A Systematic Review on Parent and Clinician Support for Transgender and Gender Diverse Children and Adolescents and Their Associated Outcomes

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Acknowledgments

As a cisgender person, I wish to express my stance of solidarity and allyship to transgender and gender diverse children and adolescents. I want to acknowledge and celebrate all transgender and gender diverse children and adolescents who are leading an awe-inspiring *gender revolution* (Travers, 2018). It is impossible to name everyone who helped me reach this point; I am grateful for all of them. I would, however, like to thank the following people for their most valuable support:

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Abstract

Although there is a common understanding that strong support is critical for the well-being and mental health of transgender and gender diverse adolescents, there is currently no systematic review that addresses how parent and clinician support are associated with transgender and gender diverse children and adolescents outcomes. Hence, the main objective of the present systematic review was to explore and document the differential constructs related to support such as acceptance, connectedness, and affirmation, and non-supportive behaviors such as rejection, harassment, discrimination, and violence, and how these are associated with various outcomes (e.g., mental health and physical health) for transgender and gender diverse children and adolescents under the age of 19. The study design was informed by area expert consultations and pilot searches. Eligibility criteria were established to include all original research of quantitative or mixed-methods design, including transgender and gender diverse participants and/or their parents' and clinicians' self-reports, and studies published in English peer-reviewed journals. A complex electronic search strategy was developed to obtain a broad range of results from four databases relevant to our study topic (PsycINFO, MEDLINE, Scopus, and socINDEX). The findings of the systematic review provided salient information and allowed us to make recommendations that will help to inform public health policy-making at the provincial and federal levels and help social workers, family counselors, and psychologists in the development and implementation of effective parenting programs and policies.

Keywords: Transgender, Gender Diverse, Parent, Clinician, Support, Acceptance, Adolescents, Children

Résumé

Bien qu'il soit généralement admis qu'un appui solide est essentiel au bien-être et à la santé mentale des jeunes transgenres et issus des minorités de genre, il n'existe actuellement aucune analyse systématique sur la manière dont le soutien des parents et des cliniciens est associé au bien-être physique et mental des enfants et jeunes transgenres. Par conséquent, l'objectif principal de la présente revue systématique était d'explorer et de documenter les constructions différentielles liées au soutien, telles que l'acceptation, le support et l'affirmation, ainsi que les comportements non favorables, tels que le rejet, le harcèlement, la discrimination et la violence, ainsi que la manière dont ce soutien ou non-soutien est associé à la santé mentale et santé physique des enfants et jeunes transgenres de moins de 19 ans. Le plan de l'étude s'est appuyé sur les consultations d'experts locaux et sur des recherches pilotes. Les critères d'éligibilité ont été définis de manière à inclure toutes les recherches dont les méthodes étaient quantitatives ou mixtes, et celles avec des participants qui étaient des jeunes transgenres et /ou leurs parents ou cliniciens, et publiés en anglais dans des revues évaluées par les pairs. Une stratégie de recherche électronique complexe a été développée pour obtenir un large éventail de résultats à partir de quatre bases de données pertinentes au sujet d'étude (PsycINFO, MEDLINE, Scopus et socINDEX). La présente recherche a permis d'identifier les lacunes dans la littérature actuelle sur le soutien des parents et des cliniciens auprès des enfants et jeunes transgenres et a permis de fournir des informations et des recommandations qui éclaireront la pratique des décideurs afin d'élaborer des politiques de santé publique aux niveaux fédéral et provincial et aider les travailleurs sociaux et les psychologues dans l'élaboration et la mise en œuvre de programmes de soutien social.

Mots-clés : Transgenre, Diversité de genre, Parent, Clinicien, Soutien, Acceptation, Adolescent, Enfant

Definition of Terms

Assigned sex: Sex assigned to infants (i.e. usually male or female) at birth based on a visual inspection of primary sex characteristics (Airton & Meyer, 2018).

Cisgender: A person whose gender aligns with the sex they were assigned at birth (Airton & Meyer, 2018).

Cross-dressing: Practice of dressing up in the clothes typically referring to another gender (Airton & Meyer, 2018).

DSM: Acronym for the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. The most recent version is the DSM-5 (APA, 2013).

Gender: Term used to describe characteristics of people that are socially constructed, which would be in contrast with characteristics that are biological and legal (sex) (Airton & Meyer, 2018).

Gender creative: Developed by Ehrensaft (2011), this term describes a child who does not abide by the gender binary norms and transcends those norms to uniquely, and with artistry, evolve into a gender that is unique to them.

Gender diverse: For this thesis, we use gender diverse in addition to "transgender" to include non-binary identities. See non-binary term.

Gender expression: How a person publicly presents their gender. This can include behavior and outward appearances such as dress, hair, make-up, body language, and voice. A person's chosen name and pronoun are also common ways of expressing gender (Airton & Meyer, 2018), as well as the type of restroom one uses.

Gender identity: Each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender *spectrum*. A person's gender identity may be the same or different from the sex assigned at birth (Airton & Meyer, 2018).

Gender non-conformity: A term used to describe when someone's gender expression varies from what is traditionally expected of a person based on their gender identity or assigned sex (Airton & Meyer, 2018).

Gender-variant: A term that is synonymous to gender non-conformity, which denotes someone's gender as variant to the sex assigned at birth (Airton & Meyer, 2018).

Non-binary: A term used to describe someone whose gender identity exceeds traditional notions of man and woman. Non-binary peoples' gender expressions and identities vary widely. Many non-binary people use gender-neutral pronouns (Airton & Meyer, 2018).

Sex: Primary a medical and legal category which is assigned at birth based on biological characteristics. These characteristics may include chromosomes, gonadal tissue, hormone levels, and/or external genitalia (Airton & Meyer, 2018).

Transgender or trans: Umbrella term referring to people whose gender identities and expressions are not typically associated with the sex that they were assigned at birth (Connolly, Zervos, Barone, Johnson, & Joseph, 2016).

Chapter 1: Introduction

From transgender characters played by trans actors in popular TV series (e.g., *Transparent*; Soloway, 2014, and *Orange is the New Black*; Kohan, 2013) to TV's first transgender superhero acted by transgender actor Nicole Maines in *Supergirl* (Gustines, 2018), to the largest-ever cast of transgender actors in the *Pose* TV series (Bernstein, 2018), as well as popular books featuring transgender and gender diverse children stories and experiences (e.g., *I Am Jazz*; Herthel & Jennings, 2014; *The Boy & the Bindi;* Shraya & Perera, 2016, and *Sparkle Boy*; Newman & Mola, 2017), it is reasonable to infer that the visibility of transgender people whose gender identities and expressions are not typically associated with the sex assigned to them at birth has increased tremendously in the past decade in North American mainstream media (Konst, 2018; Riggs & Due, 2015; Steinmetz, 2014). Notwithstanding the significance of this increase in media visibility, has societal acceptance of transgender people also increased concurrently? In addition, has this increase in media visibility led to increased acceptance and support of transgender children and adolescents by their families and by their clinicians? The present study explored the specific context of the home and family (i.e., parents and caregivers) as well as the health care context in terms of acceptance and support of transgender and gender diverse children and adolescents by employing a socio-ecological framework of resilience approach to map the empirical literature on this topic.

In line with greater media visibility for transgender people, there is also a growing body of evidence coming from North America, Europe, and Southwestern Pacific contexts concerning the well-being and mental health of transgender and gender diverse children and adolescents (Arcelus, Claes, Witcomb, Marshall, & Bouman, 2016; Clark et al., 2014; Connolly et al., 2016; Grossman & D'Augelli, 2007; Spack et al., 2012; Veale, Watson, Peter, & Saewyc, 2017; Walls,

Laser, Nickels, & Wisneski, 2010). According to data from a sample in the United States, 26% of transgender adolescents have attempted suicide, while 45% have seriously contemplated taking their own lives (Grossman & D'Augelli, 2007). A recent report shows that the situation has not improved since Grossman & D'Augelli's 2007 report. Hence, while we know that there is close to 14% of adolescents who reported a previous suicide attempt overall, there are important disparities by gender identity in suicide attempts (Toomey, Syvertsen, & Shramko, 2018). Indeed, female-to-male adolescents reported the highest rate of attempted suicide (50.8%), followed by adolescents who identified as not exclusively male or female (41.8%), male-to-female adolescents (29.9%), questioning adolescents (27.9%), female adolescents (17.6%), and male adolescents (9.8%) (Toomey, Syvertsen, & Shramko, 2018). These numbers are unfortunately striking and demonstrate the ongoing vulnerability of transgender and gender diverse children and adolescents. In addition, it has been found that gender non-conformity in childhood was associated with greater risk for physical, sexual and psychological victimization, and Post-Traumatic Stress Disorder (PTSD) over the life course, regardless of the person's gender identity (Roberts, Rosario, Corliss, Koenen, & Austin, 2012).

In line with socio-ecological models of human development (e.g., Bronfenbrenner, 1979, 2000), in which different relationships have powerful and strong impacts on an individual's psychosocial development, researchers have started to consider factors beyond individual experiences of transgender and gender diverse children and adolescents (Johns, Beltran, Armstrong, Jayne, & Barrios, 2018; Mehus, Watson, Eisenberg, Corliss, & Porta, 2017). For example, the relationships that young people have with their parent/caregiver(s) and how the family unit may support their gender diverse identities and expressions are aspects that have caught the interest of researchers since the early 2000s. Indeed, f*amily systems theory* (Bowen,

1985) also suggests that individuals within the same family cannot be understood in isolation from one another, but rather as a part of their family, which acts as an emotional unit. In addition, the quality of interactions within one's family system can result in relatively healthy or unhealthy psychological development for the members of the family unit. Furthermore, a close relationship with at least one parent who provides warmth, fair expectations, monitoring of the child's activities, and an organized home environment also helps foster the development of resilience in a child (Conger & Conger, 2002). In this sense, we can view parent support and the home itself as a safe haven, a place where transgender and gender diverse children and adolescents can feel accepted, supported and behave as their authentic selves, thereby bolstering resilience. As a matter, previous studies have shown that transgender adolescents who are supported by their parents have better overall health, including lower rates of suicide, self-harm, and depression (Travers, Bauer, Pyne, & Bradley, 2012). When parents demonstrate strong support for their child's gender identity, the latter are more likely to report good mental health and self-esteem, with reports of a suicide attempt in the past year by 4% of the respondents, as compared to 57% for adolescents who reported that their parents were not strongly supportive of them (Travers, Bauer, Pyne, & Bradley, 2012). In addition, when children are supported in their transgender identities, they appear to thrive in similar ways as cisgender (i.e., a person whose gender identities matches their sex assigned at birth) children (Olson, Durwood, DeMeules, & McLaughlin, 2016).

Conversely, when adolescents are not supported in their various gender identities and expressions by their parents, they are at higher risk of experiencing increased psychological distress (Le, Arayasirikul, Yea-Hung, Jin, & Wilson, 2016; McConnell, Birkett, & Mustanski, 2016), including higher levels of depression (Yadegarfard, Meinhold-Bergmann, & Ho, 2014).

Furthermore, transgender adolescents are also at greater risk of suicide and suicidal ideation. Based on a previous study (Grossman & D'Augelli, 2007), transgender adolescents who have attempted suicide reported significantly more verbal and physical abuse from their parents compared to transgender adolescents who did not attempt to take their own life.

The health care provided to transgender and gender diverse children and adolescents also matters in terms of their psychological development. Historically, children and adolescents who presented signs of gender non-conformity were referred to mental health specialists whose goal was to help them accept the sex assigned to them at birth and adopt the culturally-defined and appropriate gender behaviors that would match the sex assigned to them at birth (Ehrensaft, 2017). In other words, their gender behaviors were encouraged to be in alignment with traditional models of gender development and gender roles. Practices of this sort still exist nowadays, but they have been prohibited by many mental-health-related organizations such as the *American Psychological Association* (DeLeon, 1998). More contemporary mental health treatment models, however, have moved away, to various extent, from this reparative model of care. According to Ehrensaft (2017), these contemporary models can be divided into three major models: (1) the *live in your own skin* model (e.g., Zucker & Bradley, 1995; Zucker, Bradley, Owen-Anderson, Singh, Blanchard, & Bain, 2010), (2) the *watchful waiting model* (i.e., Dutch model) (e.g., Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis & van Goozen, 1998; Delemarre-van de Waal & Cohen-Kettenis, 2006; Gooren & Delemarre-van de Waal & Gooren, 1996), and (3) the *gender affirmative* model (e.g., Ehrensaft, 2012; Hidalgo et al., 2013; Malpas, 2011; Menvielle, 2012).

Depending on what model of care is adopted by mental health professionals, the quality and impact of support that transgender and gender diverse children and adolescents receive could

vary in relation to the outcomes of children and adolescents' well-being. Indeed, previous studies suggest that therapeutic approaches that encourage adolescents to accept their given body and assigned gender may inadvertently cause psychological harm (Travers et al., 2012; Wallace & Russell, 2013). It is therefore of utmost importance for clinicians to be mindful of the specific needs of transgender and gender diverse children and adolescents when it comes to their medical and mental health care.

Taken together, socio-ecological models of human development and systems theories point to the importance of support for transgender and gender diverse children and adolescents, who are likely to experience various challenges in their daily lives because their gender identities and expression do not conform to mainstream gender expectations. The background information presented above, including the literature and previous studies, suggests that support may exert a tremendous influence on the development and maintenance of sound mental health and well-being in transgender and gender diverse children and adolescents (Johns et al., 2018; Mehus et al., 2017; Ryan et al., 2010; Valentine & Shipherd, 2018). It is therefore surprising that a systematic review that addresses how support and non-supportive behaviors from parents and clinicians are associated with transgender and gender diverse children and adolescents outcomes has not yet been conducted to date. The present review aimed to explore the literature on parent and clinician support for transgender and gender diverse children and adolescents, specifically under the age of 19 years old. The findings obtained from the present study were also expected to yield proper recommendations for parents, clinicians, and policymakers in developing and implementing effective programs and policies to foster healthy life of transgender and gender diverse children and adolescents.

Chapter 2: Literature Review

In the present thesis research, two theories were helpful to frame the literature concerning parent and clinician support. The first theory was Bronfenbrenner's socio-ecological model (1979, 2000), and the second was resilience theory (e.g., Garmezy, 1991; Rutter, 1987; Werner & Smith, 1982). Considering these theories, in the following sections, first, the literature on perceived social support was reviewed. Second, the microsystem as part of the socio-ecological model (i.e., the family/parents/caregivers and health care services and clinicians) was discussed from a perspective of how parent and clinician can support transgender and gender diverse children and adolescents, and how they may help bolster children and adolescents' own resilience. Lastly, the statement of the problem of the present project was presented, including the research questions and objectives.

Perceived Social Support

Social support refers to a social network's provision of psychological and material resources intended to benefit someone's ability to cope with stress (Cohen, 2004). Since the mid-70s, researchers have started studying this concept, which has been conceptualized as a buffer against stress and as a promoter of health (e.g., Cobb, 1976; Cohen & Syme, 1985; Cohen & Wills, 1985). Indeed, Cohen and McKay (1984), Gore (1981), and House (1981) contended that social support operationalizes as a moderator between stressful life events and physical or psychological symptoms (i.e., the buffering hypothesis). Definitions are numerous when it comes to understanding social support. One of the earliest conceptualizations by Cobb (1976) suggests three main components of social support, as follows: (1) information that one is cared for and loved, (2) information that one is esteemed and valued (recognition and respect), and (3) information that one belongs to a network (group membership). Another conceptualization,

suggested by House (1981), divides social support into four types of behaviors, including: (1) emotional support in the form of love, caring, trust, listening and other similar affective behaviors; (2) appraisal support in the form of positive feedback or affirmation; (3) instrumental support in the form of a tangible resource or aid, including money, labor, and time; and (4) informational support in the form of advice or suggestions.

Perceived social support is the most frequently assessed social support concept in the literature, according to Barrera (1986). One of the many widely used measures to investigate perceived social support is the *Multidimensional Scale of Perceived Social Support* by Zimet, Dahlem, Zimet, and Farley (1988). Zimet et al.'s (1988) scale is composed of three subscale structures to measure perceived social support coming from the family, friends, and significant other. Although designed for the general population, Zimet et al.'s (1988) scale maintains its high internal consistency for specific populations such as university students in an international sample (Duru, 2007), African-American adolescents living in urban areas (Canty-Mitchell & Zimet, 2000), and Mexican American adolescents (Edwards, 2004). Moreover, perceived social support has also been investigated in the past for LGBT adolescents specifically (e.g., McConnell, Birkett, & Mustanski, 2016). Taken together, research on social support, especially regarding perceived social support, has had many decades of investigation and has been explored for multiple specific populations.

Theoretical Approach for the Present Project

Given the buffering effect of social support and its associated positive outcomes in terms of stress and distress reduction and health promotion (e.g., Cassel, 1976; Cobb, 1976; Cohen & Wills, 1985; House, 1981; Kessler, Price, & Wortman, 1985; Kessler & McLeod, 1985; Thoits, 1995; Uchino, 2004), this present project explored the literature on parent and clinician support

for transgender and gender diverse children and adolescents, specifically under the age of 19 years old. A socio-ecological and systemic approach– namely, Bronfenbrenner's socio-ecological model (1979, 2000)- was used in the present study to examine what is known about the microsystem of the child, with a specific focus on parent and clinician support of transgender and gender diverse children and adolescents. Bronfenbrenner's socio-ecological model provides a useful framework for conceptualizing factors of influence within the individual and their relationships with others (Bronfenbrenner, 1979). Public health researchers have historically used this model to map factors of influence among specific groups, such as sexual and gender minorities (e.g., Armstrong, Steiner, Jayne, & Beltran, 2016; Johns et al., 2018). This socio-ecological model highlights the dynamic relationship between factors of influence at each system level and how they collaboratively influence health and mental health. This dynamism serves to identify important missing links between factors and outcomes and helps us have a more comprehensive approach to the exploration of factors influencing psychosocial development (i.e., not only at the individual level but also in the relationships that one has with others as well).

