

# Affirmative Practice With Transgender and Gender Nonconforming Youth: Expanding the Model

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Affirmative care with transgender and gender nonconforming (TGNC) children and adolescents is a new framework under which many mental health clinicians now practice. It rests on a premise that appreciates diverse gender expressions and identities within society, and encourages the highest potential for individuals to follow their own paths to positive emotional well-being. Scientific understanding of the phenomenology of gender development in children and adolescents is scarce, and the gaps in knowledge limit evidence-based practice when working with these youths. Interventions span many domains within the physical and mental health realms, calling for providers to navigate differing interdisciplinary perspectives when optimizing assessment and treatment goals. In addition, interventions differ according to developmental stage, and newer approaches and treatments have become more popular within the last decade. For children, the concept of social gender transition has remained controversial, as relatively historical approaches (discouraging cross-gender behavior) have become outdated and more recent methods (supporting gender transition) have gained backing. Fully reversible pubertal suppression has been introduced for TGNC adolescents as a means of buying time for exploration without the pressures of irreversible pubertal advancement. Given the current deficits in scientific understanding of gender-identity development in youth, the affirmative provider often faces decisions that are challenging, complex, and unclear. This paper describes the theoretical approaches to TGNC youth across development, provides a brief overview of the current research, and offers providers a way to conceptualize and provide care that can be both supportive and scientifically driven when done in a thoughtful, balanced way.

*Keywords:* affirmative practice, gender nonconforming, transgender youth

As the number of transgender and gender nonconforming (TGNC) youth seeking services has increased significantly over the past decade, mental health clinicians have been faced with the challenge of identifying best practices in the absence of substantial empirical data to reference as a guide. The mental health field is at a crossroads in terms of defining standards of care within the context of the current understanding of gender development and the collective clinical experience of expert practitioners working with this population. Mental health providers are in a unique position to offer support and assistance with decision-making at various critical junctures in the care of TGNC youth. The decisions

vary in complexity and must take developmental, psychosocial, familial, and potentially psychiatric factors into account. Recent years have brought newer interventions to the forefront, such as pubertal suppression in younger adolescents (Hembree et al., 2009), changes to the diagnostic classification of individuals with gender-identity concerns (American Psychiatric Association, 2013), and emphasis on the debate surrounding the approach and management of prepubertal children with gender concerns (Zucker, 2008). Although clinicians both across and within disciplines agree that prioritizing best clinical outcomes is paramount, there is variation in beliefs on how that can be achieved.

The *Merriam-Webster's Online Dictionary* defines the term *affirm* as “to say that something is true in a confident way” (Affirm, n.d.). Inherent in this definition when applied to clinical work with TGNC youth is the notion that the gender identity and related experiences asserted by a child, an adolescent, and/or family members are true, and that the clinician's role in providing affirming care to that family is to empathetically support such assertions. Such an approach may appear straightforward at first pass, but a conceptual treatment model for which the underlying definition describes a single moment in time applied to the dynamic changes that occur in the process of child and adolescent

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identity and brain development is a challenge. To be affirming of an individual's identity at one point in development, yet take into account the various unknown factors shaping that individual's identity, requires an approach that neither over- nor underemphasizes the potential complexities involved in determining how gender fits into the larger picture for a given youth (American Psychological Association, 2015).

To date, Hidalgo et al. (2013) is the only group of scholars that has described a gender-affirmative treatment model for TGNC children and adolescents. These authors defined gender health as "a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection" (Hidalgo et al., 2013, p. 286). In their description of the gender-affirmative model, Hidalgo et al. explained that gender variations are not disorders, gender may be fluid and not binary, and gender development is multifaceted, involving biological, developmental, and cultural contexts. This approach is a helpful overarching view on providing affirmative care to TGNC youth. The purpose of the current article was to take the next step in this discussion, which must include the consideration of varying treatment protocols and interdisciplinary perspectives. Further, we encourage clinicians to conceptualize affirmative care as a treatment approach that supports the TGNC youth *and* appreciates the complexities inherent in the clinical care of this population. A particularly notable area for thoughtful clinical decision making relates to the widely accepted differences in the assessment and treatment aims between prepubertal children and peri/postpubertal adolescents. In this article, we have described the treatment modalities of these developmental groups, but acknowledge that a more in-depth description of affirmative care for each group is warranted.

