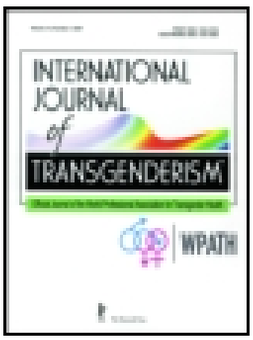

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Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens

Diane Ehrensaft[a], Shawn V Giammattei[b,c], Kelly Storck[d], Amy C Tishelman[e], and Colton Keo-Meier[f]

[a]University of California, San Francisco, Child and Adolescent Gender Center, San Francisco, California, USA; [b]Alliant International University, Rockway Institute, San Francisco, California, USA; [c]Quest Family Therapy, Santa Rosa, California, USA; [d]Private Practice, St. Louis, Missouri, USA; [e]Boston Children's Hospital, Division of Endocrinology, Boston, Massachusetts, USA; [f]Department of Psychology, University of Houston, Houston, Texas, USA

ABSTRACT

Background: This article provides a review and commentary on social transition of gender-expansive prepubertal youth, analyzing risks, and benefits based on a synthesis of research and clinical observation, highlighting controversies, and setting forth recommendations, including the importance of continued clinical research.

Methods: This article involved: (1) a review and critique of the WPATH Standards of Care 7th edition guidelines on social transition; (2) a review and synthesis of empirical research on social transition in prepubertal children; (3) a discussion of clinical practice observations; (4) a discussion of continuing controversies and complexities involving early social transition; (5) a discussion of risks and benefits of social transition; and (6) conclusions and recommendations based upon the above.

Results: Results suggest that at this point research is limited and that some of the earliest research on young gender-expansive youth is methodologically questionable and has not been replicated. Newer research suggests that socially transitioned prepubertal children are often well adjusted, a finding consistent with clinical practice observations. Analysis of both emerging research and clinical reports reveal evidence of a stable transgender identity surfacing in early childhood.

Discussion: The authors make recommendations to support social transitions in prepubertal gender-expansive children, when appropriate, as a facilitator of gender health, defined as a child's opportunity to live in the gender that feels most authentic, acknowledging that there are limitations to our knowledge, and ongoing research is essential.

KEYWORDS
Gender diversity; gender expansive; prepubertal; social transition; standards of care; transgender children

In relatively recent times, a group of knowledgeable experts came together to meticulously craft the most recent version (7th) of the WPATH Standards of Care (2011). Released over a half decade ago, the members of the working committee preparing the standards of care (SOC) could not have foreseen the explosion in gender care that was about to transpire, particularly within pediatric gender programs (Aitken et al., 2015; Chen, Fuqua, & Eugster, 2016; Durwood, McLaughlin, & Olson, 2017). With a dramatic increase in the numbers of gender-expansive children both making themselves known and in need of professional services has come an active debate on best practices for prepubertal children who are articulating, often at very young ages, a transgender identity. Fueled by the data previously collected on the persistence and desistance rates of gender dysphoria in young children seeking services at gender clinics and followed over time, the two issues presently debated are: (1) Is it too early to tell, or can those of us who work with gender-expansive children and their families ascertain a child's asserted gender identity early in life, one that will be stable over time, including throughout adulthood? and (2) If yes—it can be identified, what should we do about it? Regarding both issues, we are confronting a paradox in contemporary discourses about gender. Whereas it has been increasingly accepted among many gender theorists and practitioners that an individual's gender is evolutionary across the lifespan; it is simultaneously acknowledged that gender identity is a core and stable aspect of self-development with biological underpinnings that may surface early in life and remain permanent over the course of a lifetime. With that paradox in mind, the issue at hand is social

CONTACT Diane Ehrensaft dehrensaft@earthlink.net 445 Bellevue Avenue, Suite 302, Oakland, CA, 94610, USA.

transition in young children, where social transition is defined as a child's change from living socially as the gender that matches the sex assigned at birth, to another gender, which may involve a change in name, pronouns, presentation, and a request that others recognize the child in their asserted gender rather than the gender that would match the sex assigned to them at birth. In the prepubertal years, no medical interventions are involved. The term *social transition*, as used in this discussion, refers to an expression of one's authentic gender now shared with others in the social environment.

Social transition is one aspect of transitioning and often, although not always, the first action a transgender person takes to align with their internal sense of themselves as a gendered person, with the other aspects of transition being medical, surgical, and legal. Social transition is by far the most reversible and changeable of choices an individual might make in affirming their authentic gender. Nearly all people who work with transgender adults believe that they should have access to social, medical, surgical, and legal transition so that they can live happier lives (Byne et al., 2012; Coleman et al., 2011; Spack, 2013). Generally, people who work with transgender adolescents believe that adolescents should be able to socially transition and at the very least have access to puberty blocking gonadotropin-releasing hormone (GnRH) agonist and hormone therapy (Vance, Ehrensaft, & Rosenthal, 2014) but may have more hesitancy about surgeries for minors. Yet when it comes to children, providers may struggle to believe that early social transition is good for the child (Steensma & Cohen-Kettenis, 2011; Steensma, van der Ende, Verhulst, & Cohen-Kettenis, 2013). The data that we have on transgender adults and adolescents show that, for some, access to these social and medical interventions can be life-saving (Cohen-Kettenis & Van Goozen, 1997; De Cuypere et al., 2005) and that the younger an individual is when they are able to transition, the better their mental and physical health outcomes (Robertson, 2016). Current research shows that for adolescents who are able to access medical interventions, their levels of depression, anxiety, and suicidality drop to the same levels as the general population (Cohen-Kettenis & Van Goozen, 1997; de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011). Also, those transgender youth who have families that support their transitions and affirm their identities have significantly better physical and mental health outcomes than those who do not (Hill, Menvielle, Sica, & Johnson, 2010; Kuvalanka, Weiner, & Mahan, 2014; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). It should be mentioned here that it is not specifically medical gender-affirming interventions that are the kingpin, but more generally all experiences gender expansive and transgender individuals are afforded—medical, psychological, behavioral, social, or legal—that facilitate a person to live in their authentic gender. As a result, most professionals, regardless of their theoretical orientation, have come to believe these interventions are necessary for the overall well-being of their patients.

Prepubertal social transition will be the focus of this discussion. We will be reviewing the existent literature to analyze the present guidelines and recommendations for early social transition in the WPATH SOC 7, synthesizing what we know and what we do not know based on extant research and clinical practices with prepubertal transgender and gender-expansive children, articulating the prevailing controversies and complexities regarding prepubertal social transitions, assessing the benefits and risks of early social transitions, and offering recommendations for SOC for social transitions in prepubertal children in the context of the rapidly changing social climate and sensibilities about gender in which these children are growing and developing. Obviously, the social environment will vary from culture to culture, continent to continent, but the goal of this discussion is to arrive at a set of practices regarding early social transitions that will enhance children's gender health across the globe.

