Treatment Paradigms for Prepubertal Children

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Introduction

A parent places a call to a mental health gender specialist recommended by the child's pediatrician. Alex, their five-year-old child, has been playing with dolls and imagining himself to be a famous ballerina since the age of three. The parents have both been fine with this, believing that children should not be bound by gender norms in what they do and what roles they imagine themselves taking. Recently, however, the parents have run into a snag with Alex. He is about to start kindergarten and has grown increasingly anxious as the fall semester grows near. He expresses no worries about leaving home or facing the academic expectations in grade school. Rather, Alex breaks down sobbing that he will no longer be able to play with his dolls and his tutus, that everyone will always think he's a boy, but he thinks maybe he's actually a girl. For the next week, he vacillates between listless ennui and anxious agitation. He finds himself better able to articulate more of his upset: he does not like his body, particularly his penis; he wishes he could trade it in for a vagina; he only likes to play with girls; children in his preschool had started teasing him for liking "girl" things; he wants to grow up and be able to get pregnant and be a mommy. The tipping point for Alex's parents came when he moaned that he wished he had never been born and that he wanted to die because he was a strange kind of boy who wanted to change into a girl. The parents' growing concern prompted the call to Alex's pediatrician.

This vignette is just one variation on a theme that would bring parents to seek out psychological services for a child who is demonstrating gender stress or distress, meaning the anxiety, discomfort, or confusion emanating from the child's present gender status or explorations. The impetus for treatment might come from the parents or family, the child's school, the primary care physician, or the child. The stress or distress may be related to the child's gender identity, the child's gender

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expressions, or both. The discomfort may be situated in the child's body, psyche, relations with the outside world, or any combination thereof. Alternatively, the child may be feeling just fine, but the parents grow worried about their child's seeming gender confusion or refusal to abide by societal gender norms. Whatever the domain or locus of concern, if working within a gender affirmative approach, the treatment goal will remain the same: to promote the child's gender health, defined as the opportunity for the child to live in the gender that feels most authentic and comfortable for that child [11, 12, 17]. As no child is an island, this treatment goal will be accomplished only by taking into account the child, the family, and the social environment in which that child resides.

Until very recently, knowledge about the treatment of children who digressed from gender expectations or norms was limited to modalities that perceived such digressions as anomalies or pathologies in need of cure (cf. for example, [32], or [15]). The past quarter century has seen a radical transformation in the approach to treating children who deviate from societal gender norms, along with an explosion in the numbers of children seeking out services related to their gender identity and/or expressions [1, 5, 38] and the numbers of clinics providing services to these children and their families [18]. This expansion has been accompanied by active efforts on the part of mental health and medical practitioners to define a model of care that would be optimal for children who either indicate that they are feeling out of sync with the gender that matches the sex designated to them at birth or are troubled by the social demands of gender behaviors and presentations in the culture in which they are growing, or both. At this moment in history, the prevailing model being adapted in clinics across the globe is most commonly known as the gender affirmative model. This chapter will bring this model to life and contrast it to earlier conceived models of practice, the reparative models, and the watchful waiting approach. Focus will be on children before they arrive at the stage of puberty; therefore, the terms "child" and "children" used throughout will refer to youth who have not yet reached the early stages of puberty.

What Do Standards of Care and Clinical Guidelines Tell Us?

Only recently has the gender treatment of young children been addressed as a separate consideration in major professional organizations' standards and guidelines. For the first time, the World Professional Association for Transgender Health, the most internationally recognized organization addressing the care of transgender and gender diverse (TGD) individuals, will have a separate chapter on childhood when it releases the 8th version of its standards of care. Presently, the 7th edition provides the following guidelines specific to or applicable to gender diverse prepubertal children [39]:

