

# “Of Course, I’m Intimidated by Them. They Could Take My Human Rights Away”: Trans Children’s Experiences with UK Gender Clinics

Cal Horton

is a researcher focused on the experiences of trans children and their families, based in the UK. They are completing a PhD at Goldsmiths, University of London.

✉ [c.horton@gold.ac.uk](mailto:c.horton@gold.ac.uk)

Gender clinics engaging with pre-pubertal trans children are divided between those that endorse a gender affirmative approach and those that do not. Little evidence is available on how trans children experience non-affirmative gender clinics in early childhood. This study aimed to understand pre-pubertal trans children’s recent experiences in non-affirmative gender clinics in the UK. Data focused on a cohort of trans children who socially transitioned under age eleven. Data were drawn from semi-structured qualitative interviews with ten trans children and 30 UK-based parents of trans children, focusing on children’s pre-pubertal engagement with UK gender clinics. Themes are presented on 1) inappropriate assessment of gender; 2) trans children under pressure; and 3) distress and trauma in UK gender clinics. The article presents evidence of continued pathologisation and problematisation of childhood gender diversity in UK children’s gender clinics. It demonstrates the harms of the status quo and the need for systemic reform, providing modern affirmative care for younger trans children.

**KEYWORDS** assessment; transgender; children; qualitative research; clinical care

**DOI** [10.57814/20hf-7n94](https://doi.org/10.57814/20hf-7n94)

**LICENSE** Creative Commons Attribution-NonCommercial-NoDerivatives ([by-nc-nd](https://creativecommons.org/licenses/by-nc-nd/4.0/))

Across the 20th century medical establishments problematised childhood gender diversity (Gill-Peterson 2018). Gender clinics across multiple countries embarked on the control and coercion of trans and gender diverse children, applying practices of physical, emotional, and psychological abuse (Bryant 2006; Gill-Peterson 2018). Childhood gender diversity was pathologised in the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the diagnosis of “gender identity disorder” prominent until 2013 (Davy and Toze 2018). Gender clinics assessed children’s nonconformity, scrutinizing

interests or behaviours that they considered gender atypical, and therefore pathological (Bryant 2006). Treatment for gender identity disorder managed by psychologists, psychoanalysts, and sexologists included control of children's access to toys, friends, or clothing, and withdrawal of parental, and particularly maternal, affection (Ehrensaft 2012; Gill-Peterson 2018). Such techniques aimed to prompt a shift in behaviour to fit into normative expectations (Bryant 2006). Gender nonconforming children exposed to such pathologising approaches reported experiencing feelings of rejection, shame, and stigma, with short- and longer-term impacts on their mental health, self-esteem, and wellbeing (Bryant 2007; Williams 2017).

In 2013, the DSM-5 brought forward a revised diagnosis: "gender dysphoria" (American Psychiatric Association 2013). This diagnosis required more than just gender nonconformity, yet continued to require assessment of children's gendered preferences, interests, and friends (Davy and Toze 2018). Since then, approaches that clearly state a goal of trying to change a transgender child's identity, or trying to deter a child from identifying as trans, have moved into the fringes of psychological practice, with mainstream medical and rights bodies repudiating conversion practices (American Psychological Association 2021; Ashley 2022; Rafferty et al. 2018; Substance Abuse and Mental Health Services Administration. 2015; UN Human Rights Council 2020). Two prominent approaches to working with trans children remain: a "gender affirmative" approach and an approach of "delayed transition" (Ehrensaft 2020; Turban and Ehrensaft 2018). The former is supported by a growing body of evidence that demonstrates the high levels of mental health of supported trans children (Durwood, McLaughlin, and Olson 2017; Durwood et al. 2021; Olson et al. 2016), that acknowledges trans children's self-knowledge (Fast and Olson 2018; Olson, Key, and Eaton 2015), and that shows the protective effects of affirmed name use and family support on wellbeing and mental health (Katz-Wise et al. 2018; Klein and Golub 2016; Pullen Sansfaçon et al. 2018; Simons et al. 2013; Travers, Bauer, and Pyne 2012; Veale et al. 2017). Delayed transition, also termed "watchful waiting," is not supported by such evidence, and is critiqued for the harms inherent in an approach that places age-based barriers on when a child can be accepted and supported (Ashley 2019a; 2019b; Ehrensaft 2020; Keo-Meier and Ehrensaft 2018; Turban and Ehrensaft 2018).

In 2018, the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD) removed gender diversity from categorization under mental illness, recognizing the importance of destigmatising diverse identities, noting that being trans is not a pathology or disorder (World Health Organisation 2018). This followed a paradigm shift across a wide range of modern trans healthcare standards, moving from gender diversity as a pathology to gender diversity as something to be celebrated or normalized (AusPATH 2021; Endocrine Society and Pediatric Endocrine Society 2020; Murchison et al. 2016; Oliphant et al. 2018; Rafferty et al. 2018; Telfer et al. 2018). Alongside and in advance of a paradigm shift in clinical practice, community-driven discourse has increasingly challenged pathologisation and problematisation of childhood gender diversity (Tosh 2011). In the twentieth century, only a small number of trans children received support and affirmation in childhood (Gill-Peterson 2018). In recent years, more trans children are finding support and acceptance in childhood, as legal protections, awareness, and trans-positivity amongst families with trans children has grown (Kusalanka et al. 2014; Kusalanka and Munroe

2021; Roche 2020). Families of trans children have built support networks, learning from each other's experience, learning from trans adults, and seeing substantial benefits of childhood support and affirmation in place of rejection and shame (Kovalanka and Munroe 2021).

Despite a significant global medical shift towards affirmative care for trans children, a number of clinics remain tethered to an older approach, including UK children's gender services (including, the Gender Identity Development Service [GIDS] at the Tavistock and Portman, covering England and Wales, and the Sandyford Clinic, covering Scotland; Akkermans 2018). Within the UK, the structure, staffing, and leadership of Children's gender clinics has not significantly changed since the years when childhood gender diversity was pathologised and problematized as a disorder in need of fixing (Akkermans 2018). Within healthcare systems such as the UK, there is no literature on how approaches have adapted to ICD-11, or on whether such gender services are moving away from pathologisation of gender diversity.

A number global and national medical bodies (from countries including Australia, the US, and New Zealand) have published affirmative guidelines for clinics and services working with trans children, outlining the priorities, approaches, and support to be offered to pre-pubertal trans children within an affirmative care framework (Keo-Meier and Ehrensaft 2018; Murchison et al. 2016; Oliphant et al. 2018; Telfer et al. 2018). Within healthcare services that are not affirmative, such as is the case in the UK, the priorities, approaches, and support offered to trans children are less well documented. Limited insights are available into gender clinic practices with younger trans children and their families, with a majority of publications on this cohort written by clinicians themselves (Pullen Sansfaçon et al. 2019). Clinical accounts rarely centre the voices and perspectives of trans children. Moreover, recent articles from children's gender services in the UK have raised ethical concerns, with work described as "judgmental, intrusive... and harmful" and its presentation being experienced as "triggering trauma" (Pearce 2020, 816).

From the UK, a small number of publications have captured experiences and perspectives of trans adolescents and families attending UK National Health Service (NHS) gender clinics (Carlile 2020; Carlile, Butteriss, and Sansfaçon 2021; Pullen Sansfaçon et al. 2021; Horton 2021). These publications have highlighted a range of challenges encountered by trans adolescents, including healthcare interactions characterized by "dissatisfaction, frustration, and distress" (Carlile 2020, 7); youth dislike of "painful" GIDS assessment processes (Carlile, Butteriss, and Sansfaçon 2021, 6); and delays and barriers in access to gender affirming healthcare (Carlile, Butteriss, and Sansfaçon 2021; Children's Right Alliance for England 2016). In terms of trans children's engagements with gender clinics pre-adolescence, no UK research has specifically given voice to the experiences of trans children who engage with gender clinics pre-puberty, with this cohort's experiences and perspectives entirely missing from the data. This research aims to address this knowledge gap, seeking to understand the experiences of trans children in UK gender clinics pre-adolescence.

