Mood, Anxiety, and Other Mental Health Concerns

9

Marijn Arnoldussen and Annelou L. C. de Vries

Introduction

When considering the mental health of transgender and gender diverse (TGD) children and adolescents, it is easy to imagine how the significant challenges of navigating this experience may be a source of stress, with resultant consequences for mental health. Although this chapter shows that indeed TGD youth may be a vulnerable population in this respect, there are clearly subgroups that function well and show few mental health difficulties. For example, pubertal adolescents who are supported by their parents, accepted by their peers, and receive medical gender affirming treatment at specialized gender clinics may function well. Prepubertal gender diverse children who grow up with a supporting environment may not show any co-occurring psychiatric condition. Nonetheless, in this chapter, we discuss the mental health difficulties that TGD children and adolescents may present with. Chapter 10 focuses on neurodevelopmental concerns. Many studies reveal concerning clinical range scores on depression scales and suicidality and parent and self-reported measures of emotional and behavioral problems that are often comparable to mental health clinic-referred populations. Though, differences exist between clinics and samples. For clinical practice, it is important to not only be aware of the mental health vulnerabilities that exist in gender diverse youth, but also understand factors related to the psychological difficulties to help build resilience. This chapter discusses the factors that have been studied, as well as clinical implications.

M. Arnoldussen · A. L. C. de Vries (✉)
Department of Child and Adolescent Psychiatry, Center of Expertise on Gender Dysphoria, Amsterdam UMC, VU University Medical Center, Amsterdam, The Netherlands
e-mail: alc.devries@amsterdamumc.nl

M. Forcier et al. (eds.), *Pediatric Gender Identity*,
https://doi.org/10.1007/978-3-030-38909-3_9

Prevalence of Mental Health Difficulties in Various Samples of TGD Youth

Historically, most studies on psychopathology and psychological functioning of TGD youth have been performed in specialized gender identity clinics and came from just a limited number of such clinics. Most of the prepubertal children coming to these clinics met the diagnostic criteria for the diagnostic category used in the DSM-III-R and DSM-IV: gender identity disorder, and most pubertal adolescents had a request for medical affirmative treatment (gender reassignment at the time). The recent increase in visibility and recognition of gender diversity in youth has been paralleled by an increase in publications on other populations: high school samples, community samples, and Internet-recruited self-identified samples. In addition, several recent publications come from newer clinics presenting their chart data of a rapidly growing number of referrals, sometimes compared with matched controls. It is clear that the variability of the samples and used methods to measure mental health limit the comparability of the results. Still, most of these studies reveal high rates of mental health problems, although some exceptions exist.

Participants in early studies on this subject were mainly gender diverse prepubertal children [1–5]. More recent studies, however, also focused on the psychological functioning of gender diverse adolescents. The results of these studies were that the prevalence rates of co-occurring mental health difficulties in gender diverse children and adolescents were higher when compared to children and adolescents from the general population. Two chart review studies that were conducted in the United Kingdom and the United States found that a significant proportion of the adolescents who were assessed at a gender clinic experienced depressive symptoms [6, 7]. Other, more recent clinical-sample-based studies reported that depression and anxiety disorders were two of the most common coexisting diagnoses in transgender and gender diverse adolescents [8–14]. A chart review study that was published in 2016 on 218 gender diverse youngsters (mean age 14 years) reported that 45.7% of the assigned males at birth (AMABs) and 39.4% of the assigned females at birth (AFABs) experienced low mood/depression and that more than 20% of these youngsters (21.0% of AMABs and 23.4% of the AFABs) showed symptoms of anxiety [9]. A more recent chart review study on 1082 referred adolescents who identified as transgender or gender diverse matched with 21,317 cisgender enrollees (mean age unknown, age range 10–17 years) revealed that depressive disorders were found in 48.5% of the AMABs and 61.5% of the AFABs and that anxiety disorders were found in 37.2% of the AMABs and 38.9% of the AFABs. Both disorders occurred about five times more often among TGD adolescents compared with their matched cisgender peers [11]. Finally, a chart review study of 180 adolescents who identified as transgender and 180 matched cisgender-referred controls (mean age 19.6 years) reported that transgender youth had a twofold to threefold increased risk of depression and anxiety disorders [14]. Besides clinical sample-based studies that retrieved data regarding mental health directly from the subject's file, there are also studies that measured the psychological functioning and occurring related difficulties of gender diverse adolescents through respondent-based psychiatric

