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SPECIAL SECTION: CLINICAL APPROACHES TO ADOLESCENTS WITH GENDER DYSPHORIA

An Intersectional Approach to Therapy with Transgender Adolescents and Their Families

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Abstract
In recent years, transgender individuals have experienced both greater visibility and increased discrimination, such as direct discriminatory practices and removal of Obama-era protections for transgender students. Minority stress theory suggests that discrimination toward gender identity is related to poor mental health outcomes. This hypothesis is supported by the literature regarding transgender adults and adolescents; notably, familial rejection is highlighted as having a strong association with negative outcomes. The field of psychology has continued to explore best practices in approaches to family therapy with transgender individuals. Gender-affirming techniques have gained momentum, largely due to a recognized need for therapy techniques that aim to cultivate familial support for this vulnerable population. As transgender individuals and their families hold many social identities, including race, ethnicity, socioeconomic status, and gender, affirming family therapy involving transgender individuals must explore ways in which gender identity intersects with and is understood in context of family members' other identities. In particular, we must explore how identities may serve to bolster or impede therapeutic processes targeting acceptance. The current article aims to raise awareness of a need for an intersectional approach with gender-affirming family therapy techniques. We detail ways intersectionality can inform therapy practice and provide case examples from our work with a diverse group of transgender adolescents and their families.

Keywords Transgender · Adolescents · Family therapy · Intersectionality · Gender dysphoria

Introduction

In recent years, there has been a noticeable increase in the visibility of individuals whose gender identity is not aligned with the sex they were assigned at birth (transgender) and those who do not identify with a binary male or female gender (nonbinary) (Goldberg, 2017; Steinmetz, 2014). This important increase in visibility has been accompanied by greater experiences of discrimination, lessened public support, and clear discriminatory policies such as the removal of Obama-era protections for transgender students, and an expressed desire to narrowly define gender by genitalia at birth or by genetic testing (Gay and Lesbian Alliance Against Defamation, 2018; Jereb, 2017; Green, Benner, & Pear, 2018). Discrimination toward the transgender and nonbinary community has been associated with poor mental health outcomes (Brewster, Moradi, Deblaere, & Velez, 2013; Brewster, Velez, Mennicke, & Tebbe, 2014; Lombardi, Wilchins, Preising, & Malouf, 2002). Thus, recent increases in direct discriminatory practices cause heightened concern for the mental health of transgender and nonbinary individuals.

In order to better understand the potential impact of discrimination, one can turn to the minority stress model and associated research. The minority stress model (Meyer, 1995, 2003) was originally developed in the context of sexual orientation and has recently been applied to the experience of transgender and nonbinary individuals as well (Hendricks & Testa, 2012; Meyer, 2015). The minority stress model asserts

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that there are unique stressors associated with prejudice and stigma against LGBT+ individuals. The stress associated with the ongoing experiences of discrimination, rejection, and isolation then results in adverse mental and physical health outcomes (Hendricks & Testa, 2012; Meyer & Frost, 2013; Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015; Testa, Habarth, Peta, Balsam, & Bockting, 2015). Research has certainly borne out this association. For example, family and societal rejection are positively associated with poorer mental health outcomes in transgender individuals (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Travers et al., 2012). Thus, it is not surprising that transgender youth seeking services often present with a complex array of mental health concerns (Connolly, Zervos, Barone, Johnson, & Joseph, 2016; de Vries, 2015; Olson, Schrager, Belzer, Simons, & Clark, 2015; Steensma et al., 2014).

Transgender individuals hold many identities in addition to their gender identity (e.g., race, ethnicity, socioeconomic status, sexual orientation). These identities may also be associated with marginalization or privilege. For transgender individuals, the experience of and meaning ascribed to a transgender identity may vary according to other identities or may interact with concomitant experiences of privilege and/or oppression. Thus, an individual's array of identities may have implications for their experience of minority stress (American Psychological Association, 2015; Meyer, 2015). For example, transgender youth of color may experience marginalization on multiple counts (e.g., transphobia and racism), leading to intensified experiences of minority stress and, as a result, poorer psychosocial outcomes. Furthermore, certain aspects of one's identity (e.g., race, ethnicity, religion, class) may limit individuals' ability to access or affiliate with transgender and nonbinary communities. This associated lack of access to or acceptance within the transgender and nonbinary community likely reduces access to resources and resiliencies associated with community membership (Breslow et al., 2015; Meyer, 2015). As such, it is not surprising that transgender individuals of color have higher rates of suicide attempts, homelessness, sexual assaults, and school expulsions, though not different rates of family acceptance (James, Brown, & Wilson, 2017a; James et al., 2016; James, Jackson, & Jim, 2017b; James & Magpantay, 2017; James & Salcedo, 2017).

There is a growing consensus that clinical interventions with transgender youth and their families must address the impact intersecting identities have on the transgender experience (American Psychological Association, 2015; Connolly et al., 2016; de Vries, 2012, 2015; dickey, Burnes, & Singh, 2012; Reisner et al., 2016; Singh, 2013). Considering these recommendations, we believe it is critical to examine ways to bolster existing affirmative therapeutic practices (e.g., Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016) with an increased focus on the intersection of gender and other social identities. We also believe that knowledge of other identities can, in turn, promote family acceptance in novel ways. In this article, we apply an intersectional lens to the practice of affirming family therapy with transgender adolescents and their families. This approach guides exploration of family ambivalence about affirming gender. We highlight our description of this practice with case examples.

Associations of Family Rejection and Negative Outcomes

Research with transgender individuals indicates disproportionate rates of mental health and psychosocial problems as compared to cisgender individuals (those whose gender identity aligns with the sex they were assigned at birth). For instance, the 2015 U.S. Transgender Survey collected data from over 27,000 transgender adults from across the U.S. Of those respondents, 40% indicated a past suicide attempt, with the highest rates of attempt among those aged 18–24 years (James et al., 2016). These rates are nearly nine times the suicide attempt rate of the general U.S. population. As this was not an epidemiological sample, it is difficult to know whether the 40% statistic is an overestimate, an underestimate, or an accurate estimate. Some have noted the limitations of drawing associations from nonepidemiological studies of transgender and nonbinary individuals (Steensma, van der Ende, Verhulst, & Cohen-Kettenis, 2013). Regardless of these limitations, the U.S. Transgender Survey data provide a stark depiction of the commonality of identifying as transgender and experiencing a suicide attempt.