1. Psychological treatment:
   - Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity).
   - Psychotherapy for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on

mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

2. Social support options to alleviate gender dysphoria, for example:
   - Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy.
   - Offline and online support resources for families and friends.
3. Required competencies for mental health professionals:
   - Training in childhood and adolescent developmental psychopathology.
   - Competence in diagnosing and treating the ordinary problems of children.
4. Roles of mental health professional:
   - Directly assess gender dysphoria in children and adolescents.
   - Provide family counseling and supportive psychotherapy.
   - Assess and treat any co-existing mental health concerns of children.
   - Educate and advocate on behalf of children and their families in their community.
   - Provide children and their families with information and referrals for peer support.
5. Psychological Assessments.
   - Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's gender identity.
   - A psychodiagnostic and psychiatric assessment – covering emotional functioning, peer/social relationships, and intellectual functioning/school achievement.
   - Assessment should include an evaluation of the strengths and weaknesses of family functioning.
6. Psychological and Social Interventions.
   - Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender diverse child.
   - This also applies to peers and mentors from the community.
   - Psychotherapy should focus on reducing a child's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties.
   - Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success. Such treatment is no longer considered ethical.
   - Families should be supported in managing uncertainty and anxiety about their child's psychosexual outcomes and in helping children to develop a positive self-concept.
   - Mental health professionals should not impose a binary view of gender. They should give ample room for children to explore different options for gender expression.
   - Children and their families should be supported in making difficult decisions regarding the extent to which children are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition.
   - Health professionals should support children and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

- Mental health professionals should strive to maintain a therapeutic relationship with gender diverse children and their families throughout any subsequent social changes.

7. Early social transitions (defined as a child transitioning from one gender to another, either everywhere, or in select situations which may be expanded over time).
   - The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood.
   - Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications.

In sum, the WPATH standards of care designate the mental health professional as a key figure in the gender care of all gender diverse young children, are cautionary about early social transitions, and advocate for a systemic approach in which the social context and institutions surrounding the child are recognized as key ingredients in the care and support of the children and their families.

In 2015, a task force of the American Psychological Association drew up their own guidelines for the treatment of TGD children [3]. As with the WPATH standards of care, specific attention to the needs of prepubertal children was minimal in contrast to the emphasis on postpubertal youth. Consistent with the WPATH standards of care in almost all respects, the APA guidelines go further in stressing the necessity of understanding that not all youth will persist in a TGD identity into adulthood, coming to the conclusion: "Due to the evidence that not all children persist in a [TGD] identity into adolescence or adulthood, and because no approach to working with [TGD] children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children" ([3], p. 841). This statement becomes the cornerstone around which the APA guidelines are organized, directing psychologists to understand the varying approaches with gender diverse children and emphasizing the importance of letting children know that they have the freedom to return to a previous gender identity or evolve into a wholly different one. The most recent policy statement supporting the gender affirmative care of transgender and gender diverse youth, issued by the American Academy of Pediatrics in 2018 [28], also makes reference to the lack of clear guidelines in directing pediatric practices with TGD pre-pubertal children.

Evident in both WPATH and APA's directives, although not expressed in the AAP guidelines, is the concern about lack of knowledge and potential risks in allowing a prepubertal child to engage in a social transition from one gender to another. Shortly, it will be seen how the gender affirmative model has addressed this concern, in contrast to the other two models of care for TGD children. First, it will be helpful to review the most recent standards of care for TGD children, released in Australia in 2018 [33]. Again, the section on prepubertal children is relatively brief when compared to the extensive articulation of standards for postpubertal youth, with specific attention to early social transitions. Yet, unlike both the WPATH and APA documents, the Australian Standards of Care are far less cautious, with a more

positive bent on social transitions in young children, stating: (1) Social transition should be led by the child and does not have to take an all or nothing approach; (2) Social transition can reduce a child's distress and improve their emotional functioning; (3) If the child is expressing a desire to live in a role consistent with their asserted gender identity, the mental health practitioner tasks include providing psychological support and practical assistance to the child and their family to facilitate a social transition. The guidelines state specifically that a TGD child may not need mental health services if they are doing well within a supportive environment; lastly, in contrast to the WPATH standards of care, no mention is made of the need for extensive psychometric evaluations.

