother of year-old gender-nonconforming boy; and “[He] takes advantage of my guilt about his experience, knows I won’t say ‘no’ to some things”—S103a, mother of 8-year-old transgender boy). Illustrative of the second theme, a single parent viewed oppositional behavior as an attempt to assert control (“I feel like this is my child trying to control his environment because there are so many things he cannot control”—S105a, mother of 11-year-old transgender boy).

Parents highlighted two ways in which oppositionality was precipitated: (1) in response to parents’ restrictions on gender expression, and (2) in response to requests made by one parent more than another. Ten parents noted oppositionality secondary to parents’ attempts to either limit-set around their child’s gender expression (“Refusing to go to school after coming out ... [she] wanted to wear clothing of affirmed gender, we said to hold off”—S109a, mother of year-old transgender girl) or when encouraging gender-conforming behaviors (“[She] does get a little frustrated with me when I try to get her to go in a more feminine way with toys”—S129a, mother of 6-year-old gender-nonconforming girl). In our cross-case analyses, parents of both transgender and gender-nonconforming children reported that their children’s views of them as authority figures seemed to vary based on their own gender as parents: “He only follows directions when dad gives them. I feel like he only respects male authority” (S104a, mother of 6-year-old transgender boy). A father reported the opposite about his gender-nonconforming son: “Child seems ... to second guess what I say rather than mom” (S101b, father of 6-year-old gender-nonconforming boy).

Characterizations and Precipitants of Anger

The majority of participants reported that their children exhibited anger related to gender expression and social aspects of gender transition. Characterizations and precipitants of anger were described in five ways: (1) anger directed toward parent, (2) anger disproportionate to situation, (3) quick to anger, (4) suppressed anger, and; (5) anger outbursts/tantrums. Characteristic of the first subtheme, five parents identified examples of anger directed toward them: “Anger when I called into the boys’ bathroom in the airport and sent someone in to check on him” (S111a, mother of 6-year-old transgender boy). Five parents also reported disproportionate anger in situations related to gender expression: “... when he gets angry it’s heightened for what the issue is. It is often gender-related e.g., can’t find an outfit he wanted; doesn’t like new haircut on school picture day. Rages” (S108a, mother of 9-year-old transgender boy). In addition, nine parents noted their children were quick to anger: “Child doesn’t have patience with others who even question them ...” (S101a, mother of 6-year-old gender-nonconforming boy). Four parents observed suppressed anger characterized as “Post-transition—anger every day at school after being mis-gendered by classmates at recess/on bus ... or being bullied ...” (S109a, mother of 7-year-old transgender girl).

Last, 12 parents observed anger outbursts/tantrums precipitated by a child’s desire to express gender role behavior consistent with an affirmed gender (“Outbursts ... are frequent, especially if he can’t find his ‘boy gloves’ or something he associates as masculine ...”—S131a, mother of 4-year-old transgender boy), or in response to limits set around gender expression (“We only tell him ‘no’ if a dress isn’t appropriate for a girl also, but he still gets

angry”—S115a, mother of 6-year-old gender-nonconforming boy). Observed anger also was precipitated by being “misgendered” either in social situations: “[Angry] when someone doesn’t call him ‘he’” (S111a, mother of 6-year-old transgender boy); or in the context of legal documentation; “Anger that gender is on the passport” (S111a, mother of 6-year-old transgender boy).

Precipitants of Sadness

Half the participants reported that their children exhibited sadness related to gender nonconformity. While participants did not describe specific features characterizing sadness (e.g., crying easily, anhedonia), parents did highlight four precipitants of sadness: (1) body-related sadness, (2) non-acceptance, (3) peer exclusion, and (4) restrictions on gender expression. Nine parents referenced body-related sadness such as “Sadness about not having a male body, not being able to have biological children as a male ...” (S103a, mother of 8-year-old transgender boy). Thirteen parents identified sadness related to perceived non-acceptance by family members and peers: “Sometimes [he has asked] ‘remember that time you put me in a dress?’—the memory alone causes hurt feelings” (S131a, mother of 4-year-old transgender boy); and “Very sad when feeling rejected or not accepted by peers” (S105a, mother of 11-year-old transgender boy). Eleven parents noted sadness due to peer exclusion: “Sad when others don’t want to play ‘girl’ games with him” (S115a, mother of 6-year-old gender-nonconforming boy). Another common subtheme referenced by six parents was sadness in response to restrictions on gender expression: “When a situation comes up such as when he was going to be a ring bearer at a wedding and had to wear a tux instead of a dress” (S115b, father of 6-year-old gender-nonconforming boy).