## **METHODS**

### **The wider research and study sample**

As part of wider PhD research, data were collected from a primary sample of parents of trans children who socially transitioned pre-adolescence in the UK. Inclusion criteria focused on 1) being based in the UK, 2) being a parent of a trans child who socially transitioned under age eleven, and 3) their child currently being under age 16. This primary sample was accessed through advertisement in six closed support groups for parents of trans children in England, Scotland, and Wales, and supplemented through snowball sampling. Access to hard-to-reach families and children was enabled by the author's positionality as a parent of a trans child, and member of four of these closed parent groups, helping overcome trust related barriers to hearing from this cohort. Thirty parents were interviewed, discussing experiences with 30 trans children who socially transitioned at average age 7 (range 3–10) and whose current average age was 11 (range 6–16). This dataset was then supplemented with direct data from ten of their trans children, average age 12 at time of interview (range 9–16). All parental interviewees were cisgender (not trans), 90% were white, 93% were female, and 23% were disabled. Seventy percent were aged 40–50 years old and 10% were immigrants to the UK. Interviewees had a wide range of levels of household income and a range of levels of education, with 20% reporting secondary education as their highest qualification, while 37% reported a graduate degree and 43% a post-graduate degree as their highest qualification. In terms of sexual orientation, the parental cohort was diverse; 60% of parental interviewees were heterosexual, 7% gay or lesbian, 10% bisexual, and 23% pansexual.

### **Data collection**

In depth interviews, lasting an average of 2 hours for parental interviews and 30 minutes for children's interviews, generated a rich qualitative dataset. Interviews covered a broad range of topics including experiences in education, experiences with social transition, and interactions with healthcare, including children's gender services. Further research data on parental sessions at gender clinics and experiences in gender clinics as trans children within this cohort reached puberty are explored by the author elsewhere (Horton 2021). This article examines a subset of this broader dataset focusing on trans children's experiences in children's gender clinics before the onset of puberty. Broad exploratory questions included "have you/your child attended an NHS gender clinic?" and "can you tell me about your experience attending the gender clinic in the time before puberty?" These were supplemented by additional interview prompts asking about their initial appointments, their later/recent appointments, how the interviewees felt, or how parents perceived their child's experience. The interview methodology with trans children was flexible and bespoke, with child-friendly unstructured and semi-structured interviews, with data collection approaches adapted to individual child preference, with some interviews conducted one-on-one, some conducted with their parent present, some with their parent asking questions and recording the interview, and one child providing written responses to questions that they chose to answer. Interviews were conducted remotely on a secure encrypted platform between November 2020 and September 2021, during periods of Covid-related lockdown when in-person interviews were not feasible. Interviewees received

research information sheets in advance of participation, with one version tailored for child participants. Parents provided written informed consent. For younger interviewees, parents provided written consent on behalf of their child, with children of all ages additionally providing either written consent or verbal informed assent (Lundy et al., 2011; World Medical Association, 2013). Interviews were transcribed, and transcripts were anonymised, removing identifiable information, including names and locations. Anonymised transcripts were uploaded into NVivo for qualitative data analysis.

### **Data analysis**

Data were analysed through inductive thematic analysis (Braun and Clarke 2006) to understand interviewee experiences and perspectives, with data-driven development of codes and themes. The analysis comprised re-reading each transcript to become familiar with the data and generation of initial codes through line-by-line or section-by-section coding, coding diversely without pre-conceived coding categories. The initial codes were then reviewed to identify broader themes, with all extracts for each theme collated and re-read. The initial themes were then reviewed, and themes and sub-themes revised to ensure they were internally coherent, consistent, distinctive, and accurately captured the dataset. Each sub-theme was analysed and interpreted, including with reference to existing literature. For each sub-theme, indicative quotations from a range of interviewees were selected to accurately illustrate each sub-theme. The analysis accompanying the quotations is recognised as the author's interpretation, acknowledging the role of any researcher in actively interpreting data (Braun and Clarke 2006; Charmaz 2006).

### **Research ethics**

The research received ethical approval from the author's university, with research ethics informed by best practices in research with trans communities, alongside best practices in research with children (ITHF, 2019; Lundy et al., 2011; Moore et al., 2018; Vincent, 2018). This included recognition of the harms of past pathologising research on trans children and efforts to avoid such pathologisation (Ansara and Hegarty 2012). Additional consideration was given to the ethics of inclusion of parental accounts, use of quotations, and use of terminology, as discussed below.

### ***Parental and child accounts***

This research aims to fill a critical knowledge gap, learning about trans children's experiences in paediatric gender clinics, listening to trans children directly, as well as listening to indirect reports and impressions via the parents who accompanied them to gender clinics sessions. The strengths and weaknesses of including parental accounts are acknowledged. Centring parental voices in trans youth narratives reinforces a history of cis-splaining, paternalism and cis-dominance that has shaped trans discourse, with implications on whose voices are listened to, and whose experiences and views are considered valid (Ashley 2020; Serano 2016; 2018). Trans youth are too often sidelined to a supporting role in their own story, with risk of parental over-simplification, miscommunication, and misunderstanding of trans youth experiences. Trans-antagonistic parental accounts continue to be used to validate pathologising and trans hostile concepts, like the recently coined "Rapid Onset Gender Dysphoria" (ROGD), a dis-

credited theory that appeals to non-supportive parents, that infantilises trans youth, and that is used to discourage support for trans adolescents (Ashley 2020; Restar 2020; Serano 2018; WPATH 2018).

While remaining cognizant of these significant concerns, parental accounts are nonetheless proposed as a valuable complementary data source, particularly for pre-pubertal trans children attending gender clinics, for reasons that are both practical and ethical. In terms of practicalities, the primary sample focused on parents of socially transitioned trans children. Parents of young trans children have significant trust and privacy concerns; accessing primary accounts from young trans children without first engaging with their parents would not have been possible for a majority of this sample, with many parents clearly wanting to understand the researcher's positionality and approach before engaging. Research with younger trans children without engaging via parents would have been challenging, with most young trans children isolated from wider trans communities. The sample's average current age is 11, range 6–16, and a majority of UK trans and LGB youth groups only support youth from 13+. Engaging with younger children without parental involvement would also have been practically difficult in terms of gaining parental consent for younger interviewees. Other considerations for starting with parental interviewees were ethical.

One ethical consideration was a duty of care to trans children's wellbeing. It was judged important to be aware in advance of children's current context in relation to healthcare, before interviewing on these topics. In the UK, a high proportion of this younger cohort face challenges and traumas in terms of access to healthcare, with ongoing trauma particularly acute at the time of this research. A majority of the children within this sample were directly impacted by the December 2020 Bell vs Tavistock verdict (de Vries et al. 2021), a legal case whose judgement and subsequent interpretation curtailed access to healthcare. The case had immediate and profound impacts on the children in this cohort, and, despite being overturned at appeal, its impacts are still in effect at time of writing.

Awareness of the profound distress caused by this case, and the acute fears and uncertainties surrounding access to essential healthcare, prompted me to adopt a cautious approach, interviewing parents alone first, and then discussing with parents whether they felt their child would benefit from speaking on the topic of pre-adolescent engagements with gender clinics. Several parents, with children in current distress struggling with the impacts of denial of healthcare, advised against interviews with their children while their dysphoria and distress was high. This adult gatekeeping, while admittedly paternalistic, was a decision taken to protect vulnerable children from distressing questions at a time when distress was already high. The author's positionality as a (nonbinary) parent of a pre-pubertal trans child likely influences this approach, having seen from a parent's viewpoint the past and ongoing challenges faced by my own trans child, and knowing (indirectly, to some limited degree) the emotional burden life in a cisnormative and cis-dominant world places on a young trans child's shoulders. Priority was given to avoiding this research being a potential trigger or additional emotional burden on those young trans children who were already dealing with multiple traumas. While some readers will doubtless disagree with this approach, it was in balance the approach selected, bearing in mind the current context of removal of essential healthcare.