Whether it is the composition of the organizational entities themselves, or the passage of time, the four sets of guidelines, overlapping in many areas, part ways regarding social transitions and the need for intensive mental health involvement with prepubertal TGD children. In review, it can be said that the Australian standards of care most accurately represent the gender affirmative model for supporting prepubertal children.

The Gender Affirmative Model

Let us return to Alex. By all definitions, Alex is exhibiting gender stress. By diagnostic criteria, Alex may well qualify for a DSM 5 diagnosis of Gender Dysphoria in Children or ICD diagnosis of Gender Incongruence (DSM V 302.6 or ICD-10 F64.2). To qualify for the DSM diagnosis, he will need to meet six of the nine diagnostic criteria and fit the definition of a child experiencing a significant incongruence between the gender the child identifies with and the sex designated to that child at birth, an experience that must last a minimum of six months [2]. Applying that diagnosis to Alex may be controversial and repudiated by a mental health professional concerned about pathologizing a natural variation in gender development and stigmatizing a child who goes against the grain of social gender norms [37]. Another mental health professional not sharing that concern may use the diagnosis as a roadmap to help Alex's parents get Alex in focus psychologically, i.e., have a clear vision of who their child is both in terms of gender expressions and gender identity, and determine what Alex will need in terms of psychological supports. With or without diagnosis, Alex is distressed and the questions remain: What does Alex need therapeutically? How should a clinician go about offering supports to Alex and his family? The answer to those questions depends on the model by which the professional practices. The gender affirmative model, the ascendant approach to care for TGD children internationally, and the one emphasized in this volume, would go to work in the following fashion.

This model of care might also be labeled "listen and act," meaning that the role of the provider is to listen to the child and act in the child's best interest, running the gamut from authenticating the child's gender to facilitating gender affirming interventions, such as social transitions. The underlying premise in this model is that an individual at any age is capable of articulating their authentic gender, and the

role of the clinician is to listen to the child, assess what the child is expressing about their gender, and facilitate the child's exploration of gender in safe and loving home and social settings [10, 17]. No attempts are made on the part of either clinician or parents to change a child's gender behaviors or invalidate a child's feelings. Instead, the provider listens carefully and assists the child as they move through a variety of expected developmental processes necessary to assuming an adult gender identity and or presentation. The model of care is based on stages, not ages, meaning there is no set age for gender affirmation, only each individual person's process as they move toward gender congruence, i.e., the integration of body, identity, and expressions. Within the perspective that gender exploration and consolidation are evolutionary, life-long processes, the gender affirmative model applied to children acknowledges what is also seen in adult and mature patients – that social transitions may occur and are just as "valid" at any age or stage of life.

Practitioners who adopt this gender affirmative model vary in their evaluative procedures, but all act under the underlying premise that gender diversity signifies healthy variations, rather than anomalies, and that the goal is to facilitate a child living in their authentic gender. Some administer formal evaluations to determine a child's gender status and any co-occurring psychological issues [4]. Others, adhering to the tenet that gender diversity is a healthy variation of development, not necessarily subject to mental health diagnosis, a tenet supported by the ongoing research of Dr. Kristina Olson and her associates at The University of Washington [26, 9, 27], prefer to forego formal psychological assessments and replace them with a model of child and parent consultations. Increasingly, ongoing psychotherapy is introduced only if the child is demonstrating signs of gender stress or distress or desiring or in need of a "room of their own" to further explore their gender [12]. Emphasis may instead be put on an ecological approach, evaluating the systems in which the child is growing, including family, day care, school, religious institutions, and striving to institute plans in each of those domains to assure support and acceptance of the child as they express their gender in the manner that feels most authentic to them [20]. The gender affirmative model advocates interdisciplinary teams of mental health and medical providers; the child, parents, and allied professionals are also considered critical members of the care team [30].

Attention is also paid to siblings, grandparents, and other extended family members, under the rubric that family acceptance is a key ingredient to a child's gender health and that all family members from siblings to grandparents may need their own supports as they adjust to a child's newly articulated gender self [22]. A growing body of research is resounding in demonstrating the critical importance of family support, beginning with the research of Caitlin Ryan and her associates, followed by the research of Trans PULSE [34] and Sabra Wise-Katz and her research team at Harvard [19]. For example, in the Trans PULSE findings, suicidality in trans youth was 4% when parental support was in place versus 57% when youth faced parental rejection, a remarkable contrast.