Characterizations and Precipitants of Fears and Worries

Almost all participants reported that their children exhibited fears and worries related to gender nonconformity/GD. Characterizations and precipitants of fears/worries were described in six ways: (1) anatomic concerns, (2) non-acceptance, (3) fear of victimization, (4) anticipating failure at romantic relationships, (5) not being authentically their affirmed gender, and (6) future gender transition-related medical interventions. The majority of excerpts, identified by 33 parents, were related to children’s anatomic concerns, with 8 referencing desired future body parts (“Asks if/when she’ll get breasts”—S113a, mother of 5-year-old transgender girl), and 9 referencing undesired body parts (“Will likely be horrified by getting a period. Doesn’t want breasts”—S108b, father of 9-year-old transgender boy). Eight parents reported their children tried to hide their bodies: “He has said his penis ‘is a secret’” (S121a, mother of 4-year-old gender-nonconforming boy). — Eight parents noted concerns related to future pregnancy—both desires for pregnancy (“Has pretended he has a pregnant tummy”—S116a, mother of 6-year-old gender-nonconforming boy) and desires to never to carry a child (“Does not want a ‘baby in his body’”—S111a, mother of 6-year-old transgender boy). Six parents identified body parts that their child does not currently want (“Has tried to fold her penis to flatten”—S130a, mother of 5-year-old transgender girl). In one case, these concerns contributed to physical health ailments (“Genital infection because she tries to ignore her penis”—S120a, mother of 8-year-old transgender girl).

Sixteen parents reported child fears of social non-acceptance: “[Child] is worried sometimes that people will make fun of her for being different” (S117a, mother of 6-year-old transgender girl). Parents also identified fears of victimization: “Fears that people will hurt him physically” (S103a, mother of 8-year-old transgender boy), and anticipated failure at romantic relationships: “Fears that no one will want to date or marry him” (S103a, mother of 8-year-old transgender boy). Three parents identified children’s worries related to gender authenticity (“Fears that he’s not a ‘real boy’, not ENOUGH of a boy”—S104a, mother of a 6-year-old transgender boy), and one parent identified their child’s fear related to future medical interventions (“Fear of blood/needles. Worried about hormone blockers if needles are only delivery method”—S108a, mother of 9-year-old transgender boy).

Discussion

The purpose of this qualitative study was to elicit parental perceptions of how their TGNC children exhibited common childhood emotional and behavioral problems in relation to gender nonconformity/GD to inform ways in which EBI can be adapted to target these problems in TGNC children. As previously discussed, psychopathology in TGNC youth is thought to either be unrelated to gender identity or gender expression, or emerge secondary to gender nonconformity/gender dysphoria (GD) due to invalidating environmental responses to a child’s gender identity/expression. In terms of the first scenario, distinct EBI targeting psychiatric symptoms should be delivered without necessarily warranting significant adaptation of existing EBI. In the second scenario, however, adapting EBI to address symptoms of depression, anxiety, oppositional behavior, and anger by taking into account the unique and nuanced social experience of TGNC children would be an important first step. This approach would help ensure care is both evidence-based and gender-affirmative.