Social transition guidelines: WPATH standards of care 7th edition

Review of the guidelines

SOC 7 guidelines for prepubertal social transitions introduced the topic by referring to children who want to make a transition to a different "gender role," indicating that some of these children, in doing so, may be reflecting their gender identity, while others may be motivated by other forces (Coleman et al., 2011). While pointing out that the current evidence base at that time was insufficient in predicting long-term outcomes post-transition, recommendations were made to mental health clinicians for assisting families in making decisions regarding both timing and process of gender role

transitions for their child. The guidelines referred to the persistence/desistence data extant at the time (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008). In these studies, it was found that the majority of young children entering gender clinics who received a gender diagnosis of gender identity disorder (the standing childhood gender diagnosis at the time of the studies) no longer met criteria for this diagnosis when they reached adolescence, suggesting that a young child's gender diagnosis, as assessed by the clinics' measures, may not be consistent over time. Extrapolating from the findings of the persistence/desistence studies, the WPATH guidelines included a cautionary note on prepubertal social transition on two counts: (1) the persistence/desistence studies indicated a relatively low rate of persistence of gender dysphoria in children studied; and (2) transitioning back to one's original gender role can be stressful for a child, based on evidence of one qualitative report of two youths who experienced distress when desiring to do so (Steensma & Cohen-Kettenis, 2011). The cautionary note specifically invited families of children under the age of puberty to consider in-between solutions or compromises, rather than facilitation of a full social transition from one gender to another, with a message delivered to the child that they are always free to revert to their original gender position. The guidelines in this section of the SOC concluded with offering recommendations to mental health professionals for helping parents support their children whether they do or do not facilitate a social transition of their child, with the understanding that when puberty arrives further assessment may be needed in preparation for medical interventions where relevant.

Critique of the guidelines

The guidelines situated social transitions as relating to "gender role" with no direct reference to how that term is being used. John Money first introduced the concept of gender roles in the 1950s in his work with intersex individuals. Recognizing that our gender performance in society was not based solely on our chromosomal or genital make-up, he defined gender role as a person's verbalizations and actions that disclose the person as holding the status of male or female. It might include general mannerisms, how one carries oneself, play and recreational preferences, dreams and fantasies about oneself, and direct articulations of one's gender self (Money, Hampson, & Hampson, 1955).[1] The psychoanalytic field adopted this concept and in the psychodynamic literature, gender role, sometimes also known as sex role, refers to the second stage of gender development, after the acquisition of core gender identity (i.e., "I am boy," "I am girl"), in which the preschool age child learns, through messaging, role modeling, reinforcement, and parental identifications, how to "do," that is, perform their gender in the socially prescribed ways of their culture (Tyson, 1982). Delimiting social transition to role behaviors misses the central developmental and psychological issues for young children who desire a social transition and often directly ask for social transition in words, actions, and affect. Typically, these children do not, for example, want to change their name, their pronoun, and their mode of dress because they would like to live in the *role* of another gender. They are asking for the opportunity to exercise their outside behaviors in accordance with their inner psychological sensibility about who they are—boy, girl, or other, so that they can not only live authentically in their asserted gender identity, but also be recognized and witnessed by others as a result. By their own self-reports, anything short of that would result in an experience of gender incongruence or would fail to alleviate the stresses of already living with that incongruence. Conflating gender role with gender identity misses this central point, erroneously reducing a core sense of self to a coordinate of role behaviors.

Secondly, whereas the guidelines leave flexibility regarding consideration of social transitions in prepubertal children, there is an inherent bias in SOC 7 toward the "watchful waiting" approach to pediatric gender care (Cohen-Kettenis & Pfäfflin, 2003), in which a child is given safe spaces to explore their gender but asked to wait until puberty to transition from one gender to another. This bias is evident in both counts of the cautionary note and the reliance on the studies of persisters and desisters in which most young children in the clinical studies were no longer evidencing gender dysphoria by adolescence. However, some of the persister/desister data have been reanalyzed to indicate that more children than originally cited in the data (Steensma & Cohen-Kettenis, 2011) were found to be persisters (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013) and reevaluation of the data revealed early childhood indicators that could identify a group of young children who were asserting a gender

identity that did not match the sex assigned to them at birth and would remain stable in that identity into adolescence, and beyond. Furthermore, the persister/desister data which inform the SOC 7 guidelines on social transitions only measured children's gender dysphoria, not their sense of their gender identity or the nature of their gender expressions, the latter two to be differentiated from each other and also measured separately from gender dysphoria (Ehrensaft, 2017). Lastly, the research results may include inflated percentages of desisters, as counted among their number were those who did not return to the clinic for care; therefore, reporting all patients lost to attrition as "desisters" represents an assumption that has never been validated, and rates of persisters and desisters cannot be verified unless these patients are tracked down. Ehrensaft (2016, 2017) guided by her own clinical observations of children, perceived that the studies were actually talking about two separate categories of children who could readily be identified early in life if the proper measures were employed: some young children would be centrally exploring their gender identities while others would be exploring or articulating their gender expressions. In fact, a reevaluation by the Dutch team of their research on persisters and desisters corroborated Ehrensaft's perception by identifying early factors that differentiated persisters from desisters, including: the statement, "I am a…" rather than "I wish I were a…"; consistent, persistent, and insistent articulations of an asserted gender identity other than one that matched the sex assigned at birth; evidence of body dysphoria (unhappiness about the genitals they had); and an early history of gender-expansive behaviors, perhaps as young as the toddler age (Steensma et al., 2013). If we are to have SOC regarding social transitions that reflect the realities of transgender children who are clear from an early age of their gender identity and are persistent, insistent, and consistent in the articulation of that identity, they will best be based on both research studies and collated clinical observations that assess the more salient variable: the child's articulated gender identity, whether or not it is accompanied by dysphoria.