A second ethical consideration concerned autonomy and coercion in research with trans children. My positionality as a parent of a trans child and active member of communities of parents of trans children has provided insights into the lack of autonomy, the coercion, and the control that trans children can experience in the UK. I placed a significant emphasis in conversations with parents on highlighting that my desired approach was to open a door to any children who wanted to speak with me, while taking pains to ensure there was no coercion or pressure, and with clarity that there would be no negative consequences of children not participating. A wide number of children within this sample did not opt in to being interviewed, with 10 out of 30 opting to be interviewed. This rate of engagement could be indication of lack of trust in the interviewer; it could equally be indication of the success of a non-coercive approach to research, with many children choosing other more enjoyable activities above participating in an academic interview.

A third ethical consideration for research with trans children was recognition of the harms of pathologisation and problematization. Through my positionality as a parent of a trans child, I am sensitive to the ways in which conversations related to gender or minority status can implicitly pathologise or problematise, especially where trans children receive scrutiny or questions that they are aware their cis peers do not. I wanted to avoid explicit or implicit problematisation in interviews with children, and this informed a child-driven interview approach that shifted away from a semi-structured interview approach to open listening to the topics trans children wanted to talk about. In particular, this entailed avoiding direct questioning on potentially traumatic topics, for example, experiences in gender clinics, unless the child chose to speak on that topic. The approach in this research was to provide space and opportunity for children to share their experiences where they wanted to, while creating space and legitimacy for them to not do so. While I introduced the background to the research at the start of the interview, the interviews focused on topics that the children wanted to talk about. For some children, this moved swiftly on to issues relating to being trans, to gender clinics, to schools, to healthcare. For other children, the conversation focused on subjects such as Pokémon or Roblox, which was an equally a positive outcome. While a majority of trans children did not choose to be interviewed, this was unsurprising, and confirmed the success of an opt in rather than opt out approach to research participation.

These ethical considerations will have reduced the quantity of data provided directly from trans children. Where children did not wish to be interviewed it was important to include insights from parents. In the UK, parents accompany pre-adolescent children to gender clinics, and can be a useful second-hand source of information on children's experiences in those sessions. The risk of parental accounts inappropriately representing trans children's experiences was reduced through a number of considerations: 1) parents spoke about what they saw and experienced themselves while accompanying their child at pre-pubertal child and parent sessions in UK gender clinics; 2) parents spoke about the conversations they had had with their child immediately after clinical sessions, reporting what their child had shared with them about the session; and 3) parents shared their own interpretation of impacts on their child. These parental accounts are particularly important where data would otherwise be missing. Limitations of this approach are revisited in the discussion section.

## *Quotations*

Research ethics influenced the way in which results are presented, in particular influencing the use of quotations. In qualitative literature, quotations are used to evidence the validity of findings, to illustrate and bring findings to life, and to demonstrate how findings emerge from the dataset (Denzin and Lincoln 2018). Trans children and families attending gender clinics have long experienced control, coercion, pathologisation, and harm—a harm that was easy to perpetuate while those in power both controlled who were able to access healthcare, and simultaneously controlled the narrative, including whose voices were heard within clinical and academic publications. The vast majority of accounts of paediatric gender clinic sessions are written by those in positions of power within those facilities (Pullen Sansfaçon et al. 2019). Trans children and their families' voices are rarely heard in clinical literature, and where their perspectives are included, they are framed and interpreted by those in power. Families of trans children are extremely limited in their ability to speak out about their experiences, needing to safeguard their children's right to privacy and safety, and being unable to critique those with direct power over their lives and their child's healthcare (Carlile 2020; Horton 2021).

This research went to lengths to build trust and ensure anonymity, enabling interviewees to speak up on their experiences. The author's positionality as a (nonbinary) parent of a trans child in several ways is a positive, helping building trust with a hard-to-reach cohort. The author's positionality also risks replicating the aforementioned challenges of those with more power interpreting the words of those with less power, recognising my own relative power as an adult and recognising my outsider status as someone who has not been a child attendee of a gender clinic. Informed by these considerations, the research adopts an approach of giving weight and space to interviewee words, presenting a larger than average number of direct quotations, and enabling readers the opportunity to hear directly from the children and families involved in this research. This is part of a research ethics commitment to a) redress the balance of whose voices are heard, challenging the dominance of clinician voices in this arena; b) fulfil a trust-based commitment to interviewees who wanted their voices to be heard, and for whom knowing they would be heard offered cathartic value; and c) recognize the intrinsic value in first person narratives.

## **Terminology**

This paper uses the term “trans child” throughout—a term that resonates with a majority of this sample. Trans youth, a term typically describing those aged 12–24, would omit and erase younger trans children, who make up the majority of this sample. There are instances where those on the upper age end of this sample might be better described as trans adolescents, teenagers, or youth. However, in a small sample, this distinction makes individuals within the cohort more identifiable. In this research, steps were taken to prioritise anonymity, including dis-attributing statements to specific interviewees. An additional consideration was respecting privacy between child and parent interviewees, with some children interviewed in knowledge of their parent, but in privacy from their parent. For this reason, anonymity was afforded precedence over use of more specific and potentially more appropriate terminology, using the term trans child throughout rather than specifying where an interviewee was a trans teen-



ager. Likewise, for the nonbinary children within this sample, use of a more specific descriptor of “nonbinary child,” would reduce anonymity between child participants, and therefore the term “trans child” is used as an umbrella term including children who describe their identity as trans and/or nonbinary.

## RESULTS

Three major themes are presented: 1) inappropriate assessment of gender; 2) trans children under pressure; and 3) distress and trauma in UK gender clinics. Each theme is explored in turn, illustrated with quotations from parents [P] and children [C].

### **Inappropriate assessment of gender**

The first theme encompasses parent and child perceptions of inappropriate assessment of trans children’s identities, with sub-themes on conflation of gender identity, expression, interests, and sexual orientation; and on the problematization of gender diversity.

#### *Conflation of gender identity, expression, interests, and sexual orientation*

The first sub-theme examines perceptions of a conflation of gender identity with gender expression, gendered interests, or sexual orientation, in clinical assessments. Parents and children interviewed in this research displayed a nuanced understanding of gender, distinguishing between gender identity, gender expression, and gender stereotypes. A number expressed surprise or frustration at gender clinicians conflating diverse aspects of gender. One parent was critical of assessments that asked about their child’s hobbies or hairstyle preferences:

Some of the assessments are troubling. They’re obsessed with the stuff and choices—which I just don’t think has really any real relation to your gender identity at all. Sports and hairstyles—I don’t think that has anything to do with who we are, I think that’s just what we enjoy. [P]

Another parent, described sessions where their trans child was asked detailed questions on their preferred gender expression:

Then my child would be given worksheets about gender expression... and, like, which of these stick figures with particular hairstyles and clothes do you most identify with. And so, you know, we were trying to stay really patient and calm. [P]

Both of the above examples highlight parental frustration at clinicians assessing gendered aspects of their child’s interests or presentation. A number of parents raised concerns that their child’s clinician seemed to hold stereotyped and outdated views on gender diversity.

As trans children in this cohort became slightly older, but still before the age of puberty, clinicians increasingly focused on a child’s sexual orientation. Parents in this sample were surprised to see clinicians questioning pre-pubertal trans children on sexual orientation. For example, one parent stated, “I mean, the obsession with sexuality is bizarre” [P]. One parent considered conflation of gender identity with sexual orientation as misplaced: “[Clinicians have said] you have to wait until you’re a teenager til you know who you’re sexually attracted to before you can decide who you are. And

like, I've called that out as bullshit" [P]. Other parents questioned the appropriateness of expecting pre-pubertal children to identify or articulate their sexual orientation, a task not demanded of cis children, nor indeed of cis adults, as articulated by this parent:

He [the clinician] said ...we'd need to understand his sexuality... [We couldn't start affirmative care] until we've definitely identified [Child's] sexuality. And I was like, whoa, wait a minute. I'm a grown woman. And I don't quite know exactly what box I'd want to tick. So why the hell are you asking him to pigeonhole? ...it's totally inappropriate. [P]

### *Problematization of gender diversity*

A second sub-theme considers problematization of gender diversity in children's engagements with gender services. The children in this cohort, socially transitioned and supported at home, engaged in assessments that stretched over many years. One child described gender clinic sessions as "awkward and boring" [C]. An 11-year-old who had been socially affirmed for many years, described it thus:

Often, I just think it's a bit pointless, because like, what is the aim of this, like to make sure that I'm definitely trans, because I know that. But you, kind of, like, need to do that, to like get hormone blockers and stuff, right? [C]

This 11-year-old found the process unnecessary and unhelpful. Parents of other trans children in this sample felt the same:

[Child] is like, what am I meant to talk to him about? Like, I've got nothing to talk about, like, do I tell him that I've been like skipping in the garden like ... shall we talk about [hobby]? And it's like, literally they have nothing to talk about. [P]

Another parent highlighted the undefined scope and lack of clarity on purpose of prolonged assessment:

We've been going since [Child] was 8, and he's 12. And it was only when I said, "How is the assessment coming along?" And they said, "Oh right, well, we need to have six appointments in order to do the assessment? And I said, "Well, what have we been doing all these years then?" And they couldn't really answer me. [P]

Parents described children with self-confidence and trans-positivity, who saw no problem in being trans, with such children seeing no purpose in clinical conversations about identity.