Additional research has found elevated rates of depression, anxiety, and somatic concerns among transgender adults, and researchers have attributed these elevated rates of mental health problems to minority stress (Bockting et al., 2013, Perez-Brumer et al., 2015). These findings in adults are consistent with research among transgender youth that has demonstrated elevated rates of anxiety, depression, suicide attempts, suicidal ideation, and psychiatric diagnoses, as compared to the general population (Connolly et al., 2016; Olson et al., 2015; Reisner et al., 2016; Spack et al., 2012).

Particular attention has been paid to the relationships among family rejection, mental health, and psychosocial functioning in transgender youth. Positive associations have been found between parental rejection and outcomes such as suicidality, depression, substance use, and homelessness (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Grossman & D'augelli, 2007; Simons, Schrager, Clark, Belzer, & Olson, 2013; Travers et al., 2012). Notably, Travers et al. found that 57% of transgender youth without parental support reported a suicide attempt in the past year. This finding was in stark comparison with much lower rates (4%) among those with supportive parents. Further, transgender children who are supported in their gender identity by their families have been found to have rates of depression equivalent

to their cisgender peers, and only minimally higher levels of anxiety (Olson, Durwood, DeMeules, & McLaughlin, 2016).

While the body of research described above has consistently demonstrated an association between parental support and well-being among transgender and nonbinary youth, researchers have also acknowledged limitations of this research, such as overreliance on youth report, potential sampling bias, and a lack of ability to draw definitive causal relationships (Olson et al., 2016; Simmons et al., 2013; Steensma et al., 2013). However, despite these limitations, these individual reports are the best, current, community-level appraisal we have of the meaning of parental support to transgender and nonbinary individuals.

Therapeutic Approaches

The past two decades have seen therapy practices with transgender youth move away from shaping of gender identity according to the sex assigned at birth and rejection of transgender identity (Pleak, 2009). Instead, the emphasis has turned to a gender affirming approach. This approach incorporates several important tenets: Gender variation is a natural aspect of the human experience; gender is nonbinary and may be fluid; the development of gender involves biological, developmental, and cultural factors; understanding a young person's gender presentation requires cultural sensitivity; pathology among transgender youth more often stems from cultural reactions rather than from within the youth themselves (Edwards-Leeper et al., 2016; Hidalgo et al., 2013). Practicing within this affirmative model, therapists aim to help youth navigate gender exploration, with the goal of supporting youth in living a life aligned with their gender identity, whatever form that most comfortably takes for each individual (Edwards-Leeper et al., 2016; Hidalgo et al., 2013; Korell & Lorah, 2007). Families are guided through the process of helping youth explore and, ultimately, affirm their gender identity. Families are also guided in supporting the affirmation of youth's gender identities in family, school, and other social contexts, particularly due to demonstrated associations between social transition and improved mental health outcomes (Olson et al., 2016). In addition, families are aided in addressing any mourning of "losing a child they knew," in order to build supportive family environments (Brill & Pepper, 2008; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Cohen-Kettenis & Pfäfflin, 2003; Corbett, 2009; Lev & Malpas, 2011; MacNish & Gold-Peifer, 2011; Mallon, 2009; Malpas, 2011; McGuire, Catalpa, Lacey, & Kuvalanka, 2016; Rosenberg, 2002; Saeger, 2006; Vanderburgh, 2009; Wahlig, 2015).

Identities and Therapy

Though gender identity is often the focus of affirming models of care, gender identity intersects with other aspects of individuals' identities in important ways. Therefore, existing gender-affirming models of therapy could benefit from increased attention to how gender intersects with and is experienced in the context of other identities, such as race, ethnicity, socioeconomic status, ability, religion, immigration status, and sexual orientation (American Psychological Association, 2015; Connolly et al., 2016; de Vries, 2012, 2015; dickey et al., 2012; Reisner et al., 2016; Singh, 2013). In order to address this need, some clinicians have included discussions of family members' identities in their descriptions of family-based therapeutic approaches (e.g., Malpas, 2011; Menvielle, 2012). However, there remains a lack of focused discussion of ways to utilize knowledge of these additional identities in therapy to build acceptance.

Intersectionality and Its Application to Gender-Affirming Therapy

The theory of intersectionality provides a framework for conceptualizing the ways in which gender identity interacts with and is experienced in relation to a multitude of other social identities (Combahee River Collective Statement, 1979; Crenshaw, 1991, 1994; de Vries, 2012, 2015). In this section, we highlight central tenets of intersectionality for use in therapy, drawn from the seminal work of the creators of intersectional theory cited above.

First, intersectional theory asserts that individuals hold many social identities at the same time, and these identities interact to shape experience. For example, a person may identify as transgender female, white, upper middle class, and lesbian at the same time. This individual may experience their transgender identity differently from an individual who identifies as transgender male, Southeast Asian, pansexual, and of a lower socioeconomic class.

Second, within the theory of intersectionality, identities are not considered uniform. For example, though two individuals are both identified as lesbian, their experience of that identity and its impact on their lives are not considered equivalent. In addition, identities can be viewed as changing alongside developmental processes, educational advances, and other changes in status. Further, they may be more able to be expressed secondary to environmental changes, as in transition to high school, college, or attendance of events at LGBT-supportive locations. For example, individuals' knowledge of and ability to identify their gender identity may increase as the individual experiences developmental changes such as development of secondary sex characteristics during puberty (Cohen-Kettenis & Pfäfflin, 2003; Pleak, 2009).

Third, the theory of intersectionality suggests that holding an identity does not equate with having or relating to the same history or present experience. In other words, intersectionality theory emphasizes intragroup variation in history or experience. This variation is well observed within gender minority individuals. For example, many individuals are grouped under the umbrella term of transgender. This group may be made up of individuals who identify as transgender and have not transitioned publicly, those who have undergone gender-affirming surgeries (sometimes referred to with the term "transsexual"), and those who do not identify with the gender binary at all (sometimes referred to with the term "nonbinary"). While referred to generally using the term "transgender," a transgender male individual may experience male gender privilege, while a transgender female individual may suffer greater gender discrimination. In addition, those who identify as nonbinary may, in fact, experience their gender variation very differently from others who also identify as nonbinary. The diversity of intragroup experiences becomes far more salient when intersectional nature of experience is considered.

Fourth, the theory of intersectionality recognizes that social identities confer relative amounts of privilege or oppression depending on the social context in which a person finds themselves. Therefore, the implications of holding an identity shift as people move in and out of social contexts. An example of this shift is individuals who identify as transgender and hold a privileged socioeconomic status; their experience of their identities in society as a whole involves both privilege and oppression. When they are among individuals who are also transgender, their socioeconomic status may become more salient. In turn, when they are among predominantly cisgender-identified people who are presumed to be of similar socioeconomic status, that individual may find that their gender identity becomes more salient.