Lastly, the reference in the SOC 7 to the problems of "desocial transitioning" for pubertal or postpubertal youth with an early social transition is based on the slimmest of evidence—a case study of two youths. In the youth referenced by Steensma and Cohen-Kettenis (2011) in their short note in Archives of Sexual Behavior, two girls in the desisting group of their study had transitioned, using their own terminology, to a masculine gender role in elementary school, desired to return to their original feminine gender role, but expressed fear of teasing and shame about having been wrong about their gender, culminating in an extended period of distress. Because of the above-mentioned conflation of gender role and gender identity underlying the research protocols and lack of mention of a change in name and pronouns, it was not clear from the reported evidence whether these youths had completed a full social transition or simply presented as more masculine and now wished to evolve to a more feminine self in middle school. Further, the fear of being teased or shamed for having been wrong may be a response to external lack of supports, rather than evidence of an internally based problem. Such stress is typically dependent on social stressors, in this case a social milieu, evident throughout the world, in which there is no acceptance for a child to be fluid in their gender expressions and one in which it is not understood that gender is an evolutionary process in which there may be several iterations throughout development. With that said, the more reasonable standard of care would not be to hold a child back from a social transition but instead ensure social supports for any child who may discover new aspects of their gender over time, including an alteration or shift in gender identity and expression of that identity, with no aspersion cast on their character. If such supports are not in place or achievable through therapeutic supports, within a comprehensive standard of care, the alternative approach would be to support the child in their self-knowledge of their asserted gender identity and communicate an understanding that the impediments to social transitions are externally located, that is, there are not adults available to support the transition, rather than that there is something wrong with the child for desiring the transition or simply desiring to have others mirror back to them their authentic gender identity.

A coincidence of decisions straying from SOC 7: Social transitions/surgeries for minors

Like with all elements of SOC 7, the guidelines for social transitions in prepubertal children are not legally binding statutes, but rather an outline of best practices as understood at the writing of the document. As mentioned in the introduction, the years

following the release of SOC 7 have been accompanied by a remarkable upsurge in the number of families presenting to health professionals with children either asserting a gender identity other than that matching the sex assigned at birth or refusing to follow the social norms for gender behavior in the culture in which they live (Ehrensaft, 2017; Menvielle, 2012). This seachange has been accompanied by two areas of pediatric care demonstrating lack of compliance with or overriding of cautionary notes offered in SOC 7: prepubertal social transitions and gender affirming surgical procedures for adolescents under the age of majority. It is edifying to analyze the unifying features of the departure from WPATH guidelines in each of these areas of pediatric gender practice which represent the two bookends of development: early childhood and late adolescence.

Most central is the movement from ages to stages in assessing a child or youth's readiness for next steps in their gender consolidation—the achievement of congruence between their internal and outward experience of gender. Whereas SOC 7 emphasized developmental stage rather than age when it comes to social transitions, the reality is that asking a child to wait until the stage of puberty to engage in a full social transition is, at base, asking them to wait until they reach a certain age—the age when puberty begins to unfold, before making a radical change. The guidelines around gender affirming genital surgeries also refer to a stage—the stage of majority but that, too, translates to age rather than stage—whatever the age of majority is in a particular country. More and more surgeons are performing genital surgeries in youth who have not reached that age: "Among nearly all surgeons, the term *maturity* [emphasis in the original] rather than specific chronological age defined the desired mental readiness criterion" (Milrod & Karasic, 2017, p. 631) just as more clinicians are facilitating social transitions in young children well before the age of puberty (Ehrensaft, 2016).

Milrod and Karasic collected a convenience sample of 20 surgeons from the United States performing vaginoplasties on minors. Using semistructured qualitative interviews, they applied a constant comparative method to the interview transcripts, and their composite data led them to the conclusion that in addition to the shared practice of using maturity over chronological age in determining psychological readiness for surgery it was found that attitudes toward the WPATH SOC and reliance on the guidelines varied among the surgeons. In their findings, Milrod and Karasic captured the relationship between early social transitions and genital surgeries among minors.

The current absence of directives does not appear to stop vaginoplasties in female affirmed minors; in fact, the rate of such procedures will likely continue to increase as surgeons refine their techniques and expand their patient population in tandem with earlier social transition and gonadal treatment of gender dysphoric adolescents in the United States. (p. 634)

Relevant here is the phrase "in tandem." A domino effect is transpiring that behooves the designers of SOC 8 to pay attention to contemporary understandings of the developmental unfolding of authentic gender identity, beginning in the preschool years. Earlier social transitions are occurring because of the recognition of the existence of a cohort of children who are clear at an early age that their gender identity is other than that reflected by the sex assigned to them at birth and who, if allowed to socially transition, are appearing in research to be psychologically functioning as well as their cisgender peers (Durwood et al., 2017; Olson, Durwood, DeMeules, & McLaughlin, 2016; Olson, Key, & Eaton, 2015). Many parents have discovered this on their own, facilitating social transitions of their young children without waiting for a green light from professionals; in doing so they are discovering an increase in happiness and well-being in their child once that child is allowed to live in their authentic gender (Ehrensaft, 2016). Some of these children are now adolescents, and it makes sense that after so many years in their affirmed gender there would be no reason to hold them back until adulthood to undergo surgery(ies) that will allow them to more fully consolidate their gender. Put another way, if clinicians are straying from SOC 7 guidelines for social transitions, not abiding by the watchful waiting model favored by the standards, we will have adolescents who have been consistently living in their affirmed gender since age 3, 4, or 5. Within future guidelines, this persistent, consistent, insistent, and stable gender identity from early childhood on should serve as sufficient data to inform us that at age 15 or 16 these adolescents are firm in their gender identity and would benefit from genital surgery at that time, rather than waiting until the legal age of majority. Certainly, further research can be prioritized to follow youth who

have had earlier surgeries and assess their well-being and longer-term outcomes.

What lesson is to be learned in the discovery of the similarity of surgeons and mental health practitioners in stepping away from the present SOC in advocating, respectively, for the ability of youth to responsibly handle surgeries and very young children to clearly articulate their authentic gender? We should take with us in the formulation of the next SOC the emergent evidence so that the guidelines will be most robust and best serve the needs of pediatric patients. If the next standards more firmly situate themselves within a gender affirmative model of care in which children are acknowledged as the arbiters of their own gender, taking into account ecological factors that may impinge upon them, these children will benefit not from being held back but from being allowed to move forward in their gender consolidation.

Let us now circle back to the statement made in the introduction that we can expect social environments to vary from country to country. The WPATH SOC are intended to arrive at a set of practices regarding early social transitions that will enhance children's gender health across the globe. Taking one culture as an example, the watchful waiting model has been argued to be appropriate in the Netherlands as Dutch culture allows a far greater latitude in gender-expansive expressions in early childhood than in other Western cultures, such as the United States. Therefore, it is possible for a child over an extended period of time to be freer in their gender expressions without undergoing a full social transition; it is reported that the children are observed to do fine with this extended waiting period because of the freedom of expression (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). This is a very important point to be taken into consideration when assessing the timing and appropriateness of a social transition. We can even imagine that in a culture that has instituted a gender-free or gender-neutral environment for young children, as when in Stockholm the preschool Egalia eliminated male and female pronouns (han and hon) and instead adopted a gender-free made-up pronoun "hen" that means "friend" (Tagliabue, 2012), the elimination of gender boxes would leave nothing to transition to. However, it should be mentioned that within the Netherlands, with its greater freedom of gender expression, there are now growing numbers of families who, being exposed to the positive outcomes of early social transitions in other countries, have facilitated their young children's social transitions on their own, rather than following the guidelines of the Netherlands clinic. We do know that safety concerns within any social environment must be taken into account in assessing the advisability of a young child's social transition, but, to repeat, there is growing evidence that no matter what culture a child is growing up in, the opportunity to live in one's authentic gender, however that might be defined within one's culture, is in a child's best interest, no matter what their age.