In providing affirmative care to TGNC youth, understanding one's personal feelings and beliefs and how these impact one's ability to provide supportive treatment is important when considering the diverse range of individuals presenting with gender-identity concerns. First and foremost, we propose that to provide affirmative care to TGNC youth, providers must recognize their biases and assumptions about gender (i.e., gender as fixed and dichotomous vs. fluid and on a continuum; degree to which gender identity is malleable by external factors in childhood vs. something that can only be realized by the individual) and be forthcoming about these biases (American Psychological Association, 2015). Educating youth and families about the existing long-term empirical outcome data on TGNC youth is also important. In addition, we recognize that many aspects of affirmative practice are applicable to the broader group of TGNC youth; however, we focus specifically on youth who express more extreme gender dysphoria, desire to live as a different gender, and who are seeking specific gender-transition interventions (i.e., social transitions, physical interventions). Therefore, in this article, we sought to provide clinicians with the following: (a) strategies for implementing care that balances empirically based understanding of gender development with clinical experience of providers working in the field, (b) appreciation of the developmental differences between children and adolescents and the challenges specific to each age group, and (c) understanding of how interdisciplinary approaches and varying treatment protocols may be integrated in an affirmative-care model.

## Risks, Resilience, and Barriers to Care for TGNC Youth

Whether TGNC youth experience barriers or support as they seek health-care services depends much on factors at the individual, family, and institutional levels. Some TGNC young people experience an internal disjunction as though they are "living a lie" or that their "body doesn't match their brain," and consequently, may perceive their situation as abnormal. These feelings are often exacerbated by external factors, which include experiencing rejection, isolation, abuse, harassment, and discrimination (Grossman & D'Augelli, 2006; Lombardi, Wilchins, Priesing, & Malouf, 2002) in multiple contexts, including the family unit (Singh, Meng, & Hansen, 2014) and education system (Kosciw, Greytak, Palmer, & Boesen, 2014). These negative experiences may lead to mental health problems for TGNC youth, including depressive symptoms (Dank, Lachman, Zweig, & Yahner, 2014), self-injury (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Spack et al., 2012), and suicide attempts (Clements-Nolle, Marx, & Katz, 2006). In addition, although we assume mental health practitioners who work with this vulnerable population aim to provide services that improve quality of life, therapeutic approaches that encourage individuals to accept their given body and assigned gender may inadvertently cause psychological harm (SAMHSA, 2015; Travers et al., 2012; Wallace & Russell, 2013). Despite various challenges, Singh et al. (2014) noted the resilience of many TGNC youths, including the ability of each individual to define his or her own gender, access supportive resources, connect to a trans-affirming community, and hold more positive outlooks about their mental health.

Within a family, caretakers (e.g., parents) play an important role in mental health and overall well-being of TGNC youth (Ryan, Huebner, Diaz, & Sanchez, 2009). Although some caregivers support gender exploration in their children, others may find gender nonconformity problematic and embarrassing. Consequently, these caregivers may try to limit, prevent, or penalize a child's affirmed gender expression (de Vries & Cohen-Kettenis, 2012), which could result in a poor outcome for the child (Ehrensaft, 2012). Practitioners can help caregivers understand that, from an affirmative care perspective, only the individual can determine his or her gender identity. With this in mind, caregivers, providers, and TGNC youths can work together to make decisions that will best support the youth in an environment that will allow them to flourish.

