# CIS-SUPREMACY:

# EXPERIENCES OF TRANS

# CHILDREN AND FAMILIES

# IN THE UK

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# Abstract

Growing numbers of trans children are being supported by their families in childhood, 'socially transitioning' pre-adolescence. Globally, there is limited literature on the experiences of this generation of affirmed trans children, with extremely limited literature on the experiences of trans children and families in the UK. This thesis addresses this research gap, listening to the experiences of trans children and their parents across important domains including in families, in schools and in healthcare. I approached the research as both an outsider and an insider, building on my experience as a non-binary parent of a trans child, prompting a significant emphasis on research ethics. The research sample centres UK-based families where a trans child socially transitioned under the age of eleven, with the average age of social transition within the sample being 7 years old (range 3-10 years old). The thesis draws upon a rich qualitative dataset formed from in-depth interviews with 30 parents and 10 trans children, with data analysed through reflexive thematic analysis. Findings are interpreted thematically and theoretically, drawing upon concepts of cisnormativity, gender minority stress and pathologisation. The thesis pulls together diverse threads and experiences to explore how cis-supremacy shapes trans children's lives, shedding light on the operation and impact of cis-supremacy in key systems and institutions. This research provides a valuable addition to the existing literature, enhancing understanding of experiences of cis-supremacy in families, school and healthcare, with analysis and insight relevant for policy and practice across diverse domains.

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# Part I – Introduction

# 1 Research Overview

## 1.1 Focus

Increasing numbers of trans children are finding support and affirmation in early or mid-childhood, living authentically pre-adolescence (Keo-Meier & Ehrensaft, 2018; Roche, 2020). Trans children in the UK, as elsewhere, are known to face a wide range of challenges, living and growing up within families, schools, societies and cultures that are not always trans-positive; where trans children may encounter ignorance, abuse and discrimination (Children's Right Alliance for England, 2016). Through my own personal and family experience, and through my close links with other families with trans children and wider trans communities (as elaborated upon in section 1.5 on researcher positionality), I was aware of a wide number of challenges that trans children face in the UK. However, trans children's voices and experiences, or the voices and experiences of supportive families of pre-adolescent trans children, are rarely heard in the literature (Gill-Peterson, 2018; Keo-Meier & Ehrensaft, 2018). Whether within the domain of education, healthcare, or well-being, the current literature contains very limited qualitative insights into the experiences of pre-adolescent trans children and their families, especially in the UK (Carlile et al., 2021; Davy & Cordoba, 2020; Rickett et al., 2021).

This thesis provides a significant addition to the literature, listening to the lived experiences of trans children in the UK who are supported by their families in pre-adolescence, as well as learning from the insights of their parents. It provides experience-informed insights into the challenges trans children encounter across a diverse range of spheres including family, education and healthcare.

## 1.2 Significance of this Study

The challenges and injustices trans children can face are poorly captured within existing literature or datasets in the UK. The 2018 UK LGBT inquiry (Government Equalities Office, 2018) explicitly excluded any submissions from, or on behalf of, transgender children under the age of 16. Likewise, the 2017 Stonewall School report (Bradlow et al., 2017), a report centring the experiences of LGBT pupils in the UK, only included the experiences of secondary school pupils aged 11-19, with no inclusion of younger trans children. The exclusion of pre-adolescent trans children from UK datasets arguably enables and perpetuates erasure and disenfranchisement of trans children in UK policy and practice. For example, a lack of evidence on the lives of trans children under 16 was cited in the 2016 Gender Recognition Inquiry by the Scottish Government, framing consultation on the need, or not, for legal rights for younger trans children (Scottish Government, 2017). The lack of research on younger trans children holds direct relevance for UK policy, law and practice, with best practices for supporting trans children a topic of extensive debate in the UK at the time of completing this research (Faye, 2021).

My research, focused on the experiences of trans children who socially transition pre-adolescence, is the first such research in the UK, and one of only a handful globally (Ehrensaft et al., 2018; Olson, 2016). It deepens understanding of the experiences of pre-adolescent trans children in the UK, focusing on a specific cohort, trans children who have been supported by their families to socially transition under the age of eleven (see section 1.4 for details on terminology including the term 'social transition'). As such, the research has significant relevance for a wide range of stakeholders; from families of trans children; to policy makers and practitioners within healthcare, education or in social or children's services.

## 1.3 UK Context

Trans children's rights in England, Scotland and Wales are protected under the Equality Act 2010, with "gender reassignment" one of nine protected characteristics (Wadham et al., 2016). The protected characteristic of gender reassignment applies to trans children, encompassing anyone who "is proposing to undergo, is undergoing, or has undergone a process (or part of a process) of…changing physiological or other attributes of sex", the latter including, for example, pronoun change (Wadham et al., 2016, p.20). Equality Act protection supports trans children's rights in spheres including in education. Department of Education advice on the application of the Equality Act in schools makes explicit that transgender pupils are protected from discrimination noting that it is "unlawful for schools to treat pupils less favourably because of their gender reassignment" (Department of Education, 2014, p.17). At time of writing in 2022, there is no UK national trans inclusion guidance for schools. UK educators instead need to look to a variety of alternative guidance materials on trans-inclusion (Equaliteach, 2020; Stonewall, 2018; The Church of England Education Office, 2019). Many existing UK resources focus on the most overt and extreme forms of transphobic bullying or violence, with less focus on addressing more subtle experiences of cisnormativity and institutionalised transphobia known to make life more stressful for trans pupils (Formby, 2015; Horton, 2020).

The UK has seen a recent (since 2016) rise in political and legislative challenges to trans rights (Faye, 2021). Current legal protections are under scrutiny, and in 2022 new guidance from the UK's Equality and Human Rights Commission (EHRC, 2022) proposed an expanded interpretation of the circumstances under which discrimination against trans people, including trans children, is legal, with

consequences of this new EHRC guidance as yet to be seen. From 2018 to 2022 a series of Scottish and UK-wide consultations on reform of the 2004 Gender Recognition Act spurred debate on trans people rights, with, to date, no significant revision to the process of birth certificate change (Faye, 2021). As of 2022, there is no route for trans children to correct their birth certificate. Trans adolescent healthcare has been a topic of significant public attention over the period of this thesis (Faye, 2021). Debate on appropriate approaches to healthcare culminated in 2020 legal challenges (*Bell vs Tavistock*, 2020) that initially withdrew NHS access to trans adolescent healthcare, before being overturned at appeal in 2021 (*Bell vs Tavistock*, 2021). A majority of the children and families within this sample were directly impacted by the original December 2020 '*Bell vs Tavistock*' case, with the initial judgement and its interpretation by NHS England curtailing access to trans adolescent healthcare (de Vries et al., 2021). Ongoing media-driven pressure about trans adolescent healthcare led the UK government to launch the Cass review (Cass, 2020) into children's gender services. Anti-trans lobbying on conversion practices, combined with a pathologising 2022 interim report from Cass (Cass Review, 2022), contributed to a 2022 announcement by the UK government that trans conversion practices would be excluded from a long-awaited UK ban on conversion therapy (British Psychological Society, 2022). Trans children are affected by all of the above areas, across policy, media and law, yet their voices and experiences are rarely heard. My research therefore comes at a time of high scrutiny, alongside low evidence, on trans children's experiences in the UK.

## 1.4 Terminology

Before proceeding into the research questions and the theoretical underpinnings of the research, it is important to clarify or introduce some of the terminology used within this thesis. The word 'trans' is used to describe anyone whose gender identity does not align with the gender they were assigned at birth, with 'trans' herein including those who are binary-oriented as well as non-binary (Vincent, 2020). The antonym of 'trans' is the word 'cis', designating anyone whose gender identity does align with the gender they were assigned at birth (Vincent, 2020). The term 'transitude' is used to describe a non-medicalised state of 'being trans' or 'transness' (Ashley, 2018a, p. 4). Where all ages under 18 are included (including the youngest pre-primary and primary school children) the term "trans children" has been used. Where necessary this is divided into trans children and trans adolescents, and where appropriate the term "trans young people" or "trans youth" is used, with the term "youth" excluding younger children and including young adults (UNDESA, 2013). The research references the UK education system, utilising the term 'primary education' to include education up to age ten, and 'secondary education' from age 11 to age 16 or 18 years old. The research references the UK healthcare system or National Health Service (NHS), particularly 'primary healthcare' meaning General Practitioners (GPs) and family doctors, or 'tertiary care', which in this research typically refers to specialist NHS Children's Gender Clinics.

The term 'social transition' is used to describe the point at which a trans child is recognised as the gender with which they identify, commonly accompanied by a change of pronoun (Ehrensaft et al., 2018). A child who 'has socially transitioned' is a child who is being recognised and affirmed in their gender. 'Affirmation', and the associated healthcare paradigm of 'Gender Affirmative Care', encompasses an

approach that embraces trans children, supporting them to live authentically at any age without shame, rejection or problematisation of their identity. When referencing puberty, the thesis distinguishes between 'endogenous puberty', which is puberty driven by the sex hormone produced in an adolescents' body, a puberty that can be traumatic for many trans adolescents; and 'exogenous puberty', which is a puberty driven by externally administered sex hormones, or Hormone Replacement Therapy (HRT) (Chung et al., 2020).

## 1.5 Researcher Positionality

I am motivated to understand the forces that make the lives of trans children hard (or that can make trans children's lives easier), focusing on the impact of cisnormativity and systems of institutionalised cis-supremacy (see chapter 2 for more on these concepts). Through my own personal and family experience, and through my close links with other families with trans children and wider trans communities, I'm aware of a wide number of areas where cisnormativity influences and shapes the lives of trans children, in the UK and globally.

As non-binary parent of a young trans child, I have privileged access to families of trans children, and personal experience that has enriched my contributions to this important research topic. I was able to build upon high existing levels of trust with families of trans children through personal connections and my own active role for many years in family support groups. When speaking with trans children I framed my knowledge of the challenges trans children face in schools, disclosing my own position as a parent of a trans child, and asking children, for example, whether their school would be a good place for a trans child like my daughter to attend. This affirmative framing of my positionality was likely important in gaining trust and active participation (as discussed further in chapter 3).

I also draw upon and take inspiration from a number of other sources in framing how my positionality informs my research. I take inspiration from trans scholars like Florence Ashley, Ruth Pearce and Kelley Winters, in striving to call attention to cis-supremacy and pathologisation of trans lives, and aspiring for greater attention to ethics within research with or on trans populations. I take inspiration from parent scholars like Annie Pullen-Sansfacon, in striving to use my experience-based insights from trying to be a good-enough parent to, and advocate for, a young trans

child, to shape my approach to this cohort. I also draw upon and take inspiration from work by Karl Bryant, who wrote about moving from researchee to researcher (2007). Bryant's work, and their reference of moving from researchee to researcher resonated with me, drawing upon my own experiences as a researchee, and my experience as a clinical service-user of children's gender clinics as a parent of a trans child. I note that my experiences as researchee or service user of children's gender clinics differs very significantly from Bryant's, who was a child being researched upon, whereas my experience was as a parent of a trans child. The power differences between the role of adult researchee and parent service user, and child researchee are ones that I am very aware of, and ones that I have tried to consider in detail, as explored in my methodology section (chapter 3), particularly the section on research ethics. Nevertheless, my own experiences as a researchee and service-user, many of them negative or upsetting, have certainly influenced my ethical approach, and my emphasis on trans-positivity, depathologisation, avoidance of cisnormativity, and commitment to trans-emancipatory research, topics that are introduced in subsequent sections.

## 1.6 Publication Ethics

My research maintained a commitment to respecting the importance of timeliness of research dissemination, particularly important for research focused on the experiences of marginalised children, as discussed in the research methodology section (chapter 3). I have made efforts to publish findings in open access academic journals at the same time as completing this thesis, recognising the importance of research timeliness for trans children currently experiencing harm (see Annex 1 for details of published work). Across the following sections, where findings have already been translated into academic articles this is noted. Within my approach to publication ethics, I have also built upon work by trans scholars who emphasise accessibility and impact for trans communities. Dean Spade references how responsibilities towards trans communities influence his publication ethics:

> "I write from within and about social movements and my writing is based in a passionate desire for change, so my priority is to write in places where my work can be most available to people with cross-disciplinary investments in transformative change" (Spade, 2010, p. 4)

Accordingly, alongside a commitment to timely academic publishing, I uphold an ethical commitment to increasing accessibility and outreach, both through a commitment to publishing academic articles in open-access journals, and through efforts to communicate research findings through non-academic media including blogs, infographics and social media.

## 1.7 Research Questions

This thesis focused on understanding the experience of socially transitioned trans children and their families, with a focus on trans children who socially transition under the age of eleven in the UK. My research addressed broad research questions including:

- What external factors shape the experiences of socially transitioned trans children under the age of twelve?

- What impacts do these factors have on trans children and their families?

These broad research questions were explored across three important spheres, examining experiences at home, at school and within healthcare (see chapters 5-7). Within each of these spheres, the research investigated topic specific research questions, summarised below (see Tables 1-3).

**Table 1: Topic Specific Research Questions: Families (Chapter 5)**

| Section | Research Questions |
| --- | --- |
| 5.2 Experiences of Social Transition | 1) What are parents and trans children's experiences of pre-pubertal social transition? <br> 2) What can we learn from parent and child accounts of their experiences before and after a pre-pubertal social transition? |
| 5.3 Parent Reflections on Supporting a Trans Child | 1) How do parents who have supported a child's social transition reflect upon their experience? <br> 2) How do such parents evaluate the risks and benefits of pre-pubertal social transition, and what experience-informed advice do they have for other families? |
| 5.4 Delaying Social Transition | 1) What insights can parents of socially transitioned trans children share on their experiences of affirmation or delayed transition? <br> 2) How do such parents reflect on their approach towards the timing of social transition? |

**Table 2: Topic Specific Research Questions: Education (Chapter 6)**

| Section | Research Questions |
|---|---|
| 6.2 Trans Pupils' Experiences at School | 1) What challenges do trans children experience in primary and early secondary education?<br>2) How does institutional cisnormativity impact on trans pupils in the UK? |
| 6.3 Gender Minority Stress in Education | 1) Do trans children experience Gender Minority Stress at school?<br>2) How does GMS manifest within primary and early secondary education in the UK? |
| 6.4 Developing a Staged Model for Trans Inclusion | 1) What different approaches can schools take to trans inclusion?<br>2) How does cis-supremacy influence approaches to trans inclusion in education? |

**Table 3: Topic Specific Research Questions: Pathologisation & Healthcare**

| Section | Research Questions |
|---|---|
| 7.2 Pathologisation of Trans Children | 1) How do families with trans children experience the pathologisation of childhood transness?<br>2) What implications do experiences of pathologisation have for UK policy and practice? |
| 7.3 Parent Experiences in UK Children's Gender Clinics | 1) What are parents' experiences in UK Children's Gender Clinics? |
| 7.4 Children's Experiences in UK Children's Gender Clinics | 1) What are children's experiences in UK Children's Gender Clinics? |
| 7.5 Experiences of Puberty and Puberty Blockers | 1) What are parents' experiences of navigating puberty, including experiences accessing or attempting to access puberty blockers, with a socially transitioned trans child?<br>2) What are trans children and adolescents' perspectives on navigating puberty, including experiences accessing or attempting to access puberty blockers? |
| 7.6 Parental Decision Making on Puberty Blockers | 1) How do parents of trans children feel about puberty blockers?<br>2) How do they navigate decisions of providing parental consent?<br>3) How do parents weigh up and reflect upon the risks and benefits of puberty blockers for trans early adolescents? |

# 2 Theory and Focus

This chapter contains four sections, providing a comprehensive overview of the theoretical influences that have shaped this thesis. Section 2.1 provides an overview of the process of selecting an appropriate theoretical foundation for this thesis, explaining how the theoretical focus shifted as the research and analysis proceeded. Section 2.2 introduces three key theoretical pillars that have resonated with my data. Pathologisation, cisnormativity and gender minority stress are each introduced in turn and framed in their relevance to this thesis. These three theories are later woven across my research findings (chapters 5-7). Section 2.3 highlights the limitations of these three theoretical pillars, and my increasing shift towards greater consideration of power and subjugation. Section 2.3.1 brings into the thesis theory on white supremacy, discussing how associated scholarship resonated with and strengthened the analysis in this thesis. Section 2.3.2 pulls together all the above theoretical strands into an overarching theory of cis-supremacy. Cis-supremacy is presented as the critical theoretical framework for this thesis, building upon existing theory, supplemented with my research-driven contributions to theory (as is expanded upon in the conclusion to this thesis, in chapter 8). The final section of this chapter (section 2.4) revisits the high-level research questions (introduced in section 1.7), refining and grounding the research questions in the aforementioned scholarship and theory.

## 2.1 The Evolution of Theory

As referenced in other trans focused theses (Barras, 2021) there is a strong ethical case for centring trans scholarship and trans theoretical frameworks in research centring trans lives (Pearce, Steinberg and Moon, 2019; Vincent, 2018). This ethical commitment influenced my search for the most appropriate theoretical foundation for my thesis, drawing from a wide body of trans scholarship. This chapter provides an overview of the theories that have guided and influenced my work, bringing a theoretical lens to research on the experiences of trans children in key systems and institutions including schools, families and healthcare. My starting point lay in my key research questions (as introduced in section 1.7), wanting theory that resonated with and helped explain the external challenges that impact on trans children's lives, influencing trans children's well-being and life chances.

As I undertook my literature review and primary data collection and analysis, I identified three distinct theories and concepts as critical to the understanding of the experiences of trans children and their families. 'Pathologisation', or the framing of diversity as sickness (Suess Schwend et al., 2014), impacts significantly on trans children, influencing attitudes, institutions, policies and wider society. 'Cisnormativity' (Berger & Ansara, 2021) captures the reality of trans children navigating through environments designed by and for cis people, with no emphasis on equity or making space to welcome trans lives. 'Gender minority stress' (Hendricks & Testa, 2012) informs my consideration of the toll borne by trans children within pathologising & cisnormative societies, where institutions tolerate or enable discrimination & injustice. Each of these form theoretical pillars that support and underpin this thesis, as discussed further in section 2.2.

As I analysed and wrote up my research findings (presented in chapters 5-7), the above three theoretical strands weaved in and out of my focus, with recognition of their substantial inter-linkages. At times my research placed more emphasis on cisnormativity or gender minority stress, whilst in other places pathologisation better aligned with or added understanding to the research.

As I neared completion of the thesis, I remained dissatisfied with those three theoretical frameworks, feeling they partly, but not entirely, captured the themes and findings in my research. I was drawn to the work of Black scholars (Crenshaw, 1988; hooks, 1987), looking to critical race theory and work theorising the impact of white supremacy. I found it important to bring to the table an explicit focus on power and domination, as is discussed in section 2.3. I decided to focus more on cis-supremacy (see section 2.3.2), building from theoretical scholarship on white supremacy (see section 2.3.1). This emphasis on cis-supremacy enabled a more pronounced examination of the active nature of trans oppression and subjugation. This approach builds upon existing scholarship by trans people of colour, who draw attention to the roots of anti-trans discrimination in colonialism and white supremacy (Gill-Peterson, 2018).

Cis-supremacy evolved into an overarching theory for this thesis as elaborated in section 2.3.2. Academic scholarship on cis-supremacy is limited, and this thesis makes a contribution to theory in combining trans scholarship on pathologisation, cisnormativity and gender minority stress with theory and scholarship on white supremacy, under a banner of cis-supremacy. This combination, and the resulting overarching emphasis on cis-supremacy, enables us to recognise pathologisation, cisnormativity and gender minority stress not only as ill-informed acts of omission, but also as intentional acts of commission, symptoms of

active and systemic domination of trans children. Cis-supremacy draws focus to a

reality that trans children face inequality and injustice not only through ignorance, but

through attitudes, institutions and systems that seek to perpetuate systems of cis

dominance. This theme is introduced in section 2.3 and 2.4, and revisited in the

conclusion (chapter 8).

## 2.2 Three Key Theoretical Pillars

This section summaries three critical theories or concepts that have informed this thesis. This section encompasses i) pathologisation ii) cisnormativity and iii) gender minority stress, with each theory introduced and examined in turn.

### 2.2.1 Pathologisation

Pathologisation (or psycho-pathologisation) is a term used to describe the manner in which non-standard identities are defined by authorities as being medically disordered (Gill-Peterson, 2018; Inch, 2016). Trans identities have long been pathologised, with childhood trans-ness or transitude (Ashley, 2018a, p. 4) categorized as inherently pathological, with implications for how trans children are treated in healthcare, in legislation and in society (Winter, 2021). Pathologisation is further examined in the historical and modern context in the literature review in section 4.1.1.

Across the 20th century and into the first decade of the 21st century, a majority of research on trans children was grounded in a negative view of gender diversity (Ansara & Hegarty, 2012). A majority of such literature started from an assumption that gender diversity was disordered or pathological, focusing research into attempts to understand causation or attempts to cure or prevent a presumed confusion (Ashley, 2018b; Baril & Ashley, 2018; Global Action for Trans* Equality, 2013; Hegarty, 2009; Jones, 2017; Serano, 2018b; Stewart, 2018; Temple Newhook, Winters, et al., 2018; Tosh, 2011; Winters et al., 2018). Psychologists, sexologists and psychoanalysts dominated the field, with the voices of trans and gender diverse children or their families rarely heard in clinical literature (Ansara & Hegarty, 2012;

Bryant, 2006, 2007). Whilst trans identities were medicalised and marginalised, young trans children were near invisible in the academic literature and public consciousness, with gender diversity pathologized or hidden (Brill & Pepper, 2008; Bryant, 2007; Gill-Peterson, 2018).

In the past decade there has been a global movement away from pathologisation of gender diversity (Bryant, 2006, 2007; Coleman et al., 2012; Ehrensaft, 2012; Menvielle, 2012; Spack et al., 2012). Gender affirmative approaches, where trans identities are neither problematised nor pathologised, are becoming mainstream (Ashley, 2019c; CASW ACTS, 2015; Ehrensaft, 2016; Hidalgo et al., 2013; Lopez et al., 2017; Murchison et al., 2016; Oliphant et al., 2018; Rafferty et al., 2018). This shift towards gender affirmative approaches is underpinned by growing evidence of the harm of abuse and rejection of trans children, including the harms of 'conversion therapy' (Ashley, 2022a; Bryant, 2007; Roberts et al., 2012; Turban et al., 2020).

Attention has been be paid to pathologisation across this thesis, with depathologisation embedded into research ethics (section 3.5.6), considered in the literature review (section 4.1.1) and forming a discrete segment of the primary research (section 7.2).

## 2.4.2 Cis-supremacy in Education

**Figure 1: Cis-supremacy in education**
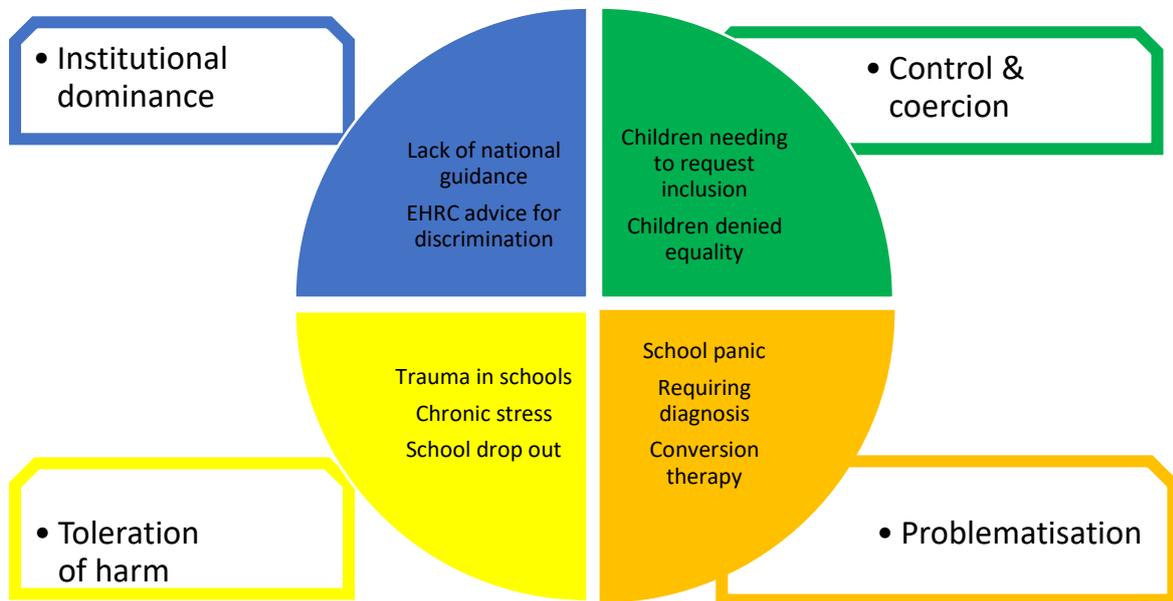


As will be explored in chapter 6 of this thesis, schools can adopt different approaches to the *control and coercion* of trans pupils. The more extreme schools (those referred to in chapter 6 as demonstrating cis-supremacy in full dominance), control pupils' self-expression and identity, forcing trans pupils to perform coercively enforced genders. Less abusive but still harmful forms of control are seen in schools where trans pupils are left to negotiate their own inclusion, where trans pupils need to make themselves intelligible and agreeable to be granted school permission to be themselves. Coercion is seen within this thesis, where trans pupils' acceptance is conditional or a negotiated compromise, where certain domains of inclusion (e.g., name change) are offered to pupils who are not overly challenging or assertive of their rights. This thesis has evidenced examples of how, in such schools, pupils who demand genuine equality can be labelled troublesome or asked to leave.

*Problematisation* is seen in both the literature (Horton, 2020; Payne & Smith, 2014a) and in this thesis in schools reacting with panic to a trans pupil or treating a trans pupil as an unexpected (or troublesome) deviation from the expected. It is seen in examples in this thesis where school leadership defined a trans pupil as an inherent safeguarding risk, or even in school leadership proposing conversion therapy for a trans pupil. Problematisation is reinforced in curricula and teaching that marginalises and others trans pupils, problematising their lives, bodies and identities.

*Toleration of harm* is seen across this thesis with examples of schools and the education system more broadly failing to protect trans pupils. As covered in this thesis (chapter 7), trans pupils can experience trauma and chronic minority stress in schools, with significant negative consequences for pupil well-being, educational attainment and school attendance. Tolerance of harm to trans children is seen in local authorities removing previously published council guidance for supporting trans pupils in schools in the face of anti-trans legal challenges (Loft & Long, 2020)

At a systemic level, *cis power and institutional dominance* over trans pupils is revealed in the continued absence of national guidance on inclusion of trans pupils in education, with anti-trans political interference in educational guidelines (Hunte, 2022b). It is apparent in statements from the UK attorney general instructing schools to "take a much firmer line", encouraging the misgendering, discrimination and segregation of trans pupils (Milton, 2022c).

## 2.2.2 Cisnormativity

A short definition of cisnormativity is 'the assumption that everyone is cisgender or should be' (Keo-Meier & Ehrensaft, 2018, p. 11). The term cisnormativity evolved from an earlier term, cissexism or cissexual privilege (Serano, 2016), and is used alongside a similar term, 'cisgenderism' (Kennedy, 2018b). Serano (2011, para. 29) talked about cissexism as a societal double-standard that conveys social and legal legitimacy on cis people's identities, with cis identities "taken for granted and considered valid in a way that trans people's are not", providing cis people with an advantage. Bauer et al. (2009, p. 356) introduced the term 'cisnormativity', and emphasised the ways in which it shapes "the policies and practices of individuals and institutions, and the organization of the broader social world", producing a society where trans people are invisible, where the existence or needs of trans people is not even considered in systems, policies and societal assumptions. Cisnormativity echoes and builds upon associated scholarship on heteronormativity (Robinson, 2016). Scholarship on heteronormativity has examined how societies and cultures reinforce an assumption that heterosexuality is 'normal', where institutions and policies privilege those who are heterosexual, and where the production of homosexuality as abnormal or inferior enables and legitimizes systemic discrimination (Berlant & Warner, 1998; Rich, 1980; Warner, 1991).

This thesis uses the term cisnormativity (Berger & Ansara, 2021), in preference to related and overlapping terms including cisgenderism (Ansara & Hegarty, 2012) and cissexism (Serano, 2016). The term cisnormativity is used for consistency and accessibility, drawing attention to areas of systemic oppression experienced and directed at trans and non-binary people. I prefer to use the term cisnormativity, echoing the semantic use of terminology such as transnormativity

(Riggs et al., 2019) and heteronormativity. For me, cissexism carries echoes of older and less used terminology like 'cissexual', whilst cisgenderism carries associations with problematic and dated terminology like 'transgenderism'. GLAAD (n.d., para. 34) advises against use of the term 'transgenderism' describing it as a term "used by anti-transgender activists to dehumanize transgender people". Terminology is recognized as evolving and dynamic.

Miller (2016) describes the impact of systemic and institutionalised cisnormativity in institutions like schools as a continued macroaggression, delegitimising trans pupils and creating schools that are unsafe for trans children. Cisnormativity normalises trans invisibility, enabling trans exclusion and erasure (Kennedy, 2018b). When trans individuals enter into contact with cisnormative systems, this can produce "a social emergency" because "both staff and systems are unprepared for this reality" (Bauer et al., 2009, p. 356). According to Newbury (2011), challenging trans inequality first requires a greater focus on cisnormativity.  Commenting on a Twitter thread of trans people expressing anger at cis people, Newbury (2013) connects this anger to structural cisnormativity. Structural cisnormativity exacts disproportionate harms to trans people, threatening their health and security and limiting their opportunities. Daily, unpredictable, distressing encounters with structural cisnormativity, leaves trans people in a "constant state of alert" that "manifests as a persistent level of stress unknown to their cis counterpart" (Newbury, 2013, para. 2).

Cisnormative systems, attitudes and practices provoke stress in trans individuals, stress that may not have been intended, or even noticed, by cis people designing, managing or participating in cisnormative systems. Consideration of cisnormativity and the impacts of cisnormative systems can also align with

theoretical scholarship on 'institutional betrayal', considering the way in which

individuals are harmed when institutions act, or more often fail to act to protect them

(Smith & Freyd, 2014).

Cisnormativity also influences research agendas and approaches, shaping

and encouraging pathologising research, producing a double standard where cis

identities are considered natural and the default, whilst trans identities are presumed

un-natural and in need of explanation (Bryant, 2007). Such cisnormative double

standards have led to a past prioritisation of pathologising research agendas that

look to determine the meaning or causation of trans children's identities, failing to

help address the challenges that impact on trans children's present or future well-

being.

Cisnormativity is an influential theory embedded across this thesis, informing

the ethical principles underpinning this research (section 3.5.6), guiding the selection

of research questions (section 1.7), and considered across the primary research

(chapters 5-7).

### 2.2.3 Gender Minority Stress

Research over the past decade has demonstrated that socially transitioned children who are supported have good levels of wellbeing (Durwood et al., 2017, 2021; Ehrensaft et al., 2018; Olson et al., 2016). Factors associated with wellbeing in transgender children include family functioning (Katz-Wise et al., 2018), family support (Klein & Golub, 2016; Simons et al., 2013; Travers et al., 2012), use of chosen name (Russell et al., 2018), inclusion and representation (Holtby et al., 2015). Research is now starting to focus on the external challenges experienced by trans children and families, recognising that poor mental health is often driven by discrimination and prejudice (Alegría, 2018; Capous-Desyllas & Barron, 2017).

The theory of 'gender minority stress' (GMS) posits that trans and gender diverse people face specific stressors that contribute to reduced levels of mental health and well-being. A framework for GMS was developed by Hendricks and Testa (2012), highlighting a range of areas of internal or external stress that can impact on the lives of trans people. Further detail on their framework, its roots in earlier scholarship on minority stress experienced by sexual and racialized minorities (Brooks, 1981; Cyrus, 2017; Hendricks & Testa, 2012; Meyer, 1995),  and its application in primary research, is provided in the literature review in section 4.1.3. Within this thesis GMS provides a critical theoretical foundation, centering the recognition that trans people are not inherently prone to poor mental health, but rather are left vulnerable to unequal outcomes in societies that do not welcome, and are often hostile to trans lives. GMS is considered within research ethics (section 3.5), within the literature review (section 4.1.3) and within the primary research, in particular in section 6.3.

## 2.3 Power and Supremacy

When starting this thesis, I was more concerned with the concept of cisnormativity, where trans individuals are disadvantaged in systems that were not designed with consideration of any need for trans inclusion. Within cisnormativity there is at times an assumption of unintentional discrimination, of systems that are designed by cis people for cis people, where trans people are an after-thought, systemically yet perhaps unintentionally disadvantaged. Across this thesis there were certainly areas where cisnormativity has shaped systems in ways that disadvantage trans children. Yet as the PhD progressed, I felt the need to look beyond cisnormativity, reflecting on the many scenarios where the presence of trans children is now recognised, where the harm to trans children of cisnormative practice is visible, and yet where systems are still not shifting or being re-configured to ensure cis-trans equality. As is discussed further in the conclusion (chapter 7), this thesis came up against institutions, attitudes and practices where there appeared a reluctance to reform, and a continuing commitment to cis-supremacist hierarchies where trans children experience subjugation, control, coercion and oppression. I was interested to go beyond an understanding of the past cisnormative forces that have shaped and created current systems that disadvantage trans children, to consideration of the current forces that perpetuate and encourage continued inequality and injustice. I looked to rich scholarship on white supremacy (section 2.3.1) for theoretical consideration of systemic forces of domination and subjugation, and brought this theoretical understanding into a focus on cis-supremacy (section 2.3.2).

## 2.3.1 White supremacy

Within this section I explore work on white supremacy, intending to draw upon this theoretical foundation to inform this thesis' examination of power and domination.

In 'Black Power' Ture and Hamilton (1967) outline the significance of institutional racism, and the role of white supremacy in the domination of black people politically, economically and socially. bell hooks finds the term 'white supremacy' is "the most useful term" to explain the "exploitation of black people and other people of color" (hooks, 1995, p. 184). According to Mills (2003, p. 42) white supremacy is a "multidimensional system of domination" that impacts across juridico-political, economic, cultural, cognitive-evaluative, somatic, and metaphysical spheres. It operates as a "power structure of formal or informal rule, socioeconomic privilege, and norms for the differential distribution of material wealth and opportunities, benefits and burdens, rights and duties" (Mills, 1997, p. 3). White supremacy describes "a system, a particular kind of polity, which is structured so as to advantage whites" (Mills, 1994, p. 110). Under white supremacy the interests and perceptions of white subjects are "continually placed centre stage and assumed as 'normal'" (Gillborn, 2006, p. 318). It produces and sustains "a one-way flow of power, whereby benefits accrue to white people, to the detriment of nonwhite people" (Walton, 2020, p. 7). Ansley describes how white supremacy bestows advantages on white people:

> "White supremacy is concretely in the interests of all white people. It assures them greater resources, a wider range of personal choice, more power, and more self-esteem than they would have if they were (1) forced to share the above with people of color, and (2) deprived of the subjective sensation of

superiority they enjoy as a result of the societal presence of subordinate non-white others" (Ansley, 1989, p. 1035).

Crenshaw (1988, p. 1365) describes white people being ignorant to systemic racialised advantages: "Because rights that other Americans took for granted were routinely denied to Black Americans, Blacks' assertion of their "rights" constituted a serious ideological challenge to white supremacy". Walton (2020, p. 9) writes about how white supremacy benefits "Whites to the detriment of non-Whites… being sustained, in part, through the actions of individuals and groups who gain a range of benefits from its continued existence".

Some scholarship on white supremacy falls into field of 'critical race theory', a discipline with a central focus on power and inequality (Delgado & Stefancic, 2002). Critical Race Theory "sets out not only to ascertain how society organizes itself along racial lines and hierarchies, but to transform it for the better" (Delgado & Stefancic, 2002, p. 4). Power is integral to scholarship on white supremacy with Mills (2003, p. 41) drawing attention to the centrality of "racial domination and subordination", whilst Ansley (1989, p. 998) talks about "the conditions of white dominance and black subordination".

Gillborn (2006, p. 319) calls out "a tendency for talk of 'privilege' to mask the structures and actions of domination that make possible, and sustain, white racial hegemony". For Gillborn (2006, p. 319) we need to centre consideration of power and domination: "the issue goes beyond privilege, it is about supremacy". Mills (1994, p. 110) emphasises the importance of centring analysis of institutionalised power, highlighting that a focus on racist attitudes or prejudices "deflect(s) attention

away from the massive power differentials… in the real world between nonwhite individuals with bigoted ideas and institutionalized white power". bell hooks also centres an examination of structural and institutionalised power differentials, stating:

> "Why is it so difficult for many white folks to understand that racism is oppressive not because white folks have prejudicial feelings about blacks (they could have such feelings and leave us alone) but because it is a system that promotes domination and subjugation?" (hooks, 2009, p. 12).

According to Walton (2020, p. 7), white supremacy "captures the reality that racism operates, in part, as a process that is constantly re-established by white agents (consciously and unconsciously), acting within societal frameworks that encourage and facilitate this re-enforcement of an unequal, racist status quo". hooks outlines the importance of recognising racism as "nefarious, global, systemic, and constant— not easily dismantled simply because a few good white people want racist thoughts and actions to go away on convenient terms" (Davidson, 2009, p. 68).

Several scholars emphasise a distinction between systemic racial injustice and racialised hatred. For hooks (2009) white supremacy describes a system that privileges white people over others, regardless of the presence or the absence of racial hatred. Ansley (1989, p. 1024) outlines a similar definition of white supremacy:

> "By "white supremacy" I do not mean to allude only to the self-conscious racism of white supremacist hate groups. I refer instead to a political, economic and cultural system in which whites overwhelmingly control power and material resources, conscious and unconscious ideas of white superiority and entitlement are widespread, and relations of white dominance and non-

white subordination are daily re-enacted across a broad array of institutions and social settings".

Ansley (1989, p. 1024) emphasises that systemic and structural uses of the term 'white supremacy' do not "constitute denial that that some forms of white supremacy are more virulent than others". Leonardo (2004) distinguishes between white supremacist groups that propagate racist violence and the wider concept of white supremacy. Leonardo (2004, p. 138) maintains that "domination … does not form out of random acts of hatred, although these are condemnable, but rather out of a patterned and enduring treatment of social groups". Gillborn (2006, p. 319) outlines that:

> "white supremacy is not only, nor indeed primarily, associated with relatively small and extreme political movements that openly mobilize on the basis of race hatred (important and dangerous though such groups are): rather, supremacy is seen to relate to the operation of forces that saturate the everyday, mundane actions and policies that shape the world in the interests of white people".

Crenshaw (1988, p. 1336) highlights the importance of distinguishing between "the mere rejection of white supremacy as a normative vision" and "a societal commitment to the eradication of the substantive conditions of Black subordination". She emphasises that condemnation of white supremacist ideals is insufficient for transformative justice:

> "(A) society once expressly organized around white supremacist principles does not cease to be a white supremacist society simply by formally rejecting those principles. The society remains white supremacist in its maintenance of

the actual distribution of goods and resources, status, and prestige"

(Crenshaw, 1988, p. 1336).

Mills (2003, p. 41) critiques equality efforts that ignore race, arguing that efforts that purport to be 'colour blind' constitute "obfuscation of the clearly asymmetrical and enduring system of white power itself". For Crenshaw (1988, p. 1364), efforts to achieve racial equality need to contend with "the political realities of racism and the inevitability of white backlash against any serious attempts to dismantle the machinery of white supremacy". Gillborn (2006, p. 318) talks about how white supremacy centres white interests, mobilising "structural and cultural forces to defend white power at the expense of the racialized 'Other'" Accordingly, any efforts for genuine equality will always constitute a radical change to the status quo (Crenshaw, 1988).

Scholars of fascism have analysed the overlaps and intersections between different oppressive forces, "the intertwining of fascism with white supremacy, patriarchy, gender hierarchy, and movements against LGBT equality" (Stanley, 2018, p. 13). Colonialism relied upon coercion and control including through the policing of racialised and gendered boundaries, with colonialisation enforcing white supremacy and anti-LGBT discrimination (Han & O'Mahoney, 2018). Researchers have emphasised the historical parallels and interconnections between white supremacy, misogyny, homophobia and transphobia, with white supremacy committed to upholding rigid social and gender norms (Capo, 2017). Janet Helms emphasises the ways in which white heterosexual men inherit both "the power to control society's resources" and ability to design how systems function, determining the "rules for competing for" society's resources (2017, p. 6). She highlights how social institutions across education, government, and healthcare are designed to maintain and

perpetuate such domination, designed by and delivering for those with institutionalised power (Helms, 2017).

Ansley emphasises that white supremacy can only be dismantled through the collaboration of different groups who have been harmed by it:

"Bringing an end to white supremacy, and otherwise redistributing power and resources, will require the union of many kinds of people who have suffered many kinds of harms, sometimes even at each other's hands" (Ansley, 1989, p. 1047).

hooks (1993) talks about collective struggle towards 'radical equality'. With reference to race, class and gender inequality, she calls for "passionate commitment to a vision of social transformation that (is) rooted in a radically democratic idea of freedom and justice for all" (hooks, 1993, p. 6).

Within this thesis I draw upon scholarship on white supremacy, building from that rich theory and bringing it into discussion on cis-supremacy (see section 2.3.2). There is a strong history of cross-learning between scholarship on different axes of oppression, recognising the multi-dimensional and intersectional nature of forces of power and domination (Crenshaw, 1991a). Cross-fertilisation between different theoretical approaches has already occurred for example in the area of 'minority stress'. In scholarship on minority stress we have seen cross-learning and collaborative evolution of theory from scholars focused on minority stress experienced by lesbian women (Brooks, 1981), gay men (Meyer, 1995), trans people (Hendricks & Testa, 2012) and minority stress experienced by racial or ethnic minorities (Cyrus, 2017; Millar & Brooks, 2022; Sattler & Zeyen, 2021; Velez et al., 2017; Wei et al., 2010). In the next section (section 2.3.2) I have built on that legacy,

drawing from scholarship on white supremacy to construct and refine a theory of cis-supremacy.

## 2.3.2 Cis-Supremacy

In this section, recognising and acknowledging the parallels to scholarship on white supremacy, I introduce and examine the concept of cis-supremacy.

Cis supremacy is understood as a situation where cis people hold power over trans people, with trans people subject to control, systemic injustice and coercive violence. Connell (2012) has written about how 'gender orders' or 'regimes' govern the functioning of societies and institutions. Sharrow (2021, p. 1) builds on that concept with explicit reference to cis-supremacy, describing how institutions are a "site for advancing, enshrining, and normalizing cis-supremacist gender orders". As white supremacy examines structural forces of power and domination that benefit white people, so cis-supremacy brings into focus the structural forces of power and domination that benefit cis people.

A body of trans scholarship explicitly and implicitly explores power and cis-supremacy, centring the importance of transformational action and systemic change, including work by Namaste (2000) Serano (2016), Pearce (2018), Spade (2015), Kennedy (2018a), Gill-Peterson (2018), Faye (2021) and Ashley (2022). Ruth Pearce (2018, p. 201) writes about how power is wielded in trans healthcare systems, shaping not only how trans people access (or are denied) healthcare, but even shaping our imagination of "trans possibilities". Referencing the institutional power held by gender service clinicians, Pearce (2018, p. 206) emphasises that "it does not really matter whether or not practitioners relish the exercise of power… Power is exercised regardless". Shon Faye (2021) writes about trans liberation,

focusing on the need to dismantle systems that marginalise trans people. Dean Spade (2012, p. 193) calls for "critical trans resistance" to support "those living under the most severe forms of coercive violence".

For Spade (2015, p.1), a critical trans politics "demands more than legal recognition and inclusion, seeking instead to transform current logics of state, civil society security, and social equality". Spade's work draws upon a combination of critical race theory, intersectionality theory, women of colour feminism, queer theory, critical disability studies and Foucauldian notions of disciplinary power and population management (2015). Spade (2015, p. 5) describes how (cis-supremacist) norms operate across society, "producing security for some populations and vulnerability for others". Spade (2015) focuses on "administrative violence" in systems that force people into narrow categories of gender to get their basic needs met, with those who are not intelligible or acceptable within those categories subject to violence and danger. Echoing Foucault's work on 'subjectification' (Dreyfus & Rabinow, 2013), Spade moves away from a focus on "oppression", proposing "subjection" as a more accurate and nuanced description of the ways in which cis-supremacist power is held and wielded (Spade, 2015). Spade highlights how cis-dominance is not only maintained by powerful individuals and institutions, but spread throughout our lives, influencing our own self-image and what trans futures we deem possible (Spade, 2015).

Spade talks about the "racialized-gendered distribution schemes that operate at the population level… (that are) founded on the production and maintenance of race and gender categories as vectors for distributing life chances" (Spade, 2013a, p. 1). Spade's focus on intersectionality and white supremacy aligns with wider influential trans theorists such as Gill-Peterson. Within the ground-breaking text 'The

Histories of the Transgender Child' Gill-Peterson (2018) examines the racialised and colonial roots of cis-supremacy, exploring how a combination of white supremacy and cis supremacy has impacted on trans children throughout the 20th century, with histories of trans children of colour subjected to greater gate-keeping, psychiatric detention or incarceration. Following in the footsteps of Black feminist scholars (Crenshaw, 1991b; Hill-Collins, 1990; hooks, 1987) Gill-Peterson emphasises that trans emancipation cannot be meaningfully achieved whilst ignoring other areas of systemic injustice (Gill-Peterson, 2018). Spade echoes this commitment to intersectionality, emphasising the roots of cis-dominance in white supremacy, and presenting critical trans politics as resistance to racialised gender norms:

> "A system of racialised gender norms operates as social control. …Enforcing and policing these lines…happens everywhere, in schools, courts, health centres, welfare offices, at checkpoints, in families, at jobs, in the media, in therapist offices, in shelters and jails and prisons. People who don't fit into their prescribed category and roles, or who are hard to read, are considered suspicious, and face surveillance, criminalisation and violence. Or they are considered disruptive, and excluded from the programmes and institutions that operate through these binaries…. Trans politics is a politics of resistance against violent gender norms" (Spade, 2013b).

The above quotation comes from Spade's intentionally accessible video manifesto titled 'Impossibility Now' (Spade, 2013b). Like many trans scholars (see also Florence Ashley), Spade centres transformative action in his scholarship, with this extending to his approach to publication:

"I write from within and about social movements and my writing is based in a passionate desire for change, so my priority is to write in places where my work can be most available to people with cross-disciplinary investments in transformative change" (Spade, 2010, p. 4).

This commitment to action and accessibility is also a key ethical commitment (as discussed in section 1.6 and section 3.5) informing this thesis, making Spade's scholarship an effective guiding framework. This thesis draws upon a strong theoretical legacy of trans scholarship to examine how cis-supremacy impacts on the lives of trans children and their families in the UK, considering paths of trans resistance, and imagining futures of trans emancipation.

## 2.4 Towards a Theory of Cis-supremacy

In this section I take steps towards a theory of cis-supremacy, articulating how key attributes of cis-supremacy apply to or impact on trans children and their families. Cis-supremacy is here defined as the exertion of power and control over trans people, in this case trans children, in cis-dominated institutions, systems and societies. Cis-supremacy relies less on feelings of hate or fear of trans people, but on attachment to or toleration of an unequal status quo. Within this theory of cis-supremacy, four components are highlighted.

- Control and coercion
- Problematisation
- Toleration of trans harm
- Cis power & institutional dominance

In this thesis I propose these four components as helpful ways of understanding the operation and impact of cis-supremacy. I have selected these four components, drawing from my analysis and reflection upon the data in this thesis, underpinned by the wider literature (as synthesised in chapter 2 and chapter 4). The above four components of cis-supremacy can be seen across all domains of trans children's lives. In this section I provide a data-informed exploration of cis-supremacy in action, looking at cis-supremacy in families (2.4.1), education (2.4.2), healthcare (2.4.3) and across society (2.4.4).

## 2.4.1 Cis-supremacy in Families

**Figure 2: Cis-supremacy in families**
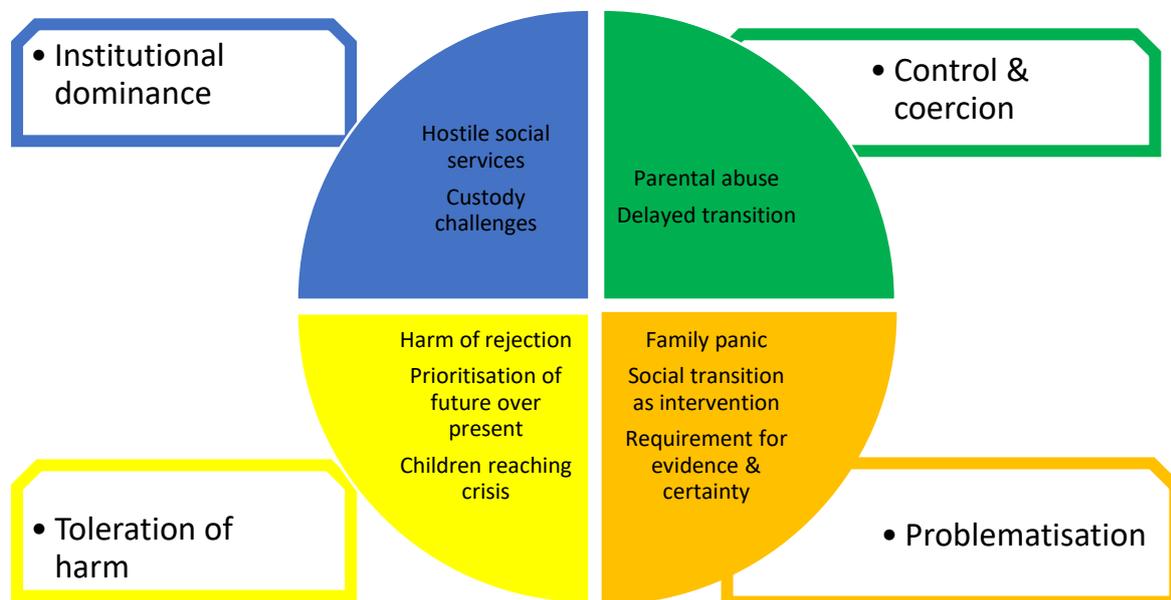


Chapter 5 of this thesis will examine how cisnormativity shapes and informs how families react to a trans child. More extreme forms of family *coercion and control* are not shown in this thesis, though glimpses of the parental abuse that we sadly know to occur can be seen in clinician accounts (Riggs & Bartholomaeus, 2018b) as well as through insights into transphobic parent groups where guides to parental coercion and control of trans children are promoted (Conrad, 2022). This thesis does however clearly evidence the control and coercion that takes place even within families who grow to support trans children in childhood.

*Problematisation* of transitude is seen in family reaction to a child's identity assertion, with carers and family members reacting with concern, fear or disbelief. Problematisation is seen in family reactions rooted in a misperception of trans as pathology or as a mental health concern. Problematisation is also embedded in

'social transition' being considered an 'intervention' that requires evidence, justification and adult approval.

Toleration of harm is seen in parental accounts of requiring a given amount of distress before accepting their child's transness. It is present in accepted mantras of a child needing to demonstrate insistence and persistence for their identity to be deemed authentic or worthy of support. Toleration of harm is present in family accounts of children growing in distress, and only at the point of self-harm, suicidal ideation or extreme distress being supported. Toleration of trans harm is inherent in cultures where supporting a trans child in early childhood is seen as exceptional or extreme, with childhood suffering accepted for trans children. Toleration of harm is inherent in approaches that encourage parents to delay acceptance and affirmation, and in approaches that value the prediction of future identities above protection of current happiness and self-esteem. Toleration of harm to trans youth is also seen in approaches, as recently endorsed by a recent UK Minister for Education, that ask schools to out trans children to potentially transphobic or abusive parents (Kelleher, 2022a)

Cis power and institutional dominance are most obvious where families come into contract with cis institutions such as social services and family courts. Within my sample one parent referenced the double standard of needing expert testimony from multiple professionals to enable a simple first name change for a transgender adolescent, when such measures would not be required for a cis child. Institutional dominance is most stark where families suffer malicious reporting to social services; when supportive families face court proceedings and threats to child custody purely for supporting a trans child. Such dominance is apparent in a number of high profile UK court cases, back to 2016 when a judge who denied the existence of trans

children removed a young child from her supportive parent (Horton, 2016). A number of subsequent UK court cases against supportive parents of trans children have ended in a variety of different outcomes in terms of custody of trans children, significantly depending on whether a cis dominant judiciary can be persuaded of the legitimacy of trans childhood (Parsons, 2020b). I am unaware of any UK cases of families being investigated or having custody challenged for rejection, coercion or abuse of a trans child. Cis dominance is also apparent in speculation that upcoming NHS guidelines will recommend safeguarding reviews for any families seeking evidence-based trans healthcare from outside the NHS (GenderGP, 2022). This type of institutional cis-dominance puts supportive families with trans children at particular risk, and fails to centre trans children's rights and wellbeing. It demonstrates trans children's potential vulnerability when facing ignorance or prejudice from cis-dominated institutions.