What we know from research and clinical practice

What we know about the social transition of prepubertal children depends on who or what you consult. Until recently, research had little to report on this specific topic and we still have limited data, especially longitudinal data, to draw upon. Mental health clinicians typically serve as front-line providers to these children and their families, yet clinical approaches to gender-expansive children and perspectives on early social transition vary greatly across individuals and between areas of the world. Although researchers and clinicians constitute two of the largest informed and involved parties in the field of transgender healthcare, we would be terribly remiss to overlook either the experiences or the autonomy of gender-expansive children and their families. All of these sources—researchers, clinicians, and children and their families—will be examined to gain a fuller understanding of what we know about prepubertal children and social transition.

Children and families

First, it should be noted that in order to provide informed care we must consistently honor and follow the lead of those we are set to help. A young person's gender and the decisions of a family to support their child's asserted gender identity are deeply personal and private matters. Windows into this experience are available through various channels—knowing a child who has socially transitioned, reading the blogs and books of socially transitioned children or their affirming parents, or watching documentaries that cover the family-centered process of affirming a child's gender identity. Across these sources, two profound observations are routinely underscored—a child's intense need for the affirmation and alignment of their known

gender identity and the remarkable power of a social transition to support the health and well-being of a transgender child. Through a social transition, children often express great relief that people understand who they are while parents describe a deep joy and comfort previously unseen in their young child. While utilizing research and clinical practice, we must be responsible listeners and observers as the people we study or treat teach us what there is to know about their experience. Although many families seek the care of professionals when contemplating a child's social transition and find this assistance immensely beneficial, other families can safely and effectively facilitate their child's need for gender affirmation and alignment through a social transition with little to no aid from professionals.

A young transgender child is dependent upon their parents or caregivers to provide them safe access to and supportive guidance through a social transition. Many parents struggle initially to understand their child's gender identity and the treatment options available. Gaining information about gender diversity and transgender children paired with receiving clinical and/or peer support allows many parents to move into acceptance of their child's gender identity, which enables them to provide the safe access and supportive guidance needed. Some parents, most notably those who have deeply transphobic belief systems, may engage in damaging behaviors such as rejecting their child's asserted gender identity, shaming their child for their gender identity or gender expression, withholding necessary treatment or seeking to convert their child's gender to conform to their assigned sex. In doing so, these parents typically believe that they are offering support to their children by preventing them from going down the "wrong" path and helping them conform to a more "normal" gender. Unfortunately, self-perceived parental support does not necessarily translate to actions that are in the best interests of a child. These parenting behaviors, and the belief systems that inspire them, generate profound risks to young, dependent children, causing them to doubt their own clarity about themselves or attempt to hide their authentic gender, with all the accompanying psychiatric symptoms that accompany such retreat, suppression, or repression. All efforts to engage a parent in accessing information and support should be exercised to maximize positive outcomes for the child at the center of this process and avoid such untoward consequences.

Since medical treatment is not necessary prior to the onset of puberty, mental health providers, rather than medical providers, are often the first professionals sought out by families; therefore, their role in providing affirmative, informed care to young transgender children is increasingly critical. For those who are clinicians, the work should steadily be focused on assisting families and individuals, including the young children in these cases, to meet their needs in a way that honors their wisdom and capacity with a process that is client-centered and collaborative (Edwards-Leeper, 2017; Edwards-Leeper, Leibowitz, & Sanggan-janavanich, 2016; Ehrensaft, 2016; Ehrensaft, 2017; Giammattei, 2015; Hidalgo et al., 2013; Malpas & Janssen, 2015; Singh & Dickey, 2017).

Research

Transgender healthcare, and especially the healthcare needs of young transgender children, is a fast-growing and ever-critical part of medical care. Just a decade ago, social transitions in young children were not only rare but more rarely understood, supported or studied. While data on transgender adults have been building over several decades, research on young children is only now beginning to yield results. The TransYouth Project (TYP) at the University of Washington is the first large-scale, longitudinal study of gender-expansive and transgender youth (ages 3–12). An early finding of the TYP's research challenged the notion that prepubescent transgender children are unclear about their gender. Using self-reports and implicit measures, the TYP found that transgender children know their gender as clearly and consistently as cisgender children of the same gender (Olson et al., 2015). Results of this study, based on parent's and children's self-report, showed that prepubertal, socially transitioned children exhibit similar levels of depression and while not significant, slightly higher levels of anxiety than the study's control groups and national population averages (Durwood et al., 2017; Olson et al., 2016). Olson and colleagues theorized that the marginally higher levels of anxiety found in transgender children, still falling well below a clinical range, are likely due to factors such as privacy concerns in children who have not disclosed their transgender identity to peers, peer victimization, and microaggressions in children who

have disclosed, as well as body dysphoria and worries about the effects of a looming puberty. The socially transitioned children in the TYP study also reported high levels of self-worth, a factor known to be indicative of future mental health (Durwood et al., 2017). These data show that socially transitioned transgender children are not suffering from elevated levels of mental health issues, as has often been assumed.

The TYP findings present good news that is in contrast to prior data derived from studies of older adolescent and adult transgender populations who were not able to socially transition in childhood that indicate significantly increased rates of anxiety and depression, including suicide attempts (Budge, Adelson, & Howard, 2013; Reisner et al., 2015). These data can be understood as highlighting the benefits of social transition as a profoundly positive and protective intervention for young transgender children. Socially transitioned children potentially have stronger family and social supports, that not only help facilitate social transitions, but are likely to allow these children to avoid or minimize disruptive minority stressors, such as discrimination and rejection, that lead to poor mental health outcomes (Hendricks & Testa, 2012; Wallace & Russell, 2013). It is important to note that the participants in the TYP study are also disproportionately from higher income families—another factor associated with better mental health—but previous studies of children from high-income families reported higher levels of anxiety and depression showing that income is not a standalone protective factor (Singh, Bradley, & Zucker, 2011).

The research on parental support for transgender youth shows that family rejection greatly increases negative outcomes for these youth (Ryan et al., 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013). The Canadian Trans Youth Health Survey (Veale, Saewyc, Frohard-Dourlent, Dobson, & Clark, 2015) showed that supported youth were four times as likely to experience good or excellent mental health and were far less likely than their unsupported peers to consider suicide. The Trans Pulse project (Travers et al., 2012) also showed remarkable benefits for transgender youth who experienced parental support, including improvements in life satisfaction, physical health, self-esteem, intent to parent, and availability of adequate housing. The Trans Pulse data suggest that anything less than clear and strong parental support may be detrimental to children, finding poor mental health outcomes for youth who did not receive such support. Further, the children from these studies and other socially transitioned children, will likely have future access to medical care that will allow them to minimize distressing secondary sex characteristics that create dysphoria and mental health struggles for transgender people as they age.