The microsystem surrounding an individual, as a part of the ecological systems theory, is one of the most influential on individual development (e.g., Rosa & Tudge, 2013; and Seidman et al., 1995). As such, the family unit, as part of the microsystem, exerts a tremendous influence on an individual's psychosocial development. Socio-ecological models of human development also reinforce the reciprocal and transactional nature of human interactions. Indeed, how the family unit may support transgender children and adolescents' gender diverse identity/expression has caught the interest of researchers since the early 2000s (e.g., Boenke, 2003). For example, it is common for parents to experience *shock* once they become aware of their child's transgender or gender diverse identities and expressions (Ellis & Eriksen, 2002; Lev, 2004; Pullen Sansfaçon,

Robichaud, & Dumais-Michaud, 2015). Moreover, it appears that this initial period of *shock* is often the precursor for the start of their own journey towards acceptance of their child (Gray, Sweeney, Randazzo, & Levitt, 2016; Rahilly, 2015). A transgender child's experiences, therefore, cannot be understood in isolation but needs to be explored from a family perspective. What kinds of changes does a family experience when one of their members is transgender? Is acceptance equal across members of the family unit or are there intra-familial differences across members of the family? A number of studies have shown, for example, that mothers tend to be more supportive than fathers (e.g., Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015; Wren, 2002) and that having a transgender child greatly impacts the family as a whole (e.g., Gray et al., 2016).

Health care services and clinicians (i.e., medical or mental health care professionals who are directly involved in the care and treatment of patients), also part of the microsystem, are in a unique position to offer support and assistance with decision-making at various stages in the care of transgender and gender diverse children and adolescents. These decisions vary in complexity and must take developmental, psychosocial, familial, and potentially psychiatric factors into account, which puts clinicians in a very important role in supporting transgender and gender diverse children and adolescents (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016). Newer models of care to support transgender and gender diverse children and adolescents in their transition have emerged in the most recent decades, focusing on pubertal suppression in younger adolescents (Hembree et al., 2009), changes to the diagnostic classification of children and adolescents with gender identity concerns (American Psychiatric Association, 2013), and debates surrounding the approach for prepubertal children whose gender identities and expressions do not match the sex that they were assigned at birth (Zucker, 2008).

In addition to using a socio-ecological framework, a resilience approach was used in the present study to address the critical roles of protective factors and mechanisms by considering each system of support (in our case, parents and clinicians). This approach is helpful (e.g.,Grossman, d'Augelli, & Frank, 2011, Hendricks & Testa, 2012; Kosciw Greytak Palmer, & Boesen, 2014; McConnell, Birkett, & Mustanski, 2016) to understand further how the relationships that transgender and gender diverse children and adolescents have with their parents and clinicians may serve to bolster children and adolescents' resilience. Indeed, resilience research focuses on the complex interactions among the many ecological systems of a child or adolescent's life that promote competent functioning under adversity (Masten, 2011). Numerous individual, relational, and contextual factors are associated with being resilient, for example, the availability of supportive community resources and supports (Bowes, Maughan, Caspi, Moffitt, & Arseneault, 2010). Several components have been found to be particularly critical in fostering resilience in children and adolescents, including enhancing social and emotional support, improving connectedness, increasing self-esteem, and encouraging individuality and self-competence, as well as fostering a sense of power (Bell, 2001; Mustanski, Newcomb, & Garofalo, 2011). Another central process in building resilience is the development of coping skills. When adversity occurs, an appraisal of the significance of the stressor or threatening event takes place and coping responses are triggered to focus on the adversity or on the emotions generated by the stressor. The responses can also be socially focused. An example could be seeking support from others (Antonovsky, 1979; Lazarus, 1966). With this strategy (i.e., support seeking), resilience can be conceptualized as a bidirectional process, in such that children and adolescents are seeking support themselves and/or their parents and clinicians offer supportive care. Hence, we can view parent and clinician support as a means to foster resilience

of transgender and gender diverse children and adolescents. In the present study, social support in the form of parent and clinician support was explored to see whether it would be associated with lower aspects of mental health and health challenges among transgender and gender diverse children and adolescents as expected.

Bronfenbrenner's Mesosystem and Microsystems and Their Factors of Influence

The mesosystem consists of the connections between microsystems, which are also influential on the development of the child (Bronfenbrenner, 1979, 2000). The microsystems discussed in the following section are the family and parent context, and the health care services (i.e., clinicians, mental health providers, etc.). These microsystems are discussed independently and in connection with one another.

Family and factors of influence within the family unit. According to Bronfenbrenner (1979, 2000), families and parents of transgender children and adolescents are part of multiple ecological systems that are likely to exert influence on this microsystem. Hence, the way parents can be supportive will depend on an array of different factors. When looking at the specific parent-child relationships, transgender and gender diverse children and adolescents who are supported by their parents have better overall health, including lower rates of suicide, self-harm, perceived burden, and depression, and higher life satisfaction (Simons, Schrager, Clark, Belzer, & Olson 2013; Travers, Bauer, Pyne, & Bradley, 2012). When parents demonstrate strong support for their child's gender identity, the latter are more likely to report good mental health and self-esteem, with reports of a suicide attempt in the past year by 4% of the respondents, compared to 57% for adolescents who reported that their parents were not strongly supportive of them (Travers, Bauer, Pyne, & Bradley, 2012). In addition, when children are supported in their transgender identities, they appear to thrive in similar ways as cisgender (i.e., a person whose

gender identities matches their sex assigned at birth) children (Olson, Durwood, DeMeules, & McLaughlin, 2016).

Conversely, when adolescents are not supported by their parents in their various gender identities and expressions, they are at higher risk of experiencing increased psychological distress (Le, Arayasirikul, Yea-Hung, Jin, & Wilson, 2016; McConnell, Birkett, & Mustanski, 2016), including higher levels of depression (Yadegarfard, Meinhold-Bergmann, & Ho, 2014). Furthermore, transgender adolescents are also at greater risk of suicide and suicidal ideation. One study by Grossman & D'Augelli (2007) has indicated that transgender adolescents who have attempted suicide reported significantly more verbal and physical abuse from their parents than transgender adolescents who did not attempt to take their own life. Data coming from self-reports of transgender adults has also reinforced the idea that parental rejection is associated with increased odds of both suicide attempts and substance misuse (Klein, & Golub, 2016).

Schools are an important part of a child's microsystem and in some cases, schools may be a place where transgender children and adolescents can live as their authentic gender selves. but most generally, schools continue to remain largely detrimental places for transgender and gender diverse children and adolescents. Indeed, based on data from the 2007 report from the Gay, Lesbian and Straight Education Network (GLSEN; U.S. data), 85% of transgender students reported verbal harassment, 49% experienced physical harassment in school, and 34% reported physical assault (Kosciw, Diaz, & Greytak, 2008). Additionally, 69% of transgender adolescents reported feeling unsafe in school due to their sexual orientation or gender presentation (Graytak, Kosciw, & Diaz, 2009). To corroborate on these previous studies, a study by Sausa (2005) demonstrated that 96% of reporting transgender adolescents (aged 16–21) experienced verbal harassment and 83% experienced physical harassment in schools in Philadelphia. Lastly, based

on Canadian data from the 2011 First National Climate Survey on Homophobia, Biphobia, and Transphobia in Canadian Schools by the Egale Canada Human Rights Trust (Taylor et al., 2011), 79% of transgender students felt unsafe in their schools, particularly with respect to the use of washrooms, change rooms, and corridors, 63% of transgender students reported having been verbally harassed about their sexual orientation, 74% of transgender students reported having been verbally harassed about their gender expression, and 37% of transgender students reported having been physically harassed. Taken together, these studies show how pervasive school harassment is for transgender children and adolescents and how they regularly experience negative school experiences.

Based on this background concerning the school experiences of transgender children and adolescents, it is reasonable to infer that the school context is likely to have an influence on the home context and parents. When transgender and gender diverse children and adolescents come home after experiencing such adverse incidents in schools, it is important to consider how the home context could represent a place where children and adolescents are supported. Unfortunately, data from the U.S. based on the 2009 National School Climate Survey show that only 7.3% of transgender students reported incidents of harassment and assault at school to a family member “always” and 55% of transgender adolescents never reported school victimization experiences to family (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010). Of those who did report these experiences to a family member, 75% of these family members never addressed the incident with the school, suggesting that parents may not be advocating for their gender diverse child even when they experience harassment at school (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010).

Despite these results, some parents of transgender and gender diverse children and children and adolescents themselves seem to try to influence schools on behalf of the transgender students. Several reports have described parents taking on an advocacy role for their child to facilitate a more stable environment for the transition of their child (e.g., Birnkrant, & Przeworski, 2017; Travers, 2018). It should be noted here that there are likely to be disparities in advocating for transgender children and adolescents. Travers (2018) and Manning, Sansfacon, Newhook, and Travers (2015) report that parental advocacy on behalf of transgender children and adolescents is not limited by race and class privilege, but by the availability of and access to cultural capital and the resources that are helpful for families who are willing to support their child.

The family context, as part of the microsystem, is, therefore, an important developmental context, being critical for transgender and gender diverse children and adolescents (McConnell, Birkett, & Mustanski, 2016). Being accepted and supported by parents matters for all children and adolescents; it might be even more critical for transgender and gender diverse children and adolescents, because of the adversity they face on a regular basis in schools(e.g., Graytak, Kosciw, and Diaz, 2009; Kosciw, Diaz, & Greytak, 2008; Sausa, 2005, Taylor et al., 2011). For instance, one parent of a young transgender boy recounts in a study by Travers (2018) that, "[…] when you have a solid foundation of who you are and knowing that the people around you believe in who you actually are, it's a lot easier to take that adversity" (p. 198).

Health care services. In exploring the importance of clinician support for transgender and gender diverse children and adolescents, the history of mental health treatment models of transgender and gender diverse children and adolescents as well as the tensions between three contemporary models of care (i.e., the live in your own skin model, the watchful waiting model,

and the gender affirmative model) need to be addressed to understand how these models may have shaped approaches of a clinician's support for their patients/clients. Historically, children and adolescents who presented with signs of gender non-conformity were referred to mental health specialists whose goal was to help them accept the sex assigned to them at birth and adopt the culturally-defined and appropriate gender behaviors that would match that sex assignment (Ehrensaft, 2017). In other words, their gender behaviors were encouraged to be in alignment with the traditional model of gender development and gender roles. Practices of this sort have been referred to as reparative therapies. Although these practices still exist nowadays, they have been prohibited by many mental-health-related organizations such as the *American Psychological Association* (see DeLeon, 1998) and the *Canadian Psychological Association* (CPA, 2015). These conversion therapies aimed at "changing someone's sexual orientation" often incorporate strict rules regarding conformity to traditional gender roles and behaviors. Moreover, having a stance against conversion therapy for gender identity, CPA has released a statement in support of adolescents and adults having the right to define their own gender identity (CPA, 2010).

More contemporary mental health treatment models, however, have moved away, to various extent, from this reparative model of care. According to Ehrensaft (2017), these contemporary models can be divided into three major models: (1) the live in your own skin model (e.g. Zucker & Bradley, 1995; Zucker, Bradley, Owen-Anderson, Singh, Blanchard, & Bain, 2010), (2) the watchful waiting model (i.e., Dutch model) (e.g., Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis & van Goozen, 1998; Delemarre-van de Waal & Cohen-Kettenis, 2006; Gooren & Delemarre-van

de Waal & Gooren, 1996), and (3) the gender affirmative model (e.g., Ehrensaft, 2012; Hidalgo et al., 2013; Malpas, 2011; Menvielle, 2012).

The first model – the live in your own skin model - by Bradley and Zucker (1995) takes a medical-social perspective (Ehrensaft, 2017). In this perspective, younger children have greater "gender brain" plasticity that would allow mental health providers to use interventions that aim to encourage the child to express and identify with the sex they were assigned at birth (e.g., through interventions aimed at behavior modification, ecological interventions, and/or family system restructuring). These practices are based on the premise that being transgender is a harder way to live one's life, both because of social stigma and potential hormonal treatments and surgeries to align a person's body with their transgender identity (Ehrensaft, 2017). If by puberty, the child still does not identify with the sex assigned at birth, only then the child will be supported in transitioning to their affirmed gender. According to this model, a social and medical transition needs a "stamp" of approval based on clinical interviews and psychometric testing in order to confirm that the affirmed gender identity is legitimate. This model has been widely criticized for potentially causing harm to children and adolescents. In fact, major health organizations, including the World Professional Association for Transgender Health (WPATH, 2014), the American Psychological Association (APA, 2015), and the American Psychiatric Association (APA, 2018), have issued statements opposing practices that attempt to alter the gender expressions or identity of an individual, including children and adolescents (Ehrensaft, 2017). These organizations view diverse gender expressions and gender identities as normal and as positive variations of the human experience and they encourage self-exploration and self-acceptance rather than trying to shift gender identity and gender expression in any specific direction (APA, 2015). Therefore, attempting to behaviorally modify gender-nonconforming

behavior in children and adolescents and help them "live in their own skin," that is, the sex assigned to them at birth (Keo-Meier & Ehrensaft, 2018) without careful consideration of children and adolescents' values can be highly damaging. As a matter, in a paper by Wallace and Russell (2013), a Canadian study which evaluated clinical interventions, findings have shown that the live in your own skin model "appears to be an enhanced risk of fostering proneness to shame, a shame-based identity and vulnerability to depression" (Wallace & Russell, 2013, p. 120). The risk, therefore, of engaging in a practice that may force children and adolescents to conform to a gender that matches their sex at birth, and foster shame and depression by doing so, is extremely harmful to transgender and gender diverse children and adolescents.

In contrast with the live in your own skin model, the second model – the watchful waiting model does not use interventions to encourage children to identify with the sex assigned at birth, but rather, observes the child until puberty (Cohen-Kettenis, & Pfäfflin, 2003). This observation of the child, however, warns against any social transition until the child hits puberty. In addition, like the live in your own skin model, the watchful waiting model necessitates clinical interviews and psychometric tests to conclude that the affirmed gender identity is, there again, authentic. This model has been criticized by parents of children who do not see the point in waiting for a social transition when it increasingly appears that children who are supported in their affirmed gender identity are developing in healthy and positive ways (e.g., Durwood, McLaughlin, & Olson, 2017; Olson, Key, & Eaton, 2015). These first two models have been merged together under the umbrella of pathological approaches for transgender children and adolescents, as described by many researchers (e.g., Hill, Menvielle, Sica, & Johnson, 2010; Menvielle, & Hill,

2011). This pathological approach has been contrasted with the third model, which is termed the gender affirmative model.

As opposed to the first two models, the third one – the gender affirmative model– encourages the multiple trajectories explored by transgender and gender diverse children and adolescents and validates these trajectories as healthy (Menvielle, 2012), even for children who have not yet reached puberty (Ehrensaft, 2017). Specifically, in such affirmative practices, parents encourage their children's gender explorations (Brill & Pepper, 2008). The goals of affirming interventions are to destigmatize gender variance, promote self-worth, strengthen parent-child bonds, nurture peer support, and teach advocacy skills (Ehrensaft, 2012; Hidalgo et al., 2013; Malpas, 2011; Menvielle, 2012). These practices, which are recommended by the work of an international consortium of gender affirmative theoreticians and practitioners, have been however criticized for their lack of evidence-based data (Ehrensaft, 2017). Proponents of this model view mental health treatment of gender diversity in children and adolescents as a collaborative treatment in which all decisions are carefully taken between the professional, the child, and their family. It is worth mentioning that there is no requirement for ongoing psychotherapy or psychometric testing with this approach, in comparison to the first two models.

Taken together, these three models of care (i.e., the live in your own skin model, the watchful waiting model, and the gender affirmative model) help us understand how families and parents of transgender and gender diverse children and adolescents have historically and currently have navigated the medical system. These models of care have had an impact on how parents can accept and support their child in their various gender expressions and identities in other contexts such as the home. In addition, depending on what model of care is being used by mental health professionals (i.e., the live in your own skin model, the watchful waiting model, or

the gender affirmative model), parents' supportive attitudes and approaches for their child could vary.

In addition, research has suggested important roles of clinicians as an educator for and a collaborator with parents of transgender children and adolescents (Gower et al., 2018; Fontaine, 2002). Specifically, Gower et al. (2018) have argue that health-care providers can take on an educational role for demonstrating the importance of support to parents, and this professional competence requires proper training. A study by Fontaine (2002) also documented the reports of clinicians indicating that family relationships, community contexts, and the degree of societal acceptance may explain why some transgender adolescents experience difficulties while others are resilient. In this sense, it is important to take into consideration how parents and clinicians can collaboratively promote positive psychosocial development for transgender and gender diverse children and adolescents. Hence, this collaboration seems to be critical for these children and adolescents to foster their resilience in the face of adversity experienced in various contexts.