### 2.4.3 Cis-supremacy in Healthcare

**Figure 3: Cis-supremacy in healthcare**
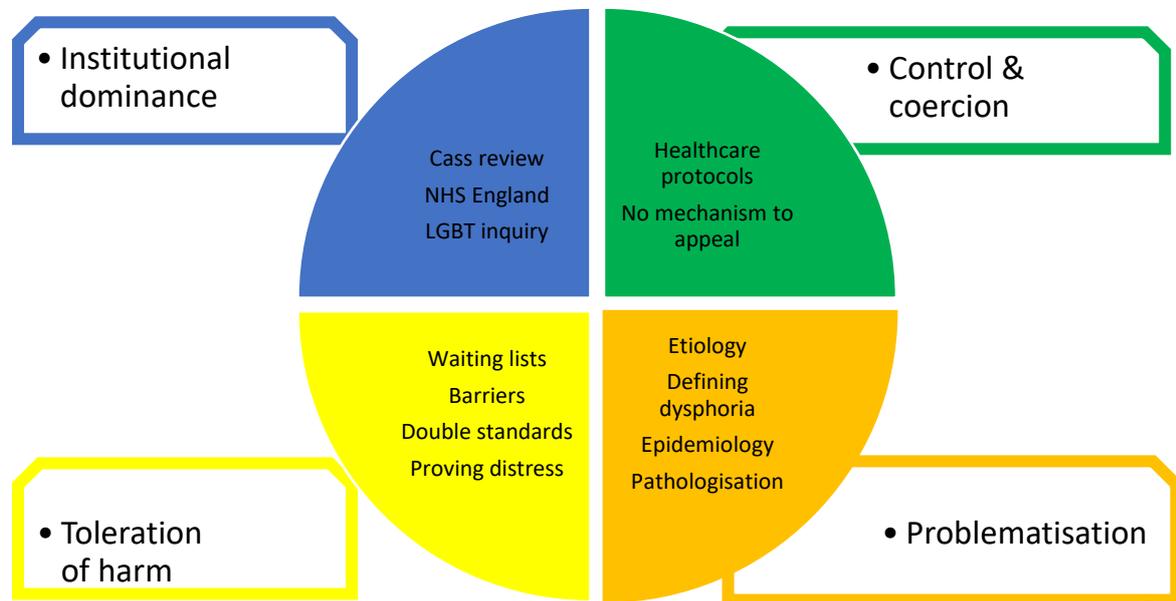


*Control and coercion* can be seen across trans youth healthcare protocols and practices in the UK. Under current NHS protocols, trans youth are obliged to submit themselves to ongoing psychotherapy, in order to be eligible for access to wider healthcare (NHS, 2020). Interim guidance from the Cass Review reinscribes such coercion, with psychoanalytical counselling still proposed as essential for access to endocrine services, and participation in research a compulsory prerequisite for access to medication (Cass Review, 2022). Commitment to the control of trans youth is evident in statements from the UK Minister of Health Sajid Javid that emphasise the appropriateness and indeed importance of clinicians questioning and challenging trans children on their identities before gaining support or access to healthcare (Milton, 2022b). My thesis has evidenced the feeling of powerlessness that children and families describe in a system where gatekeepers hold absolute power, with no clear routes to challenging clinician authority and no emphasis on child rights.

*Problematisation* of childhood transitude is seen across trans youth healthcare in the UK. Despite the World Health Organisation's ICD-11 (2021) commitment to depathologisation, no proactive effort or commitment from the NHS or UK government has been seen. Instead, NHS authorities and UK healthcare stakeholders, whilst nominally acknowledging transitude is not a mental health disorder, continue to problematise trans children. This is evident in healthcare research priorities such as those prioritised by the Cass Review that problematise trans existence, asking for evidence on the etiology or epidemiology of transness (Cass, 2020; Cass Review, 2022; Milton, 2022b). This type of problematisation or pathologisation was also seen in the 2021 Nuffield Council for Bioethics call for evidence on 'care and treatment for children and adolescents in relation to their gender identity in the UK' that sought evidence on the "nature of gender dysphoria", looking for evidence and consensus on whether gender dysphoria is "a genetic, hormonal, neurodevelopmental or psychiatric condition" (Nuffield Council on Bioethics, 2021). In a critique of Nuffield's search for cis-led consensus on trans healthcare Pearce (2021b, para. 16) highlights the error in presuming consensus of views is feasible or desirable when contending with anti-trans prejudice: "There is no dispassionate, ethical middle ground to be found between those who wish to support young people to explore their identities and needs, and eliminationists who have openly aligned themselves with racist, homophobic, and transphobic rhetoric".

Processes like the Cass Review also assert cis institutional power in their inclusion of anti-trans contributions, with Cass specialist stakeholder engagement research including opinion from deeply pathologising professionals alongside and on equal footing to the views of trans-positive professionals (Cass Review, 2021b). The Cass Review has been criticised for its approach to consensus, with professionals

from the Australian children's gender service stating that "Cass seems keen to find a way forward that ensures 'conceptual agreement' and 'shared understanding' across all interested parties, including those who view gender diversity as inherently pathological" (Pang et al., 2022b). The Cass Review chose not to prioritise any basic ethical commitments to separating out the opinions of actively anti-trans professionals, being unwilling or unable to ethically navigate an area where individual prejudice is known to heavily bias professional opinions and practice (Brown et al., 2018; Riggs & Sion, 2017; Stroumsa et al., 2019; Turban et al., 2018). Problematisation of trans children within UK healthcare directly feeds into problematisation in politics, media and wider society. An example of this can be found in the 2022 statements from the UK Minister for Health Sajid Javid, who emphasised the need for clinicians to look for evidence of 'what has caused children to be trans', citing the Cass Review to claim that transitude is likely to be a response to "child sex abuse" (Milton, 2022b).

*Toleration of harm and devaluation of trans lives* can be seen across UK healthcare. The NHS has allowed waiting lists for initial appointments in children's gender clinics to grow year on year, from an unacceptable 10 months wait for appointment in 2016, through to 2022 when the service is currently seeing those who were referred 5 years ago in 2017 (personal records). Access to puberty blockers is a time-sensitive intervention, and healthcare services have given no weight to the suffering of trans children and adolescents caused by such delays. Healthcare services are not taking responsibility for the short and long-term damage to trans lives where access to critical healthcare is denied. Double standards can be seen in the discrepancy in the evidence required, or the hurdles and delays to accessing the same medication when used for trans you or cis youth (e.g. puberty blockers when

administered to cis children in precocious puberty) (Giordano & Holm, 2020). Double standards and the devaluation of trans lives are also evident when the UK media reports on one woman consenting to go through testosterone-driven puberty and later regretting testosterone-driven pubertal changes as evidence of unacceptable harm, whereas hundreds of trans girls going through unwanted testosterone-driven puberty, against their wishes, whilst waiting for or being denied access to healthcare is seen as acceptable (Baker, 2019). I recall an informal conversation with a GIDS clinician some years ago, who related how if even one of her patients accessed hormones and later regretted it, it would weigh heavily on her conscience. When asked if the hundreds more trans youth who are forced through exactly the same pubertal changes but against their wishes weighed similarly on her conscience she replied it did not. It struck me then, as now, that this is evidence of a gross discrepancy, of an acceptance of trans suffering, with trans lives, bodies and trans happiness valued significantly less than cis lives.

*Cis power and institutional dominance* can be seen in the lack of trans leadership in or trans accountability in trans healthcare. Cis dominance is shown in the current (as of late 2022) wording of the NHS website for gender dysphoria, that was in 2020 revised to include unevidenced and widely dis-credited mis-information on trans children's healthcare (NHS, 2020). The NHS as a body has been unresponsive to trans community demands for transparency in the evidence or process that led to the addition of material that is most commonly put forward by anti-trans groups (personal correspondence with those who have submitted complaints). Cis dominance is shown in the Cass Review explicitly disavowing trans expertise in its governance, clearly stating in its original design that its assurance group "deliberately does not contain subject matter experts or people with lived

experience of gender services" (Cass Review, 2021a). This exclusion of trans expertise, a stark demonstration of cis-supremacy in healthcare governance, is all too common in the UK. In a 2021 critique of a pathologising Nuffield Council on Bioethics consultation on trans youth health (a consultation that problematised trans existence and contained no trans community leadership in design or governance) Pearce (2021b, para. 10) emphasised that, in excluding trans leadership they "are reproducing, once again, the power imbalance that has dominated trans medicine for the past two centuries". Cis-dominance is evident in the Equality and Human Rights Commission consulting with known anti-trans lobby groups before calling for the government to exclude trans people from protection from conversion therapy (Hunte, 2022a).

Cis dominance over trans youth can be seen in examples from my data (presented in section 7.2) of authorities refusing to question the actions of transphobic healthcare professionals. One parental interviewee from my dataset described encounters with a transphobic paediatrician who had advised their child's school to misgender and reject their child, "making sure that [Child] is reminded of her 'biological reality', and making sure that adults and other children around her right are reminded" [P]. The parents were confident that this prejudice-based intervention was against standards of acceptable medical practice, but described finding no institutional support, with healthcare authorities backing their cis professional. The parents described their local health board completely dismissing their complaint, responding to say that "she can do no wrong really, she's our trusted professional in this area. And she's had all the training" [P]. This is just one example of systemic failure to take seriously complaints of transphobic practice, with no institutional accountability for associated harm. The same pattern can be seen in the

lack of successful routes to challenge clinician authority within GIDS - I have had privileged access to a number of well-documented complaints that have been entirely dismissed by the cis-led authorities who manage complaints about GIDS practice.

Cis-dominance is also evident in systemic unresponsiveness to trans feedback. For example, trans and community led evidence-based submissions (including submissions by myself, by trans academics and community groups) to the consultation on the 2016 GIDS service specification were entirely ignored (GIRES, 2016). Likewise, trans-child focused submissions to the 2018 Women and Equalities Committee's inquiry into health and social care and LGBT communities were all discarded[1] and excluded from the resulting report and action plan (Government Equalities Office, 2018). Trans-centred research was also noticeably ignored in the Cass Interim report (Cass Review, 2022), with cis clinician expertise from pathologising healthcare centres in the Netherlands and UK centred, with limited citation of clinician's from affirmative healthcare centres in the US or Australia, and with community and youth voices noticeably absent (Pang et al., 2022b). Cis power is also evident when powerful cis actors like the Prime Minister, the Secretary of

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[1] In late 2018 I collated trans child focused submissions to the 2018 LGBT health inquiry. Out of the 61 submissions that were made publicly available, 18 focused on trans children's healthcare. 9 were from anonymous parents of trans children, 1 from a named parent of a trans teen, 1 from an anonymous trans teen, 5 from organisations and 2 from adults. All criticised the harms in GIDS' outdated approach to trans children's healthcare. I also collated (collected through closed parent support groups) copies of submissions that were submitted but not published (as some parents asked for their submission to be kept private and not published on the government website – these tended to focus on specifics of failings in the care of individual children under GIDS). I was sent copies of an additional 7 unpublished submissions. Altogether I collated 25 submissions that focused on trans children's healthcare (out of around 85 total submissions). Despite this enormous effort, trans children's healthcare was not considered in the subsequent report and action plan – after the consultation was closed those running the consultation announced that the review would only focus on health issues of relevance to all LGBT people, excluding any focus on trans-specific healthcare.

State for Health and those with ministerial equality briefs question the validity of, or

call to remove, trans children's healthcare (Hansford, 2022; Milton, 2022b, 2022d;

Parsons, 2020a; Raza-Sheikh, 2022).

## 2.4.4 Societal Cis-supremacy

In this final sub-section on developing a theory of cis-supremacy I move beyond the domain-specific focus of this PhD, to consider cis-supremacy at wider societal level. I draw both from my research as well as my own positionality as someone with lived experience in the UK to reflect upon how cis-supremacy operates at a societal level. A detailed evidence-based analysis of societal cis-supremacy and its impacts on trans children is beyond the scope of this thesis, however here I give an example of how a theoretical framework of cis-supremacy provides a useful tool for such an analysis.

**Figure 4: Societal Cis-supremacy**



- Institutional dominance
- Control & coercion
- Toleration of harm
- Problematisation

Platformiong of hate groups
Transphobia in all political parties
Media prejudice & culture war

Culture of fear & insecurity
Powerlessness

Harms to trans children unreported
Double standards
Acceptible transphobia

Media scare stories
Moral panic
Social contagion
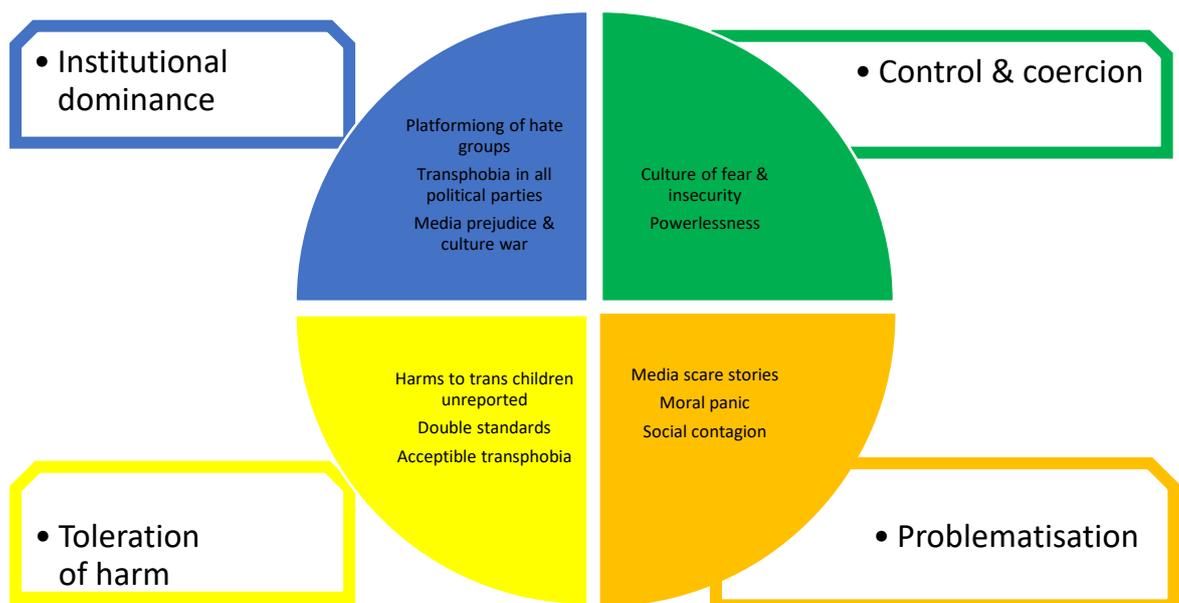
*Control and coercion* at a societal level is seen in the production of a culture of insecurity and fear for trans children and supportive families. Across my dataset families and children referenced consistently high levels of fear and stress in a UK society where trans possibilities, especially for trans children, are tightly controlled. Within this thesis interviewees highlighted examples where trans children's rights

were under attack, with efforts to control and limit access to healthcare, access to spaces and access to safety. The UK's approach to consulting on trans rights, trans-inclusive education, or trans children's healthcare can itself operate as a form of coercion. Without trans leadership, such consultations can be overwhelmed with anti-trans input, with trans communities feeling compelled to respond simply to defend existing rights. Pearce emphasises that "we respond not with hope or optimism, but in fear. This is the power you wield over us" (2021b, para. 18).

*Problematisation* of trans children at a societal level is present across UK media, with an onslaught of mis-information and scare stories with headlines like 'children sacrificed to the trans lobby' (Baker, 2019). Problematisation is seen in the UK government calling for an investigation into reasons behind a rise in the rate of referrals of trans boys when the actual number remains far below expected population prevalence (Ashley, 2019d).

*Toleration of trans harm* at a societal level is evident in the child rights stakeholders who could stand up for trans children's rights and well-being, but who choose not to. Examples include Children's Commissioners advocating against trans children's rights (Adamson, 2021), children's rights groups furthering anti-trans debate about trans children (Duffy, 2016), or more often, groups failing to speak up for trans children's rights (Horton, 2018). Toleration of trans harm is evident in UK media coverage driving a moral panic that inflates the harms of a single adult who regrets the medical interventions they chose and consented to, whilst ignoring the harms voiced by hundreds of trans people denied essential healthcare (Baker, 2019).

*Cis power and institutional dominance* over trans children at a societal level is visible in actions of the UK's Equality and Human Rights Commission, in providing

Equality Act guidance that emphasises opportunities for discrimination against trans people (Milton, 2022a). Cis-dominance is visible across UK politics, with transphobia dominating the 2022 UK Conservative leadership contest (Kelleher, 2022b), and persistent anti-trans rhetoric seen across all UK political parties (The Week UK, 2022). Cis-dominance is deeply entrenched across UK media, with media coverage that stokes misinformation and culture war about trans children (Faye, 2021; Kelleher, 2022c). This includes a majority of mainstream UK newspapers, particularly the Sunday Times, the Telegraph and the Guardian, as well as specialist publications from the Economist to the British Medical Journal (GATE, 2022; Levin et al., 2018; Uglow, 2019; Wells, 2021). Anti-trans sentiment and specific hostility to trans children's rights and evidence-based healthcare is also well-documented in the UK national broadcaster, the BBC (Duffy, 2020, 2021; Hopper, 2017; Hunte, 2021; ILGA Europe, 2022).

Evidence of toleration of trans harm is also present in the UK government's discontinuation of funding to tackle LGBT bullying in schools despite acknowledging that LGBT youth are disproportionately at risk with significant short and long-term harms (Hunte, 2020; ILGA Europe, 2022)

## 2.4.5 Theory-Driven Research Questions

Cis-supremacy, and associated concepts of pathologisation, cisnormativity and gender minority stress constitute important theories for my research, encompassing critical external factors that impact on the experiences of trans children and their families in the UK. Across the data-focused chapters (chapters 5-7) and in the conclusion to this thesis (chapter 8) I will examine two theoretically framed research questions:

- How do cisnormativity, pathologisation and gender minority stress impact on trans children's experiences in the UK?

- How does cis-supremacy in key systems and institutions including schools, families and healthcare shape trans children's lives?

# 3 Methodology

## 3.1 Research Design

Within this thesis I have prioritised qualitative research, analysing primary data drawn from in depth interviews with families with trans children. The research was informed by a critical realist epistemology, with an experiential orientation to data (Braun & Clarke, 2013). This approach centres interviewees' own accounts of their experiences, in keeping with the study's exploratory research questions that prioritise listening to people's own experiences (see sections 1.7 and 2.4). The research design adhered to reflexive thematic analysis, an approach suited to exploratory studies in novel or under-researched areas (Braun & Clarke, 2006; Rendle et al., 2019).

Qualitative data were drawn from a sample of 30 families with trans children in the UK. There are no reliable numbers on the number of trans children in the UK, as is the case internationally (Ashley, 2019d). Surveys from the US have shown 1 in 250 (Meerwijk & Sevelius, 2017), 1 in 140 (Herman et al., 2017), or 1 in 20 (Pew Research Center, 2022) teenagers or young adults are transgender. Within this research the inclusion criteria for parent interviewees were i) being a parent or carer of a socially transitioned trans child in the UK; ii) their child having socially transitioned under the age of eleven; and iii) their child currently being under age 16. To recruit participants, details about the study were shared on closed online spaces in six UK support groups for parents of trans children. None of these six support groups are actively trans-hostile, with group moderators ensuring the groups are a safe space away from transphobic discourse. Avoidance of advertisement on trans-hostile parenting fora was judged as unlikely to affect the sample, as trans-hostile

parents would by definition not support a trans child's social transition under the age of eleven, and therefore would not fall into the cohort prioritised in this research. Additional interviewees were brought in via snowball sampling, through introduction from other members of these parent support groups. Access to hard-to-reach families and children was enabled by my positionality as a non-binary parent of a trans child, helping overcome trust related barriers to hearing from this cohort (Dwyer & Buckle, 2009; Paechter, 2013). I am a member of four of these closed online spaces and posted there directly, with other parents sharing details on two other groups. I had previously met several interviewees at trans family support groups, although the majority of interviewees were unknown to me prior to the research. The interviews were empathetic and open. They were designed with the explicit intent of putting interviewees at ease, using active listening techniques (Rogers & Farson, 2015) to provide interviewees with the space to share their experiences. Researcher positionality, with aspects of being both an insider and an outsider to research participants (Paechter, 2013), shapes this research, with a priority on authenticity, ensuring the research accurately represented the diverse experiences and perspectives shared by interviewees (Dwyer & Buckle, 2009). No incentive or token of appreciation was provided to interviewees, beyond the opportunity to anonymously share their experiences with broader audiences. The sample of interviewed parents were also asked to consider inviting their trans child to participate, with a third of their trans children opting to share their experience.

## 3.2 Sample

Thirty parents were interviewed from across England, Scotland and Wales. Individualised demographic information is not presented, responding to participant requests for additional privacy in a small, vulnerable and potentially identifiable cohort. 30 (100%) parental interviewees were cis; 27 (90%) were white; 28 (93%) were female and 7 (23%) were disabled. 21 (70%) were aged 40-50 years old, and 3 (10%) were immigrants to the UK. Interviewees had a wide range of levels of household income, and a range of levels of education, with 6 (20%) reporting secondary education as their highest qualification, 11 (37%) reporting a graduate degree and 13 (43%) a post-graduate degree as their highest qualification. In terms of sexual orientation, the cohort was more diverse than the national average, with 18 (60%) parental interviewees in this sample identifying as heterosexual, compared to 94% of adults in the UK on average (Office for National Statistics, 2021). From the parents in this sample 7 (23%) were pansexual, 3 (10%) bisexual and 2 (7%) were gay or lesbian.

The parents interviewed shared experiences of 30 socially transitioned trans children, including 15 girls, 12 boys and 3 non-binary children. These children socially transitioned at an average age of 7 years-old (range 3-10 years old). At time of parental interview, the trans children of these parents were on average age 11 years-old (range 6-16 years old). Further details on the children of the interviewed parents are provided in Annex 2. Ten trans children, who were children of ten of the interviewed parents, were also interviewed. These children were on average 12 years old at time of interview (range 9-16 years old) and had socially transitioned an average of 4.5 years before the interview.

## 3.3 Data Collection

Interviews were conducted remotely via Microsoft Teams during the period December 2020 to November 2021. Research has shown remote interviews can be effective at building interviewee rapport and enabling sharing of deeply personal experiences (Jenner & Myers, 2019). Semi-structured interviews, covering broad topics including healthcare, education and families, lasted 1-3 hours (mean 2 hours) for parents, and 20-50 minutes for children (mean 25 minutes). Interviews utilised broad open-ended questions, allowing interviewees to talk openly and at length around each topic. For example, under the theme of social transition, key parental questions included: "Has your child socially transitioned? Can you tell me about your experience?". Following each initial answer, prompts were used flexibly to elicit further responses for example "Can you tell me about the time before the point of social transition", "What do you remember about the time when the social transition occurred?", "How were things in the months/years after that?"

The interview methodology with trans children was flexible, adapting to individual child preference with most interviews conducted one-to-one by the researcher, two conducted with their parent present, two with their parent asking agreed questions and recording the interview and one child providing written inputs. Rapport was established through informal discussions on interests or hobbies (e.g. Pokémon or Roblox) followed by open-ended questions, allowing children to steer the conversation into topics they wanted to talk about. Interview flexibility is recognised as a strength when conducting insightful qualitative interviews with children (Bushin, 2007).

Questions for trans children were tailored to their age, with, for example on the topic of social transition, broad questions such as "Do you remember before your

parents understood your identity?", "Can you tell me about that time?", with prompts such as "And what happened next" and "Do you remember how you felt at that time?".

## 3.4 Data Analysis

Data were analysed through reflexive thematic analysis (Braun & Clarke, 2006) to understand child and parental accounts of the challenges trans pupils experienced. Researcher positionality enabled both an insider and outsider rapport with interviewees, as a non-binary parent of a trans child (Paechter, 2013). In reflexive thematic analysis, researcher knowledge and positionality is valued as a resource to enrich analysis, prioritising "reflexive and thoughtful engagement with the data" (Braun & Clarke, 2019, p. 594). My approach prioritised representing interviewee accounts "as faithfully as possible", while prioritising data that most meaningfully answered the study's research questions, "acknowledging and embracing the reflexive influence of my interpretations as the researcher" (Byrne, 2022, p. 4). To help me reflect in detail on the quality of my approach, the study was designed to meet each element in a 20 point checklist for quality reflexive thematic analysis (Braun & Clarke, 2021). This included demonstrating selection of a research methodology that aligns with the proposed research questions, ensuring consistent application of that methodology across the research, and producing a well-developed and justified analysis (Braun & Clarke, 2021).

Each subset of the data corpus was inductively coded, with data-driven development of codes and themes. Transcripts were re-read to become familiar with each subset of data, generating initial codes by coding diversely without pre-conceived coding categories. The initial codes were then reviewed to identify broader themes, with all extracts for each theme collated and re-read. The initial themes were then reviewed, and themes and sub-themes revised to ensure they were internally coherent, consistent, distinctive, and accurately capture the dataset. Each sub-theme was analysed, and interpreted, including with reference to existing

literature. The analysis is recognised as my own interpretation, acknowledging the

role of any researcher in actively interpreting data (Braun & Clarke, 2006; Charmaz,

2006).

Indicative quotations from a range of interviewees were selected to accurately

illustrate each sub-theme. Research ethics influenced the way in which I presented

findings, in particular influencing the use of quotations. In qualitative literature,

quotations are used to evidence the validity of findings, to illustrate and bring findings

to life, to demonstrate how findings emerge from the dataset (Denzin & Lincoln,

2018). In this research an extra consideration influenced my approach towards

quotations. Trans children and families have long experienced control, coercion,

pathologisation and harm, a harm that was easy to perpetuate while trans voices

were rarely heard within clinical and academic publications about trans children

(Ansara & Hegarty, 2012). The vast majority of academic accounts of trans children

are written by cis clinicians (Pullen Sansfaçon et al., 2019). Trans children and their

families' voices are rarely heard in clinical literature, and where their perspectives

are included, they are framed and interpreted by those in power (Ansara & Hegarty,

2012). Families of trans children are also extremely limited in their ability to speak

out about their experiences, needing to safeguard their children's right to privacy and

safety, and being unable to critique those with direct power over their lives (Carlile,

2020). Accordingly, an effort was made to include multiple quotations in each section

of the findings (chapters 5-7), with this decision informed by the underpinning

approach to research ethics (as further discussed in section 3.5). A number of

interviewees expressed a hope that their voices would be shared directly, noting a

lack of voice of parents of socially transitioned trans children in the literature or wider

discourse, and emphasising the privacy and safety concerns that limit their ability to safely share their experiences in other fora.

In one section of this thesis, section 6.3, data on trans children's experiences in education (data that were inductively coded with data driven analysis in section 6.2) were also deductively coded. This additional coding enabled data to be analysed according to a particular theory, in this case Gender Minority Stress, seeking to better understand how Gender Minority Stress manifests within schools. In this section of the thesis, quotations are relegated to supporting tables of exemplar quotes, keeping the focus on better understanding GMS. This is in contrast to other parts of the thesis where interviewee quotes are prioritised and centred.

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

## 3.5 Research Ethics

Research ethics was a very significant consideration throughout this thesis, an emphasis that is recommended by other trans scholars (Vincent, 2018b). This section outlines a large number of ethical considerations that I have embedded across the research.

### 3.5.1 Informed Consent

Research participants received a project information sheet in advance, outlining the purpose of the research, their rights, and how their data would be used, with one version tailored for child participants. Parents and adolescents provided written informed consent, and for younger interviewees, parents provided written consent on behalf of their child, with children of all ages additionally providing either written consent or verbal informed assent (Lundy et al., 2011; World Medical Association, 2013). After interview each parental interviewee completed a short demographic survey.

The research design ensured that consent was informed and voluntary (ITHF, 2019). Research participants have a right to be informed in advance about the nature of the research, and how research findings will be utilised and disseminated, any risks or benefits, and a right to make decisions on whether to participate without any pressure or coercion. Informed consent required that a) information presented to participants was understandable and appropriate b) participants understood the information presented c) the participant indicating formally that they understood they are consenting to participate (Moore et al., 2018).

For the parent/guardian interviews, there was a multi-stage process. First of all, parents were sent their own consent forms, which they were asked to read and sign before their own interview. During their interview their understanding and consent was checked with some simple yes or no questions such as: "Do you understand how the research will be used?" "Do you understand what efforts I will take to ensure your privacy?" ending with "do you have any questions before we begin?". At the end of the parental interview, I discussed my aims for interviews with trans children, highlighting the reasons for this data being important. I then introduced different options for interviewing their child, and talked each option through, whilst highlighting clearly the options for their child to not participate. I followed up with an email containing further information specific to child interviews and asked them to think through whether their child would like to, and they both would consent to their child being interviewed. Where children wanted to be interviewed, and parents provided consent, I then followed up to talk through a plan for each child interview, working jointly with the interviewed parent to tailor an interview approach to their specific child, being flexible on approach, on timing, on focus. This flexibility extended to the ways in which questions were asked (including in writing or with visual prompts).

In addition to parental consent, the trans children who participated also needed to consent to their interviews. Children have a right to understand the purpose of such interviews, to understand how their words will be used, to understand that they have a right to stop the interview at any point, or to withdraw their consent to the interview being used, without giving a reason, and without any consequences (Alderson & Morrow, 2022). Where possible, children's informed consent was sought in addition to their parent/guardian's consent. Moore et

al. (2018) adds to the general requirements of informed consent three additional elements for children: 1) openings for choice and disagreement 2) negotiation and renegotiation of the scope of children's consent and 3) an agreement at the end of the research activity that reaffirms children's consent and negotiates any limits to sharing information that might have arisen.

Efforts were made and facilitated by parents to explain the purpose of the interview in days leading up to the interview, ensuring children have time to understand in advance. At the start of each interview, informed consent was discussed again, with options for the participant to read the information sheet and consent form, to have it read aloud, or to have the information summarised in simplified language. I made it clear that there was no compulsion or consequence of non-participation. I also let child interviewees know that their words would be anonymised. I ran through some questions to check they understood that they are not under compulsion - for example, "Do you have to answer my question?" (No); or "Will there be any problems if you do not answer questions" (No). The additional requirements proposed by Moore (2018) were embedded into the research, ending each interview with a review of consent and any limitations on information that has been shared during the interview.

For younger children who have may not be able to give what is considered to be informed consent, the process instead aimed for 'informed assent' (World Medical Association, 2013). Lundy (2007) outlines that children should not be forced to demonstrate their capacity before having their voices listened to – and that all children have important voices, perspectives and insights. Some children's right to be heard risks being denied if research processes rely only on informed consent. For children too young or otherwise unable to provide written informed consent, their

informed assent to participate was checked verbally and through use of simple non-verbal cues including body language (Bourke & Loveridge, 2014).

### 3.5.2 Confidentiality and Data Management

Interviews were conducted remotely and recorded via a secure encrypted platform (Microsoft Teams). Recordings were saved on a secure Sharepoint site and deleted after transcription. Anonymised transcripts were prepared after each interview, with care to remove any identifying information, with the transcripts (in Word) saved securely. Personal references (names, locations) were removed or anonymised in the transcript, to ensure the transcripts did not contain identifiable personal information. The anonymized interview transcripts were then uploaded into Nvivo for data analysis.

I'm aware from my own experience as a parent of a trans child how important cconfidentiality and anonymity are for this cohort. I am using a pseudonym for this research to safeguard my own daughter's right to privacy. Trans children and their families have a right to privacy, a right to choose if and when to disclose that they are trans, and therefore ensuring confidentiality and anonymity is critical. Interviewees emphasised the importance of individual quotes not being identifiable, given the vulnerable and small population that this research cohort is taken from. For this reason, joint with research participants, it was agreed to go a step beyond the usual criteria for anonymity, and to avoid linking individual quotes to specific pseudonyms, as well as omitting child ages from specific parental quotes, thereby preventing identification from stitching together pieces of individually anonymized data. Due to the levels of trans hostility in the UK (Faye, 2021), this particular cohort places a high level of importance on privacy and safety, and a

strong duty of care was upheld to respecting interviewee preferences in how their data were shared.

In addition to aspects of ethics covered in the above sections on informed consent and confidentiality, the next section presents four supplementary elements of research ethics that I have embedded into this thesis. This considers firstly, how best practices in trans community focused research have informed the research; secondly, how best practices in child-centred research have informed the research; thirdly, the ethics of including parental perspectives, and fourthly, how I have embedded the research's theoretical foundations (as introduced in chapter 2) into research ethics.

### 3.5.3 Trans-Community Research standards

Additional research standards are proposed for research on trans communities "because of a long history of intolerance, bias, and psychopathological stereotyping in this specialty" (ITHF, 2019, para. 1). Accordingly, trans-community and trans-scholar endorsed research standards have been embedded into research ethics across this thesis.

Trust and transparency is critical for gaining and maintaining participation from a hard-to-reach target group, and for ensuring the research is supported by families and trans communities (ITHF, 2019). A trans-community virtual discussion group 'International Transgender Health' (ITHF, 2019, para. 4) has developed research standards, asking researchers to publicly provide answers to questions on research aims and intended impacts, including "What is the specific objective of the study and its intended impact on future trans lives?" In this thesis I ensured the research information sheet openly stated its aims and objectives, including clarity on

my commitment to ensuring the research aims to benefit trans children. The same trans community group (ITHF, 2019, para. 4) also ask about researcher commitments to accessibility of research findings, asking "Will the results of this research be published in open access journals or channels?" Throughout this research I have made efforts to publish in open-access journals (including 11 peer reviewed articles in open access journals), and ensuring all research outputs are available on my website (www.growinguptransgender.com). I have also made efforts to produce accessible content outside of journal format, including through blogs, twitter threads, and infographics.

In addition to the above standard on transparency, Vincent (2018b) outlines five other categories to consider when working on trans-focused research. These are: the importance of transgender history; the significance of nuanced language use; the benefits of feminist methodological contributions; the value of intersectionality and the necessity of respecting trans spaces. An informed understanding of trans history has significantly shaped the whole of this thesis, influencing the design of this thesis (see chapter 1), the selection of research questions (section 1.7), the approach to theory (chapter 2) and the approach to research ethics (section 3.5). Understanding of the significant harms, past and present, of pathologisation of trans children, has providing a critical foundation from which a commitment to trans-emancipatory and de-pathologising approaches has grown. Across the thesis efforts have been made to ensure use of nuanced and trans-positive language. The research has also been influenced by feminist and emancipatory scholarship (as discussed in chapter 2). Intersectionality has been considered in the sampling, in the presentation of research findings, and across the analysis and recommendations. Consideration has been made of respecting trans

spaces, including respect of trans children's emotional space, ensuring interviews with trans children are guided by what they want to talk about, and avoiding forced or coerced questioning on topics that may be sensitive or emotionally hard. Care has been taken to ensure trans voices are at the forefront of the research, including consideration of the ethical implications of any areas of research that centre cis parental voices (as discussed in section 3.5.5).

### 3.5.4 Child-Rights Informed Research Ethics

The research has also built upon child-rights informed approaches to research with children (Lundy, 2018; Marshall et al., 2015). Children need a 'safe space' to express their views without coercion, on topics that are engaging and of interest (Lundy et al., 2011; Lundy & McEvoy, 2012). Efforts were made to provide reassurance that participation in any form was entirely optional. The interviews were designed to be engaging, with children choosing the topics for discussion, including some children choosing to speak more about hobbies or interests than issues specific to being trans.

Existing best practices for research with children note the importance of facilitation to help children express their views, building capacity and confidence to engage with the areas of research (Lundy et al., 2011; Lundy & McEvoy, 2012). In this research, efforts were made to explain to how the areas of inquiry relate to wider discourse or academic literature, for example sharing information with children on the areas where existing research lacks child voice. The research has also been driven by the topics of concern raised by interviewees, the decisions or practices that impact on their lives. Marshall (2015, p. 1) highlights that "children often lack power and influence in the decisions that are made for them and that, as rights-holders,

they are entitled to be heard and to help shape the decisions that impact on their life". Ethical research with children also ensures that children's research contributions are not purely extractive, but are taken up into influence, policy change and action (Lundy, 2018). Ethical research needs to prioritise a fast turn-around, before child interviewees grow up and age out of the circumstances and institutions they want to change (Lundy, 2018). This consideration has significantly shaped my approach, recognising the importance of research findings being of relevance and utility not just for future generations, but for this current generation of trans children. Accordingly, I've upheld a commitment to publishing in academic journals concurrent with, or in advance of, completing this thesis (see also section 1.6).

Appropriateness and necessity are another ethical consideration in research involving children. Greig and MacKay (2013, p. 169) ask "Are your research questions necessary and of substance? Have the questions been answered before? Do the questions require the involvement of child participants? Can your research be answered accurately by proxy?" These questions also relate to the question of value or worthiness of the research. In this thesis I have made sure to focus on topics that are appropriate. The research areas cover important areas with direct relevance for policy and practice across diverse spheres, with direct relevance to trans children's well-being. They include many areas where there is an absence of child-voice in current research, confirmed through thorough review of the literature (see chapter 4). The research presented in this thesis could not effectively be done by proxy, and whilst parents can and do provide important insights, the inclusion of trans children's first-hand perspectives is of vital importance.

Care was taken to respect children's time, keeping interviews short, with most interviews around twenty minutes. Care was also taken to avoid being intrusive into

children's personal lives, and instead focusing on what lessons from their experience they think may have relevance for other trans children. Questions were open and broad such as "how have you found school?", enabling interviewees to volunteer the information that they want to share. Moore (2018, p. 91) emphasises the importance of child research participants having "a high degree of choice and control, physical and emotional safety, and checks to ensure they did not experience any distress through their participation". Care was taken to conduct the interviews in a space and at a time that was safe, comfortable and familiar for the children, with all interviews taking place virtually with the child speaking online from their own home. Flexibility on interview timing was prioritised, finding a time where children were able to engage with the research. Efforts were made to ensure the interviews were as comfortable as possible, including regular check-in throughout the interviews on comfort, and energy levels. I monitored visual and verbal cues of emotional reactions, and provided regular opportunities to wrap up or continue the interview.

When working with children who are at risk of bullying, discrimination or minority stress there needs to be additional consideration of safeguarding (Draucker et al., 2009). A distress protocol (Draucker et al., 2009) was developed, providing an agreed protocol in the event a child or adolescent had become distressed during an interview, although in this research this did not occur. A bigger focus was on preventative effort, to ensure interviews with children or adolescents would not prompt distress. The interviews were designed to be positive, without focusing on difficult or traumatic issues. I judged it important to know in advance of each interview some information on children's current context, especially in relation to current levels of stress or distress, before each interview. A first step included discussion with their parent before the interview, to ascertain a child's current

emotional wellbeing, and any areas of sensitivity or trauma. This enabled tailored questioning that avoided direct questioning on topics of current or recent trauma. I felt this was particularly important where parents felt children were under acute immediate stress over puberty and denial of puberty related healthcare.

In the UK, a high proportion of the cohort of children in this sample were, at time of interview, facing acute challenges and traumas in terms of access to healthcare. A majority of the children within this sample were directly impacted by a December 2020 court judgement, informally known as '*Bell vs Tavistock*', a legal case whose judgement and subsequent interpretation curtailed access to healthcare (de Vries et al., 2021), as will be discussed further in subsequent chapters. The case had immediate and profound impacts on the children in this cohort, and, despite being overturned in September 2021 at appeal, its impacts remained in effect throughout the time of data collection. Awareness of the profound distress caused by this case, and the acute fears and uncertainties surrounding access to essential healthcare, prompted me to adopt a cautious approach, interviewing parents alone first, and then discussing with parents their child's current well-being, and any areas of trauma, especially related to puberty or healthcare. Several parents, with children in current acute distress, struggling with the impacts of denial of healthcare, felt interviews with their children at this point in time, whilst their dysphoria and distress was high, was not in their interests. This adult gatekeeping, whilst admittedly paternalistic, was a decision taken to protect vulnerable children from distressing questions at a time when distress was already high. My positionality as a (non-binary) parent of a pre-pubertal trans child likely influences this approach, having seen from a parent's viewpoint the past and ongoing challenges faced by my own trans child, and knowing (to some limited degree) the emotional burden life in a

cisnormative and cis-dominant world places on a young trans child's shoulders. Priority was given to avoiding this research being a potential trigger or additional emotional burden on those young trans children who were already dealing with multiple traumas.

In practice, this approach entailed avoiding direct questioning on potentially traumatic topics, for example, experiences in gender clinics or experiences of puberty, unless the child chose to speak on that topic. The approach in this research was to provide space and opportunity for children to share their experiences where they wanted to, whilst creating space and legitimacy for them to not do so. Whilst I introduced the background to the research at the start of the interview, the interviews focused on topics that the children wanted to talk about. For some children, this moved swiftly on to issues relating to being trans, to gender clinics, to schools, to healthcare. For other children, the conversation focused more on subjects such as Pokémon or Roblox, which was an equally positive outcome, demonstrating the success of a non-coercive approach to data collection with children.

A further consideration in research with trans children, relates to issues of autonomy and coercion. My positionality as a parent of a trans child and active member of communities of parents of trans children, has provided insights into the lack of autonomy, the coercion and control, that trans children can experience in the UK. I placed a significant emphasis in conversations with parents on highlighting that my desired approach was to open a door to any children who wanted to speak with me, whilst taking pains to ensure there was no coercion or pressure, and with clarity that there would be no negative consequences of not participating. A wide number of children within this sample did not opt in to being interviewed (with 10 out of 30 opting to be interviewed). This rate of engagement could be indication of a lack of

trust in the interviewer; it could equally be indication of the success of a non-coercive approach to research; with many children choosing other more enjoyable activities above participating in an academic interview.

Finally, ethical research with trans children needs to be empowering, focusing on strengths and positives, not only on risks and vulnerabilities. Pullen Sansfaçon et al (2018) emphasise the importance of trans researchers undertaking interviews with trans adolescents/youth, recognising the importance of creating safe and comfortable interview environments for trans youth participants.  I made efforts to ensure the interviews were confidence building and positive experiences, asking trans children what they like about being trans, talking positively about awesome trans people I know within the interviews, making sure to value and embrace trans lives. I also communicated clearly my trans-positivity and my positionality, especially my status as a proud parent of a trans child.


### 3.5.5 Including Parental Voice in Research

Within this research, I took a decision to include parental perspective, alongside child and adolescent perspectives. Parental accounts are proposed as a valuable complementary data source, particularly for pre-pubertal trans children, recognizing the important knowledge and insights that parents of trans children (may) hold. This approach also recognises the practicalities of research with pre-adolescent children. Parents of younger trans children have significant trust and privacy concerns, and accessing primary accounts from younger trans children without first engaging with their parents would not have been possible for a majority of this sample, with many parents clearly wanting to understand the researcher's positionality and approach before engaging. Research with younger trans children without engaging via parents

would also have been practically challenging, with most young trans children isolated from wider trans communities. The sample's average current age is 11, range 6-16, and a majority of UK trans and LGB youth groups only support youth from 13+. Engaging with younger children without parental involvement would also have posed challenges in terms of securing parental consent for younger interviewees.

Nonetheless, the strengths and weaknesses of including parental accounts are acknowledged, with specific reference to the implications of cis parents talking about the experiences of trans children. Across past and recent research, there has been a tendency for research to centre cis voices in research on trans people, whether that be cis clinicians, cis researchers, or cis parents of trans children (Ansara & Hegarty, 2012; Serano, 2016). Trans youth are too often side-lined to a supporting role in their own story, with risk of parental over-simplification, miscommunication and misunderstanding of trans youth experiences. The centering of parental voices in narratives about trans youth reinforces a history of cis-splaining (a concept parallel to the term man-splaining, wherein a person with cisgender privilege (mis)interprets trans experiences, talking over trans voices (SJWiki, n.d.)), paternalism and cis-dominance. These approaches have shaped trans discourse, with implications on whose voices are listened to, and whose experiences and views are considered valid (Ashley, 2020; Serano, 2016, 2018b). Trans-antagonistic parental accounts continue to be used to validate pathologising and trans hostile concepts, like the recently coined 'ROGD' (Rapid Onset Gender Dysphoria), a discredited theory that appeals to non-supportive parents, that infantilises trans youth, and is used to discredit and discourage support for trans adolescents (Ashley, 2020; Restar, 2020; Serano, 2018b; WPATH, 2018).

In this research the risk of parental misrepresentation or misinterpretation of their children's experiences was minimised by asking parents to speak on the things that are in their knowledge; things that they have seen and experienced, their own perceptions, and insights that their children have shared with them.

### 3.5.6 Depathologisation as research ethics

Vincent (2018b) argues that researcher understanding of trans histories is critical to ethical research on trans populations. The history of research on trans children is one deeply marked by pathologisation (see section 4.1.1 for further details). I hold it as an ethical imperative to attend to the pathologisation of trans children across this thesis, understanding the past and present impacts of pathologisation, and taking steps to avoid the perpetuation of pathologisation within research and practice. An ethical commitment to the depathologisation of trans children has been embedded across this research, influencing my choice of theoretical framing, informing my research methodology, and guiding data collection, analysis and dissemination of findings.

A long history of deeply pathologising research on trans children holds significant responsibility for the enormous challenges facing trans children today (Tosh, 2011). Any ethical research in this area needs to understand and consider how to ethically respond to the pathologising research that has until recently dominated this field. I hold it as an ethical obligation to reject and distance myself from past pathologising research in this thesis, and to ensure my research approach and priorities are explicitly depathologising. In this work I intentionally exclude research that focuses attention on scrutinising, analysing or problematizing gender diverse identities. Instead, my research takes as given that trans identities are

equally as valid as cis identities. This stance aligns well with other cross cutting considerations, including minority stress theory, with its focus on the institutions, attitudes and systems outside of a minoritised individual; with analysis and inquiry centred on the external prejudices, ignorance or stigma that makes life hard for marginalised people.

A depathologising approach to this thesis also affects how I have engaged with past literature that pathologises trans children. I maintain that continued citation of pathologising research signals lack of care and concern of the harm that has been and continues to be caused. The continued uncritical platforming of pathologising research is experienced as a micro-aggression by those who care for trans emancipation (Pearce, 2020). Here I look to the work of people of colour such as Toni Morrison who have emphasised the important distinction between work that is not racist, and work that is emphatically anti-racist. Referring to racial injustice, Toni Morrison (1995, p. 6) argues that "oppressive language does more than represent violence, it is violence; it does more than represent the limits of knowledge, it limits knowledge". She concludes that "it must be rejected, altered and exposed". In this thesis I maintain that ethical research on trans children cannot continue to ignore the harms of pathologising research, continuing to unquestionably cite work that has contributed to and continues to contribute to harm, work that is actively used to encourage the rejection of trans children, or work that is used to deny healthcare or civil rights.

When reviewing and citing literature, this research has upheld an ethical commitment to citing de-pathologising and trans-positive research. In adopting an actively depathologising approach to this research, work that pathologises and harms trans children has not been cited. Where pathologising research has merit for

discussion, I have cited the work of non-pathologising researchers who have critiqued or evaluated that research (Ashley, 2019c, 2019e; Pyne, 2014a; Restar, 2020; Serano, 2018b; Temple Newhook, Pyne, et al., 2018; Tosh, 2011). It is worth here adding that pathologising researchers do not describe their work in these terms, just as non-pathologising researchers tend to frame their research under terminology such as 'affirmative' or 'trans positive'. In this thesis I have taken a step further, adopting an explicitly depathologising approach.

### 3.5.6 Being Attentive to Gender Minority Stress.

Trans children and parents of trans children are both at risk of experiencing Minority Stress (Testa et al., 2015) (as is examined further in section 4.1.3). Within this research, I upheld an ethical duty of care to being attentive to the well-being of interviewees experiencing stress. I made efforts to ensure the interview process is a positive experience for research participants. My positionality as an insider-researcher provides me with a good understanding of common areas of trauma and stress, both as experienced by myself directly, as encountered indirectly via my own child, and as related to me within closed insider-spaces such as parent support groups.

In keeping with a commitment to minimise research contributions to minority stress, I made the following commitments within my approach to research:

- Acknowledging current trauma and minority stress.
- Committing to depathologisation of trans identities
- Committing to respect of trans identities

- Proactively challenging cisnormativity in the research

- Showing empathy and understanding

- Recognising the implications of researcher distrust and research fatigue

- Valuing interviewee ambitions and priorities on research leading to timely practical change.

- Acknowledging researcher positionality

- Ensuring an adaptive interview approach responsive to interviewee interests and priorities

I upheld a strong duty of care to research participants and wider trans children and trans communities across the research, ensuring the research does not contribute to harm, discrimination or pathologisation of a vulnerable group (ITHF, 2019). From the very start, I took steps to avoid cisnormative and pathologising research framings that focus on defining or verifying trans identities (Bryant, 2007). The thesis takes as given that trans children exist; this is taken as the lived reality from which research questions are asked, rather than as a research question requiring theoretical legitimisation. Theoretical framings that focus on identity have been critiqued for not centring people's lived experience (Namaste, 2000). Namaste (2009) calls out the harms of approaches that exoticise and other trans existence, noting the epistemic violence inherent in theorising about trans bodies and trans lives . Through my positionality, as a parent of a trans child, I am sensitive to the ways in which conversations related to gender, or minority status, can implicitly pathologise or problematize trans children, especially where trans children receive scrutiny or questions that they are aware their cis peers do not. I wanted to avoid explicit or

implicit problematization in interviews with children, and this informed a child-driven interview approach, that shifted away from a rigid semi-structured interview approach, to open listening guided by prompts, listening to the topics trans children wanted to talk about. The research did not dwell on theoretical framings about trans identities focused in a pathologising way on individual identity development, but instead looked at the ways in which societies, cultures and institutions shape trans lives. As part of creating a safe and non-pathologising environment I made it clear to child interviewees that the research is not interested in understanding or questioning their identity, but in the wider world that they experience.

### 3.5.7 Trans-emancipatory Research

This project learnt from trans-positive research, work that has focused on the lived experiences of trans people, targeting research questions with critical relevance for policy and action (Kennedy, n.d.; Pearce, 2018; Vincent, 2018; Vincent, 2018). The research committed to centring the topics and theories that I felt were most relevant to improving trans children's lives. The ways in which the theoretical framing influenced the ethical approach I have outlined can be encapsulated as a commitment to trans-emancipatory research. Building on wider work on emancipatory research (Noel, 2016), a trans-emancipatory approach to research is one that recognises, and takes account of, the role of cisnormativity, and pathologisation of gender diversity, in upholding structural injustice (Wesp et al., 2019). I therefore maintain an ethical commitment to trans-emancipatory research, recognising that gender diversity is neither pathological nor problematic, acknowledging that trans lives are equal to cis lives, and being attentive to cisnormativity or pathologisation of gender diversity within and across the research.

## 3.6 Researcher Reflexivity

Self-reflexivity is recommended as a component of ethical qualitative research (Oliphant & Bennett, 2020). Ruokonen-Engler and Siouti (2016, p. 745) note that "knowledge production is an inter-subjective, relational activity", with reflexivity proposed as a way of taking into account a researcher's "entanglements in a research process" (2016, p. 748). They argue that "by making visible the researcher's own biographical entanglements with the research topic, it is possible to make visible the relation of the researcher's attitude to hegemonic discourses, national and ethnocentric perspectives, hierarchies and power relations, and also to conventional analytical categories" (2016, p. 749). They encourage researchers to respond to six biographic questions. To make this reflection transparent, these questions are here responded to directly in turn.

*1. What personal experience do I have with my research topic?*

I have personal experience as a parent of a trans child, as a non-binary adult, and as a member of a number of parent support groups.

*2. How did I come to study the specific topic in the field?*

I came to study this topic after a sequence of events. First of all, I undertook extensive learning about best practices for supporting trans children, prompted by my experience as a parent of a trans child. As a parent I needed to defend my own child's rights in a number of local spheres, which quickly moved to also trying to address national and international systemic challenges. My own research and evidence-based advocacy efforts highlighted the inadequacies of the current academic literature, and the ways in which current literature influenced discourse, policy and practice in negative ways, reinforcing pathologising and transphobic

practices. The absence of research data on younger trans children in the UK seemed to be a particular barrier to improved practice. For example, the 2016 Scottish GRA consultation (as discussed in section 1.2) drew a connection between a lack of data on trans children and a presumed and justified lack of need for trans children to have legal recognition. This highlighted a need for research on this population.

### 3. What is my relationship to the topic being investigated?

The arena of inequality and injustice is one that personally moves and motivates me. The topic of trans inclusion also resonates with me personally, reflecting my own struggles with negotiating gendered spaces and gendered restrictions throughout childhood, as a non-binary person who lacked the vocabulary and knowledge to claim a non-binary identity until adulthood. I'm also motivated by my personal direct and indirect connections to trans children in a wide range of circumstances, seeing clearly the inadequacies of the status quo and the harms too often inflicted on trans children.

### 4. How did I gain access to the field?

I was already established in communities for parents of trans children, and the study was advertised on four groups of which I was already a member. It was further shared with two other groups through connections who I had met at various community events.

### 5. How does my own position (age, gender, class, ethnicity, economic status, etc.) influence interaction in the field and the data collection process?

I engage in the research as a white, middle-aged, middle-class British non-binary person. Parental interviewees were aware of my positionality as a parent of a trans

child from the outset (with recruitment conducted through closed parent support groups of which I am a member). This positionality influenced parent trust and willingness to be interviewed (as divulged by interviewees), as well as influencing parent trust in facilitating interviews with trans children. Insider researcher status enabled "intimacy and openness" (Paechter, 2013, p. 75), whilst leaving the potential for things to be unsaid that would be spelt out to an outsider researcher. Efforts were taken to combine empathetic listening, building rapport and creating a safe space for interviewees to share their experiences, alongside effective use of prompts to ensure interviewee meaning was understood. In interviews a warm and open conversation was enabled, including sharing empathetically from my life and answering any questions interviewees had about my own experience. My positionality as a non-binary researcher was sometimes disclosed and sometimes not, depending on how much interviews crossed onto topics of introspection, identity or positionality.

I was aware of my relative power in conversations with trans children, and took steps to consider the ethical implications of this positionality (further discussed in section 3.5 on research ethics). In interviews with trans children, conversations frequently included sharing some details of my trans child, including speaking positively about transitude (a synonym for trans-ness, coined by Ashley (2018a, p. 4)), with children aware that I held an insider/outsider position, with indirect insight into some experiences as an advocate for my own trans child.

## 6. What is my interpretation perspective?

In this research cohort I felt common ground with, empathy with, and respect for all of my interviewees. This common ground and empathy likely made parts of the research emotionally more taxing, with difficulties in the dataset often mirroring

difficulties in my own life. Interviewees felt able to share with me their experiences in great detail, including sharing difficult experiences and emotions. Being privileged to hear long and emotionally open personal stories had a big impact on me through the year of data collection and throughout data analysis. Having strategies for maintaining positivity and hopefulness was important in managing my own well-being as a researcher directly affected by the hostility and negativity surrounding trans communities. This experience mirrors experiences written about by other trans researchers- see, for example, work by Pearce (2020) on maintaining insider researcher well-being in research that is emotionally difficult. Within the analysis, emotional reflexivity and bracketing was important in managing my own mental health, including memo keeping and informal journaling to engage with data that was emotionally heavy and that resonated with my own experiences and life challenges, both as a parent of a trans child and as a non-binary individual operating in a trans-hostile UK context. Areas of interviews or analysis that were emotionally difficult for me I sometimes set aside and returned to when feeling emotionally capable. Notably, there is one emotionally difficult area of the dataset I have not succeeding in returning to, analysing or writing about (the impacts of the initial December 2020 Bell Court case on families and children in this cohort).  This topic is revisited in section 3.9.

## 3.7 Research Limitations

A number of potential limitations are noted, relating to parental perspective, the make-up of the families in this sample, and to gaps in the dataset.