[Child] doesn't really understand what the point of her being there is. She just thinks she's gone for a chat. She doesn't feel a need to talk about her being transgender, because she doesn't really see it as an issue. [P]

Children and parents alike in this cohort were not clear why prolonged questioning was required, seeing this as an indication of entrenched problematization of gender diversity. Trans children themselves shared their frustration of having to explain their gender to (cis) clinicians who saw the world in very cisnormative and heteronormative terms. One child commented:

I'm pretty sure everybody working there is a cisgender heterosexual person, which is surprisingly normal for clinics that care for not cis-

gender not heterosexual people, which is kind of really scary. [C]

Another child felt adult clinicians were unenlightened and unqualified to understand or give advice to them, saying “I think my friends are better than counsellors. Yeah, they’d probably understand” [C]. Trans children questioned the assumption that clinicians they regarded as cis and straight would be at all qualified to talk to trans children about gender or identity or about the challenges of being trans in a cis-dominant world.

The findings across this theme highlight experiences of inappropriate assessment of gender, with children and families raising concerns about assessment of gender expression, interests, and sexual orientation. These findings align with literature on trans adults’ experiences, with examples of a need to simplify or perform a stereotyped gender to meet the expectations of cisnormative clinicians (Pearce, 2018; Vincent, 2020). Research has highlighted examples where trans adults deviating from a normative trans narrative faced additional scrutiny from clinicians, including potential denial of access to healthcare (Pearce, 2018; Riggs et al., 2019; Vincent, 2020), or past criticism of adult gender clinics categorising and (de)legitimising gender based on an individual’s sexual orientation (Pearce 2018). The findings examined here also echo experiences shared by trans teens in current UK gender services, who highlight areas of inappropriate assessment of gender (Carlile 2020).

### **Trans children under pressure**

The second major theme considers experiences of trans children being under pressure, with sub-themes on trans children forced to defend their interests and identities; “proving themselves” trans; enforced questioning; and children being assessed to an unknown standard, by clinicians who they did not trust.

#### *Trans children forced to defend their identities and interests*

The first sub-theme considers experiences of trans children placed under pressure, required to defend or justify their identity or interests. One parent shared an example, describing a gender clinic session with a then 7-year-old trans boy, a child who had asserted himself as a boy from a very young age, who at that time had been socially transitioned and affirmed as a boy for a year.

She took him next door, and was showing him videos of strong women, so women who did, you know, strong athletes or women who did very manly things, and was telling him that it was okay, he could still be a girl and do manly things. And did you know that you don’t have to—you don’t have to change your gender to do these things. [P]

The clinician undertook this in a room away from his parents, and they only learnt about it afterwards, when their son reported it back to them. The parent felt this approach was inappropriate for their child on a number of levels. For one, they felt it conveyed a clear message to their son that the clinician considered him to be a girl; there was no parallel discussion on the diverse ways in which boys can express themselves. The parent felt this invalidation from an authority figure was potentially harmful for their child. Secondly, the parent reported that their gentle child, who was uninterested in strength, found the clinician’s focus on strength or athleticism bewildering. The parent also perceived in the encounter an unspoken assumption: that a strong six- or

seven-year-old girl might find it easier to identify as a trans boy than a sporty girl. The parent felt this assumption displayed no understanding of the immense cisnormative and transphobic pressures on a young child, including often from parents, not to assert a trans identity. Overall, the encounter created a breakdown in trust, raising serious concerns amongst the parents, who thereafter refused to let the clinician see their son alone. The parent speculated that this clinician's approach could have a far greater negative impact on any trans children who were vulnerable, especially those facing rejection and dismissal from their family.

Other families reported clinicians challenging children to defend their hobbies, clothing or friends.

They'd ask how's your weekend, and she'd mention, you know, having a lightsaber battle in the garden with her brothers. And they would just jump on that. And she would say to them, but all of my friends who are girls play lightsabers, and Pokémon, and climb trees, why can't I? Why are you asking me about it? That doesn't mean I'm not a girl. And yet, that's what they were fixated on every time. [P]

This parental experience raises an important point: that trans children face clinician-directed scrutiny of their interests or hobbies in a manner that would not be accepted for cis children. Trans children were expected to perform gender, or to defend their gender, to an unknown and unmeetable standard. Another parent noted their daughter being challenged on her clothing choices: "They'd challenge her] if she was wearing jeans, despite the fact she was sat next to her cis mother in jeans" [P].

### *Proving yourself trans*

A second sub-theme relates to trans children being required to "prove themselves" trans. A majority of parents spoke about this theme, as exemplified by this parent: "It's always about to kind of prove that she's really trans" [P]. Another parent contrasted a "prove yourself" approach with the provision of emotional support: "Tavi [Tavistock Gender Clinic] aren't offering emotional support, because actually, that doesn't seem to be what their remit is. They seem to be about picking you apart and making sure that you prove yourself trans enough" [P]. Parents raised concern that a process centred primarily on assessing their child's identity was not beneficial to their child's wellbeing:

There's never been a focus on "We believe who you are. What are the things in your life that make it difficult? And how can we enable you to cope with those things better?" The stuff that would actually be helpful. None of that, none of that. [P]

Another parent described the identity assessment as debilitating for their child: "This combative 'prove yourself trans enough' approach... it's intensely debilitating to go through their process" [P]. Parents knew their child was being assessed on their transitude (Ashley 2018) and felt that any area of deviation from a stereotyped narrative of their affirmed gender, or any deviation from a stereotyped trans narrative, would be counted against them. A number of clinicians had expressed opinions that trans children who were friends with children of all genders, who enjoyed toys or activities that are enjoyed by a range of genders, or who did not dress in a stereotyped manner, were not likely to be 'really' trans.

Several trans children and parents also raised concern that clinicians expected a stereotyped narrative about gender dysphoria. One child commented: “Because I don’t have enough dysphoria, because I don’t act trans, or because whatever reason, they think is valid to invalidate someone” [C]. A number of clinicians challenged children on the legitimacy of their gender dysphoria, arguing that non-typical accounts of dysphoria would make them ineligible for future medical interventions. Clinicians challenged children if their dysphoria manifested in individualised ways, delegitimizing their experience if their dysphoria related to social dysphoria, or if their dysphoria related to future secondary sexual characteristics more than dysphoria with primary sexual characteristics.

### *Enforced questioning*

One parent referenced an expectation that their child would answer any and all questions put to them: “I think he would say that he feels that he has to” [P]. One parent expressed frustration at her child being expected to answer questions in a clinical context on topics that would not be expected of cis children:

But it’s the clunkiness of the way that they do things like that. The fact that they feel that that is appropriate. I think any other child, you know, a cis child, being expected to sit with someone that they’ve met a couple of times, or maybe never met before, and be asked those kinds of questions. [P]

Another aspect of pressure noted by parents, was a tendency for clinicians to return to the same questions appointment after appointment, with parents making a comparison to interrogation. Parents felt that discussions were shaped by the topics that clinicians felt children needed to be pushed on, not driven by the challenges children wanted to talk about, as shared by one parent:

Every time it was that push with them, having that conversation, well, you know, you’ve got a friend, why don’t you tell your friend. You know, he sounds like a really good friend, I’m sure he’d be fine with it. And you know, [Child] having to defend his right to not say anything. [P]

A parent summarised the approach of returning to questions where a clinician was dissatisfied with a child’s answer as “like torture. Drip, drip, drip” [P]. Parents pointed out that their cis children, and cis children in general, are not pushed so hard to answer (repeated) questions in such a clinical encounter.

