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Trans and Gender-Nonconforming Children and Their Caregivers: Gender Presentations, Peer Relations, and Well-Being at Baseline

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This study, involving a community-based sample of 45 predominantly white primary caregivers of 45 trans and gender-nonconforming (TGNC) children between 6 and 12 years of age, provides descriptive data on children's gender presentations, peer relations, and well-being. Most (n = 31; 69%) of the children were *cross-gender identified* (CGI). That is, 17 of 28 children assigned male at birth explicitly and consistently identified as girls, and 14 of 17 children assigned female at birth explicitly and consistently identified as boys. The 14 remaining children appeared to have nonbinary gender identities (e.g., "boy-girl") or to identify with the sex and gender they were assigned at birth but were gender-nonconforming, or their gender identities were uncertain. This subgroup was labeled *non-CGI*. Most of the children were in the normal range for internalizing (64%), externalizing (67%), and total behavior problems (62%), yet a sizable minority were in the borderline-clinical/clinical range for these symptoms. Children in the CGI group had fewer internalizing and total problems than children in the non-CGI group. Child's degree of gender conformity, caregiver's level of anxiety, and child's peer relations were correlated with children's well-being; children in the CGI group were reported to have better peer relations than children in the non-CGI group. Caregivers' rates of depression and anxiety appeared to be similar to normative samples, although anxiety may have been slightly elevated. Findings from this study add to a small but growing body of literature that documents the well-being of TGNC children growing up in supportive and affirming familial environments.

Keywords: family acceptance, gender-nonconforming, nonbinary, trans, transgender children

Trans people have garnered mainstream attention with, for example, Laverne Cox being the first openly trans person to appear on the cover of *Time* magazine (Steinmetz, 2014), the public transition of Caitlyn Jenner (*Vanity Fair*, 2015), and President Barack Obama being the first to use the word *transgender* in a State of the Union speech (Jaffe, 2015). We use *trans* to differentiate from *cisgender* (i.e., assigned female at birth and identify as a girl/woman; assigned male at birth and identify as a boy/man). *Trans* refers to all other alignments of gender identities and assigned sex at birth, including binary (e.g., female-to-male; trans-girl) and nonbinary (e.g., genderqueer, gender fluid) trans identities (Simmons & White, 2014).[1] We use *gender-nonconforming* to refer to children whose gender presentations differ substantially from what is typically expected for their gender (e.g., "pink boys"; Ehrensaft, 2016). Despite this increase in attention to trans issues, trans individuals continue to face alarming rates of discrimination and violence at the hands of family members, peers, schools, and other institutions (Haas, Rodgers, & Herman, 2014; Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). According to the 2015 National School Climate Survey, among the sample of lesbian, gay, bisexual, and trans (LGBT) youth, trans students reported the most negative experiences, with more than half report-

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[1] *Transgender* can be an inclusive term, but with children, *transgender* is often used to refer to those with binary, cross-gender identities (i.e., individuals assigned female at birth who identify as boys, and vice versa; Olson, 2016).

ing that they endured verbal harassment related to their gender expression (Kosciw et al., 2016). Several state legislatures and school districts also have tried to restrict restroom use based upon anatomy (Bosman & Rich, 2015), leaving many trans individuals with few safe or reasonable options.

In turn, many trans youth and adults appear to have an elevated risk for negative outcomes, such as depression and suicidal ideation (Grossman & D'Augelli, 2007; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Toomey, Ryan, Diaz, Card, & Russell, 2010). A study of more than 6,000 trans adults reported a lifetime suicide attempt rate of 41% (Haas et al., 2014). Cross-national, clinical studies of trans and gender-nonconforming (TGNC) children and adolescents referred for gender-related issues have reported mean scores on measures of behavior problems to be in the borderline-clinical or clinical range (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; de Vries, Steensma, Cohen-Kettenis, VanderLaan, & Zucker, 2016). More than 60% of the children (six to 11 years of age) in Cohen-Kettenis et al.'s (2003) two clinic-referred subsamples exhibited borderline-clinical or clinical-level symptoms. It is generally understood that these high rates of mental health problems reflect, and are in part a consequence of, the actual and anticipated rejection and discrimination that TGNC individuals face in almost every setting with which they interface (family, neighborhood, school, employment, etc.; Haas et al., 2014; Klein & Golub, 2016). In other words, TGNC individuals are thought to experience *minority stress* – the stress or state that results from being a part of a socially marginalized group (Brooks, 1981; Meyer, 2003)—which can have an impact on psychological health (Herman, 2013; Rood et al., 2016; Tebbe & Moradi, 2016).

Theories of social support from a stress and coping perspective propose that social support can serve as a buffer to help protect individuals from negative influences (Lakey & Cohen, 2000), including minority stress. The degree to which TGNC youth feel supported within their peer and familial relationships may influence their psychological health and adjustment (Higa et al., 2014; McConnell, Birkett, & Mustanski, 2015; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013). Trans adults who reflected on their key needs as children cited positive peer and educational environments, freedom from verbal harassment and abuse, and physical safety as salient issues (Riley, Clemson, Sitharthan, & Diamond, 2013). A cluster analysis of 232 LGBT youth (including 22 trans adolescents) revealed that those who experienced high family and peer support showed positive psychological functioning; by contrast, those who received high peer but low family support showed relatively poorer adjustment, and youth who reported low levels of peer and family support fared the worst (McConnell et al., 2015).

Beyond the role of social support more broadly, there is also evidence that specific affirmation of trans youth's gender identities may play a key role in promoting psychological adjustment (Hidalgo et al., 2013; Hill, Menvielle, Sica, & Johnson, 2010; Olson, Durwood, DeMeules, & McLaughlin, 2016). One study (Hill et al., 2010), involving parents participating in an affirmative intervention for families with TGNC children, reported children's ($N = 31$; ages 4 to 17 years) mean internalizing and externalizing scores in the normal range. A recent groundbreaking community-based study involving 73 prepubescent (ages 3 to 12 years) binary trans children, whose parents had supported their social transitions (involving nonmedical procedures, such as changing their first names, pronouns, hair, and clothing to better align with their gender identities), showed no elevations in depression compared to population and control group averages, and only marginally higher symptoms of anxiety (Olson et al., 2016). These findings are consistent with clinicians' reports that the anxiety and distress exhibited by many TGNC children dissipate after children are supported in their gender nonconformity and in their gender identities (Ehrensaft, 2011, 2012).