Clinical

Clinical approaches to the care of gender-expansive children fall into three models—reparative, watchful waiting, and gender affirmative. The reparative model's view that a transgender identity is pathological and undesirable inform reparative therapy's attempts to change a person's gender identity and gender expressions to match the social expectations of a person's assigned sex. With conformity at the forefront of the reparative approach, social transitions are not considered appropriate or necessary. From this perspective, it is often assumed that gender is a malleable construct when a child is still young, and that early environmental interventions can be successful in allowing a child to accept a gender orientation that aligns with their sex assigned at birth, if caught and treated before it is "too late" and gender is no longer malleable. First targeted at "effeminate" boys in an attempt to make gay boys straight, the approach was then extended to gender-expansive young children in attempt to ward off a transgender outcome, with the assertion that it is a far harder trajectory to be transgender than cisgender, so better to offer a child a cisgender future while we can. We see this approach first in the work of Richard Green at UCLA in the 1980s, later in the work of Kenneth Zucker and his colleagues in Toronto (Green, 1987; Zucker & Bradley, 1995) and still remaining in the lexicon and practice of many clinicians and researchers around the globe. Decades of work since then have resulted in knowledge that "the expression of gender characteristics, including identities that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative" (Coleman et al., 2011, p. 4). Having established that gender diversity is not a pathology, reparative therapies are not indicated or appropriate. Reparative therapies also bear profoundly concerning potentials to create harm (Minter, 2012; Wallace & Russell, 2013) and are

therefore considered unethical and are prohibited by law in many places.

The watchful waiting approach evolved from the first model of care for transgender children developed in the Netherlands, often called the Dutch Protocol. The Dutch Protocol is informed by the belief that gender dysphoria, or a transgender identity, persists into adolescence in only a small minority of people (Steensma & Cohen-Kettenis, 2011). As outlined earlier, this research suffers from potential methodological flaws and the way the data have been interpreted suggests that providers be more concerned about the rare cisgender child being treated for gender dysphoria at the expense of the many transgender and gender-expansive children who would be helped if social transition were an option. The result of this interpretation has the potential to have profound negative impacts on treatment practices in pediatric transgender healthcare (Winters, 2014). In general, the watchful waiting approach is a cautious practice in which assertions of gender diversity and the consideration of a social transition are either tempered or held as possibly true and beneficial, but not until it is determined that the child is capable of knowing their gender with great validity, usually sometime after the advent of puberty (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003). When a child's gender identity is unclear, the watchful waiting approach can give the child and their family time to develop a clearer understanding and is not necessarily in contrast to the needs of the child. For children who are clear about their gender but are prohibited from exploring or experiencing the benefits of affirming their gender through a social transition, the watchful waiting approach can create potentially harmful disruptions by negating a young child's gender identity and delaying the development of their asserted gender identity, especially in cultures that do not support gender diversity.

Similar to the watchful waiting approach, the gender affirmative approach has a foundation of collaboration with children and families to understand and affirm a child's gender and works to meet the child's needs as they develop. In contrast to the watchful waiting approach, however, the gender affirmative model does not involve waiting for puberty or adolescence to facilitate a child's affirmation of their authentic gender, instead endorsing prepubertal social transitions where appropriate (Ehrensaft, 2012; Hidalgo et al., 2013). Gender affirmative care places substantial significance on a child's understanding of their own gender and allows the child, and their knowledge of their gender, to lead the way to interventions. Social transitions are viewed, explored, and supported as an important and effective intervention that nurtures a transgender or gender-expansive child's health and well-being. The gender affirming approach has allowed for a salient "ex-post facto test" (i.e., response to intervention) that enables us to discern the profound and overwhelmingly positive effects a social transition can have for gender-expansive children. With the help of social transitions, some children previously struggling with serious mental health and behavioral issues, carrying multiple diagnoses and treated with various psychotropic medications eventually settle into a significantly more stable life free of such issues, (mis)diagnoses and medications (Nealy, 2017).

Protocols and clinical approaches that outline therapeutic interventions have an incredible capacity to assist a child and family as they explore the child's need for a social transition, yet the nature, length, and focus of these interventions should be individualized and centered around a family's needs. Because it is not a pathology, therapy should not be a requirement for a child based solely on the presence of gender diversity. Parental support is vital to the health and well-being of any child and this is increasingly true for a gender-expansive child. If not fully present, clinical work to facilitate or strengthen parental support is crucial. The multidimensional family approach (Malpas, 2011) is one example of a rich and comprehensive therapeutic framework that delineates several areas for supportive work including parental engagement, individual assessment and therapy for the child, parent coaching, systemic family therapy, and a multifamily support group. If a decision is made for a child to socially transition, families often need support and assistance dealing with disclosures, working with their child's school, navigating legal issues, coping with unsupportive people, and making connections to affirming communities.

Controversies and complexities in care: Early social transitions

Controversies abound with regard to social transition and general best practices in caring for prepubertal gender-expansive youth. Several factors combine to

fuel these disputes, most significantly the aforementioned traditional emphasis on the watchful waiting approach with concerns about detransition (de Vries & Cohen-Kettenis, 2012); a paucity of research on prepubertal gender-expansive youth; a dearth of validated clinical measures of gender identity in young children; and proclivities and biases that are manifest when not enough research is available to inform families and clinicians caring for young children. We list and briefly discuss some of the paramount controversies below.

Concerns about detransition

One of the most frequently cited reasons for advising parents to discourage prepubertal social transition is that youth may "desist" or eventually assert a cisgender identity in adolescence (Steensma et al., 2011). Several aspects of this advice are problematic. First, inherent in this premise is an assumption that it is more detrimental to eventually detransition than it is to live in a gender that feels foreign and "wrong" for the duration of childhood. This is an untested assumption, one which may in fact be causing harm, based on the data that adolescents seeking medical care in Amsterdam and elsewhere have generally presented with significant mental health distress and morbidities. Given the data emanating from the TYP (Durwood et al., 2017; Olson et al., 2016), it seems that social transition may serve a protective function for the psychological well-being of at least some transgender youth. Second, very little data exist on desistence rates and most of the research has been critiqued as possibly flawed, as discussed in the previous section on the SOC. Desistance rates cannot be accurately determined without valid measures of gender identity in children. Yet, at the time the research was conducted, no valid measures of gender identity were available aside from child statements which could be influenced by any number of factors, and which conflated statements about gender-related wishes with statements about actual identity. In other words, if cisgender children were incorrectly thought to be transgender in early research, rates of desistence would be inflated. This is an important issue, as it is possible that gender identity is as stable in gender-expansive children as cisgender children.