### *Assessment to an unknown standard, by clinicians who they did not trust*

A fourth sub-theme, was children being assessed to an unknown and unclear standard, by strangers with whom they did not have a trusted relationship. Several children found the experience of being expected to talk about sensitive and personal topics with adults who were complete strangers both invasive and emotionally exposing. In a large number of cases, clinicians changed frequently, due to the high staff turnover in UK children’s gender clinics, and children were expected to open up on demand to new clinicians who were complete strangers, who had not earned their trust. These sessions were likely to repeat ground that children had already faced questioning on from earlier clinicians. One child commented: “There were two people I was talking to, and they were both strangers, I didn’t know them... I don’t really want to talk about being

trans to complete strangers” [C]. Parents talked about the additional challenges and stresses on children who could not open up in clinical interviews. One parent spoke of the pressure on their autistic child to speak openly in front of strangers:

There’s additional stress with her being autistic. The expectation that she should be able to talk very openly. I mean, for any young person, to talk really openly to strangers about something as intimate as their body and their gender identity... [P]

Parents felt that clinical encounters were insufficiently child-friendly, with children expected to speak in situations where they were uncomfortable. A parent described clinicians with little understanding, or little care, of the need for a child-friendly safe environment:

[Child would have their teddy] cuddling it, or sit on my lap, and [the clinician would say,] “Why you sitting on—you don’t need to sit on your mum’s lap. Go on, get off your mum’s lap. Go sit on your own chair. You don’t need your teddy. Put your teddy bear away.” And I just think, do you know what? He’s [age], you’re taking him to a really strange place, and you’re asking him all these questions. And he’s a child. I think that’s where the relationship that was supposed to have been built didn’t happen. Because it was very judgmental. [P]

The topic of trust was raised by a number of interviewees, both parents and children, with children’s trust in their clinicians decreasing over time. Children who disliked and distrusted their clinicians were expected to continue engaging with the service or face withdrawal of eligibility to access healthcare at puberty. As one child said, “I have zero trust in Sandyford [Gender Clinic] whatsoever. And I would say that to their faces” [C]. A parent concurred: “I’ve said that really clearly to them: she doesn’t trust you. You’ve lost all her trust” [P].

The findings across this theme highlight experiences of pressure in clinical interactions, with children pushed to defend their interests, children expected to prove their transitude, children feeling forced to answer (repeated) questions, and children being assessed to unknown standards by clinicians who they did not trust. These findings align with wider literature on experiences of coercion and control in trans healthcare, as well as literature on trans normativity in psychology, and the persistence of a stereotyped trans narrative (Pearce, 2018; Riggs et al., 2019; Vincent, 2020).

### **Distress and trauma in UK gender clinics**

The final theme in the dataset was trans children experiencing distress and trauma in pre-pubertal gender clinic assessments. A number of parents described their child finding sessions traumatic or upsetting. One parent referenced that repeated distress and trauma resulted in their child completely refusing to engage: “She was five and a half when we first went. I think between five and a half and nine, we went six monthly. ... It was so traumatic. ... The last few sessions [Child] refused to engage with them at all” [P]. Parents described a pattern of distressing sessions: “We know coming out of it, probably one or both of us is going to cry. ... Something’s going to be upsetting. Or something really stupid is going to be said or asked of us” [P]. Other parents used emphatic language to describe their child’s dislike of the gender clinic. As one said, “[Child] won’t leave me. She hates being there” [P]. And another: “We still unfortunately

have got the same therapist now who [Child] absolutely hates with a passion. ... She's very judgmental" [P].

Parents also referenced their child's need to recover emotionally after each session. As one said, "It always takes it out of her emotionally. She always goes very quiet. ... It's very draining, the appointments. ... They are a bit of an endurance test. I can't say we ever look forward to them" [P]. Another expressed similar experiences: "On the way home, we would rant about how awful it had been. Because it was so unpleasant, and get it all out of our system. It's quite a long drive, so it was sufficient time" [P]. One child commented similarly: "[After a gender clinic session] I used to feel neutral, now I feel worse" [C]. A parent described gender clinic sessions having a significant negative impact on their child: "It was an emotional unpicking of who she was. It's never been therapeutic for her. It's always caused massive fallout. The build-up before and after appointments have been some of our most stressful periods" [P].

A number of interviewees described children feeling compelled to answer questions they found uncomfortable or inappropriate. One child emphasised: "[Sessions are upsetting] when we talk about genitals and bodies" [C]. A number of parents emphasised the distress their children displayed when forced to talk about their bodies in ways that made them uncomfortable, with no clear rationale for putting children through such questioning. One parent, themselves experienced in working with vulnerable children, found their child being questioned on underwear inappropriate"

So, when he was like, okay, so what pants are you wearing today? I was like, my whole kind of like, all of my safeguarding training and all that kind of stuff like just pricked of like, how dare you sit and ask my child about their underwear? Like, why is that appropriate? Why has it got anything to do with you? [P]

Other parents noted their child being asked intrusive and distressing questions about their body. For instance, one parent reported their child being told "we've got to talk about your genitalia. We've got to talk about do you touch them in the shower or not when you're cleaning" [P]. Another parent emphasised that trans children are routinely put through questioning that would not be accepted outside of a gender clinic:

That's a traumatic experience. Like, if that was any other stranger. You'd be calling the police. You wouldn't just be going, oh, yeah, we've got to do this. And we're gonna have to tolerate it because we want to get support. It's disgusting. It really is disgusting. [P]

A majority of interviewees described incidents of trauma, distress and discomfort; yet trans children were presented with few options to enable them to disengage from harmful processes, distressing questioning, or toxic individuals. Several parents speculated on the harm embedded in a system that taught trans children to endure poor or abusive treatment. One child summarised their experience of powerlessness and intimidation: "Of course, I'm intimidated by them. They're terrifying. They have all this power to control my life. Who wouldn't be scared of that?" [C].

These accounts of how trans children in the UK experience engagements with gender clinics bring to mind literature from those who attended, and were harmed by, children's gender clinics in past decades (Bryant, 2006). Bryant wrote of his experiences many years afterwards, whereas this research enables at least some insights into how trans children in the UK are experiencing gender clinics in the present.

## DISCUSSION

The themes emerging from the dataset highlight a range of concerns trans children and their parents have with current paediatric gender clinics in the UK, namely the sole NHS children's gender clinic for England and Wales (GIDS at the Tavistock) and the sole children's gender clinic for Scotland (Sandyford). Interviewees raised concerns on the what they saw as an inappropriate focus on broad aspects associated with gender, including clothing preferences, hobbies, toys, and hairstyles. Interviewees perceived these questions as outdated, stereotyped, and unrelated to trans children's needs. Trans children were put under pressure, challenged on their identity and interests, and left feeling the need to prove themselves and their identity. Trans children were expected and required to answer questions from strangers to pass an unknown assessment standard. Children were expected to do this in stressful environments, where they were expected to open up and answer any and all questions, regardless of their relevance, appropriateness, or the child's comfort. Interviewees highlighted a range of examples of distress or trauma, with trans children finding pre-adolescent assessments upsetting, invalidating, or harmful. Areas of questioning that would not be accepted for cis children, including on bodies, on sexuality, on clothing, and on hobbies or interests, appeared standard for trans children.

A cross cutting issue that is not directly explored in this paper is the power dynamic between UK paediatric gender clinics and trans children. Many parents within this sample spoke of the potential consequences of disengagement from the gender service, mentioning a wide range of potential repercussions for a trans child and their family, including potential social services involvement, potential problems with schools and GPs, and potential custody issues for children in separated families, alongside an ever-present fear of denial of access to NHS medical care at puberty. These issues are further explored in a separate paper (Horton, forthcoming). Trans children and families were forced to choose between accepting harmful prolonged assessments, assessments that spread across many years without end, or risking the uncertainties associated with disengagement from paediatric gender services. This power dynamic between gender clinicians and trans children places the aforementioned experiences of harm into a broader context of cis-dominance over trans children.