This growing body of evidence has led to consensus among health care professionals that interventions designed to steer a child's gender identity or expression toward what is typically expected for the child's assigned sex at birth are neither clinically sound nor ethical [Coleman et al., "World Professional Association for Transgender Health" (WPATH), 2012]. Many clinicians advocate a "gender affirmative model" (Hidalgo et al., 2013), advising parents to be supportive of their TGNC children and to follow the children's lead, as appropriate, as the children express their "true gender selves" (Ehrensaft, 2012, p. 341). In this model, "gender health is defined as a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection" (Hidalgo et al., 2013, p. 286). Caregivers, who play a powerful role in how children express gender through clothing, hair styles, and so forth, may be able to mitigate potential negative outcomes that may result from minority stress by supporting and affirming children's gender identities and expressions (Kuvalanka, Weiner, & Mahan, 2014).

Yet, parents and other caregivers who seek to support TGNC children often face resistance from extended family, school and health care professionals, and others (Kuvalanka et al., 2014; Sansfaçon, Robichaud, & Dumais-Michaud, 2015). These children are at the center of controversy with regard to how and whether parents should support their gender presentations (Olson et al., 2016). In part because of the fluidity of some children's gender identities, supporting young children's social transitions remains controversial, and "divergent views are held by health care professionals" (Coleman et al., "WPATH", 2012, p. 17). According to Olson (2016), some critics of the affirmative model are concerned that affirmation may lead to "persistence" of trans identities beyond childhood, implicitly suggesting that persistence of a trans identity is a negative outcome that should be prevented. Olson (2016) and others have argued that studies reporting low persistence rates of childhood gender dysphoria into adolescence and beyond have not distinguished between binary trans, nonbinary trans, and cisgender gender-nonconforming children. In turn, scholars such as Olson (2016) have called for researchers to distinguish between children who are insistent upon and persistent about a cross-gender (i.e., binary trans) identity, and those TGNC children who are not.

Certainly, more studies are needed to examine and track the gender identities and well-being of TGNC children, as such studies—especially those focusing on children with nonbinary gender identities (Olson, 2016)—are scarce (Institute of Medicine, 2011; Olson et al., 2016; Coleman et al., "WPATH", 2012). Understanding the experiences of TGNC children and their families over time, including their various sources of minority stress and social support, will better equip family members, educators, clinicians, and policymakers concerned with improving outcomes for TGNC youth.

The Current Study

The Trans*Kids Project, a community-based study of 49 families with TGNC children six to 12 years of age, aims to expand upon existing studies in key ways. First, the most prominent studies involving TGNC children have been clinical studies (e.g., Cohen-Kettenis et al., 2003). For our study, primary caregivers of TGNC children were recruited mainly through online parent support groups and were generally accepting and supportive of their children's gender presentations by the time of data collection, which may or may not be true of caregivers who bring their children to gender clinics (Olson et al., 2016). Second, the pioneering, community-based study by Olson and colleagues (2016) focused on a subset of trans children: those with cross-gender (i.e., binary trans) identities. Our community-based study differs in that it captures a broader range of TGNC children, including those with nonbinary identities, an understudied group (Olson, 2016). Our study also reports on the well-being of TGNC children's primary caretakers, another understudied group (Hill et al., 2010; Johnson & Benson, 2014). Thus, our study contributes to the burgeoning literature in this area and furthers understanding of the variation of experiences of this diverse population.

The current study analyzed data from the baseline phase of the Trans*Kids Project. A primary aim of the study was to provide descriptive data on children's gender presentations. These data will be used for comparison at later waves of data collection. A second aim was to establish a baseline of children's well-being. Previous studies have reported conflicting findings in regard to the emotional and psychological health of TGNC youth, with some finding high levels of psychopathology (Coates & Person, 1985; Cohen-Kettenis et al., 2003), and others not (e.g., Olson et al., 2016). We anticipated that, because of the self-reported acceptance and support of caregivers, the children in our study would be doing relatively well compared with some previous studies of TGNC youth, despite the minority stress that the children likely face in their daily lives. We also provide baseline data on the primary caregivers' well-being, given the importance of caregivers' emotional health for children's well-being. Lastly, we explore correlates of children's well-being, including children's age, degree of gender conformity, and peer relations. Thus, our research questions are:

1. What are the gender presentations of the TGNC children in our study at baseline? How many of the children appear to be cross-gender identified (i.e., binary trans)?
2. How well are the TGNC children in our study doing at baseline? How does the children's well-being compare to some previous studies' reports on TGNC children?
3. How well are our participants (i.e., primary caregivers of TGNC children) doing at baseline in regard to their levels of depression and anxiety?
4. Which, if any, of our study variables are associated with children's well-being?

Method

Data collection for the baseline assessment occurred between 2011 and 2013. Primary caregivers of TGNC children participated in telephone interviews and then completed hard copies of questionnaires. Eligibility criteria included having a "transgender or gender-variant" child between the ages of six and 12 years old to capture the experiences of caregivers with TGNC children prior to and during the transition to adolescence. Children being prepubescent was not an eligibility requirement given we had no concrete way of assessing onset of puberty; however, caregivers were asked about and did speak to the onset of puberty, and this information is shared.

Sample

Forty-nine primary caregivers (44 mothers, three fathers, two grandmothers) took part in phone interviews. All 49 were also invited to complete questionnaires, including demographics and standardized scales; 45 returned their questionnaires to the researchers. Demographic data on the 45 participants (41 mothers, two fathers, two grandmothers), all from different families, are provided in Table 1. The vast majority ($n = 43$) identified as White. Eighty percent of participants earned at least a bachelor's degree. The most common type of family structure ($n = 32$) was the child living with the same two parents from birth to the time of study enrollment. To estimate each family's social class, Hollingshead's Four Factor Index of Social Status was used, taking into account the education-level and occupations of caregivers, classifying families on a 5-point scale ranging from I (major business/professional; i.e., higher social status) to V (Unskilled laborers and menial service workers; i.e., lower social status). Following the lead of previous studies (e.g., de Vries et al., 2016), we then collapsed the ratings into three social class rankings: I, II-III, and IV-V. Most of the families fell in the first ranking: namely, business/professional (the highest social status ranking).