The gender affirmative model evolved in reaction to the first and on the foundation of the second of the two other prevalent models developed to treat gender diverse children, both of which continue to be practiced nationally and

internationally. With that said, it will be helpful to understand how the gender affirmative model stands in contrast to these two other models – the "live in your own skin" and the "watchful waiting" model, to which we will now turn.

The "Living in Your Own Skin" Model

Traditionally, prevailing models for treating gender expansive children involved some form of what has come to be known as "reparative therapy" for gender identity [24]. Applied to children, this model involved therapeutic efforts to change the gender behaviors and identities of children to conform to the prevailing standards for gender, within a binary model of gender-divided "appropriateness" for males and females [15]. Although illegal in several states in the U.S. and one province in Canada (Ontario) [14], the model of care is still used, especially in church-based counseling programs and more conservative mental health institutions [16]. While argued by its developers not to be a reparative technique (though description of their intervention techniques speaks otherwise), the treatment model for pre-pubescent children that had as its goal a change in the gender presentations of a young child became best known in the work of Drs. Susan Bradley, Kenneth Zucker and their colleagues at the Center for Addiction and Mental Health in Toronto [40, 41]. This model has become known as the "living in your own skin" approach. The goal of the treatment is to facilitate young children accepting the gender that matches the sex designated to them at birth. The underlying premise is that young children have a malleable gender brain and can be influenced to achieve psychological congruence between their sexed body and the gender identity that would match that body according to social expectations. The rationale for implementing this treatment was that living life as a cis- rather than a transgender individual relieves the child both of the burdens of the stigmatization of being a transgender person and the added medical interventions (hormones, surgeries) that might accompany a transgender identity [7]. With the requisite that the parents consent to the treatment, the "living in your own skin" interventions include removing "cross-gender" toys and activities, replacing them with toys and activities more "gender-appropriate", introducing same-gender playmates to replace opposite-gender playmates, encouraging same-gender parent to become more active in the child's life while asking the opposite-gender parent to step back, and involving both parents and child in ongoing psychotherapy [23].

If, however, such efforts are not implemented or a child is still expressing a desire to live in the opposite gender by adolescence, the sensitive period for gender malleability is over, and therefore it is too late to employ "living in your own skin" methods. In those instances, every effort is made to help a youth socially transition and receive medical interventions (hormones, surgery) to achieve gender congruence. In sum, the "living in your own skin" model, which got its name from Dr. Zucker's explanation of his treatment program as helping pre-pubertal children to live in the gender that matches the sex designated at birth and the body accompanying that designation, ergo, their own skin, synthesized behavior modification, social

engineering, and psychodynamic psychotherapy to achieve the set goals of gender congruence between designated sex at birth and child's gender identity. The "living in your own skin" approach is in part informed by the extant research indicating that the majority of young children referred for gender-related care and receiving a gender diagnosis (Gender Identity Disorder in the past, Gender Dysphoria more recently) do not continue to identify as TGD at puberty (see Chap. 2 and [31]). It is therefore assumed that a young child may be still be flexible and able to conform to others' expectations for their gender. As will be discussed shortly and is discussed in earlier chapters of this text, this underlying assumption is problematic in light of the critiques of the "persistence" research for its problematic methods and conclusions [13].