The above insights into UK pre-pubertal children's gender services reveals a system that is not centring the wellbeing of trans children. The service prioritises an extended assessment of trans children's identities, with a greater emphasis on assessing hobbies, expression, or interests, than on listening to and affirming trans children's self-conception. Extended coercive assessments reduce trust between child and clinician, with clinicians appearing uninterested in supporting trans children in the areas where they might be struggling, such as dealing with cisnormativity or transphobia. The approaches highlighted above suggest a continued problematisation of childhood gender diversity—after all, cis children are not required to attend gender clinics to have their hobbies, interests, or identities scrutinised. This continued problematisation of childhood gender diversity appears to run counter to recent global developments, in particular the de-pathologisation of gender diversity as endorsed by the World Health Organisation in ICD-11 (World Health Organisation 2018). The UK's approach also runs counter to a growing body of research on supporting trans children's wellbeing. Research emphasises the importance of family support (Katz-Wise



et al. 2018; Simons et al. 2013; Travers, Bauer, and Pyne 2012), the protective value of use of affirmed name (Pollitt et al. 2019; Russell et al. 2018), and the importance of reducing gender minority stress (Tan et al., 2020; Tan et al., 2021; Veale et al., 2017; Watson and Veale, 2018). There is no evidence that extended identity assessment enhances trans children's wellbeing, prompting questions on its place in modern, de-pathologised healthcare for trans children. The UK would do well to draw lessons from health services across the globe who have committed to depathologisation of trans children, providing child-centred affirmative care for trans children of all ages.

### **Implications for practice**

This research extends previous literature in useful ways, providing parent and child perspectives on trans children's interactions with gender clinics in pre-adolescence. The themes described in this paper paint a picture of a children's gender service that does not centre trans children's wellbeing. This has implications for a wide range of actors, in the UK and globally. For those currently reviewing children's gender services, this research provides evidence of harm and evidence of outdated, stereotyped, and pathologised approaches to childhood gender diversity. The insights presented here raise important questions on how fit for purpose the current system in the UK is for trans children. Lessons can be learnt from gender services in other countries that take an affirmative approach, embracing rather than problematising childhood gender diversity (AusPATH 2021; Endocrine Society and Pediatric Endocrine Society 2020; Murchison et al. 2016; Oliphant et al. 2018; Rafferty et al. 2018; Telfer et al. 2018).

For clinicians currently working within UK children's gender services, this research provides child and parental perspectives on the experience of attending pre-pubertal assessments. Ethical and child-centred clinicians can learn from these accounts and adjust their care accordingly. For those involved in governance, leadership and review of the UK's approach to paediatric care for trans children, these accounts demonstrate the harms built into the status quo, and the critical need for reform. This research highlights the distance UK paediatric gender services need to travel to deliver modern, depathologised healthcare for trans children, as necessitated under ICD-11.

For parents supporting younger trans children, and for trans children and adolescents, this research highlights poor experiences in children's gender clinics. Trans-positive families and supported trans children might take strength from these accounts to challenge cisnormative or transphobic clinical practices. This research may help parents and children consider in advance and communicate to clinicians what they consider appropriate or inappropriate areas of questioning in clinical engagements with younger trans or gender diverse children. For authority figures interacting with trans children and families, including social services, Child and Adolescent Mental Health Services (CAMHS), primary care practitioners (GPs), and schools, this research may provide useful insights into the problems within children's gender clinics, and the reasons some children and families may wish to disengage.

### **Limitations**

One limitation of this research is the inclusion of parental accounts alongside child accounts. Parental contributions may be shaped by parental and, at times, cisnormative framing, with a risk of parents misunderstanding, misrepresenting, or misinterpret-

ing their child's experience. Parental accounts are also limited by parents only being able to share the experiences that they witnessed, or the experiences, emotions and impacts that their children were willing to share or reveal to their parent.

A second limitation is that the experiences captured in this sample centre on trans children who have socially transitioned under the age of eleven and children who, to differing degrees, have found support and trans-positivity at home, with affirmation from at least one parent. A number of parents in this sample had taken proactive steps to reduce harm, such as offering solidarity in joint de-stressing conversations after harmful appointments; preventing their child from being left alone with trans-negative clinicians; and challenging clinicians on inappropriate questions. Several families had entirely disengaged from NHS gender services in an attempt to protect their child's well-being and self-esteem. Even with parental support, trans children in this sample described gender clinicians as "terrifying" in the power they wield over trans children. This study cannot, however, draw any conclusions on how trans children with less parental support, or trans children in hostile and abusive homes, are impacted by engagements with paediatric gender clinics.

## CONCLUSION

This research has provided unique and important insights into recent and ongoing practices in children's gender clinics in the UK. Trans children and their parents shared examples of the harms, injustice and trauma imbedded in the current system. These children's and parental accounts raise important questions on the purpose, benefits and harms of the current UK system. The current system prioritises extended clinical assessment and problematisation of childhood gender diversity, an approach that sits uneasily alongside recent global health commitments to de-pathologisation of gender diversity (World Health Organisation 2018). As other health services across the globe build upon existing commitments to child-centred affirmative care for trans children of all ages, the UK risks being left further behind, with trans children bearing the cost.

## REFERENCES

- Akkermans, Rebecca. 2018. "The UK Gender Identity Clinic for Young People." *The Lancet Child & Adolescent Health* 2 (12): 851. [https://doi.org/10.1016/S2352-4642\(18\)30347-X](https://doi.org/10.1016/S2352-4642(18)30347-X).
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association.
- American Psychological Association. 2021. "APA Resolution on Gender Identity Change Efforts." [https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf?fbclid=IwAR2\\_wnhOS29PPkopoMraFYPUiIBxfFLI9R-13cAwHaDRHKBKojfJe70o4MO4](https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf?fbclid=IwAR2_wnhOS29PPkopoMraFYPUiIBxfFLI9R-13cAwHaDRHKBKojfJe70o4MO4).
- Ansara, Y. Gavriel, and Peter Hegarty. 2012. "Cisgenderism in Psychology: Pathologising and Misgendering Children from 1999 to 2008." *Psychology & Sexuality* 3 (2): 137–60. <https://doi.org/10.1080/19419899.2011.576696>.
- Ashley, Florence. 2018. "Don't Be so Hateful: The Insufficiency of Anti-Discrimination and Hate Crime Laws in Improving Trans Well-Being." *University of Toronto Law*

