Editor's Corner

Human Development 2013;56:285–290
DOI: 10.1159/000355235

Human Development

The Gender Affirmative Model: What We Know and What We Aim to Learn

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In the summer of 2013, Dr. Jack Drescher published an editorial opinion about gender-nonconforming children in the *New York Times* in which he stated: "Currently experts can't tell apart kids who outgrow gender dysphoria (desisters) from those who do not (persisters), and how to treat them is controversial" [Drescher, 2013, p. 1]. As members of a four-site child gender clinic group, we concur with Dr. Drescher regarding the controversy, but take issue with his assessment of experts and their inability to differentially assess "persisters" and "desisters" in childhood. We would like to take this opportunity to outline the gender affirmative model from which we practice, dispel myths about this model, and briefly outline the state of knowledge in our field regarding facilitators of healthy psychosocial development in gender-nonconforming children. The major premises informing our modes of practice include: (a) gender variations are not disorders; (b) gender presentations are diverse and varied across cultures, therefore requiring our cultural sensitivity; (c) to the best of our knowledge at present, gender involves an interweaving of biology, development and socialization, and culture and context, with all three bearing on any individual's gender self; (d) gender may be fluid, and is not binary, both at a particular time and if and when it changes within an individual across time; (e) if there is pathology, it more often stems from cultural reactions (e.g., transphobia, homophobia, sexism) rather than from within the child.

Our goals within this model are to listen to the child and decipher with the help of parents or caregivers what the child is communicating about both gender identity and gender expressions. We define gender identity as the gender the child articulates

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as being – male, female, or something else. Research and our clinical experience suggest that many children develop a strong sense of gender identity at a young age. In most children, that identification will match the sex assigned on the child's birth certificate, but in a small minority the affirmed gender will be other than that assignment. Learning from the work of Milton Diamond [2000], we understand gender identity, both in its match and mismatch with assigned natal sex, as primarily informed by a child's cognitions and emotions, rather than by genitalia and observable external sex characteristics. Gender identity is then to be differentiated from gender expressions: the manner in which a child presents gender to the world – physical appearance, toys chosen, preferred playmates and activities. The category ''gender-nonconforming children'' embraces all children exploring, questioning, or asserting their gender identities and/or their gender expressions outside of cultural expectations. By differentiating gender expressions from gender identities, we have a tool for sorting out the children who are insistent, persistent, and consistent in their affirmation of a cross-gender identity from those children who are either asserting or exploring gender-nonconforming expressions within acceptance of their natal gender assignment.

We have worked to dispel the myth that gender identity formation is synonymous with sexual identity formation (i.e., sexual orientation). Simply put, sexual identity refers to the gender(s) one is romantically and/or sexually attracted to, while gender identity has to do with what gender you are. These are two separate lines of development, albeit ones with crossovers for certain children. For example, many young boys explore the margins of gender identity on the way to later discovering their gay sexual identities; these boys will often fall within the category of desisters, shedding either their earlier gender nonconformity or dysphoria and developing into males who identify as gay [Ehrensaft, 2011].

In this model, gender health is defined 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. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at later risk for developing a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts [D'Augelli, Grossman, & Starks, 2006; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Roberts, Rosario, Corliss, Koenen, & Bryn Austin, 2012; Skidmore, Linsenmeier, & Bailey, 2006; Toomey, Ryan, Díaz, Card, & Russell, 2010; Travers et al., 2012]. While the developmental impact of our approach has yet to be rigorously studied, some evidence suggests that gender-nonconforming children are negatively impacted when given the message by therapists, doctors, or families that their gender expression must conform to traditional gender roles associated with their birth-assigned gender [Hill, Menvielle, Sica, & Johnson, 2010]. Psychotherapies attempting to tweak a child's gender identity or expressions have been shown to suppress authentic gender expression and create psychological symptoms [Bryant, 2006; Green, Newman, & Stoller, 1972]. What we can deduce is that these psychotherapies are unsuccessful because they aim to alter a child's emerging gender identity (i.e., an internal sense of self) by attempting to change the child's nonconforming gender expression (i.e., a behavior). Similar behavioral efforts to change aspects of *sexual* identity (i.e., reparative psychotherapies for homosexuality) have also proven unsuccess-

ful, deleterious, and lacking in efficacy [for a review, see Anton, 2010]. Professional health organizations, including the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Psychological Association, recommend against implementing such change efforts in clinical care [AAP, 1993; Anton, 2010; APA, 2000].