The average age of the 45 children [28 assigned male at birth (AMAB); 17 assigned female at birth (AFAB)] was 8.5 years ($SD = 1.8$; range = 6 to 12 years). At least 80% ($n = 36$) of the children were White (see Table 1 for detailed demographic data). Most children (80%; $n = 36$), according to participants' reports, were prepubescent. Nine of the children had reportedly begun puberty; six of the nine were taking puberty suppression medication.

Procedure

Prior to this first Wave of data collection, an advisory board was created (consisting of a parent of a trans child, a trans-affirmative clinician, an advocate for TGNC individuals, and a veteran researcher in the field of LGBT youth) and a pilot study was conducted in 2010 (see Kuvalanka et al., 2014, for more details). Approval from the first author's Institutional Review Board was received prior to recruitment. Purposive and snowball sampling techniques were utilized. Study announcements were distributed via professional contacts of the investigators and the study's advisory board members, including administrators of two online support groups for caregivers of TGNC children. Most of the study participants learned about the study through postings to these online support groups. From there, some participants shared the study announcement with caregivers of TGNC children whom they knew through other means. Potential participants contacted the first author via email or telephone to set up a time for the one-on-one telephone interview, which was conducted by either

Table 1
Summary of Caregiver (N = 45) and Child (N = 45) Demographics

Demographic item	Mean (*SD*)/%	Range/*n*
Age of caregivers (in years)	42.4 (7.09)	31–67
Type of caregiver		
Biological mother	89.0	40
Biological father	4.4	2
Biological grandmother	4.4	2
Adoptive mother	2.2	1
Racial/ethnic groups of caregiver		
White	95.6	43
Latina	2.2	1
Native American & White	2.2	1
Education of caregiver		
GED or technical/trade school	4.4	2
Associate's degree	6.7	3
Some college	8.9	4
Bachelor's degree or higher	80.0	36
Sexual Orientation of caregiver		
Heterosexual	75.5	34
Bisexual/pansexual	17.8	8
Lesbian	6.7	3
Family structure		
Two-parent since child's birth	71.1	32
Caregiver divorced or separated	22.2	10
Caregiver single, never married	2.2	1
Child living with grandparents	4.4	2
Family social class		
I	55.6	25
II–III	42.2	19
IV–V	2.2	1
Locale: Region of United States[a]		
West	48.9	22
Midwest	17.8	8
Northeast	17.8	8
South	13.3	6
Age of children (in years)	8.5 (1.8)	6–12
Child's sex assigned at birth[b]		
AMAB (assigned male at birth)	62.2	28
AFAB (assigned female at birth)	37.8	17
Child's race/ethnic group		
White	80.0	36
Latina & White or Mexican & White	11.1	5
Native American & White	4.4	2
White & other	4.4	2
Children received GID[b] diagnosis	68.9	31

[a] Regions: https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf; one participant from Canada. [b] GID = Gender Identity Disorder (now Gender Dysphoria; American Psychiatric Association, 2013).

the first or the second author, and lasted approximately 60 to 75 min. Interviews were digitally recorded and then transcribed verbatim. Participants then received hard copies of questionnaires and returned them to the researchers upon completion. Each participant was given a $25 gift card to a retail store as a "thank you" for participation in the study.

Measures

Children's gender presentations. We utilized multiple indicators to gain an understanding of children's gender identities and degree of gender conformity (relative to societal expectations for assigned sex at birth). Participants completed the *Parent Report—Gender Identity Questionnaire* (GIQ; Johnson et al., 2004), a 16-item measure developed for use with TGNC children to gauge degree of gender conformity. Participants circled the responses for each item that best described their child; for example, answer choices for "His/her favorite playmates are," included: (a) *always boys*, (b) *usually boys*, (c) *boys and girls equally*, (d) *usually girls*, (e) *always girls*, and (f) *does not play with other children*. Response values for answer choices *a* through *e* ranged from 1 to 5, depending upon sex assigned at birth, with higher scores indicating greater gender conformity relative to the child's assigned sex. If a participant chose answer choice *f* for any item, no points were assigned for that item, and the item was not included in calculations. If an item was left blank, it was not included in calculations. Response values for all items were summed and then divided by the relevant number of items to get an average item score. Cronbach's alpha for this sample was .75.

Participants were asked during the interview and via the questionnaire if their child had received a diagnosis of gender identity disorder (GID) of Childhood (now termed *Gender Dysphoria;* American Psychiatric Association, 2013). During the interview, caregivers were asked to describe the child's gender development from the time they first came to recognize that their child's gender identity and/or expression differed from what is typically expected to how the child was currently identifying and expressing their gender. Participants were also asked if they used the term *transgender* to describe their child, and why/why not. On the questionnaires, participants were asked: "How would *you* describe your child's gender identity (her/his sense of being male, female, or something else) at this moment?" and "How would *your child* describe her/his own gender identity (her/his sense of being male, female, or something else) at this moment?"

Children's well-being. We assessed children's well-being by having caregivers complete the *Child Behavior Checklist* (CBCL; Achenbach & Rescorla, 2001), a 118-item (plus the opportunity to write in "other problems"), widely utilized measure that assesses children's internalizing, externalizing, and total behavior problems. Each item was rated on a 3-point scale for the past 6 months: 0 = *not true*, 1 = *somewhat or sometimes true*, and 2 = *very true or often true*. Following the lead of other researchers (e.g., de Vries et al., 2016), we did not include item #110 ("wishes to be the opposite sex") when calculating the children's total problems scores in order to avoid artificial inflation of total behavior problems. The CBCL is a nationally normed measure that provides standardized *t* scores ($M = 50$; $SD = 10$) for comparison. We calculated: (a) *t* score for Internalizing symptoms ($n = 32$ items); (b) *t* score for Externalizing symptoms ($n = 35$ items); (c) Total Problems raw score (Internalizing and Externalizing items, plus the remaining items); and (d) clinical range scores (>90th percentile) for the three indices. Cronbach's alpha for all items was .95.

