Teach your parents and providers well

Call for refocus on the health of trans and gender-diverse children

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Since the mid-20th century, children's gender diversity* has been treated as a matter of psychopathology.[1-3] Throughout North America and Europe, children who express their gender in unexpected ways have been compelled to comply with the gender constraints of their particular cultural and historical moments.[3] This contrasts with the historical respect for gender-diverse people evident in many non-Western communities, including in various Indigenous nations throughout Canada.[4†] Traditions of respecting gender diversity continue in many parts of the world.

Today, however, we are witnessing a substantial progression of the field—what some have termed a paradigm shift.[5] Globally, health care providers acknowledge that gender is "a matter of diversity, not pathology,"[6] and gender identity is being formally recognized as a deeply personal and fundamental human right.[7]

The American Academy of Pediatrics recently released a comprehensive guide for supporting gender-diverse children.[8] In Canada, several professional organizations have released statements affirming gender-diverse children,[9-11] yet physicians lack specific guidance and are left to rely on a limited body of research. Much of this research focuses on the dichotomous question of whether a child will "persist" or "desist" in a non–birth-assigned gender identity.

We argue that this narrow focus on prediction is misplaced. An understanding of the developmental trajectory of gender identity is important. However, our main priority is not predicting children's adult identities; it is supporting children's present and future health and well-being.

This analysis reviews previous research on childhood gender diversity, recent research on brain development and socioemotional well-being, and emerging research on affirmative care. We reflect on questions to guide the conversation about gender-diverse children into the 21st century.

Beyond the desistance myth

Directives regarding the care of gender-diverse children have derived primarily from a small body of research based on children in clinical settings in Toronto, Ont,[12] and in the Netherlands.[13-15] These studies have been interpreted to suggest that about 80% of children who we might think of as transgender will not identify as transgender as adults. It has become common to see these studies cited as a reason to discourage children's assertion of a non–birth-assigned gender, framing transgender children as "confused."[16] Yet recent reviews suggest the utility of the concept of desistance is limited,[16-19] and have raised the following 7 critiques.

Many children never asserted a transgender identity. Many children in these desistance studies never asserted a transgender identity and thus would not have been expected to seek transition.[16-19] The outdated tools from the *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition, revised, and 4th edition used in these studies conflated *gender identity* and *gender expression*. This means that a small subset of children who asserted a non–birth-assigned gender identity (and thus might be termed *transgender*) were mixed in with a much larger superset of children (who might be termed *gender nonconforming*) who behaved in ways that resisted gender-stereotyped expectations, but who might have continued to identify with their birth-assigned gender.

Consistency often leads to continuance. In fact, these studies suggest that children who consistently assert a transgender identity are likely to continue to do so.[16-19]

Assumptions were made about loss to follow-up. Youth who refused or neglected to participate in follow-up should not be assumed to be cisgender.[16-19] These studies tended to count participants lost to follow-up—more than 30% in one study[12]—as desisters. This risks a substantial overestimation of the number of young adults assumed to be cisgender.

Some assert a transgender identity later in life. Young people might assert a transgender identity at a later point in adulthood.[16-19] The mean age of follow-up ranged from 15.9 years[14] to 23.2 years[12]; however, we do not know if these young people asserted a transgender identity later in adulthood. The Williams Institute estimates that 0.6% of US adults identify as transgender.[20] One British study revealed that the median age that trans adults self-identified to medical providers was in their 40s.[21]

*A **glossary of gender terminology** is available at **www.cfp.ca**. Go to the full text of the article online and click on the **CFPlus** tab.

†"While it is important not to romanticize Aboriginal peoples as being uniformly accepting of gender and sexual fluidity, research and oral histories reflect widespread respect and honour for Two-Spirit people."[4]

Some assert a nonbinary identity. Many trans children and adults do not identify as male or female.[16-19] The 2015 US Transgender Survey of more than 27 000 transgender adults indicates that 35% of trans-identified adults identify as nonbinary.[22] However, studies of desistance excluded consideration of nonbinary identities. For instance, one study classified a young person who identified as "50% male and 50% female" as having "desisted."[14] These individuals might consider themselves on the trans spectrum but would confound the dichotomy of persistence or desistance.