Firstly, the findings include a significant emphasis on parental perspectives, with a risk of cisnormative or transphobic framing and interpretation (Ashley, 2020; Serano, 2016, 2018b). Parental accounts risk misunderstanding, misinterpreting or misrepresenting trans children's experiences, with recent examples of trans-antagonistic parental accounts used to infantilise and discredit trans youth (Ashley, 2020; WPATH, 2018). Parents are also limited in only having access to the information that they have themselves seen, or that their child has been willing to share with them. The risk of parental misinterpretation is mitigated by asking parents to speak about things that are within their knowledge; what they did, what they saw, what impacts on their child they observed. It is also critical to acknowledge the context in which parental observations occur. These observations were drawn from families in which at least one parent was affirming, and where children were affirmed in their primary residence. Parental observations from transphobic and rejecting parents of trans children have noted less positive accounts of trans children's wellbeing; and critics have pointed out that living in trans-hostile homes is likely relevant to the well-being outcomes that trans-hostile parents observe, with extensive literature drawing a connection between safe and affirming homes and trans youth well-being (Hill et al., 2010; Pollitt et al., 2021; Riggs et al., 2020; Russell et al., 2018).

A second acknowledged limitation is the make-up of the families in this sample. The experiences captured in this sample centre on trans children who have socially transitioned under the age of eleven, children who, to differing degrees, have

found support and trans-positivity at home, with affirmation from at least one parent. Experiences here cannot be assumed to relate to other cohorts; in particular, to the experiences of trans children with less parental support, or trans children in hostile and abusive homes. This sample also includes only those children who became aware of and asserted their identity in pre-adolescence, and cannot necessarily be assumed to apply to those who assert their identity during or after adolescence.

This sample itself was diverse in some respects, though a majority of parental interviewees were cisgender women (100% cis and 93% female). This profile aligns with researcher experience of UK parent support groups being largely populated by cis women, and research from other countries that has similarly noted an over-representation of women in active roles advocating for (or against) their children (Kuvalanka et al., 2014). The parental sample was 90% white, with limited insight into the parenting experiences of Black parents and other parents of colour. The parental sample also lacked representation of trans parents, and only included 3 parents of non-binary children. Sampling strategy and researcher positionality are both acknowledged as potentially influencing participation. Interviewees were accessed through parent support groups, potentially influencing the sample towards those parents who are most comfortable with accessing in-person and online communities. Researcher positionality could also potentially influence participation, with prospective interviewees being aware of the researcher's situation as a non-binary parent of a socially transitioned trans child. This positionality was both critical in gaining trust, access and engagement from a hard-to-reach group, and at the same time could potentially deter engagement from parents who were less positive about support for trans children. This latter factor is not regarded as significantly impacting on the sample, as the sample selection criteria focused on families where

a child had socially transitioned in pre-adolescence, a criteria that would in any case exclude transphobic and trans-sceptical families.

A final potential limitation is on the length of the follow-up of these children, with the children in this sample having socially transitioned for an average of four years at the time of parental interview. Longitudinal research with a longer follow up may offer additional insights and perspectives.

## 3.8 Areas for Further Research

This research has focused on a specific sample of families where trans children have been supported to socially transition in pre-adolescence in the UK. Further research from other samples, contexts and cultures can examine areas of similarity or divergence to the experiences presented here.

Further research can examine experiences that are under-examined in this thesis' sample group. Noting the limited ethnic diversity of the parents in this sample, further targeted research can examine experiences of parents of colour. Further research can explore fathers' experiences and perspectives, as well as considering the experiences of trans parents. Further research can examine the distinct challenges non-binary children may face in contexts lacking institutional and social recognition of non-binary identities (Paechter et al., 2021).

This research examined parental experiences and perspectives an average of four years after the point of their child's social transition. A majority of the parental interviewees were interviewed when their child was at the cusp of adolescence (average age eleven). Further research can follow up on this or a similar sample on a longer time-scale, examining how experiences and perspectives look at 5-10+ years after social transition. Likewise, the interviewed children within the sample were an average of 12 years old at time of interview. Further follow up could be of interest as children grow into adolescence and beyond.

Family support is known to be a key pillar of resilience for trans children (Katz-Wise et al., 2018; Klein & Golub, 2016; Simons et al., 2013; Travers et al., 2012). How the experiences outlined in this thesis are experienced by young trans children without family support merits further investigation. Future research could examine

stressors and supports experienced by trans children in unsupportive homes.

Research can examine how to best support parents to overcome cisnormative or

transphobic prejudice, or how to protect trans children from abusive parents.

## 3.9 Personal Reflections

Within this section I wanted to take note of the particular challenges that have influenced my experience as a researcher throughout this thesis, noting also its impacts on my research and my own well-being. In this section I take inspiration from Ruth Pearce who documented in her own thesis her trials engaging in research that resonated with and mirrored the challenges she saw and lived with in daily life. Dr Pearce outlines the trials of being an insider researcher:

> "I was engaging on a daily basis with stories of transphobia and cisgenderism from medical providers and the mainstream media, as well as narratives of hardship, anguish and internalised transphobia from research participants. The very act of managing my feelings while entering the field, analysing my data and attending research events became an increasingly difficult form of emotional labour…My 'insider' familiarity with the subject matter and the field meant that I empathised easily with participants' stories. The topic of trans health was very 'close' to me as I began fieldwork, but feels even 'closer' at the time of writing… (My) experiences meant that posts written by distressed individuals within the community sphere were particularly hard to read" (Pearce, 2016, p. 100).

Within her thesis, Ruth Pearce reflects upon the particular challenges where distressing research material is close to one's daily reality, where "the line that divided my research topic from my everyday life was blurry at best" (Pearce, 2020, p. 814). Shared experiences and emotional connection to distressing data can put a researcher under added emotional strain.  Dr Pearce describes the toll of trying to persist through research "as I buckled under the emotional weight of an immense number of distressing stories from research participants" (Pearce, 2020, p. 809),

highlighting the "enormous cognitive effort… to regulate, control, reduce, and/or displace feelings of immense sadness…and to quite often fight back tears'" (Pearce, 2020, p. 814).

All of the above chimes with my own experiences throughout this thesis, as a non-binary researcher in a trans-hostile country, as a parent trying to advocate for my trans child's rights against frequent encounters with discrimination, ignorance or prejudice, as a parent trying to sustain a trans child's well-being and self-worth against incessant cultural and societal messages to the contrary, and as a member of parent support communities, trying to offer daily support and advice to other parents struggling through difficult and dark times for families with trans children. I was also deeply aware that the challenges I was seeing and hearing about were the tip of the ice-berg, well aware of the hardships faced by trans children navigating external hostility whilst also facing parental rejection or abuse.

I undertook this research throughout a period of heightened attacks and hostility towards trans people and trans children. I was directly impacted by the hostile political, media and policy landscape, with harmful rhetoric and threats to trans children's rights impacting directly on my family's life, operating under a constant feeling of stress, fear and insecurity. I was also aware of my own relative privilege within this space, as a white middle class researcher with more security and ability to advocate for our family's rights. Hearing so many stories of trans children being systematically failed and harmed left me feeling a significant responsibility to quickly share their stories and experiences, to be part of a change that is so desperately needed. This feeling of pressure and responsibility drove me to complete the PhD quickly, working late into the night every night for several years,

fitting in research alongside a full-time job, childcare, advocacy and personal survival through additional unexpected challenges such as a pandemic and home-schooling.

I achieved a lot. However, one area of analysis is missing from this thesis. The majority of interviews were conducted in the period after the original Bell vs Tavistock court case, and before that court case was overturned at appeal. Families and children within this cohort were directly impacted by the court case, sharing stories of harm, of acute distress, hopelessness, pain and anger at a system that fails trans children at every turn. My own family were also impacted by the court case, with ramifications for my own child. Throughout the period of analysis and writing up this thesis, there was one body of data that remainder untouched – data on the impacts of the Bell Court case verdict and its interpretation by NHS England on trans children, adolescents and supportive families. This data sat looking over me for many months, yet I found myself unable to engage with it, to do justice to those stories and experiences, to manage my own emotions of betrayal, fear and anger and effectively analyse and write up the impacts of that court case.

In the end I did not manage to engage with that part of my dataset, and have left it untouched. My inability to engage with data on the impacts of the Bell case was partly its rawness, the acuity of the harm, but also my own lack of hope that stakeholders (outside of those already hurting) would ever listen or care about the harms enacted on vulnerable trans children and adolescents. Research on the experiences of trans children I experience as a constant battle between hope and despair. Needing to maintain enough hope in the possibility of change to keep writing, but often being overwhelmed by the hopelessness of the current predicament, and the lack of power held by trans communities to be even heard let alone have power or influence. On this one particular topic, I didn't manage to raise

my level of hope above the level of despair enough to analyse and write up this part

of the data. I decided I needed to prioritise my own well-being, leaving data on the

impacts of the Bell Court case unanalysed and unshared.

Other researchers have written about developing techniques for managing

emotional strain during research (Rager, 2005; Schulz et al., 2022). As I reach the

end of this thesis, I am yet to find a technique that has worked for me. Some

researchers (Chatzifotiou, 2000) talk of the importance of access to counselling, but

having experienced transphobic microaggressions from a number of past

counsellors I've tried to engage with, this route did not seem to be open. Other

researchers talk of the importance of ongoing self-reflexivity (Rager, 2005), yet

juggling research with full time work, with child care, with advocacy, with home-

schooling during a pandemic, whilst writing with a sense of urgency, did not seem to

leave space for the kind of relaxed self-reflection that could perhaps be useful. Other

researchers (Schulz et al., 2022) talk of leaning on and gaining solidarity from peers

and communities – again this didn't seem to particularly be an option through this

thesis, partly due to isolation during a pandemic, partly due to the isolation that

comes from being anonymous and carefully guarding my child's right to privacy, and

partly, or perhaps primarily, through awareness of the burden already carried by so

many within trans communities. I was very aware of my own relative privilege and

the more acute challenges faced by many in trans communities or in families trying

to advocate for trans children, especially those facing other axes of marginalisation,

hostility, illness or insecurity, and did not wish to burden them with my own stress.

Seeking emotional support from outside of trans communities or parent support

communities did not seem viable, as it remains hard for those outside of trans

communities, particularly those who have not faced direct insecurity, to understand the strain and chronic crises that trans communities are facing.

Despite being overstretched and burnt out, I also found myself regularly needing to respond to a continual onslaught of consultations, to analyse and advocate on the inadequacies of influential reports or policies (WPATH SOC8 draft chapters, Cass Review reports, GRA consultations, Nuffield Council on Bioethics consultations, GIDS Service Specification consultation, to name just a few), and to take up invitations to act as academic peer reviewer in a field where pathologising and harmful research is still accepted. Most of this was very much done as a form of damage control. Dean Spade has written about "the zillions of articles and student papers from around the country that I feel pressured to review in order to do damage control as increasing numbers of students and professors get "fascinated" by the topic of trans people and our legal problems (Spade, 2010, p. 4). Within the UK, the policy environment for trans children is so weak, so uninformed, so toxic and so harmful, that I often felt compelled to contribute. The number of peer reviews I have felt compelled to undertake in order to recommend rejection is high, with pathologising and harmful work on trans children common. Policy processes across the UK (Nuffield consultation, Gender Recognition Act consultation, Cass review) continue to side-line and ignore trans community expertise, with trans knowledge discounted and rarely given a leadership role. This puts trans researchers continually on a back foot, defending against the next bad faith policy report, put into a situation of trying to avert the most significant damage from processes designed without trans leadership. Other trans researchers have written about how such unaccountable consultations operating as a harmful form of coercive control, consistently extracting from trans communities without responsibility to trans communities (Pearce, 2021b).

Researcher burnout cannot be easily explicated from the context in which research is being conducted, with wider issues of cis-supremacy across the UK creating a hostile and harmful environment for existence either as a trans person or as a person motivated to defend trans children's rights.

I share these reflections less as a conclusion, but perhaps as an example for others. Perhaps other PhD researchers finding themselves similarly struggling through an emotionally taxing thesis conducted against an emotionally taxing political climate, will find reassurance and some comfort in knowing that they are not alone in such struggles.

# 4 Literature Review

This thesis aimed to enhance knowledge and understanding, and it was therefore important to build the research from existing literature and evidence. This section provides an in-depth overview of existing literature on trans children and families, with the literature review divided into four major themes, examining the non-pathologising literature on trans children, and considering trans children's experiences in families, in education and in healthcare.

## 4.1 Trans Children

Relevant literature on trans children is here presented in three key themes: pathologisation, well-being, and Gender Minority Stress. This section informs work published in two recent articles (Horton, 2022a, 2022i).

### 4.1.1 Pathologisation

Pathologisation forms an important theme within the literature on trans children, as well as being a key theory underpinning and cutting across this thesis (as covered in chapter 2). This section of the literature review introduces and summarises the key literature on pathologisation.

**History of Pathologisation**

Pathologisation is the construction of people's "behaviour or characteristics as pathological or disordered" (Ansara & Hegarty, 2012, p. 142). Homosexuality was

designated a mental disorder in the World Health Organisation's International

Classification of Disease (ICD) up until 1973, with this classification impacting upon

how sexual minorities were viewed and treated across society (Meyer, 2003).

Depathologisation of homosexuality in the ICD had widespread ramifications across

disciplines "in not only psychology, but biology, law, sociology, religion and politics",

underpinning action to reduce discrimination and protect civil liberties (Robertson,

2004, p. 163). Whilst homosexuality was depathologised, gender diversity was

explicitly categorized as disordered and pathological in international medical

standards like the World Health Organisation's International Classification of Disease

(ICD) right up until the latest version, ICD-11, that came into effect in January 2022

(Meyer et al., 2002; World Health Organisation, 1992, 2018).

Prior to ICD-11, childhood gender diversity was explicitly pathologised with

the once named 'Gender Identity Disorder of Childhood' categorized in a chapter on

mental and behavioural disorders (Winter, 2021). Decades of research and practice

aimed to cure or prevent gender diversity, a damaging approach with severe

consequences for trans and gender diverse children (Ashley, 2019g, 2022a; UN

Human Rights Council, 2020). Assumptions that poor mental health was intrinsic to

mentally disordered gender minorities, meant that efforts to 'help' such minorities

focused on attempts to suppress or change their identity, rather than efforts to tackle

areas of discrimination or persecution (Meyer, 2015; Testa et al., 2015).

Pathologising gender clinicians deemed it easier and better to (try to) change a

child's identity or expression, than to reform wider society to be accepting of diversity

(Bryant, 2007; Gill-Peterson, 2018).

## Movement for Depathologisation

Across the twentieth century and into the present, trans communities from around the world have fought against pathologisation (Davy et al., 2018; Gill-Peterson, 2018; Global Action for Trans* Equality, 2013; Tosh, 2011). Depathologisation refers to "the removal of diagnostic classification and clinical practices that conceptualise sexual, gender and bodily diversity as a mental disorder, illness or malformation", alongside recognition of diversity as a human right worthy of celebration (Suess Schwend et al., 2018, p. 1594). Since 2009, the International Campaign to Stop Trans Pathologisation coalesced activism in an International Day of Action Against Trans Pathologisation (Suess Schwend, 2020). This campaign prioritised depathologisation of gender diversity in childhood, highlighting the need for reform across contexts including within the family, society, school and healthcare (Davy et al., 2018; Suess Schwend, 2020).

There has been some progress in a movement towards depathologisation over the past decade, particularly within some areas of healthcare policy. Within psychiatry there is growing commitment to "complete depathologisation – uncoupling gender diversity from the stigma of diagnostic classification and clinical practice suggesting illness or disorder" (Perlson et al., 2021, p. 1). Gender affirmative approaches that celebrate diversity have been endorsed by leading global and national healthcare bodies (AusPATH, 2021; Murchison et al., 2016; Oliphant et al., 2018; Telfer et al., 2018; World Health Organisation, 2021). Trans identities were removed from categorization as a mental health disorder in ICD-11 (World Health Organisation, 2021). This recategorization followed much debate on whether childhood gender diversity should be categorized at all in ICD (Global Action for Trans Equality, 2012; Suess Schwend et al., 2018). A compromise position resulted

in a newly defined 'gender incongruence of childhood' removed from categorization under mental health disorders, joining 'gender incongruence of adolescence and adulthood' in a new chapter on sexual health (Winter, 2021). As ICD-11 comes into effect from January 2022, healthcare bodies across the globe are now tasked with putting this paradigm shift into policy and practice (World Health Organisation, 2021). As Inch (2016, p. 193) explains: "Medical professionals, policy makers, academics and practitioners have a duty to end the pathologisation" of trans identities. Research has shown that the belief that trans people are mentally ill is the most powerful factor underpinning anti-trans prejudice, with continuing pathologisation legitimising and reinforcing discrimination (Winter et al., 2009).

Depathologisation at the global level of the World Health Organisation will only be a significant step towards meaningful depathologisation, if that global policy change feeds into national and sub-national policies, attitudes and practices (Murray, 2019b). Pathologisation was for many decades endorsed and legitimised within medical practice and social policy, with areas of pathologisation often unacknowledged or covert, and thus harder to acknowledge and dismantle (Global Action for Trans Equality, 2012). Pathologisation remains deeply ingrained across wider institutions, systems and societies, with pathologising narratives, regulations, laws and approaches commonplace (Global Action for Trans Equality, 2012). O'Connor emphasises that "although psycho-pathologisation of trans people is due to be removed from the ICD of the WHO, it will take longer to change social, political and medical systems that continue to pathologise trans people" (2019, para. 8).

## UK Context

Even as global medical consensus has moved towards trans positivity, affirming childhood gender diversity as a part of human diversity to be celebrated, the legacy of pathologisation remains (American Psychological Association, 2015; Ashley & Domínguez, 2021). Murray (2019b, sec. 5) describes the continued influence of pathologisation on current UK and Irish trans healthcare services as "an echo of that dark past", noting that "the continued treatment of trans identity as a mental health condition harms our communities, young and old".  In terms of trans children's healthcare the basic model of gender healthcare for trans children in the UK has not changed since the days when  childhood gender diversity was explicitly labelled a disorder in need of prevention or cure (Akkermans, 2018), as will be explored further in this thesis (see chapter 7, in particular sections 7.2-7.4). Pathologisation within clinical and academic literature across several decades has reinforced and legitimised pathologisation of trans children in wider society (Ansara & Hegarty, 2012). Examples of pathologisation can be seen in UK media discourse around trans youth, with terminology describing transness as a 'plague', 'epidemic' or talking of 'contagion'(Thornton, 2021). Language of transness as an epidemic or as a problem may be regarded as an indicator of embedded pathologisation and trans-negativity in UK society.

A paradigm shift from childhood gender diversity as pathologised and problematic, to childhood gender diversity as a valued or celebrated part of human diversity has profound implications for UK social policy across diverse spheres. With ICD-11 now in effect (from January 2022), it would be valuable to better understand how decades of trans pathologisation have shaped UK society, and how such pathologisation manifests in the lives of trans children in the UK today. Such an

analysis is presented in section 7.2, shining a light on areas of enduring

pathologisation of trans children and helping identify priorities for embedding

depathologisation in UK social policy and practice.


## 4.1.2 Well-being

Well-being is a second broad theme in the literature on trans children, with evidence

on key factors influencing trans children's well-being introduced in this section.

Studies from multiple countries highlight disproportionately high levels of poor

mental health amongst trans adolescents (Srivastava et al., 2021; Strauss et al.,

2020; Veale, Watson, et al., 2017). UK clinical and community surveys demonstrate

elevated prevalence of depression, self-harm and suicidal ideation (Arcelus et al.,

2016; Baker et al., 2016; Holt et al., 2016). In a 2017 UK school survey of 500 trans

adolescents, 45% reported having attempted suicide and 84% reported self-harm

(Bradlow et al., 2017). In contrast, literature has shown high levels of well-being

amongst trans children living in affirming environments and families, with supported

trans children having levels of mental health similar to non-trans peers (Durwood et

al., 2017; Olson et al., 2016; Whyatt-Sames, 2017). Research is turning to

consideration of gender minority stress (see section 4.1.3) as a key driver of mental

health differentials, recognising the external stressors that make life harder for trans

children and adolescents (Hendricks & Testa, 2012; Tan et al., 2020; White Hughto

et al., 2015).

Evidence demonstrates that mental health differentials are driven by external

discrimination, rejection and social marginalisation, rather than being intrinsic to

being trans (White Hughto et al., 2015). Pathologising assumptions about transness

lead to the mis-interpretation of poor mental health as evidence of inherent

pathology, with pathologisation in turn driving prejudice and discrimination, perpetuating gender minority stress (Winter et al., 2009). Experiences of minority stress during adolescence contribute to poor mental health that may persist into adulthood, creating ongoing health and economic disparities (Veale, Watson, et al., 2017). These disparities can be reduced or prevented through identifying and reducing risk factors known to be social determinants of mental health inequities that shape minority stress (Tan et al., 2019). Research on trans adolescents from the USA, Australia and Canada has shown that: i) minority stress is a significant predictor of depression, PTSD and suicidality (Srivastava et al., 2021); ii) prevalence of these conditions is predominantly caused by factors external to the individual (Strauss et al., 2020); and iii) interventions to increase social inclusion and reduce minority stress can substantially improve mental health (Bauer et al., 2015).

Existing international evidence points to a number of protective factors (Pullen Sansfaçon et al., 2018; Veale, Peter, et al., 2017) that safeguard trans adolescent mental health, across diverse spheres including family, school and healthcare. Family support is protective against adverse mental health outcomes including reducing self-harm, suicidality and depression (Katz-Wise et al., 2018; Klein & Golub, 2016; Pullen Sansfaçon et al., 2020; Simons et al., 2013; Travers et al., 2012). Other research has emphasised the importance of the use of a chosen name (Pollitt et al., 2021; Russell et al., 2018). The topic of family support, and its contributions to trans children's well-being is explored in this thesis, as presented in chapter 5.

School support is protective of mental health (Horton, 2020; McBride, 2021; Ullman, 2017). A negative educational climate places trans pupils under persistent psychological stress, contributing to high levels of depression, self-harm and suicidal

ideation (Bartholomaeus & Riggs, 2017a; Horton, 2020; McBride, 2021; McGuire et al., 2010). Primary research on trans children's experiences at school, as relevant to their well-being, is presented in this thesis in chapter 6. Access to affirmative healthcare is also important for safeguarding trans children and adolescent mental health (Achille et al., 2020; Allen et al., 2019; Costa et al., 2015; de Vries et al., 2011, 2014; Khatchadourian et al., 2014; Mahfouda et al., 2017, 2019; Olson-Kennedy et al., 2018; van der Miesen et al., 2020). Healthcare and its impacts on trans children's well-being comprises a key theme in this thesis, examined chapter 7. A more in-depth review of literature on trans children's experiences in families (section 4.2), schools (section 4.3) and healthcare (section 4.4) is presented in subsequent sections of the literature review.

### 4.1.3 Gender Minority Stress

A third major pillar of literature on trans children's well-being engages with the concept of gender minority stress (GMS). GMS is also an overarching theory informing this thesis, as introduced in chapter 2.  The concept of 'Minority Stress' was originally coined by Virginia Brooks (1981), writing in the early 1980s on the way in which lesbian women experienced additional stressors linked to their minority and marginalised social status. This work by Brooks was built upon by Meyer (1995, 2003), initially focused on the experience of gay men, who expanded the theory to consider the ways in which a marginalised social identity led to differential health and wellbeing outcomes. Meyer (1995, 2003) argued that these health differentials were not an intrinsic component of being gay, but a result of prejudice, stigma and discrimination.

Minority stress theory has since its inception provided an alternative to pathologising theories that presented sexual and gender minorities as inherently disordered (as discussed in section 4.1.1). Meyer (2003) argued that data on mental ill-health in lesbian, gay and bisexual populations was used to justify an interpretation that sexual minorities were inherently disordered. This view of minorities as mentally disordered was, in turn, used to justify efforts to 'convert' people to a heterosexual orientation, alongside efforts to 'protect' youth from knowledge about the existence of such sexual minorities (a parallel that continues to this day with trans youth). Meyer argued that minority stress was "socially based, stemming from social processes, institutions, and structures beyond the individual" (2003, p. 4). Meyer divided stresses into those further from an individual, termed 'distal' stresses and those closer to an individual 'proximal' stresses. He focused on (a) external, objective stressful events and conditions (chronic and acute), (b) expectations of such events and the vigilance this expectation requires, and (c) the internalization of negative societal attitudes (2003, p. 5). Meyer also focused upon resilience and stress ameliorating factors, which he divided into those factors that enable individual resilience, and factors that enable group resilience (2003).

Brooks and Meyer's work on minority stress was important in challenging societal assumptions that low levels of mental health in gay, lesbian and bisexual people were inherent to those groups, and was important in focusing attention on the way in which marginalisation drove mental health disparities. For trans people, there was until recently a similar societal assumption that trans people, including trans children, were inherently prone to poor mental health (Bryant, 2006; Riley, 2012). Trans communities and trans positive researchers have challenged this assumption, with growing evidence that poor mental health in trans youth is driven by the hostile

environments that surround them (de Vries et al., 2014; Edwards-Leeper & Spack, 2012; Fisher et al., 2014). The view of mental health disparities being driven by societal persecution is further validated by evidence that trans children in supportive environments have good levels of mental health (Durwood et al., 2017; Olson et al., 2016).

In a 2012 article, Hendricks and Testa (2012) adapted Brooks and Meyer's theoretical model, tailoring it to trans and gender diverse people's experience of minority stress. Focusing on clinical guidance for psychologists working with trans communities, Hendricks and Testa argued that cis psychologists lacked 'cultural competence' to effectively support gender minorities, in particular due to a common underestimation of the impact of what they termed 'Gender Minority Stress' on mental health. In 2015 the same authors contributed to a 'Gender Minority Stress and Resilience Measure' that further developed the theoretical model of gender minority stress, acknowledging the differences between cis sexual minorities and trans minorities, and tailoring their model to the specific experiences of trans communities (Testa et al., 2015). They noted areas of distal stress distinct to trans minorities, with additional forms of discrimination, including barriers to legal recognition, discrimination in or barriers to healthcare, or barriers to accessing public facilities. They also noted additional areas of proximal stress, particularly what they termed 'non-affirmation', for example when trans people are misgendered. They proposed nine areas of gender minority stress or resilience: gender-related discrimination, gender-related rejection, gender-related victimization, non-affirmation of gender identity, internalized transphobia, negative expectations for future events, nondisclosure, community connectedness, and pride.

The theory of gender minority stress has provided the underpinning framework for a number of research studies on trans people, examining the link between gender minority stress and suicidality (Testa et al., 2017), or the link between stigma and health (White Hughto et al., 2015). Research, mostly quantitative, has also expanded to consider the impact of gender minority stress on youth, predominantly on older adolescents and young adults (Chavanduka et al., 2021; Chodzen et al., 2019; Delozier et al., 2020; Hatzenbuehler & Pachankis, 2016; Hidalgo et al., 2019; Hunter et al., 2021; Veale et al., 2017), as well as research on the minority stress experienced by supportive parents of trans children (Hidalgo & Chen, 2019). This thesis has expanded understanding of gender minority stress as experienced by trans children, in particular examining trans children's experiences of gender minority stress in education in section 6.3.

## 4.2 Families

A significant part of existing literature on trans children focuses on families. This part of the literature review starts with an examination of literature on family responses to trans children, before considering the specific topic of social transition. This section informs work published in four recent articles (Horton, 2021a, 2022b, 2022d, 2022e).

### 4.2.1 Parental Responses to Trans Children

Research has demonstrated that family support is vital for mental health and wellbeing, highlighting the importance of building trans-positive family units that can provide affirmation, safety and emotional security for trans children (Katz-Wise et al., 2018; Klein & Golub, 2016; Pullen Sansfaçon et al., 2020; Simons et al., 2013; Travers et al., 2012). Family support is shown to be linked to better mental health outcomes, including: lower likelihood of engaging in non-suicidal self-injury, lower rates of suicidal ideation, fewer suicide attempts, fewer depressive symptoms, a decreased sense of burdensomeness stemming from the youth's transgender identity, higher self-esteem, and higher levels of life satisfaction (Simons et al., 2013; Travers et al., 2012; Veale, Peter, et al., 2017).

In the twentieth century only a small number of trans children received support and affirmation in childhood (Gill-Peterson 2018). Older academic literature highlights toxic and harmful patterns of parents responding to trans children with prejudice, pathologisation and cisnormativity (de Bres, 2022). Many of the parents interviewed in the first decade of the twenty-first century described a long journey to acceptance, thinking their child's non-conformity was a phase, policing options for gender expression or gender authenticity, providing rewards and punishments for

conformity, engaging in actions that aimed to deter or prevent acceptance of a trans identity (Hill & Menvielle, 2009). Parents reported these reparative efforts were unsuccessful and had a destructive impact on their child. After witnessing their children's depression and negative behavior spiraling, parents eventually moved towards supporting their child's identity (Hill & Menvielle, 2009). Retrospective research on trans adults' experiences similarly highlights extensive negative impacts of childhood rejection. A survey of 104 trans adults reflecting upon their parent's response to their gender in childhood found only 13% described their parents as supportive (Riley, 2012). A majority (43%) reported parental negativity towards gender with family rejection associated with isolation, lack of trust, low self-esteem, depression, addiction, suicidal ideation and PTSD (Riley, 2012). Parental rejection and abuse sadly continue into the present day (Caelan Conrad, 2022; Greenesmith, 2020). Modern abusive parental practices towards trans children are not well captured in the academic literature, though brief insights into parental rejection can be seen from clinicians or nursery worker accounts (Brody, Forthcoming; Riggs & Bartholomaeus, 2018b).

Older pathologising literature on families with trans children includes substantial focus on the cisnormative concept of transition as 'loss', whether that be loss of specific gendered future expectations parents may hold for their child, or loss of the privilege and comfortability that parents had assumed for their child's future (Alegría, 2018; de Bres, 2022; Norwood, 2013). The concept of loss, with some parents even using terms like 'mourning', highlights the power of cisnormativity, and the distance cis parents need to travel to understand their children and to dismantle deeply entrenched cisnormativity (Riggs, 2019a). Parents can experience disenfranchised loss, feeling a type of grief whilst being unable to talk about it openly

or find others who understand, and these parents, particularly fathers, can respond by disengaging emotionally (Blum, 2017; Gregor et al., 2015). Lev (2005) talks about the stages of Family Emergence following a change to a family, from discovery and disclosure to turmoil, to negotiation, to finding balance. Other families talked about the challenges of resetting their gendered assumptions, reflecting on how parents come to understand their child through a process of reflecting upon their own gendered self (Alegría, 2018; Bull & D'Arrigo-Patrick, 2018).

Over the past decade a body of academic literature has examined parental journeys to becoming supportive and factors influencing parental acceptance (Katz-Wise et al., 2021; Neary, 2021; Pullen Sansfaçon et al., 2015, 2020; Riggs et al., 2020). Qualitative research has tended to focus on white middle class mothers, with mothers in such samples commonly performing the majority of support, education and advocacy for their children (Alegría, 2018; Birnkrant & Przeworski, 2017). Fathers' voices are less present in the literature, and often reported indirectly through interviews with mothers (Kuvalanka et al., 2014), though some research has focused on fathers (Blum, 2017). Pullen Sansfaçon et. al (2015, p. 52) reviewed parental experience in Canada with a focus on parental journeys to acceptance, noting that parents "experienced decision making as fraught with anxieties and fear…. consistently feeling unsure about the best path to take" (Pullen Sansfaçon et al., 2015, p. 52). Whilst a majority of literature focuses on parents of trans adolescents, a small but growing body of global literature focuses specifically on the experiences of families of younger trans children (Barron, 2014; Bull & D'Arrigo-Patrick, 2018; Cherry, 2018; Dierckx et al., 2016; Galman, 2020; Kuvalanka, Mahan, et al., 2018).

Parental acceptance is known to be made more challenging by the pressure of negative or hostile reactions from family and wider community (Cherry, 2018; Galman, 2020; Kuvalanka, Mahan, et al., 2018; Pullen Sansfaçon et al., 2020). Blum (2017) examines the ways in which external community connections, current events, and social policy impact on how a family responds to the transition of a family member, noting the ways in which social stigma enables or impedes family acceptance. Many supportive families face rejection and judgement from their wider families and communities, including religious communities (Alegría, 2018; Schofield, 2013). Parents try to protect their child from negative responses, including by pre-empting clear expectations of respect and non-intrusion (Alegría, 2018). A number of studies report that even though parents knew standing by their child was the right thing to do, it still took courage to do so, given the level of parental scrutiny, judgement and hostility encountered (Pullen Sansfaçon et al., 2020). One parent noted "You risk losing your family, marriage, network" (Pullen Sansfaçon et al., 2020, p. 48). Parents experience judgement and blame (Johnson & Benson, 2014; Kuvalanka, Allen, et al., 2018), with mothers and especially queer mothers particularly targeted (Johnson, 2014, 2). Supportive parents face social ostracisation and secondary stigma (Hidalgo & Chen, 2019; Johnson & Benson, 2014). Parents find themselves experiencing 'institutional erasure' "a lack of policies that accommodate trans identities or trans bodies, including the lack of knowledge that such policies are even necessary" (Bauer et al., 2009, p. 354). Parents can come up against laws, policies or practices that discriminate against trans children (Pullen Sansfaçon et al., 2020). Parents can also find themselves inappropriately reported to and investigated by social services, just for supporting a trans child in their identity (Barron, 2014; Johnson & Benson, 2014; Kuvalanka et al., 2019). When inside the

legal system, parents and other primary carers including grandparents reported challenges built upon ignorance, prejudice and cisnormative bias (Kuvalanka et al., 2019, 2020; Kuvalanka & Bellis, 2021).

Parents of trans children can be left isolated, with online support and online communities being valuable (Pullen Sansfaçon et al., 2020; Schofield, 2013). Sharing experience with families who understand can help parents feel "less anxious, fearful, and alone" (Hillier & Torg, 2019, p. 1). Family support groups for parents with trans and gender diverse children are highlighted across the literature as playing an important role in helping parents find the knowledge, trans-positivity and confidence to affirm and advocate for a pre-adolescent trans child (Galman, 2020; Horton, 2021a; Kuvalanka, Mahan, et al., 2018). In the past decade, growing numbers of parents of trans children are accessing community support groups, whether in-person or virtual, enabling families to learn from each other's experiences, exchanging stories and providing peer support (Kuvalanka et al., 2014; Pullen Sansfaçon et al., 2015; Pyne, 2016). Parents of trans children report learning from stories exchanged, often in confidence, with other families with trans children; as well as through listening to and learning from the childhood experiences of trans adults (Galman, 2020; Pullen Sansfaçon et al., 2015, 2020; Roche, 2020). In closed parent networks families of trans children report seeing substantial benefits of childhood support and affirmation in place of rejection and shame (Kuvalanka & Munroe, 2021). The stories and lived-experience of families of trans children shared within parent networks are influential in shaping parent community consensus on appropriate support for trans children; yet these parental accounts are little captured in the academic literature (Chen et al., 2017; Kuvalanka et al., 2014; Kuvalanka & Munroe, 2021; Olson et al., 2019)

As parents move to support their trans children, parental advocacy can become a critical parental role, with literature highlighting the challenges that are faced by parents advocating for their trans children across diverse sectors and situations (Chen et al., 2017; Katz-Wise et al., 2021; Neary, 2021; Pullen Sansfaçon et al., 2015, 2020; Riggs et al., 2020). Many parents find themselves taking on a significant amount of advocacy to try to keep their child safe, as one parent stated "accepting trans children is one thing; getting others to understand, support, and accept them is something else entirely"(Pullen Sansfaçon et al., 2020, p. 48). Outside of academic journals, insights into family experiences advocating for pre-pubertal trans children can be found in books such as the US and Canada focused 'The Trans Generation' (Travers, 2018), the US focused 'Histories of the Transgender Child' (Gill-Peterson, 2018) and the UK focused 'Gender Explorers' (Roche, 2020), works that examine child and family experiences, centering individual stories.

The literature notes a common phenomenon of parental transformation from ignorance to awareness to advocacy (Galman, 2020; Gray et al., 2016; Katz-Wise et al., 2021; Kuvalanka, Mahan, et al., 2018). Parent-centred perspectives can also be found in memoirs, particularly by white mothers with experience advocating for the rights of trans girls including 'How to be a Girl' from the US (Mack, 2021), and 'About a Girl' from Australia (Robertson, 2019), showing parental journeys from ignorance to understanding to advocacy. Supportive parents grow to understand the legal, social and institutional barriers to understanding, recognition and rights for their children (Pullen Sansfaçon et al., 2021). They understand the need for advocacy and activism to secure or safeguard rights, as recorded in the literature by one parent of a trans child: "As I stand here speaking at a rally for the first time in my life, Abby

knows she is loved, but at some point, a parent's love will not be enough" (Galman, 2020, p. 148). Parents often start out seeking to overturn one specific area of discrimination harming their child, later shifting into a wider advocacy role, noting that a "shift from advocacy as remedy to advocacy as activism is rooted in an interrogation not of the problem of having a transgender son, but rather the problem of cultural cisgenderism" (Galman, 2020, p. 150). Some parents found the process of learning to advocate for their child gave them confidence and assertiveness that transferred into wider life (Bull & D'Arrigo-Patrick, 2018). Many studies highlight the ways in which parenting and advocating for a trans child changes parents, with many parents experiencing a "bigger transformation than their transgender children" (Kuvalanka, Mahan, et al., 2018, p. 375).

Parental activism and visibility provides a challenge to the status quo of erasure and invisibility of trans children (Pullen Sansfaçon et al., 2020). Many parents are moved to undertake political and social advocacy against a tide of judgement and harassment (Galman, 2020; Johnson & Benson, 2014; Katz-Wise et al., 2021). Several authors note the toll on parents who support and advocate for their child, and the additional burden placed on families with less privilege including Black or other minoritised parents (Gray et al., 2016; Johnson & Benson, 2014). Several studies also consider how intersecting axes of inequality and marginalisation impact on parental capacity and ability to support and advocate for a trans child (Carlile et al., 2021; Neary, 2021; Pullen Sansfaçon et al., 2015, 2021; Rahilly, 2015).  Galman (2020) argues that the parents who support their trans children are those willing to accept secondary stigma, to challenge existing parental and cultural norms, and to risk isolation and rejection from their wider families and communities. Galman (2020, p. 150) suggests "a combination of prior experiences with

marginalization combined with fear for their child, as the recipe for willingness to support, transform, advocate, and recognize their child's horizontal identity".

Literature has examined the stresses that parents of trans children face across diverse domains (Brill & Pepper, 2008; Malpas et al., 2018), along what some have characterized as a "complicated and precarious [parenting] journey" (Ehrensaft, 2011, p. 169). Stresses can come from family and local community interactions, coping with societal judgement or abuse, and managing worries and concerns over a child's well-being and safety (Ehrensaft, 2011). Stresses can also come from a wider political and societal climate of hostility and persecution, with one father of a trans teen describing how discriminatory legislative bills left him "in a constant state of anxiousness because you're continually having someone insult your child" (Blum, 2017, p. 76). Living at a time of public debate and discrimination, many parents have reported fears of existing legal protection and social acceptance being rolled back (Alegría, 2018). Parents with pre-existing white middle class privilege experienced the shock at suddenly understanding the precariousness of indirect loss of privilege, understanding the fragility of human rights protections and the enormity of the legal, cultural and social challenges to overcome (Alegría, 2018; Barron, 2014).

Literature has considered the experiences of supportive parents of trans children as an example of minority stress (Hidalgo & Chen, 2019). Bull (2018, p. 18) considers how "transition happens for everyone in the family, and parents take on a targeted identity" alongside their children, whilst Johnson and Benson (2014) describe the experience in terms of 'secondary stigma'. Advocating for trans children within a transphobic and cisnormative world puts parents into an "exhausting" position where they are "required to engage in constant vigilance and an array of parental responsibilities to advocate, educate, respond, and protect"

(Riggs & Bartholomaeus, 2018a, p. 15). Hidalgo & Chen (2019) assessed gender minority stress in 24 cisgender parents of trans or gender non-conforming children aged 4-11, half of whom had socially transitioned. They found extensive experiences of 'distal stress' including peer discrimination, social discrimination, family rejection, friends' rejection, rejection by other parents, verbal victimization, as well as mis-gendering and non-affirmation of their child. Parents also experienced 'proximal stress' including stress relating to challenging their own cisnormativity, stresses related to fears of their child's future safety and happiness as a vulnerable minority (fears that can hold parents back from affirming their child), and stress related to disclosure or non-disclosure of their child's gender modality (that they are trans). Indirect minority stress and secondary stigma, with frequent experiences of hostility and experiences of threat, placed a huge burden on parents of trans children, with a significant toll on mental health (Alegría, 2018; Johnson & Benson, 2014; Pullen Sansfaçon et al., 2015; Riley, 2012). Indirect minority stressors contributed to negative mental and physical health outcomes in parents, including social isolation, guilt, anxiety and worry, poor self-care, stress, and caretaker fatigue (Hidalgo & Chen, 2019).

Within this section on families, whilst a lot of research has focused on parental experiences, much less has focused on pre-adolescent trans children's perspectives. Very few studies actually spoke to pre-adolescent trans children, and those few that did tended to be very brief interviews with an extremely limited focus, primarily asking children about their hobbies, gender expression, identity and coming out (Barron, 2014). Cisnormativity is apparent in interviews with trans children, for example interviewees asking children to explain their identity (Barron, 2014). A lack of parental trust in interviewers is a known barrier to research that includes trans

children, for example research by Barron (2014) only included four families of children aged 5-8, with the researcher outlining the time and multiple visits required to build up trust. Research on and with trans children remains focused on identities and transition journeys, with cisnormativity and pathologisation influencing research focus (de Bres, 2022). Dierckx (2016, p. 93) talks about the need for trans-positive research that makes a committed effort to "move away from heteronormative and transphobic problematisation of trans families". Family-focused research that explicitly avoids problematisation of the existence of trans children is presented in chapter 5 of this thesis.

## 4.2.2 Social Transition

One of the most critical topics of relevance to families with trans children, is 'social transition' (Ehrensaft et al., 2018). A 'social transition' is considered the point at which family and or community respect and affirm a trans child's identity, commonly accompanied by a shift in pronoun (Ashley, 2019e; Ehrensaft, 2020). It is distinct from diverse gender expression, with Ashley (2019b, p. 679) noting that "social transition involves something beyond gender non-conformity and speaks to a shift in lived gender identity".

Within trans children's healthcare there are two competing and conflicting paradigms on appropriate support for pre-pubertal trans children, 'delayed transition', and 'affirmation'  (Ashley, 2019e; Turban, 2017). Affirmative approaches advise supporting a child in their identity, prioritising current well-being without age based barriers on children living authentically (Ehrensaft et al., 2018; Temple Newhook, Winters, et al., 2018). This approach views family acceptance as critical for child self-

esteem and mental health, for those children whose identity will remain constant into adulthood, as well as for those who may have a more fluid identity, including those who may go through two or more 'social transitions' (Ehrensaft, 2021; Keo-Meier & Ehrensaft, 2018; Temple Newhook, Pyne, et al., 2018). A 'social transition' need not entail an end point, and may also provide an opportunity for self-understanding through, rather than just before transition (Ashley, 2019c). Bioethicist Florence Ashley (2019c, p. 6) points out that "changing names, pronouns, and undergoing transition-related interventions is routinely used by trans people in an exploratory manner, largely to positive effect".

Existing literature has noted the benefits of childhood social transition in terms of mental health and well-being (Turban, 2017). A study on 73 socially transitioned trans children aged 3-12 found they had high levels of positive mental health, with levels of depression similar to cis children (Olson et al., 2016). A follow up study on 116 socially transitioned trans children aged 6-14 found high levels of mental health and self-worth in socially transitioned trans children, concluding "these findings are in striking contrast to previous work with gender-nonconforming children who had not socially transitioned, which found very high rates of depression and anxiety" (Durwood et al., 2017, p. 1). A majority of healthcare guidance published since 2015 supports pre-pubertal social transition, recommending affirmative approaches to supporting trans children, including guidance from the American Academy of Pediatrics (Rafferty et al., 2018), the Paediatric Endocrine Society Special Interest Group of Transgender Health (Lopez et al., 2017), and from national healthcare standards in Australia (Telfer et al., 2018) and New Zealand (Oliphant et al., 2018).

A second paradigm, 'delayed transition', also known as 'watchful waiting', puts age-based barriers on social transition, with an emphasis on delayed acceptance or

affirmation of a child's identity, with children prevented from socially transitioning until a prescribed age, often around puberty (de Vries & Cohen-Kettenis, 2012; Ehrensaft et al., 2018; Giordano, 2019). The World Professional Association for Transgender Health (WPATH) published Standards of Care Version 7 (SOC 7) in 2011, in which it implicitly endorsed 'delayed transition', through warnings against pre-pubertal social transition (Coleman et al., 2012). SOC 7 provided suggestions on approaches to delaying transition, including a suggestion that families consider "in-between solutions or compromises (e.g., only when on vacation)" (Coleman et al., 2012, p. 17).

Two pieces of evidence underpinned SOC 7's 2011 recommendation against social transition, both of which have been subject to critique. Firstly, SOC7 references literature on so-called 'desistance', or the idea that trans children are likely to stop being trans at the start of puberty. Literature on this topic has been widely condemned as both flawed and misinterpreted (Ehrensaft et al., 2018; Priest, 2019; Temple Newhook, Pyne, et al., 2018; Temple Newhook, Winters, et al., 2018), critiqued for "methodological, theoretical, ethical, and interpretive concerns" (Temple Newhook, Pyne, et al., 2018, p. 1). These older statistics on 'desistance' are also challenged by more modern research, with recent longitudinal studies from Australia (Tollit et al., 2021), USA (Olson et al., 2022) and Spain (De Castro et al., 2022) showing a large majority of trans and non-binary children and adolescents continuing to identify as trans or non-binary (96% across child and adolescent age groups in Australia over a ten-year period, 97.5% of children under 12 at 5 year follow up in the USA, and 97.6% of children and adolescents at 2.6 year follow up in Spain). The second evidence strand underpinning SOC 7's caution against social transition is a letter to the editor, referencing a case of two Dutch children (Steensma & Cohen-

Kettenis, 2011). A closer analysis reveals that neither of the two children referenced in that letter, in fact none of the children in that study, had experienced social transition according to today's definition (Ashley, 2019b). They had non-conforming gender expression, but did not change pronoun or name, and they remained referred to as their gender assigned at birth (Steensma et al., 2011). The usage of this case, involving a small number of children who did not socially transition, to justify restrictions on supporting trans children, can be considered inappropriate, and ethically flawed (Ashley, 2019b).

Critics of 'delayed transition' argue that any potential risk of transition needs to be weighed up against the risks or harms of denying social transition (Ashley, 2021; Ehrensaft et al., 2018). Ashley highlights that the categorization of 'social transition' as a clinical 'intervention' requiring justification and evidence is itself a deeply cisnormative approach; they argue that delaying or preventing a child from having their identity respected is a more active intervention in the child's life, requiring greater evidence to justify it, than an approach that respects a child's self-knowledge (Ashley, 2019c).

A third paradigm, that of explicit attempts to convert or coerce a trans child into a cis identity, is condemned by mainstream health professionals (AusPATH, 2021; British Psychological Society et al., 2017; Coleman et al., 2012). Paediatric medical institutions across a number of countries have emphasized that efforts to convert trans children to a cisgender identity are both ineffective and unethical (Telfer et al., 2018). The UN Independent Expert on Protection Against Discrimination based on Sexual Orientation and Gender Identity called conversion practices "degrading, inhuman and cruel" (UN Human Rights Council, 2020, p. 21). A number of studies have outlined the harmful effects of conversion therapy, with the

effects most pronounced on trans people who endure conversion therapy in childhood (Turban et al., 2020). Research has shown that exposure to conversion practices before the age of ten is significantly associated with severe psychological distress and lifetime suicide attempts (Turban et al., 2020). Children exposed to such practices are known to experience a severe loss of self-esteem and a sharp increase in depression, leaving them at risk of school drop-out and substance abuse (Turban et al., 2020). As explicit conversion therapy has moved outside of what is deemed acceptable, or in some locations legal, there remains a significant grey area, with conversion practices continuing, including from healthcare professionals, but without explicit labelling as such (Ashley, 2022a). The UN report on conversion therapy underscored the harm of therapies that aim to change a child's gender identity from trans to cis, or that hold a child being cis as preferable to a child being trans (UN Human Rights Council 2020). The same report also emphasised that "practices aimed at changing gender identity include preventing trans young people from transitioning" (UN Human Rights Council, 2020, p. 11).

Trans children's own experiences and perspectives on pre-pubertal social transition are very rarely seen in the literature (Ehrensaft et al., 2018; Gill-Peterson, 2018). Some insights into the impacts of childhood affirmation or rejection can be gained from retrospective research with trans adults (Kennedy, 2020; Turban et al., 2020), but there is limited research on children's experiences of pre-pubertal social transition. In terms of parental perspectives and experiences, existing research provides limited perspectives on navigating or supporting social transition. Kuvalanka et al. (2014) interviewed 5 mothers of socially transitioned pre-pubertal trans girls on the transformations (of child, of family, of community) that accompanied or were prompted by their child's social transition. Olson et al. (2019) interviewed parents of

socially transitioned pre-pubertal children collecting parental perspectives on two items; examining whether parents perceived a decision to socially transition as child-led, and examining whether parents also discussed with their child the potential for a future second or third transition. Kuvalanka (2018) interviewed six US-based parents of socially transitioned trans children, documenting initial parental reactions, including brief references to efforts to discourage children from asserting their identity. This thesis has significantly added to the body of literature on the topic of social transition, with innovative research on this topic presented in chapter 5.

## 4.3 Education

Experiences at school form another significant body of existing literature that is synthesized here. This section starts with an examination of general literature on trans children's experiences in education, before drilling down into evidence on pre-adolescent trans children's experiences in education, particularly in primary school (K1-11). This part of the literature review informs work published in four recent articles (Horton, 2020, 2022c, 2022i; Horton & Carlile, 2022)

### 4.3.1 Overview of Global Literature

As increasing numbers of trans children are supported in childhood, a generation of trans children are socially transitioning at or before primary school (Durwood et al., 2017; Roche, 2020). Global literature has highlighted common challenges faced by trans children in education (Horton, 2020; McBride, 2021). This literature review draws upon evidence from across the globe, particularly from anglophone countries, though notes the potential for similarities and differences between country or context.

Trans pupils are vulnerable to gender minority stress at school, at risk of experiencing invalidation, problematisation and stigmatisation (Frohard-Dourlent, 2018; Marx et al., 2017; Pyne, 2014b). Trans adolescents are known to face high levels of discrimination and violence, experiencing bullying, de-legitimisation or harassment from peers as well as from adults (Bradlow et al., 2017; Davy & Cordoba, 2020; Francis & Monakali, 2021; Human Rights Campaign, 2018a; Kosciw et al., 2018; Martín-Castillo et al., 2020; Meyer et al., 2016). The cumulative stresses of navigating unsafe and trans-hostile environments is a significant risk to trans pupils' mental health and educational attainment (Case & Meier, 2014; Sinclair-Palm & Gilbert, 2018; Snapp et al., 2015).

Within the global literature on trans children's experiences in education I have identified nine themes: (1) Pathologisation and victim narratives (2) Discrimination and violence (3) Environmental stress (4) Individual accommodation on request (5) From school panic to affirmation and representation (6) Teacher barriers to action (7) Ambition and allies (8) Child voice and child rights and (9) Cisnormativity. This section examines global literature corresponding to those nine themes.

## Pathologisation and victim narratives

There is a long history of pathologisation, misgendering and invalidation of trans children that impacts upon trans children's experiences at school (Frohard-Dourlent, 2018; Gill-Peterson, 2018). Ansara and Hegarty (2012, p. 152) highlight the ways in which pathologising or cisnormative language can "dehumanize, silence and erase". Riggs and Bartholomaeus (2018a) provide an example of a parent of a five year old trans girl being asked by a school to provide a psychiatrist report and have genetic testing before the school might accept her. Pathologising approaches can also be expressed in more subtle ways, that nevertheless erase and delegitimize (Frohard-Dourlent, 2018), such as when trans children's identities are denied, or replaced with pathologising and delegitimizing terms (for example referring to children who are 'gender confused'). The erasure of the word 'trans' when referring to trans children can be understood as a form of erasure, that can lead to a denial of trans children's "self-intelligibility" (Kennedy, 2018b, p. 135).

There is a tradition of stigmatization and problematisation of trans children (Kennedy, 2018b; Pyne, 2014b) defining trans children through their association with trauma (Marx et al., 2017). Educators also need framings that centre joy, euphoria,

romance, laughter, strength and resilience (Marx et al., 2017; Shelton & Lester, 2018). Trans pupils, living in cisnormative environments, may develop particular strengths or types of cultural capital (Pennell, 2016b). Work on trans 'cultural capital' builds on similar work on the 'transcultural capital' (Meinhof & Triandafyllidou, 2006) minoritised migrants apply to navigate dominant cultures. Trans cultural capital can include navigational capacity, which can be described as being able to navigate through systems not designed for trans pupils;  linguistic capacity, which involves challenging linguistic norms that marginalise, erase or other trans pupils; familial capacity, which means finding support from trans peers, trans communities and trans-led narratives; and resistant capital, which is the ability to fight against discrimination and advocate for equality (Pennell, 2016a).

Descriptions of trans children and youth often centre a victim narrative (DePalma & Jennett, 2010), framing them as in need of protection (Marx et al., 2017). This singular and simplistic framing as 'at risk' (Frohard-Dourlent, 2018) homogenises, pathologises and others trans youth as inherently separate from healthy cis peers (Blair & Deckman, 2019; Marx et al., 2017; Miller, 2016b). A victim framing also individualises the challenges trans pupils face (Shelton & Lester, 2018), overlooking the structural inequalities harming them (Smith & Payne, 2016).


### Discrimination and Violence

Trans children face multiple areas of overt discrimination, including segregation and denial of access to appropriately gendered spaces (Kennedy, 2018a; Kosciw & Pizmony-Levy, 2016; Kuvalanka et al., 2020; Neary, 2021; O'Flynn, 2016; UNESCO, 2016). School based anti-trans discrimination targeting trans pupils of all ages is

apparent in a number of surveys, with trans pupils prevented from using their name or pronoun at school, and pupils forced to use inappropriately gendered facilities (Kosciw et al., 2016, 2018). Harm is compounded when schools enable trans children to be drawn into public debates on whether schools should actively discriminate against trans pupils, with examples of schools inviting parental consultation and debate on trans inclusion (Herriot et al., 2018; Miller et al., 2018; Sinclair-Palm & Gilbert, 2018).

