

Child

Background/Introduction

These standards of care pertain to prepubescent gender diverse children. They are based on research, ethical principles, and accumulated expert knowledge. The principles underlying these standards include the following: 1) childhood gender diversity is an expected aspect of general human development (Endocrine Society and Pediatric Endocrine Society, 2020; Telfer et al., 2018); 2) childhood gender diversity is not a pathology or mental health disorder (Endocrine Society and Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018); 3) diverse gender expressions in children cannot always be assumed to reflect a transgender identity or gender incongruence (Ehrensaft, 2016; Ehrensaft, 2018; Rae et al., 2019); 4) guidance from mental health professionals with expertise in gender care for children can be helpful in supporting positive adaptation as well as discernment of gender-related needs over time (APA, 2015; Ehrensaft, 2018; Maplas et al., 2018; Telfer et al., 2018); 5) conversion therapies for gender diversity in children (i.e., any “therapeutic” attempts to compel a gender diverse child through words and/or actions to identify with, or behave in accordance with, the gender associated with the sex assigned at birth) are harmful and we repudiate their use (APA, 2021; Ashley, 2019a, Paré, 2020; SAMHSA, 2015; Telfer et al., 2018; UN Human Rights Council, 2020).

Health Professionals: Throughout the text, we employ the term “health professionals” broadly to refer to professionals working with gender diverse children. Unlike pubescent youth and adults, prepubescent gender diverse children are not eligible to access medical intervention (Endocrine Society and Pediatric Endocrine Society, 2020); therefore, when professional input is sought it is most likely to be from a clinician specialized in psychosocial supports and gender development. Thus, this chapter is uniquely focused on developmentally appropriate psychosocial practices, although other health professionals such as pediatricians and family practice health professionals may also find these standards useful as they engage in professional work with gender diverse children and their families.

Gender Diverse: This chapter employs the term “gender diverse” given that gender trajectories in prepubescent children cannot be predicted and may evolve over time (Steensma et al., 2013a). The term, “gender diverse” includes transgender binary and non-binary children, as well as gender diverse children who will ultimately not be transgender. We also recognize that terminology is inherently culturally bound and evolves over time. Thus, it is possible that terms used here may become outdated and/or offensive with time.

Within this chapter, we describe aspects of care intended to promote the well-being and gender-related needs of children. We advocate that everyone employ these standards, to the extent possible. We also understand that there may be situations or locations in which the recommended resources are not fully available. We urge health professionals/teams lacking resources to continually work toward meeting these standards. However, if unavoidable limitations preclude components of these recommendations, this should not hinder providing the best services currently available. In those locations where some, but not all, recommended services exist, choosing not to implement potentially beneficial care services risks harm to a child (Murchison et al., 2016; Telfer et al., 2018; Riggs et al., 2020). Overall, it is imperative to prioritize a child’s best interests.

A vast empirical psychological literature indicates that early childhood experiences frequently set the stage for lifelong patterns of risk and/or resilience, and contribute to a trajectory of development more or less conducive to well-being and positive quality of life (Anda, et al., 2010; Masten & Cicchetti, 2010; Shonkoff & Garner, 2012). The available research indicates that, in general, gender diverse youth are at greater risk for experiencing psychological difficulties (Ristori & Steensma, 2016; Steensma et al., 2014) than age matched cisgender peers as a result of encountering destructive experiences, including trauma and maltreatment stemming from gender diversity-related rejection and other harsh, non-accepting interactions (Barrow & Apostle, 2018; Giovanardi et al., 2018; Gower et al., 2018; Gossman & D'Augelli, 2007; Hendricks & Testa, 2012; Reisner et al., 2015; Roberts et al., 2012; Tishelman & Mascis, 2018). Further, literature indicates that prepubescent children who are well accepted in their gender diverse identities are generally well-adjusted (Malpas et al., 2018; Olson et al., 2016). Assessment and treatment of children typically emphasizes an *ecological* approach, recognizing that a child needs to be safe and nurtured in each setting they frequent (Belsky, 1993; Bronfenbrenner, 1979; Kaufman & Tishelman, 2018; Lynch & Cicchetti, 1998; Tishelman, et al., 2010; Zielinski & Bradshaw, 2006). Thus, our perspective, drawing on basic psychological literature and knowledge of the unique risks to gender diverse youth, emphasizes the integration of an ecological approach to understanding the needs of gender diverse children and to facilitating positive mental health in all gender care. This perspective prioritizes fostering well-being and quality of life for a child throughout their development. Additionally, we also embrace the viewpoint, supported by the substantial psychological research cited above, that psychosocial gender affirming care (Hidalgo et al., 2013) for prepubescent children offers a window of opportunity to promote a trajectory of well-being that will sustain over time and during the transition to adolescence. This approach potentially can mitigate some of the common mental health risks faced by transgender teens, as frequently described in literature (Chen et al., 2020; Edwards-Leeper et al., 2017; Haas et al., 2011; Leibowitz & De Vries, 2016; Reisner et al., 2015a; Reisner et al., 2015b).