There is no evidence of being "trapped." There is no evidence that affirmative support traps cisgender youth in a transgender identity.[16] Affirmative care does not equate to transition. Affirmative care is a neutral approach that supports children in the identity, expression, and needs they are currently experiencing, and refrains from directing a child toward any particular identity.[23‡] In contrast, there is substantial pressure in our society for all children to adopt a cisgender identity.[16]

Studies do not examine harm of suppression. Most crucially, these studies do not examine the potential harms of directing children to suppress an intimate, fundamental element of their sense of self.[16-19] In a Hastings special report on the ethics of treating gender-diverse children, Drescher and Pula ask if the harms of pushing children to conform to gender norms might be "so unknown or so great that it is unethical to offer such treatment at all."[25] The authors add:

> Since the clinicians freely admit that they are unable to distinguish persisters from desisters … are the children who will grow up to be trans being subjected to unnecessary stress in order to preserve the well-being of the majority who will not?[25]

As providers, we reflect that even if it were true that most children who assert a transgender identity in childhood later adopted a cisgender identity, this would still tell us nothing about how best to support these children to experience full, healthy, and happy lives.

Global standards affirm that gender differences are not disorders.[7] When we assume that it would be preferable for trans children to conform to the gender they were assigned at birth, we tell parents and children that there is a preferred version of human being for which to aim, and imply hope that the child will "recover" from their trans identity. When we set up families to wait for recovery to occur, the opportunity might be missed to bestow the parental validation that every child, irrespective of gender identity, requires for healthy psychoemotional development.

Supporting the health and well-being of gender-diverse children

In moving past the desistance myth, researchers and clinicians are then able to focus instead on the more crucial question: How do we foster optimal health outcomes for gender-diverse children? Emerging research indicates that children who are not permitted to express their gender freely within their key developmental contexts, including family and school, might be at risk of negative psychosocial outcomes,[23] both in the short-term[26] and into adolescence and adulthood.[27-29] These include low self-esteem,[27] low life satisfaction,[26] poor mental health,[27,28] lack of adequate housing,[27] posttraumatic stress,[28,29] and suicidal thoughts and attempts.[27]

Canadian research indicates that one of the key areas of distress for trans and gender-diverse youth is lack of parental support.[27] A well-designed provincial survey of more than 400 trans youth in Ontario, funded by the Canadian Institutes of Health Research, revealed that young people whose gender identities are not strongly supported by their parents face an attempted suicide rate 14 times higher than their supported peers do.[26] Trans youth without strong family support also reported less positive mental health, more depression, lower self-esteem, and lower life satisfaction. The authors concluded that "anything less than strong support may have deleterious effects on a child's well-being."[27]

A recent American case-control cohort study found that children who are supported in their gender identities can enjoy positive mental health outcomes equal to their cisgender peers.[30,31] In a commentary for *Pediatrics*, Dr Ilana Sherer notes that "this finding is truly stunning in light of the numerous studies that show depression and anxiety internalizing psychopathology scores up to 3 times higher"[32] for children whose gender identities were not affirmed.

In the wider field of child development, an extensive body of research on children's socioemotional and neurobiological brain development links critical and sensitive periods of brain development throughout childhood with secure and nurturing caregiving environments.[33-36] Negative social and caregiving experiences are associated with increased biological stress responsivity.[37] Sustained high levels of stress responsivity in early and middle childhood across populations have been demonstrated to be key predictors of maladaptive stress responses including anxiety, depression, aggression, and self-harm.[38]

A recent analysis of approaches in caring for gender-diverse children concluded that urging children to conform to gender-stereotyped expectations might decrease parent-child attachment and "risk that identity

‡A small number of youth have reported that it was difficult to tell peers at school that they were no longer transitioning.[14] These voices point to the importance for all children of working toward school environments that support and celebrate gender diversity in all its complexity. In another study, the one youth who decided not to transition after accessing puberty blockers expressed gratitude for being allowed to explore their gender, even though they decided ultimately not to transition.[24]

will be organized around the experience of shame and lead to persistent shame proneness and to depression, both in childhood and later in life."[39] Analyzing child development literature in this light suggests that dismissal of gender identity might catalyze traumatic stress responsivity, while affirmation of a child's gender identity could provide a protective "buffer" for biological stress responsivity and socioemotional well-being. This affirmative respite could reduce maladaptive stress responses and enhance brain development in structures linked with learning, memory, impulse control, and emotional stability.[40,41]