Evidence from diverse locations continues to show trans pupils experiencing hostile school climates (Fayles, 2018; Grant & Zwier, 2011; Greytak et al., 2009; Human Rights Campaign, 2018; Kosciw et al., 2012, 2016, 2018; Peter et al., 2016; Taylor & Peter, 2011; Ullman, 2017) with high incidences of verbal harassment, bullying, physical abuse and sexual harassment (Bradlow et al., 2017; Human Rights Campaign, 2018; Kosciw et al., 2016; Murchison et al., 2016; Peter et al., 2016; Reed et al., 2010). Kosciw (2018) found a steady increase in negative remarks about trans people in schools between 2013 and 2017, highlighting that progress is not linear or guaranteed. Trans pupils report a lack of safety across multiple locations, including in primary schools (Meyer et al., 2016) especially in gendered spaces like changing rooms and bathrooms (Kosciw et al., 2016, 2018). In a 2017 US survey of over 5,000 trans adolescents, only 16% reported always feeling safe at school (HRC, 2018). A hostile school climate can have extensive consequences for trans pupils' ability to thrive (Greytak et al., 2009). Trans pupils experiencing harassment and transphobia are less likely to be able to concentrate in class (Robinson et al., 2014), have lower educational aspirations and poorer educational attainment (Fayles, 2018; Greytak et al., 2009; Kosciw et al., 2012; Robinson et al., 2014). Trans pupils report hiding at lunch times, avoiding gendered spaces like bathrooms and changing rooms

(Jones & Hillier, 2013; Robinson et al., 2014), and not participating in extra-curricular events and activities due to a lack of safety (Jones & Hillier, 2013; Kosciw et al., 2016). Within the UK a small body of quantitative research has explored the challenges reported by trans adolescents. The 2017 Stonewall School Report found 45% of 500 surveyed secondary school trans pupils had attempted to take their own life and 84% reported self-harm (Bradlow et al., 2017). Qualitative research predominantly considering the experiences of trans pupils in UK secondary schools has highlighted experiences of harassment and exclusion (Bower-Brown et al., 2021; Leonard, 2019; Paechter et al., 2021).

Trans youth have high levels of school absenteeism due to harassment (Greytak et al., 2009, 2013; Kosciw et al., 2012, 2016; Robinson et al., 2014; Taylor & Peter, 2011). Lack of affirmative or safe school environments is also associated with trans pupils dropping out of education or transferring schools (McGuire et al., 2010; O'Flynn, 2016). A negative school climate (combined with wider systemic oppression), leaves trans pupils with low levels of optimism about their chances of future success and happiness (Murchison et al., 2016).

## Minority stress

Cisnormative school climates place trans pupils under persistent psychological stress (McBride, 2021; Miller, 2016b; Ullman, 2015a). Institutionalised cisnormativity (Bauer et al., 2009) negatively affects trans pupils, delegitimizing their identities and making their lives harder in multiple and systemic ways (McBride, 2021; Miller, 2016b). Trans pupils experience persistent microaggressions, that they recognize as symptoms of deeply embedded structural inequality and violence (Woolley, 2017),

yet schools are likely to view them as individual isolated acts. Schools may already be aware of overt, individualized, intentional acts of transphobia or violence, but they need to also be aware of the compounding effects of subtler acts of cisnormativity, including systemic practices that are not intended to cause harm to trans pupils (Riggs & Bartholomaeus, 2018a). Beyond physical safety, trans pupils need to feel emotionally safe and welcome in school (Brill & Pepper, 2008). In the words of one parent of a young primary school aged trans child (Slesaransky-Poe et al., 2013, p. 30): "I needed to know if he would be physically and emotionally safe; feel welcomed, respected, and fully embraced; and be able to focus on learning".

A persistently stressful and hostile school climate can make school about survival rather than success and fulfilment (Miller, 2016b), with environmental stressors detrimentally affecting educational achievement and wellbeing (Ullman, 2017). The educational disadvantage trans youth experience is not individualized, but structural and systemic (McBride, 2021). Trans pupils experiencing macro and micro aggressions (Miller, 2016a) are forced to develop defensive strategies (Bowers et al., 2015; Greytak et al., 2013; Ingrey, 2018; Kennedy, 2018b) that are emotionally and cognitively difficult, reducing wellbeing and ability to learn and thrive. Areas of gender segregation can increase the minority stress felt by trans pupils (Bowers et al., 2015; Greytak et al., 2013; Ingrey, 2018; Kennedy, 2018a), placing them under additional surveillance and pressure to conform (Woolley, 2017). Socially transitioned children who have not disclosed their gender modality - that they are trans - carry an additional stress (McGuire et al., 2010) as they navigate systems that assume they are cis.

Approaches that prioritise an individualized anti-bullying discourse, including

the UK Government's approach (Carlile, 2019), overlook the systemic nature of the challenge faced by trans children in schools (Ansara & Hegarty, 2012), and distract from the systemic reforms needed to ensure trans children are welcomed as equals at school (Frohard-Dourlent, 2018; Riggs & Bartholomaeus, 2018a). The literature highlights a need for schools to move away from an exclusive focus on safety, on violence and on individual bullies and victims, to understanding and dismantling the systemic operation of cisnormativity in schools (Frohard-Dourlent, 2018; Miller, 2016b; Payne & Smith, 2014b).

## Individual Accommodation on Request

Few schools provide trans-inclusive adaptations prior to having a known trans pupil (Davy & Cordoba, 2020). The literature reports a tendency for schools to only take reactive actions to accommodate a trans pupil on request (Davy & Cordoba, 2020; Omercajic, 2015), often prompted by informed parent advocacy for their trans child (Davy & Cordoba, 2020; Neary & Cross, 2018; Riggs & Bartholomaeus, 2018a). Schools often only accommodate access to appropriate bathrooms after pupils or parents request such access (Ingrey, 2018). This approach means trans pupils' access is to be requested, negotiated and permitted. Ingrey (2018) highlights the rights violation of requiring trans pupils to apply for access, rather than the system proactively making trans pupils welcome. Trans pupils are "subjected to an approval process for a simple act of accessing a suitable washroom space; this process is humiliating, pathologizing and alienating, and ultimately transphobic" (Ingrey, 2018, p. 781). An individualised accommodation on request approach leaves the status quo intact, maintaining an "artificial hierarchy" (Serano, 2016, p. 13) where the dominant gender (Ingrey, 2018) is validated as 'natural'. In the process this

pathologises trans pupils' gender modality (that they are trans – Ashley, 2022c), with trans pupils' identities requiring approval and formal exception from the 'norm'. Trans pupils' right to identity and basic dignity is dependent on them submitting themselves to a pathologising and daunting process of justifying their needs and their identities to cis teachers or school administrators (Ingrey, 2018). This accommodation may be particularly hard for children who are gender fluid or non-binary (Omercajic & Martino, 2020) – though it needs to be noted that the current literature has little consideration of non-binary children (Airton & Koecher, 2019; Paechter et al., 2021).

Meyer and Leonardo (2018) conducted interviews with teachers, and found reluctance to make trans-affirmative school changes unless, and until, they personally knew a trans pupil. This is seen in the wider literature, with numerous examples of schools only making changes when forced to do so, when they encountered their first known trans pupils (Baldwin, 2015; McBride, 2021; Mitchell et al., 2014; Slesaransky-Poe et al., 2013). These children may "shoulder an immense responsibility as singular sites of all learning and change", becoming "sacrificial lambs" (Meyer et al., 2016, p. 9), whose privacy and right to equality of education are neglected in order for the school to commence incremental adaptation. Meyer et al. (2016, p. 9) discuss the "ethical dilemma of this pedagogy of exposure", asking how we can prompt trans inclusive school changes without a trans pupil or family needing to make themselves vulnerable.

Supportive parents and carers are relied upon to advocate for their trans children (Neary, 2021), educating their children's teachers, and advising on inclusive policies and curricula (Bartholomaeus & Riggs, 2017a). Families of trans children cannot just presume their children will be safe and welcomed in schools, and instead need to be constantly vigilant, to protect and advocate for their children (Hill &

Menvielle, 2009; Johnson et al., 2014; Neary, 2021; Pullen Sansfaçon et al., 2015; Rahilly, 2015; Riggs & Bartholomaeus, 2018a). Parental advocacy on behalf of trans children is an ongoing requirement, with support for trans inclusivity not automatically sustained or replicated across a school (Johnson et al., 2014; Riggs & Bartholomaeus, 2018a). Effective inclusion needs to be embedded in clear trans-affirmative policies and procedures (Bartholomaeus & Riggs, 2017a), that are developed proactively, rather than enacted upon request (Baldwin, 2015).

An individualised approach, listening to a child's voice, hearing their needs and being guided by a child's own individual path is absolutely critical to child-centred care (Whyatt-Sames, 2017). Where families are supportive of their trans child, a collaborative trusting relationship between families and schools can help ensure an effective child-focused path to providing a friendly, welcoming school (Slesaransky-Poe et al., 2013). However, the literature highlights that this individualised approach should not be a way of shifting responsibility onto pupils (Frohard-Dourlent, 2018) and is not a substitute for proactive structural changes to ensure trans children are made welcome in our schools (Omercajic & Martino, 2020). Frohard-Dourlent (2018) imagines a future where trans pupils don't need to self-advocate, because schools are already set up to recognise their existence.

## From School Panic to Affirmation and Representation

There is a pervasive culture of silence (Frohard-Dourlent, 2016b; Ullman, 2014; Ullman & Ferfolja, 2015) around trans lives at school that has a negative impact on trans children (Ryan et al., 2013). This culture of silence is reinforced through multiple means, from a history of formal legislation against LGBT inclusion in

schools[2] (Carlile, 2019), to teacher self-censure (Roberts et al., 2007), through to approaches that police offensive language without empowering teachers to provide alternative positive narratives (DePalma & Atkinson, 2009b). A culture of silence is also promoted by cisnormativity, wherein any trans representation is perceived through a lens of hyper-visibility (DePalma & Atkinson, 2006). Trans (and LGB) equality can be seen as controversial in a way that does not extend to other equalities (Atkinson & DePalma, 2008) with some commentators considering children 'too young' to learn about their trans classmates (Bartholomaeus & Riggs, 2017a). The presence and increasing visibility of trans children in primary and nursery classrooms (Riggs & Bartholomaeus, 2018a) forces primary school educators to face up to the silence surrounding trans lives (Payne & Smith, 2014b). Unprepared schools can enter into 'school panic', when a culture of silence comes up against the reality of trans children's lives (Bartholomaeus & Riggs, 2017a; Smith & Payne, 2016). DePalma and Atkinson (2009a, p. 887) note that:

> When marginalized groups begin to challenge society's expectation that they will remain invisible and silent, they are faced with a choice between invisibility (where they have traditionally been assumed not to exist) and surplus visibility (where their mere presence seems excessive).

The literature emphasises that schools need to adopt a 'usualising' approach to trans inclusion, where trans people are destigmatized to the point that their visibility is no longer of note (Carlile, 2019; Iskander & Shabtay, 2018). Trans people can be made part of everyday life through incorporation into different parts of the curriculum

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[2] Section 28 was a statute in place in the UK between 1988 and 2003, that banned the "promotion" of same-sex relationships in schools (Carlile, 2019)

(Mitchell et al., 2014) moving trans lives in schools 'from surplus visibility to ordinariness' (DePalma & Atkinson, 2009a, p. 884).

Existing literature notes that curricula are cis-dominated (Miller et al., 2018) with trans identities nearly invisible (Miller, 2016a). Many children do not see any representations of trans people at school (Mitchell et al., 2014; Peter et al., 2016). Erasure of trans visibility delegitimizes trans identities (Miller, 2016b), forming a systemic macro aggression where trans pupils need to continuously self-advocate and educate to be read as valid (Frohard-Dourlent, 2018). When schools do not affirm or represent trans identities, this impacts on trans children's self-image, belonging and sense of worth (Miller, 2016a; Ullman, 2014). Exclusion from the curriculum gives a message that trans identities are inferior (Miller, 2016b; Shelton, 2016). Marginalisation and exclusion at school and in wider society, teaches trans pupils there is no place for them in the school or the wider world (Ryan et al., 2013; Ullman, 2017).

Affirming trans-positive school environments are important for trans pupils, improving mental health, wellbeing, self-esteem, school engagement and sense of belonging (Bartholomaeus & Riggs, 2017a; Day et al., 2018; Olson, 2016). Children who are affirmed at home and at school have positive academic and emotional outcomes (Davy & Cordoba, 2020). Miller (2016a, p. 6) highlights the importance of schools being affirming with a "pedagogy of recognition" where trans pupils can see that they are valued, not merely tolerated. Trans representation can also have huge importance for gender questioning children, with access to the word 'trans', and knowledge of the existence of trans identities opening doors to self-discovery (Kennedy, 2018b). Most pupils do not see any trans representation in schools (Bradlow et al., 2017), and the representation that does exist is mostly negative,

framing trans people as 'at risk' (Bittner et al., 2016). In these contexts trans pupils can gain confidence and self-esteem from any positive trans representation (Snapp et al., 2015). An inclusive curriculum explicitly tackles the misconceptions that underpin transphobia (Meyer et al., 2016) and reinforces peer acceptance (Kosciw et al., 2012; Ryan et al., 2013), with increased peer support creating a more positive school climate for trans pupils (Jones et al., 2016; Kosciw et al., 2012). Trans representation in the classroom sends pupils a message that teachers support them, that they have a right to be safe in school (Kosciw et al., 2012; Peter et al., 2016), that they are not alone (Miller et al., 2018). A trans-affirmative curricula builds a more supportive, welcoming school climate (Martino & Cumming-Potvin, 2017; Peter et al., 2016), and improves wellbeing of trans pupils (Greytak et al., 2013; Kahn & Lindstrom, 2015). Trans pupils who feel able to fully participate as an equal in school, being open, when they choose, about their identity and being able to discuss 'transitude' (Ashley, 2018a, p. 4) at school, had a greater sense of belonging (Greytak et al., 2009). Trans pupils having a sense of belonging at school correlates to pupil wellbeing, academic motivation and academic achievement (Kosciw et al., 2012; Ullman, 2015a).

The literature notes that trans inclusion is needed in education on bodies and puberty (Jones et al., 2016), though with care not to limit inclusion to Relationships and Sex Education, which can be pathologising (Carlile, 2019; Formby, 2015). Trans positive representation in literature provides a "pedagogy of possibility" (Bittner et al., 2016, p. 2) that disrupts cisnormativity (Cumming-Potvin & Martino, 2018) showing trans people "as part of vibrant, supportive communities, living fulfilling and productive lives" (Parsons, 2016, p. 11). Trans representation in history, showing

historic fights for rights and visibility, helps validate and give hope to trans pupils, whilst also raising acceptance from cis peers (Snapp et al., 2015).

## Teacher Barriers to Action

Trans pupils can experience bullying, transphobia, ignorance and hostility from teachers and school staff (Bartholomaeus et al., 2017; Formby, 2015; Kuvalanka et al., 2014; Reed et al., 2010; Taylor & Peter, 2011), causing significant harm (Robinson et al., 2014). Teachers can also contribute to a hostile climate through inaction when pupils are facing transphobic harassment (Bowers et al., 2015; Greytak et al., 2009; Kosciw & Pizmony-Levy, 2016; McGuire et al., 2010; Robinson et al., 2014; Ullman, 2015a, 2017). Trans pupils who do not feel supported by their teachers are more than four times as likely to leave school if they encounter discrimination (Jones et al., 2016), with teacher failure to intervene seen as a violation of trust (Meyer & Stader, 2009). The literature notes that teachers have enormous power to "affirm or belittle the existence of youth in their classrooms" (Kearns et al., 2017, p. 12). Some teachers and school administrators are positive, well-informed and affirmative, and even just one supportive and trusted teacher can make a profound impact on a trans pupil's experience of school (Bartholomaeus & Riggs, 2017a; McGuire et al., 2010; Mulcahy et al., 2016; Palkki & Caldwell, 2018; Ullman, 2017).  In schools where teachers were protective and affirming (Meyer et al., 2016), consistently intervening to disrupt marginalising behaviour, pupils experienced lower rates of bullying (Greytak et al., 2013; Jones et al., 2016), had lower rates of school absenteeism (Jones et al., 2016; Ullman, 2015a), and higher rates of happiness and self-esteem (Kosciw et al., 2013; Ullman, 2015a). Perceived acceptance from teachers matters as much as protection (Ullman, 2014), with

teacher positivity about gender diversity significantly correlated with pupil wellbeing (Ullman, 2015a, 2017). Trans pupils spoke of the importance of having at least one adult who could advocate for them, help them understand their rights, and help them navigate cisnormative institutional cultures and regimes (McGuire et al., 2010).

A key barrier to trans inclusion is teacher willingness, with some staff not believing it is their job to include or affirm trans youth (Meyer & Leonardi, 2018), or having "barriers to empathy" (Blair & Deckman, 2019, p. 2). Bowers (2015) notes that school staff will be shaped by negative attitudes, misinformation or transphobia endemic in society. Teachers who were willing to refer to LGB (lesbian, gay, bisexual) identities in their classroom were less willing to include trans people (Formby, 2015), considering the topic taboo (Pullen Sansfaçon et al., 2015), too complex (Mitchell et al., 2014), or too difficult (Cumming-Potvin & Martino, 2018). However, once teachers tried trans and LGB inclusiveness, they were surprised to find children capable of engaging sensitively and thoughtfully (Carlile, 2019). School staff can be overwhelmed by inertia, aware of the need to support trans pupils, but holding on to pre-established prejudices around transitude as an undesirable 'deviation' (Frohard-Dourlent, 2018). Teachers and school administrators may wrongly assume the existence of transphobic institutional and legal regulations where discriminatory regulations do not exist (Frohard-Dourlent, 2016b).

Teacher lack of knowledge remains a barrier, with this finding referenced across literature from countries including Canada (Pullen Sansfaçon et al., 2015), Australia (Bartholomaeus et al., 2017) and the UK (Carlile, 2019). Ill-informed teachers can do harm, by relying on stereotypes that reinforce prejudice (Mitchell et al., 2014). Teachers may also experience fear and anxiety at the presence of trans children in their classroom (Blair & Deckman, 2019; Payne & Smith, 2014b; Smith &

Payne, 2016), the arrival of a trans child forcing teachers to become aware of (but not necessarily challenge) cisnormative assumptions and practices. Research has shown that teachers may lack confidence in how to identify school practices that harm trans pupils, or in how to identify transphobic or cisnormative stereotypes, bias or prejudice in teaching materials (Bartholomaeus & Riggs, 2017a). Teachers preferred to focus on "the problem" of fitting trans pupils into a cisnormative school, prioritising individualised actions like name change, rather than considering wider trans-inclusive adaptations (Smith & Payne, 2016). Literature has shown that teachers and school staff who have undertaken specific training on working with trans pupils, and those with trans friends or family, had more positive attitudes and greater confidence in working with trans pupils, and were more likely to advocate for their trans pupils (Bartholomaeus et al., 2017; Bowers et al., 2015). Staff who had knowingly taught at least one trans pupil had more positive attitudes on trans inclusion (Bartholomaeus et al., 2017; Bowers et al., 2015), building confidence with experience (Davy & Cordoba, 2020). However, some research has shown that a majority of teachers had not knowingly had a trans pupil (Bowers et al., 2015). Mentorship arrangements between staff with prior experience and staff who are new to trans-inclusion were found helpful in raising confidence, though such support is rare, especially in primary schools (Bartholomaeus & Riggs, 2017a; Davy & Cordoba, 2020; Slesaransky-Poe et al., 2013).

Another barrier identified in the research is teacher concern about wider community or parental opposition to support for trans pupils. Teachers were likely to assume parents as a whole would disapprove of LGBT inclusion (Depalma & Atkinson, 2010) and used this as justification for not acknowledging gender diversity in their teaching. Without school-set expectations, some teachers were likely to focus

on the perceived preferences of trans-antagonistic parents, rather than centring the needs of trans children (Malins, 2016). Teacher fear, underpinned by the impacts of anti-trans and anti-LGBT legislation, is identified in the literature as a significant obstacle (Carlile, 2019), with teachers feeling they needed courage to deliver LGBT inclusive curricula (Atkinson & DePalma, 2008; Carlile, 2019). Teachers avoided the topic (Cumming-Potvin & Martino, 2018; DePalma & Atkinson, 2006), believing they needed explicit permission to talk about it (DePalma & Atkinson, 2009b). Teachers need a network of support to enable and encourage trans inclusivity (Malins, 2016). DePalma (2009b) emphasizes how teachers aiming for LGBT school equality may need extra cross-school support, as they can feel isolated and worry about being perceived as 'subversive'. Existing research has shown that in locations like the UK, with a history of LGBT exclusionary school legislation, proactive policy and school-wide efforts are needed to ensure teachers gain confidence that trans inclusion is not controversial or unusual, but essential and routine (Mitchell et al., 2014). Similar efforts are needed when schools come under the pressure of conservative campaigns against trans-inclusion in education, campaigns that put pressure on schools in many countries to overlook their responsibility towards trans pupils (Bartholomaeus & Riggs, 2017a; Jones et al., 2016). Evidence has shown that reference to legal mandates and government or educational guidance is an important support for teachers and school administrators, making the connection to obligations to provide equality of opportunity safety, and physical and emotional wellbeing for all children (Carlile, 2019; DePalma & Atkinson, 2009b; Mitchell et al., 2014). Leadership, policies and guidelines from national or sub-national government are particularly helpful to ensuring school commitment (Bartholomaeus & Riggs, 2017b). Existing literature highlights the importance of governments providing clear

legislation and guidance to uphold the rights of trans children in education (Riley, 2012). Unfortunately, governments are frequently slow on delivering this leadership (Neary & Cross, 2018; Riley, 2012), failing in their duty of care for trans children.

Martino and Cumming-Potvin (2018) reference the ways in which teacher action or inaction in support of trans pupils is influenced as much by media landscape as by formal policy, or the ways equality-related policies are framed and understood through media narratives. Similar findings on teacher approaches to LGBT inclusion being shaped by media discourse have been reported in the UK (Carlile & Paechter, 2018). In contexts where national policy or media landscape is hostile to trans pupils, schools and teachers having an ethical commitment to caring for their trans pupils becomes important (Miller et al., 2018). Leadership and support at school level is critical for teacher action (Malins, 2016). Class teachers look for assurance that they have their head teacher's backing (Mitchell et al., 2014). In many schools, head teachers (principals) are proactively working to ensure equality of opportunity for trans pupils (Meyer et al., 2016). Equality motivated school governors or school board members can play a critical role in ensuring teachers and school leadership have a clear mandate to support their trans pupils, ensuring teachers understand and tackle cisnormativity, providing a welcoming school (Meyer et al., 2016).

## Ambition and Allies

The literature challenges the ambition we should have for trans-inclusivity in our schools, shifting from a focus on protection to school environments that affirm, validate and welcome trans pupils as equals (Case & Meier, 2014; Meyer &

Leonardi, 2018; Sinclair-Palm & Gilbert, 2018; Snapp et al., 2015). The literature also emphasises the importance of teacher allies (Meyer et al., 2016) and the need to raise our imagination of what teachers and school administrators are able to do to support their trans pupils (Atkinson & DePalma, 2008; Frohard-Dourlent, 2016b). The literature calls for raised ambition for teacher allies, moving beyond protection of an individual pupil, to being willing to dismantle cisnormative structures, policies and approaches that delegitimise and marginalise trans pupils (Case & Meier, 2014; Marx et al., 2017; Meyer et al., 2016; Meyer & Leonardi, 2018; Peter et al., 2016).

Educational researchers have highlighted the systemic inequalities experienced by trans pupils as a significant human rights issue (Greytak et al., 2009; Martino & Cumming-Potvin, 2016; Ullman, 2014), necessitating a shift from trans inclusion to trans emancipation in our schools (Mayo, 2007). Where there is a systemic injustice, as is the case for trans pupils in schools today, allies have a responsibility to act as a social justice advocate (Gonzalez & McNulty, 2010; Kearns et al., 2017). Teacher allies can ensure there is clear communication across the school on trans equality, mentor and support empowerment of trans pupils to assert their rights, sponsor LGBT groups, educate school staff and advocate for pupils' rights and wellbeing across the school and beyond the school gate (Case & Meier, 2014; Gonzalez & McNulty, 2010). Educational researchers have also emphasised that teacher education and training needs to move beyond basic education on the existence of trans people and on transphobic bullying. (Bartholomaeus & Riggs, 2017a; Meyer & Stader, 2009; Parsons, 2016). Trans pupils wanted teacher training to help ensure staff take action to tackle cisnormativity in educational systems and classrooms, improving equality of opportunity for trans pupils (Frohard-Dourlent, 2018; McGuire et al., 2010). Trans pupils often have a good understanding of the

structural factors underpinning the challenges they face in school, and wanted

school staff to acknowledge and be proactive in tackling these systemic barriers

(McGuire et al., 2010). Literature highlights the importance of training to help school

staff understand the ways in which school cisnormativity marginalises trans pupils

(McGuire et al., 2010), positioning trans pupils as lesser or other (Marx et al., 2017;

Miller, 2016b). Trans pupils also wanted school educators to be more active in

speaking up for trans rights in external processes and policy fora, helping them

overcome areas of structural oppression that impede their access to justice and

equality in education and beyond (McGuire et al., 2010).

Bartholomaeus and Riggs (2017a) highlight the many examples of cisgender

teachers and school administrators who are already effectively advocating for, and

standing up with, trans pupils in schools (Martino & Cumming-Potvin, 2017; Ryan et

al., 2013). Literature has noted that feeling safe at school needs to be recognised as

the bare minimum to expect for our trans children (Ullman, 2015b) with educators

instead needing to ensure schools are inclusive and affirming (Bartholomaeus &

Riggs, 2017a) places where trans pupils belong, where they are loved, where they

succeed and thrive  (McGuire et al., 2010; Miller et al., 2018). Miller (2016) aspires

for a future where trans pupils are commonplace and normalized, where trans pupils

are protected from minority stress, where gender diversity does not lead to

macroaggressions or marginalization, where there is trans representation across all

school materials and curricula, where schools support and embrace trans pupils of

all ages.

## Child Voice and Child Rights

A child-rights informed approach centres trans children's right to an educational experience that is safe, inclusive and affirming, a right to "gender legibility" (Miller, 2016b, p. 34), in schools where they can have an equitable experience to their cis classmates. Existing literature emphasises that trans children have a right to privacy, to gender marker change, and a right to choose if, and how, and when, to disclose their gender modality (that they are trans) (McGuire et al., 2010). Trans children also have a right to be visible in schools, open about their transitude (Ashley, 2018a, p. 4) to their classmates and school. Riggs and Bartholomaeus (2018a) provide an example of a parent feeling their child and family had been pushed towards not disclosing their transitude, to simplify the situation for the school and other parents, not centring the needs and rights of the child. Research highlights a range of circumstances and contexts where trans children's existing legal rights are not respected, where schools fail in their legal duty towards trans children (Ingrey, 2018; Taylor & Peter, 2011). In countries where trans children have legal protection, literature emphasises the importance of ensuring administrators, teachers and pupils are aware of these rights, with mechanisms to hold schools accountable when these are not fulfilled (Schindel, 2008). Schools also have a responsibility to advocate for trans children's needs and rights, including through educating unsupportive or unenlightened parents (Grossman et al., 2009). Trans children and supportive parents need to know their rights in order to claim them (Davy & Cordoba, 2020), and in order to challenge where there is ongoing inequality and injustice (Schindel, 2008). Meyer and Keenan (2018) outline the limitations of legally mandated protection of trans children, arguing that beyond an individual trans child's rights,

there needs to be a focus on a school's responsibilities, ensuring there is institutional accountability for systemic change.

LGBTQ clubs, also called Gay Straight Alliances (GSA) in North America, can provide trans children with peer support in an affirming and safe space, an escape from ignorance and cisnormativity (Kosciw et al., 2012, 2016; Marx & Kettrey, 2016; McGuire et al., 2010; Taylor & Peter, 2011). Trans youth with access to a GSA report more welcoming school climates, lower rates of victimization, greater feelings of school connectedness and less school absenteeism (Greytak et al., 2013). GSA members report a greater sense of empowerment (Poteat et al., 2016), can come together to jointly challenge systemic injustice and advocate for changes at school (Gonzalez & McNulty, 2010; Greytak et al., 2009), increasingly prioritising trans related advocacy (Poteat et al., 2018). Trans pupils who feel empowered and know their rights, who framed the discrimination they endure as related to societal and systemic prejudice, were more likely to respond with activism, and more likely to feel optimistic about being able to contribute to social change (Jones et al., 2016; Jones & Hillier, 2013). Luecke (2018) discusses components of a 'Gender Facilitative School', with an emphasis on empowering all children to be advocates and supporters of their gender expansive peers.

Many studies note the resilience of trans pupils, their agency to resist injustices and advocate for themselves and their peers (McBride, 2021). Wernick et. al. (2014) emphasise that marginalised youth need to identify and drive their own solutions, including through educating peers to join them in collective action. Kjaran and Jóhannesson (2013) highlight the importance of an emancipatory approach that prioritises listening to trans pupils' stories, including their experiences of encountering and resisting cisnormativity and structural violence. However minority

youth cannot be left to single-handedly challenge ingrained and dominant systems of cisnormativity, and the institutional and systemic discrimination that affects their lives (McBride, 2021).

## Cisnormativity in education

Martino et al. (2020, p. 1) highlight a tendency for some trans inclusion approaches, especially in primary schools, to focus purely on gender stereotypes, noting how this side-steps issues of genuine trans inclusion, and "eschews the necessity of addressing cisgender privilege and cisnormativity in the education system". Neary (2021) discusses the limits of individualising and conditional methods of inclusion, where trans children are forced to bend themselves to fit into cisnormative systems. Literature has highlighted the insufficiency of some efforts towards trans inclusion (Pullen Sansfaçon et al., 2021). Even when schools *do* try to accommodate trans students, it is often attempted through reactive accommodation that lacks integration and fails resolve more systemic issues (Martino et al., 2020). Smith and Payne (2016, p. 34) point to a lack of commitment to institutional and systemic change, noting that "failure to make structural changes is indicative of narrow interpretations of gender-inclusive schooling". Smidt and Freyd (2018) question the ambition of approaches to trans inclusion that fail to recognise cisnormativity or address areas of institutional oppression.

As introduced in section 2.2.2 of this thesis, cisnormativity is 'the assumption that everyone is cis(gender) or should be' (Keo-Meier & Ehrensaft, 2018, p. 11). Phipps and Blackall (2021) draw attention to the ways in which cisnormative gender regimes are embedded in school culture. Research has examined the ways in which school cisnormativity disadvantages and harms trans pupils (Bartholomaeus &

Riggs, 2017; Cumming-Potvin & Martino, 2018; McBride & Neary, 2021). Miller (2016, p. 3) describes how school cisnormativity privileges cis pupils, reinforcing a culture of educational injustice, where minoritized students are "forced to focus on simple survival rather than success or fulfilment". Research has started to consider the ways in which cisnormative school cultures contribute to pupil stress (Ingrey, 2018; Kennedy, 2018b; Riggs & Bartholomaeus, 2018a). McBride and Neary (2021, p. 1) emphasise the ways in which "cisnormativity permeates all aspects of school life", legitimising harassment, invalidation and discrimination. Cisnormativity is embedded within educational environments, sustained by "surveillance and self-surveillance" (Cumming-Potvin & Martino, 2018, p. 42). Literature has called attention to the cisnormative roots of policies, attitudes, and practices that may not aim to cause harm, but nonetheless contribute to making schools unsafe environments for trans children (Bartholomaeus & Riggs, 2017a; Riggs & Bartholomaeus, 2018a). Institutional cisnormativity in schools can be invisible or un-noticed by cis educators, whilst placing trans pupils under a "constant state of alert", experiencing perpetual minority stress (Newbury, 2013, para. 2)

### 4.3.2 Trans Inclusion in Primary School (K1-5)

Literature on trans inclusion specifically in primary schools is limited (Horton, 2020; McBride, 2021). The majority of school surveys of trans pupils focus on secondary school pupils or young adults (Bradlow et al., 2017; Day et al., 2018; Fayles, 2018; Human Rights Campaign, 2018; Kosciw et al., 2018; LGBT Youth Scotland, 2019; Ullman, 2015a). The majority of qualitative research on trans pupils also focuses on the experience of secondary school pupils or young adults (Jones et al., 2016; Porta et al., 2017; Snapp et al., 2015). Some UK research has gained insight into younger

trans children's experiences through parental interview (Davy & Cordoba, 2020), though not specifically focused on experiences in education. The few academic articles to have spoken directly with socially transitioned trans children at primary school, research that often only speaks to a handful of such children, provide limited insights into their experiences at school, often focusing on the period prior to a social transition, including the school's immediate reaction to child wanting to socially transition at school (Barron, 2014; Luecke, 2011). More insights may be found in non-academic work, such as interviews conducted by Roche (2020).

A number of studies from Canada and the US capture the experiences of teachers who have taught socially transitioned trans children (Frohard-Dourlent, 2016b; Kearns et al., 2017; Luecke, 2018; Marx et al., 2017; Meyer et al., 2016; Meyer & Leonardi, 2018; Omercajic, 2015; Yannalfo, 2018). Several qualitative studies from Canada, US and Ireland focus specifically on teachers' experiences supporting trans pupils at primary school (Neary & Cross, 2018; Payne & Smith, 2014b; Reznek, 2017). Perspectives on trans inclusion in education from parents and carers of trans children can also be found in the literature, with studies from Australia (Riggs & Bartholomaeus, 2018a), the UK (Davy & Cordoba, 2020), Ireland (Neary, 2018; Neary & Cross, 2018), US (Capous-Desyllas & Barron, 2017; Galman, 2020), and Canada (Pullen Sansfaçon et al., 2015). In the case of pre-adolescent trans children, or at least for those with supportive families, parents and carers often take on a significant role in advocating for school trans inclusion (Davy & Cordoba, 2020; Neary, 2021). Across parental accounts there is significant focus on common experiences of overt discrimination, rejection and segregation in education, or schools ill-prepared for including trans pupils, of families needing to advocate for their children's right to education (Kuvalanka et al., 2014). This thesis has added

significantly to the existing literature on trans children's experiences in education, focusing on the experiences of socially transitioned pre-pubertal trans children in education in the UK, including a focus on experiences of trauma and gender minority stress (Testa et al., 2015), as presented in chapter 6.

## 4.4 Healthcare

Trans children's healthcare is the focus of a final significant body of existing literature that is introduced here. This section synthesises evidence on two major topics related to healthcare, experiences in trans children's gender clinics (section 4.4.1) and healthcare relating to puberty (section 4.4.2). This section informs four recently published articles (Horton, 2021b, 2022g, 2022h, 2022j).

## 4.4.1 Children's Gender Clinics

Gender clinics have a long history of pathologising gender diversity, regarding trans and gender diverse children as failing to conform to normative expectations, having what was termed 'Gender Identity Disorder' (Gill-Peterson, 2018). Under a paradigm where diversity was seen as disordered, gender clinics focused on trying to identify psycho-social factors that caused childhood gender diversity (Lev, 2005; Turban & Ehrensaft, 2018). Pathologising clinical research on trans children and their families (as well as on gender non-conforming cis children), looked for causal links between childhood gender diversity and factors including parenting style, mother's mental health, childhood trauma, childhood family break up and other theorised causes of children developing what was considered a 'disordered' understanding of their own identity (Lev, 2005; Turban & Ehrensaft, 2018). Clinicians have noted that these gender clinic approaches were grounded in "a fundamental assumption of pathology – that something has gone wrong with a child's gender development and functioning; the purpose of the assessment is to decipher what went wrong so it can be fixed" (Berg & Edwards-Leeper, 2018, p. 105).

Gender clinics across multiple countries embarked on the control and coercion of trans and gender diverse children, applying practices of physical, emotional and psychological abuse (Bryant 2006; Gill-Peterson 2018). Gender clinics assessed children's non-conformity, scrutinizing interests or behaviours that they considered gender atypical, and therefore pathological (Bryant 2006). Treatment for 'Gender Identity Disorder', managed by psychologists, psycho-analysts and sexologists, included control of children's access to toys, friends or clothing, and withdrawal of parental, and particularly maternal affection (Ehrensaft 2012; Gill-Peterson 2018). Such techniques aimed to prompt a shift in behaviour, to fit into normative expectations (Bryant 2006). Decades of such research, psychotherapy and "medical violence" (Sullivan, 2017, p. 3) failed in its intent to erase gender diversity, instead causing deep harm to the children it attempted to treat. Gender non-conforming children exposed to such pathologising approaches reported experiencing feelings of rejection, shame and stigma, with short and longer-term impacts on their mental health, self-esteem and well-being (Bryant 2007; Williams 2017). Children subjected to this 'treatment' were taught to feel ashamed, developing low self-worth, accompanied by poor mental health and high levels of self-harm or suicidal ideation (Bryant, 2006; Bryant, 2007; Gill-Peterson, 2018; Scholinski & Adams, 1998; Sullivan, 2017). One person, subjected to this treatment as a child, described "the shame of knowing that those I was closest to disapproved of me in what felt like very profound ways" (Bryant, 2007, p. 4). In 2013 a revised diagnosis was introduced, that of 'gender dysphoria' (American Psychiatric Association 2013). This diagnosis required more than just gender non-conformity, yet continued to require assessment of children's gendered preferences, interests and friends (Davy and Toze 2018).

Defining gender diversity as disordered or pathological is now widely considered outdated, prejudiced and harmful (AusPATH, 2021; Endocrine Society & Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018). Efforts to control, shame or coerce gender diverse children are condemned by a broad range of international healthcare practitioners (American Psychological Association, 2021; Ashley, 2019f, 2022a; Telfer et al., 2018; UN Human Rights Council, 2020). Approaches that clearly state a goal of trying to change a transgender child's identity, or trying to deter a child from identifying as trans, have moved into the fringes of psychological practice, with mainstream medical and rights bodies repudiating conversion practices (American Psychological Association 2021; Ashley 2022; Rafferty et al. 2018; Substance Abuse and Mental Health Services Administration. 2015; UN Human Rights Council 2020). There is growing recognition that mental health inequalities are driven by societal cisnormativity, prejudice and minority stress, and that it is our society that needs fixing and not trans people (Austin et al., 2020; Chodzen et al., 2019; Hendricks & Testa, 2012; Tan et al., 2021; Veale, Peter, et al., 2017; Veale, Watson, et al., 2017).

Being transgender is now recognised by the medical establishment as a non-pathological part of human diversity, with space for trans lives to be celebrated and normalised, as a valued and important part of our families and communities (AusPATH, 2021; World Health Organisation, 2021). A conceptual shift from gender diversity as pathological, caused by family dysfunction or childhood trauma; to gender diversity as a positive part of our diverse world, is a profound shift, with significant implications for the focus and purpose of gender clinics for families with pre-pubertal trans children (Pyne, 2014b). Trans-positive therapeutic practice for families of younger trans children has moved away from an attempt to identify a

cause of gender diversity, such as through psycho-analysing mother-child relationships, towards an emphasis on therapy and education to help families better support their trans or gender diverse children (Coolhart, 2018; Keo-Meier & Ehrensaft, 2018; Oliphant et al., 2018; Riggs, 2019b; Telfer et al., 2018). There is growing consensus of the benefits of what has come to be known as a 'gender affirmative approach' (Keo-Meier & Ehrensaft, 2018). A shift to affirmative support for trans children and their families has been endorsed by a wide number of global and national healthcare bodies across countries including USA, Australia and New Zealand (Endocrine Society & Pediatric Endocrine Society, 2020; Murchison et al., 2016; Oliphant et al., 2018; Telfer et al., 2018). A number of global and national medical bodies (from countries including Australia, US, New Zealand) have published affirmative guidelines for clinics and services working with trans children, outlining the priorities, approaches and support to be offered to pre-pubertal trans children within an affirmative care framework (Keo-Meier and Ehrensaft 2018; Murchison et al. 2016; Oliphant et al. 2018; Telfer et al. 2018). Trans children, adolescents, and families, receiving affirmative healthcare, report high levels of satisfaction (Bartholomaeus et al., 2021; Inwards-Breland et al., 2019; Pullen Sansfaçon et al., 2020; Tollit et al., 2018).

Despite a significant global medical shift towards affirmative care for trans children, a number of clinics remain tethered to an older approach, including UK children's gender services (these include GIDS, the Gender Identity Development Service at the Tavistock and Portman, covering England and Wales, and the Sandyford Clinic, covering Scotland) (Akkermans 2018). Within healthcare services that are not affirmative, such as is the case in the UK, the priorities, approaches and support offered to trans children is less well documented. Within the UK, at time of

writing in Summer 2022, the structure, staffing and leadership of children's gender

clinics has not significantly changed since the years when childhood gender diversity

was pathologised and problematized as a disorder in need of fixing (Akkermans

2018). Changes to the structure and remit of NHS Children's Gender Clinics are

anticipated in late 2023 under the auspices of the NHS commissioned 'Cass review'

into gender identity services (Cass, 2020), though those future and as yet un-

specified changes are outside of the scope of this thesis. Services at present remain

housed within mental health trusts, and continue to be run by psychologists, with an

ongoing domination of a psychoanalytical approach to working with parents of trans

children (Akkermans, 2018). Continued commitment to a psychoanalytical approach

is exhibited within recent publications by children's gender clinic staff, with examples

of clinicians keeping 'dream diaries' to analyse their own sub-conscious reflection of

their encounters with parents of trans children, and accounts where clinicians

examine and analyse the clothing and even the physical bodies of parents of trans

children (Bonfatto & Crasnow, 2018).

A small number of publications have captured experiences and perspectives

of trans adolescents and families attending UK NHS (National Health Service)

gender clinics (Carlile 2020; Carlile, Butteriss, and Sansfaçon 2021; Pullen

Sansfaçon et al. 2021; Horton 2021). These publications have highlighted a range of

challenges encountered by trans adolescents, including healthcare interactions

characterized by "dissatisfaction, frustration, and distress" (Carlile 2020, 7); youth

dislike of "painful" GIDS assessment processes (Carlile, Butteriss, and Sansfaçon

2021, 6); and delays and barriers in access to gender affirming healthcare (Carlile,

Butteriss, and Sansfaçon 2021; Children's Right Alliance for England 2016). Limited

insights are available into gender clinic practices with younger trans children and

their families, with a majority of publications on this cohort written by clinicians themselves, with clinician accounts rarely centering the voices and perspectives of trans children (Pullen Sansfaçon et al. 2019). Recent articles from children's gender services in the UK have raised ethical concerns, with work criticised as "judgemental and intrusive", as trauma-inducing, and as an "exercise of symbolic violence" (Pearce, 2020, p. 816). This thesis has significantly added to the existing literature on experiences at children's gender clinics, with research presented in chapter 7.

### 4.4.2 Puberty and Puberty Blockers

Over the past decade, a diverse body of research has enhanced understanding of effective approaches to enabling wellbeing in transgender children (Turban & Ehrensaft, 2018). Affirmation, including family support, use of preferred name and pronoun, and support for social transition are all associated with positive mental health, and low levels of depression or anxiety (Olson et al., 2016; Pollitt et al., 2021; Russell et al., 2018). Global and national healthcare bodies endorse 'affirmative healthcare' (Hembree et al., 2017; Murchison et al., 2016; Telfer et al., 2018). A number of quantitative clinical studies have shown the benefits of affirmative healthcare, including access to 'puberty blockers' (Achille et al., 2020; Cohen-Kettenis et al., 2011; de Vries et al., 2014; Khatchadourian et al., 2014; Miesen et al., 2020).

GnRH agonists, colloquially known as 'puberty blockers', have been in use for delaying early (precocious) puberty in children since the 1960s, and have been used for delaying puberty in trans adolescents from the late 1980s (Cohen-Kettenis et al., 2011). Puberty blockers halt the progress of endogenous puberty, including pausing

or delaying the changes associated with puberty such as the development of secondary sex characteristics (for example deepening of voice, development of breasts), the development of fertility (maturation of gametes) and pubertal increases in bone density (Telfer et al., 2018). Puberty blockers have a temporary and reversible impact on pausing the development of secondary sex characteristics, with development of secondary sex characteristics recommencing once puberty blockers are discontinued (Hembree et al., 2017). Puberty blockers also have a temporary and reversible impact on fertility - when puberty blockers are discontinued, endogenous puberty recommences, including the maturation of gametes (Hembree et al., 2017).

Global and national healthcare guidelines from institutions such as WPATH (the World Professional Association for Transgender Health), the American Academy of Paediatrics, and national healthcare services in countries such as Australia and New Zealand, have endorsed the use of puberty blockers as a vital component of healthcare for trans early adolescents (Murchison et al., 2016; Oliphant et al., 2018; Telfer et al., 2018; WPATH, 2020). The global Endocrine Society produced consensus based trans healthcare guidance in 2017, recommending puberty blockers for trans adolescents "at early puberty" (Hembree et al., 2017, p. 3880). Quantitative research highlights the important benefits of puberty blockers with evidence of them being protective for trans adolescent mental health (Achille et al., 2020; Miesen et al., 2020; Tordoff et al., 2022). At the same time, evidence has highlighted potential risks of puberty blockers, noting potential side-effects including 'hot flushes', particularly when used in adolescents who are in late puberty, and concerns relating to bone density, particularly when blockers are used without HRT for many years (Rew et al., 2021). Beyond these concerns, there is an overarching

criticism of the quality of evidence underpinning the use of puberty blockers (Rew et al., 2021). A 2021 UK National Health Service evidence review concluded that the evidence underpinning blocker usage was of "very low certainty" (National Institute for Health and Care Excellence - NICE, 2021, p. 21), though the assumptions and methodology behind that evidence review have been strongly critiqued (Eckert, 2021).

Debate and discussion on the use of puberty blockers has intensified in recent years, entwined with politicised attacks on trans healthcare more broadly (Abreu et al., 2021). At the same time as increasing medical consensus, politicised and ideologically driven attacks on trans adolescent healthcare have led to political and legal interference in, or restrictions on, access to puberty blockers (Abreu et al., 2021; Leibowitz et al., 2020). Controversy about trans healthcare in the UK culminated in a December 2020 court judgement that, in practice, following NHS England guidance, removed access to puberty blockers for trans early adolescents in England and Wales (*Bell vs Tavistock*, 2020), though the case was later overturned on appeal, with significant criticisms of the shortcomings in the original judgement (*Bell vs Tavistock*, 2021). At present, in countries including the UK, US and Australia, puberty blockers remain a topic of culture war associated public and media debate (Faye, 2021), in spite of strong statements released by medical professionals defending their use (AusPATH, 2021; WPATH, 2020).

The literature contains diverse perspectives on the trans adolescents' healthcare needs, including a range of stated reasons for prescribing puberty blockers to trans adolescents who want to access them (Rew et al., 2021). The Endocrine Society notes that for many trans adolescents, "pubertal physical changes are unbearable", with puberty blockers leading to "a better psychological and

physical outcome" (Hembree et al., 2017, p. 3880). Other sources emphasise puberty blockers offering time, whether that be time for adolescent decision making about HRT, time for clinician diagnosis, or time for parents to learn to understand or accept their child (Brik et al., 2020). Current literature on puberty blockers provides limited experience-based insights from trans adolescents or their families (Rew et al., 2021). Only two studies, both from the Netherlands, focused on trans adolescents' or parents of trans adolescent's perspectives on puberty blockers (Vrouenraets et al., 2016; Vrouenraets, de Vries, et al., 2021). Both of these studies primarily captured the experiences of older adolescents, with a median age of 17-years-old (range 14-27 years-old) (Vrouenraets et al., 2016; Vrouenraets, de Vries, et al., 2021). The Dutch research emphasised the importance of puberty blockers in reducing suffering related to the development of secondary sex characteristics, in providing time for decision-making on gender affirming treatment, or as a first step towards gender affirming treatment (Vrouenraets et al., 2016; Vrouenraets, de Vries, et al., 2021).

Where trans adolescents wish to access puberty blockers, parental support is recognised as critical, both in health systems where parents can play a key role in enabling or impeding trans adolescent access to healthcare (Riggs et al., 2020; Riggs & Bartholomaeus, 2018b), and in circumstances where family rejection would leave trans adolescents at risk of poor mental health or homelessness (Ashley, 2019a; Priest, 2019). Parents are known to face barriers to understanding their trans children, with a well-documented need for information, advice and support across different domains including social, legal and healthcare (Pullen Sansfaçon et al., 2015; Riggs, 2019a; Riggs et al., 2020). This thesis has added significantly to the existing evidence base on puberty blockers, centring children and family experience and insight, with primary data-driven research presented in chapter 7.

# Part II - Findings

Chapters 5-7 present primary research undertaken within this thesis. Chapter 5 explores experiences in families. Chapter 6 focuses on education and schools. Chapter 7 examines experiences of pathologisation and healthcare. Each chapter starts with a summary of the chapter's research aim, before presenting in turn a series of related areas of research, with each discrete piece of research structured according to research findings, discussion and conclusion. Within the presented research findings, themes and sub-themes are illustrated with quotations from parents [P] or children [C]. As discussed in the section on confidentiality and data management (section 3.5.2), quotes are not attributed to named pseudonyms for reasons of participant safety and privacy, protecting against patchwork identification. The findings chapters come with a trigger warning, with several sections (particularly sections 5.2, 6.2 and 7.5) including accounts of child trauma, with references to violence, distress, self-harm, suicidal ideation and attempted suicide.

# 5 Families

## 5.1 Research on Experiences in Families

The existing literature on families provides limited insights on the experiences of parents who have supported a child's pre-pubertal social transition, with even less insight from trans children who socially transitioned pre-adolescence themselves (Olson et al., 2019). This research examines insights from families where parents have supported a trans child to socially transition under the age of eleven in the UK. This research aimed to enhance understanding of social transition through examining three discrete and inter-related areas of research, considering experiences of social transition (section 5.2), parental reflections on social transition (section 5.3) and experiences and parental perspectives on delaying social transition (section 5.4). Within each section the research addressed topic specific research questions (outlined in table 1).

**Table 1: Topic Specific Research Questions: Families**

| Section | Research Questions |
|---|---|
| 5.2 Experiences of Social Transition | 1) What are parents and trans children's experiences of pre-pubertal social transition? <br> 2) What can we learn from parent and child accounts of their experiences before and after a pre-pubertal social transition? |
| 5.3 Parent Reflections on Supporting a Trans Child | 1) How do parents who have supported a child's social transition reflect upon their experience? <br> 2) How do such parents evaluate the risks and benefits of pre-pubertal social transition, and what experience-informed advice do they have for other families? |
| 5.4 Delaying Social Transition | 1) What insights can parents of socially transitioned trans children share on their experiences of affirmation or delayed transition? <br> 2) How do such parents reflect on their approach towards the timing of social transition? |

## 5.2 Experiences of Social Transition

This section has informed the published article:

Horton, C. (2022). "Euphoria": Trans children and experiences of pre-pubertal social transition. *Journal of Family Relations*.

### 5.2.1 Research Aim

Section 5.2 focused on two topic specific research questions: 1) What are parents and trans children's experiences of pre-pubertal social transition? 2) What can we learn from parent and child accounts of their experiences before and after a pre-pubertal social transition? This section provides an important addition to literature that rarely centres child or family experience of childhood social transition.

### 5.2.2 Findings

Within this piece of research on parent and child experiences of social transition, key findings are divided into experiences before and after a pre-pubertal social transition. Pre-transition interviewees highlighted a range of challenges, presented in sub-themes on children 'correcting assumptions', 'becoming distressed', 'struggling alone', 'reaching crisis', or 'growing withdrawn and frustrated'. Post-transition interviewee responses are presented in sub-themes of 'a weight being lifted', 'validation at school', and 'well-being'.

## Challenging Experiences Pre-transition

The first major theme explores parent and child experiences pre social transition.

### *Children correcting assumptions*

This sub-theme captures the ways in which trans children challenge assigned labels, including examples of children asserting their identity to their parents, as well as to their siblings and peers. Children correcting their parents' assumptions around gender identity was a common theme in many parental accounts, with some trans children correcting their parents from age 2-3, insisting on being correctly gendered. One parent described how their young child challenged their assumptions: "he kept correcting us" [P]. Another parent recalled how their child would assert her identity every time she was misgendered:

> She was saying say 'sister not brother' every time I said 'oh pass your brother the bla bla bla', she would say 'sister, not brother', say 'she not he' [P].

Some children asserted their gender more vocally as they joined primary school. A parent recalled a conversation with their child on the first day of starting school (age 4-5):

> (I said) 'I've got two big school boys now'. And she just looked at me, and she just went 'school girl mummy' [P].

Some children were able to challenge mis-classification with self-confidence, with parents describing how their children asserted themselves "She said to me, mum, you do know I'm a girl, don't you?" [P]. Several interviewed children remembered trying to correct their parent regularly from a young age: "At about 4 I kept telling my mom that I felt like a boy" [C]. Other children prioritised getting their peers to

correctly gender them; one parent found out that their child had been asserting her identity in front of other children, without parental knowledge:

> Our older child said to us that whenever they'd gone to parks, soft plays or that kind of thing where children meet each other…. for as long as he could remember, whenever they'd gone to places where they met other children, she had introduced herself as [new Name], she had introduced herself as his sister [P].

These accounts of children correcting misassumptions, align with wider research on young trans children's identities, with a body of psychological research demonstrating that pre-school and primary school-aged trans children have a strongly felt gender identity and know who they are (Fast & Olson, 2018; Olson et al., 2015; Rae et al., 2019).

### *Becoming distressed*

The second sub-theme highlights examples of children growing increasingly distressed at being misgendered, with their parents noticing their child's distress, and children recalling their own frustration and sadness. One trans child reflected on how it felt before their parents understood and affirmed them.

> Interviewer: "Was it hard to show your feelings when you were younger?"
>
> Child: "I did like (Cross facial expression). I think they knew that I was angry".
>
> Interviewer: "How did it make you feel? Were you bothered?"
>
> Child: "I was kind of bothered".
>
> Interviewer "Can you tell me any emotions that you might have felt?"

Child: "Anger, sadness".

Many parents recalled noticing how misgendering affected their child's happiness and well-being.

> She was kind of happy before, but, every time she was called a boy's name, she wasn't happy. Every time I used the wrong pronouns. She wasn't happy…. these things would upset her [P].

Another child recalled how it had felt when they were being misgendered:

> When people got it wrong, when I corrected them, they said sorry, so it was alright. It didn't feel that good (visibly upset here) before I corrected them [C].