The theory of intersectionality applies directly to family work with transgender adolescents and their caregivers. For example, a transgender youth of color who is well supported in their racial identity by their family but not in their gender identity may feel both empowered and disempowered at home. Their school experience may involve discrimination toward one or both identities as they may find support in a LGBT association at school, while experiencing oppression due to their racial identity. In the classroom, they may be misgendered and they may experience racial prejudice. As it pertains to mental health, the experience of discrimination would shift across settings and would be multiplied and perhaps intensified as multiple identities are affected.

Intersectional Family Therapy with Transgender Individuals

Extant models of family therapy with transgender youth focus on enhancing family support and improving the family environment by bolstering acceptance, processing family concerns, building access to care, improving school supports, and addressing safety concerns. Various models of care have been suggested, including family approaches involving parental education, coaching, support and therapy as well as child group and individual therapy (Greytak, Kosciw, & Diaz, 2009; Malpas, 2011; Menvielle & Tuerk, 2002; Oransky, Burke, & Steever, 2018). In addition, some practitioners utilize models of ambiguous loss to address the loss of a sense of a person who remains present in the family (McGuire et al., 2016). Parents and caregivers of transgender youth may find their own identities conflicting with their values related to gender conformity (Malpas, 2011; Menvielle, 2012; Oransky et al., 2018). In order to promote positive outcomes for all transgender youth, it is vital to develop and practice approaches to family therapy that can help families navigate and address the multiple ways other aspects of their identities impact their ability to affirm their child's gender.

The theory of intersectionality aligns well with models of therapy in which addressing oppression and marginalization are considered critical to processes of therapeutic change. Approaches that take this perspective include those centered in understanding historical trauma (DeGruy Leary, 2005), critical consciousness (Dolan-Del Vecchio, 2008), and approaches informed by feminist family therapy (Carter & Peters, 1996) [for a review, see Dee-Watts Jones (2010)]. These models allow for locating patients in their own and their families' identities. Doing so allows providers to gain understanding of the impact of identity bias and marginalization on mental health outcomes.

Case Examples

The following four case studies illustrate our work with families of transgender adolescents and include ways in which we have applied an intersectional framework to inform and enhance our provision of care. In utilizing intersectionally-informed, gender-affirming therapies, the therapists in these examples are infusing the four primary understandings derived from intersectionality in their therapeutic work with transgender and nonbinary adolescents and their families. These tenets are: individuals hold many social identities at the same time which interact to shape experience; identity is not held to be uniform across the lifespan, it can shift alongside developmental processes, educational advances, and other changes in status; holding an identity does not equate having or relating to the same history or present experience as others who hold the same identity; and social identities confer relative amounts of privilege or oppression depending on social context (Combahee River Collective Statement, 1979; Crenshaw, 1991, 1994). Using intersectionally-informed affirming family therapy provides opportunities

to address historical and cultural meanings associated with gender. Doing so allows therapists to break from the assumption that all families are wholly involved in either rejection or acceptance of their transgender or nonbinary adolescent based on beliefs about gender identity alone.

We have divided these case studies into sections: family intake sessions; adolescent-focused work; work with caregivers; and return to family work. The family intake sessions section details our intake of the family where clinicians initially pose questions about family members' various identities. In these sessions, providers challenge their own held assumptions about identities and treat transgender adolescents and their families as the experts in their own identities and experiences (Dee-Watts Jones, 2010). They ask about the various aspects of family members' identities in the interest of gaining information about how they each relate to gender affirmation. Therapists aim to understand how different family members may hold identities that vary from those of the family group, and how these identities interplay during family members' interactions about gender identity. They also attempt to understand how identities have become more developmentally salient over time. Asking about identities early on in the process sets the stage for deeper explorations about identity as adolescent, caregiver, and family session's progress.

A guiding principle in intersectionally-informed gender-affirming family therapeutic practice is that therapists are tasked to provide opportunities to identify and address identities while not making doing so a requirement for receiving therapy. Much like the practice outlined in Dee-Watts Jones (2010), the therapist is inviting a conversation about social identity implying that identity is meaningful and germane to therapeutic work. Thus, the invitation to explore how social identities inform family gender acceptance can be accepted at any point in the therapeutic process and is not required in order to proceed.

The adolescent-focused work section focuses on gaining an understanding of the adolescent's experience of their identity; exploring their experience of how family reactions are exacerbating or providing refuge from gender dysphoria and other comorbid symptoms; and providing a safe therapeutic space that allows the adolescent to manage their own distress while the family is negotiating their ability to provide support, or while family support is absent. This may involve the processing of information related to family sessions and discussion of caregivers' intersecting identities that the child is learning about. The provision of adolescent-focused individual and group therapy is essential. In these contexts, providers can help the adolescent address family and societal rejection and any mental health symptoms that emerge as a result. In addition, peers can provide support through a group therapy context.

The working with caregivers section details ways in which caregivers utilize individual sessions and a caregiver support group to help them better understand how their own intersecting identities influence their reactions to their child's gender. It also describes ways in which some caregivers process their sense of loss. Our clinical experience has shown us that caregivers' reactions to their children's gender identity are most often embedded in the context of other aspects of their identity and that these sessions become essential for caregivers to process their own sense of confusion, shame, or loss in a setting that is removed from their child.

Finally, in the return to family work section, we discuss how families return to therapy together after gaining psychological resources and a supportive network of either teens or parents who have validated their identities and understood their perspective. We have aimed for caregivers and adolescents to return to these sessions with an acknowledgment that they are all people who hold many identities.

Each case study is broken down into the four categories described above (family intake sessions; adolescent-focused work; work with caregivers; and return to family work). The goal of the case studies is to highlight how the tenets derived from the intersectionality framework can be used to build greater understanding both within and among caregivers and youth. It should be noted that the actual therapeutic process often involves a weaving back and forth between the four modalities.

Of note, the case studies presented below are composites of cases and do not contain any identifying information. In writing our case composites, we followed a series of steps outlined by Duffy (2010). Our procedure included: identifying the clinical focus of each case example; choosing a series of cases demonstrating the focus; drawing illustrative clinical material from each case; blending the illustrative clinical material to create a single, coherent narrative; and finally, using deidentified demographic details. These details were taken from each case, without overusing details from one specific case. Given the small size of our patient population, we utilized this method in order to provide relevant examples while not risking the discovery of the identity of any individual. Thus, though these cases are composites, the stories within them are true to shared patient experiences.