The Watchful Waiting Model

The second form of treatment was developed in the Netherlands at the Vrije Universiteit Medical Center [6, 8]. In this model, children brought to their clinic at a young age are first psychologically evaluated, as in the above model, to determine whether they exhibit gender dysphoria and to identity co-occurring psychological issues. Those children who are identified as having gender dysphoria are offered ongoing psychotherapy, along with psychological supports for their parents. Parents are encouraged to allow their children to explore and express their gender as the child desires at home or in specific protected environments. However, for those children who at an early age express a strong desire to live in the other gender, a watchful waiting approach is recommended: allowing a child-free rein in their gender expressions but holding off on facilitating a full social transition from the gender matching their designated sex at birth until adolescence [8]. The rationale for the waiting period is based on three assumptions: (1) On the basis of their own research in their program, only a small percentage of the children receiving a diagnosis in early childhood maintain that diagnosis in adolescence, so best to wait until adolescence and the beginning stages of puberty to be able to better discern a child's stable gender status; (2) Even for the child who may appear quite clear in their affirmed gender identity, having them switch genders early in life might cognitively pigeonhole them prematurely into a gender identity that had not yet been established, depriving them of the opportunity for perhaps needed further exploration of their gender identity; (3) premature social transition may prevent a child from being realistic about the phenotypic features of their body based on their chromosomal sex.

Relying on codified diagnostic categories, if by adolescence the youth still, in the watchful waiting model qualifies for a diagnosis of gender dysphoria and is articulating a transgender identity, a youth will then be afforded the opportunity for a social transition and for medical interventions that will allow the youth greater gender congruence, with certain age requirements set for puberty blockers, gender affirming hormones, and surgeries, as outlined in subsequent chapters. In sum, the watchful waiting approach supports a child in evolving into the gender identity that is most authentic to them, without attempting to change them, but also takes a

cautious approach with prepubertal children regarding changes in their gender identity roles. Unless a prepubertal social transition has already occurred prior to presentation to the clinical team, this model postpones social transitions until adolescence.

Recall that, like in the living in your own skin model, the research on which this model for treatment of prepubertal children is based is the findings about persistence and desistance of gender dysphoria in young children, with the presupposition that the majority of children will "desist" by adolescence. One of the main problems with this research is that it relied on psychiatric classification and failed to measure the main variable that would determine if a young child would be a good candidate for social transition. That would be their gender identity. In this research, no differentiation is made between gender identity and gender expressions, and thus the baby gets thrown out with the bathwater when little children who are clear about their gender identity in insistent, consistent, persistent fashion are lumped together with children who are exploring gender expressions but not an alternative gender identity [12, 13, 21]. It should also be mentioned that linguistically the term "desistance" most often refers to a phenomenon that would best be halted or extinguished, which can very well send a message to clinicians that gender diversity, when it appears in childhood, should be taken with a grain of salt, as it might just disappear, a potentially "good outcome." Unwittingly, this message to a clinician may then subliminally communicate to parents or to a prepubertal child who wishes to socially transition that a more conforming gender outcome would be preferred over the child's asserted gender identity.

Circling back to the gender affirmative model, the main arena in which this model parts ways with the watchful waiting model is around the issue of social transitions. The gender affirmative model starts with the dictum that gender health is defined by the opportunity of the child to live in the gender that feels most authentic to them with no rejection or aspersion. Following that rubric, to prevent a child who has been insistent, consistent, and persistent in their articulated gender identity from expressing their gender identity as they experience it is perceived as unnecessary and possibly harm-inducing, rather than risk-aversive [13, 21]. Further, since gender is considered a lifelong developmental process, rather than being fixed at a certain age, there is less concern than in the watchful waiting model that a premature social transition might lock a child into a gender identity from which they cannot exit. Instead, every effort is made to leave all gender pathways open, with supports offered if the child finds themself evolving into a different gender, either in expression or identity, over the course of time. Lastly, the assumption that a child will be cognitively constricted by potentially losing track of their own body parts and phenotypic sex has no evidence base. Quite to the contrary, socially transitioned young children remain all too aware of their body parts. Recently, gender affirmative practitioners have witnessed the stress that can accompany this realization profoundly minimized by new social narratives in which children grow to understand that most girls have vaginas, but some have penises, and most boys have penises, but some have vaginas, allowing gender diverse children to experience themselves not as an anomaly but a variation on a theme.