- Journal* 68 (1): 1–36. <https://doi.org/10.3138/utlj.2017-0057>.
- Ashley, Florence. 2019a. “Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth.” *Clinical Child Psychology and Psychiatry* 24 (2): 223–36. <https://doi.org/10.1177/1359104519836462>.
- Ashley, Florence. 2019b. “Watchful Waiting Doesn’t Mean No Puberty Blockers, and Moving Beyond Watchful Waiting.” *The American Journal of Bioethics* 19 (6): W3–4. <https://doi.org/10.1080/15265161.2019.1599466>.
- Ashley, Florence. 2020. “A Critical Commentary on ‘Rapid-Onset Gender Dysphoria.’” *The Sociological Review* 68 (4): 779–99. <https://doi.org/10.1177/0038026120934693>.
- Ashley, Florence. 2022. *Banning Transgender Conversion Practices*. Vancouver, Canada: UBC Press.
- AusPATH. 2021. “Public Statement on Gender Affirming Healthcare, Including for Trans Youth.” <https://auspath.org/gender-affirming-healthcare/>.
- Braun, Virginia, and Victoria Clarke. 2006. “Using Thematic Analysis in Psychology.” *Qualitative Research in Psychology* 3 (2): 77–101. <https://doi.org/10.1191/1478088706qp0630a>.
- Bryant, Karl. 2006. “Making Gender Identity Disorder of Childhood: Historical Lessons for Contemporary Debates.” *Sexuality Research & Social Policy* 3 (3): 23–39. <https://doi.org/10.1525/srsp.2006.3.3.23>.
- Bryant, Karl. 2007. “The Politics of Pathology and the Making of Gender Identity Disorder.” PhD diss. University of California, Santa Barbara.
- Carlile, Anna. 2020. “The Experiences of Transgender and Non-Binary Children and Young People and Their Parents in Healthcare Settings in England, UK: Interviews with Members of a Family Support Group.” *International Journal of Transgender Health* 21 (1): 16–32. <https://doi.org/10.1080/15532739.2019.1693472>.
- Carlile, Anna, Ethan Butteriss, and Annie Pullen Sansfaçon. 2021. “‘It’s like My Kid Came Back Overnight’: Experiences of Trans and Non-Binary Young People and Their Families Seeking, Finding and Engaging with Clinical Care in England.” *International Journal of Transgender Health*. <https://doi.org/10.1080/26895269.2020.1870188>.
- Charmaz, K. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage.
- Children’s Right Alliance for England. 2016. “Children Speak out on Transgender Issues.” Longon UK: Children’s Right Alliance. [http://www.crae.org.uk/media/118087/CRAE-BULLETIN\\_TRANS\\_FINAL.pdf](http://www.crae.org.uk/media/118087/CRAE-BULLETIN_TRANS_FINAL.pdf).
- Davy, Zowie, and Michael Toze. 2018. “What Is Gender Dysphoria? A Critical Systematic Narrative Review.” *Transgender Health* 3 (1): 159–69. <https://doi.org/10.1089/trgh.2018.0014>.
- Denzin, Norman, and Yvonna Lincoln, eds. 2018. *The SAGE Handbook of Qualitative Research*. 5th ed. LA: SAGE Publications Inc.
- Durwood, Lily, Léila Eisner, Kaitlyn Fladeboe, Chonghui Gabriella Ji, Samantha Barney, Katie A. McLaughlin, and Kristina R. Olson. 2021. “Social Support and Internalizing Psychopathology in Transgender Youth.” *Journal of Youth and Adolescence*. <https://doi.org/10.1007/s10964-020-01391-y>.
- Durwood, Lily, Katie A. McLaughlin, and Kristina R. Olson. 2017. “Mental Health and Self-Worth in Socially Transitioned Transgender Youth.” *Journal of the*

- American Academy of Child and Adolescent Psychiatry* 56 (2): 116–123.e2. <https://doi.org/10.1016/j.jaac.2016.10.016>.
- Ehrensaft, Diane. 2012. “From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy.” *Journal of Homosexuality* 59 (3): 337–56. <https://doi.org/10.1080/00918369.2012.653303>.
- Ehrensaft, Diane. 2020. “Treatment Paradigms for Prepubertal Children.” In *Pediatric Gender Identity: Gender-Affirming Care for Transgender & Gender Diverse Youth*, edited by Michelle Forcier, Gerrit Van Schalkwyk, and Jack L. Turban, 171–85. Cham: Springer International Publishing. [https://doi.org/10.1007/978-3-030-38909-3\\_13](https://doi.org/10.1007/978-3-030-38909-3_13).
- Endocrine Society, and Pediatric Endocrine Society. 2020. “Transgender Health.” [https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position\\_statement\\_transgender\\_health\\_pes.pdf](https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position_statement_transgender_health_pes.pdf).
- Fast, Anne A., and Kristina R. Olson. 2018. “Gender Development in Transgender Preschool Children.” *Child Development* 89 (2): 620–37. <https://doi.org/10.1111/cdev.12758>.
- Gill-Peterson, J. 2018. *Histories of the Transgender Child*. Minneapolis, IL: University of Minnesota Press.
- Horton, Cal. 2021. “‘It Felt like They Were Trying to Destabilise Us’: Parent Assessment in UK Children’s Gender Services.” *International Journal of Transgender Health*. <https://doi.org/10.1080/26895269.2021.2004569>.
- ITHF. 2019. “Transgender Research Informed Consent (TRICON) Disclosure Policy.” Facebook Site. *International Transgender Health Forum*. <https://www.facebook.com/groups/transgenderhealth>.
- Katz-Wise, Sabra L., Diane Ehrensaft, Ralph Vettters, Michelle Forcier, and S. Bryn Austin. 2018. “Family Functioning and Mental Health of Transgender and Gender-Nonconforming Youth in the Trans Teen and Family Narratives Project.” *Journal of Sex Research* 55 (4–5): 582–90. <https://doi.org/10.1080/00224499.2017.1415291>.
- Keo-Meier, Colton, and Diane Ehrensaft. 2018. *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children*. Washington, DC: American Psychological Association.
- Klein, Augustus, and Sarit A. Golub. 2016. “Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults.” *LGBT Health* 3 (3): 193–99. <https://doi.org/10.1089/lgbt.2015.0111>.
- Kuvalanka, Katherine A., and Cat Munroe. 2021. “Parenting of Trans Children.” In *The SAGE Encyclopedia of Trans Studies*, edited by A. Goldberg and G. Beemyn, Vol. 2, 597–601. Thousand Oaks: Sage. <https://doi.org/10.4135/9781544393858>.
- Kuvalanka, Katherine A., Judith L. Weiner, and Derek Mahan. 2014. “Child, Family, and Community Transformations: Findings from Interviews with Mothers of Transgender Girls.” *Journal of GLBT Family Studies* 10 (4): 354–79. <https://doi.org/10.1080/1550428X.2013.834529>.
- Lundy, Laura, Lesley McEvoy, and Bronagh Byrne. 2011. “Working With Young Children as Co-Researchers: An Approach Informed by the United Nations Convention on the Rights of the Child.” *Early Education and Development* 22 (5):

- 714–36. <https://doi.org/10.1080/10409289.2011.596463>.
- Moore, Tim P, Morag McArthur, and Debbie Noble-Carr. 2018. “More a Marathon than a Hurdle: Towards Children’s Informed Consent in a Study on Safety.” *Qualitative Research* 18 (1): 88–107. <https://doi.org/10.1177/1468794117700708>.
- Murchison, Gabe, Deanna Adkins, Lee Ann Conard, R Ph, Diane Ehrensaft, Timothy Elliott, Linda A Hawkins, et al. 2016. “Supporting & Caring for Transgender Children.” Human Rights Campaign. <https://www.hrc.org/resources/supporting-caring-for-transgender-children/>.
- O’Brien, Bridget C., Ilene B. Harris, Thomas J. Beckman, Darcy A. Reed, and David A. Cook. 2014. “Standards for Reporting Qualitative Research: A Synthesis of Recommendations.” *Academic Medicine* 89 (9): 1245–51. <https://doi.org/10.1097/ACM.0000000000000388>.
- Oliphant, J, J. Veale, J Macdonald, R Carroll, R Johnson, M Harte, C Stephenson, and J Bullock. 2018. “Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand.” Hamilton, New Zealand: Transgender Health Research Lab, University of Waikato. <https://researchcommons.waikato.ac.nz/handle/10289/12160>.
- Olson, Kristina R., Lily Durwood, Madeleine DeMeules, and Katie A. McLaughlin. 2016. “Mental Health of Transgender Children Who Are Supported in Their Identities.” *Pediatrics* 137 (3): e20153223. <https://doi.org/10.1542/peds.2015-3223>.
- Olson, Kristina R., Aidan C. Key, and Nicholas R. Eaton. 2015. “Gender Cognition in Transgender Children.” *Psychological Science* 26 (4): 467–74. <https://doi.org/10.1177/0956797614568156>.
- Pearce, Ruth. 2018. *Understanding Trans Health: Discourse, Power and Possibility*. Bristol, UK: Policy Press.
- Pearce, Ruth. 2020. “A Methodology for the Marginalised: Surviving Oppression and Traumatic Fieldwork in the Neoliberal Academy.” *Sociology* 54 (4): 806–24. <https://doi.org/10.1177/0038038520904918>.
- Pollitt, Amanda M., Salvatore Ioverno, Stephen T. Russell, Gu Li, and Arnold H. Grossman. 2019. “Predictors and Mental Health Benefits of Chosen Name Use Among Transgender Youth.” *Youth & Society*. <https://doi.org/10.1177/0044118X19855898>.
- Pullen Sansfaçon, Annie, William Hébert, Edward Ou Jin Lee, Maxime Faddoul, Dalia Tourki, and Céline Bellot. 2018. “Digging beneath the Surface: Results from Stage One of a Qualitative Analysis of Factors Influencing the Well-Being of Trans Youth in Quebec.” *International Journal of Transgenderism* 19 (2): 184–202. <https://doi.org/10.1080/15532739.2018.1446066>.
- Pullen Sansfaçon, Annie, Denise Medico, Damien Riggs, Anna Carlile, and Frank Suerich-Gulick. 2021. “Growing up Trans in Canada, Switzerland, England, and Australia: Access to and Impacts of Gender-Affirming Medical Care.” *Journal of LGBT Youth*. <https://doi.org/10.1080/19361653.2021.1924918>.
- Pullen Sansfaçon, Annie, Julia Temple-Newhook, Frank Suerich-Gulick, Stephen Feder, Margaret L. Lawson, Jennifer Ducharme, Shuvo Ghosh, and Cindy Holmes. 2019. “The Experiences of Gender Diverse and Trans Children and Youth Considering and Initiating Medical Interventions in Canadian Gender-Affirming Speciality Clinics.” *International Journal of Transgenderism* 20 (4):