Tiffany

Tiffany was a 17-year-old Dominican and African-American adolescent who had been assigned male at birth and who identified as transgender female. She was referred by a community-based clinic where she had been treated due to emerging suicidality several months after coming out to her mother as transgender. Tiffany had come out publicly as transgender several months prior to intake and had quickly socially transitioned. She was dressing in female clothes, using she/her pronouns, and the name Tiffany. Although she had privately identified as a girl since around the time of puberty, she had been living as a gay male for the last several years.

Upon intake, Tiffany presented with significant anxiety and depression stemming from acute gender dysphoria,

experiences of misgendering and harassment, and ongoing fears about continued rejection. She expressed hopelessness about a positive future and attributed her hopelessness to her mother's unwillingness to support her medical transition.

Family Intake Sessions

During intake, the therapist providing therapy for Tiffany met with Tiffany and her mother. The therapist asked for information about each family member's identities, in particular noting that different aspects of identity may influence views on gender identity, gender roles, gender expectations, and gender transition. Family members were also encouraged to reflect upon the most salient aspects of their identity. The therapist noted to the family that aspects of each person's identity can be associated with strength as well as struggle and explained that she hoped to return to these themes over the course of therapy. She then asked about aspects of identity that the family had not yet mentioned, including ability status (whether family members experienced disabling mental or physical health conditions), documentation status (ability to live legally in the USA), and socioeconomic status. She asked open-ended questions and accepted the answers the family provides without attempting to fit their identities into categories.

Through this process, the therapist learned that Tiffany lived with her mother, who identified as Dominican and was raised in a strict Catholic church. Both mother and Tiffany reported that Tiffany's father was not regularly involved in her life, and her mother had full legal custody. Tiffany and her mother identified as able-bodied. During the intake sessions, Tiffany and her mother found themselves caught in conflict. Tiffany experienced urgency around beginning her medical transition; however, her mother was unwilling to sign the consent forms for hormone therapy. Tiffany had previously purchased hormones on the street, paying for them with money she made through sex work. Therapeutic work with the family together reached an impasse when Tiffany threatened to once again buy "street hormones" if her mother would not consent for medically supervised treatment. Though Tiffany's mother expressed fear about this outcome, she remained steadfast in her unwillingness to consent to medical transition, but had trouble voicing her reasons why.

Adolescent-Focused Work

Tiffany attended individual therapy sessions to develop coping skills to deal with her feelings of rejection by her mother and to work on symptoms of anxiety and depression. Initially, Tiffany was guarded due to the therapist's feminine, cisgender presentation, which Tiffany admitted triggered feelings of dysphoria within her. She was additionally worried that she had to prove that she was transgender and ready for hormones. As such, she was hesitant about discussing the extent of her depression and anxiety and felt pressure to dress "ultra-femme" when going to therapy sessions. In conversation with the therapist, she also disclosed that she was worried that the therapist, who identified as white, would not be able to validate her mother's cultural values.

At the outset, individual therapy focused on building a peer support network for Tiffany both within and outside of the clinic. Tiffany attended a transgender support group, where she initially struggled due to the fact that she was one of only a few transgender females in the group. (Most group attendees were transgender males.) She was not the only person of color in the group and reported that she felt more comfortable to explore other aspects of her identity in this setting, "like I can focus on being a woman." Tiffany's therapist also worked on Tiffany's behalf within the school system (e.g., advocating for the school to allow her to use the faculty bathroom, and helping the school to understand her experiences of distress within school related to her marginalized identities). This helped to lower Tiffany's level of distress day to day so that Tiffany could better tolerate working with her mother through her barriers to supporting Tiffany's transition.

Work with Caregivers

Tiffany's mother entered treatment very concerned about the loss of her child. Tiffany's mother had understood her child's identity first as a Dominican and African-American male who was raised in a neighborhood with significant violence. In addition, she had been raised in a society in which men who looked like her child were too often criminalized. Her worries about her child's safety had increased when Tiffany came out as a gay male. Therefore, the attendant desire to keep her child safe had been the backdrop to her parenting practices across her child's life. Tiffany's mother reported that she was not particularly surprised when Tiffany came out as transgender and she did not doubt the veracity of her daughter's identity. At the same time, she reported to the therapist that she believed if she supported Tiffany's medical transition, she would only be supporting an intensification of the violence and "shunning" that her child faced on a daily basis.

Tiffany's mother had given great thought to the concern of her child's intersecting gender and racial identities. She deeply understood the reality of being a transgender woman of color both in the world and in the family's neighborhood. Moreover, Tiffany's mother expressed concern that, if she supported her daughter's medical transition, the family would lose support of Tiffany's grandparents, aunts, and uncles. Tiffany's mother also feared that she would lose her important church community, as she had noted that they had not been supportive of the LGBT individuals they had seen in the community or in the media. Tiffany's mother had gone to great lengths to try to hide her child's previously held gay

identity from family and her church community; however, she expressed fear that she would not be able to hide her daughter's physical transition.

In caregiver sessions, Tiffany's mother had frank conversations with the therapist about the potential impacts of disallowing her daughter from transitioning. Tiffany's mother understood the potentially irrevocable rupture it could create in their relationship, the impact that it could have on her depressive symptoms, and the fact that her child might engage in sex work again in order to afford street hormones. Tiffany's mother was once again quite honest about her decision-making process. She believed that a decision to support her daughter's transition would ultimately lead to greater loss and pain than Tiffany was feeling at the time.

Return to Family Work

Despite Tiffany's mother's refusal to approve hormones, she was loving and caring in family sessions. Tiffany's mother listened carefully to education on gender dysphoria, given both by the therapist and by Tiffany. She presented as extremely worried about Tiffany's depressive symptoms and her history of suicidality. She asked accepting family members to spend time with Tiffany and provide support for her when she was not at home. In addition, she drove her to all mental health and psychiatric appointments to ensure that she attended. She was also quite sympathetic to Tiffany's experience of harassment in the community and at school, and she went to lengths to protect her (e.g., arranging for home-based tutoring and driving her to school).

In therapy sessions, Tiffany explained her daily, lived experience of gender dysphoria and the hurtful impact of her mother's lack of support. Tiffany acknowledged her mother's fear that she would face harassment as a transgender woman of color; however, she explained that she was willing to take this risk due to the pain of her current gender dysphoria. Tiffany's mother was sympathetic to Tiffany's experience. She acknowledged that her daughter was in pain. At the same time, she remained unwilling to change her mind about providing consent to her daughter's medical transition.