Developmental research has focused on understanding various aspects of gender development in the earliest years of childhood, based on a general population of prepubescent children. This research has typically relied on the assumption that child research participants are cisgender (Olezeski, et al., 2020) and has reported that gender identity stability is established in the preschool years for the general population of children, most of whom are likely not gender diverse (Kohlberg, 1966; Steensma, et al., 2013a). Recently, developmental research has demonstrated that gender diversity can be observed and identified in young prepubescent children (Fast & Olson, 2018; Olson & Gülgöz, 2018; Robles, et al., 2016). Still, empirical study in this area is limited, and at this time there are no psychometrically sound assessment measures capable of reliably and/or fully ascertaining a prepubescent child's self-understanding of their own gender and/or gender related needs and preferences (Bloom et al., 2021). Therefore, this chapter emphasizes the importance of a nuanced and individualized clinical approach to gender assessment, as also recommended in various guidelines and literature (Berg & Edwards-Leeper, 2018; De Vries & Cohen-Kettenis, 2012; Ehrensaft, 2018; Steensma & Wensing-Kurger, 2019). Research and clinical experience have indicated that gender diversity in prepubescent children may, for some, be fluid; we have no reliable means of predicting an individual child's gender evolution (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, et al., 2013a), and the gender related needs for a particular child may vary over the course of their childhood.

It is important to understand the meaning of the term "assessment" (sometimes used synonymously with the term "evaluation"). There are multiple contexts for assessment (Krishnamurthy, et al., 2004) including rapid assessments that take place during an immediate

crisis (e.g., safety assessment when a child may be suicidal) and delimited assessments when a family may have a circumscribed question, often in the context of a relatively brief consultation (Berg & Edwards-Leeper, 2018). In this chapter, we focus on comprehensive assessments, useful for understanding a child and family's needs and goals (APA, 2015; De Vries & Cohen-Kettenis, 2012; Srinath et al., 2019; Steensma & Wensing-Kruger, 2019). This type of psychosocial assessment is appropriate when solicited by a family requesting a full comprehension of the child's gender and mental health needs in the context of gender diversity, needs that often go hand in hand. In these circumstances, family member mental health issues, family dynamics, and social and cultural contexts, all of which impact a gender diverse child, should be taken into consideration (Barrow & Apostle, 2018; Brown & Mar, 2018; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Tishelman & Mascis, 2018, Ristori & Steensma, 2016; Cohen-Kettenis et al., 2003; Steensma; et al., 2014). We elaborate upon this further in the text below.

We encourage health professionals working with gender diverse children to strive to understand the child and family's various aspects of identity and experience: racial, ethnic, immigrant/refugee status, religious, geographic, and socio-economic, for example, and be respectful and sensitive to cultural context in clinical interactions (Telfer et al., 2018). Many factors may be relevant to culture and gender, including religious beliefs, gender-related expectations, and the degree to which gender diversity is accepted (Oliphant et al., 2018). Intersections between gender diversity, sociocultural diversity, and minority statuses can be sources of strength and/or social stress (Brown & Mar, 2018; Oliphant et al., 2018; Riggs & Treharne, 2016).

Each child, family member, and family dynamic is unique, and potentially encompasses multiple cultures and belief patterns. Thus, we urge health professionals of all disciplines to avoid stereotyping based on pre-conceived ideas which may be incorrect or biased (e.g., that a family who belongs to a religious organization that rejects gender diversity will be rejecting of their child) (Brown & Mar, 2018). Instead, it is essential to approach each family openly and understand each family member and family pattern as distinct.

Summary of Recommendations

Statement 1: We recommend that health professionals working with gender diverse children should receive training and have expertise in gender development and gender diversity in children, and general knowledge of gender diversity across the life span.

Statement 2: We recommend that health professionals working with gender diverse children should receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.

Statement 3: We recommend that health professionals working with gender diverse children should receive training and develop expertise in autism spectrum disorders and other neurodiversity conditions or collaborate with an expert with relevant expertise when working with autistic/neuro-diverse, gender diverse children.

Statement 4: We recommend that health professionals working with gender diverse children should engage in continuing education related to gender diverse children and families.

Statement 5: We recommend that health professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.

Statement 6: We recommend that health professionals conducting an assessment with gender diverse children should consider relevant developmental factors, neurocognitive functioning and language skills.

Statement 7: We recommend that health professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).

Statement 8: We recommend that health professionals should consider consultation and/or psychotherapy for a gender diverse child and family/caregivers when families and health professionals believe this would benefit the well-being and development of a child and/or family.

Statement 9: We recommend that health professionals offering consultation and/or psychotherapy to gender diverse children and families/caregivers work with other settings and individuals important to the child in order to promote the child's resilience and emotional well-being.

Statement 10: We recommend that health professionals offering consultation and/or psychotherapy to gender diverse children and families/caregivers provide both with age appropriate psycho-education about gender development.

Statement 11: We recommend that health professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.

Statement 12: We recommend that parents/caregivers and health professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.

Statement 13: We recommend health professionals and parents/caregivers to support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.