A majority of parents and children were operating in a world without trans possibilities, and described how a lack of access to trans narratives impeded understanding:

> He used to cry himself to sleep a lot. And we used to have what we used to call sort of meltdowns, where you'd be hugging him. And you know, and he couldn't be consoled, because and this is when he was about, I suppose it started when he was about six or seven, these meltdowns. And because he wanted a beard, and you know, as a cis person, it just sounded ridiculous to me, you know, that a six-year-old would be crying about wanting a beard [P].

Another trans child described how it felt when they were incorrectly gendered.

> Interviewer: "What did it feel like when people got it wrong?"

> Child: "Like crying".

These examples highlight the strain, stress and distress trans children can experience while they are not being understood, supported or affirmed in their identity.

### *Struggling alone*

The third sub-theme captures experiences where parents were not aware of their child's distress, or did not know that depression or anger were related to identity. This theme highlights examples of children struggling on their own, and parents only later understanding their child's experiences. Some children were aware of, but did not assert their identity very young, hiding their gender identity from their family, often for several years, dealing with their feelings and emotions alone. Parents only became aware of their child's lonely struggle when their child came out to them:

> There was one night when [Child] was absolutely bereft, and I was just, we were just lying in his bed, and I was just like hugging him and I was like, you know, you can tell me anything. Like, it doesn't matter. But if there's something and we can do something to help, then, you know, it's so much better if we talk about it. And that's when he was like, 'mummy, I'm a boy, like everybody thinks I'm a girl and I'm - I'm just not - like - I am a boy' [P].

Children had tried to suppress their identity, and were in need of parental acceptance.

> And we were laid in bed one night reading a story. And she turned around to me, and she just said, 'my, my heart keeps making me feel like a girl and I can't make it stop' [P].

Within this sub-theme, other parents were aware of their child's depression or anger, but had not understood the connection to gender identity. Several parents who had

noticed their child's depression, felt relief once they understood what was happening, and once they were able to help their child.

> But she'd been so low and so depressed for such a long time. And it was like, the lightbulb moment for us as a family. It was like, oh, so that's what's been wrong all this time. We can help with that, you know, and so, because we could look back and say, yes, that was obviously why you were struggling so much. We knew she'd been thinking about it for a lot longer than, you know, that moment [P].

For a few parents, understanding that their child had struggled with disclosing their identity, helped them understand past difficulties they had observed: "She was a very angry child, and looking back, it's kind of clear where that came from" [P].

> Within this sub-theme, parents only later understood what their child had been through prior to coming out. A parent recounted how their child has described the time before disclosing their identity:

> She has sort of said little things to me, like how she felt she was climbing a really, really, really, really tall ladder. And she felt like she finally got to the top and was able to see, which I quite liked as an analogy from like, a seven-year-old, when she said that, and that it was a really hard climb, and a really long and lonely climb. but she did it, you know, so she feels quite proud of it [P].

These accounts echo literature on trans adults' childhood memories, with research emphasising there often being a significant gap between a person understanding their identity, and them disclosing their identity to anyone else (Kennedy, 2020).

Within this sub-theme we hear examples of children experiencing extreme distress, pain, frustration and suicidal ideation, before disclosing their identity. Several parents described their children being in acute despair before disclosing their identity, some of which parents were only fully aware of later.

> She was so depressed and it later came out that she had been coming downstairs, and it wasn't just once, she said she used to come downstairs and hold the kitchen knives, and will herself to die. Like she wanted to kill herself. She would have only been 6 years old at that time. And finding out that your child was in so much distress like that, and not able to tell me, I mean, she sort of said to me, 'I decided that I couldn't do it and I just had to tell you I'm a girl instead' [P].

Another parent only found out about the depth of their child's suffering when their child confided in a friend.

> I was picking up my child from a birthday party and another parent came over. And said that my child had confided to their child, that they wanted to die by suicide, because they were so miserable. … My child is literally nine years old, and they want to die by suicide [P].

One parent shared their child's description of why she benefits from attending counselling sessions with a trans-positive counsellor:

> She said, even the other day, that she enjoys having those meetings, because it helps her get some of her demons out. I think that was the language she uses. She's like, I've still got all this pain and frustration from

before mummy, from before I came out, and it helps to talk to them, because it helps to get it out [P].

These accounts provide insights into the acute distress trans children may feel when they are not understood, or fear being rejected, by those closest to them.

### *Growing withdrawn and frustrated*

Within this sub-theme parents describe recognising their trans child's growing frustration and depression, as they waited for parental acceptance. Several parents noticed their children's well-being declining while they were waiting for the world, and for their families, to understand them and support them.

I saw that she was becoming more withdrawn. I saw that she was struggling with school… The best way I can describe it is there was just this air of sadness around her. And I don't really know how else to articulate it [P].

Parents noted how living inauthentically caused their child pain.

Well, just how unhappy [Child] was when she was having to live as [assigned Name]. Because effectively she was being forced to live like that. She didn't want to be a boy - having to present as a boy was, you could see, it was painfully uncomfortable for her [P].

Parents noted how living inauthentically had negative impacts across all areas of their child's life:

I think that before he, before he transitioned socially, yes, absolutely, he was completely struggling in the world [P].

Parents reported slowly understanding how much being correctly gendered mattered to their child. One parent described their child's reaction, after a stranger referred to their child as a boy, and the parent did not 'correct' them.

> When we left the store and he was like 'thank you for letting me be a boy, mummy'. And I. That, that is straight from his heart, you're letting me be a boy. And I'm, like, the power that you have, as a parent, to utterly destroy your child in that one second [P].

A number of children grew increasingly frustrated at delays in parental support. One parent emphasised their child's exasperation whilst waiting for their parents to grow in awareness and understanding. The parent recalled the conversation when they discussed affirming their child.

> Like her face was saying 'oh for fucks sake like someone gets it'. Like you stupid people. I'm six and I'm spelling this all out for you. So, we were like ok, 'you'd like us to say [new Name]'. 'Yeah'. 'And you'd like us? Well does that mean you'd like us to say she and her? Sigh. 'Yes' (exasperated obvious yes) [P].

One parent reported how their child remembers that period pre-support.

> She often refers to it as, you know, like, 'when everyone was idiots', and 'when none of the rest of you had a clue about anything'. I get the sense from conversations I've had with her, that she was literally just waiting for the rest of us to catch up. And I, you know, I think she knew who she was from before she could even speak. And so, for her, the transition was us catching up [P].

These accounts highlight how parents grew to recognise the negative impacts on trans children of rejection or being denied recognition.

## Experiences post-transition

The second major theme explores parent and child experiences post social transition.

### *A weight lifted*

Within this sub-theme parents and children describe significant positive impacts of parental affirmation and social transition. A majority of parental interviewees described a weight being lifted from their child once parents understood and embraced their child's identity: "But she, you know, as soon as she told us, she was like, the weight had been lifted" [P]. Several parents described significant emotional shifts once children were affirmed.

> She was a really, really angry toddler and young child. And, and almost all of that dissipated with transition [P].

> It was brilliant for him. It was brilliant for him, the meltdowns stopped [P].

> She just, she just changed overnight, you know, back to this bubbly, vivacious child that I hadn't seen for a couple of years. And, and she continued, you know, she's dancing down the street, singing all the time, she's just sunshine [P].

Once using affirming language, parents understood how important it was for their child.

> And the benefits were immediate, her - at every stage, every time we had a conversation that validated her, there would be this shift, there would be this light in her eyes, that we were seeing her [P].

It was really, it was just so amazing to see how such a small action could make such an impact. And conversely how misgendering can do the reverse [P].

A child interviewee was asked how they felt when their parents used affirming language: "It felt right and it gave me the biggest feeling of euphoria" [C]. These accounts align with findings from a growing body of research that demonstrate the importance of family support for trans children (Hill et al., 2010; Pollitt et al., 2021; Riggs et al., 2020; Russell et al., 2018)

### *Validation at school*

Within this sub-theme, interviewees reflected on the critical importance of social transition at school, with positive impacts on their child's happiness, stress levels, and willingness to attend school. One parent recalled the strain placed on a child who was affirmed at home, but was not socially transitioned at school.

And I think, it was from that point, she was so happy, fully living as a girl. And then it was like, right, off you go to school in your boys' school uniform. And pretty much weekly from that point. It always seemed to be in the bath. She'd say 'When can I go to school as a girl? When can I go to school as a girl? [P].

Some families had a longer period of affirmation at home, without affirmation in other spheres including at school, noting the stress and strain this placed on their child:

Things deteriorated quite rapidly because she was [new name] full time at home, and with a couple of select friends, and then had to go and be in boy mode at school, and see her dead name (old name used before social transition) written down everywhere, and answer to her dead name on the

register, and (we noticed) very rapidly deteriorating behaviour at home because of that [P].

Several parents emphasised a dramatic improvement in their child's willingness to attend school once affirmed there.

In the sense that it made her happier - Yes. It was a huge deal for her. She was miserable going to school in a boy's uniform. Honestly, it was a fight every day, the day that she was allowed to go in a dress, she was up and ready for school. You know, before I'd even got out of bed. Yeah, completely changed her life [P].

Before he transitioned, he was actually coming home from school, really, really angry. And he's, you know, he is a very well-behaved child. He likes to do the right thing. But he was coming home angry. And literally overnight, when we agreed that date (for social transition at school), he changed. He was happier, the anger had gone [P].

Another parent described a conversation with teachers, and the significance of teacher support to their child:

So, we were sat there at the end of the normal parents evening, and there was the teacher and the student teacher there. And I said, oh, [Child] wants me to tell you something. She would like to wear the girl's uniform to school. And he said, straightaway, not a blink, that's absolutely fine. And [Child]'s reaction was to burst out crying, she just burst, burst out crying, leaning into me, that first bit of acceptance from outside of the family [P].

One parent reflected on the stresses of a school initially offering acceptance of a name change without acceptance of affirmed pronoun:

She (teacher) went, 'no problem, … after we've finished, do you want to go and change the label on your school peg, the label on your books and all that sort of stuff'. And he (child) literally grew like a couple of inches in his seat when all this was going on. Then she said, 'is there anything else you want to say?' And he said, 'I want to be a boy. I want you to call me 'him''. And at this she baulked, and she went, … 'Why don't we try that in September?'. And he shrunk down, his grip got hard, you know, when he was holding my hand. And I just looked at him. And I just said, 'No, we change everything now. We cannot - we do not have the right to say you can change your name, but you can't change your pronoun. He knows what he wants, he is absolutely certain. We are changing his pronoun' [P].

Once children were affirmed at school, their happiness and willingness to attend school increased:

They changed all his books to have his new name on and new pronoun … and he came home sort of high as a kite [P].

Another parent described their child being happier after socially transitioning at school, in spite of experiencing increased harassment and bullying.

The social transition bit at school, I guess, in that period, from September to January, was hard in terms of managing it, and then it got easier, because then I wasn't worried about, like, are we doing the right thing. It was clear we were doing the right thing. It was crystal clear that she was happier. And she was happier, even though she was dealing with a lot more, you know, difficult stuff from her peers [P].

These accounts of the importance of school affirmation are in line with research on the importance of trans-positive supportive educational environments for allowing trans children to thrive (Horton, 2020; McBride, 2021).

## *Well-being*

Within this sub-theme, interviewees noted the positive impacts of social transition across diverse areas of trans children's lives. Parents reflected on what difference social transition meant to their child. Happiness was a key word used to describe the difference affirmation made to their children.

> Through that period, [Child] just got happier and happier and happier [P].

> Seeing how happy she was. It was like there was a huge weight off her shoulders [P].

> Definitely, it improved things. She was a lot happier. Definitely improved [P].

> We're seeing a happier child for - since the social transition [P].

A parent, interviewed jointly with their child, asked how affirmation made their child feel.

> Parent: Can you remember when we started calling you he and him? what that felt like?

> Child: It. made. It made me feel joyful. And happy.

Several parents described how much difference affirmation, both at home and at school, made to their child's wellbeing:

> And just the benefits, were so clear, to her, you know - to see who she was. And her behaviour and her attitude, and, you know, little things, like she'd

been really slow to pick up reading. But I don't think there's a coincidence that, literally within a couple of months of her transitioning, she was reading, and by the end of year three, so a year after social transition, she had caught up and began to overtake peers, you know, there's that kind of - how much of her brain power had been given over to existing in a world that didn't see her as who she was. And when she was allowed to be herself, all other aspects of her life kind of began to, to catch up and fall into place, as they should have been [P].

Parents noted significant improvement in their child's well-being across diverse domains.

She was happy, content. She started to go into loads of different social clubs, she joined Brownies, she went to youth group, she joined a netball club, she went to drama club, and she had a network of close friends that - she was just a really happy, settled child [P].

Several parents were surprised that children's educational performance improved after social transition.

Academically he went through the roof. Which was the most astonishing thing [P].

They (the school) did notice this massive change in her …. you know, she had no interest in school whatsoever, she wasn't doing very well, but now she's just a sponge. Now she's not worrying about gender stuff as much. And she's able to concentrate and give her opinions freely in class…she's actually doing really well in all of the areas at school… It's like, it's freed her. [P].

These findings highlight the different ways in which social transition can protect trans children's well-being, with interviewees noting improvements in educational achievement, social connections, and childhood happiness, aligning and reinforcing existing literature (Durwood et al., 2017; Olson et al., 2016).

## 5.2.3 Discussion

Parental accounts pre-transition reveal common examples of children correcting assumptions, asserting their identity at home and amongst their peers. When trans children were not understood or promptly affirmed, parents noted growing distress, with misgendering and mis-categorisation affecting trans children's happiness. The stresses of being mis-categorised and misunderstood put a strain on trans children, that can be recognised as a form of gender minority stress. Some children tried to adhere to cisnormative expectations, only disclosing their identity at a point of distress or despair. For some young children, their despair was acute, and some carry longer-term impacts linked to the fear and pain of rejection or not being understood. Many parents reported noticing increasing levels of sadness and frustration as their child waited for family, school and peers to accept and affirm them. These accounts highlight a range of levels of distress and despair, with a common thread of children being unable to thrive or enjoy their childhoods whilst unsupported, whilst dealing with instances of non-affirmation and rejection. These examples can be understood as evidence of toleration of harm within a theory of cis-supremacy.

The accounts also highlight a striking theme of improvements in well-being post-social transition, with children referencing the happiness or 'euphoria' of being

affirmed and living authentically. Parents describe a weight off their child's shoulders, with affirmation reducing stress, anger and frustration, and with children able to succeed in other aspects of their lives once their gender identity was affirmed. Parental accounts emphasised the importance of in-school affirmation, with noticeable improvements in child willingness to go to school, enjoyment of school, and enthusiasm for social and extra-curricular activities. Parents, interviewed at an average of four years since their child's social transition, noted that affirmation at home and at school was associated with both an immediate and a sustained improvement in happiness. Parents also reported improvements in educational attainment, that they perceived as direct outcomes of affirmation. Several described trans children as unable to thrive before social transition, with affirmation "setting them free".

Accounts of distress and unhappiness prior to affirmation align with what is known about the negative mental health consequences of family rejection. A body of predominantly quantitative research has shown the negative effects of childhood rejection, with evidence that non-affirmation leads to insecure attachment (Wallace & Russell, 2013), shame (Turban, 2017), psychological harm (Priest, 2019), lack of belonging, PTSD and low self-worth (Ehrensaft et al., 2018). Trans children and adolescents are known to be at risk of poor mental health, with a wide variety of studies noting high levels of depression, anxiety or suicidal ideation (Srivastava et al., 2021; Strauss et al., 2020; Veale, Watson, et al., 2017). A growing body of research has also shown that poor mental health is not intrinsic to being trans, with evidence showing the role of discrimination and gender minority stress in driving mental health differentials (Hendricks & Testa, 2012; Tan et al., 2021; Veale, Peter, et al., 2017). Evidence demonstrates a wide range of external factors that correlate

with good mental health including family support (Katz-Wise et al., 2018; Klein & Golub, 2016; Pullen Sansfaçon et al., 2020; Simons et al., 2013; Travers et al., 2012), social affirmation (Durwood et al., 2017; Olson et al., 2016; Whyatt-Sames, 2017), and safe and welcoming trans-inclusive primary and secondary education (Horton, 2020; McGuire et al., 2010).

This study also aligns with the reflections of clinicians with decades of experience working with trans children and their families. Clinician Dr Diane Ehrensaft notes that supportive families "are discovering an increase in happiness and well-being in their child once that child is allowed to live in their authentic gender" (Ehrensaft et al., 2018, p. 5). She notes that "through a social transition, children often express great relief that people understand who they are, while parents describe a deep joy and comfort previously unseen in their young child" (Ehrensaft et al., 2018, p. 7).

Parental interviewees acknowledged that they started out with low understanding of the harms and stresses of rejection or denied social transition, as well as having limited understanding of the potential benefits of affirmation. A number expressed surprise at the positive impacts they observed accompanying social transition. It is also important to note that a majority of both parents and children were initially (before social transition) navigating through a world without visible trans 'possibility models' (Pearce, 2021a). With no visible reference point of socially transitioned trans children, a majority of both parents and children in this sample stumbled through periods of turmoil and distress, without access to other possibility models of how life could be.

### 5.2.4 Conclusion

This research highlights common experiences of child distress, sadness, frustration and despair in the time before social transition. In contrast, trans children described feelings of "joy" or "euphoria" once they were supported by their parents. Parents, in turn, observed profound and sustained improvements in mental health, well-being, educational attainment and happiness once their children had socially transitioned. These qualitative insights complement existing quantitative data on the protective mental health benefits of family and school affirmation (Olson et al., 2016; Simons et al., 2013). The research highlights the importance of positive 'possibility models'. Trans children, parents and carers, and those around them, need to be aware of positive possibilities; that trans children do not need to endure rejection, distress and despair; that pre-adolescent social transition and affirmation presents opportunities for trans children to enjoy a positive and happy childhood.

The research has relevance for families with pre-adolescent trans children, who can draw from this research encouragement to listen to and support their trans children. Professionals working with trans children and families need to understand the importance of pre-pubertal social transition for many trans children, taking an evidence-led approach that recognises the harms of childhood rejection, the benefits of family and community affirmation.. The research also has significant relevance for policymakers and legislators, demonstrating the need for evidence-based policy and practice that recognises the importance of social transition in safeguarding trans children's mental health and well-being.

## 5.3 Parent Reflections on Supporting a Trans Child

This section has informed the published article:

Horton, C. (2022). "I never wanted her to feel shame": Parent reflections on supporting a transgender child. *Journal of LGBT Youth*.

### 5.3.1 Research Aim

Section 5.3 examines parental decision making related to social transition. It contributes to the literature, being the first study to explore how parents with experience-based insights navigate and evaluate the risks and benefits of pre-pubertal social transition. This section explored the following topic specific research questions: 1) How do parents who have supported a child's social transition reflect upon their experience? 2) How do such parents evaluate the risks and benefits of pre-pubertal social transition, and what experience-informed advice do they have for other families?

### 5.3.2 Findings

Parents reflected upon their experiences of supporting their child's social transition. Five themes are presented: 1) loss of control, and loss of security 2) feeling support for social transition was their only viable option 3) evaluating affirmation 4) the risks of transition, and the risks of rejection 5) advice for other families to support their child.

**Loss of control, loss of security**

A number of parents described how moves towards affirmation were scary for them, even though they felt it was the right step for their child.

We just knew, in our guts, it was the right thing to do. Even though it was the terrifying, scary thing to do. It was the right thing to do for her [P].

Several parents described how each step of affirmation felt like a step into the unknown, with the parents reluctant and fearful of each step, and only able to see the positive impacts on the other side.

I think it's a step thing. I think whenever there is a significant and clear change, that's always hard. So, the cutting of the hair was very, it's a step. The changing of the name was a step. The transition in school was a step … and looking back … of course, it was the right thing to do. But it was hard at the time [P].

Some parents referenced how following a trans child's lead, affirming them in childhood, can feel like a loss of parental control, and a step into the unknown, with the unknown feeling unsafe and threatening. One parent highlighted, that faced with a child asking for affirmation, parental control is illusionary, and that the real choice may be between a happy trans child, or a sad trans child.

I would say make a child happy, you know, at all costs, listen to your child, … there's nothing you can do to make the kid trans, and there's nothing you can do to make your kid not trans if that's who they are - the only thing you can do is create an unhappy trans kid, or a sad trans kid. That's the only control you have [P].

One parent described how supporting a trans child feels like a step away from the comfort and safety of the known, a step that takes parental courage to take.

That point at which your child comes out to you, at that point, all you can see is the fear of the future, but you haven't yet experienced the happiness of your

child. So, it's this precipice that you know, you have to, you have to have the courage to jump off of with, holding your child's hand, you know, they've been brave enough to tell you, now, you have to be brave enough to take this leap with them. And, and I can promise you that your child will thank you, and your child will be happier if you do that. But it is, it's really, it's a leap of faith in themselves, and a leap of faith in their child. It does take courage [P].

### Feeling support for social transition was the only viable option

A majority of parents emphasised that they had reached a point where they did not see affirmation as a choice, but as their only positive option.

> I feel that we couldn't have not done it. She would have been miserable. So, it's not like I think, oh, this was a great thing. But I'd, we wouldn't have had a happy child had we not done it. So, it feels like we had to [P].

> If your child is insistent, then what other choice do you have really? ... I do think they've experienced that acceptance and that that has benefited them [P].

> It felt like something that was an unstoppable momentum that needed to happen at that time [P].

Parents had come to understand that not supporting a social transition, was forcing their child to pretend to be someone they were not.

> It was just calling what he wanted, he wanted to be called a boy's name… It wasn't going to work for him, to simply pretend and to carry on as he was [P].

Because she was so unhappy. I guess, we could have just delayed it for another year, but we would have had a very, very unhappy child. I don't think we could have avoided it forever [P].

Unless you see the effect it's having on the child, you don't, you know, there's no doubt in my mind that this was needed. That he would, he would be miserable, now, if we had forced him to continue as he was [P].

Others were prompted to support when they realised the extent of their child's distress.

That was the point where I was like, I can't keep making this child go to school in boys' uniforms. It was a struggle every day. And I think that was the turning point for me [P].

I felt quite calm about it once we decided that we needed to do it, because at the end of the day, when your child, when you're being told that your child is having suicide ideation, the idea of them changing their name suddenly becomes much less upsetting. Because you've got something to compare it to, which is actually bad [P].

## Evaluating affirmation

Almost all the parents in this sample talked about their child's improved happiness after social transition, and regarded affirming their child as critical in protecting their child's happiness and well-being.

I think, as parents, we see, we get to look through that window more than most people do. And we see the distress, and we see the unhappiness and

the frustration with 'Why do these people keep calling me the wrong thing? You know, can't they see?' [P].

Well, I think if you're a parent, and you see your child in distress, you know, a little child feeling like they don't want to live, and that you can, that can stop, by you just saying, Okay, wear what you want, we'll call you [Name]. You know, it's literally, you know, how could you live? How could you tell your child that that's wrong? She was so precious, I just wanted her to be happy, and to want to live, you know? [P].

So, for me, it's about making sure that I don't do any damage to my child emotionally. … my main objective is that they are - have good self-esteem, they're happy [P].

Reflecting on the benefits of acceptance for their child, a majority of parents were categorical that affirmation had been a positive thing for their child.

I think it was the best thing to happen to my child…. And for everybody to know that this is who she is - it was definitely the right thing for her to do [P].

It's the best thing for her. And it's the best thing for her mental health…. In terms of like, is this the right thing for [Child]? Yeah. Hundred percent [P].

An improvement in their child's current happiness was a key reassurance that affirmation was the right approach.

So, when you see that enormous change in your child, and you just know that what you're doing is right for them. And you don't care what barriers you face when that's, when that's what you've got, living with, you know, a happy child, that's all we want [P].

Every kind of step we took towards affirming her just felt right [P].

Several parents emphasised the importance of children knowing that they have their parents' unconditional affirmation and acceptance.

If you're tuned in to your child, and you're listening to your child, you really can't go very far wrong. And that kind of mantra we had in our head of, well, you know, even if she changes her mind, we've shown that we'll support and love regardless, and that's never a bad message for a child to grow up with. You know, and even if she changed her mind now, next week, next month, next year. All of our kids have grown up knowing that, you know, they're loved and supported for who they are. And that, that can't ever be wrong [P].

## Risks of transition, risks of rejection

Parents were asked to share reflections on what they saw as the risks of supporting a social transition. Most outright rejected the idea that there was any risk associated with accepting their child.

100% of, no harm has ever come of showing somebody unconditional acceptance…I don't think there are any risks [P].

Instead, most parents emphasised the risks inherent in not supporting trans children.

The risk was that my child was unhappy. The risk was that my child felt unaccepted.

I think for me, why would I make him live his childhood feeling unhappy with who people see him as? Why would I do that? I'm not gonna make him live repressed and unhappy [P].

Several parents noted shame as an important risk they wanted to protect their child from.

> I don't see what benefit can come of telling them that they can't do that. Because it's, it could be shame inducing [P].

Other families shared their views on the negatives that they had seen in families where children's transition was blocked [P].

> I know people who have allowed their children to be girls at home, but boys at school, because, that suits them, but it is like, I accept you, I accept you at home, but I'm embarrassed for you to be yourself in the world. That's not a great message for a child… I never wanted her to feel shame about who she is [P].

Some cis parents described having greater appreciation of the risks of rejecting their child, from talking with trans adults about their childhood experiences.

> You just have to talk to some trans adults, and listen to them … because a lot of trans adults will talk about the trauma of being forced not to be transgender. You know, it didn't change them, it just gave them mental health scars [P].

Several parents expressed guilt about not understanding their child quickly enough.

> And you know, I still feel tremendous guilt that we that we didn't see her for so long [P].

> You know, it's - six is still really, really young. But I still feel tremendous guilt that she was trying to communicate to us all that time, that we, and we didn't get that [P].

### Advice for other families to support their child

Parents recommended other families support and affirm their trans children, prioritising their current happiness.

> I think it's the best thing to do. I truly believe it's the best thing to do for a child. And if they change their mind, doesn't matter, does it? You know, they've been happy for that period. So, yeah, I can't see why anyone would not do it [P].

> I just want him safe and well and happy. And if us accepting this does that, well, then why wouldn't we? [P].

There was consensus from all interviewees that the social transition had been a positive thing for their child, and that they would recommend prompt affirmation to other families with trans children: "I'd do it all the same again, just quick and, quick and sharp, just do it" [P].

> A number of parents referenced negative media and societal discourses surrounding pre-pubertal trans children's social transition. Several interviewees commented on where they felt those critiques failed to understand their situation, with interviewees highlighting the low stakes of any social changes, all of which are reversible.

> They haven't seen that impact of, of a child who's desperately sad and angry all the time - who's not participating in life, who's not - yeah who's not participating in life, that, that's the clearest I can put it really, and allowing her to socially transition and be who she was, set her free - it allowed her to fully participate in life. And, again, nothing's irreversible. It was hair, and clothes and names, all of which could have reversed at any time [P].

Parents who had experienced supporting a trans child, felt strongly that listening to children, respecting them, accepting them, and following their lead, is hugely important.

> I think by the time they come to you and ask that, the chances are they've been through enough shit. And the least you can do is support them. As a parent, that's literally your job [P].

> I mean, I would just say, listen, listen to what your child's saying. Don't brush it under the carpet. Don't make them feel ashamed or don't ostracise them for them telling you who they truly are, and support them [P].

Parents within this sample were unanimous in their perception that social transition had been pivotal and beneficial for their child.

> The only thing that I'd like to say, is that it's an absolute vital and pivotal moment for it to happen for a trans child…It's been one of the best things that happened for us and [Child] - the happiness that it has brought [P].

### 5.3.3 Discussion

Parents reflected upon their experiences of supporting a trans child's social transition. Parents spoke of a lack of control and a loss of security as their life moved in a direction they had not anticipated, and did not feel prepared for. This finding resonates with other qualitative research on the challenges parents of trans children can encounter (Pullen Sansfaçon et al., 2015), as well as echoing literature on parental experiences of 'ambiguous loss',  (Bartholomaeus & Riggs, 2017a). Horsnell (2021) highlights the importance of working with parents to help process the

feeling of loss some associate with a child's transition, recommending counselling to help parents acknowledge and process their emotions to better be able to support their child.

Many parents described support for their child's social transition as the only positive option available to them, with parents reluctantly and fearfully taking that step. This finding aligns with other studies showing social transition is driven by trans children rather than by parents (Olson et al., 2019; Rae et al., 2019). It illustrates how parents, whose lives and worldviews are shaped by cisnormativity (Newbury, 2011; Serano, 2011), can be reluctant or resistant to embracing 'trans possibilities' (Pearce, 2021a). These findings emphasise the support parents may require, to overcome their own cisnormativity, to relinquish 'control', and to become open to showing love, support and genuine acceptance of trans children. The fact that parents required such clear evidence of harm to move them towards support for social transition, can also be understood as examples of three dimensions of a theory of cis-supremacy, the problematisation of trans childhoods, the toleration of harm, and cis control and coercion of trans children.

Parents within this sample also evaluated the benefits of social transition, describing it as protective for their child's happiness and well-being. Parents rejected any suggestion that supporting a pre-pubertal social transition was risky, instead emphasising the risks of continuing to reject their child. Parents reflected upon advice for other families, emphasising how positive it had been for their child. Parents were unanimous in recommending other parents to follow their child's lead, affirming them in the present, perceiving this as safeguarding their child's well-being, happiness and self-esteem. These parental reflections chime with existing child-focused quantitative research on the positive mental health of socially transitioned

trans children (Durwood, McLaughlin, and Olson 2017;  Olson et al. 2016) and existing qualitative insights into parental experiences of social transition (Kuvalanka et al., 2014). These findings also reinforce retrospective research on the negative mental health toll of childhood rejection, drawn from research with trans adults and trans youth (Ehrensaft et al., 2018; Katz-Wise et al., 2018; Priest, 2019; Turban et al., 2020; Wallace & Russell, 2013).

### 5.3.4 Conclusion

The findings presented in this research, in combination with wider evidence on the protective health benefits of childhood affirmation, hold relevance for institutional policy and practice towards pre-pubertal social transition, with implications for health services, schools and social services. Obstacles to parental support for trans children, grounded in individual, societal and institutional cisnormativity, also reinforce the importance of parents finding support to help them to effectively affirm and advocate for a trans child (Riggs & Bartholomaeus, 2018a). These areas where parents may need support in order to effectively protect the well-being of trans children have implications for professionals interacting with parents of trans children, including social workers, counsellors, children's Gender Service clinicians, and primary healthcare providers including General Practitioners.

## 5.4 Delaying Social Transition

This section informs the published article:

Horton, C. (2022). ["I was losing that sense of her being happy" - Trans children and delaying social transition.](#) *LGBT+ Family Studies*.

### 5.4.1 Research Aim

Section 5.4 examines parental perspectives on the competing paradigms of delayed transition or childhood affirmation. It provides a critical addition to the literature, drawing from parents with experience-based insights to examine parental perspectives on the timing of pre-pubertal social transition. This section explored the following topic specific research questions: 1) What insights can parents of socially transitioned trans children share on their experiences of affirmation or delayed transition? 2) How do such parents reflect on their approach towards the timing of social transition?

### 5.4.2 Findings

Findings are structured into two major themes and a number of sub-themes, each illustrated with parental quotations. The first theme explores ways in which cisnormativity drives delays, with sub-themes on dismissal, misinformation, relinquishing certainty, restricted affirmation, and putting up hurdles and stalling. The second theme explores the ways in which delay leads to distress, with sub-themes on delays harming trans children, reflections on further delay and reflections on delayed transition.

## Cisnormativity Driving Delays

The first theme explores different ways in which parents reported and reflected upon delaying the affirmation and support of their child. Cutting across the sub-themes presented below is the concept of cisnormativity. Accounts reveal how ignorance, pathologising misinformation and misassumptions about trans children were embedded in cisnormative attitudes, assumptions and cultures, with cisnormativity motivating, legitimising and encouraging delay.

### *Dismissal*

Dismissal was referenced across a majority of parental accounts, with parents describing initially dismissing their child's identity. Many cis parents had no prior awareness of trans children, and disregarded their child's assertions as something they assumed would stop with time. Only after noting their child's persistence and insistence around gender identity, did some parents start to consider that their child might be trans.

> (At a) certain point, we realised that it wasn't going to (change), that he
> actually meant it. And we actually started listening, which took, sadly, took
> longer than it should have [P].

Other parents were distracted by the day-to-day challenges of parenting, and didn't have the energy or time to properly consider their child's identity. A parent whose child asserted herself at pre-school age, recalled disregarding their child's assertions.

So, this had been going on for quite a long time. And I was busy, and had my hands full with two small children. And I just didn't really think anything of it [P].

## Misinformation

For a number of parents, early encounters with inaccurate pathologising information provided discouragement from supporting their child. Many parents received discouragement from friends or family, or received misinformation on 'desistance'.

Because of the lack of information early on, I stumbled across the desistance, 80% figure that gets bandied about. And I must admit, I held on to that for a while thinking, oh, well, this is just going to be a phase. Because there wasn't a wealth of information out there to say otherwise [P].

Other families were discouraged after taking advice from healthcare professionals, being told information that, with hindsight, they realised to be unhelpful or incorrect.

Our very first CAMHS (Child and Adolescent Mental Health Service) assessment…they spent an hour talking to her, and just dismissed this as – 'we see this a lot with boys who have an older sister', 'she's worshipping her older sister', or he, because they were using male pronouns, you know, 'your child is worshipping their older sister'. 'And that's what all of this is, this is a manifestation of that wanting to be closer to big sister'. And it didn't feel right. But because I had no knowledge or experience, I took what the experts were saying as oh, okay, well, even though it didn't feel right, I tended to be - lean towards the, well, you're more knowledgeable than me. So, I guess there

might be something in that we should wait a while. But she did become more

unhappy [P].

Many parents were pressured not to support their child's identity, often receiving discouragement or coercion from multiple sources.

We, you know, there were various people kind of trying to talk us into that

(delaying support) - Tavistock (Children's Gender Identity Service) being one

of them. My mum was one of them. In that she was really deeply concerned

about how we would be judged. About how - how difficult things would be, if

we, if we made this decision to allow her to socially transition [P].

Another parent initially felt they should not affirm their child, because their child did not conform to a stereotyped trans narrative.

I sort of did my own research and things online. And I was sort of always

waiting for those- that kind of that magic phrase, you know, 'I am a boy', but it

never came, there was always 'I want to be', 'I want to be a boy', 'I want to be

a man', you know, whatever it was. But I suppose it all sort of came to a head

when he told a friend at school, that he was really a boy, that was I think, in

year five (age 9) [P].

Another parent's partner held misinformed views on how negative a trans person's life possibilities would be, with that fear holding them back.

(The father thought) life is just going to be awful. And that visceral fear

paralysed him, definitely [P].

*Relinquishing Certainty*

Many parents reported initially having a desire for certainty, wanting to be confident both in a child's current trans identity, and in the future stability and consistency of that identity. Many parents described seeking reassurance that their child was definitely and permanently trans before they could support their identity. A shift in emphasis from trying to predict their child's future identity, to sitting with them in their present, was needed for many of these parents to support their child.

> So, I think meeting them where they are and trying not to, kind of, you know, predict the future for a little person, and literally sit with them and where they are in that moment, in that time [P].

Several parents grew into confidence that supporting their child in childhood would be positive, regardless of their future identity, again highlighting the low stakes of supporting changes that are entirely reversible.

> If this turns out to not be who she is, the worst-case scenario is that she grows up knowing she's loved and supported for who she is, regardless. Nothing that happens, kind of under the age of 14, 15, 16 is permanent or irreversible [P].

> And we just kind of had this mantra early on that, that the kids would grow up knowing that they were loved and supported for who they were, regardless of what that was. And that, you know, that had to come first [P].

*Restricted Affirmation*

A number of parents followed 'delayed transition' (also called 'watchful waiting') guidance to support any non-stereotyped clothing preferences or gender expression

or interests, without affirming their child's identity. A number of parents highlighted how negative this experience was for their child's happiness.

> What I watched was my child become more and more and more unhappy. Because we were still using male pronouns and we were still using birth name. And, you know, the, the playing with the toys you want, and, you know, dressing in the clothes you want, didn't matter. That wasn't what this was about for her. For her. It was I need you to see me as the girl I know who I am. And we weren't doing that [P].

Parents reported the harms of trans children denied access to trans possibilities:

> From about the age of five - say five or six, you know, (we were) saying 'you can be any kind of boy you want'. We enrolled her in a boys' ballet class, which she loved and, you know, 'boys can do anything', 'boys can like ballet', 'boys can wear what you want' and everything. And but then I would say she very much was saying, 'no, but I - I'm a girl', and there was a lot of sadness [P].

### *Putting up Hurdles and Stalling*

Some parents decided to put up hurdles, telling themselves that if their child was sufficiently determined and persistent, then they would support them.

> [Partner] used to say 'we'll put obstacles in the way and if he can overcome them, then we will follow his lead'. So, it's not just blindly following his lead and saying, you know, whatever you want darling, you know, we'll, we'll support you. We did put up those hurdles. And I literally had hurdles in my

mind that if he - he needs to try to get over the hurdles. And if he can, then, then we will follow his lead. But those hurdles were definitely there…They were things like he did ask to be called [Name], at least 10 times. So, they're 10 different hurdles. And every time he kept on going to the next one, and kept on going to the next one. And he didn't give up. If he had given up and stopped asking, then we wouldn't have done anything, we wouldn't have moved forward…. I needed absolute clarity on what he was asking. … he had to demonstrate that he was absolutely certain - which he did [P].

Another parent described challenging their child on their certainty, requiring their child to repeatedly assert their need for support, to the point of their child being frustrated.

I delayed things to the point where I knew that he meant it. But any further than that? You know, that already, to me felt like I was pushing it a bit. 'Are you sure?', 'are you sure?', 'you should just leave another month'. See if he complains again, you know, that already was making him quite frustrated [P].

Many parents were afraid of being accused of over eagerly supporting or encouraging a trans identity, and responded by making an effort to be passive, making sure their child independently drove every step.

It'd been a long time coming. I think the signs were there quite early, you know, from way before she was seven. But I think we kind of eked it out and, you know, didn't want to push it really, and wanted it to come from her. And it very much came from her. She really pushed it on, you know [P].

As parents moved towards supporting their child, parents reported common attempts or justifications for stalling or postponing support.

You do kind of say, 'well, let's just wait'. 'Let's just wait a little while' or 'let's wait until after the school holidays before we inform the school'. …so yeah, there probably would have been a little bit of that 'let's just wait until after the holidays'… But the truth is that my child has always been sure - there's never been a moment when she's not sure. So, you know, I've realised that over the years, especially now she's a bit older [P].

A majority of parents acknowledged that their child would have transitioned earlier if they could have.

(She was) four when she actually socially transitioned. But had we allowed her to, she would have done it long before [P].

Several parents reflected on their attempts to postpone support:

And actually, we hit a tipping point where it became clear we were holding her back, rather than waiting for any positive reason [P].

Other parents stalled in affirming their child out of a wish to keep the whole family on the same page:

And I felt a bit like I was stuck in the middle for a while, because wanting to do everything I could to ensure that she was happy and supported at a pace that he (the child's father) was comfortable with. So yeah, I'd say it took me about six months. But interestingly, I never doubted what she was saying from the day she told me, I never doubted what she was saying. It was always the, I've got to manage other people along this. And therefore, because I was trying to manage other people along, it was almost easy to use that as an excuse to wait, if that makes sense [P].

One parent feared the reactions of wider family, and held back their child's social transition out of a desire to protect their child. With some time, the parent realised that denying affirmation was not protecting their child.

> I guess initially, I wasn't sure it would kind of, you know, I wasn't sure it was completely right, it felt like a risky step to take for her, in terms of the danger I was exposing her to. And also, the damage, you know, from - the family relationships have been really difficult. And I, you know, I wanted to protect her from that. But it became clear that that wasn't protecting her at all [P].

Other parents recognised with hindsight that their need for certainty, their anxiety about their child 'changing their mind', was linked to a fear of social judgement, with a fear of social judgement holding them back from promptly affirming their child.

> We had to have conversations like, well, what if she changed her mind next year? you know, and that kind of, you have to get past your own discomfort and your own kind of like, God, wouldn't it be really embarrassing if we did all this? And we made them sit through training and we did all that kind of stuff. And then she turns around in six months or a year and says oh actually, no, it's not - I want to go back to - And you have to kind of get over your own sense of societal judgement. And kind of like, wouldn't that be really embarrassing to have to go and explain to friends and colleagues and everyone that, you know, we'd got it wrong [P].

A number of parents spoke about coming to understand that they needed to put societal judgement to one side, and centre the needs of their child.

> I was too concerned about the outside world and it's actually no - put your child front and centre - if something is going to make them happier, more

confident, more able to just simply be and to be the child that they are - then why would we not try and do that [P].

## Delays Leading to Distress

The second theme explores parental reflections on delayed affirmation, considering experience-informed perspectives on delays harming trans children, on the (in)feasibility of further delay, and parental evaluation of 'delayed transition' as an approach.

### *Delays Harming Trans Children*

A number of parents recognised that their delay in acceptance had caused harm to their child.

> I feel like I'd taken probably about a year to accept it privately…I knew I was hurting him. This, the anger, the tantrums, the refusals to leave the house [P].

Several parents acknowledged delaying their child's social transition as long as they could, up until the harm was clear.

> We did try to keep her, you know, as a boy, for my gosh, couple of years probably. And it got harder and harder. It was daily arguments. If, you know, in the house she was, you know, dressed as a girl. But leaving the house was a nightmare. Because she didn't want to wear boys' stuff, she wasn't comfortable in it - getting her hair cut was a nightmare. Just, yeah, it was just a nightmare. So, there's nothing – I don't think that we could have delayed it any longer than what we did, in all honesty [P].

Even though the majority of parents in this sample affirmed their child at a relatively young age (average age seven), a number of parents expressed regret at delaying for too long.

> So actually, one of my regrets as her parent is that it took us probably six months to a year to affirm her. Because at the age of eight, we were then doing all this research, finding things like the flawed, you know, detransition stats… [P].

Parents acknowledged that their own ignorance, misconceptions and lack of access to positive trans possibilities, delayed their child being affirmed.

> I think my ignorance and lack of education in this area had a lot to do with why our timeline is the timeline it was [P].

### Reflections on Further Delay

Parents were asked to reflect on if they could have delayed further, noting that a majority of children in this sample socially transitioned at a younger age than is advised by proponents of 'delayed transition'. Many parents were adamant that they felt they had already delayed a lot (or too much), and felt that further delays would have been "cruel".

> I wasn't willing to watch him suffer….it definitely wasn't - it wouldn't have been right to - to leave it any longer for him [P].

> To have delayed it would have been cruel in my mind, it would have been cruel [P].

Parents felt any further delay would have had a significant negative impact on their child's mental health and wellbeing.

> As to consequences, I think they would have been pretty dire [P].

> But I think if I had not done what I did in terms of supporting social transition and supporting her pronoun she'd have had a bloody unhappy couple of years… If I'd stuck to what they'd said in terms of 'watchful waiting', I don't know where we'd be really right now. She was so desperately unhappy. I think if I hadn't said, you can be who you want to be. I don't know, I dread to think where we'd be now. We're really close. And just, you know, and she's such, she's such a happy little soul. And I was losing that. You know, I was losing that sense of her being happy (interviewee visibly upset) [P].

Some parents speculated both on the implications further delay would have had on their child's well-being and ability to thrive, as well as the strain prolonged rejection would have put on a whole family unit.

> I would have an extremely unhappy child - Probably, probably quite dysfunctional as well I would have thought, and the pressure it would put on the family would have been massive. I don't think we could have coped with that [P].

## *Reflections on the 'Delayed Transition' Approach*

Across the dataset, a large majority of parents described delaying transition to some extent, ranging from months to several years. The parents in this sample, who had experiences of delaying transition and who all affirmed their child before

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adolescence, felt that the 'delayed transition' approach, with its arbitrary age-based barriers to transition, was a harmful approach.

> I don't believe in that or advocate for that, because who does that benefit? It certainly doesn't the child - and I think it works adversely for the child. I mean, for me, that absolutely makes no sense, because you're in effect not accepting your child for who they are. But also, you are causing huge amounts of mental distress. And you're not - at the end of the day, it's about the well-being of your child, isn't it? And if you're delaying it, you're not actually putting your child first. I know that if I did that, for my child, she would have faltered, and that's not something I would entertain. So, no I don't, I don't believe in that [P].

A number of parents highlighted that age-based barriers to social transition do not take into account the impact of multi-year rejection on a child.

> I think every child is different. You know, he told us at the age of two that he was a boy. Some children just say that much later, some discover it later, you can't put an age on something, it has to be a case by case [P].

Others reflected on the reality that delaying support denies a child a chance to enjoy their childhood.

> If they start asking you age four, and you wait till age eight, that's four years of not being accepted by your parents [P].

A few parents who had initially listened to advice from others to delay their child's transition, strongly recommend against this approach.

Well, in some ways, we did delay, because she told us at eight and she partially socially transitioned at 10. And she didn't fully socially transition until 11. So - but what happened was, I watched my child's happiness and mental health fall off a cliff. So, I wouldn't recommend that at all. Because - but I wouldn't recommend that, because I saw the impact that that had on my own young person [P].

Other parents noted how advice to delay transition, including from NHS Children's Gender services (the Tavistock), had reduced supportiveness of extended family, with an ongoing strain on relationships:

And then we had a phone call with a Tavistock clinician. And I said, 'what am I supposed to do?' You know, at that point, I had a child who was very dysphoric... And I was like, I just, I just need to know what am I supposed to do? … And they were clearly advocating 'watchful waiting'. But the watchful waiting thing, I think, is really harmful because it's stopped certainly my parents from fully buying into what she's needed. So, we are now more than two and a half years down the line from changing her pronouns. And from her social transition. My parents are still advocating a watch and wait kind of approach. So, I think that the rhetoric of that is really - in my experience that has been really damaging…. I am watching and waiting. And I'm like, loving my child. I remember my dad saying to me, you know, what if you know, she changes her mind? I'd rather have a happy kid for the next couple of years [P].

A number of parents contrasted their own experience with families they knew who had delayed supporting their child for longer.

There are parents in [local support group] who denied their kids for years, whose kids ended up self-harming and, you know, ended up in hospital after attempts at suicide. And so, you know, we're a really good, happy story [P].

Several parents had seen the positive impacts on their child's life that came from social transition, and highlighted the costs and risks of delaying social transition:

None of that would have happened. None of that would have happened if we'd waited. And waiting is only ever a positive thing if stuff isn't happening while you're waiting. If time is marching on and life is continuing in the background while you are doing this 'watchful waiting'. It's not a neutral option to just press pause, because the rest of the world doesn't pause. And, and actually I think it was reversed. I think she had been living her life on pause. And allowing her to socially transition was like pressing play, and allowing her to fully participate in life as who she was [P].

Other parents noted the parallels between delayed affirmation, rejection and conversion therapy.

It is a kind of coercive control method of conversion therapy – like you really are going to have to persist in this, and I'd rather you didn't. This really is the message you are giving your children, like no permission to be who they are. And I just see that as long-term damaging to mental health for your child. So as a concept I absolutely hate it, and would never recommend it [P].

### 5.4.3 Discussion

Interviewed families shared insights into the many delays, barriers and hurdles that trans children face, even within families that are considered 'affirming'. These data show a strong influence of cisnormativity on delays to affirmation of trans children. Parents operating in a cisnormative world without trans possibilities were initially likely to dismiss their children's assertions. Misinformation, including from healthcare professionals, discouraged supportiveness. This misinformation was built on cisnormative and pathologised assumptions of trans children's identities as less stable, authentic or worthy of respect than cis children's, alongside a greater fixation on predicting a child's future than on enabling current happiness and self-esteem. Several parents attempted acceptance or encouragement of expansive gender expression or gender roles, without affirming their trans child's identity. Societal pathologisation and ignorance about trans children led parents to fear being accused of having influenced their child into a trans identity. This fear, alongside a parental desire to be confident that a child had persisted without any active encouragement, led to many parents putting barriers in trans children's way. Many trans children needed to overcome hurdles of persistence and insistence, as well as implicit discouragement of being trans, to earn parental affirmation. Cisnormative expectations and fear of cisnormative social judgement led to parents stalling affirmation, finding reasons and justifications for postponing social transition. These cisnormative barriers to affirmation reported by parents align with a limited body of research from the perspective of professionals interacting with families of trans children. Brody (Forthcoming) provides a nursery worker's account of parental dismissal of a young gender-diverse child. Riggs and Bartholomaeus (2018b) provide clinician insight into parental stalling, gaslighting and delays to affirmation.

The accounts highlighted in this research, and the limited wider research, emphasise the ubiquity of delays to trans children gaining family affirmation.

The second major theme explored parental perceptions on the link between delays and distress. The parents within this sample had supported social transition of their children at an average age of seven years old. A majority of parents understood that delays had caused their child harm, with several expressing regret that they had contributed to their child's distress. Nearly every parent described delays as a part of their story. Many parents in this sample described having delayed as much as they could, to a point where further rejection and delay would have been "cruel". A few parents described delaying affirmation of their child for several years, and watching their child's distress grow. Those who had followed health professional guidance to delay transition, also termed 'watchful waiting', had observed negative impacts on their child's mental health and well-being. Without exception, the parents in this sample (30 parents with direct experience of raising a trans child), advised against the 'delayed transition' approach. Many whose children asserted themselves in pre-school or infants' school, described any attempt to deny affirmation until puberty as harmful, shame-inducing and as taking away a child's right to a happy childhood. This second theme on delays leading to distress, aligns with existing quantitative literature on gender minority stress (Tan et al., 2021; Veale, Peter, et al., 2017), and on the links between childhood parental rejection and insecure attachment (Wallace & Russell, 2013), shame (Turban, 2017), psychological harm (Priest, 2019), lack of belonging, PTSD and low self-worth (Ehrensaft et al., 2018).

Across the dataset, parents shared many examples of action, or inaction, to delay affirmation. In many families trans children had to meet a high standard of distress, of insistence, persistence and trans-ness to gain parental support. This can

be seen as an example of 'toleration of harm' under the dimensions of a theory of cis-supremacy. The children in this dataset are amongst the youngest trans children to socially transition and be affirmed in their identity, and yet even these families' stories are characterised by extensive implicit or explicit strategies to dismiss or delay transition. These data highlight the cisnormative forces that discourage and delay affirmation of trans children, and the negative consequences for those children. A majority of the delays referenced by the parents in this sample would not have been easily visible to those outside of their home, with many efforts to delay social transition focused on private conversations between parent and child.

This section adds to our understanding in two important ways. Firstly, current literature (Ashley, 2019c; Ehrensaft, 2021; Temple Newhook, Winters, et al., 2018) on the competing paradigms of 'delayed transition' and 'affirmation' provides few experience-based insights into how parents attempt to delay transition, or on how parents reflect upon the impacts and consequences of those delays. This study provides an important addition to the literature by illuminating parental experience and perspectives on delaying transition. Secondly, existing literature suggests a clear distinction between 'affirmation' or 'delayed transition'. This study challenges a simplistic division between affirmative or delaying approaches, providing important nuance into the ubiquity of delay, even within families who based on support for pre-pubertal social transition could be considered to have followed an affirmative approach. These findings have significant relevance for families with trans children, as well as for professionals supporting trans children and families.

### 5.4.4 Conclusion

This research highlights widespread delays to affirmation of trans children, with such delays found in nearly all parental accounts from a sample of families who could be considered 'affirmative', given their support for a pre-pubertal social transition. Across the dataset, extensive cisnormative barriers to support were apparent. Even though these families had supported and affirmed a trans child in childhood, at an average age of seven years old, parental narratives highlight deeply embedded resistance to trans possibilities. The study shines a light on the challenges, frustration and trauma of trans children who have experienced rejection and delay, even within families who appear to be, or who have come to be affirming, with entrenched cisnormativity impeding affirmation.

Families within this sample were unified in their positivity about supporting and affirming their child, with the only regrets spoken about being regrets at having been too slow in supporting their child. Families in this sample had experience-based insights into the negative repercussions on their child's well-being of delay, dismissal and rejection, with every interviewee emphatic on the harms intrinsic to 'delayed transition'. These findings highlight the need for professionals to provide better evidence-informed advice and guidance for parents and carers of trans children. Guidance can help parents be aware of, and supported to overcome cisnormative barriers to affirmation. Guidance can also help parents who are well-intentioned but ill-informed to recognise the harms of childhood delay, dismissal and rejection.

# 6 Education

## 6.1 Research on Experiences in Education

In the UK, trans children continue to experience a large number of areas of inequality, including within education (Children's Right Alliance for England, 2016). Within this thesis trans inclusion in education is explored through three main strands. Section 6.2 examines pupils' experiences of cisnormativity and trauma at school. Section 6.3 examines pupil experiences at school through the lens of gender minority stress (GMS). Section 6.4 brings in consideration of cis-supremacy within a Trans Inclusion Staged Model (TISM), seeking to conceptually make sense of the pathologisation, toleration of gender minority stress and overarching cis-supremacy that characterises so many trans pupil's experience in UK schools, even in schools that, on some level, purport to trans inclusion. Within each section the research addresses topic specific research questions (outlined in table 2).

**Table 2: Topic Specific Research Questions: Education**

| Section | Research Questions |
|---|---|
| 6.2 Trans Pupils' Experiences at School | 1) What challenges do trans children experience in primary and early secondary education?<br>2) How does institutional cisnormativity impact on trans pupils in the UK? |
| 6.3 Gender Minority Stress in Education | 1) Do trans children experience Gender Minority Stress at school?<br>2) How does GMS manifest within primary and early secondary education in the UK? |
| 6.4 Developing a Staged Model for Trans Inclusion | 1) What different approaches can schools take to trans inclusion?<br>2) How does cis-supremacy influence approaches to trans inclusion in education? |

This chapter adds to the literature, learning about the experiences of pre-teen trans children in UK schools, examining trans children's experiences in primary schools (aged 4-11 years old), as well as considering experiences during the first two years of secondary school (aged 11-13 years old). This cohort holds important experiential insights, drawing from experience navigating primary and secondary schools unaccustomed to including trans pupils. Almost all of the children in this sample were the first known trans child in their primary school, a generation coming up against institutionalised cisnormativity in schools unaccustomed to welcoming or even recognising trans pupils.