Given Tiffany's mother's fears about providing consent for medical transition, Tiffany and her mother focused on other types of support that Tiffany's mother could provide, such as her advocacy with Tiffany's school. Ultimately, Tiffany's mother did not object to Tiffany's medical transition when Tiffany reached majority age. Together, Tiffany and her mother built an understanding that Tiffany's mother felt that she could not be the person "green-lighting" Tiffany's medical transition; however, she could build acceptance for it when Tiffany made the decision on her own.

Jordan

Jordan was a 14-year-old, African-American, transgender male who identified that he was sexually and romantically attracted to females. He indicated he/him pronouns were affirming to him. Jordan came out as transgender at the age of 14 to his parents, who expressed initial shock, fear, and dismay and immediately brought him to therapy. He entered into treatment severely and persistently dysphoric. He felt both rejected by his parents and guilty for the pain he believed he was causing them.

Although Jordan had only recently come out as transgender to his parents, he later revealed that he had a long-standing internal male identity that he had neither fully understood nor shared with others out of fear of rejection. He shared his transgender identity with his parents when the physical changes accompanying puberty had led to a level of distress he no longer felt he could manage on his own. Jordan had been hesitant to share his transgender identity partly due to his history of gender-nonconforming behavior, which had mostly been met with resistance from his family.

Family Intake Sessions

During intake, the psychologist working with Jordan's family conducted a full social-emotional evaluation, including questions about how various aspects of Jordan's family's identities may have been impacting their beliefs about gender and gender transition. This interview provided the psychologist with an opportunity to address the family's current positions of privilege, as well as their experiences of oppression and hardship. The therapist also explored how Jordan's coming out as transgender threatened certain aspects of the family's current privilege.

Jordan's parents reported that the family, including Jordan's parents, Jordan, and his brother, resided in a large home in a predominantly upper-class suburb. Jordan's parents stated that they hailed from working-class backgrounds and had watched their parents struggle to pay bills in their youth. They identified their upward social mobility as a significant source of pride and their class status as a salient aspect of their identity as parents and adults. They noted that their class status freed them to make decisions about their children's lives without much concern for cost. In particular, Jordan's father expressed that his greatest life achievement had been creating a life for his children that was relatively "worry-free" when compared to his upbringing.

Jordan's parents noted that they held strong binary gender beliefs, influenced by cultural norms in their families of origin and current community, and that Jordan's father had always referred to his wife and daughter as "my princesses."

Jordan's parents presented the following questions to the psychologist: Was there some kind of medical test to see if

Jordan is *really* transgender? Was it possible that therapy would help Jordan want to "remain a girl?" In addition, Jordan's parents expressed concern that: he was too young to know that he was transgender, he would be seen as a "freak" by others, and he would be "choosing" a life of increased discrimination. These questions underscored the family's urge to maintain existing gendered norms in their home and in their lives. Although Jordan's parents admitted to noticing gender nonconforming behavior and expression during Jordan's childhood (e.g., persistent requests to wear masculine clothes, active identification with male characters in movies and video games), they had downplayed these behaviors as part of a phase and had urged Jordan to conform to more traditionally feminine behaviors.

During intake, the psychologist explored what Jordan's gender identity meant in relationship to Jordan's and his parents' other identities. With the therapist's help, Jordan's family expressed their unique intersection of gender, class, and racial identities. The psychologist and family worked together to recognize that Jordan's gender identity conflicted with the family's privilege derived from their class status. Jordan's parents shared their worries that if Jordan transitioned, or came out publicly as transgender, they would be marked as deviant within their tight-knit, "conventional" and insular community, which by their report espoused heteronormative beliefs. They feared that they would be "othered" in such a way that they would lose the privilege and status among their peers, and would lose status, friendships, and important connections.

Jordan's mother's sense of loss was profound. She described herself as a proud homemaker who had spent the vast majority of the last 14 years focused on her children's development. She had worked hard to cultivate a mother–daughter bond with Jordan based on shared enactments of traditional femininity (e.g., getting their hair and nails done). She recounted times that she had felt personal rejection when Jordan's requested not to wear the "beautiful gowns" that she had lovingly picked out. It was clear that Jordan's parents believed that a "return to normal" was the only way to lessen his and his family's distress.

Adolescent-Focused Work

Jordan's symptoms of depression were closely tied to his fears that his family could not accept him. Up until this point in his life, he had experienced his family as being quite close and supportive and had, at times, curbed his gender nonconforming behavior in order to maintain familial harmony. Jordan was simultaneously fearful that he would lose his parents' emotional and financial support and worried he was causing them emotional pain. He expressed that his close friends supported him, but that he also wanted to remain close with his family, sharing that he loved going with his mother to the salon and believed strongly that "Boys can get their nails done too!"

At the same time, he resented the fact that his parents were asking him for a medical test to prove or justify his gender identity. He felt as though his self-awareness was in question, and was upset that the family believed he was simply "going through a phase." Because of these conflicting feelings, Jordan shut down when the therapist attempted to explore ways for him to talk to his parents and share his experience.

Individual sessions helped Jordan identify, reflect on, and put words to feeling in preparation for family sessions. He began to be able to state that he wanted to maintain the family rituals "just without the girl stuff." Through conversations with the therapist, he was also able to better understand how his parents' social identities impacted their own reactions to and understanding of his gender identity.

Work with Caregivers

Parent sessions focused on three tasks: gaining awareness of the origin of Jordan's parents' concerns; understanding where parent identities created challenges for affirming support of Jordan's gender; and the provision of psychoeducation and coaching. An exploration into how gender identity and gender transition intersected with various parts of Jordan's parents' identities was particularly fruitful as it provided a foundation for understanding Jordan's parents' initial reactions and led to ideas of how increased support could be attained.

For Jordan's father, Jordan's newly disclosed transgender identity threatened what he saw as his greatest accomplishment, achieving a relatively "worry-free life" for his family as compared to the upbringing he had experienced. He viewed Jordan as being newly at risk, which he felt undermined his identity as a protective father. He believed that he had built an environment for his family that was free of much of the hardship he had experienced during his childhood. Allowing hardship into Jordan's life would involve giving up the privilege Jordan held.

Jordan's parents both expressed binary, conventional views of gender roles and expectations. They described these views as stemming from their familial and cultural histories and as being embedded in beliefs maintained by their community. They saw gender nonconformity as a mark of deviance that would not go unnoticed. Jordan's father recounted his teenage years growing up in an environment in which LGBT individuals ended up shunned, lonely, or living on the street. He recounted his own stories of teasing other kids for their gender nonconforming behavior back when he was in school. These memories further fueled his concerns about his child's safety, and his own fears about his impending failure as a father in terms of protecting his child.