Statement 14: We recommend health professionals discuss the potential benefits and risks of a social transition with families who are considering it.

Statement 15: We recommend health professionals to consider working collaboratively with other professionals and organizations to promote well-being of gender diverse children and minimize adversities they may face.

All of these recommendations are based on the integration of background literature and the extensive expertise of a carefully selected group of experts. The field of child gender diversity is relatively new and burgeoning; in some cases empirical research evidence is limited, yet strong

recommendations can be made based on synthesizing general literature on child development, research and scholarship related to gender diverse children, and expert knowledge.

Statement 1:

We recommend that health professionals working with gender diverse children should receive training and have expertise in gender development and gender diversity in children, and general knowledge of gender diversity across the life span.

Health professionals working with gender diverse children should acquire and maintain the necessary training and credentials relevant to the scope of their role as professionals. This includes licensure and/or certification by appropriate national and/or regional accrediting bodies. We recognize that specifics of credentialing and regulation of professionals vary globally. Importantly, basic licensure and/or certification may be insufficient in and of itself for work with gender diverse children, as health professionals specifically require in-depth training and supervised experience in childhood gender development and gender diversity in order to provide appropriate care.

Statement 2:

We recommend that health professionals working with gender diverse children should receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.

Health professionals should receive training and supervised expertise in general child and family mental health across the developmental spectrum from toddlerhood through adolescence, including evidence-based assessment and intervention approaches. Gender diversity is not a mental health disorder; however, as cited above, we know that mental health can be adversely impacted for gender diverse children (e.g., through gender minority stress) (Hendricks & Testa, 2012) which may benefit from exploration and support; therefore, mental health expertise is highly recommended. Working with children is a complex endeavor, involving an understanding of a child's developmental needs at various ages, the ability to comprehend the forces impacting a child's well-being both inside and outside the family (e.g., Kaufman & Tishelman, 2018) and an ability to fully assess when a child is unhappy or experiencing significant mental health difficulties, related or unrelated to gender. Research has indicated high levels of adverse experiences and trauma in the gender diverse community of youth, including susceptibility to rejection or even maltreatment (APA, 2015; Barrow & Apostle, 2018; Giovanardi et al, 2018; Reisner et al., 2015; Roberts et al., 2012; Tishelman & Mascis, 2018). Health professionals need to be cognizant of the potential for adverse experiences and be able to initiate ameliorating interventions in order to prevent harm and promote positive well-being.

Statement 3:

We recommend that health professionals working with gender diverse children should receive training and develop expertise in autism spectrum disorders and other neurodiversity conditions or collaborate with an expert with relevant expertise when working with autistic/neuro-diverse, gender diverse children.

The experience of gender diversity in autistic children¹ as well as in children with other forms of neurodiversity may present extra clinical complexities (de Vries et al., 2010; Strang et al., 2018a). For example, autistic children may have difficulty self-advocating for their gender-related needs and may communicate in highly individualistic ways (Kuvallanka, et al., 2018; Strang et al., 2018b). They may have varied interpretations of gender-related experiences, given common differences in communication and thinking style. Because of the unique needs of gender diverse neurodiverse children, health professionals providing support to this population should receive training and develop expertise in autism and related conditions, or at the very least, collaborate with autism specialists or other professionals with the appropriate expertise (Strang et al., 2018a). Such training is especially relevant as research has documented higher rates of gender diversity in autistic youth than in the general population (de Vries et al., 2010; Hisle-Gorman et al., 2019; Shumer et al., 2015).

Statement 4:

We recommend that health professionals working with gender diverse children should engage in continuing education related to gender diverse children and families.

Continuing professional development on gender diverse children and families may be acquired through various means, including through readings (journal articles, books, websites associated with gender knowledgeable organizations), attending on-line and in person trainings, and joining peer supervision/consultation groups (Bartholomaeus et al., 2021).

Continuing education includes: 1) maintaining up-to-date knowledge of available and relevant research on gender development and gender diversity in prepubescent children and gender diversity across the life span; 2) maintaining current knowledge regarding best practices for assessment, support, and treatment approaches with gender diverse children and families. This is a relatively new area of practice and health professionals need to adapt as new information emerges through research and other avenues (Bartholomaeus et al., 2021).

Statement 5:

We recommend that health professionals conducting an assessment with gender diverse children should access and integrate information from multiple sources as part of the assessment.