## 6.2 Trans Pupils' Experiences at School

This section has informed the published article:

Horton, C. (2022)*.* Institutional cisnormativity and educational injustice: Trans children's experiences in primary and early secondary education in the UK. *British Journal of Educational Psychology.*

### 6.2.1 Research Aim

Section 6.2 examines trans children's experiences in primary and early secondary education from an institutional and systemic perspective, through a lens of cisnormativity. Data on trans children's experiences in education were inductively analysed to examine how cisnormativity impacts on trans pupils in the UK. I aimed here to extend understanding of institutional cisnormativity in education, with a focus on the experiences of pre-teen trans children in the UK. This section addresses two topic specific research questions:

1) What challenges do trans children experience in primary and early secondary education? 2) How does institutional cisnormativity impact on trans pupils in the UK?

### 6.2.2 Findings

This section explores the role of institutional cisnormativity in shaping trans children's experiences at school. The research findings are structured into three major themes with consideration of i) institutional cisnormativity in UK schools ii) a failure to protect trans children and iii) experiences of educational injustice. Each theme is explored, centring the voices of the trans children and families interviewed.

## Institutional cisnormativity in UK schools

This theme examines parent and child insights into how institutional cisnormativity is experienced in UK schools. The first sub-theme examines the impacts of cisnormative policy, where policies fail to consider the existence, needs or rights of trans pupils. The second sub-theme considers the impacts of cisnormative curricula, in schools that fail to acknowledge trans lives or represent trans experiences.

### *Cisnormative policy enabling transphobic action*

The first sub-theme examines accounts of cisnormative policy and its impacts on trans children. Trans pupils and families reported a number of experiences of discrimination and segregation of primary aged trans children that they traced to cisnormative policy frameworks that omitted consideration of trans children. Several trans pupils were denied access to appropriate facilities such as toilets or changing rooms throughout their time at primary school. Discriminatory treatment had direct impacts on trans pupils' well-being, sense of school belonging, and in some instances their physical health. One trans boy reported:

> The doctor said I had developed a kink in my bladder because I couldn't bring myself to go to any of the toilets in primary [C].

Another parent described their child "holding in her wee" [P] at primary school. The parent emphasised "she was doing it because she didn't want to use the boys' toilets" in a school that had said she could not use the girls' toilets. One pupil was segregated to a room by himself on a year six (age 10) residential. The parent remarked that this treatment at primary school "singled him out. At secondary school he hasn't been on any residentials, even though I've wanted him to – I think that

might be why" [P]. One trans girl was denied access to appropriate changing facilities at secondary school, required to change on her own in a remote location away from other children. The parent referenced their child "not really understanding why she can't get changed with the girls in the girls' space" with the child describing the segregated space off on their own as "creepy" [P].

In these cases, families pointed to the absence of effective trans inclusion policies, the lack of understanding of existing legal protections, and a lack of explicit consideration of trans children's rights in educational policy at school, county and national level. An absence of trans-inclusive policy left trans pupils vulnerable to decisions informed by individual prejudice. One primary school head teacher denied an eight-year-old trans girl access to girls' toilets, reportedly stating, "'I'm worried what she would do in the girls' toilets" [P]. The parent perceived this statement as clear indication of ingrained prejudice towards their trans child by school leadership, an example of how individual prejudice mixed with an absence of inclusive policy enabled transphobic practice. Across the dataset, examples revealed a number of situations where transphobic practice was not explicitly mandated in policy. Instead, cisnormative policy that failed to consider the needs or rights of trans pupils was open to being interpreted to enable transphobic action.


## *Cisnormative curricula*

Cisnormativity was observed to cut across a number of areas of the curriculum, in particularly education on human bodies, education on puberty, and gender divided sports. Parents referenced their knowledge of cisnormative educational materials, for example simplistic depictions of 'boy's bodies' or 'girls' bodies' in lessons that

reinforced messages of trans pupils being illegitimate, inauthentic or not belonging. Several parents described how such lessons at primary school could prompt, legitimise or intensify invasive and inappropriate questioning of trans pupils, with one parent noting the consequences for their child:

(Then) he had to walk a lot further through the school to get to a private toilet, just so that he could pee in peace, without (anyone) asking him about his genitals [P].

In this case, the parent traced a direct causal link between an upsurge in harassment of their child, and cisnormative primary school lessons on human bodies. Other areas of primary school curriculum exclude and harm trans pupils, with a parent describing their child as finding mainstream puberty education "triggering" [P]. Schools commonly allowed trans pupils to drop out of specific trans-exclusionary lessons, whilst continuing to teach their peers from a cisnormative curriculum that marginalises and stigmatises trans people. One parent commented on her ten-year-old being allowed to miss primary school on the days of lessons on puberty or reproductive health so that they "didn't get affected negatively by cisnormativity and the hetero-centric way it was being taught". She emphasised "that's not inclusion, is it?" [P].

In the absence of proactive trans-inclusive curricula, education and visibility about trans people fell on the shoulders of young trans pupils. Some pupils initially took on this role with enthusiasm, for example through educating their own peer group. However, enthusiasm waned when they met the same questions year after year. A parent highlighted the burden this placed on their child at primary school:

When people asked questions … she'd quite happily answer them. But the novelty very rapidly wore off … By the end of year four (age 9) … it started to bother her more … people would just bug her with questions about it all the time [P].

School inaction left young children to self-educate their peers and other year groups, a task that trans pupils found stressful. For the youngest trans pupils, answering questions from older children who were five or more years older than them was intimidating and overwhelming. A parent reported the burden placed on their child in a primary school without a proactive approach to trans-positive education:

She's having to carry and shoulder the burden of educating her peers about her transgender identity. I mean, she does a lot of that. I think we've seen at times the wear that's put on her, talking to people, answering questions. It's kind of an additional onerous requirement to put on her when she's young [P].

Another parent emphasised the immense pressure on their child at primary school, "every single day, going to school, explaining himself" [P].  A child recounted the ongoing strain they were under at primary school: "It was exhausting. I had a panic attack at school once" [C]. An 11-year-old reported getting questioned "a lot" when they were younger, finding it "very tiring" and wishing primary school teachers could have done more, "maybe like, them explaining, instead of me" [C]. These pupils reflected on the negative impacts of being left to educate other children and even adults at primary school. A number of schools asked their young trans pupils to be the ones to formally present to and educate their primary or secondary school on the existence of trans people. Many of the trans pupils did not want to do this, with a

parent recalling their child being asked to educate their peers at the start of secondary school:

> (Child said to them) I don't want to do that. That's my worst nightmare. And I think the school just thought that would be so much easier [P].

Many pupils in this sample wanted proactive education and awareness raising about trans people at primary school, and felt it was unfair that they were shouldering this burden as young children. Throughout their time at primary school, the vast majority of trans pupils in this cohort saw zero trans representation, and almost all were the only openly trans pupil in their school.

## Failure to protect trans children

This theme examines parent and child insights into school failure to protect trans children. The first sub-theme considers the ways in which schools may tolerate abuse of trans pupils, with examples of bullying, violence, mis-gendering and transphobic abuse. The second sub-theme examines experiences of pupil isolation.

### *Toleration of Abuse*

School safety is foundational requirement for equality of opportunity in education, yet for many trans pupils school remains an unsafe institution. Within this sub-theme interviewees reflected on feeling unsafe in primary and secondary schools where persistent abuse was tolerated. Asked if they felt safe at school, a trans pupil responded "No" [C]. Their parent, interviewed separately, emphasised the same point: "They just don't feel safe, they never feel safe" [P]. Trans pupils experienced

threats and harassment, both at primary and in early secondary school. A parent highlighted their child's experiences in the first year of secondary school:

> She's been maliciously outed by a child repeatedly and we've had a real issue with bullying and with threats [P].

Another parent described their child's experiences of harassment at primary school:

> She had a boy asking her when she was going to cut her [genitals] off. He kept saying to her things like that [P].

Many primary schools had told the parents in this sample that they were responding to their first out trans pupil. Parents felt such schools had access to limited training or guidance. A frustrated parent whose child had been negatively impacted whilst a primary school took time to learn about trans-inclusion said: "I don't have the time for people to learn. I need them to be able to keep my child safe straight away" [P]. The transition to secondary school was difficult for many trans pupils, and in several cases transphobic violence became more pronounced as trans pupils entered into their first years at secondary school:

> He was physically assaulted … he was pinned down; they punched his head (called him) [slur] [slur] [P].

Schools varied significantly in how seriously they dealt with individual incidents, and in several cases secondary schools only took transphobic harassment seriously once a parent escalated their concern outside of the school leadership:

> Twice, I've had to report hate crime to the police, almost as a lever to get the school to do a bit more [P].

It was only then when the police went into school that they were like, okay,

maybe we need to do something [P].

Several parents felt that schools had a lower expectation of school safety for trans pupils than for cis pupils, and were slow to respond to transphobic victimisation. Parents were concerned that cis teachers and school leaders did not understand the particular dynamics or harms of transphobic harassment. One parent whose child faced a combination of racism and transphobia noted different school responses. Their secondary school had zero tolerance for racist abuse, taking swift action, but for "the transphobic stuff they just excused it – they just didn't know how to deal with it" [P]. Several trans pupils felt their school underestimated the seriousness of transphobic abuse. One pupil, who experienced transphobic bullying at primary and in early secondary school wanted "more sanctions for transphobia – at least (recognise) that it is a real thing" [C]. Some schools were proactive in tackling overt explicit transphobia, particularly abuse involving specific transphobic slurs, but were less willing to act on transphobia that was not overt. Some schools failed to tackle ingrained cisnormative or transphobic attitudes, with this manifesting as a continuous undercurrent of lower-level abuse from a wide range of pupils. A parent highlighted negative experiences at the start of secondary school:

There was bullying from day one, and I don't think school necessarily see –

it's micro behaviours and micro aggressions that he experiences [P].

Pupils recalled how misgendering was experienced as a persistent painful microaggression, with a child recalling their experience at primary school:

I remember crying a lot at school because of dead naming and the wrong

pronouns [C].

Several pupils experienced persistent misgendering from adults, including from teachers. An 11-year-old outlined emotions of "anger, sadness" [C] at teachers taking nearly a year to get her name right when she was at primary school. Misgendering from adults was perceived as particularly threatening, seen as delegitimising, and leaving a trans child vulnerable to wider abuse from across the school community. One child with experience of misgendering from adults at primary and secondary school emphasised: "It is so much more scary when an adult misgenders you" [C]. This sub-theme highlights the impacts of cisnormative cultures where transphobic abuse is poorly understood, tolerated, and inadequately addressed.


### *Pupil isolation.*

In some primary schools, transphobia manifested in more passive but equally damaging ways, with pupils "freezing them out" [P]. A psychologist came to monitor one young trans pupil's experience and "they described him, by the end of lunchtime, as emotionally and physically exhausted; he spent the entire hour trying to get someone to play with him" [P]. This type of isolation at primary school was reported by a number of interviewees:

> Because all of the rumours about me … people stayed away from me" [C].

> "He was being isolated at school in the playgrounds; comments made about him in the corridors [P].

A number of parents felt schools did not recognise the ways in which ingrained cisnormativity and transphobia contributed to exclusion, with schools suggesting trans children were responsible for their own isolation. One parent, whose child

experienced persistent isolation at primary school, commented that there is a "sort of victim blaming approach – if a child is literally hanging back and not sitting with the rest of the class on the mat. There's a reason for that" [P]. Parents and children noted their challenges in getting school leadership to recognise the strain experiences of bullying, misgendering, violence and isolation placed on trans children. School unwillingness to safeguard trans children's wellbeing seemed to be linked to an overly narrow definition of transphobic bullying, with schools only confident to act where transphobic harassment was both explicit and individualised. Respondents also noted that schools were unaware of many problems or areas of invalidation. Parents and trans children limited the number of incidents and obstacles they formally raised as concerns, saving their interactions for the most egregious incidents, and allowing a large number of individually less serious incidents or practices to go unreported. Only with hindsight did parents and children reflect on the chronic impact of incidents or trans-exclusionary practices on child well-being and ability to succeed and thrive at school.

## Educational Injustice

This theme examines parent and child insights into educational injustices experienced in UK schools. The first sub-theme explores accounts of school drop-out, with pupils missing out on months or years of education, or leaving mainstream education entirely. The second sub-theme examines experiences of institutional trauma, exploring the harms trans pupils have experienced in UK schools.

### *School drop-out*

Trans children are at a high risk of losing access to education. A number of trans pupils were taken out of school when it became clear their primary school could not meet their needs. One UK Catholic primary school head teacher had asked for parental permission to take a young trans pupil for conversion therapy, to make them conform to gendered expectations. The parent was worried whether the school would apply at-school conversion efforts despite parental objection, and instead pulled their child out of school. For other pupils, harassment, microaggressions, bullying or violence resulted in school drop-out, with pupils missing months or years of schooling. One parent described their child dropping out of early secondary school: "There was about nine months when he was out of school" [P]. Another parent gave an account of their child's unwillingness to continue attending primary school following months of bullying:

> He dropped out of school … he was a school refuser from like the end of year two (age 7) [P].

For several trans children, school failure to ensure emotional and physical safety pushed them out of mainstream education entirely. A parent reported on their child being forced out of mainstream education early in secondary school:

> She wasn't safe as far as we were concerned. So, we just said, she's never going back…She will not be going back to any mainstream school at all, because I cannot trust them [P].

Some schools actively pushed trans pupils out of school. A parent described a teacher advising them to leave a secondary school that was unable to keep a trans pupil safe:

She (a teacher) was like, 'I just think you should take him to a different school'. And I was like, you do realise it is illegal to tell – like that's - you can't do that. She's like, 'well, it's just not going well, is it, and it's not gonna end well for either of us so I just think you should just take him somewhere else [P].

### *Institutional trauma.*

Pupils wanted their teachers to understand the stress they can feel in cisnormative schools. One pupil felt their primary school did not understand the chronic strain they were under: "That it's difficult. It is difficult" [C]. A parent considered how much harder life is for trans pupils than for most of their peers, reflecting on their child's experience of multiple years of strain at primary school:

This year, for example, is the first time that I've ever heard [Child] say, I wish I wasn't trans. Because I think he looks at cis kids and thinks, God their life is so much easier than mine. I think he gets exhausted by cisnormativity really [P].

Children and parents talked about the negative impact chronic gender minority stress had on children's health. A child who had been forced out of mainstream education due to persistent bullying at primary school commented:

My mental health and emotional and physical health are all dropping at – not a slow pace not a fast pace, but a pace that is not exactly acceptable to me [C].

A parent reflected on the strain of a trans pupil who had experienced violence and bullying in early secondary education:

> They constantly were sending her home because she was too sick to be at school because she was vomiting all the time because she was so – just an anxious ball of anxiety and mess [P].

Early secondary education was a time of acute trauma for a number of trans pupils, with a failure in school safeguarding of trans pupils having significant effects: "I think they're fairly deeply scarred by that experience [P]. Parents recounted a significant negative impact upon their child: "It traumatised her entirely going there" [P]. Another parent recounted their child's experiences of acute trauma in early secondary education:

> It was horrific, the school just didn't, they didn't understand his needs or how to support those like at all … then he tried to take his own life [P].

Those with experiences of trauma in primary or early secondary education experienced ongoing impacts, experiencing ongoing anxiety and fear:

> Unless he gets strong vibes to the contrary, he'll often assume that boys his age are homophobic or transphobic [P].

> We got a report through that just said that she'd suffered trauma in (secondary) school, we were referred to CAMHS and she was diagnosed with generalised anxiety disorder [P].

> At that time, [Child] then was so frightened of going (to school) … [Child] was just so scared of most grownups [P].

A parent remembered a conversation they had had with their child on the injustices they had faced in early secondary education:

> On [Child's] (school report) it said 'has an issue with authority'. And [Child] was like, I don't have an issue with authority, authority seems to have an issue with me [P].

This sub-theme highlights accounts of institutionalised trauma experienced by trans pupils in UK primary and early secondary education. For a number of trans children, a lack of emotional or physical safety had profound impacts on their well-being, self-confidence and willingness to attend school. Within this sample, a third of the trans children had left at least one school, had missed a year or more of education, or had dropped out of mainstream education entirely, due to school failure to create a trans-inclusive environment.

## 6.2.3 Discussion

This research demonstrates how the absence of effective trans-inclusive school policy, combined with poor understanding of wider legal protections, can contribute to transphobic practice, enabling discrimination and segregation. Within the literature Payne and Smith (2014a, p. 408) highlight how in the absence of clear policy teachers are left to navigate trans inclusion alone, with potential for responses grounded in "fear" and schools entering into "crisis-mode". Where schools hold very basic trans-inclusion policies, such as just holding an anti-transphobic bullying policy, such limited policies can be interpreted as an upper boundary on school-endorsed inclusion (Ullman, 2018). Frohard-Dourlent (2016b) discusses how a lack of knowledge and a default assumption of transphobic policy can impede equality and

action, even where discriminatory policy does not exist. Cisnormative policies risk excluding, disenfranchising and harming trans pupils, and schools have a duty to ensure that clear commitment to trans inclusion and equality cuts across educational policy in a way that is explicit, and that centres trans pupil wellbeing.

Research findings on cisnormative curricula align with literature on the ubiquity of cisnormativity, and how it can be embedded across the curriculum in ways that may not even be noticed by (cis) teachers or school leaders (Martino & Omercajic, 2021; McBride & Neary, 2021). Payne and Smith (2014a) consider how a lack of teacher training, knowledge or confidence impedes action to address cisnormativity in school curricula. Cisnormativity in schools can be enforced through a combination of invisibility and hypervisibility, where trans lives are not seen, and even limited trans representation can be perceived as excessive (DePalma & Atkinson, 2006; McBride & Neary, 2021). Miller (2016b, p. 3) talks about the ways schools perpetuate "identity erasure", creating cultures of ignorance and delegitimization, where prejudice and stigma can thrive. Ferfolja and Ullman (2021) examine how students are left to educate their peers in schools that discourage conversation on gender diversity. The burden of representation experienced by trans pupils has notable parallels to literature on the demands placed on queer teachers in cis-hetero-centric schools (Martino & Cumming-Potvin, 2016).

Across theme two, accounts highlight the influence of institutional cisnormativity on pupil experiences of abuse and isolation. These findings reinforce existing literature on institutional cisnormativity and its role in maintaining unsafe school environments (Bartholomaeus & Riggs, 2017b; Frohard-Dourlent, 2016a; Martino & Cumming-Potvin, 2018; Martino & Omercajic, 2021; McBride & Neary, 2021). These findings also align with literature critiquing the limitations of a narrow

focus on bullying (Ferfolja & Ullman, 2021; Frohard-Dourlent, 2016b; Ullman, 2018). Where approaches to transphobic bullying are individualised, broader cis-supremacist hierarchies are left unchallenged (Ferfolja & Ullman, 2021). Payne and Smith (2012) review how a narrow focus on bullying avoids a necessary focus on school cultures that legitimise and privilege cis identities.

Across the final theme we can see evidence of trans children being harmed by institutionalised cisnormativity in education, with these harms situated under an umbrella of educational injustice. Research highlights examples where systemic failures left trans pupils in unsafe environments, contributing to school drop-out. The examples presented here highlight a reality that trans children in the UK cannot confidently rely on being able to uphold their right to education. This research resonates with literature on 'institutional betrayal', considering the way in which individuals are harmed when institutions act, or more often fail to act to protect them (Smith & Freyd, 2014). Some research has applied the concept of institutional betrayal to trans children's experiences at school, outlining the harms when institutions fail in their duty of care towards trans pupils, and calling upon school leaders and individual teachers to show 'institutional courage' in creating safe schools for trans children  (Smidt & Freyd, 2018). Here we can go further and propose a link between institutional betrayal and cis-supremacy, when institutions systematically and knowingly fail to protect the trans children under their care.

This present study evidences the trauma and chronic gender minority stress trans pupils can experience in primary and early secondary education. Several trans children in this sample were traumatised by negative experiences at school, with school-based trauma putting trans pupils at risk of short-term harms and longer-term health inequalities. These findings reinforce wider literature on the institutionalised

marginalisation of trans pupils (Frohard-Dourlent, 2018). Ferfolja and Ullman (2021) talk about a lack of school accountability for the negative experiences of trans pupils in education. Frohard-Dourlent (2018) critiques a culture of reluctance to acknowledge the injustices trans children face in school. Miller (2016) references how cisnormativity veils injustice, framing educational inequalities as expected and acceptable, concealing a crisis of inequality and injustice in schools (Miller, 2016).

The examples above demonstrate the significant impacts of cisnormativity in schools. McBride and Neary (2021, p. 1) critique excessive focus on the negative impacts of educational cisnormativity, lest this produce a pathologising victim narrative that negates trans pupils' capacity for self-advocacy and for independently resisting cisnormativity. This research does indeed highlight and recognise the immense capability of many young trans children to resist and self-advocate. On the other hand, this research also demonstrates how isolated many young trans children are (within this cohort almost all were the only out trans child in their school), how many battles there are to fight, and how exhausting it is to combat and cope with institutional cisnormativity year after year at a young age. As educators, parents and child rights advocates, we can recognise and support trans children's agency, whilst also clearly standing by a basic tenet; that life should not be so hard for our trans pupils.

Under each of the themes explored above, trans children and families shared personal experiences of injustice, inequality and trauma. Many of these parents and children had not shared these experiences previously, highlighting their isolation, their fears of attracting negative attention and their concerns for privacy and safety. Many of the families and children interviewed asked for their anonymised words to be shared with teachers, policy makers and leaders in education. The interviewees

were united in wanting educators to learn from the difficulties they had endured, with parents and even young trans children expressing a strong desire for other trans children to be protected from the negative experiences they had endured. Many of the interviewees expressed frustration that genuine trans inclusion was still not commonplace, with low expectations for trans pupils, and a perception that trans equality was seen by school leadership and policy makers as a step too far.

Serano (2016) has described cisnormativity as a societal 'double standard' that advantages cis people. The examples above demonstrate the ways in which cisnormativity in schools creates this double standard, putting trans children in a position that would not be tolerated for the majority of pupils. Cisnormativity is deeply entrenched in societies and institutions, with children assigned from birth into a rigid binary. This system is reinforced throughout the school ecosystem in cisnormative policies, approaches, assumptions and cultures, with particularly negative consequences for trans children. The interview data presented above highlighted school acts of commission and, perhaps more often acts of omission, that demonstrated a lack of care, and a failure to protect trans children from harm, findings that align with literature on institutional betrayal (Smidt & Freyd, 2018; Smith & Freyd, 2014). Cisnormativity wields power in part through its invisibility, with institutional cisnormativity operating without active or conscious effort. To cis teachers, educators or pupils, cisnormativity can remain un-noticed; passive; unconscious; 'how things have always been done'. This ubiquity could make it seem unalterable, neutral and benign. Yet for trans pupils, as illustrated across this research, cisnormative systems, attitudes and practices can be experienced as active, enforced, oppressive and suffocating. Cisnormative attitudes normalise trans injustice, making it acceptable for children to lose access to education and

normalising expectations of inequality or trauma in school. Cisnormative approaches can also individualise inequalities, veiling their structural roots, and obscuring systemic responsibilities. Where schools persistently fail to protect trans pupils, in spite of growing evidence of gender minority stress, trauma and educational inequalities, we may interpret this as evidence of cis-supremacy in action (as discussed further in chapter 8).

### 6.2.4 Conclusion

This section has provided child and parental insights into the challenges faced by trans children within cisnormative primary and secondary schools, shining light on experiences and consequences of institutional cisnormativity. A large number of families reported experiences of discrimination and segregation, in schools where cisnormative policy enabled transphobic practice. Trans children were harmed and de-legitimised by trans-exclusionary curricula, growing up in environments of invisibility and hypervisibility, where a desire for equality and inclusion left peer education on the shoulders of young trans children. More than a third of trans children in this sample had experienced extensive and extended harassment, bullying, and abuse, alongside rejection and isolation, with parents expressing concern that school leadership did not recognise the strain placed on trans children. Systemic failures left trans pupils in unsafe environments, contributing to school drop-out and trauma. For a number of trans children, a lack of emotional or physical safety had profound impacts on their well-being, self-confidence and willingness to attend school. Within this sample, one-third of trans children had left at least one school, had missed a year or more of education or had dropped out of mainstream education entirely, due to school failure to create a trans-inclusive environment. This

section highlights examples of cis-supremacy in our schools, with evidence of the problematisation of trans children and toleration of trans harm.

This element of the thesis offers a significant contribution to the literature in three ways: firstly, through accessing and listening to the voices of a sample of trans children who socially transitioned at or before primary school in the UK; secondly, through examining the ways in which cisnormativity manifests in schools; and finally, by exploring the link between entrenched cisnormativity and experiences of educational injustice. The research aims to fill an important knowledge gap, providing evidence to inform school policy and practice.

## Implications for policy and practice

This research highlights the need for educators, policy makers and school leaders need to take transformative action to protect trans children in our schools. Such action can start with recognition of the educational injustices experienced by trans children; acknowledgement of school and sector-wide responsibility to address institutional cisnormativity; and commitment to genuine equality for trans pupils. Further research can continue to examine what actions are effective in reducing institutional cisnormativity. Concerted effort is required to build trans-emancipatory schools (as is explored in section 6.4), schools that are ready to welcome trans children, ensuring in-school safety, and protecting children from trauma in primary and secondary education.

## 6.3 Gender Minority Stress in Education

In this part of the thesis, I examine the same data on trans children's experiences in education as was analysed in section 6.2 above, here taking a different approach to data analysis and interpretation. Whilst section 6.2 adopts a data-driven approach with inductive coding driving the analysis, and with rich focus on interviewee voice, here the data is examined through a lens of gender minority stress, with deductive coding and theory-driven data analysis. This section has informed the development of the published article:

Horton, C. (2022). Reducing Gender Minority Stress – Support for trans pupils in our schools. *International Journal of Transgender Health*.


### 6.3.1 Research Aim

Section 6.3 adds significantly to current literature, applying the GMS framework to data on trans children's experiences in UK schools. Within this section deductive coding is applied to the dataset on trans children's experiences in education, examining how GMS manifests within primary and early secondary education in the UK. It explores the following topic specific research questions: 1) Do trans children experience Gender Minority Stress at school? 2) How does GMS manifest within primary and early secondary education in the UK?


### 6.3.2 Findings

This section analyses accounts of GMS at school from parents and trans children within this research sample in affirming families where trans children have been supported to socially transition under the age of eleven. This section centres application and exploration of theory, examining the range of ways in which different

components of GMS manifest in education. In contrast to other parts of this thesis where primary data and interviewee voice is at the heart of the presentation of research findings, here the theory and examination of GMS takes centre stage, with quotations from trans children [C] or parents [P] relegated to tables of exemplar quotes under each part of the analysis. The analysis considers each component of the GMS framework exploring external stressors such as discrimination, rejection, victimisation and non-affirmation, internal stressors such as internalised transphobia, negative expectations for the future, non-disclosure and gender dysphoria, alongside consideration of trans pride and connectedness.

## Discrimination

Discrimination was mentioned in three ways, with examples of trans pupils being denied access to appropriate toilets, denied access to changing facilities, or experiencing forced isolation on school trips, with trans children not permitted to share rooms with their friends (see Table 4). When discussing issues of discrimination, many interviewees referenced the importance of parental advocacy in overcoming discrimination. A majority of parents in this sample, and some children, spoke about the important role parents played in challenging school discrimination. Interviewees shared examples of school discrimination being dismantled through parental advocacy, with families describing regular school interaction to safeguard their child's rights. Several interviewees drew a connection between their social status (referencing being white, middle class, or holding professional status) and their confidence and success in tackling school-based discrimination. In contrast, parents who described holding minoritised or marginalised identities, reported more obstacles and less swift success in challenging discrimination. Looking across the

data on discrimination highlights a potential pattern, where trans children who happen to have parents with the knowledge, confidence and opportunity to challenge school discrimination faced less discrimination, or discrimination for a shorter time, than trans children without such family circumstances. Several parents described support from child rights advocates (usually informal advocates from LGBT) organisations or LGBT communities) as critical in overcoming in-school discrimination. One parent highlighted the positive effect of having even one professional advocating on behalf of their child, standing up for their right to avoid discrimination.

Power and authority were an implicit sub-theme within data on discrimination. Interviewees talked about a substantial power imbalance between those enacting school-based discrimination (cis adults in positions of school authority) and those discriminated against (young trans children with little power or knowledge of their rights). Several interviewed children appeared unaware of their right not to be discriminated against, or mentioned that they only became aware that they had experienced discrimination as they became older. A number of child interviewees described feeling unable to challenge adult authority figures, particularly when they were in primary school. Several children who had or were still experiencing discrimination appeared resigned to it, expecting unequal treatment just because they are trans.

**Table 4: Exemplar quotes relating to discrimination**

"I don't think he was allowed into the boys loos, actually". [P]

"The school had her - they made her use the disabled toilet". [P]

"And I told them unequivocally that if [Child] wants to be in a dorm with the boys, then that's his legal right" [P].

"Well mainly it's just (mum who goes) complete Karen on them. If anything bad happens to me like at all. I don't know when the school helps me". [C]

"There was one instance where I had to say to the school. No, hang on a minute. My daughter is a girl. She has socially transitioned. By law, she can use the girls' toilets, because she is a girl". [P]

"I think if she'd been going alone, in a situation where she didn't have parental support …despite the fact she's bright and articulate and persuasive, I think it would be really hard for her to advocate for herself to be able to use, for example, girl's facilities, to be able to manage issues around changing and swimming, to be able to ask for staff to use pronouns. Which, you know, would have harmed her, I think, without us there fighting her corner every step of the way" [P].

## Rejection

Interviewees referenced two types of rejection: rejection from peers, and rejection from teachers and school staff (see Table 5). Examples included children being isolated in the playground or classroom, or being unwelcome in friendship groups. In terms of teacher rejection, parents described their children as being acutely aware of discomfort exhibited by teachers and school staff, experiencing it as rejection from a school authority figure. Two sub-themes were identified: the influence of transphobia and the impact of a lack of trans-positivity. Several parents felt school staff underestimated the link between transphobic attitudes and trans children's isolation. Several parents felt peer rejection was encouraged by other parents. One participant

recalled overhearing parents tell their children not to play with her six-year-old child, with this regarded as directly related to her being trans. Analysis across the dataset highlights a potential correlation between rejection and schools that were not trans-positive. Several children who had attended multiple schools, commented on experiencing less peer and teacher rejection in schools that were more proactively trans-positive. Schools that did little to demonstrate trans positivity were perceived by trans children and families as implicitly encouraging and legitimising rejection.

**Table 5: Exemplar quotes relating to rejection**

| |
|---|
| "If everyone is afraid of you, it makes it a lot harder for them to want to try and approach you" [C] |
| "Nobody really talked to me" [C] |
| "Sort of freezing them out… They had a fairly secure friendship group, which then ostracised them". [P] |
| "If a child is literally hanging back and not sitting with the rest of the class on the mat. There's a reason for that. And it's not because they are distancing themselves from their friends". [P] |
| "It's really hard to make new friends when you feel so fragile and guarded". [P] |

## Victimisation

Experiences of victimisation included bullying, harassment, and verbal and physical abuse (see Table 6). Across the dataset school responses to victimisation varied considerably. Some interviewees reported a handful of incidents of bullying or abuse, with schools responding swiftly and assertively to every incident, providing a clear message that transphobic victimisation would not be tolerated. About one-third of interviewees reported significant problems with violence, bullying and abuse. A

number of trans children and families reported never feeling safe at primary school. Many trans children in this sample had left a school in primary or the first two years of secondary due to persistent victimisation. More than a handful of trans children had lost out on months or in some cases years of education, and several trans children were forced out of mainstream education entirely.

Across references to victimisation two sub-themes were identified, corresponding to child powerlessness and a lack of understanding of transphobic victimisation. Where schools were not proactive in ensuring physical and emotional safety, several parents and children described feeling they (or their child) had no choice but to endure persistent unchallenged victimisation, or drop out of school. Interviews revealed that trans children faced daily pressures, including from otherwise affirming families, to continue to attend schools where they were not physically or emotionally safe. This was particularly the case where parental circumstance excluded options such as moving house or home-education.

A number of trans children and families also felt that schools did not understand transphobic victimisation. Several interviewees described school leadership being ill-prepared to act where a trans child faced chronic group-wide harassment, rather than a single aggressor. Interviewees also felt that school teachers struggled to recognise transphobic abuse where it did not include extremely overt transphobic slurs.

**Table 6: Exemplar quotes relating to victimisation**

"Because all the bullies like and all the things like I didn't get help with… like, and pushed down the stairs, that was, why I didn't feel safe". [C]

"On the 2nd day people from all different schools were chanting my dead name in the line". [C]

"There were three incidents of him being bullied by his teachers at that school". [P]

"It said like [Child] is a (T-slur). Like scratched on the toilet door". [P]

## Non-affirmation

Non-affirmation is a component of GMS, recognising the harm trans individuals experience when their identity is not recognised or actively denied (Delozier et al., 2020). Across the dataset three types of non-affirmation were discussed, including non-affirmation from pupils, non-affirmation from adults including teachers, and systemic delegitimization (see Table 7). On an individual basis, parents and children described trans children encountering non-affirmation from peers, through acts of deadnaming and misgendering (by the use of an inappropriate name or pronoun), and through de-legitimisation with assertions that they were not a "real", i.e., cis, member of their gender. Parents reported that trans pupils at a young age experienced non-affirmation as particularly threatening when it came from older year groups within the school (for example a five-year-old experiencing non-affirmation from 9–10 year-olds). Parental interviewees felt schools were more proactive where child non-affirmation was clearly intended to cause harm, whilst neglecting action where non-affirmation stemmed from confusion, miseducation or ignorance. Analysis across the dataset suggests that peer non-affirmation may be more likely in schools with limited trans representation or trans inclusive education. Several parents were frustrated that schools would punish a child for misgendering, without working to

build a culture of trans legitimacy and inclusion, an approach that parents viewed as undermining peer group cohesion.

Interviewees also discussed incidents of misgendering from adults at school. Trans children commented that experiences of non-affirmation from teachers and school authority figures were more upsetting than incidents of non-affirmation from their peers. Several pupils reported teachers taking months or years to get their pronouns correct. Parents highlighted the chronic stress of being in a classroom where a trans pupil's validity could, at any moment, be publicly undermined by the class authority figure. Interviewed children noted how intimidating it was to challenge an adult when they were very young, also emphasising that teachers could interpret asserting themselves as inappropriate or overly challenging.

Interviewees also shared examples of systemic delegitimization. A majority of pupils and parents described schools as lacking in trans visibility; several interviewees mentioned teachers avoiding the word trans (especially in primary schools); and many interviewees provided examples of lessons with trans-exclusionary content, especially cisnormative curricula on bodies, puberty and reproduction. Experiences of de-legitimisation within lessons added to the challenges trans pupils faced, with pupils and parents sharing examples where trans-exclusionary lessons resulted in increased peer scrutiny, harassment or ostracisation. Experiences of systemic non-affirmation appeared to be pervasive across schools, with many parents perceiving their school to be unaware of, or unconcerned about its impact. Many families connected this systemic non-affirmation to a fall in their child's self-confidence, with a number of parents perceiving their child's trans positivity and self-worth diminishing as they grew older and moved into secondary school.

**Table 7: Exemplar quotes relating to non-affirmation**

"It was certainly deliberate misgendering by some children, older ones particularly". [P]

"I remember crying a lot at school because of dead naming and the wrong pronouns" [C].

"(with school staff member) it was wilful, fair enough, the first misgendering or the first name confusion, fine. But it was the fact that I'd say you mean, he, 'well, yes, so she'll be'. Wilful…I explained to the school, I said, I do not want that woman in a room on her own with my son, because they are going to do harm and not good". [P]

"She's having to carry and shoulder the burden of educating her peers about her transgender identity. … I think it's a lot to carry at such a young age" [P].

## Internalised Transphobia and Negative Expectations for the Future

Interviewees did not particularly share reflections on internalised transphobia, though several interviewees described children disliking being trans, and wishing they were cis (see Table 8). Several parents speculated that these feelings were exacerbated by trans children seeing how much easier life is for cis classmates. Negative expectations for the future were shown in several ways. Parents and children described trans children being distrustful of both peers and adults, with several children describing protecting themselves from harm by assuming all people are transphobic unless overtly shown otherwise. A 13-year-old who had endured persistent persecution at a primary school, reported a fear of being murdered every time they walked down the street (see Table 8). Negative expectations for the future and a lack of hope contributed in some cases to high anxiety about how bad transition to secondary school might be. For one child in the sample, the associated anxiety prevented them even starting secondary school, with them missing the whole of the first school year (age 11–12).

**Table 8: Exemplar quotes relating to internalised transphobia and negative expectations**

| |
|---|
| "This year, for example, is the first time that I've ever heard [Child] say, I wish I wasn't trans" [P]. |
| "I can't wear a skirt… as an AMAB (assigned male at birth) person for 10 minutes without the fear of getting murdered in the streets, which is quite distressing as you can imagine" [C]. |

## Non-disclosure

Issues related to disclosure came up in three ways, with interviewees focusing on decision making about disclosure, on the stresses of handling a lack of control over disclosure, and experiences of being outed (see Table 9). A number of trans children had socially transitioned in early childhood, in cisnormative environments where open transitude (being trans (Ashley, 2018a, p. 4) was met with overt or implicit disapproval. Several parents reported that their children disclosed less frequently as they grew towards adolescence, and were unsure which of their peers remembered or knew their gender modality (that they were trans). Parents felt this uncertainty about who knew and who did not, appeared to pose an additional strain. A number of parents and children described difficult decisions related to disclosure upon transition to a new school, particularly on transition to secondary school when faced with a mixed cohort of pupils, including some who remembered their social transition, and some who did not. At a time of evolving new friendship groups, a number of parents perceived these additional stresses as a barrier to their children establishing easy trust with new peer groups.

In a number of cases parents described how their child's privacy about their trans gender modality was weaponised against them by peers, adding to stress and

worry. In other instances, parents shared examples where their child's right to non-disclosure was undermined by systemic cisnormativity; with inappropriate information on school records, registers, or forms leading to disclosure without permission. In the majority of examples shared by parents, in-school instances of outing occurred unexpectedly, publicly, and without meaningful support afterwards. Parents commented that schools were unaware of the profound impact this had on some trans children, who saw non-disclosure as an important component of their in-school safety and confidence.

**Table 9: Exemplar quotes relating to non-disclosure**

| |
|---|
| "It's kind of been times where people have not known that I'm trans and said, kind of transphobic comments and expected me to laugh, and it's been a bit awkward" [C]. |
| "I don't want to say they couldn't have done any worse, but it was definitely not a positive experience…. in the hall where they do the vaccines, they had like my medical records basically on show... slip ups like that can make so much difference to one kid's experience in school" [C]. |
| "(Coming out) was relatively easy [when younger] - and then it just got harder as I absorbed more social stigma". [C] |
| "She's been maliciously outed by a child repeatedly and we've had a real issue with bullying and threats... But it's really difficult because she doesn't, she doesn't want to have to come out". [P] |

## Gender Dysphoria

Gender dysphoria in the context of schools was mentioned in two main ways, with interviewees highlighting the stresses as children approached or entered into puberty, and the ways in which cisnormative curricula impacted on dysphoria (see

Table 10). A majority of parental interviewees, and several child interviewees, referenced trans children experiencing increasing levels of stress in the years leading up to puberty. A majority of trans children had worries and fears about pubertal development, with one child mentioning this as weighing heavily in her thoughts every day. The stresses of being different to their cis peers intensified as cis peers progressed through puberty. A number of children and families described how dysphoria was affected by experiences at school, for example describing how cisnormative lessons on human bodies, on puberty, or on reproductive health exacerbated and made it harder to cope with dysphoria.

**Table 10: Exemplar quotes relating to gender dysphoria**

"(When using the correct name and pronoun at school) it would give me euphoria and it would feel normal, but if they got it wrong, I would feel as though I wanted to disappear". [C]

"It's all very difficult because puberty has kicked in because it's all really emotionally fraught". [P]

"(For puberty education) they separate them boys and girls…. we had to pull him out… there's no way he was going in the girl's section. But equally, it would be potentially quite triggering for him to be in the boy's section… So there really wasn't a place for him". [P]

## Lack of connectedness

In the GMS framework (Testa et al., 2015), 'connectedness' is an important component of resilience to GMS, with its inverse a lack of connectedness likely to exacerbate stress. The area most spoken about in this dataset in terms of lack of connectedness, was the isolation of trans children within cis majority schools, families and communities (see Table 11). A number of children spoke about being

the sole (out) trans child in their primary school, with several parents also noting that their child was the only (out) trans person that they were aware of in their family or community. One trans child reported finding community amongst cis LGB peers in an LGBT club at secondary school, but commented that, if such a club had existed at primary school, they felt they would have been the only member. Parents highlighted a lack of trans or LGB community for pre-adolescent trans children, both inside and outside of school, with the majority of trans or LGB youth groups only starting at age 13. A number of trans children mentioned the relief and connectedness they found at secondary school, once they encountered openly LGBT peers, providing a sub-community at school. Children valued being able to talk openly about being trans, and having a peer group who could jointly critique or laugh about areas of cis- and heteronormativity within their schools. This dataset included no examples of trans children encountering an openly trans adult at primary school, with parents perceiving it to be a burden for a child to be the sole trans representation for their school peers and teachers. Only one child in this sample knew an openly trans adult at their secondary school, reporting this as immensely positive for them.

**Table 11: Exemplar quotes relating to connectedness**

"I think sometimes, if you're a trans person, and you don't know any other trans people around you, it can feel very lonely and very isolating... I think seeing other trans people and just listening to other trans people probably was a big factor in helping me feel a lot better about like, what I was going through". [C]

"He finds it difficult because he can't talk about any, any of these issues that he has with any of his peers, he doesn't feel comfortable, because none of them understand what he's going through". [P]

"So, there's these amazing people that I know called, there's a group called Mermaids who are really, really nice. And it's full of trans people …. And there are lots of children who, well there are not any trans boys that're my age, but there were these two trans girls who I loved talking to. That's really nice. To get to meet a lot of people that go through the same thing as me". [C]

"It's vital to see that she's not the only person in the world that he feels like she does" [P].

"([Child] didn't want to go to school LGBT club), I think she thinks it is outing herself if she goes there. I think she feels like she - she doesn't really want to go there". [P]

"[Child]'s going to turn 13 in three months, LGBT Youth Scotland will start working with him when he's 13… He'll have a lot more active support, you know, meaningful support. But at the moment, it's just go outside and deal with the viciousness of the world and then come home and we'll make you feel bad about that. You know. It should be better than that, shouldn't it?". [P]

## Lack of trans pride

Trans pride is considered the final component of resilience under the GMS framework; with the inverse, feelings of shame and low self-worth, contributing to GMS. In this dataset several children spoke of the importance of trans pride, drawing pride particularly through their connections to trans communities and other trans

children (see Table 12). Parents also speculated on the ways in which school culture or practice can erode or undermine children's feelings of trans pride. One parent described how their young trans child had been explicitly banned from using the word 'trans' to describe themselves at primary school, as though it was something shameful. Other parents described children losing confidence or pride in their identity as they grew older, with parents drawing a connection between cisnormative schools, and pupils losing trans pride. Several parents felt schools without positive representation risked conveying a negative message to trans pupils, that transitude was tolerated, rather than accepted or celebrated.

**Table 12: Exemplar quotes relating to trans pride**

| |
| --- |
| "He's very, he's very proud of his identity". [P]<br><br>"Being transgender makes me know that I am how I want to be and who I want to be". [C]<br><br>"I think my daughter is very trans positive. They are very confident in their own identity. I think they would like much more in terms of school and friends and awareness of trans people". [P]<br><br>"If you're always reacting (to bullying) on an incident-by-incident basis, I think the risk is that she becomes stigmatised and LGBT identities are stigmatised that, that it becomes something shameful or secretive when we think she should be, you know, positive about her identity". [P]<br><br>"It's easy to tell your child to celebrate who they are - and they're wonderful exactly the way they are when they're six, or seven or eight and they have no concept of the wider world. But at 12 or 13. And, and not just transphobia but she knows about racism…". [P] |

### 6.3.3 Discussion

In terms of discrimination, parents and children highlighted examples of being denied access to toilets, changing rooms or accommodation on school trips. These accounts of young trans children experiencing discrimination in primary and early secondary education add to the literature, contributing to existing evidence of trans adolescents' experiences of discrimination (Kosciw et al., 2018; Kuvalanka et al., 2020; Neary, 2021). The dataset also emphasised inequalities in which pupils were able to challenge discrimination, with younger children being unaware of their rights, and finding it hard to challenge adult authority figures, often relying on parents to challenge discrimination. Analysis revealed that parental ability to challenge discrimination was influenced by axes of parental privilege, influencing how long children had to tolerate discriminatory policy and practice. These findings reinforce existing literature on parents drawing upon their existing social capital to challenge discrimination (Bartholomaeus & Riggs, 2017a; Neary, 2021). These findings suggest that pupils without parental support are likely to be vulnerable to extended discrimination, with negative impacts on their self-confidence and mental health. This reinforces existing literature by McGuire (2010) that emphasises the importance of trans pupils having at least one adult to advocate for their rights. This section suggests a need for systemic methods of protecting trans pupils from discrimination, including a need for clear policy and action to safeguard children's rights. It draws attention to the inadequacy of reliance on parents to challenge discrimination, highlighting the need for wider support, including from professionals concerned with child mental health, to help ensure trans children are not left to endure discrimination.

Interviewees highlighted examples of peer rejection and rejection from teachers or school staff. Several parents drew a connection between school unwillingness to demonstrate trans-positivity, and school cultures that tolerated or facilitated pupil rejection. Parents and children highlighted how cisnormative schools delegitimised trans pupils, creating environments that they saw as enabling the isolation of trans pupils. This feeds into wider literature on the influence school culture has on pupil acceptance and belonging, with perceived acceptance from teachers correlated with pupil wellbeing (Meyer et al., 2016; Ullman, 2017). These findings reinforce the importance of building school cultures of inclusion and trans-positivity.

Regarding victimisation, interviewees shared experiences of bullying and emotional or physical abuse, examples that are common across wider literature on trans pupils in schools, though rarely documented in primary education (Bradlow et al., 2017; Kosciw et al., 2018). Parents and children described a wide range of school attitudes and responses to victimisation, noting that many schools were quick to respond to overt transphobic bullying from a single perpetrator. Several interviewees felt schools misunderstood and were ill-prepared to respond to transphobic victimisation. Where schools did not protect trans pupils, interviews highlighted family and child powerlessness, left to choose between endurance of ongoing victimisation or dropping out of school. These findings align with wider literature on schools failing to understand, and being under-prepared to tackle transphobia (Woolley, 2017). This research reinforces the importance of schools listening to and believing trans pupils' experiences, and being guided by trans pupils' needs in ensuring school is a safe and welcoming environment for all.

Trans children experienced non-affirmation from pupils and teachers, as well as systemic delegitimization, with schools more willing to tackle the former. Teacher non-affirmation is known to have a profound negative impact on trans pupils, whereas even one supportive teacher can be protective (Kearns et al., 2017; Palkki & Caldwell, 2018). Wider literature has shown the impact of action to address systemic delegitimization, with efforts to raise trans representation across the curriculum resulting in higher acceptance from peers (Snapp et al., 2015).

The dataset highlighted examples where parents felt poor experiences in education had contributed to trans pupils expressing a dislike of being trans. This finding is a concern given existing research with trans adolescents that found a significant link between internalised transphobia, gender minority stress, and clinical diagnoses of depression, underlining the importance of building school cultures that celebrate and embrace transitude (Chodzen et al., 2019). This research also highlights challenges relating to pupil confidence, with some pupils holding low expectations for the future. This findings echoes wider literature from older adolescents that has shown a link between negative school climates and trans pupils with low levels of optimism about their chances of future success and happiness (Kosciw et al., 2018).

Issues related to disclosure were a source of stress for many trans pupils in this sample, including stresses of being outed, or worrying about how to navigate disclosure, particularly when moving to secondary school. These findings provide important additions to the literature, strengthening insight into stresses of at-school disclosure for younger trans children. Relating to gender dysphoria, stresses increased as children approached or entered into puberty, influencing their well-being at that stage of education. Whilst puberty related dysphoria is well documented

in trans adolescents, these findings add to the literature specifically in terms of their impacts on well-being in education. Under connectedness and trans pride, trans children found strength and confidence from trans positivity and connection to trans communities and to LGB or trans children, mirroring research that has highlighted the importance of school connectedness or belonging (Hatchel et al., 2019). These dimensions of resilience were impeded for trans children within this sample by their isolation in cis-dominated schools, families and communities. In a number of interviews, there appeared to be a link between school approach and children's pride or shame about being trans. These findings on the importance of connection and trans pride, are found in wider literature on the experiences of trans adolescents, with research emphasising that schools need to do more to reinforce and build self-worth and trans pride (Marx et al., 2017; Miller, 2016a). The specific cohort in this sample is particularly isolated, with few out trans peers at primary school, and without access to trans youth groups that often only cater to adolescents. These findings highlight the importance of building trans-positive spaces for younger trans children, and working to build trans positivity within primary and early secondary school environments.

## 6.4.4. Conclusion

Existing literature demonstrates the importance of reducing gender minority stress (GMS) to protect trans children's mental health, but provides limited evidence on how GMS manifests at school, impeding efforts to reduce school-based GMS. This qualitative research, applying the GMS framework to trans children's experiences in primary and early secondary education in the UK, illuminates the range of stressors that can impact on trans children at school. All interviewees described some

experiences of GMS. A large majority of interviewees outlined multiple experiences across a wide range of categories of the GMS framework. The breadth of experiences of GMS highlights the importance of recognising and addressing all of these dimensions when supporting trans children in education. Schools and professionals supporting pupil mental health have a responsibility to address in-school GMS, taking preventative early action to reduce GMS driven mental health inequalities.

These examples can be understood as evidence of cis-supremacy in our schools, in particular the toleration of harm to trans children. The extensive stressors described in this research demonstrate a critical need for systemic change across the educational system. This research evidences the harms the current system inflicts on trans children, highlighting that the burden for systemic change needs to be borne by actors within the sector, rather than asking trans children to become more resilient, or leaving children or their families to fight for institutional change. Teachers, school leaders, and educational professionals interested in inclusion, equity and educational achievement need to build educational cultures that reduce GMS on trans pupils. Actors within education need to understand the range of areas of school-based GMS and their cumulative impacts on trans children's wellbeing. Educators need to acknowledge GMS as a key threat to trans pupils' willingness to attend school, recognising the impact of chronic stress on trans pupils' ability to thrive and succeed in education. Educational professionals need to develop and uphold effective policy and action to identify, monitor and reduce GMS in schools, protecting trans children's rights, and committing to building safe educational environments for trans pupils. Educators can look to existing literature on how to build trans-inclusive schools (Horton, 2020), distinguishing between different

approaches to trans inclusion and shifting ambitions towards trans-emancipatory education (Horton & Carlile, 2022). Further research can examine how educational policy and practice can best reduce GMS at school.

Parents, carers and youth services need to understand the impacts of GMS on trans children, to advocate for trans children's rights, and to provide opportunities for trans pride and trans connectedness. Families are recommended to listen to, take seriously and document trans children's experiences of GMS at school. Families need to recognise the significant strain placed on children's shoulders when they face multiple areas of GMS on a regular basis. Families can communicate trans children's GMS related challenges to school teachers or leaders, emphasising concern of negative impacts on mental health. They can advocate for trans children's right to safe and equitable access to education. Alongside vital systemic change within education, families can also look for opportunities to reinforce trans pride and self-esteem, including through building connections with other trans children and trans communities.

Professionals interested in children's well-being, including educational psychologists, senior leads in mental health, SENCOs, or counsellors, need to be proactive in safeguarding trans children's mental health. Early action to reduce GMS in schools and families is a key preventative and protective priority. Professionals need to understand the areas of GMS experienced by trans pupils, recognising the cumulative strain they place on trans children, and the potential impact of chronic stress on trans pupils' mental health. Mental health professionals can help educate school leadership and teachers on gender minority stressors, their contribution to mental health differentials, and the school's responsibility to reduce exposure to

GMS, safeguarding trans children's mental health. Professionals can advocate for trans pupils' rights, especially where pupils lack parental advocates. They can educate in-school staff to be active allies for trans children in tackling GMS, so that trans children are not left to overcome areas of inequality and exclusion alone. Mental health and well-being focused professionals can also support trans pupils to understand GMS, to vocalise and make sense of their own experiences of GMS, and to recognise the systemic rather than individualised roots of injustice. School-based mental health professionals can also connect to families, educating families of trans pupils on GMS, providing advice and support to families on how to reduce GMS at home, and highlighting the critical role of family support and affirmation in safeguarding trans children's mental health.

## 6.4 Developing a Staged Model for Trans Inclusion

The data in this section has informed an article co-authored with Dr Anna Carlile:

Horton, C. and Carlile, A. (2022) [“We just think of her as one of the girls” - Applying a Trans Inclusion Staged-Model to trans children’s experiences in UK primary and secondary schools](). *Teachers College Record*.

The material presented in this section (section 6.4), as with the entirety of this thesis, is my work. My research was expanded on in collaboration with Dr Carlile in our co-authored article. In our co-authored article we took my staged model and applied it to a combined dataset drawn from my research and Dr Carlile's research. This collaborative scholarship is not included in this thesis.

### 6.4.1 Research Aim

Section 6.4 brings in explicit consideration of cis-supremacy within education, developing and presenting a framework to help us understand and articulate the differences between diverse approaches to trans inclusion in education, examining conceptually how cis-supremacy limits the effectiveness of approaches purporting to trans inclusion. This section addressed two topic specific research questions: 1) What different approaches can schools take to trans inclusion? 2) How does cis-supremacy influence approaches to trans inclusion in education?

### 6.4.2 Conceptualizing Trans Inclusion as a Staged Model

Under the heading of 'trans-inclusive' education there are a multiplicity of intentions, aspirations and assumptions. From my experience, conflation of different approaches under one heading of trans-inclusive education impedes understanding, analysis and action towards trans-equality. In this section I propose a staged-model

for trans inclusion, the Trans Inclusion Staged-Model (TISM) as a way of making sense of the pathologisation, toleration of gender minority stress and overarching cis-supremacy that characterises so many trans pupil's experience in UK schools, even in schools that, on some level, purport to trans inclusion. This staged-model aims to more clearly distinguish and differentiate between different approaches to trans inclusion in schools, illustrating four discrete approaches. There is value in utilising this staged-model as a conceptual framework for clarifying distinctions between diverse approaches to trans inclusion, drawing attention to their ideological assumptions, priorities and limitations.