Children's peer relations. The Peer Relations Scale (Cohen-Kettenis et al., 2003; de Vries et al., 2016) was constructed from three items on the CBCL: "Doesn't get along with other kids," "Gets teased a lot," and "Not liked by other kids." Item scores were summed to get a peer relations score. Possible scores could range from zero to six. Cronbach's alpha for this sample was .80.

Caregivers' well-being. Caregivers' well-being was assessed via self-report measures of depression and anxiety. The Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) is a 20-item measure that assesses the frequency of depressive symptoms (e.g., "I had crying spells") during the past week. Responses were on a 4-point scale and ranged from *rarely* (0) *to most or all of the time* (3). Scores are the sum of participants' responses to the questions. After reverse scoring appropriate items, possible scores range from 0 to 60. A score of 16 points or more is considered in the clinical range of depressive symptoms. Cronbach's alpha was .86.

The State–Trait Anxiety Inventory for Adults (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) measures short-term and stable levels of anxiety. The STAI-S consists of 20 statements (e.g., "I feel nervous") that evaluate how respondents feel "right now . . . at this moment." Responses are on a 4-point scale from 1 = *Not at all* to 4 = *Very much so*. The STAI-T consists of 20 statements that assess how people "generally feel." Responses are on a 4-point scale and range from 1 = *Almost never* to 4 = *Almost always*. After reverse scoring, scores for both the STAI-S and the STAI-T range from 20 to 80. Cronbach's alphas for the STAI-S and STAI-T were .93 and .91, respectively.

Data Analyses

Descriptive statistics are reported for children's degree of gender conformity and gender identities, children's well-being and peer relations, and caregiver's well-being; tests for differences were conducted to examine whether there were differences by child's sex assigned at birth, family structure, or social class. Correlation coefficients are also reported for all continuous variables.

Results

Findings should be understood in light of participants' reports that they were accepting of their children's gender presentations. When asked how supportive they were of their child's gender identity, all (n = 45) participants checked off: *very supportive*. When asked how supportive they were of their child's gender expression, 93% (n = 42) of caregivers responded with *very supportive*.

Children's Gender Presentations

According to the caregiver-report measure, the children's average score on the GIQ was 2.00 (SD = 0.54; range = 1.06 to 3.57); 95% CI [1.83, 2.16], with higher scores indicating greater gender conformity relative to sex assigned at birth. Scores did not differ significantly by assigned sex. The mean GIQ score appears to be similar to or lower than scores of gender conformity (i.e., the children in our sample appeared to exhibit more gender *non*conformity) reported in two studies of TGNC children that utilized the same measure (Hill et al., 2010; Johnson et al., 2004).[2] For example, the mean score for Johnson et al.'s (2004) clinic-referred sample was 2.83 (SD = 0.62).

Most (69%; n = 31) participants reported that their children had received a diagnosis of GID from a mental health clinician; no significant difference by sex assigned at birth. The 14 participants whose children had not received a diagnosis provided various explanations. Most (n = 10) said that the diagnosis was unnecessary; five said that they perceived the label as stigmatizing; one said that the child's doctor chose not to use a GID diagnosis, because their family's health insurance would not cover services related to gender issues. Other participants shared various reasons: one mother said her child was about to start on puberty blockers and, so, expected the diagnosis to "be coming soon"; another reported that the doctor had stated that her child was "gender fluid"; another explained that a therapist had said that the child "met all the criteria for GID" but would not document the diagnosis due to the child's young age at the time (five years of age).

Based upon participants' descriptions of children's gender identities in the interviews and in their written responses, the majority (69%; n = 31) of the children explicitly and consistently (to the various people in their lives) identified as the gender "opposite" that which they were assumed to be at birth (i.e., girls assigned as males at birth, and vice versa). Of these 31 children, 17 had been assigned male at birth, and 14 had been assigned female. Their average age was 8.7 years (SD = 1.9; range = 6–12 years). We refer to these binary trans children as *cross-gender identified* (CGI).

The remainder of the children (31%; n = 14) did not, according to their caregivers, consistently identify their gender as being "opposite" that which they were assumed to be at birth. Of these 14 children, 11 were assigned male at birth, and three were assigned female. Reportedly, these children sometimes said that they wished that they were the "opposite" gender, said that they were a combination of girl and boy, and/or stated they identified with the gender they were assumed to be at birth but persistently behaved in ways that were considered atypical for that assumed gender. Some examples of how participants described these children's gender identities were:

> She [9-year-old child AMAB] describes herself as "mostly girl" or "way more girl than boy."
>
> (He) [6-year-old child AFAB] will say, "I'm a girl, but I like boy stuff" or "I'm a girl, but I like to be called a boy."
>
> He [8-year-old Child AMAB] calls himself a "boy-girl."
>
> I think he [6-year-old child AMAB] kind of sees himself as both. And he's talked recently about being a girl with a penis.

Thus, some of the children in this subgroup appeared to present as nonbinary trans or as cisgender gender-nonconforming, or their gender identity was uncertain (e.g., a child inconsistently articulated a cross-gender identity). Given this diversity of gender presentations, we refer to this subgroup of children as *non-CGI*; that is, the children in this subgroup differed from the children in the CGI subgroup in that they did not clearly and consistently identify as the gender "opposite" that which they were assumed to be at birth. The average age of the children in the non-CGI subgroup was 7.9 years (SD = 1.5; range = 6–10 years); the age difference between subgroups was not statistically significant. See Table 2 for comparisons by subgroup (CGI and non-CGI).

A one-way ANOVA compared children's GIQ scores by subgroup (F = 21.19; $p < .001$); the non-CGI group (M = 2.46; SD = 0.60; range: 1.81 to 3.57) demonstrated significantly more gender

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[2] We provide descriptive mean comparisons to prior studies' findings; this does not refer to statistical comparisons.