Precipitous social transition could propel a child toward an avoidable transgender identity

This statement suggests that gender is malleable and a "choice," yet data from transgender children suggest that in fact they are not flexible with regard to gender. Social learning theory would posit that based on modeling of adults and peers, along with social shaping and reinforcement, children assigned a certain sex will identify with their "learned" gender, which is in fact the case with most cisgender children. Gender-expansive youth defy this logic, typically resisting the social engineering of gender implicit in the learning theory model, suggesting that other forces are influencing gender identity, ones that may be outside of social learning, or environmental and family control. Furthermore, this is a value-laden statement suggesting that it is preferable for a child to avoid embracing a transgender or gender-expansive identity, and that diversity with regard to gender is inherently wrong and not as good as a cisgender identity. It also suggests that quality of life in childhood is negligible and can be sacrificed in the service of getting gender "right."

How can a young child possibly know their gender? Gender expression vs. gender identity

One of the challenges in decision-making with young gender-expansive children is discerning when gender expressions differ from societal norms versus when a child is expressing a deep essential gender identity discordant from assigned sex. Very little is known about the "gender journey" and the factors that persuade families to support social transition in young children. The TYP (Durwood et al., 2017; Olson et al., 2016), while yielding meaningful information, studies children only postsocial transition, so the journey is still unknown.

Many of the measures of gender in young children, when examined closely, conflate gender expression and gender identity, with some exceptions (e.g., implicit measures of gender and direct questioning). Much of what is known about gender expansiveness in young children resides with the few expert clinicians who work with this population and families; anecdotal data are not persuasive to skeptics and others who have no contact with young gender-expansive youth. To establish accurate and widely accepted SOC for gender-expansive children, more research is needed along with development of measures that

validly discern gender identity and differentiate it from gender expression.

"This couldn't be real. I never saw it coming." Influence of culture and social circumstances

The Gender Affirmative Model hypothesizes that gender identity is influenced by a number of factors, including socialization and culture (Hidalgo et al., 2013), yet these factors and their impacts are relatively unexplored in young children. Developmental influences that may inform the ways that prepubescent children of different ages cognitively understand and verbalize their gender identity also need more study. We know from other literature, such as suggestibility research (Ceci & Bruck, 1995) that children's verbal statements, cognitions, and memories are influenced by what they are told by adults, who are often accepted by young children as the authority in all areas, including gender norms. When adult communications differ from a child's reality, beliefs, or experiences, children will often defer to adults, even if that acquiescence leads to some confusion. These complicated dynamics have not been researched, but theoretically some gender-expansive children may struggle to comprehend and articulate ideas and experiences that emanate from within but conflict with the information they receive from others, a struggle that may persist until they approach puberty or even afterward. This factor, however, does not preclude young children from being transgender or gender expansive, but the assertion, and understanding of gender identity may be obscured or transformed by outside forces, often rendering parents stunned when their growing child first formulates and then articulates their transgender identity.

"Aren't we putting our child at risk by exposing them to social rejection or harassment if we allow them to socially transition in a world that will not be accepting?" Balancing safety with gender affirmation

Another important consideration regarding social transition is balancing child safety and acceptance with enabling a child to live in accordance with their experienced gender identity prior to puberty. In some cases, the risks of transition, based on family and social rejection, exposure to peer bullying and possible maltreatment, may supersede the priority to live in accordance with a genuine gender identity. Families and others need to weigh the costs of transition against social forces that cannot always be modified. At times, there are no perfect options, except perhaps to engineer safe spaces where the child can fully express their authentic gender self with the understanding that the need to keep it under wraps in other places is not because there is something wrong with them, but because the world might look unkindly on people who are expansive in their gender. Considerations regarding physical safety need to be balanced against the risks of harm possibly encountered by refraining from social transition. The secrecy and incongruence of living in a "pretend" gender also carries with it the potential for significant psychological damage and therefore in any specific circumstance the choices need to be carefully weighed.

"You have to fit in one box or another." Nonbinary youth/individualized nature of transition

Social transition, although often discussed as a dichotomous concept (e.g., a child has or has not transitioned) can actually be complex and not an "all or nothing" decision. The research in the TYP only includes youth who have made a binary social transition (e.g., from boy to girl) (Durwood et al., 2017; Olson et al., 2016). This project omits nonbinary youth, for whom "transition" may be more individualized and not consistent with any particular social gender norms; this is a group that is sorely understudied. In addition, often social transition in children with binary gender identities is gradual and occurs over time. As of yet, research has not examined the experiences of youth who may choose to transition in a manner outside of the gender binary or the compromises families may make as gender is explored.

The risks and benefits of social transitions

Many of the risks and benefits of social transition or the lack thereof have been alluded to in each of the previous sections, especially in the discussion about the controversies that are inherent in an approach that embodies both positive and potentially negative effects. What seems clear from the both the current research and clinical wisdom is that the benefits significantly outweigh the risks. Thus, helping with social transitions where appropriate would seem to fit well with the purpose of the SOC, which in its current version states "they offer standards for promoting

optimal health care and guiding the treatment of people experiencing gender dysphoria" (Coleman et al., 2011, p. 8).

While there are some transgender and gender-expansive people who will never experience the incongruence of gender dysphoria, at least not on a level that meets the criteria for a diagnosis, for others, regardless of age, this incongruence can be quite debilitating. Since social transition is one treatment for this incongruence, the risks and benefits of social transition are inherently tied to the experience or potential for the experience of gender dysphoria. Therefore, understanding the experience of gender dysphoria may help make sense out of why access to social transition, regardless of age, should be an option.

In clinical practice, when speaking with transgender and gender-expansive people of all ages, it appears that humans have a mental map of who they are supposed to see when they look in the mirror. When a person cannot see themselves, the result can be very disturbing and anxiety producing. For children this more often happens through the social mirror of family, school, and friends. When people walk through the world, they expect those around them to mirror back who they are. When this does not happen, the anxiety mounts and depression may set in, creating an extreme form of existential angst. Many adolescents and adults report feeling lost and begin to wonder if they actually exist. "Why can't anyone see me?" Every day they may get up, knowing who they are and experiencing some peace in this, then someone misgenders them and they are left standing naked in front of the mirror hating the things that get in the way of being seen. Most cultures have mistaken the body for the truth, yet for many gender-expansive people, it is actually the lie that blocks people from seeing them and eventually in despair from being able to see themselves. The ability to socially represent yourself in line with your internal sense of self allows one to see themselves and moreover for the world to mirror back what they know to be true, making social transition for some the key to successfully navigating the world as a whole person. Therefore, the ultimate benefit of social transition, especially in a culture that does not allow much room for gender diversity, is that it allows one to be authentic. From the gender affirmative perspective, authenticity leads to connection, security, attachment, empowerment, and overall well-being whether you are 5, 14, or 50 years old.