When caregivers and TGNC youths decide to seek care, a lack of services to address their unique needs is often a challenge. Grant et al. (2011) found that transgender adults were unable to access adequate care because health-care practitioners lacked the competence to provide affirmative treatment, and we surmise that this applies to youth as well. Insurance coverage is another barrier to treatment. Most insurance companies continue to deny coverage for the puberty suppressing medication recommended for many TGNC adolescents, arguing that the diagnosis associated with such treatment is a mental health one, rather than a medical one (Edwards-Leeper & Spack, 2012). Therefore, mental health clinicians are faced with an ethical dilemma in diagnosing these youth, as assigning the *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5, 2013)* gender dysphoria diagnosis (previously gender-identity disorder in *DSM-IV-TR, 2000*) may result in

denial of coverage for medical services (Edwards-Leeper & Spack, 2012). Given the astronomical expense of the puberty suppressing medication, insurance denial precludes many youth from receiving the intervention recommended by the Endocrine Society (Hembree et al., 2009) and the World Professional Association for Transgender Health (WPATH) (Coleman et al., 2012).

### Affirmative Practice With TGNC Children

When prepubertal TGNC children present in practice, the affirming clinical approach to assessment and treatment often involves complex factors encompassing several domains. As with any child, one must consider environmental factors (e.g., peer relationships, family dynamics, school environment) as well as individual characteristics (e.g., temperament, resiliency, coping strategies) when determining target areas for intervention, if any. However, in addition to these routine factors, clinicians are being sought to assist parents in deciding whether or to what extent a child should be supported in a social gender transition (Steensma & Cohen-Kettenis, 2011). This may involve using a different name and pronoun, and/or expressing a different gender (e.g., through clothing, hairstyle) in limited (partial) or all situations (complete). Lacking the empirical evidence that most other mental health interventions have, this subject remains controversial, has no straightforward answer, and requires an in-depth understanding of the contextual issues surrounding the decision. Eligibility for medical and physical interventions is not a consideration in prepubertal TGNC children.

A review of the existing literature provides scientific context to the current debate. The three published peer-reviewed studies that followed prepubertal gender nonconforming children into adolescence found that a minority persisted in their cross-gender identity (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). However, it is important to note that these persistence rates varied by study (12–50%), likely due to factors such as the varying degree of childhood gender dysphoria within the populations studied and differing outcomes of interest. A recent study found the most important predictor (not determinant) of persistence to be the intensity of the initial childhood cross-gender identification and whether it continued into puberty (Steensma et al., 2013). The impact of childhood social transition itself on persistence rates was shown to be a predictor of gender dysphoria in adolescence, particularly for birth-assigned male individuals. However, these findings were correlational; thus, it is difficult to draw definitive conclusions. A small, retrospective qualitative study conducted on adolescents whose childhood gender dysphoria persisted versus those whose dysphoria did not, found that mental health problems occurred for some youth who partially socially transitioned in childhood and then transitioned back to birth-assigned gender in adolescence, particularly among individuals assigned female at birth (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011).

The origins of gender-identity development, particularly when it does not match the assigned gender, go beyond the scope of this article. Currently, scholars agree that there is no one factor—biological, psychological, or social—to explain gender-identity development in children, but rather it is complex and will require more rigorous, longitudinal research. Despite the limitations of the

existing research, three general conclusions can be drawn to inform balanced affirmative practice: (a) Most childhood gender dysphoria desists; however, the more intense the identification in childhood, the more likely it will persist into adolescence; (b) if gender dysphoria persists and intensifies into puberty, the chances of it continuing increase; and (c) there is likely a relationship between gender nonconformity in childhood and later LGBQ sexual orientation for some individuals. These conclusions drive clinical decision making in several ways.

### Childhood Social Transitioning

Three conceptual perspectives have been described for approaching early social transition in TGNC children (Drescher, 2013; Zucker, 2008): supporting social gender transition, discouraging transition, and wait-and-see ideologies. The ethical dilemmas have been well-documented in the literature (Pleak, 1999), yet clinicians are unable to reach consensus regarding a solution that best meets the needs of *all* TGNC children. We believe that the affirming provider should be familiar with the theoretical premises of these approaches in an effort to appropriately educate parents and families about the benefits and limitations of each. Further, the recent SAMHSA (2015) report on the use of conversion therapy with sexual and gender-minority youth clearly states that affirmative care involves approaching each child individually, recognizing that many TGNC children will not persist in their affirmed gender in childhood and that early social transitioning may be in the best interest of some children, but not others (see pp. 48–50 for a summary). Similarly, the American Psychological Association's "Guideline for Affirmative Practice with Transgender and Gender Nonconforming People," (APA, 2015) includes the following guideline specific to youth: "Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood" (p. 841).