Statement of the Problem

A systematic review method was employed to help gather all relevant evidence that fits pre-specified eligibility criteria, in order to answer the following review questions: (1) how is parent support (e.g., acceptance and affirmation) for transgender and gender diverse children and adolescents associated with mental health, and physical health outcomes?; (2) alternatively, how is non-supportive parenting (e.g., rejection, harassment, abuse, and violence) for transgender and gender diverse children and adolescents associated with mental health, and physical health outcomes?; (3) how is clinician (e.g., medical or mental health care professionals) support (e.g., acceptance, affirmation) for transgender and gender diverse children and adolescents associated with mental health, and physical health outcomes?; and (4) alternatively, how are non-supportive

behaviors (e.g., rejection, discrimination, refusal to treat, harassment) from clinicians of transgender and gender diverse children and adolescents associated with mental health, and physical health outcomes?; and (5) how are parent support and clinician support related, and how are these associations related to transgender and gender diverse children and adolescents, in terms of mental health, and physical health outcomes? In addition to these five questions regarding the expected findings of the studies, a sixth question related to the quality of the studies themselves was added, as follows: (6) does each of the studies reviewed in the present have a clear focus of research question and/or study objectives, a comprehensive literature review, an appropriate inclusion criteria to select people, an appropriate methodological quality (i.e., related to research design, study sample, sources of potential biases [confounders, respondent bias], data collection and the measures used, data analysis), a transparent description of results, and finally does the data supports the author's interpretation?

For the questions 1 to 5, we expected that parent and clinician acceptance, support, and affirmation would all be associated with positive outcomes for transgender and gender diverse children and adolescents. We also expected that non-supportive parenting and clinician behaviors such as rejection, harassment, verbal and physical abuse, and violence would all be associated with negative mental health outcomes for transgender and gender diverse children and adolescents. For the question 6, there was not a specific hypothesis, due to its exploratory nature.

To answer our research questions, the present project used explicit, systematic methods to minimize bias in the identification, selection, synthesis, and summary of studies. In relation to our research questions, the objective of the systematic review was to explore and document the differential constructs related to parent and clinician support and how these are associated with

various outcomes for transgender and gender diverse children and adolescents; such outcomes included mental health, physical health, and social-emotional outcomes.

By using a systematic approach, the present project attempted to identify gaps in the current literature on parent and clinician support of transgender and gender diverse children and adolescents and map the "boundaries of the existing literature in order to identify where generalizations occur and also the limits of those generalizations" (Pickering & Byrne, 2014, p. 535). The findings of the systematic review were expected to provide salient information and allow us to make recommendations that would inform public health policy-making at the provincial and federal levels and help social workers, family counselors, and psychologists in the development and implementation of effective parenting programs and policies.

Findings from previous studies have also reinforced the idea that parents of transgender and gender diverse adolescents should be informed of appropriate knowledge and strategies to best support their child (e.g., Field & Mattson, 2016; Platero, 2014; Riley, Sitharthan, Clemson, & Diamond, 2011). Therefore, this systematic review aimed to summarize the current literature to inform our key stakeholders—namely, families of transgender and gender diverse children and adolescents, as well as community organizations who work with these families—on the latest recommended parenting and clinician practices.

Ultimately, we hoped that the findings of this review can provide a strong rationale for parent and clinician support serving as protective factors for transgender and gender diverse children and adolescents. In this sense, we viewed parent and clinician support as important social determinants of health which help buffer negative mental health and health outcomes for transgender and gender diverse children and adolescents.

Chapter 3: Method

A systematic review helps gather all relevant evidence that fits pre-specified eligibility criteria to answer a specific research question. A systematic review uses explicit, systematic methods to minimize bias in the identification, selection, synthesis, and summary of studies. When a review follows a systematic methodology, it can provide reliable findings from which conclusions/recommendations can be drawn and decisions made (Oxman & Guyatt, 1993). Some key characteristics that should be included in a systematic review are: (1) clear objectives with a transparent, explicit, and reproducible methodology; (2) identification of all studies that would meet the eligibility criteria; (3) an assessment of the validity of the findings of the included studies; and finally, (4) a systematic presentation, and synthesis, of the characteristics and findings of the included studies (Shamseer et al., 2015).

This systematic review project was prepared in accordance with the *Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols* (PRISMA-P; Moher et al., 2015). Please see Table 1 for the 17-item checklist of the items that were reported in the present systematic review's protocol (Shamseer et al., 2015). Indeed, a PRISMA-P protocol was developed at the initial stages of this research to serve as guidelines for the present systematic review. This methods section was intended to provide both the rationale for the review and details on the methodological and analytic approach.

Table 1

PRISMA-P (Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols) 2015 Checklist

Section and topic	Item No	Checklist item	Checked
ADMINISTRATIVE INFORMATION			
Title:		Protocol for a Systematic Review: Parent and Clinician Support of Transgender and Gender Diverse Children and Adolescents and their Associated Outcomes	✓
Identification	1a	Identify the report as a protocol of a systematic review	✓
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	N/A
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	N/A
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	✓
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	✓
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	✓
Support:			
Sources	5a	Indicate sources of financial or other support for the review	✓
Sponsor	5b	Provide name for the review funder and/or sponsor	✓
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	✓
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	✓
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)	✓

METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	✓
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	✓
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	✓
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	✓
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	✓
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	✓
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	✓
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	✓
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	✓
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesized	N/A
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2, Kendall's τ)	N/A
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	N/A
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	✓
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	N/A

Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)	N/A

Eligibility Criteria

Studies were selected according to the criteria outlined below. By presenting the inclusion and exclusion criteria, the goal here was to provide an unambiguous description of planned eligibility criteria for the present systematic review, as recommended by Shamseer et al. (2015).

Study designs. The eligibility criteria were established to include all original research of quantitative study designs. The present study also included mixed-methods study designs in which the quantitative data was extractable. Qualitative study designs were excluded in the present study because of the nature of the review, which was to explore the associations between social support and children and adolescents' outcomes. All studies included in the present study had to be reported in the English language and in peer-reviewed journals. Grey literature (i.e., literature that was produced by governments, academics, business, and industry, but which was not controlled by commercial publishers) and conference abstracts were excluded.

People. Studies with transgender and gender diverse children and adolescents or their information were included in this review. In addition, studies were included if the mean age of participants was under 19 years old, inclusively. A primary reason of targeting this age range was to investigate the uniqueness of social support and relationships before emerging adulthood (e.g., Arnett, 1998). Additionally, the present study considered studies in which parents and clinicians were reporting on transgender and gender diverse children and adolescents, as their child or as their patient/client. Some challenges arose when reviewing studies that include transgender children or adolescents as part of larger studies with lesbian, gay, bisexual, trans, and

queer (LGBTQ) communities (Marshall et al., 2017). To remain as inclusive as possible for transgender and gender diverse children and adolescent's specific issues, the present research included studies from LGBTQ samples only if the data was extractable on participants who identify and/or express their gender as transgender or gender diverse.

Interventions. Only direct associations between social support and non-supportive behaviors and participants' outcomes were considered. Some associations were suspected to either have positive effects or adverse health-related outcomes on transgender and gender diverse children and adolescents. The scope of this review, therefore, warranted an examination of all these different associations that influence transgender and gender diverse children and adolescents. Guided by this aim, interventions were not investigated in the present review.

Time of publication. Studies published from January 2000 to the time of the search (February 2019) were included in the present research. The January 2000 inclusion criterion is based on the literature on transgender children and adolescents and their families which started in the early years of the 2000s (e.g., Boenke, 2003). In addition, models departing from the pathologizing of transgender children and adolescents and therefore affecting their families and clinicians started to emerge in the early years of the 2000s as well (e.g., Chen-Hayes, 2001) with, for example, strengths-based models for school and family counselors to assist gender non-conforming children, adolescents, and family members in affirmative ways.

Information Sources

Initial identification of potential databases was based on consultation with the Liaison Librarian to the Department of Educational and Counselling Psychology. To avoid the unnecessary duplicates by searching too many databases or what, a clinical researcher and expert on systematic reviews has referred to as "overproduction" (Sampson, 2016) in systematic

reviews methodology, four databases were identified: (1) one core database used in health sciences knowledge syntheses (PsycINFO), (2) another core database of academic journals covering medicine, nursing, pharmacy, and health care (MEDLINE), (3) one multidisciplinary database of peer-reviewed article records covering the arts, medicine, science, social sciences, and technology (Scopus), and one subject-specific database related to our topic (socINDEX) (Page et al., 2016; Sampson, 2016). Systematic review protocols were also searched through the Cochrane Database of Systematic Reviews, Campbell Collaboration, and PROSPERO to determine if another systematic review on our topic was either completed or in progress.

The specific search strategies were created by the first author and the Educational and Counselling Psychology Liaison Librarian with expertise in systematic review searching. The PsycINFO (OVID interface, 1906 onwards) strategy was developed first and was then peer-reviewed by two reviewers with expertise in LGBTQ research. After the PsycINFO strategy was finalized, it was adapted to the syntax and subject headings of the three other databases (MEDLINE: OVID interface, 1946 onwards; Scopus: Elsevier interface, no dates specified; and socINDEX: EBSCO interface, no dates specified) in collaboration again with the Educational and Counselling Psychology Liaison Librarian.

Search Strategy

The subject headings and text words used in the search strategy related to the three components of our review question: (1) parents/caregivers and clinicians, (2) children and adolescents, and (3) transgender and gender diverse identities. Search terms focusing on transgender and gender diverse identities were numerous (i.e., either used for/by transgender children and adolescents) and these terms have continued to change over time (Reicherzer, 2008). Hence, similarly to Marshall et al. (2017), the full list of search terms for this component of the search was extensive and consisted of terms related to gender identity (e.g., “male-to-

female"), diagnoses (e.g., "gender identity disorder"), and language historically used (e.g., "transvestite").

No study design was imposed on the search. Language limits were imposed to only include studies in the English language due to resource limits. Date range limits were also imposed on the search, as discussed in the eligibility criteria section. No publication type limit was imposed, however. To determine if relevant studies were from peer-reviewed journals, the research team (i.e., a doctoral student and myself) used Ulrich's web tool, which provided detailed information on print and electronic serials, such as that if a journal had academic/scholarly content (i.e., peer-reviewed). Please see Appendix A for the search strategies.

Study Records

Data management. Literature search results were first uploaded into Endnote to proceed with deduplication of search results. After the deduplication of the results was done, the relevant search results were uploaded to the Rayyan Software, an internet-based software program that facilitated collaboration among reviewers during the study screening and selection process (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016). Based on the inclusion and exclusion criteria, a screening and selection tool for stage 2 (full-text) assessments was developed..

Selection process. Two reviewers (myself and a doctoral student) independently screened the titles and abstracts (stage 1) yielded by the search against the inclusion criteria, using Rayyan software. Following this step, I obtained full reports for all titles that appear to meet the inclusion criteria or where there was any uncertainty. With the doctoral student, we then screened independently the full-text reports and decide whether these meet the inclusion criteria (stage 2). At both stage 1 and 2, we resolved disagreements through discussion through

the chat option in the Rayyan software. Only for stage 2, we completed the screening and selecting tool for each of the article included from Stage 1. Neither of the reviewers was blinded to the journal titles or to the study authors or institutions.

Data collection process. Using a standardized Excel form, I extracted data from each eligible study after the screening and selection process was done. Data extracted included, but was not limited to demographic information, methods, details about the associations between parent and clinician support or non-supportive parent or clinician behaviors and children and adolescents reported outcomes.

Companion studies (i.e., multiple reports of a single study, using the same people) were expected, given the results of a previous scoping review conducted by the author on parent support of transgender and gender diverse children and adolescents (Parent, Wong, & Konishi, 2018). For the case of having considerable number of companion studies, a meta-analytic method is usually required to be performed. However, there was not such a case for the present study (i.e., there were only three companion studies). Accordingly, the companion-studies situation was treated by considering all the different sources as one paper and extracted all the data on the same form.

Data Items

The following information was extracted for this systematic review: the name of the study and authors, the study location, the research question/claim, and/or objectives, the theoretical/conceptual framework, sample demographics, information about who is reporting (children, adolescents, parent, or clinician), the methods, the conclusions, the associations between support and non-supportive behaviors and children and adolescents outcomes, future research, and recommendations from authors.

Outcomes and Prioritization

A preliminary scoping review (Parent, Wong, & Konishi, 2018) on parent support for transgender and gender diverse children and adolescents has revealed associations between parent support and transgender and gender diverse children and adolescents' outcomes. The resulting outcomes from the preliminary were related to mental health specifically. Here is a list of the mental-health-related outcomes (please see below) found from the scoping review. These outcomes were used for the present systematic review to be examined in relation to parent and clinician support for transgender and gender diverse children and adolescents.

A. Outcomes reported in children and adolescents' reports

1. Mental-health-related outcomes

a) Psychological distress

b) Depression

c) Reports of suicide attempts

d) Post-Traumatic Syndrome Disorder (PTSD)

e) Internalizing and externalizing behaviors

f) Subjective well-being

g) Perceived burden

2. Substance-use (e.g., alcohol) behaviors

a) Alcohol-use

B. Outcomes reported in parents' reports

1. Mental-health related outcomes

a) Depression

b) Anxiety

c) Externalizing, and internalizing tendencies

Risk of Bias of Individual Studies

To assess the risk of bias and methodological quality of potential studies, a quality assessment tool was developed to meet the specific needs of this systematic review. Indeed, most of the commonly-used quality assessment tools such as the *Newcastle-Ottawa Scale* (NOS; Wells et al., 2015) and the STROBE (Von Elm et al., 2007), for example, did not fit the needs of the present systematic review, as the selected studies did not include any intervention research, including randomized controlled trials (RCT; comparing the treatment and control groups), neither were intervention studies. The quality assessment tool developed respected the following characteristics, as recommended by Sanderson, Tatt, and Higgins (2007):

> (1) including a small number of key domains; (2) being as specific as possible (with due consideration of the particular study design and topic area); (3) being a simple checklist rather than a scale; and (4) showing evidence of careful development, and of their validity and reliability (Sanderson, Tatt, & Higgins, 2007, p. 674).

The quality assessment tool contained the following domains, which were drawn from *McMaster University' Health Evidence*™ quality assessment tool for reviews articles: clear focus of research question and/or study objectives, comprehensive literature review, appropriate inclusion criteria to select people, methodological quality (i.e., related to research design, study sample, sources of potential biases [confounders, respondent bias], data collection and the measures used, data analysis), transparent description of results, data supporting author's interpretation. The risk of bias and quality assessment was undertaken by me and a sample of these critical appraisal decisions (25%) was also appraised by the doctoral student. The results

of the risk of bias assessments were incorporated into data synthesis and reported in the results section to further report on their potential influence on the findings of the review.

Data Synthesis

A systematic narrative synthesis was provided with the information presented in the text format, as well as tables to summarize and explain the characteristics and findings of the included studies (Boland, Cherry, & Dickson, 2017). The narrative synthesis explored the relationships and findings both within and between the included studies.

Chapter 4: Results

Data Retrieval

As seen in Figure 1, the search identified 546 citations in PsycINFO, 1,319 citations in MEDLINE, 631 citations in socINDEX, and 3,721 citations in Scopus. Therefore, before deduplication, the total numbers of citation results across the four databases was 6,217 results. After deduplication into Endnote, the total number of citation results across the four databases was 4,665 results. These 4,665 citations were then imported into Rayyan for Stage 1 – titles and abstracts screening and selection. This stage was conducted independently by two different reviewers, me and a doctoral student. When the blind was removed on Rayyan, there were a total of 237 conflicts which were resolved between the two reviewers. Therefore, there was a 95% inter-rater agreement between me and the doctoral student for Stage 1. This stage resulted in including 148 articles for Stage 2 – full-text screening and selection (i.e., 4506 citations were excluded).

Stage 2 was conducted, again, independently by the two reviewers to minimize the risk of bias (Shamseer et al., 2015) and avoid the possibility of excluding relevant studies (Edwards et al., 2002). When the blind was removed on Rayyan, there was a total of 14 conflicts which were resolved between the two reviewers. Therefore, there was a 90% inter-rater agreement between me and the doctoral student. This final screening and selection stage resulted in including 12 articles (i.e., 136 articles were excluded). The reasons for exclusion at that stage were as follows: wrong mean age (58 studies excluded), no association between support-related predictor and health outcomes (40 studies excluded), not of empirical design (15 studies excluded), wrong population (12 studies excluded), wrong study design (10 studies excluded), and not from a peer-reviewed journal (1 study excluded).