interviews or psychological questionnaires [15–17]. De Vries et al. examined coexisting related difficulties in 105 TGD adolescents (mean age 14.6 years) who were referred to a gender identity clinic through the Diagnostic Interview Schedule for Children (DISC), a respondent-based psychiatric interview assessing all common DSM-IV Axis I mental disorders in children and adolescents [15, 18]. It was found that the majority (67.6%) of the 105 referred adolescents had no concurrent psychiatric disorder, while 32.4% had at least one and 15.2% had two or more comorbid diagnoses. Disorders that were the most common were social anxiety disorder (9.5%), major depression (8.6%), oppositional defiant disorder (8.6%), and specific phobia (7.6%). Anxiety disorders were the most common in the referred adolescents (21%), followed by mood disorders (12.4%) and disruptive disorders (11.4%). These relatively low percentages of psychiatric conditions compared to some other clinic samples were explained by the authors by the fact that the studied sample may be a selected sample supported by parents and growing up in an accepting (Dutch) environment [15].

The above studies used different measurements to examine coexisting related difficulties. However, since some of the studies used similar measures, cross-clinic comparisons can be made. For example, three studies that were performed in gender identity clinics in Los Angeles, Toronto, and Amsterdam used the Beck Depression Inventory II to measure whether there were depressive symptoms in the participating adolescents [16, 17, 19, 20]. A study that aimed to describe the baseline characteristics of gender diverse adolescents (mean age 19.2 years) seeking care at a transgender youth clinic in Los Angeles found that 24% of the sample had Beck depression scores in the mild-to-moderate depression range and 11% had scores in the severe-extreme depression range [16]. Another study on 203 gender diverse adolescents (mean age 16.3 years) who were assessed in a transgender youth clinic in Toronto found that 41.6% of the AFABs and 34.4% of the AMABs had Beck depression scores in the severe-extreme depression range [17]. On the other hand, a Dutch follow-up study of 70 adolescents (mean age 16.6 years) who received puberty suppression reported that the mean baseline Beck depression score of the adolescents was below the clinical range [19]. These lower rates of depression might reflect that these adolescents trust that they are helped and supported by receiving puberty suppression to prevent suffering from puberty development. However, it is unclear what the reasons are for the different results between clinics; it might be due to different cultural, social, and clinical environments.

In addition to aforementioned occurring emotional difficulties among TGD adolescents, there are also studies that found that adolescents who identify as gender diverse or transgender have a higher risk of developing an eating disorder [7–9]. Three chart review studies reported prevalence rates of eating disorders in referred gender diverse adolescents ranging from 4.8% to 13.3% [7–9]. However, these results concern young people who were referred to specialized gender identity clinics, and it is unclear whether these percentages also apply to gender diverse young people in the rest of population.

Finally, up until now, only one case report of a gender diverse adolescent with psychosis has been published [21]. In this case report, Meijer et al. described a

17-year-old adolescent AFAB who was diagnosed with bipolar schizoaffective disorder and who started with hormonal treatment at age 19 after his counselors from the gender clinic and his treating psychiatrist concluded that his gender dysphoria was a possible factor in the onset of his psychotic symptoms. Although when this person was 25 years old, after a mastectomy, hysterectomy, and metoidioplasty were performed, he experienced his second and last full-blown psychotic episode, his transgender identity never changed, and it was concluded that satisfaction with the gender-affirmative therapy was high and that gender-affirmative treatment could be possible and safe in this vulnerable population.

The above results are all based on gender diverse adolescents who presented for care at gender identity clinics which means that these may be different for gender diverse adolescents in the general population who may not have similar rates of mental health difficulties. However, two large community sample-based studies on mental health of TGD youth report similar results as the aforementioned studies [22, 23]. Clark et al. found that gender diverse adolescents (mean age unknown, age range 12–18 years), compared to their cisgender peers, reported a significantly higher rate of depressive symptoms (41.3% vs. 11.8%) [22], and Veale et al. described that these youngsters (mean age unknown, age range 14–18 years) experienced significantly more emotional distress than their peers who do not experience gender incongruence [23].