The premise behind supporting prepubertal social gender transition is that helping a child to live in the gender with which they identify minimizes shame, affirms their stated gender identity at the time, and assumes there is no reason to prevent a future transgender identity because it is not considered pathological. According to the WPATH "Standard of Care," Version 7 (SOC 7; Coleman et al., 2012), childhood social transition has led to initial improvement in mental health outcomes early in the process. The premise behind discouraging social gender transition is that most TGNC children will not persist as a gender different from what they were assigned at birth, and we do not currently have medical or psychological means to predict an individual child's future course. Thus, there will undoubtedly be "false positives" who transition early and later are faced with the challenge of transitioning back to their assigned gender. In a wait-and-see theoretical approach, the premise exists to neither encourage nor discourage gendered behavior, by allowing the child to remain gender neutral or gender fluid. The challenge with universally taking this approach is that, in reality, many areas of children's lives are influenced by societal representation of gender, which is often binary. Thus, for those children whose gender identity and/or expression fall outside of the sex dichotomy, maintaining a neutral stance may be more idealistic than realistic, particularly if the social and familial environments do not support nonbinary gender expression

in all arenas of life. Regardless of the approach, the importance of working with and educating adults and peers in the child's life about the benefits of approaching gender in a nonbinary way may be a primary focus of treatment.

Given the lack of evidence-based treatment guidelines and the limitations in the scientific research on gender development, it is misguided to universally employ any one of the aforementioned approaches to all TGNC children, as doing so fails to take into consideration the wide variability and potential complexity present for each child. The combination of anecdotal experiences from clinicians who are familiar with this population and the scientific research suggests that a highly individualized and nuanced approach is appropriate when guiding families on this issue. Important factors to assess include, but are not limited to, diagnostic criteria for gender dysphoria, parent-child interactions, motivations behind a child's assertion, potential adaptive strengths that the child/family may have in facing potential victimization and bullying, presence of co-occurring psychiatric diagnoses, and the relationship between psychiatric diagnoses and underlying gender dysphoria.

How can a clinician both affirm a child's stated gender identity at a certain moment in time, yet appreciate the possibility that the identity may change as the child develops? It is important that affirming clinicians consider the various ideologies and research to date, while taking individual factors into account. Clinicians who follow an affirmative approach might support the child in whatever gender, or combination of genders, the child embraces. This might involve thoughtfully taking the child's lead and allowing the child to explore their gender identity. Explicitly discouraging behaviors and interests that align with the child's stated current gender identity is not affirming. At the same time, assisting a child in navigating a wider repertoire of interests and behaviors (i.e., that may be stereotypically associated with the child's assigned gender) might be helpful in expanding a concrete and binary view of gender that may exist. When failing to consider the reality that for many children, especially those of a young age, gender identity is fluid and still forming, some providers may inadvertently presume a certain trajectory for a child and relay that message to the child.

Some key principles that may serve as a guide to an affirming, yet balanced, clinician include the following. First, it is important to understand the source of the motivations behind the desire to live in a certain gender role, which involves establishing a relationship with families and showing appreciation of parent-child dynamics that often drive behaviors in early development. Second, clinicians are encouraged to be aware that any decision to recommend gender transition in this age group should prioritize the child's psychological well-being (Ehrensaft, 2012) by appreciating and addressing all potential benefits and risks involved in both transitioning and not transitioning. Third, when indicated, clinicians understand that a social transition can occur gradually (i.e., in the home setting first) or partially, and the child's response to these initial steps (e.g., correlation to reduction in co-occurring mood or anxiety symptoms) may be an indication of how prepared that child is to navigate the transition in other situations (e.g., school). Lastly, it is recommended that clinicians help families appreciate the importance of using language that allows for future gender exploration when interacting with their child, yet minimizes shame. For example, the clinician should listen for language in family members that presumes the child's future identity (e.g.,