- 371–87. <https://doi.org/10.1080/15532739.2019.1652129>.
- Rafferty, Jason, Committee on Psychosocial Aspects of Child and Family Health, Committee On Adolescence, and Section on Lesbian, Gay, Bisexual and Transgender Health and Wellness. 2018. “Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents.” *Pediatrics* 142 (4). <https://doi.org/10.1542/peds.2018-2162>.
- Restar, Arjee Javellana. 2020. “Methodological Critique of Littman’s (2018) Parental-Respondents Accounts of ‘Rapid-Onset Gender Dysphoria.’” *Archives of Sexual Behavior* 49 (1): 61–66. <https://doi.org/10.1007/s10508-019-1453-2>.
- Riggs, D. W., R. Pearce, C. A. Pfeffer, S. Hines, F. White, and E. Ruspini. 2019. “Trans-normativity in the Psy Disciplines: Constructing Pathology in the Diagnostic and Statistical Manual of Mental Disorders and Standards of Care.” *American Psychologist*, 74 (8): 912–924. <https://doi.org/10.1037/amp0000545>.
- Roche, Juno. 2020. *Gender Explorers: Our Stories of Growing Up Trans and Changing the World*. London, UK: Jessica Kingsley Publishers.
- Russell, Stephen T., Amanda M. Pollitt, Gu Li, and Arnold H. Grossman. 2018. “Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth.” *The Journal of Adolescent Health* 63 (4): 503–5. <https://doi.org/10.1016/j.jadohealth.2018.02.003>.
- Serano, Julia. 2016. *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. 2nd ed. Berkeley, CA: Seal Press.
- Serano, Julia. 2018. “Everything You Need to Know about Rapid Onset Gender Dysphoria.” *Medium*, August 22. <https://medium.com/@juliaserano/everything-you-need-to-know-about-rapidonset-gender-dysphoria-1940b8afdeba>.
- Simons, Lisa, Sheree M. Schrage, Leslie F. Clark, Marvin Belzer, and Johanna Olson. 2013. “Parental Support and Mental Health among Transgender Adolescents.” *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine* 53 (6): 791–93. <https://doi.org/10.1016/j.jadohealth.2013.07.019>.
- Substance Abuse and Mental Health Services Administration. 2015. “Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth.” Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Tan, Kar Hou Kyle, Gareth Treharne, Sonja Ellis, Johanna Schmidt, and Jaimie Veale. 2020. “Gender Minority Stress: A Critical Review.” *Journal of Homosexuality* 67: 1471–89. <https://doi.org/10.1080/00918369.2019.1591789>.
- Tan, Kyle K. H., Gareth J. Treharne, Sonja J. Ellis, Johanna M. Schmidt, and Jaimie F. Veale. 2021. “Enacted Stigma Experiences and Protective Factors Are Strongly Associated with Mental Health Outcomes of Transgender People in Aotearoa/ New Zealand.” *International Journal of Transgender Health* 22 (3): 269–80. <https://doi.org/10.1080/15532739.2020.1819504>.
- Telfer, M. M., M. A. Tollit, C. C. Pace, and K. C. Pang. 2018. “Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents.” Melbourne: The Royal Children’s Hospital. <https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf>.
- Tosh, Jemma. 2011. “‘Zuck Off!’ A Commentary on the Protest Against Ken Zucker and

- His ‘Treatment’ of Childhood Gender Identity Disorder.” *Psychology of Women Section Review* 13 (1): 10–6.
- Travers, R., Greta Bauer, and Jake Pyne. 2012. “Impacts of Strong Parental Support for Trans Youth: A Report Prepared for Children’s Aid Society of Toronto and Delisle Youth Services.” *Trans Pulse*, October 2. <https://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf>.
- Turban, Jack L., and Diane Ehrensaft. 2018. “Gender Identity in Youth: Treatment Paradigms and Controversies.” *Journal of Child Psychology and Psychiatry* 59 (12): 1228–43. <https://doi.org/10.1111/jcpp.12833>.
- UN Human Rights Council. 2020. “Practices of So-Called ‘Conversion Therapy’: Report of the Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity.” [https://doi.org/10.1163/2210-7975\\_HRD-9970-2016149](https://doi.org/10.1163/2210-7975_HRD-9970-2016149).
- Veale, Jaimie F., Tracey Peter, Robb Travers, and Elizabeth M. Saewyc. 2017. “Enacted Stigma, Mental Health, and Protective Factors Among Transgender Youth in Canada.” *Transgender Health* 2 (1): 207–16. <https://doi.org/10.1089/trgh.2017.0031>.
- Vincent, Ben. 2018. “Studying Trans: Recommendations for Ethical Recruitment and Collaboration with Transgender Participants in Academic Research.” *Psychology & Sexuality* 9 (2): 102–16. <https://doi.org/10.1080/19419899.2018.1434558>.
- Vincent, Ben. 2020. *Non-Binary Genders: Navigating Communities, Identities, and Healthcare*. Bristol, UK: Policy Press.
- Vries, Annelou L. C. de, Christina Richards, Amy C. Tishelman, Joz Motmans, Sabine E. Hannema, Jamison Green, and Stephen M. Rosenthal. 2021. “Bell v Tavistock and Portman NHS Foundation Trust [2020] EWHC 3274: Weighing Current Knowledge and Uncertainties in Decisions about Gender-Related Treatment for Transgender Adolescents.” *International Journal of Transgender Health*. <https://doi.org/10.1080/26895269.2021.1904330>.
- Watson, Ryan J., and Jaimie Veale. 2018. “Transgender Youth Are Strong: Resilience among Gender Expansive Youth Worldwide.” *International Journal of Transgenderism* 19 (2): 115–18. <https://doi.org/10.1080/15532739.2018.1474832>.
- Williams, C. 2017. “DiscoSexology Part V: An Interview with Zucker’s Patient.” *TransAdvocate*, February 2. [https://www.transadvocate.com/part-v-interview-with-zuckers-patient-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy\\_n\\_19727.htm](https://www.transadvocate.com/part-v-interview-with-zuckers-patient-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy_n_19727.htm).
- World Health Organisation. 2018. “International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision).” <https://icd.who.int/browse11/l-m/en>.
- World Medical Association. 2013. “World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects.” *JAMA* 310 (20): 2191. <https://doi.org/10.1001/jama.2013.281053>.
- WPATH. 2018. “WPATH Position on Rapid-Onset Gender Dysphoria.” [https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/9\\_Sept/WPATH%20Position%20on%20Rapid-Onset%20Gender%20Dysphoria\\_9-4-2018.pdf](https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/9_Sept/WPATH%20Position%20on%20Rapid-Onset%20Gender%20Dysphoria_9-4-2018.pdf).

## **ACKNOWLEDGEMENTS**

Thank you to Will, to my PhD supervisors Anna and Sheryl, and to all the children, adolescents, and parents who shared their experience.