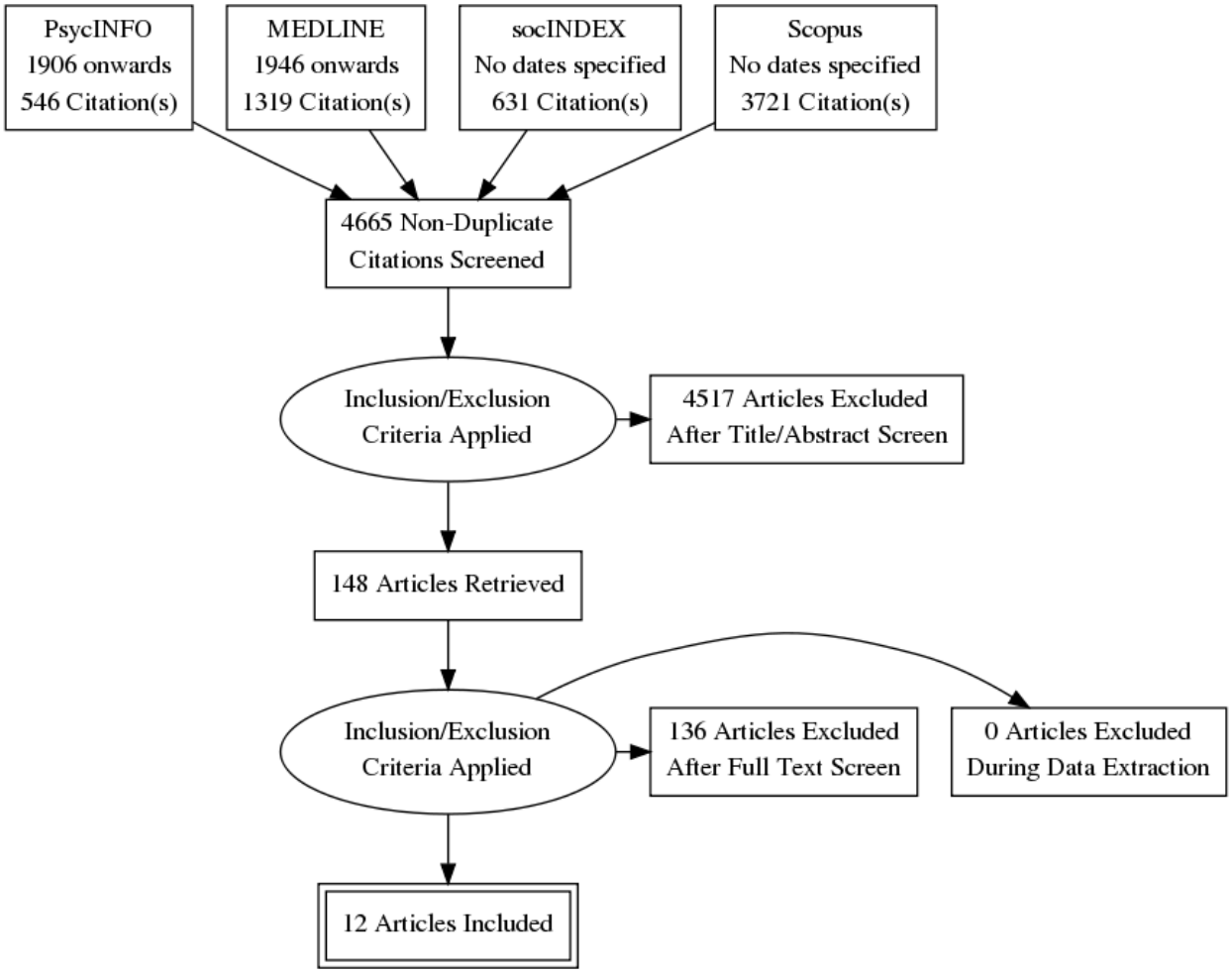

Figure 1. Prisma diagram of the screening and selection process.

Study Characteristics

As seen in Table 2, among the 12 studies included, there were three studies that counted as companion studies, which means they used the same dataset (i.e., to conduct secondary data analysis in this case). Therefore, these three companion studies were reported altogether throughout this thesis. In terms of study characteristics, Table 2 reports on the study authors, date of publication, study design, study population, and location of study (country, state or province and/or city). Among the 10 studies included, all of them were published from 2010 and later (even if our eligibility criteria allowed for studies published from 2000). In addition, six of them related to parent support and four of them related to clinician support. Transgender and

gender diverse children and adolescents were the ones who were reporting in eight studies, one reported the perspectives of their parents, and one reported the perspectives of both parents and adolescents. Lastly, the location of the study was mainly from the United States in eight studies, from Canada in one study, and from the United Kingdom in one other study.

Table 2

Study Characteristics

Source (authors and date of study)	Type of support	Study design	Study population	Location of study
Birkett, Newcomb, & Mustanski (2015)	Parent	Longitudinal data from a quantitative study design	Adolescents	United States (Chicago)
Bouris & Hill (2017)	Parent	Cross-sectional data from a quantitative study design	Adolescents	United States
Budge (2015)	Clinician (and parent)	Longitudinal data from a mixed-methods study design	Adolescents	United States
Clark, Veale, Greyson, & Saewyc (2017)	Clinician	Cross-sectional data from a mixed-methods study design	Adolescents	Canada (all provinces represented)
Costa, Dunsford, Skagerberg, Holt, Carmichael, & Colizzi (2015)	Clinician	Longitudinal data from a quantitative study design	Adolescents	United Kingdom (London)
Grossman, D'augelli, & Frank (2011)	Parent	Cross-sectional data from a mixed-methods study design	Adolescents	United States (New York City)
Hill, Menvielle, Sica, & Johnson (2010)	Clinician	Cross-sectional data from a mixed-methods study design	Parent	United States (across different states, 1 parent from Canada (Ontario))
Katz-Wise, Ehrensaft, Vetters, Forcier, & Austin (2018)	Parent	Cross-sectional data from a mixed-methods study design	Adolescents and parent	United States (New England)
Simons, Schrager, Clark, Belzer, & Olson (2013)	Parent	Cross-sectional data from a quantitative study design	Adolescents	United States (Los Angeles)
Three companion studies (1) Gower, Rider, Brown, McMorris, Coleman, Taliaferro, & Eisenberg (2018) (2) Taliaferro, McMorris, & Eisenberg, (2018) (3) Taliaferro, McMorris, Rider, & Eisenberg (2018)	Parent	Cross-sectional design from a quantitative study design	Adolescents	United States (Minnesota)

Participant Characteristics

Participant characteristics were described in Table 3 in terms of sample size, age of the participants (range and mean), participants' ethnic and racial background, the sampling strategy, and the data collection method used in each study.

Table 3

Participant Characteristics

Source (authors and date)	*N*	Age (range and mean)	Race/ethnicity	Sampling strategy	Data collection method
Birkett, Newcomb, & Mustanski (2015)	*n*=22 participants with a transgender identity among a sample of 231 LGBTQ adolescents	16–20 years old (*M*= 18.74 at baseline)	Among the overall sample, 128 identified as African-Americans, 40 identified as multiracial or Asian/Native American racial identity, 34 identified as White, 29 as Latinos	Project Q2; Via incentivized peer recruitment and e-mail advertisements, cards, and flyers distributed in LGBT-identified neighborhoods and LGBT-identified events	Adolescents' self-reports on surveys across 6 times points within 3.5 years
Bouris & Hill (2017)	*n*=28 gender minority adolescents among a larger sample of 163 adolescents	16–19 years old (*M*= 18.4)	16 adolescents identified as African American/Black, 9 as multiracial, and 3 identified as African American/Black and Latino	Project READY; Outreach at LGBT venues and events, snowball sampling, and referrals from other studies	Interviewer-administered survey
Budge (2015)	*N*=1 (Lia)	18 years old	Latina-Italian	Referred to Budge's independent practice from the director of the LGBT center at the university she was planning to attend in the fall	Surveys answered throughout treatment (i.e., at baseline, Session 5, Session 10, Session 15, Session 20, and termination)
Clark, Veale, Greyson, & Saewyc (2017)	*n*=323 transgender adolescents aged from a larger sample including young adults (*N*=923)	14-18 years old	Among the overall sample, 73.9% of participants identified their ethnicity as White, 10.2% Indigenous (which included First Nations, Inuit and Métis), 6.0% East Asian or Southeast Asian, 1.8% West Asian or Arab, 1.7% Black, 1.3% Latino, 1.3% South Asian and 3.8% other or multiracial	Recruitment through a national network of health professionals and investigators across Canada, transgender youth advisory council members, community organizations, social media, and online advertising	Adolescents' self-reports on various surveys, including open-ended questions

Source (authors and date)	*N*	Age (range and mean)	Race/ethnicity	Sampling strategy	Data collection method
Costa, Dunsford, Skagerberg, Holt, Carmichael, & Colizzi (2015)	*N*=201 adolescents	*M*= 15.52	Not reported	Adolescents referred to the Gender Identity Development Service (GIDS) and who completed the diagnostic procedure (about 6 months) were invited to take part in follow-up evaluations	Adolescents' self-reports on measures every 6 months from the first visit
Grossman, D'augelli, & Frank (2011)	*N*=55 transgender adolescents (described as 31 MTF and 24 FTM adolescents)	15-21 years old; MTF; *M*=17.5 (*SD* = 1.6) FTM; *M*=19.5 (*SD* = 1.6)	Ethnically, 22 were of Hispanic heritage and 33 were not. Regarding race, 41 identified as White, 7 as Black/African American, 3, more than one race, 2 American Indian, and 1 did not provide information on race	Recruitment via programs of two social and recreation services agencies which provide services to LGBTQ people, and snowball sampling techniques	Structured interviews and adolescents' self-reports on a battery of standard mental health measures
Hill, Menvielle, Sica, & Johnson (2010)	*N*=42 parents	Mothers; 22–58 years old (*M* = 43.5); fathers; 35–61 years old (*M*= 46.6). The children ranged in age from 4 to 17.5 years (*M* = 8.0)	Eighty percent of mothers were White, while 10% were Hispanic, one was Black, and one identified as multi-racial. Eighty-five percent of the fathers were White, with only one identifying as Hispanic	Parents were all affiliated with the Children's Program located in the U.S.	Parents' self-reports on various measures about their child and themselves
Katz-Wise, Ehrensaft, Vetters, Forcier, & Austin (2018)	*N*=96 family members (i.e., 33 families); 33 TGN adolescents, 48 cisgender caregivers and 15 cisgender siblings	TGN adolescents, 13 to 17 years old (*M*= 15.18); 48 cisgender caregivers, 37 to 69 years old (*M*= 50.33); and 15 siblings, 14 to 24 years old (*M*= 17.93)	Race/ethnicity of the sample was primarily White (73% TGN adolescents, 92% caregivers, 73% siblings) or mixed race/ethnicity (15% TGN adolescents, 2% caregivers, 7% siblings)	Community-based sample recruited via support organizations, youth drop-in centers, lesbian, gay, bisexual, transgender, and queer (LGBTQ) organizations, homeless shelters, medical and mental health providers, and gender clinics	Both parents and adolescents participated in a one-time, one-on-one semi-structured interview and surveys were given

Source (authors and date)	*N*	Age (range and mean)	Race/ethnicity	Sampling strategy	Data collection method
Simons, Schrager, Clark, Belzer, & Olson (2013)	*N*= 66 transgender adolescents	12-24 years old (*M*=19.06)	Ethnically-diverse sample: Caucasian (51.5%) and Other (48.5%)	Recruitment via Center for Transadolescents Health and Development at Children's Hospital Los Angeles	Adolescents' self-reports on various measures
Three companion studies (1) Gower, Rider, Brown, McMorris, Coleman, Taliaferro, & Eisenberg (2018) (2) Taliaferro, McMorris, & Eisenberg, (2018) (3) Taliaferro, McMorris, Rider, & Eisenberg (2018)	For (1) and (2), *N*=2,168 transgender and gender diverse adolescents. Among this sample, a subsample of *n*=1,635 transgender and gender diverse adolescents for (3).	Adolescents were in grades 9 and 11 (i.e., ages 14–15 and 16–17)	For the overall sample, ethnicity/race was described as follows: 58.7% identified as Non-Hispanic (NH) White, 11.9% of the sample identified as Hispanic, 11.8% NH multiracial, 9% as NH Asian/Pacific Islander, 6.5% as NH black, and 2.1% as NH American Indian.	Anonymous population-based survey conducted every 3 years with students in grades 5, 8, 9, and 11 by the Departments of Education, Health, Human Services, and Public Safety. All public-school districts are invited to participate.	Population-based survey (i.e., 2016 Minnesota Student Survey (MSS))

To answer the research questions described earlier (p. 30), the study questions were examined by types of support, namely – parent and clinician support. The findings from each study in terms of the associations between parent and clinician support and non-supportive behaviors and their associated health outcomes are described in both text format and in tables below. Please see Table 4 for a summary of these associations.

Table 4

Study Results

Source	Association between support and non-supportive behaviors and health-related outcome
	Parent support
Birkett, Newcomb, & Mustanski (2015)	Social support (i.e., from parent, friends, and significant other) was associated with lower levels of distress but did not have a significant impact on later levels of psychological distress.
Bouris & Hill (2017)	Maternal warmth was negatively related to suicidal ideation and maternal acceptance negatively related to NSSI, suicidal ideation, CAS, and being HIV positive.
Grossman, D'augelli, & Frank (2011)	Social support (i.e., from family and friends) was a significant predictor of lower depression, and lower internationalizing problems.
Katz-Wise, Ehrensaft, Vetters, Forcier, & Austin (2018)	In unadjusted models, better family communication and greater family satisfaction were associated with less self-harm, fewer depressive and anxious symptoms, and greater self-esteem and resiliency. After controlling for TGN adolescents' age in years and TGN adolescents' gender identity (adjusted model), family communication reported by adolescents remained significant for all outcomes except self-harm. Family satisfaction reported by TGN adolescents remained significant in adjusted models for all outcomes except resiliency, which became marginally significant. In sum, better family communication and greater family satisfaction were associated with fewer adverse mental health outcomes and greater self-esteem and resiliency among TGN adolescents. Family communication reported by caregivers and family satisfaction reported by caregivers and siblings were not significantly associated with any mental health outcomes among TGN adolescents.
Simons, Schrager, Clark, Belzer, & Olson (2013)	After controlling for covariates (age, nationality, and assigned sex), parental support was significantly associated with higher life satisfaction, lower perceived burden, and fewer depressive symptoms
Three companion studies (1) Gower, Rider, Brown, McMorris, Coleman, Taliaferro, & Eisenberg (2018) (2) Taliaferro, McMorris, & Eisenberg, (2018) (3) Taliaferro, McMorris, Rider, & Eisenberg	(1) Feeling more connected to parents was related to significantly lower odds of all seven indicators of emotional distress and substance use relative to those reporting less connected relationships with parents. (2) Among adolescents who engaged in NSSI, depression emerged as the most important risk factor associated with repetitive NSSI, and parent connectedness represented one of the two most important factors to protect against repetitive self-injury. (3) Lower levels of connectedness to parents and non-parental adults represented the top two protective factors to characterize the NSSI +SA group from the no self-harm group. The leading protective factors to differentiate the NSSI + SA group from the NSSI only group included lower levels of perceived school safety and parent connectedness. Finally, the co-occurring negative health-risk behavior that showed the largest and most consistent effect distinguishing between groups of transgender/GNC students across all three analyses was running away from home. This study also examined factors associated with increased risk for a suicide attempt among transgender/GNC students who self-injure. A mental health problem, physical or sexual abuse, relationship violence, bullying victimization, less parent connectedness, lower grades, lower levels of perceived school safety, and running away from home were associated with an increased likelihood that adolescents who engaged in NSSI

(2018)	also attempted suicide. The leading factors to differentiate the NSSI + SA from the NSSI only group were parent connectedness and school safety.
Clinician support	
Budge (2015)	Interaction between hormone therapy and psychotherapy enhanced one another to enable Lia's psychological well-being to improve over time throughout her treatment with her clinician.
Clark, Veale, Greyson, & Saewyc (2017)	Among adolescents from the overall sample, levels of comfort with a family doctor were negatively correlated with foregone mental health care in the previous 12 months, but not correlated with foregone physical health care.
Costa, Dunsford, Skagerberg, Holt, Carmichael, & Colizzi (2015)	Psychological support was associated with better psychosocial functioning in adolescents with gender dysphoria. Moreover, puberty suppression (GnRHa) was associated with further improvement in global functioning. Finally, global functioning improved steadily over time in adolescents with gender dysphoria receiving both psychological support and GnRHa.
Hill, Menvielle, Sica, & Johnson (2010)	Associations were found between the affirmative approach used by the mental health provider and transgender adolescents' outcomes (externalizing, internalizing, and peer relations outcomes). Specifically, parents who contacted the affirmative program in the U.S. (participants mainly lived throughout the U.S. and one participant lived in Canada, Ontario) rated their child's behavior as less pathological overall on the peer relations and internalizing and externalizing problems, compared to other samples of children diagnosed with gender identity disorder in the Netherlands and Canada.

Research Questions 1 & 2: Associations with Parent Support

Starting with longitudinal data, it was found by Birkett, Newcomb, and Mustanski (2015), that LGBTQ adolescents who reported a lower total score of social support (from family, friends, and significant other) were more likely to report increased levels of psychological distress. However, in the time-lagged model, prior levels of support did not predict later levels of distress, suggesting that social support serves as an immediate buffer against stress, but not over time (Birkett et al., 2016). Findings from cross-sectional data (i.e., Grossman, D'augelli, & Frank, 2011) corroborate Birkett et al. (2016) results. Indeed, Grossman et al. (2011) found that greater perceived social support (family and friends support altogether) predicted positive mental health outcomes, but only for depression, and internalizing problems, and not for mental health problems, trauma symptoms, and externalizing problems. In addition, the majority of those who disclosed their transgender identities reported that their parents' first reactions to being very

negative or negative; and although there were more positive reactions, on average, three years later, most parental reactions remained very negative or negative. Similar to Birkett (2016), social support was assessed through a general score of support from family and friends, which made it hard to distinguish the effect of only family support from that of friends. One recent study by Simons, Schrager, Clark, Belzer, and Olson (2013) assessed parental support on its own. These authors found that parental support was significantly associated with higher life satisfaction, lower perceived burden, and fewer depressive symptoms. Taken together, these three studies all point out, in various ways, to the importance of parent support, and social support for transgender adolescents, helping increase likelihoods to report higher psychological well-being and mental health for transgender adolescents.