A comprehensive assessment, when requested by a family, can be useful for developing intervention recommendations, as needed, to benefit the well-being of the child and/or other family members. This form of assessment is common when first forming an individualized plan to assist a gender diverse prepubescent child and family members (De Vries & Cohen-Kettenis, 2012; Malpas, et al., 2018; Telfer et al., 2018; Tishelman & Kaufman, 2018; Steensma & Wensing-Kruger, 2019). In such an assessment, integrating information from multiple sources is important in order to: 1) best understand the child's gender needs and make recommendations; 2) identify areas of child, family/caregiver, and community strengths and supports specific to the child's gender status and development, as well as risks and concerns for the child, their

¹ There is not consensus regarding language to describe the experience of autism in individuals. Some have expressed a preference for identity-first language (e.g., "autistic child"), while others have advocated for person-first language (e.g., "child on the autism spectrum"). Therefore, we employ a mix of both identity-first and person-first language for autism in this chapter.

family/caregivers and environment. Multiple informants, for both evaluation and support/intervention planning purposes, may include: child, parents/caregivers, extended family members, siblings, school personnel, health professionals, community, broader cultural and legal contexts, and/or other sources as indicated (Berg & Edwards-Leeper, 2018; Srinath, 2019)

A health professional conducting an assessment of gender diverse children needs to explore gender-related issues, but also take a broad view of the child and environment, consistent with the ecological model described above (e.g., Bronfenbrenner, 1979) in order to fully understand the factors impacting a child's well-being and areas of gender support and risk (Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Berg & Edwards-Leeper, 2018; Tishelman & Mascis, 2018; Whyatt-Sames, 2017). This includes understanding strengths and challenges for the child, family and in the environment. We advise that health professionals conducting an assessment with gender diverse children consider incorporating multiple assessment domains, depending on the child and family's needs and circumstances. Although some of the latter listed domains below do not directly address the child's gender (items 7-12), they need to be accounted for in a gender assessment, as indicated by clinical judgment, in order to understand the complex web of factors that may be impinging on the child's well-being in an integrated fashion, including gender health, consistent with evaluation best practices a (e.g., APA, 2015; Berg & Edwards-Leeper, 2018; Malpas et al., 2018) and develop a multi-pronged intervention when needed.

Summarizing from relevant research and clinical expertise, assessment domains often include: 1) a child's asserted gender identity and gender expression, currently and historically; 2) evidence of dysphoria and/or gender incongruence; 3) strengths and challenges related to the child, family, peer and other's beliefs and attitudes about gender diversity, acceptance and support for child; 4) child and family experiences of gender minority stress and rejection and/or hostility due to the child's gender diversity; 5) level of support related to gender diversity in social contexts (school, faith community, extended family, etc.); 6) conflict regarding child's gender and/or parental/caregiver/sibling concerning behavior related to the child's gender diversity; 7) child mental health, communication and/or cognitive strengths and challenges, neurodiversity, and/or behavioral challenges causing significant functional difficulty; 8) relevant medical and developmental history; 9) areas that may pose risk (e.g., exposure to domestic and/or community violence, any form of child maltreatment; history of trauma; safety and/or victimization with peers or in any other setting; suicidality); 10) co-occurring significant family stressors, such as chronic or terminal illness, homelessness or poverty ; 11) parent/caregiver and/or sibling mental health and/or behavioral challenges causing significant functional difficulty; 12) child and family's strengths, and challenges.

A thorough assessment incorporates multiple forms of information gathering as necessary for understanding the needs, strengths, protective factors, and risks for a specific child and family, across environments (e.g. home/school). Methods of information gathering often include: 1) interviews with child, family members and others (e.g., teachers), structured and unstructured; 2) caregiver and child completed standardized measures related to: gender; general child well-being; child cognitive and communication skills and developmental disorders/disabilities; support and acceptance by parent/caregiver, sibling, extended family and peers; parental stress; history of childhood adversities; and/or other issues as appropriate (APA, 2020; Berg & Edwards-Leeper, 2018; Kaufman & Tishelman, 2018; Srinath, 2019).

Depending on the family characteristics and/or the developmental profile of the child, methods of information gathering also may also benefit from including the following: 1) child and/or family observation, structured and unstructured; 2) structured and visually supported assessment

techniques (worksheets; self-portraits; family drawings, etc.); and 3) child play assessment (Berg & Edwards-Leeper, 2018).

Statement 6:

We recommend that health professionals conducting an assessment with gender diverse children should consider relevant developmental factors, neurocognitive functioning and language skills.

Given the complexities of assessing young children who, unlike adults, are in the process of development across a range of domains (cognitive, social, emotional, physiological), it is important to consider the developmental status of a child and gear assessment modalities and interactions to the individualized abilities of the child. This includes tailoring the assessment to a child's developmental stage and abilities (preschoolers, school age, early puberty prior to adolescence), including using language and assessment approaches that prioritize a child's comfort, language skills, and means of self-expression (Berg & Edwards-Leeper, 2018; Srinath, 2019). For example, relevant developmental factors, such as neurocognitive differences (e.g., autism spectrum conditions), and receptive and expressive language skills should be taken into account in conducting the assessment. Health professionals may need to consult with specialists for guidance, in cases in which they do not have the specialized skills themselves (Strang et al., 2020).

Statement 7:

We recommend that health professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).

Health professionals conducting an assessment with gender diverse children and families need to account for developmental, emotional, and environmental factors that may constrain a child's, caregiver's, sibling or other's report or influence their belief systems related to gender (Riggs and Bartholomaeus, 2018). As with all child psychological assessments, environmental and family/caregiver reactions (e.g., punishment), and/or cognitive and social factors may influence a child's comfort and/or ability to directly discuss certain factors, including gender identity and related issues (Srinath, 2019). Similarly, family members may feel constrained in freely expressing their concerns and ideas, depending on family conflicts or dynamics and/or other influences (e.g., cultural/religious; extended family pressure, etc.) (Riggs & Bartholomaeus, 2018).