Staged-models or maturity models are widely used across diverse spheres and sectors to benchmark and improve practices (McLeod et al., 2020; Tarhan et al., 2016). Such models have been critiqued as a static assessment tool, when used to place snapshot judgements on processes, institutions or practices that are complex and dynamic. Here this staged-model is not presented as a rigid evaluation tool, but instead intended to provide the language and conceptual clarity to have more meaningful discussions on different approaches to trans inclusion. This section aims to prompt readers to reflect upon the ideological and ethical underpinnings of each proposed level, and to question where current trans-inclusive practices lie. Benchmarking against a staged-model can be a helpful way of understanding the strengths and weaknesses of current practice, and can provide a stepping stone from which to prioritise actions for improved practice. This model defines four staged levels, ranging from trans-oppressive, to trans-assimilationist, to trans-accommodative, through to trans-emancipatory (see next section for details).

Whilst it can be used to assess established practice, the TISM is intended to be future looking, for shaping strategies and action plans. It is recognised that the

benchmarking of practice is subjective and dynamic. For example, what aspirations for trans emancipatory practice look like from a point of trans oppressive practice may differ significantly depending on the aspirations we hold as we move closer to a position of gender justice. This is proposed as a strength of the TISM, with expectations, ambitions and priorities not set in advance, rather providing a framework to enable self-driven evaluation and progress. The TISM can help those who are committed to equity and justice to make progress towards trans-emancipatory education.

The TISM is also designed to ensure approaches to trans inclusion benefit all pupils, including those with least privilege. There is value in the proposed staged-model for drawing attention to those who are ill-served by current practice, illuminating why some trans-inclusive practices can fail to benefit all trans pupils. This section recognises (and explores) the limitations of non-emancipatory approaches to trans inclusion. Such approaches are hypothesised as more likely to benefit a certain type of trans pupil: those with parental support and social capital, those who are binary-oriented, non-disclosing, who do not challenge cis-dominant institutional hierarchies, often those who are white, and who have access to healthcare. This aligns with wider literature on the ways in which schools can operate to marginalise and exclude pupils who fall outside of the expected and tolerated norm (Carlile, 2012; Demie, 2021), including literature on the role of racism and white supremacy in such exclusion (Gillborn, 2005). This staged-model holds value in drawing attention to those who are at risk of being left behind in non-emancipatory approaches to trans inclusion.

## 6.4.3 Presenting a Trans-Inclusion Staged-Model

This section proposes a staged-model of trans inclusion, from trans oppressive to trans emancipatory (see Table 13). This section provides an overview of the four proposed levels of trans inclusion, grounded in existing literature.

**Table 13: Staged- model: from trans oppressive to trans emancipatory**

| Level | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Approach** | **Trans-Oppressive** | **Trans-Assimilationist** | **Trans-Accommodative** | **Trans-Emancipatory** |
| **Locus of change** | No change | Individual child allowed to change | Class or year group | Whole school |
| **Time-scale for change** | No change | One discrete moment | While specific child is present | Sustained forever |
| **Power structure** | Cis-supremacy in full Dominance | Cis-supremacy with exceptionalism | Benevolent cis-supremacy | Gender justice and trans liberation |
| **Significance of change** | Status quo | Brief glitch in the matrix then reset / recategorisation then business as usual | Temporary accommodation / accommodation within discrete parameters | Genuine power shift to cis trans equality |
| **Outcome** | Oppression | Assimilation | Accommodation | Emancipation |

This staged-model for trans inclusion contrasts four levels or approaches to trans inclusion in schools ranging from trans oppressive, through to trans emancipatory.

At the first level of the framework, schools, policies or areas of educational practice are considered trans-oppressive. In this cis-supremacist approach, trans identities are actively persecuted and disenfranchised, with trans pupils forced to present and align with their incorrectly assigned gender. A trans-oppressive approach is pathologising, assuming trans pupils are illegitimate, inferior or unworthy of rights, making no space for trans well-being. Across global literature there are numerous examples of schools adopting a trans-oppressive approach, with significant consequences (including acute gender minority stress) for trans children in schools that are hostile and discriminatory (Ferfolja & Ullman, 2017; Ingrey, 2018; Luecke, 2018; Meyer & Keenan, 2018; Miller et al., 2018; Omercajic & Martino, 2020).

The second level in the framework aspires for trans-assimilation. In this approach, a trans pupil can be re-categorised, shifting from one binary box to the other, and is then expected to disappear into a cisnormative system without wider implications for a school. A trans-assimilationist approach assumes a trans pupil is exactly the same as a cis pupil, but mis-categorised. It assumes a binary-oriented trans pupil, who can change their category, and then disappear un-noticed within a school that immediately regains its appearance of uniform cis-ness. A trans-assimilationist approach can suit or appeal to some trans pupils, especially those who are gender-conforming, who "pass", who are non-disclosing, and who are binary-oriented. Martino and Cumming-Potvin (2017) provide an example of a teacher adopting a trans assimilationist approach, accepting a trans child as though cis, without consideration of anything further being needed. Frohard-Dourlent

(2016b) similarly highlights how a teacher discourse of "open-mindedness" can contribute to trans-assimilationist approaches, where a pupil's transitude (Ashley, 2018a, p. 4) is dismissed, without any recognition of the ways in which assimilationist approaches can perpetuate systems of inequality. Echoing similarities between white supremacy and cis-supremacy (as discussed in section 2.3), Frohard-Dourlent (2016b) draws a comparison to white people who describe "not seeing race" and the way this discourse can reinforce and avoid scrutiny of the racism (or here cis-supremacy) embedded in institutions and cultures.

Martino and Cumming-Potvin (2017) describe how a swift transition of a trans child from one category to another can be accomplished within a school without disrupting cis-supremacy, and without considering any need for action beyond that very moment of transition. Davy and Cordova (2020) note that such schools can readily re-categorise binary oriented trans pupils, yet struggle to effectively absorb non-binary pupils. McBride (2021) references literature on visibility, noting that invisible minorities can be side-lined and ignored. Martino et al. (2020, p. 2) reference the "erasure of trans personhood within school communities", where trans pupils are absorbed into a cis-mainstream without any effort towards active trans inclusion.

At level three of the framework schools prioritise trans accommodation, where adaptations or disruptions to the cis-dominant status quo are negotiated or permitted on an individualised basis. This accommodative approach is often driven by a single pupil or their family, with a visible trans pupil providing the catalyst for adaptations catering to that specific child. A trans accommodative approach recognises that trans pupils can have different needs to cis pupils. However, it still pathologises transness, assuming a trans pupil is a one-off, a diversion from the norm, with everything in the

school reverting to business as usual once that pupil has passed through that class or year group or left the school. When taking an accommodative approach, there may be an assumption that changes are being made just for that one pupil, and there is often a significant burden (and associated gender minority stress) on individual pupils to ask for, educate on, or advocate for the adaptations that they need.

Martino and Cumming-Potvin (2017) talk of the impact of an "out" trans student disrupting the familiar and taken for granted cisnormative binary. Several authors have written about the immense burden placed on trans children, or their families, when expected to advocate for their own inclusion in cisnormative institutions that were not designed with trans pupils in mind (Davy & Cordoba, 2020; Neary & Cross, 2018; Riggs & Bartholomaeus, 2018a). The same authors emphasise the inequalities inherent in accommodative approaches, in systems where pupils and parents draw on their existing social capital, connections, power and privilege to demand accommodation. They recognise the likelihood of inferior outcomes where pupils or parents lack the knowledge, capacity, authority or power to assert their rights. In an accommodative approach, the power structure of cis-supremacy remains in place; accommodation has to be requested, and may be denied. While cis-supremacy is in place, trans pupils are by default put into a position of having to make themselves "coherent and intelligible to adults who have the power to (dis)allow" their inclusion (Frohard-Dourlent, 2018, p. 11).

A trans-accommodative approach often regards accommodations as a short-term aberration, with institutions reverting to the earlier status quo once a known trans pupil has left. Meyer and Keenan (2018, p. 749) emphasise the deficiencies in an approach that is "primarily focused on the management of individual people and

cases, rather than institutional change". Schools in this approach risk perpetually

burdening trans pupils, placing them in a position of precarity where they need to

negotiate their own inclusion. McBride and Neary (2021, p. 2) describe how trans

adolescents disrupt institutional cisnormativity through "individual and collective acts

of resistance".  Trans adolescents may be effective in challenging discriminatory

policy or practice, though this does not deny the emotional toll of putting adolescents

in such a position (Meyer et al., 2016). In order to resist and challenge cisnormativity

trans youth have to assert and stand up for their own rights, a position where they

"risk becoming identifiable and targetable" (McBride & Neary, 2021, p. 4). Such

pupils are forced into a position as a visible minority, with the potential of being

singled out as a troublemaker. Frohard-Dourlent (2018, p. 2) notes how schools that

we could describe as assimilationist or accommodative "mark trans students as

troublesome because they, (intentionally or otherwise) highlight the limits of the

gendered assumptions that underlie many school practices".

Across the literature there are examples of schools more easily assimilating a

certain type of trans pupil; one that is gender conforming, binary-oriented, non-

disclosing, who can be easily absorbed into a cis-dominant system with barely any

disruption (Frohard-Dourlent, 2018). Schools find it simpler to accommodate "binary

trans students, because their genders are more culturally intelligible" (Frohard-

Dourlent, 2018, p. 2). Binary-oriented trans pupils are easier to assimilate or

accommodate without significantly changing the gendered assumptions on which

schools are run. Non-binary pupils "are more threatening to the dominant paradigm"

(Frohard-Dourlent, 2018, p. 9) presenting challenges to (cis-supremacist) schools.

Level four: trans-emancipatory education, describes schools where trans pupils

are understood as genuine equals to their cis classmates. This entails a genuine

power shift to a position of gender justice and trans liberation, where trans pupils are genuine equals to their cis classmates. Existing literature provides limited insights into trans emancipatory education. Frohard-Dourlent (2018, p. 1) "argues for more systemic changes that do not require the presence of trans bodies, and instead offer possibilities for educational spaces in which all students would experience fewer pressures of gender". Neary (2021) highlights how parents advocating for trans children do not want individualised accommodation of their particular child, but rather aspire towards schools where gender is less rigidly policed for all children.

Across the four levels the varied influence of cis supremacy is noted. Cis supremacy is here understood as a situation where cis people hold power over or are privileged over trans people, with trans people systemically disadvantaged. Sharrow writes about how institutions are a "site for advancing, enshrining, and normalizing cis-supremacist gender orders" (2021, p.1). Schools that ignore cis-supremacist hierarchies are complicit in perpetuating, legitimising and enabling discrimination (Ferfolja & Ullman, 2021). Frohard Dourlent (2016b, p. 68) emphasises how approaches that fall short of emancipation avoid "a systemic analysis of how power functions to constitute both students and educators within systems of gender conformity". Here the model makes this consideration of power explicit, focusing on cis-supremacy, and acknowledging the ways in which non-emancipatory approaches to trans inclusion may aim to assimilate or accommodate a trans pupil, whilst leaving underpinning structures, processes and systems of cis-supremacy unchallenged.

***A note on non-disclosure versus assimilation***

Disclosure is a term to describe how and when an individual decides to share with others information about their being trans. Across any of these levels of the TISM, an important distinction is made between a school imposing their own agenda onto a trans child's approach to disclosure (pushing a trans child into being out as trans, or pushing a child to being non-disclosing), and a child being enabled to make their own decisions on disclosure. It is important to note that trans children may assert their right to non-disclosure across all approaches (including in trans-emancipatory or trans-oppressive schools). The description of assimilation in level 2, therefore, is not a description of an individual child's preference to assimilate and be presumed cis, but where a school implicitly or explicitly encourages or demands assimilation.

As mentioned in section 6.4.1, I have also applied my Trans Inclusion Staged Model to primary data on trans children's experiences, examining how different approaches to trans inclusion manifest in UK schools. This application of the TISM drew upon a combined dataset (of research data collected by me and by my co-author) in an article written in partnership with Anna Carlile (Horton & Carlile, 2022). This collaborative scholarship is not included here, ensuring this thesis is all my work.

## 6.4.4 Recommendations for trans emancipatory education

This section moves to a focus on practical guidance for educators on building supportive and emancipatory environments for trans pupils. Five important institutional and cultural shifts are introduced, building both from the research in this thesis, and the wider literature.

My thesis emphasises the importance of a shift from a narrow definition of school safety towards a wider focus on emotional safety. Violence and transphobic abuse remain a serious concern for many trans pupils. However, even in contexts where schools have a commitment to protection from transphobic bullying, trans pupils can experience cisnormative microaggressions that impact on pupil wellbeing. Commitment to tackling intentional transphobic bullying is very important, but it is a first step towards building a positive school climate for trans pupils rather than an end goal. Educators need to understand the ways in which trans pupils experience and are negatively impacted by systemic cisnormativity, recognising the additional burden on trans pupils, and the cumulative stress trans children can experience at school.

This research and the wider literature (as summarised in chapter 4) highlight the systemic barriers to trans-emancipatory education. There are pressures and disincentives to trans-inclusive practice that need to be recognized and strategically addressed. These barriers include the culture of silence surrounding LGBT and especially trans lives in schools, with schools still recovering from the legacy of discriminatory legislation such as Section 28. Clear leadership is essential, and in the absence of strong trans-inclusive leadership at national level this leadership and commitment needs to be shown by governors, head teachers and individual members of staff.

A third shift that is needed is from individualized accommodation to proactive adaptation. The research presented within this thesis has reinforced themes in the global literature (see chapter 4), that trans-inclusive adaptations are often prompted by a specific pupil, a 'sacrificial lamb' who sends a school into 'panic'. Individualized adaptations may not be sustained or transferred to wider classes. This thesis has

evidenced that this approach puts huge pressure on trans children and families, who are left to advocate for their own inclusion. The current emphasis on following an individual child's needs and preferences is absolutely critical, but needs to be combined with schools making pre-emptive and sustained changes to benefit current and future trans pupils.

The fourth shift that is required is from accommodation to a rights and responsibilities based approach. My research has emphasised that in the UK a default approach centres on schools asking trans students what they want and seeing what adaptations can be accommodated, a 'negotiation' approach. My thesis has demonstrated that trans pupils and families may not be aware of their rights, or may be uncomfortable claiming their rights. A child rights-based approach emphasizes the entitlements that trans pupils have, recognising that child rights are not negotiable or limitable. Schools need to prioritise a focus on institutional responsibilities, ensuring schools are fulfilling their duty of care to trans pupils.

A fifth shift is in raising our ambition of what it means to be an effective ally to trans pupils. The research presented here has shown that our bar of ambition needs to be raised from a basic level of respect - using correct pronouns, not discriminating against trans pupils, intervening in cases of abuse - to addressing the systemic injustices that harm trans pupils. Integral to this is an understanding of cisnormativity and cis-supremacy within education systems and cultures. My thesis has highlighted the ways in which cisnormativity privileges cisgender individuals and makes life harder for trans pupils. Trans pupils shoulder a triple burden of persistent often unintentional delegitimisation, having to educate their peers and even staff about gender diversity and cisnormativity, and having to self-advocate for their right to a trans-inclusive school. In the absence of effective and informed allies, trans pupils

face this challenge alone. This burden is likely to be even harder to bear for the many trans pupils facing additional stresses, including those with unsupportive or abusive families, those facing harassment and hate inside and outside of school, and those with wider intersecting axes of marginalisation including disabled trans children, neurodiverse trans children and trans children of colour.


## 6.4.5 Conclusion

This section highlights the impact of cis-supremacy, and particularly cis institutional dominance, on trans children's access to equality in education. The TISM emphasises the structural and systemic nature of trans oppression, illuminating the power imbalances embedded in non-emancipatory approaches and acknowledging the need for fundamental reform of the "institutionalised mechanisms of power that disadvantage trans people" (Spade, 2007 p.20). The TISM acknowledges how institutions like schools codify and perpetuate norms of social control that dictate which children are accepted and acceptable in school (Spade, 2015).  Spade (2015, p.5) notes how norms uphold systems of domination that "produce security for some populations and vulnerability for others", calling for action to tackle the population-level conditions that instil vulnerability. Serano (2016) has written on how forces like cisnormativity and cis-supremacy function in part through their invisibility as the unmarked status quo. The TISM recognises how systems of oppression like cis-supremacy work in the background, as presumed 'neutral' features, un-noticed by cis people, until they are brought to our attention by their clash with, and impact on, trans children (Spade, 2015). Building on Kumashiro (2004, p.46) it is noted that "challenging oppression requires more than simply becoming aware of oppression…because people are often invested in the status quo".

The TISM also emphasises the vital importance of prioritising solutions that will benefit the most vulnerable, recognising who is left out in assimilationist or accommodative approaches. Echoing work by Namaste (2011) it challenges us to prioritise solutions that will benefit all trans children, rather than actions or accommodations that will elevate only a subset of less marginalised individuals. An important acknowledged limitation of the TISM is its one-dimensional focus on trans-inclusion. It is certainly critical to understand intersectionality, gendered racialisation and the interplay between cis-supremacy and for example, white-supremacy and ableism (Spade, 2015; Gill-Peterson, 2018). Trans emancipatory education cannot be meaningfully achieved whilst ignoring other areas of systemic injustice (Gill-Peterson, 2018). This recognition feeds into the proposed application of the TISM. It is proposed as a tool and framework for driving forward conversations, priorities and action upholding an aspiration and commitment to trans emancipatory education, alongside wider commitments to intersectional equity and justice. It is not proposed as a rigid pass or fail assessment or evaluation tool, and its limitations in drawing attention to the experiences of Black, disabled, neurodiverse trans pupils are noted. We do anticipate it providing a framework for further youth-led conversations on what trans emancipatory education looks like for pupils who are, for example, trans and Black, trans and an immigrant, or trans and in the care system.

This section is concluded not with a reductive list of actions to achieve trans-emancipatory education. Nicolazzo (2016, p.138) asks readers to "wade through the murkiness of systemic trans oppression with us". As educators we need to commit to asking ourselves "hard questions about how we may still be complicit in furthering trans oppression in our policies and practices even when we take positive steps" (Nicolazzo, 2016, p.142). Being trans-emancipatory requires a dynamic and ongoing

commitment, rather than being viewed as a static singular achievement, prompting us to continue to push the boundary in pursuit of trans emancipation, equity and justice in education.

Three opportunities for ensuring continued progress towards trans-emancipatory education are highlighted. Firstly, researchers analysing trans inclusion in education are invited to identify and articulate areas of school practice that are trans-oppressive, trans-assimilationist, trans-accommodative or trans-emancipatory. Secondly, it is recommended that tools are developed to help benchmark school performance across the different domains of this trans inclusion staged-model. There may be particular utility in a school assessment matrix geared towards trans children and adolescents, enabling trans children, or their families to evaluate their educational experience in terms of trans inclusion. Finally, the data points towards a need "for educators to imagine new possibilities" (Nicolazzo, 2016, p.140). There is also a need greater acknowledgement of cis-supremacy within efforts labelled as trans inclusive, recognising cis-supremacy as incompatible with an aspiration for gender justice and genuine equality.

# 7 Pathologisation & Healthcare

## 7.1 Research on Pathologisation and Experiences in Healthcare

This chapter examines data on trans children's experiences of pathologisation and healthcare in the UK. Research considers the pathologisation of trans children across institutions and society (section 7.2), experiences in NHS children's gender clinics (section 7.3 and 7.4), and experiences of puberty and puberty blockers (section 7.5 and 7.6). Within each section the research addresses topic specific research questions (outlined in table 3).

**Table 3: Topic Specific Research Questions: Pathologisation & Healthcare**

| Section | Research Questions |
|---|---|
| 7.2 Pathologisation of Trans Children | 1) How do families with trans children experience the pathologisation of childhood transness?<br>2) What implications do experiences of pathologisation have for UK policy and practice? |
| 7.3 Parent Experiences in UK Children's Gender Clinics | 1) What are parents' experiences in UK Children's Gender Clinics? |
| 7.4 Children's Experiences in UK Children's Gender Clinics | 1) What are children's experiences in UK Children's Gender Clinics? |
| 7.5 Experiences of Puberty and Puberty Blockers | 1) What are parents' experiences of navigating puberty, including experiences accessing or attempting to access puberty blockers, with a socially transitioned trans child?<br>2) What are trans children and adolescents' perspectives on navigating puberty, including experiences accessing or attempting to access puberty blockers? |
| 7.6 Parental Decision Making on Puberty Blockers | 1) How do parents of trans children feel about puberty blockers?<br>2) How do they navigate decisions of providing parental consent?<br>3) How do parents weigh up and reflect upon the risks and benefits of puberty blockers for trans early adolescents? |

This chapter adds significantly to the available literature, bringing an important contribution centering child and parental experience-based perspectives. In terms of trans children's engagements with gender clinics pre-adolescence, no UK research has specifically given voice to the experiences of trans children who engage with gender clinics pre-puberty. Likewise, the existing global literature on puberty blockers and wider trans youth healthcare is almost entirely absent the voices of trans children, trans adolescents, or their families (Rew et al., 2021). This research fills an important research gap, bringing in child and family experiences to a body of healthcare literature that is dominated by clinician perspectives, wherein the voices and experiences of trans children or their families are rarely heard (Rew et al., 2021).

## 7.2 Pathologisation of Trans Children

This section has informed the development of the published article:

Horton, C. (2022). De-pathologising diversity: Trans children and families' experiences of pathologisation in the UK. *Children and Society.*

### 7.2.1 Research aim

Trans children have long been impacted by pathologisation, with childhood transitude until recently defined as a disorder, and with this categorisation impacting on how trans children are treated (as discussed in section 4.1.1 of the literature review and in section 2.2.1 of the theory chapter). This piece of research (presented in section 7.2) aimed to understand how pathologisation of trans children currently manifests at individual, institutional and societal levels across the UK, examining how its impacts are experienced by trans children and their families. This section of the thesis addressed two topic specific research questions: 1) how do families with trans children experience the pathologisation of childhood transness? and 2) what implications do experiences of pathologisation have for UK policy and practice?

### 7.2.2 Findings

Findings are presented in three levels, considering experiences of pathologisation at individual level, within institutions, and across society.

**Individual Manifestations of Pathologisation**

Parents discussed experiences of pathologisation within families, and across local communities.

### *Family Pathologisation*

The supportive parents in this sample described how pathologising assumptions about trans-ness led to conflict and relationship breakdown within families. A majority of parents in this sample reported at least one significant family member or close friend holding pathologising beliefs, and criticising parental support for a trans child. One parent emphasised "family relationships have been really difficult". In many situations where close friends or family held pathologising attitudes, this culminated in fracture of relationships.

> I lost a really dear friend over this (supporting my child's identity), he kind of felt that [5-year-old child] was manipulating me [P].

In a number of cases, pathologising attitudes about transness contributed to family breakdown, for example where grandparents could not accept affirming a trans child.

> (Grandparents) they disowned us… they blamed me entirely... I allowed him to wear boys swimming shorts at the swimming pool, I allowed him to have his hair cut, therefore, I had made him trans [P].

Parents perceived such breakdown in family or community cohesion as grounded in deeply held pathologisation narratives, with family or friends convinced that childhood transitude (Ashley, 2018a, p. 4) was a sign of mental illness, and that support for trans children was inappropriate or even abusive. In several cases, parents had received family pressure to engage in abusive and harmful conversion practices, encouraging parents to deny their child's identity or advocating for 'therapy' to teach their child to accept their coercively assigned gender. In many cases, trans children were aware of transphobic attitudes held by family members,

with examples of family members expressing pathologising and offensive views in front of trans children.

> She's had a member of her own family tell us we were - say that we were bad parents in front of her and say that if she told us she was a dog would we let her eat out of a bowl on the floor. So, she knows people in her own family can be you know, really anti trans [P].

Where pathologising attitudes were held by grandparents, family fracture was a source of ongoing pain for parents and trans children. Parents reported trying to maintain children's self-esteem by emphasising that it is not their child's transitude, but family member ignorance or bigotry, that drove family fracture.

### *Local Community Pathologisation*

Many parents in this sample had encountered pathologising assumptions or beliefs about transness within their local community. One parent related how "initially, it was difficult. I've been called a child abuser and all sorts" [P]. In a number of examples community members reacted to supportive parents with suspicion or judgement. In other cases, community members reacted to supportive parents with anger.

> And I had a mum march up to me…. And she said, did you want to have a boy? Is that why you've done that to her? [P].

Interviewees described harassment and verbal abuse, as well as community members reporting supportive parents to social services simply for allowing freedom in gender expression (clothing, hairstyle) or for respecting a child's pronoun or identity.

> There were some periods where we had, like abuse shouted at us in the streets. And we had lots of complaints put into the school about us. We had malicious referrals to social care [P].

Parents noted community members having emotive responses even to the word transgender being used about a child.

> I think some people are sometimes afraid of the word transgender. I remember. Just mentioning it to someone and they're like, oh, you know, we would never call [Child] that [P].

Many parents reported being ostracised from a community or friendship group, particularly where other parents did not want their own children to socialise with a trans child. Some community members reacted as though transness was

contagious, as though proximity to a trans child would cause another child to be confused about their gender.

> There was a girl whose parents were uncomfortable about my child transitioning. And had said, I don't want her using the girls' toilets, because that might make my child confused about her gender [P].

Interviewees felt such concerns were rooted in negative assumptions about transness, as though transness was pathological and something children needed to be protected from.

## Institutional Pathologisation

The second theme considers evidence of professional and institutional pathologisation of trans children, with sub-themes considering pathologisation within the field of education, healthcare or law.

### *Pathologisation Within Healthcare*

Within generalist healthcare parents described professionals who acted and spoke in ways that indicated pathologising assumptions. Numerous parents shared examples of healthcare professionals reacting to a trans child or supportive parent negatively or with hostility. Several parents speculated that pathologising assumptions, ignorance and fear were driving poor reactions, with such professionals considering trans children as inherently a problem. Several parents felt the NHS overall was still set up on an assumption that childhood transitude was a problem or a mental health issue.

I can remember about so many years ago CAMHS (Child and Adolescent

Mental Health Service) decided that being trans wasn't a mental health issue.

I mean, the therapists are lovely, but I'm not sure really what their role is for

people like [Child] who, who knows who he is… You know, it's an extra

medicalisation of it. Isn't it? Extra talk therapy. He's always hated going….

He's never sort of wanted to go [P].

Several parents had encountered GPs or secondary healthcare professionals who

expressed pathologising attitudes, dismissing childhood identities or critiquing

parents for supporting a trans child. Where parents encountered healthcare

professionals providing pathologising and harmful advice on trans children, parents

found healthcare trusts unresponsive to complaints, with no sectoral commitment to

depathologisation.

[Healthcare professional] wrote a report, a copy of which went to school… and

there are about six recommendations, making sure that [Child] is 'reminded of

her biological reality', and making sure that adults and other children you

know, around her, are reminded… We've made a complaint to the trust… the

trust basically sent one back saying, you know, she can do no wrong really.

She's our trusted professional in this area. She's had all the training [P].

### Pathologisation Within Education

Within education families encountered pathologising attitudes about childhood

transitude (Ashley, 2018a, p. 4). Several families described school head teachers not

permitting a trans child to socially transition (e.g., change pronoun) at school without

a psychological diagnosis.

The school were very much like, if you can get a diagnosis, like let's medicalize this, and as soon as we get this bit of paper that says, this is a medical condition. But you know, at the same time, the World Health Organisation, were saying, hey, guys, this is an identity, this is not a medical issue [P].

In more cases, schools agreed to accept a trans child on the condition the child was enrolled in NHS gender services and seeing NHS psychologists.

(Head teacher wanted confirmation) that we've been through CAMHS (Child and Adolescent Mental Health Service) that we'd, we'd had backing by a GP, that we'd, we'd had a diagnosis. He wanted to know that we were in the system and being diagnosed [P].

Pathologisation of trans children across schools was also visible in how school teachers or leaders approached transitude. In one school a trans pupil was banned from using the word trans to describe themselves for several years.

The school said he's not allowed to say to anyone that he's trans…. Don't use those words. That remained the case for a few years in primary school [P].

Another school sent out a letter informing other parents of a child's transition, whilst reassuring those parents that the word trans had not been used in front of their young children. The parent felt this action revealed pathologising assumptions about transness, that the school leadership felt even the word trans was inappropriate for a trans child's peers to know about.

### *Pathologisation Within Legal Services*

Families also described encounters with pathologising professional attitudes in legal and child protective services. One parent, whose co-parent disagreed with a simple first name change, experienced a full day's court process, including testimony from 5 professionals including psychologists, just to gain court approval for a first name change for a trans adolescent.

> (First name change) it's a very, very lengthy process, very intrusive…. doctors and (Endocrine clinic), (Gender Clinic) and the school, it was five professionals that had to provide a statement to say why they think [Child] should change her name. We had the final hearing and it was an all-day hearing....  My understanding was that I was told to change your first name of your child is a fairly straightforward process (normally). It was it was - some of it was politicised - it was to do with the Keira Bell case and you know, the way that our children are treated and the justification that I have to go through on [Child's] behalf just to change the name that's been used for the last 5 or 6 years is mind blowing. It was really very difficult for us. But we knew that we had to do it in order for the name change to go ahead [P].

The supportive parents in this sample had not encountered a legal challenge to their custody of their trans child, but most were aware of other families who had gone through traumatic legal challenges related to affirming a trans child. Many parents in this sample described living in fear of a legal challenge by ignorant and pathologising legal or child protective services.

> Worst case scenario is social services get involved and they don't understand where we're coming from at all… The worst-case scenario is they'll take our child away from us. I've lost faith and I've lost trust [P].

Parents also referenced the continuing lack of access to full legal recognition as a continued legacy of pathologisation, with trans children requiring a medical letter to enable update of their passport, and being entirely without route to updating their birth certificate.

## Societal Pathologisation

Parents described the ways in which pathologisation of trans children was embedded at societal level across the UK, with this section distinguishing between systemic pathologisation and media pathologisation.

### *Systemic Pathologisation*

At a systemic level parents considered the continued legacy of decades where childhood transitude was defined as a pathology and disorder, noting this legacy has not been acknowledged or addressed at a systemic level across the UK establishment.

> I think a big issue is to do with how the (UK Gender Service) was formed… it all came from that kind of Freudian psychoanalytic background… the higher ups and the powers that be are still working within that framework … and it's allowed the, the narrative in the media to build of it being this psychological

disorder, because that's what it's still treated as by the experts who are supposed to be caring for our kids [P].

Parents pointed to a lack of clear commitment to depathologisation of childhood transitude across the UK. Despite knowing of the global shift away from pathologisation of childhood transitude, parents did not feel they had UK institutional backing to challenge pathologising attitudes or practices. Parents noted how pathologising assumptions about childhood transitude are widespread across the UK, with no national or sectoral guidance condemning pathologisation or committing to depathologisation of trans children. Frequent exposure to pathologising individual attitudes across institutions left parents with high levels of stress in any interactions with professionals.

The most stressful thing is that any interaction with officialdom comes with the fear of not knowing how the person that you're dealing with is going to treat you… when someone's got control over some aspect of your life, then you know, it, it's extra stressful. A doctor, a social worker, a teacher, a school nurse, they have control and they effectively you know. We can complain … but you do feel very powerless... There's no official guidance anywhere to point to, to go here you are in the wrong. You kind of have to convince them with your own research that what they are doing is wrong [P].

Where parents came up against family, community, professional or institutional pathologisation, they struggled to advocate for depathologising approaches without legitimacy from sources like the NHS or national government. Several parents contrasted the UK with other countries like America or Australia where national health authorities speak positively of trans children as a positive part of human

diversity. Many parents expressed frustration at a lack of depathologising communication or leadership from the NHS, whilst also noting NHS practices that they felt reinforced and legitimised pathologising approaches and attitudes. Parents referenced the use within the NHS of pathologising terminology, such as talking of trans children as 'children distressed about their gender', referring to trans children with 'co-morbidities' (with the implication that being trans is itself a 'morbidity'), questioning the 'aetiology' or 'epidemiology' of trans children, or referencing non-linear transitions in terms of 'desistance', a term drawn from criminology (Serano, 2018a). Parents questioned the NHS use of pathologising language about trans children, considering it both an indicator of embedded pathologisation, and a legitimiser of pathologising practices across society.

### Pathologisation in Media

Many parents discussed pathologising media discourse about trans children, and the ways in which it perpetuated and reinforced pathologising attitudes and actions across UK society.

> Really angers me the crap narrative that's in the media that has been co-opted by the people with power…. there's no one in a position of power that's on our side. That gets it - that's. It feels like shouting into the void [P].

Several interviewees highlighted examples of media using explicitly pathologising language when talking about trans youth, for example references to the much critiqued idea of 'social contagion', framing that uses language associated with pathology (Ashley, 2020; Restar, 2020; WPATH, 2018). Parents were significantly

affected by what they saw as pathologising and problematising discourse in UK media, describing the stress and distress it caused them and their children.

> (Impact of public discourse) is really difficult. I basically don't follow stuff at all. And if I hear stuff on the radio, I often just turn it off, because it's too upsetting to hear [P].

Parents saw direct links between pathologisation within media, and the challenges and pathologisation they encountered at individual and institutional levels, with deep rooted societal pathologisation making the UK an unsafe place for trans children.

> Just - it's beyond belief this country. I'd leave in a heartbeat at the moment, I'd leave in a heartbeat - if I could. It's a persecution isn't it [P].

### 7.2.3 Discussion

Three domains of pathologisation are presented. Within families and local communities parents encountered a large number of pathologising attitudes or assumptions about childhood gender diversity being a problem. These attitudes were reinforced by widespread societal misconceptions, including pathologising media tropes. Pathologisation at individual level caused significant distress, rejection and isolation, causing family and community fracture. As explored in section 5.4, pathologising assumptions had also prompted several parents to delay acceptance of their own children, with consequences for trans children's childhood happiness and self-esteem. Within this sample all interviewed parents were at time of interview supportive of their trans child. It is important to note that this sample does not include the families where parental pathologisation inspires and legitimises rejection and abuse of trans children throughout childhood (Ashley, 2019a).

At an institutional level, parents reported a number of encounters with professionals who held pathologising attitudes about childhood transitude. These professionals held positions of power and authority, with pathologisation at this level having significant impacts on trans children's lives in spheres like education and healthcare. At an institutional level, families and trans children encountered professionals wanting diagnosis before being willing to accept or respect the rights of trans children. In other cases, pathologisation narratives prompted professionals to treat childhood transitude as a problem or safeguarding concern. In most cases explored herein, pathologising professional practice was not explicitly mandated or part of formal institutional policy. Rather, in the absence of de-pathologising institutional policy, professional practice was influenced by pathologising attitudes and assumptions. Many professionals wanted institutional backing before taking any depathologising actions or approaches, and in the absence of institutional commitment to depathologisation many defaulted to pathologising approaches.

At a systemic level, parents noted a lack of clear policy-level commitment to depathologisation of trans children. Without leadership and explicit commitment to depathologisation, parents felt un-supported in their efforts to challenge pathologising attitudes or practices. A lack of systemic commitment to depathologisation left affirmative families feeling insecure, needing to individually defend or assert the importance of depathologisation, without any wider systemic legitimacy. Respondents highlighted numerous cases where pathologisation was not explicitly mandated, but where it is "strongly implied and enforced" as default across diverse sectors and institutions (Murray, 2019b, para. 56). Many parents spoke on how their families had been deeply affected by systemic and societal pathologisation of trans children, describing high levels of stress and precarity, of feeling abandoned

and let down by institutions like the NHS. Parents raised frustration that they or their children were left alone to advocate for depathologisation of trans children, without any systemic backing, in the face of entrenched society-wide pathologisation.

Terminology appeared to be a cross-cutting indicator and legitimiser of pathologisation, with this apparent in a number of ways. Avoidance of use of the word 'trans' to describe trans children, especially for children who identify with and take pride in the word trans, is an indication of delegitimisation or problematisation of trans identities in childhood. This was noted by interviewees across different spheres, with examples of teachers, grandparents, neighbours or medical practitioners reacting negatively to the term 'trans' when applied to a child. This avoidance of recognising trans children was also noted by parents in national media, in political discourse, and in research and healthcare policy, with parents commenting on the explicit avoidance of the word trans even in healthcare discussions on children accessing gender clinics, instead focusing on 'children distressed about gender' or 'children confused about gender'. Other pathologising terminology parents noted in UK discourse about trans children includes talk of 'co-morbidity', a focus on 'desistance', research into 'aetiology' or 'epidemiology' and descriptions of 'social contagion', language that highlights entrenched pathologisation. Thornton (2021, para. 2) describes how pathologising discourse uses "epidemiological imagery…because it couches two extremely dubious premises; being trans is contagious; being trans is harmful".

Parents in this sample called into question why pathologisation appears to be so deeply entrenched in the UK, and why there appears to be little movement towards depathologisation of trans children. Parents specifically talked about what they saw as a failure in NHS leadership on the depathologisation of trans children.

Whilst mainstream healthcare practice in other countries has moved away from pathologising views on gender diversity, NHS children's gender services and the NHS more broadly have less clearly distanced themselves from the problematisation of gender diversity (Pang et al., 2022a). Parents contrasted what they had experienced in terms of embedded pathologisation in the UK, with what they had seen as efforts to celebrate and normalise trans children in some other countries. Parents felt the NHS and UK children's gender services have failed to communicate depathologisation narratives, legitimising and enabling the continued harm of pathologisation across wider UK society. Systemic failure to provide depathologising leadership can be considered an example of 'institutional betrayal' (Smith & Freyd, 2014). 'Institutional betrayal' is arguably applicable in circumstances like this, where the institutions that have legitimised and perpetuated decades of societal and systemic pathologisation fail to take action to redress that harm (Smith & Freyd, 2014). Persistent and widespread institutional betrayal, specifically and knowingly harming trans people, can be understood as evidence of cis-supremacy in action. Indeed, across this section, we can see examples of multiple dimensions of cis-supremacy, from institutional dominance in institutions unaccountable to trans communities, to pathologisation being used to justify control and coercion of trans children, to problematisation of transitude and toleration of harm.

## Implications for UK Policy and Practice

This research highlights examples of pathologisation of trans children being deeply embedded across the UK, with impacts on actions and approaches at family, community, institutional, media and societal levels. In this section we look forwards, to consider how we take positive steps towards a future where the principles of

depathologisation of childhood transitude endorsed in WHO ICD-11 can be realised across the UK. Recommendations are considered across three areas, considering leadership, action and depathologisation without ableism.

### *Commitment and Proactive Leadership on Depathologisation*

In other countries, leadership for depathologisation of trans children has come from trans communities, from paediatricians, and from primary care practitioners (Abreu et al., 2021; Akkermans, 2019; Ashley & Domínguez, 2021; Winter et al., 2016). Countries like Argentina have approached depathologisation from a human rights or child rights perspective, prioritising equality and justice (Suess Schwend, 2020). In the UK, trans communities have long been advocating for depathologisation, often in the face of heavily pathologising narratives from the NHS, from government, from the UK media (Davy et al., 2018). As ICD-11 comes into effect from January 2022, this prompts an important question on roles and responsibilities. How is the NHS is going to enable depathologisation of trans children within healthcare and across wider society? Who can drive forward systemic and societal action to overcome deeply embedded pathologisation? Given past pathologisation was driven through psychology, psychiatry and healthcare, all of which falls within the domain of the NHS in the UK, the NHS arguably holds ultimate responsibility for addressing and dismantling this harmful legacy.

In the absence of leadership and commitment at national or NHS level, professionals across diverse spheres can do more to speak up against pathologisation. Professionals across diverse sectors can scrutinise institutional policy and practice, to ensure trans children are accepted, celebrated, and

normalised without pathologisation. Professionals in healthcare, education, social and legal services can actively challenge policies and practices that problematise trans children. Professionals can draw attention to policy gaps, where an absence of depathologising policy commitments facilitates the persistence of pathologising practice. Action at institutional level without the backing of the NHS is likely to be challenging. Professional associations can add their voices to a call for greater NHS commitment and leadership on upholding a duty of care to trans children, including commitment and leadership on depathologisation. The absence of institutional action across the UK to take responsibility for depathologisation, continues to harm trans children, and action to address this harm needs to be taken up as a child rights concern.

### *Strategic Communication and Action on Depathologisation.*

Across the examples of pathologisation examined in this study, pathologising approaches were rarely explicitly mandated in policy and never acknowledged as pathologisation - there were no policies on 'pathologisation of trans children' that can simply be removed. Rather, pathologising approaches were implicit and unacknowledged, an assumed default that was hard to address or overcome. This finding highlights a need for strategic communication and targeted action to enable meaningful depathologisation the UK. Professionals, particularly in NHS leadership, could play a role in clearly communicating depathologising narratives to UK media and UK communities, normalising and celebrating trans children. Assertive trans positive public-faced communication efforts about trans children are needed, recognising and starting to address the deeply entrenched pathologisation that has,

with NHS legitimisation, become embedded across UK society. Professionals across diverse spheres can also take action to address vestigial pathologisation of trans children, and identifying and addressing areas where pathologisation is embedded into institutional approaches, systems or attitudes. Depathologisation needs to be an explicit institutional commitment, ensuring professionals know they have institutional backing for depathologising practice, and enabling institutional accountability for the harms of pathologising practice. Strategic action on depathologisation needs to be genuinely prioritised, resourced, and put into action, with implications for training, for policy and for practice. Individual sectors working with trans children and their families can start by examining their ways of working through a lens of pathologisation, considering whether processes and assumptions would stand up to scrutiny in a post-pathologisation world. Sectors can also embed depathologisation into their commitments and complaints mechanisms, instilling confidence that pathologising approaches are not acceptable in modern practice.

### *Depathologisation Without Ableism*

Depathologisation is herein upheld as an important policy priority, recognising the continued harms of treating transitude as a mental illness. At the same time, it is important to recognise the risk of depathologisation narratives reinforcing and propagating ableism. Human rights scholars, including disabled and neurodiverse trans scholars, have emphasised the importance of upholding the rights of all people, including trans people with mental health, developmental or learning disabilities (Murray, 2019a). Anti-trans actors attempt to challenge and dismiss trans rights, especially trans children's rights, based on an inaccurate claim that being trans is a

mental illness (Thornton, 2021). Whilst challenging this misguided characterisation of transitude, it is important to avoid ableism. Thornton (2021, para. 5) emphasises that "when transphobes dismiss being trans as a mental illness, can we challenge the use of 'mental illness' as a category for those who are not to be taken seriously, those who can be dismissed and thrown away?". Thornton (2021, para. 4) and others caution against efforts to destigmatise transness in a way that further stigmatises mental illness, highlighting the injustices in efforts that elevate "(non-mentally ill) trans people within the social hierarchies of domination, on the backs of mentally ill people, including mentally ill trans people".

### 7.2.4 Conclusion

This section has examined experiences of pathologisation of trans children within the UK, contrasting current pathologisation with recent global policy shifts to depathologisation. The study adds to existing literature, outlining examples of pathologisation of trans children at individual, institutional and societal levels. These examples highlight the harms that pathologisation imposes on trans children and their families, drawing attention to depathologisation as a priority for trans children's equality and well-being. However, as commitments to trans depathologisation take effect in global healthcare policy, the pathway to depathologisation of trans children in practice across and beyond the UK is far from clear (Winters, 2022). Trans children need to be protected from ongoing psycho-pathologisation, necessitating proactive commitment, leadership and action. Trans depathologisation needs to be considered a critical priority for child rights and social justice.

## 7.3 Parent Experiences in UK Children's Gender Clinics

This section informs the published article:

Horton, C. (2021) [“It felt like they were trying to destabilise us”: Parent assessment in UK Children's Gender Services](#), *International Journal of Transgender Health*

### 7.3.1 Research aim

Section 7.3 focuses on parents' experiences in UK Children's Gender Clinics. This research fills an important research gap, adding parental experiences to a body of literature that is dominated by clinician perspectives, wherein the voices and experiences of families are rarely heard. This section addressed one topic specific research question: 1) What are parents' experiences in UK Children's Gender Clinics?

### 7.3.2 Findings

This section presents key findings on parents' experiences at NHS (National Health Service) children's gender clinics. Findings have been grouped under two broad themes, 'families under a microscope'; and 'a lack of trans-positive support for parents of trans children'. Each theme was broken into two or three sub-themes, each illustrated with quotes, all from parents of trans children who socially transitioned under the age of eleven.

**Families under a microscope**

The first theme considers how parents of young trans children reflect upon their own experiences with children's gender clinics, which can be described as feeling under a microscope. This theme is sub-divided into three sub-themes that capture parents

experience of family assessment, with many families perceiving it as 1) judgemental, pathologising and outdated; 2) intrusive and irrelevant 3) insensitive and inappropriate.

## *Judgemental, pathologising and outdated*

A common theme shared across many interviews was a perception of being judged during parental sessions, as one parent described:

> I was being grilled about how we'd dealt with the situation. There were times where I felt a little bit like I might be being judged [P].

A number of parents felt they were being treated as research objects in sessions that focused almost exclusively on the past, for example, concentrating exploration on infancy and early childhood without any discussion on challenges or needs in the present and future. Another parent felt mothers, in particular, were placed under judgement "You do feel, particularly as a mother, that you are very much under scrutiny". Many perceived these sessions to be grounded in pathologisation of gender diversity. A parent commented on the ways that clinicians appeared to be problematising gender diversity:

> I think the implication is 'why is this happening?' 'We don't want this to happen'. That it's definitely a problem. My sense was (the clinicians believed) it's rooted in the family, you know, something that's happened [P].

These perceptions resonate with existing literature criticising non-affirmative approaches to working with trans children and families. Affirmative children's service clinicians from other countries have critiqued approaches that problematise gender

diversity based on an assumption that it represents something that has gone wrong (Berg & Edwards-Leeper, 2018). A mismatch between affirmative practice in other countries and the UK's approach was also revealed within this research. Two families who had experienced children's gender services in (two) different countries before coming to the UK, noted a significant difference in approach, with services in other countries having only briefly asked about their child's gender history before focusing on the present and the future, whilst in the UK families were required and expected to speak about the past for sessions spreading over several years. One of these parents preferred their experience in another country where a gender affirmative approach was mainstream:

> They're much more like, okay, so you're trans, tell me about it, tell me what you want for your future… there's no 'what's caused this? [P].

Most parents in this sample had heard or read about there being differences in approach between the UK and countries where gender affirmative healthcare is common, and described the UK's approach as pathologising and outdated. One parent elaborated their concerns:

> That kind of Freudian psychoanalytic background …the higher ups are still working within that framework, and, are years behind the rest of the world on their thinking…it's allowed the narrative in the media to build of it being this psychological disorder, because that's what it's still treated as by the experts who are supposed to be caring for our kids [P].

The parents in this sample did not think that gender diversity should be problematised, and found encounters with pathologising approaches troubling and out of alignment with their own view on gender diversity, as one parent described:

You know, like I was causing it, rather than it's just a naturally occurring

thing. Perhaps it's just part of her, perhaps she was like that, and I

responded to it, rather than because I've parented in a particular way [P].

Several parents described their personal journey from trusting in the UK NHS

process, to questioning it, and then challenging it, as illustrated by this parent:

They were the very first few sessions until I kind of wised up and kind of

saw where they were going with it. It was very much about picking us

apart as a family and trying to psychoanalyse what had made her trans

and it took a couple of sessions of us kind of standing up to them and

saying well actually, we don't think - why is that relevant? Why are we

talking about that? [P].

A focus on problematising trans identities, and trying to identify a causation of a trans

identity, aligns with the experiences noted by trans adolescents in the same

children's gender clinics, who were asked "whether their gender identity has come

about due to some sort of trauma or parental pressure" (Carlile et al., 2021, p. 6).

This research provides additional insights into how pathologising assumptions about

gender diversity are encountered and experienced by parents of younger trans

children.

### *Intrusive and irrelevant*

The second sub-theme reflects upon areas of gender clinic questioning that parents

described as intrusive or irrelevant. A number of parents spoke about their

experience of being asked details of their child's birth, for example:

In our first appointment. I remember when they were asking me about like [Child's] delivery and like [Child] was induced, because I had preeclampsia.... And I was like, What the hell's that got to do with it - like, seriously? [P]

Another parent described such questions as "invasive, and I feel, unrelated at all to my child's gender". Many parents were told that the sessions' aim was "to find out how we got to here" or "to understand your full family history". Parents felt this overly broad aim gave clinicians a carte blanche to ask any questions they saw fit, including those unrelated to the families' current needs. Parents described a particular focus by clinicians on gender roles within the family, which they viewed as unnecessary and troubling, as one parent described:

They said something about how there's really strong female role models in my family. And it made me feel like that was something that they can grab onto as a reason [P].

Other parents felt uneasy about the assumptions underpinning the questions they were being asked. One parent stated "it's very much, they're still trying to look for cause". This perception of clinicians looking for a cause, and delving into topics that parents perceived as irrelevant to their child's current needs, was emphasised by numerous parents, each highlighting a slightly different focus:

It's like they were literally trying to find any other reason to pin it on. You know, it's because I'd had mental health issues in the past. And her older brother is autistic [P].

Parents were asked to speculate on how the gender of the primary care giver impacted on their child's gender identity. Parents reported being asked many questions about gender roles in their own home, about gender roles of their parents

and grandparents, about how household tasks were divided, questions that were irrelevant to their child's gender identity and current needs. Another parent commented:

> It's always felt like that of kind of like, are we ticking off every single reason why there might be some other reason why this is happening. And that was over a good few years. That's what it felt like we were doing, like, it was just exploration of every single thing in the past that could be a reason why this had happened [P].

Some parents challenged clinicians on questions they perceived as unrelated to their child's current needs:

> It felt a bit sometimes, almost looking for a reason to be trans and the whole can you draw out your family tree and tell us what roles different people in your family have? And that felt a bit well hang on gender roles and gender expression don't mean anything. We're talking about gender identity here. Where are we going with this? [P].

These themes of irrelevant or intrusive questioning of parents of younger trans children align with literature on trans adults' and older teens experiences in gender clinics (Carlile, 2020; Carlile et al., 2021; Pearce, 2018; Vincent, 2020). Carlile et al. (2021, p. 7) notes trans adolescents being asked "intrusive and irrelevant questions". This research complements the research on trans adults and teenagers, demonstrating the scope of family assessment and how it is perceived by parents of younger trans children.

### Inappropriate, Insensitive and not Trauma Informed

This sub-theme has overlaps with the previous sub-theme; in both, questioning by clinicians was perceived by interviewees as intrusive and irrelevant. This sub-theme is distinct due to its perceived impacts in terms of parental distress. Interview segments were categorised into this sub-theme where questioning was upsetting for the parent, with this inference drawn both from the language interviewees used about their experience, as well as emotional responses observed at interview, with reflection on some aspects of gender service questioning visibly provoking parental emotion.

A number of parents experienced questioning that they found upsetting; questions that they felt were inappropriate or insensitive. Parents with multiple children were asked to consider whether their trans child was copying or jealous of their cis sibling(s). Parents were asked to consider if their trans child was asserting a trans identity to gain parental affection. Where families had experienced parental separation (regardless of how amicable), this became a focus of parental gender clinic sessions as one parent shared:

> They asked me stuff like …when did she talk to you first about her
> gender? was that before or after dad left the home? You know, as if there
> was a link to him leaving [P].

Some parents were particularly concerned about how clinicians focused on family bereavement.

> They talked about the fact … that my mother died shortly after they were
> born…Like, I don't think that if my mother hadn't died, my child wouldn't be
> trans. It felt like they were looking for ways to discredit our child [P].

One parent who had experienced the death of a child, found gender clinicians continually asking her to focus on this topic:

> They were obsessed, obsessed, with the fact that I'd had a stillborn baby before ([Child] was born). And they were obsessed and like for ages every report was [Child] expresses, you know, great fear and great sadness around the brother that she had who died … and it's like, well, yeah, cos that's a sad thing to think about…Nothing to do with her identity [P].

Another parent found gender clinicians wanted to keep talking about their child's father, who had died many years earlier, speculating links between the child's father's death and the child's identity:

> Is [Child] trying to be the man in the house because their father has died - you know when you're just like, - pardon? like you're asking a 10-year-old, like, if you think they're trying to pretend to be their dad? [P].

Several families felt strongly that gender clinic sessions focusing on family bereavement was inappropriate, that discussions were not trauma informed, that questions were potentially trauma inducing, and that prompting parents to speculate on the impact of bereavement on a child's identity was not helpful, evidence-based or prioritising family or child well-being. This theme of inappropriate or insensitive parental questioning resonates with accounts from trans teens, who reference clinicians attempting to establish links between identity and trauma (Carlile et al., 2021, p. 6).

## A lack of trans-positive support for parents of trans children

A second major theme in the interviews relates to a lack of trans-positive support for parents of trans children in the UK. This theme contains two sub-themes 1) discouragement of parental support for trans children and 2) services not meeting family needs.

### *Discouragement of parental support for trans children*

A majority of parents encountered trans negative attitudes at UK Gender Services, especially when attending with younger trans children (see below for more details on percentages). Many clinicians inferred (or stated) that a trans child growing up to be a trans adult was a negative, undesirable and avoidable outcome as described by two parents:

> Seems to be the whole focus of the way [Gender Clinic] approaches it, you know, we definitely want these kids to be cis when they grow up. Because Ooh, trans [P].

> It does feel like, you know, the worst possible outcome would be that your child is trans. And it's like, well, no, not really, the worst possible outcome is that my child is dead, because you didn't give them the, the medical care that they needed. That's the worst possible outcome - there's nothing wrong with being trans [P].

These experiences align with wider literature on negative healthcare professional attitudes towards trans people evidenced across diverse fields (Brown et al., 2018; Stroumsa et al., 2019). A large number of families were given outdated and widely refuted statistics particularly around the much-critiqued concept of 'desistance'.

Clinicians quoted these statistics to advise parents not to support or affirm their child.

> We had a very, very conservative therapist who spouted the 80%
>
> desistance nonsense at us at our very first appointment [P].

These statistics and indeed the concept of desistance are much critiqued in the literature, with a number of articles challenging both the validity of older research, and its relevance for socially transitioned trans children today (Ehrensaft et al., 2018; Temple Newhook, Pyne, et al., 2018; Temple Newhook, Winters, et al., 2018; Turban & Ehrensaft, 2018). Several families in this sample were aware of the recent literature critiquing this interpretation, and were unhappy that they had been presented these statistics as applicable to their child, without highlighting the critiques, and without provision of contrasting research on the benefits of affirmation, as one parent commented:

> I remember clearly her saying, you know, 80% of children, basically de-
>
> transition, and don't go on. And I just was like, I don't think that's true.
>
> …my main memory of that first appointment is feeling really angry [P].