The results discussed so far demonstrate that mental health difficulties occur more often in gender diverse children and adolescents compared to their cisgender peers. Nonetheless, there are two studies that showed that socially transitioned prepubertal transgender children and young transgender adolescents who are supported in their gender identity have developmentally normative levels of depression and only minimal elevations in anxiety [24, 25]. Like studies of selected clinical adolescent gender diverse samples that feel supported and trust that they will receive medical gender-affirming treatment [e.g., 15, 19], this suggests that social support and affirming transgender youth in their experienced gender identity instead of their sex assigned at birth may lead to better, or even normative, mental health outcomes.

A specific mental health concern in adult transgender individuals is the alarming reported high rates of suicide attempts [26]. There are also various studies that have focused on self-harm and suicidality in transgender and gender diverse children and adolescents. There is one clinical sample-based study in which exclusively prepubertal children (mean age unknown, age range 3–12 years) participated [27]. This study found that, by parent report, TGD children show an increased rate of self-harm/suicidality as they get older. Most of the studies in which adolescents participated are clinical sample based, and despite the fact that their methods differ greatly, their results are quite similar indicating that self-harm and suicidality are more common among TGD youth in comparison with their cisgender peers [7–11, 13, 14, 16, 17, 28–31]. An American study that was published in 2007 revealed that nearly half of the 55 participants (mean age 17.5 years), who were recruited at two community centers providing services to LGBTQ+ youth in New York City, reported serious thoughts about attempting suicide and one quarter reported a

history of suicide attempts [28]. A chart study on 125 adolescents who were seeking medical care at a gender identity clinic in London (mean age 13.6 years) that was published a few years later reported that 14% of the participants had thoughts of inflicting self-injury, 24% of the participants inflicted self-injury, and 10% of the participants made a suicide attempt before they were referred to the gender identity clinic [29]. When comparing AMABs with AFABs, it was found that the number of suicide attempts did not differ but that thoughts of inflicting self-injury were more common in AMABs and that inflicting self-injury was more common in AFABs. In one of the most recent retrospective chart review studies (mean age 17.1 years), in which a psychosocial assessment administered by medicine physicians was used to measure the prevalence of self-harm and suicidality among the participants, findings were that 41.8% of the adolescents who identified as transgender self-harmed and that 30.3% of these adolescents made at least one suicide attempt [30]. It was also found that compared to AMABs, AFABs more frequently reported a history of suicide attempts and self-harming.

The results of the aforementioned studies on suicidality and self-harm are all based on gender identity clinic-referred adolescents and, therefore, may not be representative of the young gender diverse population as a whole. However, there are only a few population-based studies on self-harm and suicidality among TGD adolescents [22, 23, 32]. One of these studies, utilizing data collected through a survey that was held among New Zealand secondary school students in 2012 (mean age unknown, age range 12–18 years), reported that 45.5% of the students who identified as transgender self-harmed in the past 12 months and that 19.8% of the these students attempted suicide in the past [22]. In another study that was based on data derived from American high school students (mean age 15.4 years) who participated in a survey between 2013 and 2015, findings were that the prevalence of past 12-month self-reported suicidal ideation was nearly twice as high for gender diverse youth compared with nontransgender youth [32]. The study also reported that depressive symptoms and school-based victimization were both significantly associated with a higher risk of developing suicidal ideation among gender diverse adolescents. From the above, it can be concluded that self-harm and suicidality are of significant concern also for young transgender and gender diverse people and require the clinicians' full attention during the counseling of young gender diverse people.

Factors Related to Mental Health of Gender diverse and Transgender Youth

Different factors may be related to the mental health difficulties of TGD youth. Apart from the distress of their gender dysphoria, one important hypothesis is that these problems are related to minority stress. That is, the increased distress stemming from prejudice and rejection first observed in lesbian, gay, and bisexual minorities compared to heterosexual individuals [33]. Community sample studies show that youth who are gender diverse and have a gender different from their sex

assigned at birth may experience *gender minority* stress; compared to cisgender youth, the higher rates of bullying (up to 80%), harassment, and peer victimization mediate the higher odds of substance use, psychological distress, low life satisfaction, depression, suicidal ideation, and self-harm [14, 34–39]. In a longitudinal study following a sample of middle-school age children over time, children who appraised themselves as gender nonconforming and also felt pressure to conform to gender norms were most likely to have internalizing problems [40]. Programs that increase acceptance and tolerance and help gender diverse youth to come out in schools improve the well-being of transgender youth [41].