Table 2
Subgroup (CGI and Non-CGI) Comparisons

Variable	CGI (n = 31)	Non-CGI (n = 14)
Assigned sex at birth[a]		
AMAB (n)	55% (17)	79% (11)
AFAB (n)	45% (14)	21% (3)
Age (SD; range)	M = 8.7 (1.9; 6–12 years)	M = 7.9 (1.5; 6–10 years)
GIQ (SD; range)[b]	M = 1.79 (.37; 1.06–2.75)	M = 2.46 (.60; 1.81–3.57)
GID[c] diagnosis (n)	87% (27)	29% (4)
Social transition (n)	100% (31)	14% (2)

Note. CGI = crossgender identified.
[a] AMAB = Assigned male at birth; AFAB = Assigned female at birth; due to small cell sizes, we were not able to test whether subgroup differences in assigned sex at birth were statistically significant. [b] The mean scores of the subgroups on the GIQ (Parent-Report Gender Identity Questionnaire; Johnson et al., 2004) were statistically significant: $F = 21.19$ ($p < .001$). [c] GID = Gender Identity Disorder (now Gender Dysphoria; American Psychiatric Association, 2013).

conformity (relative to social expectations for assigned sex at birth) than the CGI group ($M = 1.79$; $SD = 0.37$; range: 1.06 to 2.75). Further, 87% ($n = 27$) of the CGI children had received a GID diagnosis, while only 29% ($n = 4$) of the non-CGI group had; because of small cell sizes, we were not able to test whether this difference was statistically significant.

Most (73%; $n = 33$) of the 45 children had fully socially transitioned; they had switched pronouns from "he" to "she" or vice versa, and they (or their parents) asked everyone in their lives to make the switch; no significant difference by assigned sex at birth. All of the 31 CGI children had socially transitioned, whereas two (14%) of the 14 children in the non-CGI subgroup had. Because of small cell sizes, we were not able to test whether CGI children were more likely to have socially transitioned than children in the non-CGI subgroup.

Children's Well-Being

Children's Total Problems raw scores on the parent-report CBCL ranged from 5 to 84 (absolute range = 0 to 234), with a mean (34.64; $SD = 23.59$) in the normal range, but the upper limit of the 95% confidence interval [27.56, 41.73] fell in the borderline-clinical range.[3] The children's mean t scores on the CBCL's subscales of internalizing ($M = 55.78$; $SD = 10.83$) and externalizing ($M = 52.96$; $SD = 11.24$) problems, as well as all of the values in the 95% CIs for the means [52.52, 59.03] and [49.58, 56.33], respectively, were in the normal range.[4] A majority of the children were in the normal range for internalizing symptoms (64.4%; $n = 29$), externalizing symptoms (66.7%; $n = 30$), and total problems (62.2%; $n = 28$), yet sizable minorities were in the borderline-clinical or clinical ranges for these symptoms (see Table 3). There were no significant differences in CBCL scores as a function of sex assigned at birth, family structure, or social class.

Given our two subgroups (CGI and non-CGI), we provide means, SDs, and 95% CIs for each subgroup here; percentages from each subgroup who fell in the normal, borderline, and clinical ranges for internalizing, externalizing, and total problems are presented in Table 3. For the 31 children in the CGI subgroup, all of the means for the three indices of the CBCL, as well as all of the values of the 95% CIs calculated around the means, were in the normal range. The CGI subgroup had a mean raw score for total problems of 27.97 ($SD = 19.59$), 95% CI [20.78, 35.15], and mean t scores for internalizing symptoms of 53.23 ($SD = 9.92$), 95% CI [49.59, 56.86], and externalizing symptoms of 51.16 ($SD = 10.29$), 95% CI [47.39, 54.93]. The mean scores (and/or the upper limits of the 95% CIs) on the three indices of the CBCL for the 14 children in the non-CGI group, however, were in the borderline-clinical and clinical ranges. The non-CGI subgroup had a mean raw score for total problems of 49.43 ($SD = 25.60$), 95% CI [34.65, 64.21], and mean t scores for internalizing symptoms of 61.43 ($SD = 10.96$), 95% CI [55.10, 67.76], and externalizing symptoms of 56.93 ($SD = 12.59$), 95% CI [49.66, 64.20]. Caution must be used when interpreting the scores for the non-CGI subgroup, especially, given the small number of children ($n = 14$). A MANOVA revealed differences between gender identity subgroups on total problems ($F = 9.53$; $p < .01$) and internalizing symptoms ($F = 6.19$; $p < .05$). That is, the children in the CGI group reportedly exhibited fewer total and internalizing problems on average than the children in the non-CGI group.

Peer Relations

Children's mean score on the Peer Relations Scale was 1.11 ($SD = 1.42$; range = 0 to 5; higher scores indicate poorer peer relations); 95% CI [0.69, 1.54]. There was no significant difference between children assigned male at birth and children assigned female. The average score of the children in our sample appeared to be lower than those reported in Cohen-Kettenis et al.'s (2003) two clinical samples utilizing the same measure and who did find significant differences by sex assigned at birth; their reported averages were 1.93 and 2.29 for children assigned male, and 1.23 and 1.56 for children assigned female. A one-way ANOVA ($F = 7.80$; $p < .01$) revealed that the children in our study's CGI subgroup ($M = 0.74$; $SD = 1.21$) had significantly lower scores on

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[3] For Total Problem raw scores, the borderline-clinical range is 38 to 48 for girls ages 6–11 years old, 39 to 48 for boys ages 6–11 years, 36 to 44 for girls 12–18 years, and 40 to 51 for boys ages 12–18 years (Achenbach & Rescorla, 2001).

[4] For internalizing and externalizing t scores, the borderline-clinical range is 60 to 63, and the clinical range is 64 and above (Achenbach & Rescorla, 2001).