Jordan's mother prized both her femininity and her conventionally-attractive physical appearance. She saw these qualities as essential to her upward mobility and, in turn, had derived

pride from being able to pass them on to Jordan. Due to the centering of feminine beauty ideals in the family's efforts at connection, she was scared to lose her child's feminine identity and in turn her connection with Jordan. Throughout Jordan's childhood, she had bristled against his attempts to wear boys' basketball shirts and his attempts cut his hair short. She reported that Jordan's desire to transition felt like a major rejection of her as a mother. Jordan's mother also feared a loss of status in her community should she be the mother with the child who did not fit the picture-perfect mold she had strived to achieve.

Through ongoing caregiver sessions with Jordan's family therapist, as well as interactions with other parents in caregiver support group sessions, Jordan's parents began to understand the meanings they ascribed to gender and gender transition, and how these meanings were tethered to the various aspects of their social identities involving privilege. Jordan's father began to understand that "protecting" his child from hardship and violence (e.g., not letting him socially/medically transition) was only increasing Jordan's felt sense of shame, dysphoria, isolation, and depression. He began to balance his desire to provide a life with reduced external stressors with his desire to provide a life in which his child could be his authentic self. He hoped that doing so would alleviate Jordan's internal distress.

As Jordan's parents gained insight into and began to manage their reactions to Jordan's transgender identity, they were able to view his history of gender-nonconforming behavior with less of an emotional reaction, even revealing past fears that Jordan was somehow "different." Over time, they noted that it was not surprising that Jordan had come out as transgender; however, they were only able to do this once they better understood their own initial reactions of resistance and distress.

Return to Family Work

Jordan was motivated to maintain his connection with his parents. Through the help of family therapy sessions, he invited them into his life by sharing videos and literature on the lives and experiences of transgender youth. Jordan also shared his feelings of gender dysphoria as well as the pain he felt when misgendered by others, particularly his parents. After 18 months of family therapy, Jordan's parents allowed him to shave his head.

Jordan's mother continued to struggle with her fears of losing status within her tight-knit, upper-class community. However, as she saw the positive impact of Jordan's social transition on his emotional well-being, she decided to face these fears. In so doing, she expressed that she found a strength she did not know she had. She was able to grow and transform the part of herself who had felt pride on finally "making it" in a "conventional," upper-class community to someone who was willing to stick up for those who did not conform to her community's norms.

In the end, Jordan's relationship with his mother deepened. They built a new relationship, based on hard-won support, understanding, and validation. The loss of their connection based on traditional femininity gave way to a shared vision of justice and advocacy in the face of LGBT marginalization. In addition, Jordan's father saw aspects of himself in his son. He likened the bravery and persistence Jordan evidenced in his transition process to the same qualities that he had relied on while working his way out of poverty. While he did not participate as fully as his wife in advocacy events, he admired and identified with his son's courage nonetheless.

Jesse

Jesse identified as a 15-year-old, Chinese-American, nonbinary, masculine-identified adolescent, who identified that they were "pansexual" (which they described as meaning they were attracted to people regardless of gender identity or sex assigned at birth). Jesse had been assigned female at birth and had been out to their father as nonbinary for about 6 months but had been out to their friends for about 2 years. They had socially transitioned at school, where they used they/them/their pronouns. Jesse entered therapy in the midst of a very serious depression, ongoing suicidal ideation, and self-harm. Jesse struggled to maintain relationships with peers and reported that a relationship with their father was "nonexistent." Jesse had a childhood history of being a "tomboy" combined with a love of wearing makeup and hairstyling as an adolescent. They were interested in hormone therapy as they felt a more masculinized body would better represent their gender identity.

Family Intake Sessions

Jesse was born to Chinese-American parents, but had been raised by their father and paternal grandmother, who had emigrated from China. Jesse and their father led a middle-class life, and Jesse's father took great pride in Chinese cultural traditions, celebrations, and history. Jesse's mother suffered from significant mental illness and had not been part of their life since early childhood. While Jesse's father had been willing to support their social transition at school, he did not allow Jesse to use their gender-neutral name and pronouns at home, and refused hormones or a legal name change. Jesse's father insisted that Jesse's grandmother would "have a heart attack and die" if she found out that her grandchild was nonbinary. He asserted that Jesse's grandmother barely understood what it meant to be transgender and certainly would not understand a nonbinary identity. He stressed that while he was growing up "she never even acknowledged what it meant to be gay."

Adolescent-Focused Work

Jesse experienced clinical distress in the context of multiple levels of familial and societal invalidation: family rejection, gender invalidation, and racism. Though they had been able to change their name and pronouns for classes at school, their name and gender assigned at birth were still printed on all school-related material (e.g., rosters for examinations, and their school id). In addition, they were often sorted into the "girls" groups during gym class. They experienced bullying from peers at school about being Chinese-American, as well as gender invalidation from teachers and administrators when they complained about the lack of consistent name and pronoun changes. Further, they often spent the day in pain or panic because they did not feel comfortable using the male or female designated bathrooms at school, and the key for the faculty bathroom was located in the teachers' lounge.

In combination with the lack of affirmation at home, these events were experienced as triggers to emotional dysregulation, self-harm, and suicidal ideation. Jesse's psychologist provided individual dialectical behavior therapy and referred them to the accompanying group to address emotional dysregulation and active self-harm. Coping skills were taught to help Jesse manage their intense emotional reactions in the face of gender invalidation, oppression, and bullying and to reduce their acts of self-harm and feelings of suicidality.

Jesse also attended a support group for transgender youth. In this group, they struggled at times to feel connected to others. While they experienced validation related to their nonbinary gender, they enjoyed socioeconomic privilege that many other group members did not, and were challenged by other group members to recognize their privileged statements or to allow room for others' voices and experiences during group sessions.

As time went on, Jesse began to struggle with their Chinese-American identity. The more Jesse heard their father say that his lack of acceptance stemmed from his Chinese cultural upbringing, the more Jesse noticed they felt disconnected from that aspect of their own identity, and began to state that they no longer wanted to be a part of their family.

Work with Caregivers

Therapy with Jesse's father focused on gaining understanding of Jesse's father's own conceptions of gender and transitioning, and helping him to express how these beliefs intersected with his other held identities. Within the context of his self-reported binary gender beliefs bound in his Chinese cultural experience, he had trouble understanding the idea of a nonbinary identity. It was confusing to him that his child wanted to begin hormone therapy but still spent hours putting on makeup. In addition, he saw his child as "soft" and "highly emotional," two attributes that he viewed as highly feminine.