It is important to keep in mind, when working with gender-expansive children there is no action or lack of action without an associated impact and a consequence. As such, we will outline the risks and benefits of social transition based on the arguments of the various approaches to working with gender-expansive children and their families.

The risks of socially transitioning

From the viewpoint of both the reparative and the watchful waiting camps, there is a fear that a social transition may send potentially cisgender children into a trajectory that will either cause distress if they detransition (desist) or create too much social pressure to be able to stop the transition, thereby ending up in a medical transition they will later regret. Another concern that has been raised is that if a gender-expansive child is allowed to socially transition, then go on a GnRH agonist at Tanner Stage 2 of puberty, thereby never experiencing the puberty associated with their assigned sex, they will never have a full understanding and self-knowledge of their gender because they were denied the opportunity to experience the "correct" puberty. As stated previously, even if they appear happy and well-adjusted, from this transphobic perspective, being a transgender person is considered a poor outcome because of the discrimination they will face and the lifelong course of medical treatments they may require. It is possible that children who socially transition are at greater risk of bullying and discrimination by peers and school staff, especially if they transition with peers who knew them before, therefore creating significant stressors for the child which could be avoided by curtailing early social transitions when a child does not yet have the social skills or resilience to stand up to such social negativity.

Another group who may be at risk if they socially transition are those children whose gender identity is outside of the boy/girl binary (e.g., nonbinary, bigender, gender fluid, and agender). For example, they may refer to themselves as a "girl-boy" or having no gender at all. The level of dysphoria for these children can be as profound as for other transgender children who identify with a binary gender. They may request gender neutral pronouns or no pronouns at all. These children often present as persistent, insistent, and consistent as those children asserting a binary transgender identity. Socially transitioning for these children is

blending gender in ways that often makes people around them, parents, teachers, peers, etc., very uncomfortable, especially if they were assigned male at birth. They are at increased risk of bullying, physical violence, and ostracism (Greytak, Kosciw, & Diaz, 2009). Parents may insist that they have to either be a boy or a girl, or believe it is a phase on the way to some other identity. Without language to describe themselves or acknowledgment of their congruent pronouns and asserted identity they are rendered invisible (Giammattei, 2015). If they move fluidly between different expressions of gender, others are likely to assume their current presentation is who they are, especially if on that day it is aligned with their sex assigned at birth. For these children, this can make them feel invalidated at every turn. These children are most at risk for negative mental and physical health risks in communities that do not tolerate gender diversity.

It should be acknowledged that social transitions can present risks not just to the child, but to the parents and family as well. A social transition can involve a grief process that includes a painful loss of the boy or girl the parents thought they had, which may make it difficult to parent their gender-expansive child. If the family lives in a conservative community, childhood social transition may also put the parents at risk of social ostracism, discrimination, and oppression by those who believe they are not correctly parenting their child or providing that child with proper guidance. This can be especially true for parents of a nonbinary child. In these situations, stigma and a loss of privilege is experienced not just by the parents, but by everyone in the family, which increases stress and can create shame (Wallace & Russell, 2013). Furthermore, the potential of losing extended family and community support as a result of supporting their child could be devastating. If the family belongs to a conservative religious and/or a racial/ethnic minority group that has rigid notions around gender, they may be at even greater risk of discrimination and ostracism. If the family is struggling socioeconomically, the work it takes to address all the systemic issues to ensure their socially transitioning child's safety may be too much to handle and the stress might negatively impact the whole family. Finally, the focus on the transitioning child may leave siblings feeling neglected or overlooked while parents focus their attention on navigating a social transition for their gender-expansive child.

It is important to note that most of these risks are related to interactions with a social environment and larger society that embrace a binary construction of gender and pathologize and stigmatize those who do not fit neatly in the gender boxes determined at birth. As such, to foreclose on a young child's social transition under these conditions is tantamount to making the victim responsible and paying the costs for the crimes and misdemeanors of the perpetrator.

It is important to note that those countries that are the most unsafe for gender-expansive people and their families are those that hold strong binary beliefs regarding gender and pathologizing views of gender and sexual diversity; what most commonly occurs is deemed healthy and everyone else is perceived as unhealthy, abhorrent, and in some cases criminalized. Religious views that pathologize gender-expansive people are often built into their laws and how they treat gender transgressions. In areas like this, the risk of social transition for young children may be far too dangerous and survival will in many cases need to take precedence over authenticity.

Benefits of social transition

The benefits of social transition are beginning to show up in research, which mirrors the data of transgender adolescents who are given access to both social transitions and medical interventions to align their bodies with their identities (Durwood et al., 2017; Olson et al., 2016) and the clinical wisdom of those who work with these children (Ehrensaft, 2016; Giammattei, 2015; Malpas & Janssen, 2015; Nealy, 2017). As mentioned earlier in this article, socially transitioned children in the current studies are showing better mental health outcomes. Extrapolating from the arguments put forth by Wallace and Russell (2013), that nonaffirming approaches to gender create ruptures in attachment, it is likely that children who are valued and seen for who they are, even if that shifts over time, will maintain secure attachments with their parents and experience less shame. As a result of being seen and valued by their parents, through their parents' facilitation of their social transition, these children may be afforded more opportunities to develop resilience in the face of negative reactions from peers and society. By listening to their child's

signals about their gender, families with a socially transitioned child will hone their skills in attuning to their child and be better able to help them navigate the stigma and prejudice they experience, in part because they will be more keenly aware of it. Families who navigate a social transition with their child and connect with others who are doing the same will find that sense of community and support that many who are marginalized rely on to survive in a world that is uninformed, rejecting, or overtly hostile (Malpas, 2016; Menvielle & Rodnan, 2011).

If young children who socially transition persist in their transgender identities and later receive puberty blockers to ward off an unwanted puberty, they will be spared aspects gender dysphoria that can occur when a one's body goes through the wrong puberty. Moreover, since they will not develop incongruent secondary sex characteristics, they will likely experience less discrimination as a result of being read as transgender. Although it would appear that a child's social transition would make them more of a target by bullies, in clinical practice this tends to disappear when the child is transgender because they are in alignment with themselves and just like any other child of their gender. It is important to note that those professionals who are affirming and support social transitions in children continue to explore its unfolding nature and always allow for movement in a different direction, including aligning with one's assigned sex.