Other studies have also investigated parent support by looking at other constructs such as the whole family communication and family satisfaction. For example, Katz-Wise, Ehrensaft, Vetters, Forcier, and Austin (2018) found that better family communication, as reported by transgender and gender non-conforming (TGN) adolescents, was associated with less self-harm, fewer depressive and anxious symptoms, and greater self-esteem and resiliency among TGN adolescents. In unadjusted models, family communication and family satisfaction reported by TGN adolescents were the significant predictors for all outcomes. Specifically, better family communication and greater family satisfaction were associated with less self-harm, fewer depressive and anxious symptoms, and greater self-esteem and resiliency. In adjusted models (i.e., age in years and TGN adolescents' gender identity were controlled), family communication reported by TGN adolescents remained significant for all outcomes except self-harm. Family satisfaction reported by TGN adolescents in adjusted models remained significant for all outcomes except resiliency, which became marginally significant ($p = .05$). In sum, better family

communication and greater family satisfaction were associated with fewer adverse mental health outcomes and greater self-esteem and resiliency among TGN adolescents. As of note, family communication reported by caregivers and family satisfaction reported by caregivers and siblings were not significantly associated with any mental health outcomes among TGN adolescents.

The mother-child relationship within the family also seems to be of great importance to transgender children and adolescents. Indeed, in many previous studies, it was shown that mothers tend to be more accepting their child's transgender or gender diverse identities (e.g., Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015; Wren, 2002). In the study by Bouris and Hill (2017), the mother-child relationship was explored to investigate if this relationship could lead to better health outcomes for gender minority adolescents. Based on correlational analyses, this study found that maternal warmth was associated with lower odds of suicide ideation. In addition, maternal acceptance of their gender identity was correlated with lower odds of Non-suicidal self-injury (NSSI), lower odds of suicide ideation, and lower odds of HIV-serostatus. Surprisingly, maternal communication about sex was not significantly correlated with any of the health-related outcomes for gender minority adolescents. Altogether, maternal acceptance was likely to be the strongest predictor of better mental health outcomes for gender minority adolescents, compared to maternal warmth, and maternal communication about sex. Lastly, for the three companion studies (i.e., Gower et al., 2018; Taliaferro, McMorris, & Eisenberg, 2018a; and Taliaferro, McMorris, Rider, & Eisenberg, 2018b), associations between various protective factors and adolescent mental health outcomes were examined in various ways. In the study by Gower et al. (2018), it was found that transgender and gender diverse adolescents who reported feeling more connected to their parents were more likely to report

lower levels of all seven indicators of emotional distress and substance use (i.e., depressive symptoms, suicidal ideation in the past year, suicide attempt in the past year, alcohol use, binge drinking, marijuana, and nicotine use) relative to those adolescents reporting feeling less connected to their parents. In addition, when the various protective factors (i.e., connection to other adults and teachers, adolescent's development opportunities, and feeling safe in the community and at school) were regressed simultaneously, parent connectedness was the only factor that remained protective for all health-related outcomes described above.

In a similar vein, Taliaferro et al. (2018a) examined associations between parent connectedness and non-suicidal self-injury. Among the adolescents who reported engaging in self-injury, parent connectedness and school safety represented the most important factors to protect against repetitive self-injury.

In the study by Taliaferro et al. (2018b), further analyses were made by taking a sub-sample (i.e., n = 1,635 transgender and gender diverse adolescents) of the analytic sample (i.e., N = 2,168 adolescents) used in Gower et al. (2018) and Taliaferro et al. (2018a), to further divide this sub-sample into three different groups, as follows: no self-harm (no NSSI or suicide attempt [SA] ever), NSSI only (NSSI one or more times in the past year, no SA ever), and NSSI + SA (NSSI and SA in the past year). By looking at the three different groups, this study found that connectedness to parents and non-parental adults were significantly greater protective factors against repetitive self-injury among the NSSI +SA group as compared to no self-harm group. Further, connectedness to parents and perceived safety at school were significantly greater protective factors against repetitive self-injury among the NSSI +SA group as compared to the NSSI only group.

Finally, the co-occurring negative health-risk behavior showing the largest and most consistent effect distinguishing between groups of transgender and gender diverse students across all analyses was to run away from home. Moreover, this study sought to identify factors associated with increased risk for a suicide attempt among transgender and gender diverse students who self-injure. A mental health problem, physical or sexual abuse, relationship violence, bullying victimization, less parent connectedness, lower grades, lower levels of perceived school safety, and running away from home were associated with an increased likelihood of attempting suicide among adolescents who engaged in NSSI.

Research Questions 3 & 4: Associations with Clinician Support

One study by Hill et al. (2010) investigated the affirmative approach to the treatment of gender variant children. Based on parents' self-reports about their transgender and gender variant children, it was found that transgender children living throughout the U.S. and the province of Ontario were not rated any less extreme in their gender variance compared to other samples from Canada and the Netherlands, who used different approaches to the treatment, namely – the live in your own skin model (e.g. Zucker & Bradley, 1995; Zucker, Bradley, Owen-Anderson, Singh, Blanchard, & Bain, 2010), and the watchful waiting model (i.e., the Dutch model) (e.g., Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis & van Goozen, 1998; Delemarre-van de Waal & Cohen-Kettenis, 2006; Gooren & Delemarre-van de Waal & Gooren, 1996), respectively. Indeed, parents rated their child's behavior as less pathological overall in peer relations and internalizing and externalizing problems in the sample in the U.S. and Ontario, as compared to the other samples (i.e., Canadian and Dutch) of children diagnosed with a gender identity disorder. In other words, "when compared to children at other gender identity clinics in Canada and the Netherlands,

parents from the sample in the U.S. and Ontario rated their children's gender variance as no less extreme, but their children were overall less pathological" (Hill et al., 2010, p. 6).

When investigating psychological support provided by a mental health professional based on longitudinal data, it was found in the study by Costa et al. (2015) that clinician support was associated with better psychosocial functioning in adolescents with gender dysphoria, especially when presenting psychological/psychiatric problems. Moreover, puberty suppression was associated with further improvement in global functioning. Global functioning also improved steadily over time in adolescents with gender dysphoria receiving both psychological support and GnRHa (puberty suppression). On the contrary, when transgender adolescents reported low levels of comfort with their family doctor, it was negatively correlated with foregone mental health care in the previous 12 months, according to Clark, Veale, Greyson, and Saewyc (2017). Reasons provided by transgender adolescents for missing needed care included previous negative experiences with health care providers and concerns that a doctor would be uneducated about transgender people.

Research Questions 5: Associations with Both Parent *and* Clinician Support

According to a longitudinal case study (Budge, 2015), the interaction of hormone therapy and psychotherapy was likely to enhance one another to enable the patient's psychological well-being to improve. The case study was based on Lia's (pseudonym) reported improvements in her mental health, family support, and identity processes across all measures from baseline to termination. She highlighted that psychotherapy was an important component assisting her with her mood, specifically learning how to experience and express her emotions. As a matter, the psychotherapy was helpful for her gender identity. Family support also improved from start to termination of the treatment. Although it is not clear what kind of support has exactly

contributed to the positive change in Lia's psychological outcomes, this might help us in part respond to our last research question, which was to explore how parent support and clinician support work together in fostering healthy outcomes among transgender children and adolescents. It should be at least recognized that appropriate clinical treatment and positive family support were involved for Lia's positive change.

Research Question 6: Critical Appraisal of the Included Studies

The studies were assessed on the following criteria: clear focus of research question and/or study objectives, comprehensive literature review, appropriate inclusion criteria to select people, methodological quality (i.e., related to research design, study sample, sources of potential biases [confounders, respondent bias], data collection and the measures used, data analysis), transparent description of results, data supporting author's interpretation. The risk of bias and quality assessment was undertaken by me and a sample of these critical appraisal decisions (25%) was appraised by a doctoral student.

Clear focus of study objective. All included studies had a clear focus, going from having a clear research objective to having clear research questions, and hypotheses.

Comprehensive literature review. In terms of literature review, some studies (i.e., Simons et al., 2013; Taliaferro et al., 2018a) included a short literature review, but this might be explained by a limited word count criterion from the journals they submitted to. Moreover, in the study by Costa et al. (2015), the authors failed to mention other models of treatment such as the affirmative model of treatment, and only describe the watchful waiting model (i.e., the Dutch model), to which they adhere to. In the study by Bouris and Hill (2017), the authors also failed to describe in more details the importance of the mother-child relationship for transgender adolescents. Indeed, previous literature has suggested that mothers tend to be generally more

supportive of their transgender children and adolescents, compared to fathers (e.g., Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015; Wren, 2002). The authors stated that the reason behind looking at the mother-child relationship only was that 98.8% of the sample reported growing up with a mother/mother figure, compared to 61.3% with a father/father-figure. However, it would have been helpful to include the information derived from previous literature showing mothers being more supportive of their transgender children and adolescents than fathers, and thus providing a relevant rationale for investigating the mother-child relationship on its own.

Appropriate inclusion criteria to select people. The inclusion criteria were clear for all studies as well. Three studies used a snowball sampling method (i.e., Birkett et al., 2015; Bouris & Hill, 2017; and Grossman et al., 2011) among other recruitment methods. While snowball sampling methods provide the advantage of recruiting populations that are typically difficult to recruit, this method can also be prone to sampling bias, which means that it is highly possible that the subjects share the same traits and characteristics. It is, therefore, possible that the sample will only constitute a small subgroup of the entire population. Nonetheless, the authors from these three studies used multiple recruitment methods to help counterbalance the risk of sampling bias.

In addition to recruitment strategies, it is important to mention that there are plenty of studies in which Caucasian participants are over-represented in samples drawn from research with LGBTQ populations. This situation may lead to failure of capturing the diversity of risk factors and protective factors encountered by diverse gender minority groups (Hendricks & Testa, 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015). For example, in Singh's (2013) a majority of the participants (drawn from a sample of 13 trans youth of color) spoke about how

the development of their racial/ethnic identities and their gender identities influenced each other; one youth felt that the pride that her family fostered in her for being Chicana was instrumental to her resilience as a trans youth (Kuvalanka, Weiner, Munroe, Goldberg, & Gardner, 2017). It is therefore important to investigate the intersections of racial/ethnic identities and gender identities in future research as these investigations have been limited in the current literature.

Notwithstanding, some of the studies included in the current review have been particularly successful in including diverse samples of participants coming from different race/ethnicity backgrounds such as the study of Bouris and Hill's (2017) that recruited a sample of gender minority adolescents of color, the study by Simons et al. (2013) that conducted their study with an ethnically-diverse sample (i.e., Caucasian [51.5%] and Other, not described [48.5%]), and the study by Birkett et al. (2015) that identified various groups of African-Americans (55%), multiracial or Asian/Native American racial identity (17%), White (15%), and Latino (13%). On the other end, samples in some other studies included in this review were less diverse, such as the one from Hill et al. (2010), with 80% percent of mothers identifying as White, while 10% identifying as Hispanic, one participant identifying as Black, and one other participant identifying as multi-racial. One study by Costa et al. (2015) failed to report information on the race and/or ethnicity of its participants, which is a limitation. Overall, as seen in the results from an earlier scoping review by Parent et al. (2018), there is a need for more diverse samples in this line of research. Notwithstanding, it seems that researchers have engaged in an effort to recruit samples that are more racially and ethnically diverse in recent years, and these efforts need to be sustained in the future.

Methodological quality. Overall, the methodological quality of the included studies was appropriate and in line with the research objectives. Most of the included studies were of cross-

sectional design, which may limit any causal inferences. Notwithstanding, a few of the included studies used a longitudinal design, namely – studies by Birkett et al. (2015), Costa et al. (2015), and Budge (2015). The latter, however, is based on only one case study, which limited the possibility for generalization, even if the study used a longitudinal study design. The longitudinal design from the study by Birkett et al. (2015) provided some insights about social support being negatively correlated with psychological distress in the cross-sectional model but reaching non-significance in the time-lagged model (i.e., longitudinal analysis). This type of finding is not achievable in a cross-sectional design, therefore there is a clear advantage of conducting longitudinal studies in this field of study.

Some of the studies also included rather small samples, such as one by Bouris and Hill (2017), with only 28 gender minority adolescents. On the contrary, having a large sample size gave a clear advantage to the three companion studies (i.e., Gower et al., 2018; Taliaferro, 2018a; and Taliaferro, 2018b), with a sample of N = 2,168 for the first two companion studies, and n = 1,635 for the third study. Indeed, a large sample size is more likely to be representative of the population. However, the fact that this sample was recruited from the state of Minnesota's public schools might limit its generalizability to other geographical regions. Another study included in this review used a large sample size (i.e., n = 323 transgender adolescents in Clark et al. (2017)), in which all Canadian provinces were represented. This kind of research likely implicates many financial, human, and time resources but has also clear advantages and one of them is the increased likelihood of having a more representative sample.

Some of the included studies also used a mixed-methods design which may help with triangulation of the findings by seeking convergence of the results from different methods (Greene, Caracelli, & Graham, 1989), compared to quantitative design only or qualitative design

only. The studies who used mixed-methods study design as part of this review were ones by Budge (2015), Clark et al. (2017), Grossman et al. (2011), Hill et al. (2010), and Katz-Wise et al. (2018). Although we only used the quantitative data from these studies for the present review, these studies may offer more breadth and depth of understanding and corroboration (Johnson, Onwuegbuzie, & Turner, 2007).

In terms of respondents, most of the studies included transgender adolescents as their primary respondent. One study was conducted with parents' reports (i.e., Hill et al., 2010) and one study gathered multi-informant reports from transgender adolescents, their caregivers, and their siblings (i.e., Katz-Wise et al., 2018). The latter study offers the advantage of gathering the voices of multiple members of the same family, which led to an important contribution to this field of research. Indeed, by using a multi-informant design, the authors were able to conclude that family communication and family satisfaction reported by caregivers and siblings were not significantly associated with any mental health outcomes among TGN adolescents, and only the reports by transgender adolescents themselves on family communication and satisfaction were associated with their mental health outcomes. One limitation of this study, however, was that for families that had two caregivers who participated, an average response was calculated with an overall score that represented both caregivers. Presumably, this method facilitated the data analysis, but we know from previous research that mothers generally tend to be more accepting than fathers, as mentioned previously. Therefore, it would have been useful to maintain the caregiver's reports independent from one another if they originated from the same family. Similarly, in the study by Simons et al., (2013), parent support referred to one or more parents altogether.

One study by Hill et al. (2010) was also critiqued for its methodological limitations by other scholars (i.e., Singh, Bradley, & Zucker, 2011). These authors listed the following methodological limitations of the Hill et al. (2010) study: (1) a small sample size which made it difficult to make statistically powerful comparisons, (2) sampling issues (some parents reported at baseline, and some other reported at another time compared to the Canadian and Netherlands samples), (3) adopted children consisted of half of the sample in the study, which was an unusual sample composition compared to the other two samples, and lastly (4) social class disparities were present between samples. Hill et al. (2010) were also transparent about other limitations pertaining to their methodological design such as exploratory post-test, cultural differences between samples, higher socio-economic status (SES) in the current sample compared to other samples, and age differences between samples. In addition, there was another limitation not indicated by Singh et al. (2011) and Hill et al. (2010) which pertained to the lack of information (e.g., sample size) for the control group (e.g., parents drawn from the community). Overall, the findings from the study by Hill et al. (2010) might need to be taken with caution and with these methodological limitations in mind.

Data collection and the measures used. In general, the data collections in the included studies were done using surveys and self-reports. One study included parents' self-reports and reports on their own child in the study by Hill et al. (2010). Most of the measures used in these surveys were widely-used measures such as the *Multidimensional Scale of Perceived Social Support* (Zimet et al., 1988) to assess social and parent support, and the *Beck Depression Inventory* (BDI-II; Beck, Steer, & Brown, 1996) to assess depression, as well as the *Rosenberg Self-Esteem Scale* (RSES; Rosenberg, 1965) to measure self-esteem. In the study by Costa et al. (2015), the data was collected using the following measures: GD-related discomfort (*Utrecht GD*

scale) and Global Psychological Functioning (*Children's Global Assessment Scale*; Shaffer et al., 1983), but there was not a sample item given for these two scales and very limited details about the scales themselves and what they aimed to measure, which made what they measured exactly unclear to the reader.

One limitation from the three companion studies (i.e., Gower et al., 2018; Taliaferro, 2018a; and Taliaferro, 2018b) is that the survey they used, namely – the 2016 Minnesota Student Survey (MSS), included some one-item or two-item measures, which may lead to lower reliability, and problems with construct validity, compared to multi-item measures. One strength of the 2016 Minnesota Student Survey (MSS), however, is that it used a two-step approach to identify transgender and gender diverse adolescents, that is, to measure both biological sex and current gender identity, which is recommended by The Williams Institute (2013) and Reisner et al., (2014). However, the current recommendation is to use the expression "sex assigned at birth" or "assigned sex" and not "biological sex" (Bauer, Braimoh, Scheim, & Dharma, 2017).

Data analysis. Overall, the data analyses chosen by the authors of the included studies were in line with their research objective and/or research questions. Budge (2015) reported only on the total score on each of the measures across time points/sessions. The way the results were reported, one cannot tell whether there were significant differences between sessions. The author could have used a paired *t*-test to report on the significant changes over time, but this information was not reported in the article.

In the study by Hill et al. (2010), although the authors apparently used the appropriate data analyses to answer their three research questions, the authors compared the current sample with "other clients attending the same clinic in Washington" (p. 19) on the *Child Behavior*

Checklist (CBCL; Achenbach & Edelbrock, 1981). It remains unclear whether this comparison group also consists of transgender children and adolescents or not.

Transparent description of results. In general, among the studies included in the present review, the results were reported in a clear fashion, both in text and with tables and figures, to help the reader have sufficient understanding of the significance of the results. One exception is the study by Taliaferro et al. (2018a). Presumably because of a limited word count criterion, the results section is very concise, and the results were not clearly reported. Specifically, the moderation effect results were not sufficiently detailed.