"When [7-year-old] Becca starts estrogen") and help families to adjust their language to reinforce all the potential identity trajectories later in life (e.g., "When Becca is older, we will love and support her whether she continues to feel like a girl or maybe returns to feeling like a boy, or identifies somewhere else on the gender continuum"). To be affirming of a child's gender identity is possible and encouraged; however, doing so requires a balanced and nuanced approach that takes into account the complexity of childhood gender-identity development over time and involves the parents, unless doing so is logistically impossible (e.g., homeless youth) or would put the youth at risk of harm.

### Affirmative Practice With TGNC Adolescents

Affirmative practice with adolescents shares some similarities with children but also diverges, particularly in that medical interventions are sometimes recommended with the former. With both groups, affirmative care involves conceptualizing each case as unique and worthy of careful evaluation and exploration into the individual's gender identity, family dynamics, and broader psychological profile, among other previously described factors. In addition, many adolescents, like children, are still clarifying their gender identity and are simply seeking assistance and support related to this with no interest in a medical intervention. Addressing concerns of other family members, including assisting parents with feelings of grief and loss that often exist, can also be a part of that work. For adolescents who *came out* after puberty, many parents are caught by surprise and need additional support and empathy around their feelings of loss and potential skepticism. Furthermore, medical interventions including puberty-suppressing medication, gonadotropin-releasing hormone (GnRH) analogues, and gender-affirming hormone treatment (e.g., testosterone, estrogen), have become the standard of care for adolescents who are formally evaluated and meet the recommended criteria. For older adolescents, surgery may be considered.

### Pubertal Suppression

The use of puberty suppressing medication (often referred to as "puberty blockers") is being used with increased frequency since the Endocrine Society developed standards of care for working with transgender individuals, which identified this intervention as a safe and recommended option for appropriate patients (Hembree et al., 2009). In addition, the most recent WPATH SOC 7 included this as a recommended treatment option for TGNC adolescents (Coleman et al., 2012). Recent empirical evidence has provided more specific support of this intervention with transgender adolescents, with results showing improved psychological functioning and improved quality of life in young adulthood (de Vries et al., 2014).

Numerous benefits of pubertal suppression have been identified (Edwards-Leeper & Spack, 2012), perhaps the most important being the added time it provides TGNC adolescents to continue exploring their gender identities without the added stress of pubertal changes that are incongruent with their identities and may cause psychological distress. The psychological issues that exist for many adolescents due to gender dysphoria and the social stigma that accompanies it include depression, anxiety, social isolation and rejection, self-injury, and suicidal ideation/attempts

(Grossman & D'Augelli, 2006; Spack et al., 2012). Pubertal suppression is often considered life saving for some TGNC adolescents (Edwards-Leeper & Spack, 2012). An additional benefit of this medical intervention is the prevention of irreversible secondary sex characteristics, such as deepening of voice, Adam's apple protrusion, alteration in bone and hand structure, and increased facial and body hair for individuals born with male bodies; and breast development, menstruation, and small stature for individuals born with female bodies. The use of a GnRH analogue for adolescents who ultimately decide to pursue additional physical transition steps to a different gender allows greater ease of *passing* in society as the gender with which one identifies without the use of expensive and invasive surgeries, procedures, and interventions (e.g., mastectomy, laser hair removal, speech therapy).