It is true that children with nonbinary gender identities may continue to experience harassment as they socially transition, although it seems that youth today are much more open to gender diversity than the adults around them (National Geographic, 2016; Savin Williams, 2005). The experience of being seen and supported by their parents may increase a secure attachment and give nonbinary children the self-esteem and resilience they need to navigate a binary world while affording them the authenticity they need.

The risks of not socially transitioning

It can be logically argued that children will continue to fare poorly if prevented from socially transitioning, particularly now that social transitioning is a phenomenon increasingly in people's lexicon and therefore in children's consciousness. It can be anticipated that experienced dysphoria will rise and the experience of not being their authentic self or recognized as such may likely lead to the very outcomes we have been seeing for years among older transgender youth and young adults: higher rates of depression, self-harm, suicidality, anxiety, and eating disorders (Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). They will also be at high risk for significant levels of dysphoria when puberty kicks in, which if not addressed will increase the aforementioned negative statistics as well as substance abuse, risky behavior, and Post-Traumatic Stress Disorder (PTSD) from the minority stress they experience following years of not being recognized as their authentic gender selves (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Giammattei, 2015; Robertson, 2016; Testa, Habarth, Peta, Balsam, & Bockting, 2015).

Furthermore, a delay in being able to explore and be seen prior to puberty puts both teens and parents at risk. By the time the teen seriously pushes for medical interventions, they may have been experiencing immense distress for years. When they finally receive treatment, they may be beyond despair, leaving little time for parents to catch up and make fully informed decisions about medical care that they can feel comfortable with. When parents do not have time to catch up, they may shut down on the whole idea of interventions for gender consolidation, which leaves the youth in a potentially dangerous or precarious place (Malpas, 2016). Parental resistance in association with a child's increased urgency can lead to family disruptions. A social transition can thus also be seen as preventive care: allowing time to explore and find the most authentic representation for the child and allowing parents time to be aware of and prepare for potential next steps.

Many parents and providers believe that if they just wait things out, their child will come around to identify with their assigned sex at birth, as in, "It's just a phase." It is true that many gender-expansive children may not grow up to be transgender, but they will be impacted by the negative messages they receive about their gender expression. For children who are clearly asserting a gender identity that does not match their assigned sex at birth, this lack of mirroring and negative messaging about their core sense of self is likely to lead to shaming and potential ruptures in attachment (Wallace & Russell, 2013). In fact, for the child who may eventually grow up to identify as cisgender, the shame they experience as a result of even simple redirection can have long-lasting effects. Many gay and

lesbian adults report gender-expansive expressions in childhood and also have many stories of being shamed for this behavior. Shaming children never leads to a positive outcome and has been shown to have adverse effects on mental and physical health, especially if that shaming is done by a child's family (Ryan, Huebner, Diaz, & Sanches, 2009). Thwarting a social transition is the perfect recipe for such shame. Facilitating a social transition, if possible, that centers the child's developing self-knowledge is the perfect preventive measure against such shame. In our clinical practices, transgender adults and adolescents who transition after puberty consistently report that they regret not starting transition earlier; the psychological pain they had to endure, the loss of relationships, the discrimination, and the physical and economic costs of medical procedures they have had to undergo to align their bodies with their gender identity could have been avoided if these options had been known and available to them. By affirming children's asserted gender identities earlier and making social transitions available to them, we can change this regret and positively impact the lives of transgender people and their families.

Conclusion

The conservative watchful waiting approach to the treatment of gender-expansive children that is in the current WPATH SOC appears to be based on binary notions of gender and pathologizing views of gender diversity. The studies used to support this stance conflate gender role and gender identity, which leads to a problematic interpretation of the results (Steensma et al., 2011). It appears that the fear of cisgender children socially transitioning has put the emotional and physical well-being of transgender children at risk. Yet, since SOC 7 was released, there has been an upsurge in gender-expansive children and their families seeking help of gender professionals and clinics, many of whom have already socially transitioned and are coming to us to make sure they are ready if medical interventions are needed.

The latest research on these children is uncovering data to show that transgender identity is valid in young children and that early family support, often including a social transition, is associated with normative mental health (Durwood et al., 2017; Olson, 2016; Olson et al., 2016; Steensma et al., 2013). Furthermore, this research is supported by clinical accounts and the narratives and observations of young transgender children and their families suggesting that social transitions in prepubertal children show positive effects in psychological functioning and social well-being. What we have witnessed are children who are happy and healthy living more authentic lives. For those not socially transitioned, we see a reduction in anxiety, depression, and behavior problems occurring after they are allowed to present authentically.

There are risks involved in the gender affirmative approach, but it appears that most of the risks that children who socially transition and their families may experience are based on minority stress in response to unsupportive environments. What is apparent to us is that gender diversity is naturally occurring phenomenon dating back as far as recorded history that crosses all locations and social strata. We have learned that no amount of behavioral modification is going to turn a transgender person into a cisgender person, it will only lead to negative mental and physical health outcomes; yet we are still trying to do this with children who are persistent, insistent, and consistent in the assertion of their gender diversity. Based on a review of the literature and clinical experience, we believe that the benefits of social transition far outweigh the risks.

Allowing children to socially transition may foster secure attachments and resilience not only in the gender-expansive child but also the entire family as they learn to navigate an often-hostile world together (Wallace & Russell, 2013). We know that family support is key to emotional well-being in children and we believe that the benefits of being seen authentically by those you love can ameliorate the issues that arise in schools and other social milieus. This is true for all gender-expansive children, even when authenticity in the future does not involve medical interventions. Our recommendation for the next iteration of the SOC is that social transition for prepubescent children who are asserting a different gender identity than their assigned sex at birth, be considered as necessary as the recommended medical interventions for transgender adults, and that interventions, both social and medical, be individually tailored based on the development of the child rather than arbitrary ages or stages. We have found that the intense relief felt by these children when allowed socially transition is palpable. Prepubertal social transition is proving to be a transition to authenticity. As we move toward developing revised

guidelines, it would behoove us to hold authenticity and gender health as our central tenets of pediatric gender care.

Note

1. It should be mentioned in this discussion that since Money's first publications his clinical practices, research projects, and published papers have been brought under scientific scrutiny, regarding both improper use of subjects without informed consent or ethical considerations, misrepresentation of data, and resulting false assertions that one's gender identity was predominantly shaped by sex labeling, social reinforcement, and messaging, an assertion most commonly disseminated in the story of John/Joan. In real life, John-David Reimer, was an infant twin who had his penis mutilated in a botched circumcision procedure, leading to Dr. Money taking the family on as patients and research subjects, advising the parents to do a genital reconstruction during infancy and raise David as a girl, a failed experiment which later led to deep psychological distress and David reclaiming life as a male in adolescence, which he was able to do for 20+ years until his death by suicide at age 38.

Declaration of interest

The authors declare that they have no conflict of interest concerning this article.

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