In the study by Birkett et al. (2015), although transgender identity was assessed for participants, there was no mention of results for transgender adolescents specifically for the mediation models (i.e., the relationship between age and psychological distress mediated by victimization and total support). Only descriptive results were reported for transgender participants, which showed that they reported greater homophobic victimization, compared to their cisgender counterparts. Despite stating this fact, the authors were unable to comment on the cultural and contextual differences which drove these differences in experiences of victimization, as well as how victimization and total support mediated the relationship between age and psychological distress for transgender participants specifically.

Data supporting the author's interpretation. Overall, the study findings and data of the included studies were supportive of the authors' interpretation of the results. However, it is worth noting that in the study by Budge (2015), the author stated that it appeared that the interaction of hormone therapy and psychotherapy enhanced one another to enable Lia's psychological well-being to improve. Lia reported improvements with her mental health, parent support, and identity processes across all measures from baseline to the termination. She

highlighted that psychotherapy was an important component of assisting her with her mood, specifically learning how to regulate her emotions. Family support also changed positively from start to termination which makes it difficult to tease apart what has really helped to create positive change for Lia's well-being. Notwithstanding, the author was being tentative in the way she reported the results by using the following idiom, "Although it is difficult to interpret what the alternative might have looked like [..]" (p. 292). Lastly, as expressed in the *Methodological quality* section above, the results from the study by Hill et al. (2010) need to also be interpreted with caution due to some methodological limitations.

Chapter 5: Discussion

Major Implications of the Present Review

Parent support. This systematic review aimed to explore various domains of support and non-supportive behaviors of parents of transgender and gender diverse children and adolescents and their associated mental health and health outcomes. Across the six studies included in this review that focused on parent support, strong associations between parent support and transgender and gender diverse children and adolescent's mental health outcomes were found. In many cases, parent support was one of the strongest protective factors among other protective factors, serving as a buffer against multiple risks factors in terms of the psychological health of transgender and gender diverse children and adolescents. Gower et al. (2018), for example, reported that parent connectedness served as the strongest protective factor against emotional distress and substance use. Those results were corroborated in the study by Taliaferro et al. (2018a; 2018b), showing that parent connectedness served as a strong protective factor against non-suicidal self-injury (NSSI) and suicide attempt, and the studies by Grossman et al. (2011) and Birkett et al. (2016) indicating that social support (including family support) was associated with lower levels of distress, lower depression, and lower internationalizing problems.

Gower et al. (2018), Grossman et al. (2011) and Birkett et al.'s (2016) findings were in line with previous research indicating that when transgender adolescents reported having both supportive family environments but also experiencing enacted stigma, the stress resulting from experiencing stigma was buffered to a certain extent by parental support (Veale et al., 2017). In other words, transgender adolescents were less likely to experience stress when they reported greater connectedness to their family, even when they experienced stigma and discrimination elsewhere (Veale et al., 2017). Looking at these findings in the light of resilience theory,

relationships in which transgender adolescents feel connected to their parents may help bolster adolescents' resilience even if they experience challenging situations (e.g., stigma, discrimination) due to the fact that their gender identities and expressions do not match people's expectations. Experiencing strong family support may lead adolescents to be able to cope with the stress associated with stigma and therefore experiencing reduced odds of emotional distress, depression, and odds of experiencing internalizing problems. In addition, because parental connectedness would help reduce the odds of distress, adolescents would have lower odds of also engaging in substance use and abuse to cope with the stress derived from negative experiences such as rejection and victimization. As a matter, these negative experiences have been associated with increased illicit drug use and prescription drug misuse among LGBT adolescents (Bontempo & D'Augelli, 2002; Kecojevic et al., 2012; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Rosario, Schrimshaw, & Hunter, 2009; Ryan, Huebner, Diaz, & Sanchez, 2009). Notwithstanding, we cannot infer any moderation or mediation pathways from the findings of the current review that would explain how parental connectedness helps to buffer against distress, depression, internalizing problems, and substance use, but those would be interesting avenues of investigation in future studies.

The *minority stress model* by Meyer (1995; 2003) may help us further understand the associations between parental connectedness and lower risks of NSSI and suicide attempt for transgender and gender diverse adolescents, identified by Taliaferro et al. (2018a; 2018b). In the minority stress model (Meyer, 1995; 2003), minorities who experience oppression from the dominant group in the society are likely to experience stress because of the oppression, and therefore have greater odds of experiencing negative health and mental health outcomes. Meyer (2003) proposed three processes by which LGB people are subjected to minority stress. The first

process is related to environmental and other external events that occur in the individual's life due to the person's minority status and that create overt stress in the person's life. The second set of processes are the anticipation and expectation that the individual has that external stressful events will occur, and the vigilance that the person must maintain because of this expectation. The third one is a process in which negative attitudes and prejudices from society are internalized. Based on these three processes, we can infer that processes at the macrosystem level, as well as the individual level, might cause acute minority stress. In their adaptation of the minority stress model for transgender individuals, Hendricks and Testa (2012) stated that among situations that can contribute to loneliness for transgender individuals is a disconnection from one's family. When experiencing minority stress coupled with loneliness and social isolation from one's family, transgender individuals experience increased odds of *suicide risk*, including NSSI, suicidal ideation, suicide attempts or lethal suicidal behavior. Therefore, we may think of parental connectedness as a protective factor against social isolation and minority stress, which would then buffer the risk to engage in NSSI and suicide attempt for transgender and gender diverse adolescents.

According to the findings of the present review, parent support was also significantly associated with higher life satisfaction, lower perceived burden, and fewer depressive symptoms for transgender adolescents, as found by Simons et al. (2013). Although Simons et al. (2013) did not elaborate on possible reasons of these associations in their study, these might be explained by theories of social support. Theories of social support from a stress and coping perspective (as described earlier) propose that social support can serve as a buffer to help protect individuals from negative influences (e.g., Lakey & Cohen, 2000) derived from negative experiences such as stigma, discrimination, victimization, and rejection. The degree to which transgender and gender

diverse adolescents feel supported within their family may influence their mental health (Higa et al., 2014; McConnell, Birkett, & Mustanski, 2015; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010), and protect them against the risk of experiencing depression and suicidal ideation (Grossman & D'Augelli, 2007; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Toomey, Ryan, Diaz, Card, & Russell, 2010). Indeed, parental support might alleviate the strain derived from negative experiences of social exclusion, often experienced by transgender and gender diverse adolescents, by bolstering adolescents' own resilience and ability to cope with stress.

With regard to the specific outcomes, *life satisfaction* and *perceived burden*, which were found to be associated with parent support (Simons et al., 2013), we may speculate that having someone (in our case, parents) who are supportive for an adolescent's own gender identity would potentially lead to a greater sense of general or global identity, which, in turn, would be resulted in greater life satisfaction and lower perceived burden. To date, mechanisms concerning about how parent support could be related to the development of self identity and confidence in transgender identity have not been investigated. An examination of the hypothetical mechanisms would provide useful information which would possibly encourage parents to cultivate pride in their transgender and gender diverse children and adolescents as suggested by Nealy (2017).

The findings of the present review also showed that better family communication and greater family satisfaction were associated with fewer adverse mental health outcomes and greater self-esteem and resiliency among transgender and gender non-conforming adolescents, according to the study by Katz-Wise et al. (2018). It was transgender adolescents' own perspective of quality of family communication and satisfaction with their family that was the most closely related to their mental health, compared to reports from their caregivers and their siblings. In other words, when transgender adolescents perceived their family to function well,

thereby, when they can communicate in a positive manner to their parents, and when the whole family functions in a positive manner, adolescents reported better self-esteem and resiliency, as well as fewer adverse mental health outcomes. Here again, it is useful to look at these findings in the light of resilience theory. Indeed, being able to share the challenges transgender adolescents face in various settings to their parents may serve to bolster their resilience and increase their self-esteem. We may want to see positive family functioning as grounds for being able to cope with stress, and for preserving a good sense of pride and self-esteem in oneself.

Moreover, Bouris and Hill (2017) demonstrated that maternal warmth was negatively related to suicidal ideation and maternal acceptance negatively related to NSSI, suicidal ideation, condomless anal sex (CAS), and being HIV-positive. Maternal acceptance, in comparison to maternal warmth, served to be highly protective against mental health risks and sexual risk behaviors. Deriving from resilience theory, parental acceptance, compared to maternal warmth, may serve to bolster pride in one's identity, and therefore, lead to the ability to better cope with stress. As a matter, previous literature has shown that maternal acceptance and support have been linked to successful coping (Hardy, Power, & Jaedicke, 1993; Kliewer, Fearnow, & Miller, 1996; and Valiente, Fabes, Eisenberg, & Spinrad, 2004). In turn, coping with stress could both protect against adverse mental health outcomes, as well as encouraging adolescents to avoid engaging in risky sexual behaviors. It is worth bringing back the wise words of a transgender child's parent, as mentioned previously, who stated, in the study by Travers (2018) that, "[…] when you have a solid foundation of who you are and knowing that the people around you believe in who you actually are, it's a lot easier to take that adversity" (p. 198).

Taken together, the included studies demonstrate strong associations between parent-support related constructs (i.e., support, connectedness, acceptance, and family communication

and satisfaction) and positive health and mental health outcomes for transgender and gender diverse children and adolescents. This conclusion, however, might come to no surprise to anyone, given previous studies that have consistently show the importance of parent support for children and adolescents who may experience difficult challenges in their daily lives (e.g., Ryan et al., 2010; Simons et al., 2013; Travers et al., 2012). Support and acceptance are important, however how can we move forward and encourage parents of transgender and gender diverse children and adolescents to engage in supportive ways, and moreover, to cultivate a sense of pride about who they are for their transgender and gender diverse child? How can parents show their child that they are unconditionally supportive of who they are? These questions may be further investigated in future studies, given that parents and caregivers play, indeed, a very important role for the well-being and health/mental health of their children.

Clinician support. This systematic review also aimed to explore various domains of support and non-supportive behaviors from clinicians of transgender and gender diverse children and adolescents, as well as their associated outcomes (i.e., mental health, and physical health). It appears that clinician support is associated with better mental health outcomes for transgender and gender diverse children and adolescents. Across the four studies (Budge, 2015; Clark et al., 2017; Costa et al., 2015; and Hill et al., 2010) included in this review that focused on clinician support, some associations between clinician support and transgender and gender diverse children and adolescents were found, however, these associations were more limited compared with parent support.

According to Budge (2015) and Costa et al. (2015), both psychotherapy and hormone therapy or puberty suppression were likely to be associated with psychological well-being and

improvements in global functioning over time, respectively. In terms of primary care, it was found that levels of comfort with a family doctor were negatively correlated with foregone mental health care in the previous 12 months, but not correlated with foregone physical health care in the study by Clark et al. (2017). Finally, in the study by Hill et al. (2010), an affirmative approach used by mental health providers was associated with transgender children and adolescents' behaviors less pathological overall on peer relations and internalizing and externalizing problems in a sample of children in the U.S. and Ontario compared to the other samples of children diagnosed with gender identity disorder in the Netherlands and Canada who used other approaches than the gender affirmative approach. These results, as stated in the results section, however, need to be taken with caution because of certain methodological limitations. Taken together, similar to parent support, clinician support was also likely to serve as a protective factor for transgender and gender diverse children and adolescents, albeit the evidence being less strong compared to parent support. It is important to note, however, that although transgender and gender diverse children and youth and their families benefit from supportive healthcare, not all families or youth themselves require or need clinical assistance in their transition journeys. Indeed, when we understand gender diversity as normal and positive variations of the human experience rather than trying to shift gender identity and gender expression in any specific direction (APA, 2015), it is reasonable to infer that not all children and adolescents and their families necessarily need clinical assistance. As a matter, many trans activists have push for the de-pathologization of gender diversity but it is important to note that fighting pathologization must also be navigated in a way that would not sacrifice access to transition-related medical procedures and counselling or clinical services *if these are needed*

(Smith, 2018). More specific recommendations are discussed in the following sections (i.e., the recommendations sections from page 76 onwards).

Both parent and clinician support. Lastly, this systematic review aimed to explore how parent support and clinician support were possibly related, and how these associations, if so, were related to mental health and physical health outcomes of transgender and gender diverse children and adolescents. Unfortunately, there were no studies, which explored these two types of support together and how they were related and how these associations were possibly related to outcomes of transgender and gender diverse children and adolescents. From a socio-ecological perspective, it would be important to explore this question in future research and investigate how both parent and clinician can, hand in hand, promote the well-being and health and mental health of transgender and gender diverse children and adolescents.

Limitations of the Included Studies

The included studies contain certain limitations. Except for three studies, all other included studies used a cross-sectional study design which may limit generalization of the findings, as well as limit our understanding of developmental perspectives based on the findings. Longitudinal study designs permit to explore how support from parent and clinician might be associated with transgender and gender diverse children and adolescents' developmental outcomes. In addition, it would be important to aim for more diverse samples (e.g., need for ethnically and racially-diverse samples, including families/parents who do not have socioeconomic privilege, and more fathers [all underrepresented in current literature]). Moreover, because of perceived differences in how parents and adolescents reported their family communication and satisfaction, it would be important for future research to explore family support from a multi-informant perspective (Katz-Wise et al., 2018). In the included studies of

the present review, only one study among the 12 studies included recruited multiple informants. Discrepancies between informants were also found in the study by Katz-Wise et al. (2017) among parents and transgender adolescents, meaning that there is a need for moving towards multi-informant inquiries in the future.

Recommendations for Policy Makers

Although there is a need for more studies in this line of work, here are some recommendations for policy makers based on the findings of this review. It is reasonable to recommend that parents provide a safe and accepting home to their transgender or gender diverse child. Indeed, parent support served as an important contributor to protect adolescents from risks related to their mental health and health. Parents and caregivers have an important role to play in their child life. Previous studies, however, have suggested that parents themselves must go through their own journey on the path leading to acceptance, support, and advocacy (e.g., Gray et al., 2016; Rahilly, 2015). Parents and caregivers should be supported in their own journeys as well and supported in their "interactions with environments that may be stigmatizing" (Katz-Wise et al., 2018) for transgender and gender diverse children and adolescents. Transgender and gender diverse children and adolescents interact with multiple other contexts that may impact their well-being, such as the school, their peer interactions, and other community environments (Shochet, Dadds, Ham, & Montague, 2006; Wickrama & Bryant, 2003). As much as parents can provide a safe and warm environment at home, they oftentimes need to negotiate and advocate for their child outside the home itself and should be supported in this advocacy as well.

Gender self-determination and parental autonomy support. One recent and interesting perspective about parents' roles for supporting transgender children and adolescents comes from the work of Ammaturo (2018). This scholar applied Arendt's (1959) concept of

'parental responsibility' that was originally used to question whether children should be made part of adults' political fights and applied it to parental responsibility regarding transgender children and adolescents. This concept is applied to navigate the tensions between the right to self-determination of the child, the child's best interests, and parents' desire to raise their children as they wish in relation to children's sexual orientation and/or gender identity. Ammaturo (2018) provides a new perspective that helps us re-articulate the concept of 'the best interests of the child' in order to draw special importance to enhancing the right of the child to gender self-determination.

Gender self-determination could be promoted with parental autonomy support, which is a parenting practice defined as one that encourages choice, minimizes pressure, and acknowledges children's feelings and perspectives (e.g., Joussemet, Landry, & Koestner, 2008). Grounded in Self-Determination Theory (SDT; Deci & Ryan, 2000), parental autonomy support practices are in line with affirmative-parenting practices, which are encouraged by many researchers, educators, and advocates of transgender adolescents (e.g., Menvielle & Hill, 2011; Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015). Specifically, in such affirmative practices, parents encourage children's gender explorations (Brill & Pepper, 2008). In the same way, parental autonomy support has been associated with positive outcomes among early adolescents, such as more adaptive emotion-regulation strategies (Brenning, Soenens, Van Petegem, & Vansteenkiste, 2015), as well as endorsement of intrinsic life goals, which in turn associated with a higher sense of well-being in adolescents (Lekes, Gingras, Philippe, Koestner, & Fang, 2010). When we take a closer look at the specific experiences of transgender children and adolescents and their parents, they must take important life decisions and actions together such as whether to take hormone blockers, or hormones to transition and when to start them, exploring fertility

issues before making decisions about blockers or hormones, as well as when and how to best express their preferred gender outside the home and in school (Ehsenhaft, 2017; Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2014). Therefore, promoting gender self-determination by encouraging parenting practices that provide transgender and gender diverse children and adolescents with autonomy might be a useful future direction in research.