In clinic-referred TGD youth, poor peer relation is one of the strongest investigated predictors for behavioral and emotional problems. Although not a direct measure of victimization, these studies define poor peer relations by positive answers to parent-rated [42], teacher-rated [43], or self-rated [44] items like "Doesn't get along with other kids," "Gets teased a lot," and "Not liked by other kids." In three such studies, a direct comparison was made between youth referred to a Canadian and a Dutch gender identity clinic. Parents, teachers, and youth reported significantly more behavioral and emotional problems in the Canadian compared to the Dutch youth [2, 45, 46]. In all three studies, poor peer relations fully explained the differences in emotional and behavior problems across the two clinics [45, 46]. A more recent study on psychological functioning and peer relationship problems in adolescents across four European specialist gender services (The Netherlands, Belgium, the United Kingdom, and Switzerland) found differences across Europe. Overall, emotional and behavioral problems and peer relationship problems occurred most in adolescents from the United Kingdom, followed by Switzerland and Belgium. Adolescents from the Netherlands showed the least behavioral and emotional problems, and their peer relations were best [47]. Cross-clinic differences may, thus, reflect that in some societies there is more peer acceptance and tolerance to gender diverse youth than in others, and that accepting environments may foster superior mental health outcomes. This knowledge is important when developing programs that help to improve the worrisome psychological functioning of transgender youth.

Of course the most important support one can get should come from the direct family. Young children, in particular, are fully dependent on their parents for receiving help and acceptance regarding their gender diverse behavior. But adolescents as well are seldom able to seek affirming care without their parents' support. Despite increased tolerance in Western societies, coming out as transgender is for many youth still difficult out of fear for their parents' reaction, whether it is justified or not. Adolescents who feel that their families accept and tolerate their sexual and/or gender minority identities have better self-esteem, social support, and general health, as well as less depression and suicidal ideation [48]. In contrast, LGBT adolescents who have parents who try to change their gender-diversity or sexual orientation, either by themselves or by sending them to a religious leader, have more depression, suicidality, and less educational attainment in young adulthood [49]. Interventions that help to increase parents' acceptance are needed.

Clinical Approach

The young TGD population is a vulnerable group in which mental health difficulties occur more often than in their cisgender peers. Since these difficulties are related to gender minority stress, creating a society that accepts and understands gender diversity in youth and decreasing stigmatization around gender-diversity are of pivotal importance. Positive media attention, accepting school climates, and activities that empower LGBT youth may all be helpful in reaching that goal. For the individual gender diverse child or adolescent, however, it is crucial to identify occurring mental health difficulties in time, and when treatment is needed, refer the adolescent to a mental health clinician. When a specialized gender clinic is far from home, mental health support should preferably occur in the surroundings of where the adolescent lives. The referring clinician should keep in mind that these local health-care providers might need support in working with gender diverse adolescents from transgender specialists [50].

When medical affirming treatment is considered, it is important to recognize and observe emerging mental health difficulties, but mental health difficulties in themselves are not an absolute contraindication to starting medical interventions [51]. It has to be estimated, however, whether a decision regarding medical treatment with lifelong consequences can be deliberately considered and complied within the adolescent's particular situation. If mental health difficulties interfere with a proper assessment of the feelings of gender dysphoria or if they impede a gender-affirmative treatment, specialized mental health care might be needed prior to the start of medical interventions.

In addition to mental health problems, other factors also play a part in deciding whether or not to start with gender-affirmative treatment. These factors include the capability to conform to a medical trajectory and the decision-making capacity of the adolescent. The decision-making capacity refers to one's ability to utilize information about treatment options and to make a choice that is in line with one's own values and preferences [52]. The decision-making capacity can vary per adolescent and per situation, and it is therefore essential to be estimated on a case-by-case basis.