Alex Through the Looking Glass

Let us return to Alex, introduced at the beginning of this chapter. Having laid out the parameters of the gender affirmative model and contrasted the model to the other two extant models – living in your own skin and watchful waiting, it is now time to take a look at how Alex might have fared in each of the three programs. To review: Alex is five, feminine in his gender expressions, articulating a wish to be a girl, and growing increasingly anxious as he is about to enter kindergarten, demonstrating signs of gender stress. His parents are seeking professional help.

If Alex were to be brought to a clinic practicing the living in your own skin model, his parents would be interviewed to uncover how they had been handling Alex's gender behaviors to date. The provider would explore influences they may have had, if any, on his gender dysphoria. A battery of psychometric tests would be administered to determine if Alex qualified for a diagnosis of gender dysphoria and to identify any co-occurring psychological issues. A program might be instituted to spend more time with Dad doing "boy-like things," substituting a mini-basketball net for tutus (with tutus removed), and encouraging playdates with other boys in his new kindergarten class. Psychotherapy would also be offered to Alex to address his distressed feelings and facilitate Alex being content living in his own skin as a boy. Supportive therapy would also be offered to the parents. However, if Alex's family lived in the state of California, for example, this form of treatment would be prohibited and a practitioner employing this form of treatment would be at risk for being reported to their licensing board for engaging in harmful, unethical practices, this in line with the directives of major health and mental health organizations, as outlined above.

If Alex's parents were to make an appointment at a clinic following the watchful waiting approach, Alex's parents would be interviewed about their child's gender history, Alex would receive a formal psychological evaluation, as in the living in your own skin model, and Alex would be eligible for psychological services, which would be recommended to afford Alex the opportunity to continue to explore his gender and to address psychological stressors, such as his reluctance to go to school and expressed wishes never to be born. Until Alex reached puberty, Alex's parents would be encouraged to continue to support his gender at home with no interference in his play choices, presentation, or playmates. However, they would be cautioned against a full social transition, as it would be too early to determine if Alex was a "persister," and what would be considered in this model as a premature gender transition might back Alex into a corner of feeling stuck in a gender identity that eventually may end up not being his authentic one. As puberty approached, Alex would be re-evaluated. Once he had experienced the first stages of puberty, he could be considered for puberty blockers to allow more time for gender exploration, along with a full social transition if a transgender identity was evident, followed by gender affirming hormones and surgical interventions, if desired.

If Alex's parents contacted a clinic using the gender affirmative approach, their experience in many ways would be similar to having made an appointment with a program adopting the watchful waiting model. The main difference would be that

the gender affirmative clinician would begin from the assumption that a young child is capable of articulating an authentic gender identity. This model, also supported by the 2018 AAP policy statement, suggests that listening to our patients, including prepubertal children, is an important aspect of support and care. This does not translate, as some critics of the gender affirmative model impute, into a clinician simply rubber stamping whatever the young child says about their gender on their first visit. Listening is a process, and for young Alex, the listening would mean taking as much time as was needed for Alex's gender story to unfold and for the adults around him to understand that story. If, upon evaluation, it was determined that Alex was insistent, persistent, and consistent in articulating a female identity and a desire to live full-time as a girl, and if parents were in support of a social transition, the clinician would help facilitate that transition, either in all settings, or in more limited settings that felt comfortable to Alex and Alex's family. If, alternatively, Alex's gender journey took him to a place where he experienced himself as a girl-boy or a rainbow kid, or some other gender-nonbinary sense of self, that pathway would be supported as well. If, as Alex grew older, Alex exhibited anxiety about continued development into a more masculine or male phenotypic puberty, or if Alex was unclear on how masculine or feminine their growing gender identity might be, Alex would be offered puberty blockers at the onset of puberty and continued resources to explore an authentic individual gender identity.

In contrast to the watchful waiting model, holding back on a gender transition until later, if it was discovered that Alex was clear in an articulation of a female gender identity, would seem counter-indicated, under the premise that gender health equates with allowing a child the opportunity to live in their authentic gender when and as they know it, no matter the age of the child. Within the gender affirmative model, the clinician seeing Alex's family would be informed by the premise that delaying what the child reports is their current state of gender expression and identity has the risk of sending a message of lack of acceptance, disapproval, or invalidation of Alex's authentic gender. As mentioned early, there is growing evidence that gender diverse youth supported by their parents have improved psychological functioning compared to youth who are not supported [29, 34], and one could easily hypothesize that facilitating a gender transition would be a significant form of parental support.