Jesse's father also explored his own identity as a dutiful son of a single mother who had "risked everything" to provide him with a better life. He was strongly rooted in this aspect of his identity and feared that allowing his child to transition at home would make his own mother call into question his gratitude for her sacrifices. In addition, he feared: "It will lead her to think I am too indulgent of a father, and that I am weak."

Jesse's father also attended a caregiver support group. In this group, he was able to speak with other caregivers about their roles and identities as parents. Through conversations with other caregivers, he was able to identify the tension he felt between his role as a father and role as a son. Other parents were able to share their experiences of balancing what it means to be a parent and a child at the same time. In addition, he drew confidence from others' stories of being surprised by the positive response of their family members to their child coming out as transgender or nonbinary.

With other caregivers, Jesse's father was able to identify a deep feeling of loss. He was able to speak about the fact that he had always envisioned raising a daughter. Other parents were able to validate his feelings and challenge him to recognize that his partial support for his child might result in the loss of the relationship altogether.

Return to Family Work

After discovering an increased understanding of his own identities and how they intersected, Jesse's father was able to explain to Jesse the tensions he was experiencing around Jesse coming out in the family home. Jesse's father was also able to communicate his sense of loss over "losing" his daughter and his fears that Jesse would confuse other people. In turn, Jesse was able to communicate the distressing nature of their gender dysphoria, how gender invalidation was impacting their feelings of isolation and hopelessness, and how hurt and rejected they felt by their father's partial rejection of their gender.

Jesse's father continued to explore and give words to his own culturally infused experiences and he was able to steady himself and make hard decisions. Jesse's father drew inspiration from his mother's decision to "risk everything" on behalf of her son. He helped Jesse come out to their grandmother who surprised the family with her level of acceptance and willingness to try to use Jesse's correct name and pronouns.

Despite increased acceptance of Jesse's gender identity and expression, their father and grandmother continued to struggle to understand what it meant to be nonbinary. For example, Jesse's grandmother stopped buying him makeup as gifts and assumed that Jesse would no longer be interested in inheriting her jewelry collection. Both of these assumptions were incorrect, but Jesse feared that explaining this to their grandmother would confuse her even more. Although he was accepting in his behavior toward Jesse, Jesse's father continued to express to the therapist his fears that Jesse was

simply confused and would ultimately pick "one side" of the binary. While he came to recognize that these beliefs were embedded in cultural and family traditions shared with his own mother, they were deeply ingrained nonetheless.

Katie

Katie was a 16-year-old, Polish-American transgender female, who did not label her sexual orientation, but rather indicated that she was sexually attracted to individuals regardless of their sexual orientation or gender identity. She presented for therapy due to her acute gender dysphoria. Her gender dysphoria was exacerbated by her mother's persistent misgendering of her, and her expressed belief that she would like Katie to "stay a boy because he is a boy." Katie reported fully understanding her female identity around the age of 12 and she came out to her family and peers at age 13. Although she had received support from some peers, her family did not approve of her female identity and did not permit her to wear feminine clothes in the home. Her mother had previously taken her to therapy in hopes of "ridding Katie of her transgender identity" and had repeatedly pulled her out of therapy when therapists suggested that the family affirm Katie's female identity or allow her to socially transition. Although Katie had experienced suicidal ideation since early adolescence, her suicidality had intensified in the months prior to her intake, during which time she was repeatedly hospitalized for suicide attempts.

Family Intake Sessions

In initial sessions, the therapist working with Katie's family asked about identities such as race, ethnicity, immigration status, and disability status. She discovered that Katie's parents immigrated from Poland to New York several years prior to her birth. Her parents remained enculturated in Polish culture and socialized predominantly with other individuals from Poland. By contrast, Katie had fully embraced "American culture," as it existed in her peer community and was acculturated to the culture of her peers. Katie reported being proud of her Polish culture, while also feeling that it was creating barriers to her "being myself." The family sessions were initially rife with conflict. Katie's mother presented as angry and accusatory while Katie responded by vacillating between angry reactivity and intense grief. Katie's father was mostly quiet in sessions, supporting the positions expressed by his wife. Of particular note, Katie attended an all-boys private school, which was particularly problematic given her desires to transition.

Adolescent-Focused Work

Katie presented with intense suicidal urges related to gender dysphoria and hopelessness about not being able to medically transition. She did not believe that her mother would allow her to transition and she was actively looking for avenues to enter the foster care system. Given her suicidal urges, Katie began dialectical behavior therapy. She learned techniques for managing intense feelings and regulating her emotions in the face of invalidation. During her individual therapy sessions, Katie also realized that underlying her sadness was a desire to be close to her family, and to preserve her Polish cultural identity while transitioning. She worried that she had let down her parents, and she noted that it was hard for her to challenge what she viewed as their culturally-embedded beliefs. Katie also attended a transgender support group where she found quick comradery and support among adolescents who were experiencing similar rejection. This buoyed her as she struggled to find acceptance in her home and neighborhood community.

Work with Caregivers

Caregiver sessions were held primarily with Katie's mother, who held the role of making decisions in the family. When discussing Katie's transgender identity, her mother initially stated that "This doesn't exist in my country." She viewed her child's transgender identity as either the product of Katie buying into an American trend or a "punishment for sins I committed in the past." In addition, she was wary of therapy in general and remained concerned that the therapist would be meeting with her child without her. She challenged the therapist's statement about "living as one's authentic self," stating that it was not something she considered a developmental goal. In addition, she stated her belief that her children should be planning their lives as they aligned with the family's goals.

Ongoing sessions with Katie's mother revealed aspects of her identity that were influencing her ambivalence regarding the idea of Katie experiencing a medical or social transition. Katie's mother viewed Katie's gender transition as conflicting with her ability to maintain her status as an immigrant, and a challenge to her identity as a business owner. Katie's mother's family had a successful business in Poland that she had come to the U.S. to expand. As the presumed oldest son, Katie was tapped to return to Poland one day to run the family business there. According to Katie's parents, Katie could not return to the family's home in Poland as a transgender woman and be accepted as the person who would head the family's business. The thought of this led Katie's mother to experience feelings of shame and beliefs that Katie identifying as female meant she would be viewed as a failure as a member of her Polish culture and family. Katie's mother reported intense fears over being shamed in her community where she currently resided as well as in her hometown where she would return to visit. This shame was so potent that she disallowed Katie from dressing in female clothes or wearing nail polish anywhere near their community. At the same time, given Katie's English language ability, Katie's parents relied on

her to translate important business and financial items, and they could not imagine the family's business successfully being brought to the U.S. without her. As such, her parents were caught between fear related to accepting and affirming Katie's gender and fear of losing her help.