Using a socio-ecological framework for future research. Andrew Solomon wrote, "Transition is a change of identity for the person who goes through it, and also for all the people who surround that person" in his acclaimed book titled *Far from the tree: Parents, children and the search for identity* (2012, p. 624), when sharing about his interviews with families of transgender children and adolescents. Some studies (e.g., Lev, 2004, Katz-Wise et al., 2018) align with the quote from Solomon (2012), suggesting that the whole family moves into transition when a transgender or gender diverse child starts their own transition journey. The whole family is nested in systems that inevitably supports or undermines these journeys. Indeed, it would be worth to explore parent support by using a socio-ecological framework. By doing so, future studies would acknowledge the importance of the macrosystem, the exosytem, the mesosystem and other contexts of the microsystem that each have a singular influence on how parents can support their child's authentic gender identities and expressions. Notwithstanding, three of the included studies (Gower et al., 2018; Taliaferro et al., 2018a; and Taliaferro et al., 2018b) opted to use a socio-ecological framework when exploring the health and well-being of transgender children and adolescents. Gower et al. (2018) stated that "understanding aspects of the family, school, and community that may protect against emotional distress and substance use is critical" (p. 788). In the three companion studies that used the 2016 Minnesota Student Survey (MSS), the focus was indeed on multiple protective factors typically assigned to various systems

of the socio-ecological model. Following the footsteps of this school-based survey, future research should continue to use a socio-ecological perspective to examine what is known among the multiple, intersecting ecological systems, with a specific focus on how these systems may influence how parents and clinicians support transgender and gender diverse children and adolescents. The following section provides a brief overview of the potential factors of influence of the macrosystem and exosystem that may have an influence on the ways parent and clinicians can provide support for transgender and gender diverse children and adolescents. Hence, future research and policy makers could seek a more comprehensive understanding of how to best support these children and adolescents based on the following macro-level and exo-level factors

The macrosystem and its potential factors of influence. The macrosystem refers to the broad culture in which an individual grows and develops (Bronfenbrenner, 1979, 2000). In the next sections, as recommendations, the following potential factors of influence of the macrosystem are discussed: social values, laws, and gender roles and their changes over time in a given society, to explain how macro-level factors may influence how parents and clinicians support transgender and gender diverse children and adolescents.

Social values. According to some authors (Ghosh, 2012; Saketopoulou, 2011), a generalized lack of societal acceptance is viewed as the reason why gender non-conformity in childhood leads to increased risks of vulnerability in terms of health, mental health, and social-emotional well-being (Ghosh, 2012; Saketopoulou, 2011). A lack of societal acceptance can take many different forms such as experiencing discrimination and victimization. These types of detrimental experiences have been associated with greater odds of Post-Traumatic Stress Disorder (PTSD), depression, stress related to suicidal thoughts, and greater odds of alcohol and drug use in samples of trans female adolescents aged from 16 to 24 (Rowe, Santos, McFarland,

& Wilson, 2015; Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016). For one of these samples (i.e., Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016), however, parental closeness was related to significantly lower odds of PTSD, depression, psychological stress, and stress related to suicidal thoughts. These findings are in line with another study with a Canadian sample of transgender adolescents aged 14 to 25 years old, which suggests that many transgender adolescents reported high levels of enacted stigma, which was associated with a high prevalence of a range of mental health concerns, but that a supportive family environment appears to reduce these negative impacts (Veale, Peter, Travers, & Saewyc, 2017).

To understand further how social values and their changes in a given society can influence psychological growth, we can look at the case of homosexuality, and how mainstream media, for example, has served to reflect a more enlightened view of gay and lesbian people over time (Streitmatter, 2009). In addition, this societal change may also have been impacted, in part, by the DSM discarding the mental illness model of homosexuality in the early 1970s (Herek, 2010). As mentioned earlier, it is reasonable to infer that social changes influence the microsystem of the family, parent/caregiver(s) and clinicians, and how these systems view their children's experiences or the child they consult with in terms of diverse gender identities and expressions. However, this is not a unidirectional relationship, parents and families who support their transgender and gender diverse child, for example, might also help to create positive social change or what Ann Travers would call a *gender revolution* (2018). In summary, macro-level factors such as generalized societal acceptance, victimization, stigma, societal values, and societal change, all together, might reinforce the importance of looking at macro-level factors when exploring parent and clinician support of transgender and gender diverse children and adolescents.

Laws. Societies are also governed by a system of rules and laws regulating the actions of its members, which is another macro-level factor that may need to be considered when examining parent and clinician support of transgender and gender diverse children and adolescents. Recently, new federal protections have been put in place in Canada, such as Bill C-16 (Department of Justice, 2017), which has updated the Canadian Human Rights Act and the Criminal Code to include the terms "gender identity" and "gender expression" to the list of prohibited grounds of discrimination. On a provincial level, many Canadian provinces offer more explicit protections for transgender and gender diverse individuals in their Charters of Rights and Freedom. In the province of Quebec, Bill 103 (Quebec National Assembly, 2016) was passed to strengthen the fight against transphobia and improve the situation of transgender minors. Because these federal and provincial protections have only recently been implemented, it is too soon to comment on the impact of these protections on the families and parent/caregiver(s) of transgender and gender diverse children and adolescents. However, as Meyer and Sansfaçon (2018) stated, the change in Canadian federal government in 2015 has led to a clear change in the way discourses around transgender children and adolescents are presented, which may impact how parents can support and protect their child. Findings from a qualitative investigation with parents of gender-variant children show that a greater level of recognition of gender diversity coming from legislative protection at both the provincial and federal levels are necessary to bring about the changes needed to create a more inclusive society for their gender-variant child (Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015). To corroborate, better laws, political support, and lobbying, as well as having politicians and leaders aware of the issues that parents of children with gender variance face were also stated as needs

from parents in another qualitative study from Australia (Riley, Sitharthan, Clemson, & Diamond, 2011).

Gender roles. Gender roles are male/female and masculine/feminine dichotomies that are generally clearly defined categories and associated with strict dress codes and standards of behavior based on biological sex in a given society. As a child grows, they learn how to behave from those around them. In this socialization process, in large part initiated by parents and caregivers, children are introduced to the roles that are typically linked to their assigned sex. Therefore, gender roles refer to society's concept of how men and women are expected to act and how they should behave (Little, 2012). In many cultures around the globe, masculine roles are typically associated with strength, aggression, and dominance, while feminine roles are typically associated with passivity, nurturing, and subordination (Little, 2012). While the nature of the transmission of these roles is up for debate (i.e., the nature of this transmission differs in psychological theories, behavioristic theories, theories favoring biological determinants, and sociologically-oriented theories; see Bussey & Bandura, 1999), there is little doubt that the microsystem (i.e., parents, caregivers, as well as clinicians in our case) is influenced by a society's conceptualization of how a girl and boy should be, should behave, and should aspire to. Hence, influenced by these cultural values, parents and caregivers will also influence their own child's gender socialization with the toys and clothes they buy them and with the enforcement (or not) of strict gender rules in play, and behavior (Martin & Ruble, 2010).

What happens when a child deviates from the gender expectations of their parents and caregivers based on their assigned sex? What power society's conceptualization of the roles girls and boys should have will have on parents and caregivers when their child, again, deviate from what is expected of them? Gender transgressions are socially sanctioned and are generally

perceived as transgressions of prescribed and culturally-valued gender roles, that are learned from very early on in life (Martin, Ruble, & Szkrybalo, 2002). The existing literature indicates that many parents tend to impose strict gender rules to their child when they first start noticing their child's gender non-conformity (e.g., Hill & Menvielle, 2009). Parents explain these policing behaviors as a way to protect their child from teasing and bullying in contexts other than the home (e.g., Travers, 2018). Some other parents do not accept their child's cross-dressing behaviors and their insistent and vocal claims to identify as another gender than the one that was assigned at birth to them. However, many parents have realized, with time, that policing their child's gender can have a profound detrimental effect on their child's well-being (e.g., Travers, 2018). Such detrimental effect may take the form, for example, of witnessing their child authentic selves and increased social confidence when allowed to cross-dress into their desired gender, and distress when they have to "revert back" into a gender that matches their assigned sex (e.g., Travers, 2018). If parents notice the importance of supporting their child's authentic selves, they are likely to navigate what the society proscribes in terms of gender roles and expectations, together with their child. Hence, many parents report the challenges that come along with supporting their child's authentic gender selves in the public space (Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015; Travers, 2018), but also the liberation felt by a child when living as their true gender selves (Ehrensaft, 2012; Travers, 2018).

From a historical point of view, it is interesting to mention that the treatment of gender non-conforming children was conceptualized as being a gender role disorder in the mid-70s (Bryant, 2006). Indeed, gender identity disorder used to be referred to as a disorder of gender role. Hence, clinicians view gender identity concerns as a matter of non-conformity to a gender role that matches the sex assigned at birth (e.g., Bates, Skilbeck, Smith, & Bentler, 1974; Green,

& Money, 1960). The diagnosis has since then been revised many times and is now called *gender dysphoria* (American Psychological Association, 2013). Historical considerations are important to keep in mind because clinicians' ability to support transgender and gender diverse children and adolescents is necessarily influenced by the historical perspectives of a diagnosis/disorder. Taken together, gender roles and the expressions of these roles in a given society are worth exploring when investigating parent and clinician support of transgender children and adolescents. They would add details on the culture and values that contribute (or not) to supporting parents, families, and clinicians of transgender and gender diverse children and adolescents.

The exosystem and its potential factors of influence. According to Bronfenbrenner's ecological model (1979), the exosystem reunites factors that have a profound influence on a child's development, even though child is not directly involved with these factors. In the next section, the following potential factor influencing the exosystem is discussed: communities and support networks (i.e., LGBTQ communities and parent networks, religious communities, and extended family and friends), to deepen our understanding of how these communities might influence the microsystem of the family, parents, caregivers, and clinicians.

Communities as support networks. The study of community influences on the family, and identifying the features of community life that impair or enhance family functioning is an important aspect of human development, according to Bronfenbrenner (1986). Various communities (i.e., LGBTQ communities and parent networks, religious communities, and extended family and friends) can act as support networks and can likely influence in various ways the microsystem of parents and caregivers and their transgender and gender diverse children and adolescents. LGBTQ communities, and trans communities specifically, can be a

precious source of support for families of transgender and gender diverse children and adolescents. Riley, Sitharthan, Clemson, and Diamond (2013) have suggested that parents of gender-variant children report on the need for access to other transgender people, as well as the need to have access to more visibility and positive portrayals of transgender individuals and communities. Through taking part in these communities, parents may benefit from support from other parents of transgender and gender diverse children and adolescents, from information pertinent to the transgender realities shared among community members, as well as choosing to take on an advocacy role, for example (Travers, 2018). Being supported by fellow parents of transgender children and adolescents may foster resilience in the parents as well, which would likely impact the resilience of their own child. A study from Mehus et al. (2017) has explored the ways family and community-based support intersect for LGBTQ adolescents aged 14 to 19, and how this interaction may affect adolescents' development. Findings from this study have shown that adolescents who reported high overlap between their family and community support reported little need for resources outside their families but found resources easy to access if they needed. Conversely, adolescents who reported little overlap between their family and community found it difficult to access other resources. In this study (Mehus et al., 2017), recognition of one's transgender identity and proper use of pronouns were ways in which parents have shown support and care for their transgender child.

Parent networks such as *PFLAG Canada* (Parents, Families, and Friends of Lesbians and Gay) and *Gender-Creative Kids* in Montreal, Quebec, are just a few examples of community organizations that are committed to offering support, education, and advocacy for transgender children and adolescents and their families. These parent networks, along with LGBTQ communities are an important form of support for families of transgender children and

adolescents (e.g., Field & Mattson, 2016). It is also worthwhile sharing the fascinating case of *Gender-Creative Kids,* which originated from a parent action group, brought together by social action research and from a self-directed group work led by Annie Pullen Sansfaçon (Pullen Sansfaçon, Ward, Robichaud, Dumais-Michaud, & Clegg, 2014; Pullen Sansfaçon, Robichaud, & Dumais-Michaud, 2015). This non-profit organization's goal is to support families of gender creative children and adolescents by offering support and advocacy parent groups, training to schools and other organizations, workshops, and create safe spaces for gender creative kids (Gender Creative Kids Canada, n.d.). Online support groups also exist and may help to normalize what families of transgender and gender diverse children and adolescents experience (Brill & Kenney, 2016). Conferences are also a good place to connect with other families in a supportive environment, one that favors validation (Brill & Kenney, 2016). Sharing experiences on how to support your child and the challenges that come with this experience is important for parents of transgender and gender diverse children and adolescents. Moreover, having the freedom to share in a safe space with people who share similar experiences is particularly important to break the cycle of isolation that a lot of parents and families of transgender and gender diverse children and adolescents experience (e.g., Field & Mattson 2016; Riley, Sitharthan, Clemson, & Diamond, 2011).

Parents of transgender and gender diverse children and adolescents and their child may also benefit from having a supportive and affirming religious institution they are affiliated with (e.g., Kuvalanka, Weiner, & Mahan, 2014). Religious affiliation can be a protective factor for LGB youth when they belong to a religious institution that holds accepting stances on same-sex marriage, for example (Gattis, Woodford, & Han, 2014). However, this relationship is complicated by the fact that some religious groups hold anti-LGBT attitudes and consider

transgender and gender diverse identities to be wrong and originating through bad influences, poor upbringing, or even demonic interference (Wilcox, 2002). Moreover, some anti-LGBT religious groups engage and support reparative or conversion therapies, even if these have been widely criticized, as mentioned earlier. As a matter of fact, Travers (2018) has shared stories, drawing from qualitative evidence, of families being ostracized from their communities where religious groups' influence is predominant and widespread because they choose to support their transgender or gender diverse child (e.g., Travers, 2018). Therefore, it may be useful to understand that religious affiliation may represent a risk in some cases, and a protective factor in others for families of transgender and gender diverse children and adolescents.

In addition to these communities, the extended family and friends are likely to have a powerful influence on families of transgender and gender diverse children and adolescents, as they may influence parents to either support or suppress their children's true gender selves (Kuvalanka, Weiner, & Mahan, 2014). We cannot talk about this topic without bringing the idea of disclosure. While many parents will wait to disclose their child's transgender and gender diverse identities and expressions to others outside the immediate family, some may seek support from members of the extended family and friends earlier on. Previous studies (Birnkrant & Przeworski, 2017; Kuvalanka, Weiner, Munroe, Goldberg, & Gardner, 2017) have suggested that parents, in some cases, experience rejection from the extended family; however, most of the parents who reported on their extended family reported initial hesitation or resistance, however over time, extended family members became more accepting of their child's gender identity (Birnkrant & Przeworski, 2017; Kuvalanka, Weiner, Munroe, Goldberg, & Gardner, 2017). In more extreme cases, some families and parents reported having to cut ties with some members of their extended family or some of their friends, if those do not accept or condemn their choice as a

parent to support transgender and gender diverse identities/expressions of their child (e.g. Menvielle, 2012; Travers, 2018). Taken together, these different communities would be important to be investigated in relation to parent and clinician support so that we can have a more comprehensive understanding of all the other communities that may play a role in supporting parents and clinicians of transgender and gender diverse children and adolescents.

Employing qualitative research methods might provide an interesting alternative to policy makers compared to quantitative research methods. Qualitative research methods could provide a platform to investigate subtilities and complexities about how the multiple systems influence how parents can best support transgender and gender diverse children and adolescents. Clinician support should not be forgotten in that respect, as it is an important piece of the microsystem, evolving with families too. In addition, when employing a socio-ecological approach to support, future research should consider exploring these concepts through the lens of intersectionality as well, as suggested by Sansfaçon et al. (2018).

Understanding gender self-determination as a children right issue. According to Article 7 of the U.N. General Assembly's Convention on the Rights of the Child (1989), a child shall have the right from birth to a name. Implied to this article, every child should be respected based on this name. Many transgender and gender diverse children and adolescents change their names as part of their social transitions, and their names and pronouns shall be respected. Indeed, a study by Russell, Pollitt, Li, and Grossman (2018) has examined the relationship between chosen name use in various contexts, and its associated outcomes in terms of mental health among transgender adolescents. The results found that chosen-name use was associated with lower depression, suicidal ideation, and suicidal behavior for transgender adolescents, which demonstrates how protective it is for adolescents to be able to be recognized with their

chosen names. Chosen names should also be framed, according to the U.N. General Assembly's Convention on the Rights of the Child as a child right, especially when the assigned name does not conform to the child's wishes.

Recommendations for Clinicians

Clinicians also have to play an important role in supporting transgender and gender diverse children and adolescents. According to Clark et al. (2017), there is a great need for improvements in clinical training and clinical practice tools related to gender-affirmative care. Clinicians who are educated in transgender health play a role that can be supportive of transgender and gender diverse children and adolescents, and their families. Indeed, the four studies included in this review (Budge, 2015; Clark et al., 2017; Costa et al., 2015; and Hill et al., 2010) revealed that clinicians who provide appropriate psychological and primary care support are associated with positive health outcomes for transgender and gender diverse children and adolescents. Conversely, past experiences of unacceptable or inappropriate care sometimes led to ongoing barriers in access to care, and increasing odds of foregone mental health care, according to Clark et al. (2017). Children and adolescents may experience negative experiences at any level of care when clinicians are not educated enough on the issues that matter to transgender children and adolescents. Annie Pullen Sansfaçon (2019), whose work is dedicated to trans children and their families, spoke at a public conference for the Pragmatics Health Ethics Research Unit in May 2019 and stated that every health care professional should be educated in affirmative care. By large, there is a great need for more education at all levels of health service provision to ensure children and adolescents experience care that maintains their dignity and autonomy.

A need for further investigation of gender-affirmative care. Although many organizations promote the use of gender affirmative-care such as the American Psychological Association (APA, 2015), it is important that future research investigate gender affirmative practices further, as suggested by Hill et al. (2010). However, since Hill et al. (2010) study was published, not much literature has investigated affirmative practices used by clinicians. Spivey and Edwards-Leeper (2019) explored future directions in affirmative psychological interventions with transgender children and adolescents and suggested to develop affirmative psychological interventions that are evidence-based. The authors also stated that not one evidence-based practice intervention is likely to act as a "one size fit all" intervention for transgender children and adolescents because this group of young people is a very heterogeneous population (Spivey & Edwards-Leeper, 2019). Therefore, the authors stressed the importance of developing an adaptive intervention for the care of transgender children and adolescents, which could provide a structure for individualizing care (e.g., Almirall & Chronis-Tuscano, 2016). Crucial to these practices would be to avoid over-pathologizing transgender and gender diverse children and adolescents and depart from a model that is solely based on diagnosis in order to access care that is crucial for the well-being of transgender and gender diverse children and adolescents.