Statement 8:

We recommend that health professionals should consider consultation and/or psychotherapy for a gender diverse child and family/caregivers when families and health professionals believe this would benefit the well-being and development of a child and/or family.

The goal of psychotherapy should never be aimed at modifying a child's gender identity (APA, 2021; Ashley, 2019a; Paré, 2020; SAMHSA, 2015; Turban et al., 2019a; UN Human Rights Council, 2020). In addition, not all prepubescent children who are gender diverse, or their families, need input from mental health professionals, as gender diversity is not a mental health disorder (Endocrine Society and Pediatric Endocrine Society, 2020; Telfer et al., 2018).

It is appropriate to consider seeking psychotherapy under many circumstances to improve psychosocial health and prevent further distress (APA 2015). Some of the common reasons for considering psychotherapy for a prepubescent child and family include the following. A child: 1) is demonstrating significant conflicts, confusion, stress or distress about their gender identity, or needs a protected space to explore their gender (Ehrensaft, 2018; Spivey and Edwards-Leeper, 2019; 2) is experiencing external pressure to express their gender in a way that conflicts with their self-knowledge, desires and beliefs (APA, 2015; Turban et al., 2019b); 3) is struggling with mental health concerns, related to or independent of their gender (Barrow & Apostle, 2018); 4) would benefit from strengthening their resilience in the face of negative environmental responses to their gender identity or presentation (Craig & Auston, 2018; Malpas et al., 2018); 5) may be experiencing mental health and/or environmental concerns, including family system problems, which can be misinterpreted as gender incongruence (Berg & Edwards-Leeper, 2018); 6) expresses a desire to meet with a mental health professional to get gender related support. In these situations, the psychotherapy will focus on supporting the child with the understanding that the child's parent(s)/caregiver(s) and potentially other family members will be included as necessary (APA, 2015; Ehrensaft, 2018; McLaughlin & Sharp, 2018).

Health professionals should employ interventions tailor-made to the individual needs of the child that are designed to: 1) foster protective social and emotional coping skills to promote resilience in the face of potential negative reactions to the child's gender identity and/or expressions (Spencer, Berg et al., 2021; Craig & Auston, 2016; Malpas et al., 2018); 2) collaboratively problem-solve social challenges to reduce gender minority stress (Barrow & Apostle, 2018; Tishelman and Mascis, 2018); 3) strengthen environmental supports for the child and/or members of immediate and extended family (Kaufman & Tishelman, 2018); and 4) provide the child an opportunity to explore their internal gender experiences (APA, 2015; Barrow & Apostle, 2018; Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). It is helpful for health professionals to develop a relationship that can endure over time as needed. This enables the child/family to establish a long-term trusting relationship throughout childhood where the health professional can offer support and guidance as a child matures, and as potentially different challenges or needs emerge for the child/family (Spencer, Berg, et al., 2021; Murchison et al., 2016). In addition to the above and within the limits of available resources, when a child is neurodiverse, a health professional who has the appropriate skill set to address both the neurodiversity and gender is most appropriate (Strang et al., 2020).

As outlined in the literature, there are numerous reasons that parents/caregivers and/or extended family members of a prepubescent child may find it useful to seek psychotherapy for themselves (Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). Some of these common catalysts for seeking such treatment, as summarized below, occur when one or more *family members*: 1) desire education around gender development (Spivey & Edwards-Leeper, 2019); 2) are experiencing significant confusion or stress about the child's gender identity and/or expression (Ashley, 2019c; Ehrensaft, 2018); 3) need guidance related to emotional and behavioral concerns regarding the gender diverse child (Barrow & Apostle, 2018); 4) need support to promote affirming environments outside of the home (e.g., school, sports, camps, etc.) (Kaufman & Tishelman, 2018); 5) are seeking assistance to make informed decisions about social transition, including how to do so in a way that is optimal for a child's gender development and health (Lev & Wolf-Gould, 2018); 6) are seeking guidance for dealing with condemnation from others regarding their support for their gender diverse child (negative reactions directed toward parents/caregivers can sometimes include rejection and/or harassment/abuse from the social environment arising from affirming decisions) (Hidalgo and Chen, 2019); 7) are seeking to process their own emotional reactions and needs about their

child's gender identity, including grief about their child's gender diversity, and/or potential fears or anxieties for their child's current and future well-being (Pullen Sansfaçon et al., 2019); and 8) are emotionally distressed and/or in conflict with other family members regarding the child's gender diversity (as needed, health professionals can provide separate sessions for parents/caregivers, siblings and extended family members for support, guidance, and/or psychoeducation) (Pullen Sansfaçon et al., 2019; McLaughlin & Sharp, 2018; 19; Spivey & Edwards-Leeper, 2019).

Statement 9:

We recommend that health professionals offering consultation and/or psychotherapy to gender diverse children and families/caregivers work with other settings and individuals important to the child in order to promote the child's resilience and emotional well-being.