Table 3

Percentage of Children With Normal, Borderline-Clinical, and Clinical Range Scores for the Three Indices on the CBCL as a Function of Subgroup

Range	Total (*n*)	CGI (*n*)	Non-CGI (*n*)
Normal			
Total Problems	62.2% (28)	74.2% (23)	35.7% (5)
Internalizing	64.4% (29)	77.4% (24)	35.7% (5)
Externalizing	66.7% (30)	74.2% (23)	50.0% (7)
Borderline-clinical			
Total Problems	8.9% (4)	9.7% (3)	7.1% (1)
Internalizing	8.9% (4)	9.7% (3)	7.1% (1)
Externalizing	15.6% (7)	12.9% (4)	21.4% (3)
Clinical[a]			
Total Problems	28.9% (13)	16.1% (5)	57.1% (8)
Internalizing	26.7% (12)	12.9% (4)	57.1% (8)
Externalizing	17.8% (8)	12.9% (4)	28.6% (4)

Note. CBCL = Child Behavior Checklist; CGI = crossgender identified.
[a] Clinical range scores (>90th percentile).

this measure than children in the non-CGI subgroup ($M = 1.93$; $SD = 1.54$).

Caregivers' Well-Being

With regard to depression, caregivers' scores on the CES-D ($n = 44$) ranged from 1 to 31 ($M = 7.82$; $SD = 6.74$); 95% CI [5.77, 9.87]. There were no significant differences by sex assigned at birth or by subgroup (CGI vs. non-CGI). Most (88.6%; $n = 39$) scored below the clinical threshold of 16 points. This indicates that caregivers did not report significant depressive symptoms, overall, and is consistent with other field tests of the CES-D in the general population, in which 15% to 19% of participants scored at or above the 16-point threshold, and mean scores ranged between 7.94 ($SD = 7.53$) and 9.25 ($SD = 8.58$; Radloff, 1977).

Regarding state anxiety, caregivers ($n = 44$) scores on the STAI-S ranged from 20 to 64 ($M = 34.59$; $SD = 9.81$); 95% CI [31.61, 37.57] and are consistent with a normative sample of adults ages 40 to 49 years, in which the mean score for women on the STAI-S was 36.03 ($SD = 11.07$) and 35.88 ($SD = 11.07$) for men (Spielberger et al., 1983). Regarding trait anxiety, caregivers ($n = 45$) scores on the STAI-T ranged from 22 to 63 ($M = 36.95$; $SD = 8.73$) and are similar to a normative sample of adults ages 40 to 49, in which the mean score for women on the STAI-T was 35.03 ($SD = 9.31$) and for men was 35.06 ($SD = 8.88$; Spielberger et al., 1983). There were no statistically significant differences by sex assigned at birth or by subgroup for either state or trait anxiety scores.

Correlates of Children's Well-Being

Table 4 provides the correlation coefficients of the nine continuous variables: child's age; child's degree of gender conformity; child's internalizing, externalizing, and total problems (with the three items that form the Peer Relations Scale removed); child's peer relations; caregiver's depression; and caregiver's anxiety (state and trait). Significant associations with children's well-being included child's degree of gender conformity, caregiver's anxiety, and peer relations.

Children's degree of gender conformity had significant ($p < .05$) but weak associations with children's internalizing ($r = .30$) and total ($r = .30$) problems. As children's scores on the GIQ increased (representing more gender conformity relative to a child's assigned sex at birth), children's internalizing and total problems increased. In other words, the less clearly cross-gender identified and cross-gender expressive the children were, the more behavior problems they were reported to exhibit. This finding makes sense in light of our finding that children in the non-CGI subgroup exhibited significantly more internalizing and total problems than children in the CGI subgroup, along with our finding that the average GIQ score of children in the non-CGI subgroup was significantly higher than the average GIQ score of children in the CGI subgroup.

Caregivers' anxiety also had significant ($p < .05$) but weak associations with children's well-being. Caregivers' state anxiety was positively associated with children's internalizing ($r = .34$) and total ($r = .31$) problems. Caregivers' trait anxiety was also positively associated with children's internalizing ($r = .34$) and total ($r = .37$) problems. As caregivers' scores of anxiety (both in the moment and longer-term) increased, children's scores of internalizing and total problems increased.

The strongest correlates of children's behavior problems were with children's peer relations; associations ranged from moderate to strong for these correlations. Scores on the Peer Relations Scale were positively associated with children's internalizing ($r = .46$; $p < .01$), externalizing ($r = .55$; $p < .001$), and total ($r = .65$; $p <$

Table 4

Correlations Among Continuous Variables

Measure	1	2	3	4	5	6	7	8	9
1. Child's Age	1	−.058	−.012	−.031	.007	−.092	.85	−.097	.054
2. GIQ		1	.221	.296*	.295*	.162	−.025	.251	.013
3. Peer Relations			1	.646***	.459**	.551***	.201	−.013	.124
4. Total Problems				1	.802***	.864***	.098	.312*	.366*
5. Internalizing T					1	.567***	.128	.344*	.341*
6. Externalizing T						1	−.005	.168	.230
7. CES-D							1	.565***	.671***
8. STAI-S								1	.630***
9. STAI-T									1

Note. GIQ = Gender Identity Questionnaire; CES-D = Center for Epidemiological Studies-Depression Scale; STAI-S = State-Trait Anxiety Inventory for Adults-State anxiety; STAI-T = State-Trait Anxiety Inventory for Adults-Trait anxiety.
$^{*}p < .05$ level (2-tailed). $^{**}p < .01$ level (2-tailed). $^{***}p < .001$ level (2-tailed).

.001) problems, indicating that children exhibiting poorer peer relations also exhibited more internalizing, externalizing, and total problems.