Our findings suggest that there is a role for adaption of EBI to better address challenging behaviors related to oppositionality, anger, sadness, and fear/worries among TGNC children, which accounts for nuances in how these problems are characterized and precipitated. For instance, interventions targeting anger coping (Lochman et al., 2008) could be adapted to include gender non-acceptance triggers (e.g., teasing around gender expression) in content related to anger management and problem-solving skills development. Additionally, any adaptation of parent management training (Webster-Stratton, 2005) may need to consider our findings of oppositional behavior arising from differences in perceived authority based on parent gender. Cognitive-behavioral treatments addressing fears/worries (O’Neil et al., 2012) can be adapted to specifically target worries about victimization, future romantic relationships, future medical interventions, gender authenticity, and non-acceptance. However, an important nuance to consider in adapting EBI is that while many of these interventions hinge on inaccurate, maladaptive cognitive patterns precipitating symptomatology among non-TGNC youth, among TGNC youth, sadness and fear often arise in response to very real, invalidating social experiences tied to gender minority status (e.g., bullying; transphobia). Thus, it may be important to integrate components of mindfulness and acceptance strategies (Hayes & Lillis, 2014) into adapted treatments.

Important to note, a similar subtheme related to precipitants of problem behavior emerged within the domains of oppositionality, anger, and sadness. Specifically, attempted restrictions on gender expression or gender identity precipitated observed oppositional behavior, anger, and sadness in TGNC children. This finding speaks to the potential therapeutic value of developmentally informed gender-affirmative care (Edwards-Leeper et al., 2016; Hidalgo et al., 2013) that would encourage active exploration of gender identity and support children in expressing gender openly. In addition, considering social gender transition *as intervention* among TGNC children with GD who are insistent, consistent, and persistent in asserting a noncisgender identity *and* for whom observed oppositionality, anger, and sadness appears exclusively related to gender nonconformity/GD may be warranted. In fact, about one third of parents in our study spontaneously noted that observed emotional and behavioral concerns dissipated once their children were supported to transition socially and live in their affirmed gender. Multiple parents commented that “since transition, [I have] a totally different child.” This finding is consistent with other studies documenting positive behavioral and emotional outcomes following social gender transition (Kavalanka, Weiner, & Mahan, 2014; Sunspace, Robichaud, & Dumais-Michaud, 2015).

Last, our findings underscore a need to incorporate modules addressing body-related concerns into any treatment developed for prepubertal TGNC children and their parents. Indeed, worries related to anatomic concerns were cited by almost every parent in our study. As TGNC children are presenting for care at younger ages, clinical providers have an opportunity to work with parents to provide age-appropriate education about sexual anatomy and reproductive health. For children who strongly express the desire to be a parent in the future, parents should be encouraged to discuss alternatives to biological parenthood (e.g., adoption). TGNC children with GD, particularly those approaching puberty, may benefit from developmentally appropriate education about medical interventions they may pursue when eligible, which could prevent the development of undesired secondary sex characteristics or induce desired body changes (Simons, Leibowitz, & Hidalgo, 2014). Incorporating education about nonmedical devices such as stand-to-pee devices and chest binders that may reduce anxiety and improve confidence in some children also may be helpful.

Limitations

The findings of this study must be considered within the context of its methodological limitations. All participants were recruited from the same clinic, which was a gender-affirming multidisciplinary subspecialty program, representing a potential source of bias and thus limiting generalizability. Parents of TGNC children who are not actively seeking care may have differing perspectives regarding their children’s emotional and behavioral functioning than the parents in our study. For instance, parents not actively seeking care may have children who are not exhibiting any behaviors interpreted as “problematic.” Alternatively, parents who avoid seeking care at a gender-affirming program may be actively rejecting their children’s gender identity or expression, and thus, we might expect even more significant emotional and behavioral concerns than those observed in our study. In addition, the overall study design was primarily quantitative, thus limiting aspects of the qualitative methodological approach. For instance, directed content analysis was conducted after all

data were collected, which did not allow for credibility checking (i.e., “member checking”) of emerging themes with parents of TGNC children during the data collection period. Also, we did not use purposive sampling in this study; however, the resulting sample was representative across a range of important variables, such as child sex assigned at birth, degree of social gender transition, and racial/ethnic identity. Furthermore, in the “free listing” method employed here, the content of participants’ written responses may have been influenced by the responses of those written before them. We attempted to reduce this limitation by requesting that, once all participants had interfaced with each sheet at least once, they review and comment on shared or divergent views expressed on the sheets. Last, we did not conduct a debrief following the free listing activity to further elaborate on parental responses, due to time constraints and the broader goals of the FG. Thus, the richness of understanding is somewhat limited.