Newly emerging evidence indicating the positive influence of family acceptance on the psychosocial well-being of gender-nonconforming and transgender youth supports our gender-affirming model of care [Ryan, Russell, Huebner, Díaz, & Sánchez, 2010; Travers et al., 2012]. In a study of lesbian, gay, bisexual, and transgender young adults, reports of family acceptance related to sexual and gender identity/expression during adolescence were associated with positive self-esteem, increased social support, and overall health in early adulthood [Ryan et al., 2010]. Family acceptance was also found to protect youth against negative psychosocial health vulnerabilities commonly faced by gender-nonconforming and transgender youth (including depression, substance abuse, and suicidality). More recently, in a sample comprised exclusively of gender-nonconforming and transgender youth, those who reported their families as being strongly supportive of their gender identity and expression in childhood endorsed more positive mental health, less depressive symptoms, high self-esteem and life satisfaction in later adolescence compared with those whose families were non-supportive [Travers et al., 2012]. As concluded by the authors: "… anything less than strong support may have deleterious effects on a child's well-being" (p. 3). If that is so, we need to dispel the myths that confuse families and prevent that support from occurring.

Myths about the Gender Affirmative Model

Two myths regarding a gender-affirming approach misrepresent its underlying beliefs and assumptions. We outline these myths here.

Myth No. 1: Gender-affirming approaches conflate gender identity and gender expression; therefore, any child who exhibits gender nonconformity is believed to be transgender.

Nothing could be further from the truth. Given that the gender affirmative model purports that gender presentations are diverse and varied, gender identity itself is multiple in its possibilities, and can be paired with infinitely varied presentations. We recognize that non-transgender individuals express their identities in manifold ways, and embrace the welcome diversity that this facilitates. We also acknowledge that the majority of gender-nonconforming children presenting for clinical care related to gender dysphoria are desisters unlikely to mature into transgender individuals [de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Green, 1987; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995]. Thus, we dispute the notion that any child who exhibits nonconforming gender expression be considered transgender. Our stance, as gender-affirming practitioners, is that children should be helped to live as they are most comfortable. For a gender-nonconforming child, determining what is most comfortable is often a fluid process,

and can modify over time. Therefore, in a gender affirmative model, gender identity and expression are enabled to unfold over time, as a child matures, acknowledging and allowing for fluidity and change. Support, problem-solving, communication and acceptance can facilitate a child's self-understanding and choices, and allow time and space for exploration and self-acceptance within an infinite variety of authentic gender selves, whether it be in identity, expression, or both. To the extent possible, parents and others should be supported to endure what can be a confusing and socially challenging period.

Myth No. 2: The gender affirmative model asserts that gender identity and gender expression are immutable and removed from social context or influence.

This myth of "essentialism" suggests that our approach endorses gender identity as fixed at or before birth and that no outside forces help shape or influence a child's identity or expression. To the contrary, we recognize that all elements of a child's sense of self – their self-beliefs, emotional responses, cognitions, perceptions, expressions and assertions – develop and are informed by a complex interplay of cultural, social, geographic, and interpersonal factors [Bronfenbrenner, 1979]. The gender affirmative model holds central an awareness of prevailing societal norms pertaining to gender identity and gender expression. These norms, present even in language and pronoun structures, support a binary interpretation of gender (e.g., male vs. female). Children with nonconforming gender expression (whether or not they exhibit gender dysphoria) are at odds with prevailing gender norms. Those whose behaviors (and/or dysphoria) "persist" do so even while vulnerable to facing considerable isolation and disdain from family, peers and others, and often without many media models or others with whom to identify. This suggests a strong constitutional component for gender-nonconforming children, albeit one never exempt from environmental forces. Our objective is to support gender-nonconforming children in what may be fundamental to all elements of their sense of self. This understanding informs our model's premises that gender presentations are fluid and changing over time as well as our orientation that, to the extent possible, children should be comfortable to freely explore a range of gender identities and expressions without external and rejecting forces impinging upon them.

From Shattering Myths to Taking Action

The fields of medicine and psychology are only beginning to uncover the developmental trajectory of gender identity and expression in gender-nonconforming children. We have much to learn about the healthy development of these children and their families. For example, what are the comparative developmental outcomes of the various approaches for treating gender-nonconforming children and youth? Can we provide a fuller, accurate developmental picture distinguishing gender-nonconforming children who are transgender from gender-nonconforming children who may not be transgender? Is there any psychological harm done if a child transitions from one gender to another and then transitions back? What are the outcomes of receiving (or not receiving) psychosocial or medical interventions characteristic of gender-affirming support, which may include reversible pubertal suppression

therapy and irreversible cross-sex hormone therapy? Can we identify resilience factors and psychosocial risk factors in gender-nonconforming children and their families? What are the effects, both positive and negative, of the family, peer, socio-economic, and socio-cultural systems in which gender-nonconforming children develop? Are there instances in which a child's beliefs about gender identity can become confused by family and social forces, and how can we help to account for and counter such forces?

We invite other theoreticians and practitioners to consider the premises we have laid forth for the gender affirmative model, and the rationale supporting them. We also encourage the development of informal, multidisciplinary networks, such as our own, comprised of providers who abide by a gender-affirming model of care, are curious about finding answers to the questions about the gender-nonconforming children and youth we serve, and are eminently guided by the oath of our professions: to "do no harm." Together, we hope to make a positive difference in the lives of these children and families and in society at large so that gender in all its iterations can flourish.

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