Discussion

This paper provides a baseline report from the Trans*Kids Project, a community-based study of 45 predominantly white families with TGNC children. Our study differs from previous studies in that we included a diverse range of TGNC children, but distinguished between those who were CGI and those who were not (Olson, 2016), and assessed caregiver well-being. Based upon caregiver reports, most of the children in our study were CGI (31 of the 45 children held a binary gender identity that differed from that which was typically expected for their sex assigned at birth); all of these children had socially transitioned. The remaining (n = 14) children in the study were categorized as *non-CGI*. Some of the children in the non-CGI subgroup had nonbinary gender identities (e.g., "mostly girl"), or they were cisgender but their gender expressions diverged greatly from social norms. Some children in the non-CGI subgroup said that they "wished" they were the "other" gender but did not (according to their caregivers at the time of data collection) clearly and consistently hold cross-gender identities. Two of the 14 children in the non-CGI group had socially transitioned, even though they may not have exclusively identified with a binary gender identity. This may speak to the complex interplay between gender identity and expression, especially amid societal norms that view gender as a binary construct (Ehrensaft, 2016). Future research should examine gender identity development and decision-making processes relative to social transition for all trans children, as well as their satisfaction with the gender presentation options available to them.

Children's Well-Being

One of our most compelling findings is that the children in our study appear to be functioning better than some previous studies' samples (e.g., Cohen-Kettenis et al., 2003). Cohen-Kettenis et al. documented higher mean raw scores (44.03 and 48.41; both borderline-clinical range) for total problems on the CBCL for their two subsamples (n = 343; n = 123) of children ages 3 to 12 years old; 61.7% and 62.1% of the 6- to 11-year-olds in each subsample had total problem raw scores in the borderline-clinical/clinical ranges.[5] Most (62.2%) of the children in our study scored in the normal range for total problems, and the total problems mean raw score fell in the normal range (although the upper bounds of our 95% confidence interval overlapped with values in the borderline-clinical range). The mean t scores for both internalizing and externalizing symptoms were also higher for Cohen-Kettenis et al.'s subsamples (i.e., most were in the borderline or clinical ranges), whereas the mean t scores (including the 95% CI values) for our children's internalizing and externalizing symptoms fell in the normal range.

We posit that the children in our study demonstrated greater well-being than children in some previous studies (e.g., Cohen-Kettenis et al., 2003) that utilized parent-report measures of TGNC children's well-being because of differences in familial acceptance. That is, some previous studies' samples of parents likely had varying degrees of acceptance of their children's gender nonconformity. The caregivers in our study, by their own self-report and as evidenced by their willingness to participate in a study such as ours, were generally very accepting of their children's gender presentations. Our findings, especially those for our subgroup of CGI children, may be more similar to those of Olson et al. (2016), whose community sample of binary trans children had all socially transitioned with the assistance of their parents, as well as Hill et al.'s (2010) sample whose caregivers were all participating in an affirmative intervention for parents of TGNC youth. Olson et al. (2016) did not utilize the CBCL, but data gathered using normed measures of anxiety and depression indicated that children's mean t score (52.2) for internalizing symptoms was in the normal range. Of course, TGNC children and their families who participate in clinic-based studies (e.g., Cohen-Kettenis et al., 2003) may experience greater levels of distress than those who do not necessarily seek clinical services. Yet, community-based studies such as ours, and the ones by Olson et al. and Hill et al., are extremely important for providing greater understanding of the range of outcomes for TGNC children and youth, and the key role of accepting familial environments in supporting positive outcomes. From a minority stress perspective, more accepting familial environments may foster well-being among TGNC children by reducing the stigma faced at home and by helping to counter the stigma and negativity these children may face in other contexts.

Although the children in our study appeared to be doing relatively well, a sizable minority reportedly had clinical-level symptoms. Compared with the CBCL normative sample (Achenbach & Rescorla, 2001), in which fewer than 10% were in the clinical range for internalizing, externalizing, and total problems, 27%, 18%, and 29% of the children in our sample were in the clinical range, respectively, on these measures. Further, the children's mean raw score on total problems actually may have fallen in the borderline-clinical range given the upper bounds of our 95% confidence interval. Most worrisome were the findings that a majority of the children in the non-CGI subgroup were in the clinical range for internalizing and total problems.

There are several possible explanations for the finding that the CGI children in our study had fewer internalizing and total problems than the children in the non-CGI subgroup. A child who, for example, exclusively identifies as a girl and has socially transitioned to living as a girl in all areas of her life with the support of her parents may receive consistent affirmation of her identity from her family, teachers, and peers via the use of correct pronouns, support in her gender expression (e.g., hairstyle; clothing), and so forth. Intentional displays of affirmation may come from those who actively support the child's trans status, whereas others who are unaware of the child's trans status may unknowingly provide affirmation by accepting the child's gender identity without question. Such shows of support may buffer the potential negative effects of minority stress for these children.

In contrast, the children in our study who held nonbinary identities, or who, for example, identified as boys but liked to wear dresses, may have received more limited affirmation of their

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[5] The earlier version (1983) of the CBCL utilized by Cohen-Kettenis et al. did not distinguish between borderline and clinical ranges; see the third footnote in this paper for current (2001) CBCL ranges for Total Problem raw scores.

gender presentations and faced stigma when they deviated from gender norms. Perhaps that is why children in the non-CGI group reportedly had poorer peer relations on average than CGI children. Children in the non-CGI group may have also faced particular difficulty navigating a gender binary world that did not provide the same recognition or structural support afforded others. Such kids may experience daily misgendering when referred to as "boys" or "girls" and feel misunderstood when, for example, they have to choose the girls' or the boys' bathroom, neither of which quite fit. Such experiences and general lack of understanding of their gender presentations could cause non-CGI children to experience significant stress, resulting in diminished well-being. Indeed, previous research with TGNC adults found that nonbinary trans respondents reported higher rates of psychological distress than binary trans respondents (James et al., 2016). Additionally, some of the children in our study categorized as non-CGI may have actually held, or would come to hold, cross-gender identities but had not yet consistently articulated them (Ehrensaft, 2016). Children in the non-CGI group were, on average, younger than the children in the CGI group; perhaps some of the children in the non-CGI group were assessed earlier in their gender identity development and were still figuring out or struggling to articulate, and, thus, were not yet affirmed in, their cross-gender identities and experienced stress as a result. In a similar vein, previous research with adult trans respondents found that those who had not transitioned, but wanted to, reported higher rates of psychological distress than those who had transitioned (James et al., 2016). Further research is needed to explore differences in well-being among TGNC children to identify the unique challenges and forms of minority stress that nonbinary trans (and other TGNC children who are not clearly and consistently CGI) may face (Webb, Matsuno, Budge, Krishnan, & Balsam, n.d.).