Another factor that influences the decision regarding medical treatment is whether the adolescent is supported by their social environment. Some families experience a lot of stress because of the gender diversity and the desire for gender-affirmative treatment of the adolescent. One of the problems that might arise, for example, is when parents have different views on the diagnosis or treatment of their child [50]. When this is the case, it is necessary to reach out to both parents and to emphasize the importance of support from parents and the recognition of the gender identity of their child. In the most favorable situation, both parents support the decision to start with medical interventions before the treatment actually begins. Unfortunately, however, this is not always the case. If it is in the best interest of the adolescent, sometimes, this decision should be made without the approval of one or more caregivers, while taking into account certain relevant legal and ethical guidelines [50, 53].

During the process of clinical assessment and transition, it is important to pay attention to issues such as support and social environment. Supportive therapy or counseling could help adolescents if they experience unpleasant or disappointing events during their transition [50]. Joining support groups or service-users groups could also offer empowerment to transitioning adolescents. Finally, clinicians should keep in mind that there are adolescents who have unrealistic expectations regarding their medical treatment and their transition. It is important to place these expectations in perspective so that disappointments can be avoided as much as possible [50].

Clinical Vignette

Ian is a 15-year-old, who was assigned female at birth. From a young age, Ian has known that he does not feel like a girl but like a boy. Ian socially transitioned at age 14 and has lived since then in the boy's role, but he is upset about his changing body. Ian often feels worthless and gloomy, and he is very anxious about what his peers think of him. At certain times, his mood is so bleak and he is so anxious that he does not manage to attend school. Ian does not receive treatment for his mental health difficulties.

Ian's father acknowledges the fact that his child is suffering from gender dysphoria, but he does not support Ian's identity. For example, Ian's father still refers to Ian using a female name and pronouns. Ian's father's greatest concern is the fact that Ian does not attend school. Ian and his father often argue about Ian's school absenteeism. Ian's father indicates that Ian should try harder to attend school, and Ian states that it is not that simple. Ian's mother is not involved in his care.

What could the clinician do?

It is important that the clinician establish a good relationship with Ian so that mutual trust arises.

Ian should be referred to psychiatric care for his mood and anxiety complaints. A point of attention in this treatment should be the self-image and self-acceptance of Ian. It is also important to involve Ian's teachers at school and his school psychologist in his treatment, so they become aware of Ian's situation. They can provide insight into the quality of his peer relations, and they can offer him extra support when needed. Furthermore, family counseling should be provided in which father can learn to understand the importance of parental support and the recognition of Ian's gender identity. Ian and his father can also work on developing a better relationship during this therapy. In addition, referring Ian to a support group may be considered. A support group could offer Ian recognition for his feelings and could provide empowerment. Finally, since Ian is suffering from his changing body, starting medical treatment once Ian and his father have adequate care should be considered, as discussed in Chap. 14.

Financial Support This chapter received no specific grant from any funding agency or commercial or not-for-profit sectors.

Conflict of Interest The authors declare that they have no conflict of interest.