At the same time, under the care of a gender affirmative practitioner, Alex's parents would be assured that if Alex was to discover later in childhood that Alex's articulated gender self was no longer a good fit, this would not represent a risk factor, but rather an opportunity to evolve into Alex's next iteration of gender, be it moving back to the original gender identity or a new one (e.g., gender nonbinary). This assurance would be predicated on the assumption that gender pathways would always remain open, that there is no one desired outcome, other than what is authentic and true for Alex. In sum, the gender affirmative model would offer supports and opportunities for Alex to live in their authentic gender at present while simultaneously continuing to explore their gender in the evolutionary unfolding of gender that may occur over time.

Where Do We Go from Here?

Of the three treatment models, the gender affirmative model is the newest approach, but the approach with the most evidence to support its potential benefit and reduction of harm in TGD children. To date, there are ongoing longitudinal studies creating a growing body of evidence to support the gender affirmative model, and increasing documentation that for some young children, early social transition may be in their best interest and with no evidence of harm [35]. More specifically, the research of Dr. Kristina Olson and associates at the University of Washington TransYouth Project provides evidence that children who have socially transitioned at an early age are doing as well mental healthwise as a matched group of cisgender children, indicating normative levels of anxiety and depression in both groups [9, 25–27]. The ongoing TransYouth Project research involves a longitudinal cross-sectional study evaluating the children on a limited number of psychological variables, but does not yet provide information about long-term outcomes, nor does it provide a comparison to children who are gender diverse but do not socially transition at young ages. Looking toward the future, more evidence-based studies are needed to document long-term outcomes for children who have socially transitioned at an early age and also for children claiming a nonbinary or alternative gender identity, with at least one such study presently being launched in a four-site NIH research project investigating gender pathways in prepubertal children. Such research will provide the means for testing the basic premises of the gender affirmative model: that listening to the child, providing parental and social acceptance, facilitating social transitions, and adopting a developmental, evolutionary, rather than static concept of gender generates well-being and positive mental health among TGD children.

The field of gender care for TGD children is in many ways in its own childhood stage. The gender affirmative model of care has been presented as the optimal model of care for TGD children, with comparison to the two other extant models of care – the living in your own skin and watchful waiting approaches. The former falls within the category of reparative forms of treatment that have now been rejected by major professional societies as unethical and harmful. Yet, the living in your own skin model continues to be practiced in certain settings that view a TGD or gender fluid/nonbinary outcome as problematic and undesirable. Some of the work ahead is to continue to educate professionals and parents alike about reparative modes of treatments' harmful effects on children [36] and their contribution to transphobic attitudes and behaviors within the world at large.

The watchful waiting and gender affirmative models live in creative tension with each other, sharing many basic premises but respectfully questioning each other in domains where they differ, particularly the advisability of early social transitions and reliance on "persistence" data that comes with its own inherent flaws and has been systematically critiqued for failing to differentiate their young subjects who were exploring their gender expressions from those who were exploring their gender identities and making the false assumption that children who dropped out of their studies could be counted as desisters because they no longer came for care at the

clinic. As the gender affirmative model becomes more ascendant as the optimal model of care, we witness gender care evolving to incorporate a more dynamic and fluid understanding of gender in which gender multiplicity replaces the gender binary. The individuals taking the lead in this evolution are not the professional experts, but the children themselves, as they demonstrate the beauty of gender in its infinite iterations. With the children to guide us, the task before us is to reach at least the adolescence of our pediatric gender care – to continue to explore, evaluate, and execute evolving models of care that consider the best interests of the child, the social milieus in which the children live, and the emerging scientific evidence and longitudinal outcome studies that will contribute to all children having a fulfilling life in their authentic genders.

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