Consistent with the ecological model described above and as appropriate based on individual/family circumstances, health professionals should prioritize coordination with important others (e.g. teachers, coaches, religious leaders, etc) in a child's life to promote emotional and physical safety across settings (e.g. school settings, sports and other recreational activities, faith-based involvement, etc.) (Kaufman & Tisheman, 2018). Therapeutic and/or support groups are often recommended as a valuable resource for families/caregivers and/or gender diverse children themselves (Coolhart, 2018; Horton et al., 2021; Malpas, et al., 2018; Murchison et al., 2016).

Statement 10:

We recommend that health professionals offering consultation and/or psychotherapy to gender diverse children and families/caregivers provide both with age appropriate psycho-education about gender development.

Parents/caregivers and their gender diverse child should have the opportunity to develop knowledge regarding ways in which families/caregivers can best support their child to maximize resilience, self-awareness, and functioning (APA, 2015; Ehrensaft, 2018; Malpas, 2018; Spivey & Edwards-Leeper, 2019). It is neither possible nor the role of the health professional to predict with certainty the child's ultimate gender identity; instead, the health professional's task is to provide a safe space for the child's identity to develop and evolve over time (APA, 2015; Rae Spivey & Edwards-Leeper, 2019). Gender diverse children and early adolescents have different needs and experiences than older adolescents, socially and physiologically, and those differences should be reflected in the individualized approach that health professionals provide to each child/family (Keo-Meir & Ehrensaft, 2018; Spencer, Berg et al., 2021).

Parents/caregivers and their children should also have the opportunity to develop knowledge about gender development and gender literacy through age-appropriate psycho-education (Berg & Edwards-Leeper, 2018; Rider et al., 2019; Spencer, Berg, et al., 2021). Gender literacy involves understanding the distinctions between sex designated at birth, gender identity, and gender expression, including the ways in which these three factors uniquely come together for a child) (Berg & Edwards-Leeper, 2018; Rider et al., 2019; Spencer, Berg, et al., 2021). As a child gains gender literacy, they begin to understand that their body parts do not necessarily define their gender identity and/or their gender expression (Berg & Edwards-Leeper, 2018; Rider et al., 2019; Spencer, Berg, et al., 2021). Gender literacy also involves learning to identify messages and experiences related to gender within society. As a child gains gender literacy, they may view their developing gender identity and gender expression more positively,

promoting resilience and self-esteem, and diminishing risk of shame in the face of negative messages from the environment. Gaining gender literacy through psycho-education may also be important for siblings and/or extended family members who are important to the child (Rider et al., 2019; Spencer, Berg, et al., 2021).

Statement 11:

We recommend that health professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.

As a child matures and approaches puberty, health professionals should prioritize working with children and their parents/caregivers to integrate psycho-education about puberty, engage in shared decision-making about potential gender-affirming medical interventions, and discuss fertility-related implications of medical treatments (Nahata, Quinn & Tishelman, 2018; Spencer, Berg et al., 2021). Although only limited empirical research exists to evaluate such interventions, expert consensus and developmental psychological literature generally support the notion that open communication with children about their bodies, and preparation for physiological changes of puberty, combined with gender affirming acceptance, will promote resilience and help to foster positive sexuality as a child matures into adolescence (Spencer, Berg, et al., 2019). All of these discussions may be extended (e.g., starting earlier) for neurodiverse children, to ensure enough time for reflection and understanding, especially as choices regarding future gender affirming medical care potentially arise (Strang et al., 2018). These discussions could include the following topics:

- Review of body parts and their different functions
- The ways in which a child's body may change over time with and without medical intervention
- The impact of medical interventions on later sexual functioning and fertility
- The impact of puberty suppression on potential later medical interventions
- Acknowledgment of the current lack of clinical data in certain areas related to the impacts of puberty blockers
- The importance of appropriate sex education prior to puberty

These discussions should employ developmentally appropriate language and teaching styles, and be geared to the specific needs of each individual child (Spencer, Berg, et al., 2021).

Statement 12:

We recommend that parents/caregivers and health professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.

Gender social transition refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm and has no singular set of parameters (Ehrensaft, et al., 2018).

Gender social transition has often been conceived in the past as binary—a girl transitions to a boy, a boy to a girl. The concept has expanded to include children who shift to a non-binary or individually shaped iteration of gender identity (Clark et al., 2018; Chew, et al., 2020). Newer

research indicates that social transition may serve a protective function for some prepubescent youth, and serve to foster positive mental health and well-being (e.g., Durwood et al., 2017; Olson et al., 2016; Gibson et al., 2021). Thus, recognition that a child's gender may be fluid and develop over time (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma et al., 2013) is not sufficient justification to negate or deter a social transition in a prepubescent child when it would be beneficial. Gender identity exploration may continue even after a social transition (Ashley, 2019b; Edwards-Leeper, et al., 2018; Ehrensaft, 2020; Ehrensaft et al., 2018; Spivey & Edwards-Leeper, 2019). Although empirical data remains limited, existing research has indicated that youth who are most assertive about their gender diversity are most likely to persist in a diverse gender identity across time (Rae et al., 2019; Steensma et al., 2013b). Thus, when considering a social transition, we suggest that parents/caregivers and health professionals pay particular attention to children who consistently articulate a gender identity that does not match the sex designated at birth. This includes those children who may explicitly request or desire a social acknowledgement of the gender that better matches the child's articulated gender identity, and/or children who exhibit distress when their gender as they know it is experienced as incongruent with the sex designated at birth (Rae et al., 2019; Steensma et al., 2013).