References

1. Zucker KJ, Bradley SJ. Gender identity disorder and psychosexual problems in children and adolescents. New York: Guildford Press; 1995.
2. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. J Abnorm Child Psychol. 2003;31:41–53.
3. Wallien MS, Swaab H, Cohen-Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. J Am Acad Child Adolesc Psychiatry. 2007;46:1307–14.
4. Pleak RR, Meyer-Bahlburg HF, O'Brien JD, Bowen HA, Morganstein A. Cross-gender behavior and psychopathology in boy psychiatric outpatients. J Am Acad Child Adolesc Psychiatry. 1989;28:385–93.
5. Zucker KJ, Bradley SJ, Lowry Sullivan CB. Traits of separation anxiety in boys with gender identity disorder. J Am Acad Child Adolesc Psychiatry. 1996;35:791–8.
6. Di Ceglie D, Freedman D, McPherson S, Richardson P. Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics. Int J Transgend. 2002;6(1):97–103. http://www.symposion.com/ijt/ijtvo06no01_01.htm.
7. Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. Pediatrics. 2012;129:418–25.
8. Khatchadourian K, Amed S, Metzger DL. Clinical management of youth with gender dysphoria in Vancouver. J Pediatr. 2014;164:906–11.
9. Holt V, Skagerberg E, Dunsford M. Young people with features of gender dysphoria: demographics and associated difficulties. Clin Child Psychol Psychiatry. 2016;21:108–18.
10. Chen M, Fuqua J, Eugster EA. Characteristics of referrals for gender dysphoria over a 13-year period. J Adolesc Health. 2016;58:369–71.
11. Becerra-Culqui TA, Liu Y, Nash R, Cromwell L, Flanders WD, Getahun D, et al. Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics. 2018;141:e20173845. https://doi.org/10.1542/peds.2017-3845.
12. Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. Child Adolesc Psychiatry Ment Health. 2015;9:9.
13. Nahata L, Quinn GP, Caltabellotta NM, Tishelman AC. Mental health concerns and insurance denials among transgender adolescents. LGBT Health. 2017;4:188–93.
14. Reisner SL, Vetters R, Leclerc M, Zaslow S, Wolfrum S, Shumer D, et al. Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study. J Adolesc Health. 2015;56:274–9.
15. de Vries AL, Doreleijers TA, Steensma TD, Cohen-Kettenis PT. Psychiatric comorbidity in gender dysphoric adolescents. J Child Psychol Psychiatry. 2011;52:1195–202.
16. Olson J, Schrager SM, Belzer M, Simons LK, Clark LF. Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. J Adolesc Health. 2015;57:374–80.
17. Chiniara LN, Bonifacio HJ, Palmert MR. Characteristics of adolescents referred to a gender clinic: are youth seen now different from those in initial reports? Horm Res Paediatr. 2018;89:434–41.
18. Ferdinand RF, van der Ende J. NIMH-DISC-IV: diagnostic interview schedule for children. Geautoriseerde Nederlandse vertaling; 2000.
19. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011;8:2276–83.
20. Beck AT, Steer RA, Ball R, Ranieri W. Comparison of beck depression inventories -IA and -II in psychiatric outpatients. J Pers Assess. 1996;67:588–97.

21. Meijer JH, Eeckhout GM, van Vlerken RH, de Vries AL. Gender dysphoria and co-existing psychosis: review and four case examples of successful gender affirmative treatment. LGBT Health. 2017;4:106–14.
22. Clark TC, Lucassen MF, Bullen P, Denny SJ, Fleming TM, Robinson EM, et al. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey. J Adolesc Health. 2014;55:93–9.
23. Veale JF, Watson RJ, Peter T, Saewyc EM. Mental health disparities among Canadian transgender youth. J Adolesc Health. 2017;60:44–9.
24. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. Pediatrics. 2016;137:e20153223.
25. Durwood L, McLaughlin KA, Olson KR. Mental health and self-worth in socially transitioned transgender youth. J Am Acad Child Adolesc Psychiatry. 2017;56:116–23.
26. Marshall E, Claes L, Bouman WP, Witcomb GL, Arcelus J. Non-suicidal self-injury and suicidality in trans people: a systematic review of the literature. Int Rev Psychiatry. 2016;28:58–69.
27. Aitken M, VanderLaan DP, Wasserman L, Stjoanovski S, Zucker KJ. Self-harm and suicidality in children referred for gender dysphoria. J Am Acad Child Adolesc Psychiatry. 2016;55:513–20.
28. Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. Suicide Life Threat Behav. 2007;37:527–37.
29. Skagerberg E, Parkinson R, Carmichael P. Self-harming thoughts and behaviors in a group of children and adolescents with gender dysphoria. Int J Transgend. 2013;14:86–92.
30. Peterson CM, Matthews A, Copps-Smith E, Conard LA. Suicidality, self-harm, and body dissatisfaction in transgender adolescents and emerging adults with gender dysphoria. Suicide Life Threat Behav. 2017;47:475–82.
31. Fisher AD, Ristori J, Castellini G, Sensi C, Cassioli E, Prunas A, et al. Psychological characteristics of Italian gender dysphoric adolescents: a case-control study. J Endocrinol Invest. 2017;40:953–65.
32. Perez-Brumer A, Day JK, Russell JK, Hatzenbuehler ML. Prevalence and correlates of suicidal ideation among transgender youth in California: findings from a representative, population-based sample of high school students. J Am Acad Child Adolesc Psychiatry. 2017;56:739–46.
33. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129:674–97.
34. Grossman AH, D'Augelli AR. Transgender youth: invisible and vulnerable. J Homosex. 2006;51:111–28.
35. McGuire JK, Anderson CR, Toomey RB, Russell ST. School climate for transgender youth: a mixed method investigation of student experiences and school responses. J Youth Adolesc. 2010;39:1175–88.
36. Toomey RB, Ryan C, Diaz RM, Card NA, Russell ST. Gender-nonconforming lesbian, gay, bisexual, and transgender youth: school victimization and young adult psychosocial adjustment. Dev Psychol. 2010;46:1580–9.
37. Liu RT, Mustanski B. Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. Am J Prev Med. 2012;42:221–8.
38. Birkett M, Newcomb ME, Mustanski B. Does it get better? A longitudinal analysis of psychological distress and victimization in lesbian, gay, bisexual, transgender, and questioning youth. J Adolesc Health. 2015;56:280–5.
39. Timmins L, Rimes KA, Rahman Q. Minority stressors and psychological distress in transgender individuals. Psychol Sex Orientat Gend Divers. 2017;4:328–40.
40. Yunger JL, Carver PR, Perry DG. Does gender identity influence children's psychological well-being? Dev Psychol. 2004;40:572–82.
41. Russell ST, Toomey RB, Ryan C, Diaz RM. Being out at school: the implications for school victimization and young adult adjustment. Am J Orthopsychiatry. 2014;84:635–43.
42. Achenbach TM, Edelbrock CS. Manual for the child behavior checklist and revised child behavior profile. Burlington: University of Vermont, Department of Psychiatry; 1983.