Despite the fact that the standard of care in various clinical guidelines supports pubertal suppression (Hembree et al., 2009), some providers remain leery about its use. One concern is the lack of research examining the impact of one's *naturally* occurring puberty on gender-identity development. For example, it is unclear whether the surge of one's endogenous hormones during puberty reinforces feelings consistent with one's assigned sex and gender. By intervening during this critical time, one might argue that providers are preventing nature from *taking its course*; an outcome which could result in TGNC adolescents not pursuing other medical interventions. Although this is a reasonable concern, when this option is weighed against the degree of psychological distress experienced by many TGNC adolescents, an affirmative model of care recommends the use of pubertal suppression. The top priority is protecting these vulnerable adolescents who are often experiencing severe psychological distress and may be at risk for taking their own lives. Given that pubertal suppression is fully reversible (i.e., one's natural puberty will resume upon discontinuing the medication) and has no significant side effects (Carel, Eugster, Rogol, Ghizzoni, & Palmert, 2009), its use is often recommended as a means of buying time for TGNC adolescents to explore gender identities without their bodies changing in irreversible ways. Due to the importance of medical interventions for some TGNC adolescent's health and well-being, providers should familiarize themselves with different medical treatment options (American Psychological Association, 2015).

Another notable point about the use of pubertal suppression is related to TGNC youth who have not been appropriately screened and whose parents have not been adequately educated about the importance of their role and approach to their adolescent's gender exploration. This is related to the difficulty that many parents and providers have with understanding gender as a nonbinary construct and acceptance of the possibility that some TGNC adolescents may ultimately revert to their assigned genders or possibly not choose to live and identify as only one gender. Although the purpose of the puberty-blocking medication is to give TGNC adolescents more time to continue exploring their gender identities in an effort to determine whether moving forward with less reversible medical interventions is desirable, some parents and providers may assume that the adolescent's gender identity is consolidated, and thus turning back is unlikely and unsupported. Anecdotal evidence suggests this can be extremely difficult for TGNC adolescents who feel *trapped* in a gender by their parents and/or providers, intentionally or unintentionally. The period of ambiguity that exists during this exploration can be hard for a set

of parents who have experienced the process of grief, loss, and eventual acceptance of their child who turned out to be different than what they envisioned. Taking an affirmative approach that allows adolescents the freedom to explore their genders, change their minds, or choose no gender can alleviate this particular concern.

For older TGNC adolescents, typically around the age of 16, gender-affirming hormone treatment may be initiated. This intervention is less reversible than puberty suppressing medication (e.g., facial hair in those born with female bodies; breast development in those born with male bodies) and has fertility implications (Coleman et al., 2012). Despite the potentially irreversible nature of this intervention, in some cases, it may be in an adolescent's best interest to initiate gender-affirming hormone treatment as young as 14 or 15 years of age. Some providers feel that requiring youth with no complicating factors to wait until age 16 to start gender-affirming hormone treatment causes distress due to not physically developing at the same rate as their peers (Olson & Garofalo, 2014). This is considered an affirmative treatment option for youth who have been on puberty-suppressing medication for several years, have adequately explored gender-identity and fertility implications of gender-affirming hormone treatment with a knowledgeable mental health provider, and do not experience any significant and untreated mental health issues. However, given the less reversible nature of these interventions, and the lack of research to support the long-term benefits of this early intervention, the decision to veer from the current protocols should be done cautiously, with thorough psychological evaluation, and within an interdisciplinary team of providers (SAMHSA, 2015).

### Affirmative Care for Adolescents Differs From That for Adults

A recent change in the field of transgender health has been a shift to an "informed-consent" model of care for adults, which is much more affirmative than previous models that required various steps prior to being *approved* for medical interventions (Ehrbar & Gorton, 2010). In the past, these requirements typically included participating in a specific duration of therapy, socially transitioning to one of the binary genders (man or woman), and living full-time as this gender for a specified period of time (referred to as the real-life experience). The current SOC 7 no longer recommends this paternalistic approach when working with and treating transgender adults (Coleman et al., 2012), as it is assumed that adult transgender individuals are in tune with their internal senses of self and gender identity, and are capable of making decisions about their own lives, bodies, and identities. An informed-consent model typically involves a discussion with a medical or mental health provider about the desired medical interventions, including benefits, limitations, risks, and psychosocial implications. In addition, a mental health referral may be made if warranted, but it is usually up to the individual to decide whether to follow through with it (Coleman et al., 2012).