Although there is a dearth of empirical literature regarding best practices related to the social transition process, clinical literature and expertise provides the following guidance, prioritizing a child's best interests (Ashley, et al., 2019b; Ehrensaft, 2018; Ehrensaft et al., 2018; Murchison et al., 2016; Telfer et al., 2018): 1) social transition should originate from the child and reflect the child's wishes in the process of making the decision to initiate a social transition; 2) a health professional may assist exploring the advantages/benefits, plus potential challenges of social transition; 3) social transition may best occur in all or in specific contexts/settings only (e.g., school, home); 4) a child may or may not choose to disclose to others that they have socially transitioned, or may designate, typically with the help of their parents/caregivers, a select group of people with whom they share the information.

In summary, social transition, when it takes place, is likely to best serve a child's well-being when it takes place thoughtfully and individually for each child. A child's social transition (and gender as well) may evolve over time, and is not necessarily static (Ehrensaft et al., 2018). Social transition can include one or more of a number of different actions consistent with a child's affirmed gender (Ehrensaft et al., 2018), including:

- Name change
- Pronoun change
- Change in sex/gender markers (e.g., birth certificate; identification cards; passport; school and medical documentation; etc.)
- Participation in gender-segregated programs (e.g., sports teams; recreational clubs and camps; schools; etc.)
- Bathroom and locker room use
- Personal expression (e.g., hair style; clothing choice; etc.)
- Communication of affirmed gender to others (e.g., social media; classroom or school announcements; letters to extended families or social contacts; etc.)

Statement 13:

We recommend health professionals and parents/caregivers to support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.

It is important that children who have engaged in a social transition be afforded opportunities to continue exploring meanings and expressions of gender throughout their childhood years (Ashley 2019b; Spencer, Berg, et al., 2021). However, not all children wish to explore their gender (Telfer et al., 2018). Cisgender children are not expected to undertake this exploration and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing and cishnormative (Ansara & Hegarty, 2012; Bartholomaeus et al., 2021; Oliphant et al., 2018).

Statement 14:

We recommend health professionals to discuss the potential benefits and risks of a social transition with families who are considering it.

Social transition in prepubescent children consists of a variety of choices, can occur as a process over time, is individualized based on both a child's wishes and other psychosocial considerations (Ehrensaft, 2018), and is a decision where possible benefits and risks should be weighted and discussed.

To promote gender health, the health professional should discuss the potential benefits and risks of a social transition. One risk often expressed relates to fear that a child will be locked into a gender expression that does not match their gender identity as they mature and continue gender exploration (Edwards-Leeper et al., 2016; Ristori & Steensma, 2016). Recent research, although limited, has found that some parents/caregivers of children who have socially transitioned discuss the option of de-transitioning (reverting to an earlier gender expression) with their children and are comfortable about this possibility (Olson, et al., 2019). Another often identified social transition concern is that a child may suffer negative sequelae if they detransition (Chen et al., 2018; Edwards-Leeper et al., 2019; Steensma & Cohen-Kettenis, 2011). From this point of view, parents/caregivers should be aware of the potential developmental effect of a social transition in a child.

On the other hand, a social transition may have potential benefits, as outlined in clinical literature (e.g., Ehrensaft et al., 2018) and supported by research (Fast & Olson, 2018; Rae et al., 2019). These include facilitating gender congruence while reducing gender dysphoria, and enhancing psychosocial adjustment and well-being (e.g., Ehrensaft et al., 2018). Studies have indicated that socially transitioned gender diverse children largely mirror the mental health characteristics of age matched cisgender siblings and/or peers (Durwood et al., 2017). These findings differ markedly from the mental health challenges consistently noted in prior research with gender diverse children and adolescents (Barrow & Apostle, 2018) and suggest that the impact of social transition may be positive. Additionally, social transition for children typically can only take place with the support and acceptance of parents/caregivers, which has also been demonstrated to facilitate well-being in prepubescent youth (Durwood et al., 2021; Malpas et al., 2018; Pariseau et al., 2019), although other forms of support have also been identified as important (Durwood et al., 2021; Turban et al., 2021). Health professionals can discuss the potential benefits of a social transition with children and families in situations in which:

- 1) there is a consistent, stable articulation of a gender that is incongruent from the sex designated at birth (Fast & Olson, 2018). This should be differentiated from gender diverse expressions/behaviors/interests (e.g. playing with toys, expressing oneself through clothing or appearance choices, and/or engaging in activities socially defined and typically associated with the other gender in a binary model of gender) (Ehrensaft, 2018; Ehrensaft et al., 2018).