Implications for practice

Recent decades have witnessed an evolution in medicine from a paternalistic approach based on a gatekeeping model to a collaborative approach based on a model of informed consent. Most North American gender clinics now practise an affirmative approach to caring for gender-diverse children,[18] with the goal "to listen to the child and decipher with the help of parents or caregivers what the child is communicating about both gender identity and gender expressions."[23]

Our practice recommendations, based on literature review and our own practice experience, are as follows:

Validation and support in the present

- Listen to and respect the child's own description of who they are. This includes inquiring about and respecting the child's chosen name and pronouns. It is not our role as providers to tell children who they are or who they will be. Instead, our role is to help children feel valued and supported.
- Direct most of the intervention and support to parents rather than the child, in the case of prepubescent children. Children who are happy and well often do best without having their diversity addressed by a clinical provider. Invest substantial time in meeting with parents alone. Even supportive parents generally need space to share concerns and worries and ask questions.
- Educate parents that gender diversity is a healthy and normal aspect of life, and that identity is a spectrum including nonbinary, male, and female identities. Remind parents that children's toy and dress preferences do not directly communicate who they know themselves to be—for example, a transgender boy's enjoyment of dresses does not invalidate his identity as a boy.
- Consult with and refer to other providers and educators as needed.

Increased access to services within a more inclusive society

Useful tools and resources for Canadian providers are listed in **Box 1**.

- Connect parents to resources such as websites, school inclusion guidelines, and referrals to other providers as needed. Peer support might be of particular importance for parents.
- Map out with parents the potential journey ahead. Remind parents of the importance of avoiding assumptions about how children will experience their own bodies. At the onset of puberty, some youth will not experience the need to transition medically, while for others it might be vital to their well-being. Review the potential role of hormone therapy, including puberty blockers.
- Develop appropriate intake and consent forms that respect chosen names and pronouns, and ensure that front-line staff are well trained and respectful.
- Consult with the child's school regarding the child's needs, and provide education and advocate for change in schools as needed.

Box 1. Useful tools and resources

Peer support
- Gender Creative Kids Canada website: **www.gendercreativekids.ca**
- Online peer support group, Canadian Parents of Trans and Gender Diverse Kids: **parentsoftranskids@gmail.com**
- Children's Hospital of Eastern Ontario: **www.cheo.on.ca/en/genderidentity**

Providing health care to trans individuals
- Rainbow Health Ontario: **www.rainbowhealthontario.ca/TransHealthGuide**

Respectful and inclusive language in forms
- Center of Excellence for Transgender Health: **www.transhealth.ucsf.edu/trans?page=guidelines-clinic-environment**

Communicating with schools about a child's needs
- Gender Inclusive Schools Toolkit from Gender Spectrum: **https://www.dropbox.com/s/1wpo37oz3wv3nan/Gender%20Inclusive%20Schools%20Toolkit.pdf?dl=0**
- British Columbia's new SOGI 123 (Sexual Orientations and Gender Identities) website, which includes policies, curriculum, and resources: **www.sogieducation.org**
- Government of Manitoba guidelines for supporting and affirming students: **www.edu.gov.mb.ca/k12/docs/support/transgender/guidelines.pdf**

Guides to respectful terminology related to trans and gender-diverse people
- Rainbow Health Ontario and The 519 community centre: **www.the519.org/media/download/2559**
- Government of Canada: **www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/reports-publications/questions-answers-gender-identity-schools/identity-schools.html**

Conclusion

And so, become yourself,
Because the past is just a good-bye.
Crosby, Stills, Nash & Young, "Teach Your Children Well"

Every child is unique. To thrive, every child needs to be seen, valued, and loved for who they are—not for who we

expect them to be. Rather than attempting to "fix" gender-diverse children,[3] medical providers have a key leadership role to play in the acceptance of the gender spectrum as a fundamental element of our human diversity. Through affirmation in the present, and celebration of whatever the future might hold, our goal is for all children to reach their full potential in all aspects of their lives.

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Competing interests
None declared

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