As is the case with adults, supporting transgender adolescents as autonomous decision makers is important and empowering. However, approaching work with TGNC adolescents the same way as with adults fails to take into account the numerous ways in which these groups differ. Specifically, adolescents' brains are still developing, particularly in the areas related to impulsivity and long-

term decision making (Steinberg, 2009). This is a critical point in considering whether it is advisable to rely solely on an adolescent's insistence that making a full gender transition, including irreversible medical interventions, is in that individual's best interest, particularly if it is a relatively recent proclamation with no history of gender dysphoria. Along these lines, the implications for fertility associated with gender-affirming hormone treatment is important to note when considering adolescents' wishes for these interventions, as it requires them to predict their future feelings about having biological children (Steever, 2014).

Adolescence is also considered the height of identity formation across multiple areas. It is possible that, for many TGNC adolescents, the solidification of their gender identities will crystallize during this time, but at varying speeds and with differing levels of insight. Thus, exploring this identity development with a knowledgeable mental health clinician and being more formally assessed for certainty about one's identity and expectations related to medical interventions may be more critical for adolescents than adults.

In addition, many adolescents are more susceptible to influence by their environments (e.g., peer groups; Simons-Morton & Farhat, 2010) and do not have the same legal rights and autonomous decision-making abilities afforded to adults. This may be detrimental to those who identify as TGNC but feel pressured by others to live in their assigned gender. In contrast, vulnerable adolescents who might be easily influenced by their peers might gravitate toward TGNC youth for support, and in doing so might identify gender identity as their primary identity struggle when in fact it may not be. Along the same line, some gender-exploring adolescents who feel more fluid in their identity may feel pressured by peers, parents, or providers to choose one gender, along with the associated medical interventions, to prove or convince others that their gender concern is real.

Finally, TGNC adolescents have family and social complications (Singh et al., 2014) that are often more intense and unavoidable than adults who are typically more independent. Thus, due to the implications of making such a change, transitioning for TGNC adolescents within the home and school environments may require more planning. For example, the impact of a TGNC adolescent's transition on family relationships could result in the adolescent having to choose between remaining in an unsupportive environment and becoming homeless. Due to the complexities described in this section, we believe that approaching TGNC adolescents in a supportive, yet thoughtful and cautious way is both affirmative and ethical.

### Affirmative Care With Cases Presenting With Additional Complexity

There are some additional circumstances that increase the complexity of work with TGNC adolescent and pre-adolescent children. First, youth who present with co-occurring mental health problems, including autism spectrum disorders, suicidality, self-injury, severe eating disorders, and/or trauma histories require additional assessment and consideration of how and whether these factors might be related to gender identity. Second, the presence of complicated family dynamics (e.g., divorced/separated parents, parents who disagree about treatment approaches) could potentially complicate treatment options. For example, some TGNC youth may identify as gender-queer or fluid in their identity, but

feel pressured by parents and others to choose a male or female identity and the medical interventions that accompany it. In contrast, TGNC youth who present with late-onset identity concerns (e.g., report no history of gender dysphoria) often cause parents to question the validity of their child's proclaimed identity and require more time to process the news. Lastly, cultural and religious factors of TGNC children and their families may play an important role in treatment; for example, families that ascribe to more traditional gender stereotypes and/or view gender identity as a binary construct may have a harder time comprehending the concept of gender fluidity or transition.

Addressing each of these complicating factors, or combination of factors, requires clinicians to be well-versed in the nuances that may present with any individual case. In addition, when complex cases present, it underscores the need for flexibility, moving cautiously, and taking an individual approach in clinical care that is both affirming and ethical. Because of the added complexity of working with TGNC youth, the importance of mental health involvement and proper psychological *readiness* evaluation prior to medical interventions cannot be overstated. Moreover, it is important to emphasize that, in an affirmative model of care, the complicating factors would not, in and of themselves, prohibit a TGNC youth from being referred for medical interventions.