Return to Family Work

Despite her initial assertion that she would never accept or understand Katie's transgender identity, Katie's mother began to show concern around Katie's suicidality. While Katie's mother did not initially view her suicide attempts as a serious matter (calling them "attention-seeking"), she responded swiftly when Katie's treatment team informed her of the seriousness of Katie's suicidality and its relationship to her rejection of Katie's gender identity. Indeed, Katie's mother identified that she held a reverence and respect for medical professionals (as opposed to mental health professionals). Due to her concern that Katie would attempt suicide, Katie's mother began to explore ways to help Katie transition socially and medically.

Of note, while Katie's mother allowed her to medically transition, she continued to experience feelings of shame and discomfort around Katie's social transition and the change in her appearance. She did not ask Katie for information about her identity or make an effort to understand her point of view and consistently misgendered her at home. Even so, Katie felt supported by the fact that her mother was allowing her to transition despite a lack of cultural understanding. Katie saw it as a sign that her mother cared about aspects of her well-being. In order to avoid ongoing conflict, Katie planned her transition in such a way that would allow her mother to find ways to work through her discomfort and shame gradually. For example, she skipped Polish cultural events in her family's local community and expressed that she and her mother could find ways for her to come out to other members of their community in time. Though it pained Katie to be left out of events, she attempted to balance this with an appreciation for her mother's willingness to support her as best she. She understood that her mother followed treatment recommendations that fit within her own need to adhere to her internally-held identities and the beliefs that supported them.

Discussion

The aim of an intersectional approach in gender-affirming family therapy is to gain an understanding of how family members' myriad identities impact their ability to understand and support a transgender youth. Increasing family support for transgender youth is paramount, given positive associations found between a lack of family support and increased risk for poor outcomes (Bauer et al., 2015; Grossman & D'augelli, 2007; Simons et al., 2013; Travers et al., 2012). The theory of intersectionality (Combahee River Collective Statement, 1979; Crenshaw, 1991, 1994), research on minority stress (Meyer, 1995, 2003, 2015), and our own clinical experience have led us to an understanding that inroads to family support of youths' gender identities are best accessed when placed in the context of the youth and family's intersecting identities. As such, we posit that family therapy aimed at improving supportive environments for transgender adolescents and young adults will be most effective when the experience and meaning of the youth's gender identity is understood in the context of family members' multiple, intersecting identities.

We believe that acknowledging and addressing how intersecting identities function to generate or lessen support of transgender adolescents allows therapists and families to uncover sources of ambivalence about gender-affirming support. Understanding a family's unique experiences of minority stress or majority privilege allows for a more nuanced exploration of family experiences surrounding the discovery of the gender identity of their adolescent.

Using this framework to inform affirming therapy, providers strive to challenge their beliefs about the adolescent and family's identities throughout therapy and treat adolescents and family members as the experts regarding their own experience (Dee-Watts Jones, 2010). Providers challenge themselves to create an open environment where their own assumptions can be addressed. Providers must make every effort to ask open-ended questions about every identity without presuming they can correctly identify a client's identities by looking at them.

Providers must thoughtfully and carefully explore risks an adolescent may face that may be compounded by their other identities. They must also work with family members to understand how their own identities are supporting or restricting their ability to affirm their child's gender. In addition, using intersectionally-informed affirming family therapy allows providers to help adolescents recognize and understand their caregivers' cultural influences that may be complicating their decisions around providing gender-related support. This increased understanding of caregivers' own identities may soften some of the rejection that is felt by the adolescent.

Some limitations exist in the case material provided in this article. A first limitation is that we chose not to present single, deidentified cases to illustrate our clinical principles and instead wrote composite case examples. While the utility of presenting composite cases has been established elsewhere (Barnett, 2012; Duffy, 2010; Sieck, 2012), we understand that the use of composite cases does not allow for descriptions of individual cases which, at times, can appear as more authentic exemplars of clinical work. We chose to write case composites rather than present single cases in order to (1) spare our patients the dilemma of being asked to consent to appearing in our published work and (2) protect the confidentiality of our

patients, who may be more easily identified, given that they hail from a specific clinical program (Barnett, 2012; Clifft, 1986; Duffy, 2010; Sieck, 2012). Thus, while our cases do not each represent single clinical experiences with a specific family, they are drawn from real-life clinical occurrences and have been carefully constructed so as to accurately represent our years of clinical experience working with transgender youth and their families. A second limitation of our case studies is that they were drawn from a clinic population that serves adolescents and therefore do not represent transgender or nonbinary youth who came out as young children and sought family therapy at that time. Intersectionally-informed therapy may look different earlier in childhood. Finally, in order to most clearly illustrate the application of an intersectional framework to affirming family therapy, we selected case examples representing adolescents with persistent, consistent, and insistent identities who wished to affirm their gender through social or medical transition. There are certainly other presentations of adolescents not represented in these examples, such as adolescents who are unsure that social or medical transition will affirm their gender or who present with other factors that complicate how a transition will be navigated (e.g., developmental delays or severe psychopathology).

A third limitation lies in the reality that discussions of intersectionality of identities may be limited by levels of comfort between therapist and client. This may be due to differences among therapist and patient identities, as well as relative level of understanding of privilege and marginalization among therapist, client and other members participating in therapy. Though the therapists in these examples were able to raise topics of identity with patients and their families, they also followed the patients' lead in discussing identities and how they related to privilege and oppression. Thus, though there were certainly other areas in which relative privilege and identity could have been explored (e.g., citizenship or disability status), if patients did not raise these topics or they were not considered germane to discussions of gender affirmation, they may not have been discussed. Certainly, an exploration of all areas of privilege and oppression of both patient and therapist could be fruitful should a patient feel comfortable in doing so with a therapist (Dee-Watts Jones, 2010).

In our experience with adolescents and their families, an intersectionally-informed affirmative family therapy process leads to increased insight on the part of caregivers, increased sense of connection between family members, greater support for the transgender youth, and a sense of safety in the family unit. Anecdotally, we find that family support often results in improved mental health as well. Future directions would include more formally codifying and standardizing the components of an intersectionally informed approach so that it can be more rigorously evaluated and disseminated.

We believe intersectional practice is a key component for navigating and resolving ambivalence about affirmation of gender. Finding inroads to support of an adolescent's gender identity can not only be lifesaving for the transgender or nonbinary adolescent, it can also provide opportunities to explore how families will transverse a new and potentially meaningful lived experience with their child.

Compliance with Ethical Standards

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

Human Participants or Animals This article does not contain any studies with human participants or animals performed by the authors.

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