2) the child is expressing a strong desire or need to transition to the gender they have articulated as being their authentic gender (Ehrensaft et al., 2018; Fast & Olson, 2018; Rae et al., 2019).

3) the child will be emotionally and physically safe during and following transition (Brown & Mar, 2018). Prejudice and discrimination should be considerations taken into account, especially in localities where acceptance of gender diversity is limited or prohibited (Brown & Mar, 2018; Hendricks & Testa, 2012; Turban et al., 2021).

Health professionals can provide guidance to parents/caregivers and supports to a child when a social gender transition is being considered or taking place, by: 1) providing consultation, assessment, and gender supports when needed and sought by the parents/caregivers; 2) aiding family members, as needed, to understand the child's desires for a social transition and the family members' own feelings about the child's expressed desires; 3) exploring with, and learning from, the parents/caregivers whether and how they believe a social transition would benefit their child both now and in their ongoing development; 4) providing guidance when parents/caregivers are not in agreement about a social transition and offering the opportunity to work together toward a consistent understanding of their child's gender status and needs; 5) providing guidance about safe and supportive ways to disclose their child's social transition to others and to facilitate their child transitioning in their various social environments (e.g., schools, extended family); 6) facilitating communication, when desired by the child, with peers about gender and social transition, as well as fortifying positive peer relationships; 7) providing guidance when social transition may not be socially accepted or safe, either everywhere or in specific situations, or when a child has reservations about initiating a transition despite their wish to do so; there may be multiple reasons for reservations, including fears and anxieties; 8) working collaboratively with family members and mental health professionals to facilitate a social transition in a way that is optimal for the child's unfolding gender development, overall well-being, and physical and emotional safety; 9) providing psychoeducation about the many different trajectories the child's gender may take over time, leaving pathways open to future iterations of gender for the child, and emphasizing that there is no need to predict an individual child's gender identity in the future (Malpas et al., 2018;)

All of these tasks incorporate enhancing the quality of communication between the child and family members, and providing an opportunity for the child to be heard and listened to by all family members involved. These relational processes in turn facilitate the parents/caregivers' success in making informed decisions about the advisability and/or parameters of a social transition for their child (Malpas, et al., 2018).

One role of health professionals is to provide guidance and support in situations in which children and parents/caregivers wish to proceed with a social transition, but conclude that the social environment would not be accepting of those choices, by: 1) helping parents/caregivers define and extend safe spaces in which the child can express their authentic gender freely; 2) discussing with parents/caregivers ways to advocate that increase the likelihood of the social environment being supportive in the future, if this is a realistic goal; 3) intervening as needed to help the child/family with any associated distress and/or shame brought about by the continued suppression of authentic gender identity and need for secrecy; 4) building both the child's and the family's resilience, instilling the understanding that if the social environment is having difficulty accepting a child's social transition and affirmed gender identity, it is not because of some shortcoming in the child but because of insufficient gender literacy in the social environment (Ehrensaft et al., 2018).

Statement 15:

We recommend health professionals to consider working collaboratively with other professionals and organizations to promote well-being of gender diverse children and minimize adversities they may face.

All children have the right to be supported and respected in their gender identities (Human Rights Campaign, 2018; Paré, 2020; SAMHSA, 2015). As noted above, gender diverse children are a particularly vulnerable group (Barrow & Apostle, 2018; Giovanardi et al., 2018; Gower et al., 2018; Gossman & D'Augelli, 2007; Hendricks & Testa, 2012; Reisner et al., 2015; Roberts et al., 2012; Tishelman & Mascis, 2018, Cohen-Kettenis et al., 2003, Ristori & Steensma, 2016). The responsibilities of health professional as advocate encompass acknowledging that social determinants of health are critical for marginalized minorities (Hendricks & Testa, 2012; Barrow & Mar, 2018). Advocacy is taken up by all health professionals in the form of child and family support (APA, 2015; Malpas et al 2018). Some health professionals may be called on to move beyond their individual offices or programs to advocate for gender diverse children in the larger community, often in partnership with stakeholders, including parents/caregivers, allies and youth (Kaufman & Tishelman, 2018; Lopez et al., 2017; Vanderburgh, 2009). These efforts may be instrumental in enhancing children's gender health and promoting their civil rights (Lopez et al., 2017).

Health professional voices may be essential in schools, in parliamentary bodies, in courts of law, and in the media (Kuvlanka et al., 2019; Lopez et al., 2017; Whyatt-Sames, 2017; Vanderburgh, 2009). In addition, health professionals may have a more generalized advocacy role in acknowledging and addressing the frequent intentional and/or unintentional negating of the experience of gender diverse children that may be transmitted or communicated by adults, peers, and/or in media (Rafferty et al., 2018). Professionals who possess the skill sets and/or find themselves in appropriate situations can provide clear de-pathologizing statements on the needs and rights of gender diverse children, and on the damage caused by discriminatory and transphobic rules, laws and norms (Rafferty et al., 2018).

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