43. Achenbach TM, Edelbrock CS. Manual for the teacher's report form and teacher version of the child behavior profile. Burlington: University of Vermont, Department of Psychiatry; 1986.
44. Achenbach TM. Manual for the youth self-report. Burlington: University of Vermont, Department of Psychiatry; 1991.
45. Steensma TD, Zucker KJ, Kreukels BP, VanderLaan DP, Wood H, Fuentes A, et al. Behavioral and emotional problems on the teacher's report form: a cross-national, cross-clinic comparative analysis of gender dysphoric children and adolescents. J Abnorm Child Psychol. 2014;42:635–47.
46. de Vries AL, Steensma TD, Cohen-Kettenis PT, VanderLaan DP, Zucker KJ. Poor peer relations predict parent- and self-reported behavioral and emotional problems of adolescents with gender dysphoria: a cross-national, cross-clinic comparative analysis. Eur Child Adolesc Psychiatry. 2016;25:579–88.
47. de Graaf NM, Cohen-Kettenis PT, Carmichael P, de Vries AL, Dhondt K, Laridaen J, et al. Psychological functioning in adolescents referred to specialist gender identity clinics across Europe: a clinical comparison study between four clinics. Eur Child Adolesc Psychiatry. 2018;27:909–19.
48. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs. 2010;23:205–13.
49. Turban JL, Beckwith N, Reisner S, Keuroghlian AS. 4.10 exposure to conversion therapy for gender identity is associated with poor adult mental health outcomes among transgender people in the US. J Am Acad Child Adolesc Psychiatry. 2018;57:S208.
50. De Vries AL, Klink D, Cohen-Kettenis PT. What the primary care pediatrician needs to know about gender incongruence and gender dysphoria in children and adolescents. Pediatr Clin North Am. 2016;63:1121–35.
51. Coleman E, Bockting W, Botzer M, Cohen-Kettenis PT, DeCuypere G, Feldman J, et al. Standards of care for the health of transsexual, transgender and gender non-conforming people, version 7. Int J Transgend. 2011;13:165–232.
52. Karlawish J. Assessment of decision-making capacity in adults 2017. https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults. Accessed 1 Dec 2018.
53. Olson KA, Middleman AB. Consent in adolescent health care 2018. https://www.uptodate.com/contents/consent-in-adolescent-health-care. Accessed 1 Dec 2018.