Conclusion and Future Directions

Overall, the findings from this study indicate that there is a role for EBI adaptation targeting TGNC children. Parents of prepubertal TGNC children identified many different examples of common emotional and behavioral challenges in childhood emerging in nuanced ways in their children. Accounting for the unique experiences of TGNC children when designing and delivering interventions targeting oppositionality, anger, sadness, and fear/worries will be an important step in expanding gender-affirmative care for this population beyond social gender transition alone. A strength of the current study is obtaining input directly from parents of prepubertal TGNC children regarding their perceived concerns of their children’s emotional and behavioral functioning. In the absence of professional consensus regarding approach to care for this vulnerable population, identifying parents’ clinical concerns and developing treatments that are responsive to those concerns are most likely to yield interest, engagement, and efficacy.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Demographic Characteristics of Parents and Their TGNC Children

Demographics	Parents (<i>N</i> = 40)	Children (<i>N</i> = 24)
Age in years, <i>M</i> (<i>SD</i>)	41.92 (5.94)	6.83 (1.99)
Assigned sex at birth, <i>n</i> (%)		
Female	25 (62.5)	9 (37.5)
Male	15 (37.5)	15 (62.5)
Socially transitioned, <i>n</i> (%)	—	15 (62.5)
Race/Ethnicity, <i>n</i> (%)		
White	32 (80)	14 (58.33)
Black	2 (5)	2 (8.33)
Hispanic/Latino	5 (12.5)	2 (8.33)
Asian	1 (2.5)	0 (0)
Multiracial	0 (0)	6 (25)
Adopted, <i>n</i> (%)	—	4 (16.67)
Presented alone without co-parent, <i>n</i> (%)	8 (20)	—

Note. TGNC = transgender and gender-nonconforming.

Table 2

Diagnostic Characteristics of TGNC Children (N = 24)

Co-occurring conditions	Participants	
	n	%
Number of <i>DSM-5</i> diagnoses met via K-SADS semi-structured interview		
Zero	7	29.2
One	7	29.3
Two	5	20.8
Three	1	4.2
Four	3	12.5
Five	1	4.2
<i>DSM-5</i> diagnoses met via K-SADS semi-structured interview		
Major depressive disorder	1	4.2
Dysthymia	1	4.2
Unspecified depressive disorder	1	4.2
Panic disorder	1	4.2
Separation anxiety disorder	1	4.2
Social anxiety disorder	3	12.5
Specific phobia	2	8.3
Generalized anxiety disorder	3	12.5
Post-traumatic stress disorder	1	4.2
Unspecified anxiety disorder	4	16.7
Attention-deficit/hyperactivity disorder	5	20.8
Oppositional defiant disorder	3	12.5
Unspecified disruptive behavior	3	12.5
Autism spectrum disorder	1	4.2
Enuresis	2	8.3
Encopresis	1	4.2

Note. TGNC = transgender and gender-nonconforming; K-SADS = Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children.

Table 3

Themes, Sub-Themes, and Application Frequencies

Themes	Participants		Number of excerpts
	n	%	
Oppositional behavior			
Attempt to control environment	1	2.5	1
“Taking advantage” of parental guilt	2	5.0	3
Restrictions on gender expression/gender identity	10	25.0	12
Gender preference with respect to authority	3	7.5	3
Problems with anger			
Anger directed toward parent	5	12.5	5
Disproportionate anger	5	12.5	5
Quick to anger	9	22.5	10
Suppressed anger	4	10.0	4
Precipitants of anger outbursts/tantrums	12	30.0	15
Sadness			
Body-related sadness	9	22.5	11
Non-acceptance	13	32.5	18
Restrictions on gender expression	6	15.0	6
Peer exclusion	11	27.5	12
Fear/worries			
Fear of victimization	2	2.5	2
Anticipating failure at romantic relationships	2	2.5	2
Future medical intervention	1	5.0	1
Non-acceptance	16	40.0	20
Gender authenticity	3	7.5	4
Anatomic concerns	33	82.5	48