Beyond the need for further research, implications of our findings of differential well-being between the subgroups of TGNC children in our study include the need for fuller consideration of what it means for family members and others to affirm a nonbinary trans or cisgender gender-nonconforming child's gender identity or expression. Family members of non-CGI trans children may face unique challenges (Ehrensaft, 2016). For example, if family members are waiting for a child to decide upon gender pronouns, those family members may experience a feeling of being "in limbo" (Pearlman, 2012, p. 60). Labels to define their relationships may not exist, leaving them to grapple with: If you are not my son or daughter, sister or brother, niece or nephew, then who are you to me? Further, parents may struggle to advocate for children with nonbinary gender identities in schools if neither the girls nor boys bathroom quite fits, or when children are required to "line up," use gym locker rooms, or participate in sports according to binary gender groupings. Children with nonbinary trans identities "may challenge family members and others to critically examine the embedded nature of gender binaries in human societies" (McGuire, Kuvalanka, Catalpa, & Toomey, 2016, p. 63) in ways that acceptance of a binary trans child's identity may not. Clinicians can support families by creating a space to explore challenges and strategies for navigating a world that is more often than not organized according to a gender binary. Additionally, clinicians can help families access supports and resources (e.g., online, offline) that can provide a sense of community with others who are navigating similar experiences (e.g., parenting a nonbinary trans child).

Importantly, given that our assignment of children to one of two gender identity subgroups was based on caregiver descriptions, it is possible that some children's gender identities were not accurately captured and that some were assigned to a group that did not reflect their identity. Future research exploring caregivers' responses to and understanding of children's gender presentations is key, given the importance of familial acceptance. Further, given that GIQ scores were significantly different by subgroup (CGI vs. non-CGI) and were also associated with children's internalizing and total problems, subgroup differences on internalizing and total problems may have been a function of the subgroup differences in GIQ scores. Performing such regression analyses was beyond the scope of the present study, but our findings suggest directions for future research that could provide more nuanced understanding of factors contributing to the well-being of TGNC children.

Caregivers' Well-Being

Another contribution of our study is the assessment of the mental health among this group of caregivers of TGNC children. Overall, the mental health of the participants, with regard to anxiety and depression, was good. Few caregivers exhibited depressive symptomology, and scores on the STAI-S appeared to be similar to normative samples. Caregiver scores on the STAI-T, which assessed general feelings of anxiety, appeared to be at or slightly above what has been reported for normative samples. This finding is not surprising, given that our participants were likely aware of the risk of harassment facing TGNC individuals and anxious about how their children would be treated by others (Kuvalanka et al., 2014). Additionally, given that caregiver anxiety scores were correlated with children's behavior problems, those caregivers whose children were exhibiting distressing behaviors may have been more anxious as a result. Conversely, caregivers' anxious behaviors may have contributed to children's internalizing symptoms and other behavior problems. More research is needed to understand the direction of these relationships and how to best support both TGNC children and their caregivers (e.g., through individual counseling or caregiver support groups) who may be anxious about the present and future well-being of their children (Kuvalanka et al., 2014).

Children's Peer Relations

Examination of children's peer relationships was warranted given previous research on the importance of social support in the lives of TGNC youth (e.g., McConnell et al., 2015). In our study, peer relations was the strongest correlate of children's well-being, a finding consistent with previous studies with clinical samples (Cohen-Kettenis et al., 2003; de Vries et al., 2016). Future research should examine the direction of these associations, in that we cannot discern whether poor peer relations led to diminished well-being, or if children's behavior problems led to poorer peer relations. Given the paucity of research in this area, further examination of how family and peer contexts have an impact on TGNC children is warranted. For example, do highly accepting home environments buffer the negative effects of poor peer relations, as theories of social support would suggest? Do positive peer relationships serve to protect children when their families are not affirming of their gender presentations? Future studies could help untangle these relationships to better understand the critical sources of support in these children's lives.

Limitations and Conclusions

There were several limitations of our study. We asked primary caregivers to provide their perspectives on their children's well-being, as well as their own level of acceptance and support of their children's gender presentations. We do not know if others (e.g., teachers) may have provided contrary assessments of the children's problems or peer relations. It is also possible that parents' self-assessment of their degree of acceptance differed from children's perceptions. Future research could garner data from multiple informants and collection methods, such as observational studies and interviews with youth. The fact that fathers were less likely to participate is also a limitation, especially given evidence that fathers are often less approving of cross-gendered play and behaviors and often hold more rigid gender stereotypes (Blakemore, Berenbaum, & Liben, 2009).

In addition, the homogeneity of our sample with regard to race and social class substantially restricts our ability to generalize our findings to all TGNC children and their caregivers. In Singh's (2013) qualitative study of 13 trans youth of color, a majority of the participants spoke about how the development of their racial/ethnic identities and their gender identities influenced each other; one participant felt that the pride that her family instilled in her for being Chicana contributed to her resilience as a trans individual. In future qualitative analyses, we will specifically examine our data pertaining to the few racial minority TGNC children in our study to highlight their experiences; we will also consider targeted recruitment of families of color for future waves of data collection. Further, although previous studies (Cohen-Kettenis et al., 2003; de Vries et al., 2016) of clinic-referred samples found that family structure and social class were significantly associated with children's well-being, we did not. This could be because our participants were more homogenous in these regards. In the future, we will ask participants about household income to assess whether this more specific indicator of social class can better represent the variation in our sample.

Finally, the participants in our study were recruited through purposive sampling means, primarily via online support groups. Thus, the caregivers in our study likely differed from most parents of TGNC children; our participants were probably more supportive and accepting of their children's gender presentations, more well-connected to online resources, and more motivated and able to participate in a study such as ours. Although our sampling method introduced an obvious bias, it also provided an opportunity to examine the well-being of TGNC youth when they have relatively accepting home environments—an area of study currently deficient in the academic literature. Our study provides additional evidence for the potentially critical role of familial social support as a buffer against the negative effects of minority stress experienced by TGNC youth.

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