Focus on the disparities of access to care. Many scholars in transgender studies have named this, *focus on disparities in access to care*, as one of the most important focus for future research, (Pullen Sansfacon, 2019; and Pyne, 2019). Indeed, these scholars have witnessed in their studies that there is an overwhelming amount of White trans children and adolescents who access care, and very few racialized children and adolescents who access care from gender clinics. Travers (2018) also recognized that "aspects of precarity related to racialization and poverty receive little to no attention in scholarly literature, in resources for transgender kids and

their families, or in mainstream or (trans-/homonormative) LGBT media" (p. 258). A lack of access to affirmative healthcare can have devastating consequences for transgender and gender diverse children and adolescents (Travers, 2018). Based on these scholars' work, it is reasonable to insist on the importance of examining these disparities in access to care by examining the role that structural and systemic racism may have in these disparities.

Focus on community health care services. As Jake Pyne, a scholar in Transgender Studies has stated in a recent public conference in Montreal (2019), parents need to receive their own support because every leap by parents contributes to improvements for their child. One answer to encourage parents and caregivers to be supportive of their child may come from community care. Indeed, multiple programs are currently provided by community health services to improve family relationships among families of transgender adolescents. One example is the Families in TRANSition program provided by Central Toronto Youth Services. The Families in TRANSition (FIT) is a group for parents/caregivers of trans and gender-questioning adolescents (aged 13-21) who have recently learned of their child's gender identity. Among many aims, the program seeks to provide tools and knowledge to help improve communication and strengthen parent relationship with their adolescents, learn about social, legal, and physical transition options, and strengthen skills for managing strong emotions (fear, sadness, worry, etc.).

In addition to supporting groups, the Central Toronto Youth Services (CTYS) published a Families in TRANSition Guide for parents of transgender youth that focused on supporting families to create a safe home for transgender and non-binary adolescents and strengthen family relationships. These types of parent support (i.e., support group and psychoeducational information) provide an optimistic perspective of what can be done for supporting parents who

wish to support their child in their transition journeys. These types of community health services can be found in many other urban centers across Canada. Many of these initiates have not yet been researched and it would be interesting for future research to pay attention to what is being done by these community health organizations.

Strengths and Limitations of the Current Review

A strength of this study is that the methods of this systematic review respected PRISMA guidelines in terms of the preferred reporting items for a systematic review. An area expert consultant provided consultation on method, which also helped to increase the soundness of this study in terms of its methods.

Certain limitations also need to be addressed. Because of limited resources, this review could not include studies that were written in other languages than English and from grey literature. It would also have been helpful to ensure literature saturation, normally done by scanning the reference lists of included studies identified through the search and circulating a bibliography of the included articles to transgender and gender diverse children and adolescent's researcher experts identified by the team.

In addition, it would have been helpful to assess the quality of this review by using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group methodology (Guyatt et al., 2008), which is being increasingly recommended by experts on systematic reviews (Shamseer et al., 2015), for example. Generally, this method assesses the quality of evidence across domains of risk of bias, consistency, directness, precision and publication bias. Quality can be adjudicated as high (further research is very unlikely to change our confidence in the estimate of effect), moderate (further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate), low

(further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate), or very low (very uncertain about the estimate of effect).

Conclusion

Overall, the findings from this systematic review reinforce the importance of parent support as a major form of support for transgender and gender diverse children and adolescents. It has been found to serve as protective for the mental health of these children and adolescents. In addition, clinician support has been found to also serve as protective for the mental health and health of transgender and gender diverse children and adolescents, although more research is needed in this area to corroborate the findings of the present systematic review. With these findings, the present study sought to provide information on the state of this field of research by identifying gaps in the literature and limitations of current literature to inform future directions of research. One important future direction would be to consider using a socio-ecological model to identify how support from the microsystem is influenced by contexts across the macro-, exo-, and meso-systems. By doing so, I believe that parent and clinician support would be investigated in a more comprehensive and holistic manner. The findings of this review were expected to inform the practice of public health policy-making at the federal and provincial levels and help social workers, family counselors, psychologists in the development and implementation of effective social support programs and policies, as well as community organizations, and families of transgender and gender diverse children and adolescents.

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Appendix

Appendix A

Search Strategies for PsycINFO, MEDLINE, Scopus, and socINDEX

1. PsycINFO

#	Query
1	exp PARENTS/ or exp ADOPTIVE PARENTS/ or exp HOMOSEXUAL PARENTS/ or exp FOSTER PARENTS/ or exp SINGLE PARENTS/
2	exp STEPPARENTS/
3	exp CAREGIVERS/
4	1 or 2 or 3
5	adolescents*.mp.
6	child*.mp.
7	teen*.mp.
8	adolescen*.mp.
9	5 or 6 or 7 or 8
10	“gender divers*”.mp.
11	"gender transition*".mp.
12	"gender transformation".mp.
13	"gender non-conforming".mp.
14	"gender nonconforming".mp.
15	"gender varian*".mp.
16	"gender fluid*".mp.

17	"gender dysphoria".mp.
18	"gender reassignment".mp.
19	"gender expression".mp.
20	"gender identit*".mp.
21	"sex reassignment".mp.
22	exp TRANSGENDER/
23	transgender.mp.
24	"non-binary gender".mp.
25	transsexual*.mp.
26	transphobia.mp.
27	exp "Transgender (Attitudes Toward)"/
28	transmen.mp.
29	"trans men".mp.
30	transwomen.mp.
31	"trans women".mp.
32	MtF.mp.
33	FtM.mp.
34	"preferred gender".mp.
35	"gender queer".mp.
36	genderqueer.mp.
37	cisgender.mp.

38	"Two-spirit*".mp.
39	exp TRANSSEXUALISM/
40	exp ANDROGYNY/
41	exp Gender Identity Disorder/
42	exp TRANSVESTISM/
43	exp Hermaphroditism/
44	exp Sex Change/
45	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44
46	4 and 9 and 45
47	*PHYSICIANS/
48	*Clinical Practice/
49	*Clinical Psychologists/
50	exp Mental Health Personnel/
51	*PSYCHIATRISTS/
52	*THERAPISTS/
53	*PSYCHOTHERAPISTS/
54	*NURSES/
55	*Public Health Service Nurses/
56	47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55
57	9 and 45 and 56

58	4 and 9 and 45 and 56

2. MEDLINE

#	Query
1	exp Parents/
2	"adoptive parent*".mp.
3	"homo* parent*".mp.
4	"foster parent*".mp.
5	exp Caregivers/
6	2 or 3 or 4 or 5
7	adolescents*.mp.
8	child*.mp.
9	teen*.mp.
10	adolescen*.mp.
11	7 or 8 or 9 or 10
12	"gender divers*".mp.
13	"gender transition*".mp.
14	"gender transformation".mp.
15	"gender non-conforming".mp.
16	"gender nonconforming".mp.
17	"gender varian*".mp.
18	"gender fluid*".mp.

19	Gender Dysphoria/
20	"gender reassignment".mp.
21	"gender expression".mp.
22	Gender Identity/
23	Sex Reassignment Surgery/
24	Transgender Persons/
25	transgender.mp.
26	"non-binary gender".mp.
27	Transsexualism/
28	transphobia.mp.
29	transsexual*.mp.
30	transmen.mp.
31	"trans men".mp.
32	transwomen.mp.
33	"trans women".mp.
34	MtF.mp.
35	FtM.mp.
36	"preferred gender".mp.
37	"gender queer".mp.
38	genderqueer.mp.
39	cisgender.mp.
40	"Two-spirit*".mp.

41	androgyny.mp.
42	"gender identity disorder".mp.
43	Transvestism/
44	hermaphroditism.mp.
45	"sex change".mp.
46	12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45
47	6 and 11 and 46
48	exp Physicians, Primary Care/ or exp Physicians, Family/ or exp Physicians/
49	exp Primary Health Care/
50	"clinical practice".mp.
51	"clinical psychologist*".mp.
52	exp Mental Health Services/
53	"Mental Health Personnel".mp.
54	"Attitude of Health Personnel"/
55	exp Child Psychiatry/ or exp Psychiatry/ or exp Adolescent Psychiatry/ or exp "Diagnosis, Dual (Psychiatry)"/
56	exp Psychotherapy/
57	therapist*.mp.
58	exp Nurses/
59	exp Nurses, Public Health/
60	48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59

61	11 and 46 and 60
62	6 and 11 and 46 and 60

3. SCOPUS

Parent Support

((TITLE-ABS-KEY (parent* OR "adoptive parent*" OR "homo* parent*" OR "foster parent*" OR "single parent*" OR "single father*" OR "single mother*" OR stepparent* OR "step parent*" OR "step-parent*" OR caregiver* OR "care giver*" OR "care-giver*"))) AND ((TITLE-ABS-KEY ("MtF" OR "FtM" OR "preferred gender")) OR (TITLE-ABS-KEY ("gender queer" OR genderqueer OR cisgender OR cisnormative OR "two-spirit*" OR "gender expansive*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change")) OR (TITLE-ABS-KEY (transsexual* OR transphobia OR transman OR "trans man" OR "trans male*" OR "transwoman" OR "trans woman" OR "trans female*" OR transmen OR "trans men" OR transwomen OR "trans women")) OR (TITLE-ABS-KEY ("gender creativity" OR "gender creative" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR "gender non-binary" OR "gender nonbinary")) OR (TITLE-ABS-KEY ("gender questioning" OR "gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR "gender dysphoria" OR "gender reassignment" OR "gender expression"))) AND (TITLE-ABS-KEY (adolescents* OR child* OR adolescen* OR teen*)) AND (PUBYEAR > 1999) AND (LIMIT-TO (LANGUAGE , "English"))

Clinician Support

((TITLE-ABS-KEY (clinician* OR physician* OR "clinical practice" OR "clinical psychologist*" OR "counselling psychologist*" OR "mental health personnel" OR psychiatr* OR therapist* OR psychotherapist* OR "counsellor*" OR nurse* OR "public health nurse*")) OR (TITLE-ABS-KEY ("primary care" OR "family physician*" OR "mental health service*" OR "attitude* of health personnel" OR "attitude* of mental health personnel" OR "child psychiatr*" OR "adolescen* psychiatr*" OR "psychiatric hospital staff" OR "psychiatric nurse*")) OR (TITLE-ABS-KEY ("psychiatry social worker*" OR therapy OR "medical personnel" OR "general practitioner*" OR endocrinologist* OR surgeon* OR "refusal to treat" OR "community mental health service*" OR pediatrician*))) AND ((TITLE-ABS-KEY ("MtF" OR "FtM" OR "preferred gender")) OR (TITLE-ABS-KEY ("gender queer" OR genderqueer OR cisgender OR cisnormative OR "two-spirit*" OR "gender expansive*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change")) OR (TITLE-ABS-KEY (transsexual* OR transphobia OR transman OR "trans man" OR "trans male*" OR "transwoman" OR "trans woman" OR "trans female*" OR transmen OR "trans men" OR transwomen OR "trans women")) OR (TITLE-ABS-KEY ("gender creativity"

OR "gender creative" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR "gender non-binary" OR "gender nonbinary")) OR (TITLE-ABS-KEY ("gender questioning" OR "gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR "gender dysphoria" OR "gender reassignment" OR "gender expression"))) AND (TITLE-ABS-KEY (adolescents* OR child* OR adolescen* OR teen*)) AND (PUBYEAR > 1999) AND (LIMIT-TO (LANGUAGE , "English"))

Parent & Clinician Support

((TITLE-ABS-KEY (parent* OR "adoptive parent*" OR "homo* parent*" OR "foster parent*" OR "single parent*" OR "single father*" OR "single mother*" OR stepparent* OR "step parent*" OR "step-parent*" OR caregiver* OR "care giver*" OR "care-giver*"))) AND ((TITLE-ABS-KEY (clinician* OR physician* OR "clinical practice" OR "clinical psychologist*" OR "counselling psychologist*" OR "mental health personnel" OR psychiatr* OR therapist* OR psychotherapist* OR "counsellor*" OR nurse* OR "public health nurse*")) OR (TITLE-ABS-KEY ("primary care" OR "family physician*" OR "mental health service*" OR "attitude* of health personnel" OR "attitude* of mental health personnel" OR "child psychiatr*" OR "adolescen* psychiatr*" OR "psychiatric hospital staff" OR "psychiatric nurse*")) OR (TITLE-ABS-KEY ("psychiatry social worker*" OR therapy OR "medical personnel" OR "general practitioner*" OR endocrinologist* OR surgeon* OR "refusal to treat" OR "community mental health service*" OR pediatrician*))) AND ((TITLE-ABS-KEY ("MtF" OR "FtM" OR "preferred gender")) OR (TITLE-ABS-KEY ("gender queer" OR genderqueer OR cisgender OR cisnormative OR "two-spirit*" OR "gender expansive*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change")) OR (TITLE-ABS-KEY (transsexual* OR transphobia OR transman OR "trans man" OR "trans male*" OR "transwoman" OR "trans woman" OR "trans female*" OR transmen OR "trans men" OR transwomen OR "trans women")) OR (TITLE-ABS-KEY ("gender creativity" OR "gender creative" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR "gender non-binary" OR "gender nonbinary")) OR (TITLE-ABS-KEY ("gender questioning" OR "gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR "gender dysphoria" OR "gender reassignment" OR "gender expression"))) AND (TITLE-ABS-KEY (adolescents* OR child* OR adolescen* OR teen*)) AND (PUBYEAR > 1999) AND (LIMIT-TO (LANGUAGE , "English"))

* TITLE-ABS-KEY = TITLE-ABSTRACT-KEYWORDS

4. SocINDEX

Parent Support

(SU (parent* OR "adoptive parent*" OR "homo* parent*" OR "foster parent*" OR "single parent*" OR "single father*" OR "single mother*" OR stepparent* OR "step parent*" OR "step-parent*" OR caregiver* OR "care giver*" OR "care-giver*") **AND** (SU (adolescents* OR child*

OR adolescen* OR teen*) **AND** (TX ("gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR "gender dysphoria" OR "gender reassignment" OR "gender expression" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR transsexual* OR transphobia OR transmen OR "trans men" OR transwomen OR "trans women" OR "gender queer" OR genderqueer OR cisgender OR "two-spirit*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change" OR "MtF" OR "FtM" OR "preferred gender" OR “gender divers*”))

Clinician Support

(SU (clinician* OR physician* OR “clinical practice” OR “clinical psychologist*” OR “counselling psychologist*” OR “mental health personnel” OR psychiatr* OR therapist* OR psychotherapist* OR “counsellor*” OR nurse* OR “public health nurse*” OR “primary care” OR “family physician*” OR “mental health service*” OR “attitude* of health personnel” OR “attitude* of mental health personnel” OR “child psychiatr*” OR “adolescen* psychiatr*” OR “psychiatric hospital staff” OR “psychiatric nurse*” OR “ psychiatry social worker*” OR therapy OR “medical personnel” OR “general practitioner*” OR endocrinologist* OR surgeon* OR “refusal to treat” OR “community mental health service*” OR pediatrician*) **AND** (SU (adolescents* OR child* OR adolescen* OR teen*) **AND** (TX ("gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR "gender dysphoria" OR "gender reassignment" OR "gender expression" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR transsexual* OR transphobia OR transmen OR "trans men" OR transwomen OR "trans women" OR "gender queer" OR genderqueer OR cisgender OR "two-spirit*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change" OR "MtF" OR "FtM" OR "preferred gender" OR “gender divers*”))

Parent & Clinician Support

(SU (parent* OR "adoptive parent*" OR "homo* parent*" OR "foster parent*" OR "single parent*" OR "single father*" OR "single mother*" OR stepparent* OR "step parent*" OR "step-parent*" OR caregiver* OR "care giver*" OR "care-giver*") **AND** (SU (clinician* OR physician* OR “clinical practice” OR “clinical psychologist*” OR “counselling psychologist*” OR “mental health personnel” OR psychiatr* OR therapist* OR psychotherapist* OR “counsellor*” OR nurse* OR “public health nurse*” OR “primary care” OR “family physician*” OR “mental health service*” OR “attitude* of health personnel” OR “attitude* of mental health personnel” OR “child psychiatr*” OR “adolescen* psychiatr*” OR “psychiatric hospital staff” OR “psychiatric nurse*” OR “ psychiatry social worker*” OR therapy OR “medical personnel” OR “general practitioner*” OR endocrinologist* OR surgeon* OR “refusal to treat” OR “community mental health service*” OR pediatrician*) **AND** (SU (adolescents* OR child* OR adolescen* OR teen*) **AND** (TX ("gender transition*" OR "gender transformation" OR "gender non-conforming" OR "gender nonconforming" OR "gender varian*" OR "gender fluid*" OR

"gender dysphoria" OR "gender reassignment" OR "gender expression" OR "gender identit*" OR "sex reassignment" OR transgender OR "trans-gender" OR "trans gender" OR "non-binary gender" OR transsexual* OR transphobia OR transmen OR "trans men" OR transwomen OR "trans women" OR "gender queer" OR genderqueer OR cisgender OR "two-spirit*" OR transsexualism OR androgyny OR "gender identity disorder" OR transvestism OR hermaphroditism OR "sex change" OR "MtF" OR "FtM" OR "preferred gender" OR “gender divers*”))

**SU = Subject Terms*

**TX = All Text*