### Importance of Interdisciplinary Work for Providing Affirmative Care

Given the etiological and clinical complexities associated with treating TGNC youth, diverse perspectives within the health-care field are necessary to provide optimal and affirmative care. Potential treatment interventions span many domains: advocacy efforts in schools and community at large, individual/family/group therapy, psychoeducation and support groups, parent consultation, psychopharmacology assessment and management, hormonal interventions (pubertal suppression and/or gender-affirming hormone therapy), fertility consultation, and/or surgical intervention. Therefore, a variety of disciplines may be useful in offering care to these adolescent and preadolescent children.

Gender-identity treatment clinics across the globe (Barrett, 2014; de Vries & Cohen-Kettenis, 2012; Esteva de Antonio, Gómez-Gil, & the GIDSEEN Group, 2013; Hewitt et al., 2012) and within the United States (Edwards-Leeper & Spack, 2012; Sherer, Rosenthal, Ehrensaft, & Baum, 2012) may have different treatment protocols outlined in their approach to caring for TGNC youth. However, they all have one major component in common: reliance on interdisciplinary perspectives and services. Within the last 5 years, the number of clinics offering gender-related services to youth within the United States has grown exponentially, with the majority of programs offering an interdisciplinary approach to assessment and treatment (Hsieh & Leininger, 2014). In addition, an interdisciplinary model is supported within clinical practice guidelines from major professional organizations, including the APA (2015), the WPATH (Coleman et al., 2012), the American Academy of Child and Adolescent Psychiatry (Adelson & AACAP CQI, 2012), and the Endocrine Society (Hembree et al., 2009).

Clinical programs for TGNC preadolescent children and adolescents differ by structure and availability of resources. The degree to which treatment protocols incorporate behavioral health providers and their roles in the treatment (e.g., determining appro-

priateness for hormonal interventions and/or providing psychosocial support) varies from clinic to clinic (de Vries & Cohen-Kettenis, 2012; Edwards-Leeper & Spack, 2012; Ehrensaft, 2012; Menvielle, 2012; Zucker, Wood, Singh, & Bradley, 2012). These protocols may depend on a number of variables, including patient age, availability of resources, ideologies of the team members, and logistical considerations.

Inherent in the clinical management of TGNC youth is the potential for disagreement among team members regarding the conceptualization of cases, evaluation processes, and treatment recommendations. The unsolved debate over the degree to which gender dysphoria is a biological or experiential phenomenon likely does little to bridge those gaps. In addition, the “gatekeeper” versus informed-consent discussion occurs within and between the teams working with youngsters. Despite the reality that, for many adolescents, gender identity may not be fully consolidated, some providers may prioritize the physical aspects of gender, while others may emphasize the psychological complexities of TGNC adolescents and highlight the social, emotional, and developmental contexts of such adolescents being considered for physical interventions. For these reasons, among others previously described, we suggest that initiation of physical interventions with adolescents only be considered after multidisciplinary perspectives are considered, which includes thorough psychological evaluation. We propose that those who practice within the affirmative-care model appreciate that requiring a thorough psychological evaluation for these youngsters is not inherently paternalistic or *unaffirming*, rather it is an appropriate and comprehensive way of ensuring that all relevant health-care perspectives are taken into account and best clinical outcomes are maximized. Although there is limited research available to guide interdisciplinary teams in making these important clinical decisions, the positive outcome data described previously were obtained through evaluations and treatments of TGNC adolescents by interdisciplinary teams, with a primary focus on mental health functioning. From this, we conclude that the importance of interdisciplinary work cannot be overstated in providing optimal care to this population.

### Conclusion

In a field in which assessment and treatment remain complex and controversial, and practitioners have minimal scientific understanding of phenomenology, supporting TGNC children and adolescents can often be challenging. Providing affirmative care is important in offering these youngsters a sense of hope, an element that is all too often missing in their lives. Balancing the provision of such care with the complexities and challenges that exist need not be impossible, yet requires providers to be aware of their assumptions and biases, recognize the developmental considerations involved, advocate creatively in the face of many logistical barriers, work within the multiple perspectives of an interdisciplinary environment, and stay current with the evolving science of gender.

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