For some hesitantly supportive parents in this sample, gender clinician advice served to actively undermine their confidence in supporting their child, giving what one parent described as "reassurance" that their child would grow out of their trans identity.

> This was the very first session we had, so he was, [Child] was, he would
>
> have been about five or six at that point. At the time, I think, because it
>
> was our very first session, we were still getting our heads around what
>
> was going on. So, when she said that initially, I must admit, we probably
>
> felt a bit of a sense of relief…I don't know, in some ways, it gave us hope
>
> … (that our child wouldn't) have a much more difficult life [P].

In some cases, clinicians used language that was perceived by parents to be emotionally manipulative. A parent of a young socially affirmed trans boy, was told by a clinician "don't give up on your daughter". This emotionally charged advice, using gendered terms that were not being used by the parents or the child, caused distress for the parent, at a point when they were still learning how to support their son. A large number of families felt their clinicians discouraged supportiveness, and criticised their affirming approach. A number of parents reported having been explicitly told by gender clinicians that they should not have supported their trans child's social transition (i.e., that they should have continued using the child's original pronoun, and should not have recognised or supported their child's identity). One such parent elaborates:

> When I first saw them, they did basically say, it was my fault. That because I'd allowed her to socially transition in terms of clothes and using a different name. Therefore, now she's more likely to be trans because of that [P].

A number of parents expressed concern about negative clinician attitudes towards transitude. One parent was frustrated that gender clinics were staffed with "professionals working with trans children that don't have any trans friends and aren't trans or non-binary". Parents reflected on the journey they had needed to come on to become trans-positive, and were frustrated at clinician transphobia or cisnormativity. Several parents discussed the fact that only with the benefit of hindsight (coming, now, from a position of trans-positivity), did they recognise the cisnormativity and transphobic prejudice inherent in, for example, a clinician reassuring a parent that their child will not be a trans adult.

Within this sample, several parents described the negative consequences that

stemmed from their experiences in gender clinics. Several parents stated that clinician dismissiveness and discouragement had delayed the time it took for them, or their co-parent, to fully support and embrace their child's identity. Where a supportive parent had a less supportive co-parent or extended family member engage with the service, supportive parents felt gender clinic staff encouraged and reinforced existing scepticism or unsupportiveness, with a parent commenting: "it felt like they were trying to, like destabilise us". Several parents worried about the negative consequences the approaches they had encountered could have on other families and their children. Parents within this sample were concerned that clinician discouragement could prevent a parent lacking certainty from supporting a trans child, and could reinforce or legitimise parental transphobic abuse and rejection.

### *Services not meeting family needs*

A second sub-theme emerging from these data was a service not meeting family needs. A review of the accounts of the 23 parents of trans children with experience attending NHS children's gender services reveals a high level of dissatisfaction with those services. 15 parents (65%) provided feedback that was overwhelmingly negative on their experience, six parents (26%) provided mixed feedback and two parents (9%) provided predominantly positive feedback.

A number of parents who had been attending appointments with the gender service for years, were unclear what was the purpose or intended benefit of the sessions as outlined below:

Interviewer: What do you think the purpose of the sessions was?

Parent: To make my life difficult? To be honest with you I really, I don't know, I, I'd say, we both come out of there. And we just think, what was the benefit? We've had no benefit, all this cost and time, because for [Child] it's a whole day out of school - for nothing.

Another parent highlighted their frustration at a service that was not providing emotional support for them or their child:

One of pointlessness, really. It baffles me. What the point of [Children's Gender Clinic) is because there was - we've never had any psychological support. There's never been a kind of counselling aspect centred around [Child's] emotional well-being. It was always a hoop jumping, box ticking, evidence gathering, prove yourself trans enough [P].

Some parents arrived at the gender clinic with expectations of support, and expectations of a trans-positive safe space to receive emotional support, and felt disappointed with the service on offer. This parent described their initial experience:

He was just incredibly dismissive and rude. I came out feeling very deflated. Because we were really excited. I don't know why, but we were. And we came out feeling really deflated. There was no support offered [P].

Another parent was visibly exhausted and depressed when asked about the benefits of attending years of parental sessions.

Interviewer: Did you gain anything from those sessions?

Parent: No. No. Nothing. Never have. Never have

In terms of the six parents who shared mixed feedback, three parents shared negative feedback on their experience of the system, alongside positive feedback on their clinicians as warm and kind individuals. Three parents described a neutral

experience at gender clinics, neither useful nor harmful, whilst describing their clinician as likeable.

> We endured - however much we like our clinicians, we endure the appointments, we're jumping through hoops, we're ticking boxes [P]. I mean, the therapists are lovely. And, you know, I really can't speak highly enough of them, but I'm not sure really what their role is … You know, it's a, it's an extra medicalization of it. Isn't it? [P].

In terms of positive feedback, two parents felt their experience at NHS gender clinics was positive. One parent described the process overall as having been helpful for them, providing a space for them to process their feelings.

> My experience of the Tavi (Gender Clinic) has been overwhelmingly positive - over the years that I've been going there, sometimes I would go my own to see [Clinician]. It was a chance for me to process and understand what was going on [P].

A parent who provided positive feedback on their clinician and their experience commented:

> It's very important to have a trans positive clinician. I think, how can you work with trans kids if you're not trans positive? I think you have to be to really, don't you? Well, I think you should be… I mean, if you're trying to help these children… I'm so relieved that we've got her because I've actually seen her fighting for trans rights outside of Tavistock. And that, that really proves to me that she cares [P].

Parents were aware of diverse experiences in children's gender clinics and were frustrated in a lack of consistency, and a lack of institutional commitment to trans

positive approaches. Supportive cis parents wanted to receive support and advice from trans positive clinicians who really understood the experiences that their family and their child was having.

Parents also expressed concern at the service failing to meet their needs. A number of parents expressed frustration or concern that they had not been told anything on the importance of family affirmation, or on the positive mental health of socially transitioned trans children who are supported at home. Parents described finding such evidence, including studies by Olson et al. (2016), through their own research, and were upset that gender clinicians had not shared or discussed this research with them, or helped educate and support them to affirm and advocate for their child. Parents also spoke at length at the many challenges they were facing across different spheres of their and their children's lives (issues discussed elsewhere in this thesis for example in sections 5.3, 6.2 and 7.2). Many of those interviewed wished gender clinic sessions could have been a positive experience for them, a source of practical advice, a safe space of trans positivity, and an emotional support to help them cope with transphobia and minority stress. Instead, the vast majority of parents in this sample described UK gender clinics as not meeting their needs, with many describing the sessions as actively distressing and harmful to their emotional well-being.

### 7.3.3 Discussion

This research gives an insight into the experiences of supportive parents of trans children in pre-pubertal children's gender services in the UK. Parents reported frustration, distress or disappointment stemming from encounters with trans-

negativity; feeling judged, under-supported and under a microscope. Many parents

found extended questioning intrusive and invasive, and did not understand why

clinicians felt they had a right to delve into all aspects of a family's history, simply

because they had a trans child. For many supportive parents, clinician

discouragement or even rebukes for supporting their trans child, added difficulties to

an already stressful time. Parents found clinician trans-negativity and

discouragement made them question their own support for their child. Supportive

parents worried that interactions with trans-negative clinicians could reinforce and

legitimise transphobic approaches in unsupportive households, and worried for the

wellbeing of trans children in trans-hostile households. Parents questioned the

purpose of extended family sessions, querying if the service was fit for purpose in a

modern healthcare system.

A cross-cutting issue that is not directly explored in this section is the power

imbalance between UK paediatric gender clinics and parents of trans children. Many

parents within this sample spoke of the potential consequences of disengagement

from the gender service, mentioning a wide range of potential repercussions for a

trans child and their family, including potential social services involvement, potential

problems with schools and GPs, denial of access to healthcare at puberty, and even

potential custody issues for children in separated families. Parents felt compelled

and coerced into continuing with assessments and clinical sessions that they disliked

or found upsetting, due to the unbalanced power dynamics inherent to the system.

The imposition of hierarchies of dominance upon families with trans children can be

understood as evidence of cis-supremacy in action, as discussed further in chapter

8.

This research also highlighted gaps in service provision for parents, with parents criticising a lack of emotional support, trans-positive education, or practical advice on dealing with minority stress, transphobia or cisnormativity. The research highlights that resources and services instead appear to be embedded in pathologising, outdated and unevidenced psycho-analysis and problematisation of gender diversity. These findings should prompt further scrutiny on the effectiveness of NHS healthcare for trans children and their families, with GIDS in England and Wales recently assessed as "inadequate" by the NHS's Care Quality Commission (2021). This research takes place at a time of growing global support for affirmative approaches that celebrate rather than problematise gender diversity (AusPATH, 2021). In 2019 the World Health Organisation took gender diversity out of classification as a mental health disorder in the eleventh version of the International Classification of Diseases (ICD-11), with implications for the ways in which trans healthcare is delivered globally (World Health Organisation, 2021). NHS trans healthcare services will also need to align with the upcoming World Professional Association for Trans Health Standards of Care Version 8 (WPATH SOC8), the latest global trans healthcare guidance, which will likely, as with AusPATH, highlight the growing evidence base supporting the benefits of affirmative approaches, including for trans children (AusPATH, 2021). These global shifts towards affirmative care, alongside growing evidence of the harms of approaches that pathologise and problematise gender diversity, present a challenge for UK children's gender services.

## Implications for practice

Parents within this sample highlighted concerns, frustrations, and distress linked to their engagements with UK NHS Children's Services, with a majority reporting a

negative experience. Parents not only criticised the UK's service, but contrasted it with what they had heard or read about gender affirmative services in other countries, wanting UK services to provide evidence based, trans-positive, affirmative support for parents with trans children. A literature review of gender affirmative clinical and therapeutic approaches to with parents of trans children reveals six components that contrast to the parental experiences described in this research.

Parental education on gender diversity (also called gender literacy) is the first component prioritised by gender affirmative clinicians or counsellors, ensuring parents and carers understand the basics of gender identity and gender expression; providing parents with a broad range of diverse trans representation; enabling parents to move towards a trans-positive outlook (Coolhart, 2018; Ehrensaft, 2016; Riggs, 2019b; Tando, 2016). This component also includes education on cisnormativity and transphobia, and on the importance of cis parents reflecting on their own assumptions, biases, and prejudices, considering how to make their home a safe space for a trans child. Riggs (2019b, p. 19) describes how conversations about gender with parents (discussing their child's gender and the parent's own relationship to gender) "can be a useful way of identifying barriers to parents affirming their children". In contrast to the questioning parents experienced in the UK, this type of parental gender questioning has a clear aim; to build parental gender literacy, in order to help parents accept and affirm their child.

A second component supports parents to learn to listen to their child, and to have confidence to affirm their child and follow their child's lead (Coolhart, 2018; Ehrensaft, 2016). This includes educating parents on the protective impact of affirmation; sharing with parents current research on the importance of family support and the protective impact of social affirmation. Coolhart (2018) notes the

importance of highlighting to parents words and actions that qualify as rejecting behaviour, explaining the negative impact this has on a child's long-term wellbeing. Where one or more parents are not learning or adapting towards trans-positivity and affirmation, this element could shift towards protection of trans children. Where parents are divided, unsupportive, or causing harm, clinician responsibility could shift towards child safety, prioritising actions to reduce "threats to the child's healthy attachments, social and emotional stability and gender health" (McLaughlin & Sharp, 2018, p. 157). This component stands in stark contrast to parent experiences in the UK, where parents criticise the NHS service for failing to provide this support and education.

A third component supports parents to process their own emotions about their child's identity (Riggs, 2019b; Tando, 2016). Coolhart (2018) emphasises that clinicians have to find ways to support and validate parents' emotional processes, without those emotions negatively impacting on their child. Riggs (2019b) emphasises the role that cisgenderism plays in parental emotions of loss, and the importance of shifting the locus of such emotions from being related to the child, to being a product of ingrained cisgenderism. Heightened emotional responses to a child's transition (like loss or grief) are rooted in societies, and parental worldviews, without trans possibilities; accepting a trans child therefore forces a fundamental shift of long-held assumptions and expectations (Coolhart et al., 2017). Tando (2016) distinguishes between a child's alignment (when a child is affirmed in their identity) and a cis parent's experience, that she describes as more of a transition. Particularly for younger trans children, a social transition can be simple and positive, a break from rejection, rather than a change in lived identity; whereas for cis parents a child's transition can be a more substantial shift. She argues that "parents are the ones who

have to fully transition, from an idea they have about who their child is, to something different" (Tando, 2016, p. 99). Clinicians and counsellors can provide a safe space for parents to process their emotions, whilst protecting trans children from shouldering that burden, ensuring homes are safe and trans-positive.  UK research showed mixed experiences on this component. The minority of parents who reported a positive experience in NHS children's gender services highlighted the support they had received to help them process their own emotions.

The fourth component supports parents to manage their own experiences of minority stress, helping parents cope with the isolation, criticism and abuse that many supportive parents of younger trans children encounter (Coolhart, 2018; Malpas et al., 2018; Tando, 2016). The fifth component includes the provision of practical advice and support to help parents navigate the challenges of supporting a younger trans child (Coolhart, 2018; McLaughlin & Sharp, 2018; Tando, 2016). This can include advice on engaging with schools, with co-parents, with siblings and extended family. It can include advice on how to talk with trans children about topics like disclosure, puberty, dysphoria or dealing with transphobia. The sixth component includes education, advice and support on how to stand up for trans children's rights, with advice on legal protections, and advice on how to safely challenge discriminatory practices (Horton, 2021a; Riggs, 2019b). Riggs (2019b, p. 100) talks of increasingly encountering parents who do not require advice or support to embrace and affirm their trans child, instead they ask for "help to advocate for their children, and …ways to … challenge cisgenderism". These final three components of affirmative support for parents of trans children were not found to be offered within the NHS service. The parents within this sample instead relied on peer support from other supportive parents of trans children, accessed through parent support groups

and networks. A number of parents expressed frustration and regret that these

important supports were not prioritised within the UK service.

These six areas of intervention (summarised in table 14 below) are referenced

across a wide range of guidance documents for affirmative therapeutic practice with

parents of trans children. These six areas can be vital for ensuring parents and

carers of younger trans children are equipped to safeguard their children's emotional

wellbeing, helping parents provide a safe and affirming home for all trans children.

**Table 14: Research driven areas for parental support**

| Areas of intervention to support parents/carers of trans children |
|---|
| o  Parental education on gender diversity |
| o  Supporting parents to listen to & affirm their child |
| o  Helping parents process their own emotions |
| o  Helping parents to manage their own experiences of minority stress |
| o  Practical advice and guidance |
| o  Education on how to stand up for trans children's rights |

## 7.3.4 Conclusion

The findings discussed above demonstrate an ongoing impact of pathologisation and

trans-negativity on supportive parent's experiences in UK children's gender clinics.

Parents shared multiple examples where they perceived gender diversity to be

problematised, where they felt judged and scrutinised rather than supported, or

where they felt clinicians discouraged supporting their trans child. These experiences

demonstrate ongoing cis-supremacy in institutions dominated by cis perspectives

and priorities and in the problematisation of trans childhood. This research takes

place at a time of growing societal trans-positivity, with medical bodies recognising trans lives as a valued part of human diversity, to be celebrated and supported (Telfer et al., 2018).

In a world and healthcare system where gender diversity is no longer considered a problem or a pathology (as was discussed in section 7.2), this element of the research raises questions on the purpose, harms and benefits of UK children's gender services' engagements with parents of pre-pubertal trans children. I highlight concerns about the degree to which the service has adapted or reformed since ICD-11 to depathologise healthcare for trans children and their families (World Health Organisation, 2021). I emphasise the road still to travel and the need to acknowledge and proactively address the legacy of decades of problematisation of gender diversity that continue to be embedded in children's gender clinic systems, attitudes and approaches. Those responsible for children's gender services, and those reviewing trans healthcare in the UK, could learn from the experiences of pathologisation and problematisation of gender diversity shared by parents who are recent and current service users, understanding the multiple negative impacts on the lives of those interviewed. NHS children's gender services need to review their aims, approaches and assumptions, to actively challenge a legacy of pathologisation of diversity, and to better meet the needs of trans children and their families.

## 7.4 Children's Experiences in UK Children's Gender Clinics

This section informs the published article:

Horton, C. (2022). ["Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away": Trans Children's Experiences with UK Gender Clinics](). *Bulletin of Applied Transgender Studies*. 1(1-2):47-70

### 7.4.1 Research aim

Section 7.4 focuses on children's experiences in UK Children's Gender Clinics. Whilst section 7.3 centres parental experiences, this piece of research centres trans children's experiences. This research fills an important research gap, bringing child voices to a body of literature that is dominated by clinician perspective, wherein the voices and experiences of trans children are rarely heard. This section addressed one topic specific research question: 1) What are children's experiences in UK Children's Gender Clinics?

### 7.4.2 Findings

Three major themes are presented i) Inappropriate assessment of gender ii) Trans children under pressure iii) Distress and trauma in UK gender clinics.

**Inappropriate assessment of gender**

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

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

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

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

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

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

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

As trans children in this cohort became slightly older, but still before the age of puberty, clinicians increasingly focused on a child's sexual orientation. Parents in this sample were surprised to see clinicians questioning pre-pubertal trans children on sexual orientation, for example one parent stated:

But yeah, I mean, the obsession with sexuality is bizarre [P].

One parent considered conflation of gender identity with sexual orientation as misplaced:

(Clinicians have said) you have to wait until you're a teenager til you know who you're sexually attracted to before you can decide who you are. And like, I've called that out as bullshit [P].

Other parents questioned the appropriateness of expecting pre-pubertal children to identify or articulate their sexual orientation, a task not demanded of cis children, nor indeed of cis adults, as articulated by this parent:

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

### *Problematisation of gender diversity*

A second sub-theme considers problematization of gender diversity in children's engagements with Gender Services. The children in this cohort, socially transitioned

and supported at home, engaged in assessments that stretched over many years. One child described gender clinic sessions as:

Awkward and boring [C].

An 11-year-old who had been socially affirmed for many years, described it thus:

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

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

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

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

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

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

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

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

> I'm pretty sure everybody working there is a cisgender heterosexual person. Which is surprisingly normal for clinics that care for not cisgender not heterosexual people. Which is kind of really scary [C].

Another child felt adult clinicians were unenlightened and unqualified to understand or give advice to them:

> I think my friends are better than counsellors - yeah, they'd probably understand [C].

Trans children questioned the assumption that clinicians they regarded as cis and straight would be at all qualified to talk to trans children about gender or identity or about the challenges of being trans in a cis-dominant world.

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

## Trans children under pressure

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

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

The first sub-theme considers experiences of trans children placed under pressure, required to defend or justify their identity or interests. One parent shared an example, describing a gender clinic session with a then 7-year-old trans boy, a child

who had asserted himself as a boy from a very young age, who at that time had been socially transitioned and affirmed as a boy for a year.

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

The clinician undertook this in a room away from his parents, and they only learnt about it afterwards, when their son reported it back to them. The parent felt this approach was inappropriate for their child on a number of levels. For one, they felt it conveyed a clear message to their son that the clinician considered him to be a girl; there was no parallel discussion on the diverse ways in which boys can express themselves. The parent felt this invalidation from an authority figure was potentially harmful for their child. Secondly, the parent reported that their gentle child, who was uninterested in strength, found the clinician's focus on strength or athleticism bewildering. The parent also perceived in the encounter an unspoken assumption; that a strong six or seven-year-old girl might find it easier to identify as a trans boy than a sporty girl. The parent felt this assumption displayed no understanding of the immense cisnormative and transphobic pressures on a young child, including often from parents, not to assert a trans identity. Overall, the encounter created a breakdown in trust, raising serious concerns amongst the parents, who thereafter refused to let the clinician see their son alone. The parent speculated that this clinician's approach could have a far greater negative impact on any trans children

who were vulnerable, especially those facing rejection and dismissal from their family.

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

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

This parental experience raises an important point – trans children face clinician directed scrutiny of their interests or hobbies in a manner that would not be accepted for cis children. Trans children were expected to perform gender, or to defend their gender, to an unknown and unmeetable standard. Another parent noted their daughter being challenged on her clothing choices:

> (They'd challenge her) if she was wearing jeans, despite the fact she was sat next to her cis mother, in jeans [P].

### *Proving yourself trans*

A second sub-theme relates to trans children being required to 'prove themselves' trans. A majority of parents spoke about this theme as exemplified by this parent:

> It's always about to kind of prove that she's really trans [P].

Another parent contrasted a 'prove yourself' approach with the provision of emotional support:

> Tavi (Tavistock Gender Clinic) aren't offering emotional support, because actually, that doesn't seem to be what their remit is. They seem to be about picking you apart and making sure that you prove yourself trans enough [P].

Parents raised concern that a process centred primarily on assessing their child's identity was not beneficial to their child's wellbeing:

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

Another parent described the identity assessment as debilitating for their child:

> This combative prove yourself trans enough approach…it's intensely debilitating to go through their process [P].

Parents knew their child was being assessed on their transitude (Ashley 2018), and felt that any area of deviation from a stereotyped narrative of their affirmed gender, or any deviation from a stereotyped trans narrative, would be counted against them. A number of clinicians had expressed opinions that trans children who were friends with children of all genders, who enjoyed toys or activities that are enjoyed by a range of genders, or who did not dress in a stereotyped manner, were not likely to be 'really' trans.

Several trans children and parents also raised concern that clinicians expected a stereotyped narrative about gender dysphoria. One child commented:

> Because I don't have enough dysphoria, because I don't act trans, or because whatever reason, they think is valid to invalidate someone [C].

A number of clinicians challenged children on the legitimacy of their gender dysphoria, arguing that non-typical accounts of dysphoria would make them ineligible for future medical interventions. Clinicians challenged children if their dysphoria manifested in individualised ways; delegitimizing their experience if their dysphoria related to social dysphoria; or if their dysphoria related to future secondary sexual characteristics more than dysphoria with primary sexual characteristics.

### *Enforced questioning*

One parent referenced an expectation that their child would answer any and all questions put to them:

> I think he would say that he feels that he has to [P].

One parent expressed frustration at her child being expected to answer questions in a clinical context on topics that would not be expected of cis children:

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

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

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

A parent summarised the approach of returning to questions where a clinician was dissatisfied with a child's answer:

> It's like torture drip, drip, drip [P].

Parents pointed out that their cis children, and cis children in general, are not pushed so hard to answer (repeated) questions in such a clinical encounter.

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

A fourth sub-theme, was children being assessed to an unknown and unclear standard, by strangers with whom they did not have a trusted relationship. Several children found the experience of being expected to talk about sensitive and personal topics with adults who were complete strangers both invasive and emotionally exposing. In a large number of cases, clinicians changed frequently, due to the high staff turnover in UK children's gender clinics, and children were expected to open up

on demand to new clinicians who were complete strangers, who had not earned their trust. These sessions were likely to repeat ground that children had already faced questioning on from earlier clinicians. One child commented:

There were two people I was talking to, and they were both

strangers, I didn't know them… I don't really want to talk about being

trans to complete strangers [C].

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

There's additional stress with her being autistic. The expectation that

she should be able to talk very openly. I mean, for any young

person, to talk really openly to strangers about something as

intimate as their body and their gender identity… [P].

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

(Child would have their teddy) cuddling it, or sit on my lap, and she

(clinician) 'why you sitting on - you don't need to sit on your mum's

lap, go on get off your mum's lap, go sit on your own chair - you

don't need your teddy, put your teddy bear away and I just think, do

you know what, he's [Age], you're taking him to a really strange

place. And he's, you're asking him all these questions. And he's a

child. I think that's where the relationship that was supposed to have

been built didn't happen. Because it was very judgmental [P].

The topic of trust was raised by a number of interviewees, both parents and children, with children's trust in their clinicians decreasing over time. Children who disliked and distrusted their clinicians, were expected to continue engaging with the service, or face withdrawal of eligibility to access healthcare at puberty.

I have zero trust in Sandyford (Gender Clinic) whatsoever. And I

would say that to their faces [C].

I've said that really clearly to them, she doesn't trust you. You've lost

all her trust [P].

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

## Distress and trauma in UK gender clinics

The final theme in the dataset was trans children experiencing distress and trauma in pre-pubertal gender clinic assessments. A number of parents described their child finding sessions traumatic or upsetting. One parent referenced that repeated distress and trauma resulted in their child completely refusing to engage:

She was five and a half when we first went, I think between five and

a half and nine, we went six monthly…It was so traumatic…the last

few sessions [Child]'s refused to engage with them at all [P].

Parents described a pattern of distressing sessions:

We know coming out of it, probably one or both of us is going to

cry…something's going to be upsetting. Or something really stupid is

going to be said or asked of us [P].

Other parents used emphatic language to describe their child's dislike of the gender

clinic.

[Child] won't leave me. She hates being there [P].

We still unfortunately have got the same therapist now who [Child]

absolutely hates with a passion. ... She's very judgmental [P].

Parents referenced their child's need to recover emotionally after each session.

It always takes it out of her emotionally. She always goes very

quiet… It's very draining the appointments… They are a bit of an

endurance test. I can't say we ever look forward to them [P].

On the way home, we would rant about how awful it had been.

Because it was so unpleasant, and get it all out of our system. It's

quite a long drive, so it was sufficient time [P].

One child commented:

(After a gender clinic session) I used to feel neutral, now I feel worse

[C].

A parent described gender clinic sessions having a significant negative impact on their child.

> It was an emotional unpicking of who she was. It's never been therapeutic for her. It's always caused massive fallout - the build-up before and after appointments have been some of our most stressful periods [P].

A number of interviewees described children feeling compelled to answer questions they found uncomfortable or inappropriate. One child emphasised:

> (Sessions are upsetting) when we talk about genitals and bodies [C].

A number of parents emphasised the distress their children displayed when forced to talk about their bodies in ways that made them uncomfortable, with no clear rationale for putting children through such questioning. One parent, themselves experienced in working with vulnerable children, found their child being questioned on underwear inappropriate.

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

Other parents noted their child being asked intrusive and distressing questions about their body.

Which to them are, well, we've got to talk about your genitalia, we've
got to talk about do you touch them in the shower or not when you're
cleaning? [P].

A parent emphasised that trans children are routinely put through questioning that
would not be accepted outside of a gender clinic.

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

A majority of interviewees described incidents of trauma, distress and discomfort; yet
trans children were presented with few options to enable them to disengage from
harmful processes, distressing questioning or toxic individuals. Several parents
speculated on the harm embedded in a system that taught trans children to endure
poor or abusive treatment. One child summarised their experience of powerlessness
and intimidation:

Of course, I'm intimidated by them, they're terrifying. They have all
this power to control my life, who wouldn't be scared of that? [C].

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

### 7.4.3 Discussion

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

A cross cutting issue is the power dynamic between UK paediatric gender clinics and trans children. Trans children and families were forced to choose between accepting harmful prolonged assessments, assessments that spread across many years without end, or risking the uncertainties associated with disengagement from paediatric gender services. This power dynamic between gender clinicians and trans children places the aforementioned experiences of harm into a broader context of cis-dominance over trans children. This section provides

evidence of a number of dimensions of cis-supremacy: institutional dominance in organisations and systems lacking trans leadership or accountability, the problematization of trans childhood, systems that facilitate or encourage the control and coercion of trans children, and systems and processes built on the toleration of trans harm.

The above insights into UK pre-pubertal children's gender services reveals a system that is not centering the well-being of trans children. The service prioritises an extended assessment of trans children's identities, with a greater emphasis on assessing hobbies, expression or interests, than on listening to and affirming trans children's self-conception. Extended coercive assessments reduce trust between child and clinician, with clinicians appearing uninterested in supporting trans children in the areas where they might be struggling, such as dealing with cisnormativity or transphobia. The approaches highlighted above suggest a continued problematisation of childhood gender diversity – after all, cis children are not required to attend gender clinics to have their hobbies, interests or identities scrutinised. This continued problematisation of childhood gender diversity appears to run counter to recent global developments, in particular the de-pathologisation of gender diversity as endorsed by the World Health Organisation in ICD-11 (World Health Organisation 2018). The UK's pathologising approach also runs counter to a growing body of research on supporting trans children's wellbeing. Research emphasises the importance of family support (Katz-Wise et al. 2018; Simons et al. 2013; Travers, Bauer, and Pyne 2012), the protective value of use of affirmed name (Pollitt et al. 2019; Russell et al. 2018) and the importance of reducing gender minority stress (Tan et al., 2020; Tan et al., 2021; Veale et al., 2017; Watson & Veale, 2018). There is no evidence that extended identity assessment enhances

trans children's wellbeing, prompting questions on its place in modern, de-pathologised healthcare for trans children (Ashley, 2022b). The UK can draw lessons from health services across the globe who have committed to depathologisation of trans children, providing child-centred affirmative care for trans children of all ages (Pang et al., 2022a).

## Implications for Practice

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

For clinicians currently working within UK children's gender services, this research provides child and parental perspectives on the experience of attending pre-pubertal assessments. Ethical and child-centred clinicians can learn from these accounts and adjust their care accordingly. For those involved in governance, leadership and review of the UK's approach to paediatric care for trans children,

these accounts demonstrate the harms built into the status quo, and the critical need for reform. This research highlights the distance UK paediatric gender services need to travel to deliver modern, depathologised healthcare for trans children, as necessitated under ICD-11.

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

### 7.4.4 Conclusion

This research has provided important insights into recent and ongoing practices in children's gender clinics in the UK. Trans children and their parents shared examples of the harms, injustice and trauma imbedded in the current system. These children's and parental accounts (in combination with the accounts referenced in section 7.3) raise important questions on the purpose, benefits and harms of the current UK system. The current system prioritises extended clinical assessment and problematisation of childhood gender diversity, an approach that sits uneasily alongside recent global health commitments to de-pathologisation of gender diversity

(World Health Organisation 2018). As other health services across the globe build

upon existing commitments to child-centred affirmative care for trans children of all

ages, the UK risks being left further behind, with trans children bearing the cost.

## 7.5 Experiences of Puberty and Puberty Blockers

This section informs the published article:

Horton, C. (2022). Experiences of puberty and 'puberty blockers' – Insights from trans children, trans adolescents and their parents. *Journal of Adolescent Research*.

### 7.5.1 Research aim

Section 7.5 examines parents and trans children's experiences of puberty and puberty blockers, guided by the following topic specific research questions: 1) What are parents' experiences of navigating puberty, including experiences accessing or attempting to access puberty blockers, with a socially transitioned trans child? 2) What are trans children and adolescents' perspectives on navigating puberty, including experiences accessing or attempting to access puberty blockers? This adds significantly to a body of UK and global literature that rarely centres experienced-based insights or children's voices.

### 7.5.2 Findings

This study includes a focus on parents and children's experiences leading up to puberty, their experiences whilst trying to access, or deciding on puberty blockers, and, for a subset of the sample, it includes their experiences whilst being prescribed puberty blockers. Interviewee accounts of puberty and puberty related medical interventions are presented within three major themes. These relate to pre-pubertal anxiety, difficulties accessing blockers, and experiences of relief and frustration on blockers.

### Pre-pubertal anxiety

The first theme relates to pre-pubertal anxiety, with sub-themes on early childhood anxiety about puberty, and experiences managing pre-pubertal anxiety.

#### Early childhood anxiety about puberty.

Many parental interviewees recalled trans children talking about wanting to avoid secondary sex characteristics at a young age, before they were aware of the concept of puberty.

> When she was four, starting to say, obviously, she didn't know what puberty was. She never heard that word. But what she was saying was, 'I don't want to grow into a man', 'I don't want to have beard'. 'I don't want to have a deep voice'. So, she was kind of listing things that are changes of puberty, that she was aware of, just from watching the world around her. [P]

Parents reported that as their children started to understand more about puberty, it led to growing anxiety or fear.

> It's always the middle of the night, isn't it - it's always, they can't get to sleep, and they come and knock on the door, and you end up having this great big, long involved discussion at one o'clock in the morning. But it was things like, 'will I get a beard?', 'will I?', 'what's gonna happen to me?'. [P]

#### Heightened anxiety as adolescence approaches.

Several parents noticed their child's distress rising as they started to see other children around them, and particularly elder siblings, enter into puberty. One parent

noted her daughter's anxiety. "She's saying 'I'm not looking forward to puberty', because she's seeing her brother go through puberty, and seeing the changes that are happening to him……She said last night. 'I'm really worried about puberty'" [P]. Some parents found their child's response to the idea of imminent puberty concerning.

> So, like we got to a point where, when it was talking about puberty, my son was telling me, if he grows breasts, he will chop them off. And that was a big red flag for me, that he was already thinking in what I'd consider quite dangerous terms about himself and his body. And he would be desperately sad, and upset, if one of his friends, for example, started their periods very early…And one of the things that happened, he stopped eating at one point…And he lost lots of weight very quickly…And it turned out that, basically, he'd got it in his head that you grow boobs and hips by eating food. And if he didn't eat, he wouldn't grow boobs and hips… as soon as he realised it made no difference, he started eating again. [P]

Other parents reflected on extreme fear and distress at the prospect of pubertal changes.

> She's been quite clear in the past that, that developing sex (characteristics), you know, developing a deep voice, or developing facial hair, or anything like that, she's been quite clear that those things will make her life not worth living… And she's not, you know, she's not messing about, she's serious when she says things like that. I know she is. She's petrified of developing any of these things…One of the only sessions at [Gender Clinic] where they separated us was the session to talk about body parts - in the car driving

home after the session, [Child] said, you know, I was really clear, I can't bear this part of my body. I'm not bothered so much about my top half mum, I cannot bear my genitals, and I will cut them off if they start growing and developing… I can't have my body change. [P]

A number of parents could see the approach of adolescence being a source of significant stress, with children worried about when it might start. "[Child] has always thought about it, and always worried about what will happen and when it's coming in, and how fast it will happen, and things like that" [P]. A number of parents described the time leading up to, and in, early puberty as a time of great stress for their child.

Yeah, so you know, over the last sort of couple of years, - not every day, but on and off, has obviously commented on things changing in her body, and how that makes her feel, and the distress that it causes…the changes are quite unwelcomed. [P]

It's all very difficult because puberty has kicked in - it's all really emotionally fraught. We have lots and lots of tears, and conversations about… 'why can't I just be a normal girl?' and her peers are in puberty, and her friends are talking about periods. [P]

One trans child, interviewed at the cusp of puberty, described puberty having been in her thoughts as a constant worry for over a year. "I properly started worrying about it when I was 10…. I'm reminded of it every day" [C]. Early pubertal changes were experienced as traumatic for some adolescents.

[Child] was always really clear. I do not want my body to develop as a boy. So, [Child] was always really clear that she wanted something that would stop testosterone and stop puberty. And she had a bit of a wobble just before her

blocker started, because her voice started to deepen. And that freaked her out, because she thought, there will be some kind of permanent changes…She was so unhappy at the thought of it. As her voice started to deepen, she found that quite traumatising. [P]

### *Information on blockers providing reassurance for trans pre-adolescents.*

A majority of parents reported that their trans children, average age 11 (range 6-16), were aware of the existence of blockers. Most parents had discussed blockers with their child years in advance of puberty starting, with several parents emphasising their view that knowledge about the existence of puberty blockers was important for reducing their child's anxiety. "I think if you wait until your child is distressed, and then start talking about puberty blockers, you have unnecessarily caused them harm" [P]. Several parents described their pre-pubertal child as desperately wanting reassurance about ability to access blockers.

She's petrified that she's gonna get hairy, and get a deep voice like her dad… that's her worries. All she can think about when we go to [Gender Clinic], and have zoom meetings with them, is she wants the blockers. [P]

A number of parents felt a strong reassurance that blockers would be accessible, was vital for managing anxiety and well-being in the years leading up to puberty.

I think as long as she knows that her future is taken care of, and that we'd do anything to make sure that she never has a deep voice, and she never gets any facial hair, that she, you know, she's comfortable to be happy in her childhood now. It's almost like, essential, to lower her anxiety, and let her thrive in the here and now - that's why, it's like a promise I've made her, over

my dead body, you will have the treatment you need, and deserve, whatever. It seemed to be the only thing that really alleviated that anxiety of hers for the future. And let her, like, live fully, in the present. [P]

I think she presumes everything will just be sorted out for her, which it always has been. So yeah, she didn't really show any anxiety or worry, really. But if you said to her, do you want to go through a male puberty? She'd be very clearly no. There was never any doubting that, but she didn't seem to worry about it. [P]

Parents of trans children at the edge of adolescence emphasised the importance of reassurance about blocker availability, even though they were aware that accessing blockers might not be straightforward in the current UK context. Several parents spoke of being willing to go to whatever lengths necessary to access blockers for their child, as they felt they were so important for their well-being: "I would do whatever I could… it worries me that I might not be able to get them easily, but I'll do my best to get them" [P]. "If we can't persuade the NHS to do the right thing, then we'll be able to use [Private Service] and just pay. We're very fortunate to be in a position where we can find the money" [P]. Parents of trans children at the edge of adolescence, who were uncertain how they could access the blockers they felt were essential, spoke with heightened emotion:

Sorry I can't speak when I'm crying. It's so annoying. Just wait for it to pass... So, in my in my mind, blockers are a lifeline, an absolute lifeline. If everything goes wrong. You've got that to turn back to, the pause button, to stop, breathe. [P]

## Difficulties Accessing Blockers

The second major theme, on difficulties accessing blockers, is divided into two sub-themes, extensive assessments for blocker eligibility, and harmful delays.

*Extensive assessment for blocker eligibility.*

Several parents were clear that having access to puberty blockers or HRT was their main reason for engaging with the children's gender services.

> (The gender clinic) have always, kind of, been a means to an end to be honest. Because you know, it was all about relieving his distress. And the only way to do that was through the medication. I mean, what the point would be going at the moment with no hope of any medical intervention, I don't know. [P]

An adolescent described their experience of putting up with Gender Clinic appointments that they dislike, purely as a route to accessing affirmative medication.

> Interviewer: Do you like your visits to [Gender Service]?
>
> Child: No
>
> Interviewer: What do you like about [Gender Service]? What parts are helpful?
>
> Child: It will help me get medication
>
> Interviewer: Are any parts of visits to [Gender Service] difficult or upsetting for you?
>
> Child: When we talk about genitals and bodies
>
> Interviewer: What do you see as the purpose of your visits to [Gender Service]?
>
> Child: To get blockers and testosterone

Interviewer: How often would you like to see [Gender Service] clinicians?

Child: As little as possible

An adolescent was clear that their only reason for accessing gender services was to get access to puberty blockers, describing their experience of an assessment that they found drawn out and difficult.

At the time being, like 10, or 11, and stuff, I just wanted blockers. So that was like, the aim of me going there. And so, a lot of the sessions felt kind of just like jumping through hoops to get to one end goal, and it's kind of tricky, because it's - the whole thing is, like you have to prove that you're trans enough for blockers, or prove that you're, you know, that if you're sad, then it's because your gender identity isn't being expressed to how you want it to, and not for other reasons, or whatever. That's quite tricky. And I think, you know, when you're talking to kids about that, it's, I mean, it'd be hard for an adult to do, so as a kid… [C]

One parent found the assessment process for referral for blockers perplexing, with clinicians asking lots of vague questions around identity and general self-image, without asking specifically how their child felt about puberty.

But like, immediately after I was like, if you want to know how they feel about puberty, 'hey (to child), how do you feel about puberty'? And my child's response was, 'I would rather die'. And like, that was the only time I actually saw an emotional response from this guy. Like he, his eyes kind of went wide. And I was like, 'that is the information you need'. [P]

Some parents were concerned the assessment process was unnecessarily upsetting, particularly the expectations that their child would talk, in depth, about their feelings about their current body.

> He will get upset. He's asked to talk about how he feels about his body, which he doesn't like to do. So that upsets him. And I'm not sure. Maybe they know, because they're more qualified than me in this business, but I'm not sure what the point is of upsetting him by making him talk about these things, whether that's got an aim, or whether it's just tick boxing: 'Oh, yeah, he gets upset when we talk about his hips, so we can tick that box'. I don't know. [P]

A number of parents within this sample were upset at clinicians sharing fringe views on puberty blockers, particularly an unevidenced theory that trans children would change to a cis identity if denied puberty blockers, and forced through endogenous puberty.

> They have said high proportions still change their minds - desist. And, it's not true that many of them get really upset and self-harm and think about suicide. So that's a bit - because - I don't believe that's correct. [P]

> They are saying that there is a high possibility that if we allow him to go through his natal puberty, he may change his mind. [P]

Parents of adolescents who had accessed blockers described the assessment as being extraordinarily drawn out, with clinicians wanting to assess identity or dysphoria over many years before permitting referral for blockers.

> You're going up there for these blooming appointments, as I say, from the age of 9 to now 15, it's a heck of a long time. And that's when they said that, you know, there is blockers, but obviously we'd need to do an assessment, we'd

need to decide, you know, whether it is transgender or whether it's something else. [P]

Another parent of an adolescent who had been prescribed blockers, described the length of assessment before referral to endocrine services as frustrating "We have to wait years, and years, and years. This is - we've been six years in the system." [P]. Parents who knew how important puberty blockers were for their child, felt worried about a requirement for their child to express their distress to strangers in order to be eligible. "I just feel, sometimes with the (Gender Service), that there's this, they must be very distressed, and (only) then we will give them puberty blockers" [P]. Several parents were concerned about their child being required to display distress at physically observable secondary sexual characteristics before becoming eligible for puberty blockers.

> There seems to be this school of thought that they have to experience some pubertal changes, because then, they might realise they're just gay… that they'll suddenly go, 'Oh, I'm not a girl, I'm a gay boy'. And it's like, no - she's a girl and the distress is real, she does not need to, you know, physically go through, you know, proper changes…. With the puberty blockers, there's been a little bit of, 'well we need to hear from [Child], that she's really distressed and unhappy in her body and the changes' and it's like, so you, you want her to experience distress and unhappiness to prove? It's always about to kind of prove that she's really trans. [P]

Several parents felt clinicians wanted their child to express extreme distress with their primary sexual characteristics to be eligible for puberty blockers.

There's this undercurrent of having to prove that you're distressed about your body. And we've had conversations with [Child] about, you know, there are so many different ways to be trans. You don't have to have any surgery if you don't want to [P]

Parents described a suite of tests to measure pubertal stage, including physical examination, blood tests and hand scans. Several parents mentioned their child's nervousness before the physical examination.

We went to endocrinology, they do a physical assessment, which [Child] was nervous about. But she said it wasn't as bad as she thought afterwards. But - I don't know if I'm honest, I wasn't that impressed with the endocrinology consultant person we saw, just seemed a bit strange. And they kind of hold up these beads, is it called an orchidometer - compares the size of the testes to these wooden beads, it all seemed a bit weird if I'm honest. [P]

One adolescent described frustration at what they perceived to be cisnormative and trans-normative barriers to eligibility. "One of the workers told my friend that they did not have enough dysphoria to get blockers - which is absolute bullshit" [C].

### Harmful Delays.

Within the NHS, trans children are assessed by gender clinic psychologists first, who will only refer on to endocrine services once puberty has begun. Several parents described struggles to get gender service clinicians to believe that their child had started puberty.

I could see that [Child] had gone into puberty. This is when I was trying to push to get the referral to [Endocrinologist], every time I went, I kept saying

'they're growing they're growing' (referring to chest area), and [Child] was telling me that he'd been pushing on them at night, because he thought, if he did that, they wouldn't grow - and I was telling them all these things about the distress, and them not having showers, and he's starting to smell, and they were just 'no, he's only a slight little thing. No, I don't think so. I don't think he's at that stage at all. When we can see, then we'll think about' and I thought no, you're not listening to me, as a parent. I know. I can see. We're up here, what for an hour? He's got baggy clothes on, he's sitting like this (bent over), you're not going to be able to see that. [P]

The parent described having to push to get a referral.

And I had to really push to get them to refer us to [Endocrinologist]. The point I, I felt that I was, I was almost like giving them ammunition to think 'oh it's the bloody parent', because I kept push, push, pushing …and when we did eventually get the referral, and he was actually in the correct stage to have, well, more than the correct stage to have blockers. So, it - that peed me off, because I thought, actually, you know, we might have been able to catch this before any real breast tissue had potentially grown, because obviously, unfortunately, although he's on the blockers, there is still some there, you know, to try and alleviate, if he decides to go down that route, the need for any surgery. But to them, it was almost - I felt that the [Gender Service] was almost, like, no, 'let's wait, let's wait. [P]

Another parent described having to fight clinicians who refused to believe puberty had started, and by the time they got to endocrinology, their child was progressed in puberty.

[Gender Service] have always been really, really - bit too casual, really, and where we are now, I'm quite cross about it all… they've always been very like: 'Well, it takes years and it's no rush', and 'it all happens, takes years to happen', and 'the voice changes, they all come much later on' and all this sort of stuff. So, I'm annoyed now, that they've let us go too far, when we've had such a long journey on this path, … I really am worried that we've left this too late…I think we were expecting (Tanner stage) 2 to 3. So, when we heard 3 to 4, it was a shock… it was upsetting for me, because I just - I wasn't expecting that we were there yet… I still wish I could rewind 6 months and push it more. [P]

Several parents felt clinicians had no care for the consequences of delayed referral, and were not guided by the child's need. A number of parents felt delays were damaging. "I know that during those early Tanner stages, pubertal changes are slow. But it's easy to say that, as an adult looking back - for the young person in it, every day feels unbearable" [P]. Many parents spoke about the delays that seemed built into the system, with any area in which a child failed to perform to clinician expectations, leading to further delays to access.

[Gender Service] insist on having these three appointments, where you talk about blockers and the consequences, talk about fertility, real kind of heavy stuff. I understand that they have to be sure that that young person understands what it is, so that they can give consent, I do get that. But it just dragged out. And I think because of Covid. And because it was on zoom, it didn't help us - sometimes the meetings were 9 o'clock, and [Child] would have to be dragged out of bed, and she'd be in a foul mood. And she didn't want to talk… dragging her out of bed and sitting there. One time she just

refused to talk. They had to have these three sessions, and we had to

rearrange one because [Child] wouldn't talk. [P]

Several parents with neurodiverse trans children felt the process was particularly

drawn out.

I would say probably about 2, 2.5 years, something like that (trying to get

approval for blockers) …Sometimes there's a bit of a bit of disjointedness

when it comes to - especially for somebody like [Child], who is on the

spectrum, talking to, essentially, strangers, you know, people at [Endocrine

Service], [Gender Service] and truly expressing how she feels… I would say,

yeah, 2.5 years there has been that discussion of, this is something that I

would like. But it is a long process, isn't it? [P]

A trans adolescent considered hurdles and delays to accessing blockers to be an act

of cis-dominance over trans youth, tracing a direct link between barriers to accessing

blockers and wider anti-trans rights issues. We should be able to consent to blockers

because it is a human right. And trans folks, as of late, have had a lot of their rights revoked,

and rolled back...” [C]. Another adolescent emphasised the urgency of getting access

to puberty blockers. You need to get hormone blockers, like, quickly…you know, it's like,

it's urgent, you can't wait for another 2, 3 years or whatever” [C].


### Experiences of relief and frustration on blockers

The final major theme considered experiences on blockers, focusing on the

experiences of the sub-set of interviewees who were, or whose children were,

currently on blockers. Out of the 30 trans children whose parent was interviewed,

seven were currently on puberty blockers at time of parental interview. Out of the 10

trans children who were interviewed, four were on blockers at time of child interview. All of the adolescents currently on puberty blockers, started on puberty blockers at age 11 or 12 years old. Sub-themes relate to the relief of having puberty blocked, as well as perspectives on the consequences of inflexible protocols for HRT.

### *Relief of having puberty blocked.*

One parent described feeling thankful that their child had been able to access blockers in early adolescence. "And so, by the time he was I think by the time he was about 12, he was receiving hormone blockers. And I was so grateful and thankful that we've been able to do that for him" [P]. An adolescent described the importance of blockers for them.

> I'm very grateful that I managed to get on blockers, at the kind of age that I did. Because it means… it means basically, I haven't kind of gone through female puberty, like, very much at all. So, I'm very grateful for that. [C]

One parent described their child feeling relief each time they receive their blocker injection.

> He's coming up for his fourth blocker now. So, he was 11 for his first one. And so, [Child] has one blocker injection every 6 months. And it's got a bit of localised pain in the injection site for a couple of days. After that, he's relieved, he's so relieved. [P]

Another parent noted the blocker reducing their child's stress, reducing emotional lability. "Well, the meltdowns stopped along with the hormone blocker, which he accessed at a young age, so that helped a lot" [P]. Another parent reflected upon how the impact of puberty blockers on her child differed from what they had expected.

So, I thought he was happy. So, I just thought we were just protecting his happiness. I thought we were preventing him decreasing in confidence and happiness. What actually happened was - well, it turns out, he wasn't as happy as I thought. Because his happiness and his confidence grew once he started on blockers. Like, he was anxious about having the injection. And then after he'd had that first injection, it was like something had been lifted away…. The year before he started blockers, I would say, every other week, we would end up having a conversation about puberty, it was a constant topic of conversation for him. And it was a constant worry for him. And all of that stopped. We didn't talk about puberty anymore. He didn't ask me anything. He wasn't anxious about anything. He was just chilled. And he could just get on with being him. [P]

An adolescent described starting blockers as anti-climactic.

Before I had hormone blockers ever, I was like, starting to wear a binder. So, I'd already kind of had like, a bit of chest development and stuff. And at the time, it's, it's strange, because, like, for so long, I was like, oh, yeah, I want to be on hormone blockers. And then, it's almost a bit anticlimactic. Because when you get on hormone blockers, it's like, the whole point is that everything like pauses, so it's kind of like, nothing changes. But I was - I definitely knew at the time, what would happen if I wasn't going to go on hormone blockers - or what the future would look like if I was not going to go on hormone blockers. So, at the time, I was very, like, you know, like, as quick as I can have them would be the best. So, I yeah, I felt that urgency, I mean, I think I would have been about 11 ish, when I went on blockers. [C]

The same adolescent emphasised what they saw as the purpose of blockers.

Like the positive of blockers isn't necessarily what the blockers do, it's more like the kind of lack of negatives that comes with them…. I was living as a boy or I'd fully transitioned before the time that I was on blockers. So, I guess, in my head, I was, you know, quite content with how I was presenting. So, blockers, in my mind gave me time, just to kind of coast by until I was old enough to get on T. That was kind of what I viewed blockers as. I think I was quite steady, kind of before and during in terms of like, what my, I felt like my gender kind of identity was. So yeah, I don't feel that it necessarily bought time for me in that way. More in like a kind of just the medical way. [C]

One parent reflected upon the different areas of their child's life that access to blockers had impacted on.

Without them, I think [Child] would totally have recoiled and shrunk - you know, like (pre-blockers), that kind of literal, physical shrinking-ness of wanting to disappear, not wanting to be seen. And the difference that is afforded to [Child] by 'passing', which is, you know, the blocker is a massive part of that, and therefore, able to, you know, take part in sport - to be able to use their voice, not be not be concerned about speaking – those basics of your fundamental human rights, of participating in your life in the way that you choose. The blocker enables so many of those things, and I don't think anybody who's outside of, you know, fighting for a trans kid or invested in this in whatever way, really considers how those things are so life changing. [P]

Another parent reflected upon the impact that they had noticed in their child once on blockers.

I think her confidence has grown. Her, you know, being on a clinical pathway, and blockers, is a massive part of that. Because that has taken a pressure off

her and a worry. That has definitely helped with her resilience and her

confidence. [P]


### Consequences of inflexible protocols for HRT.

A few families spoke of their experience of inflexible protocols relating to HRT

(exogenous oestrogen or testosterone) causing harm. In some cases, particularly for

adolescents in later puberty, blockers without any sex hormone are known to cause

side-effects (Chew et al., 2018).  One parent described the side-effects their child

experienced. "[Child] was really struggling with side effects from the blocker… their

hot flushes were like, they were awful. And, and their mood was quite flat" [P]. The

family were advised by their endocrinologist, that addition of a low-dose sex

hormone was needed to alleviate symptoms, but were informed that they could (due

to restrictive protocols) only offer oestrogen, and not testosterone, to a trans boy.

The boy in question, wanted the added hormone to be testosterone, and not the

hormone that had just been blocked, oestrogen. The parent described how the

endocrinologist refused to meet their need, giving the adolescent the options of

either coping with untreated side-effects, or taking the sex hormone he was taking

blockers to avoid. Adherence to inflexible protocols, led to an impasse, as the parent

elaborated.

> We went round and round in circles until [Endocrinologist] literally stamped his
>
> foot and was like, we're not having this discussion anymore - this is your
>
> choice, you either have the (oestrogen) patch, or the (oestrogen) pill. That's
>
> your choice. And [Child] was like, 'it's not going to happen. You can prescribe
>
> it, but I'm not going to take it'. And so, it felt like we were at loggerheads. [P]

The parent spoke about finding an NHS General Practitioner (GP) who did listen to their child's needs, who was willing to provide the healthcare they needed.

> I booked an appointment with the GP and I basically sat and poured my heart out of like, I think [Child] needs some hormone, you know, they're sat there, they've got all of these symptoms, which all seem to suggest that their body is crying out for some hormone, [gender service endocrinologist] has said that the only hormone they can give him is the one that he actually desperately doesn't want, the one that's gonna really distress him. So why can't we give him a little bit of testosterone? - if we can just start giving a bit, so that his body is not basically in withdrawal? And the GP went, 'I think you're right', like, 'this makes sense'. [P]

Several parents described the drawbacks of an inflexible one-size fits all approach that doesn't allow HRT until 16. One parent described their frustration at what they saw as NHS inflexibility, looking outside of the NHS for individualised and child-centred care.

> What I find difficult is obviously with (gender service), you've got to be 16 to get hormones. But I think when you've got a child who's been this clear cut as our daughter has, and all her friends are now wearing bras and developing, and the thought of having to wait till 16 for hormones is not good. And obviously, (private service) are much more open about prescribing that at the right time for the young person. So, we might look at that. [P]

Another parent described the extended delay before eligibility for HRT having social and emotional impacts on their child, contrasting the UK's rigid protocols with approaches they were aware of in other countries.

(He should have had HRT and started puberty at age) 13, 14 you know, with his peer group, so he's not left out all the time. It just feels like it's delayed. I feel like he's, you know, quite immature. Sensible, but kind of childlike in his likes, kind of films he watches, kind of TV that he likes, that kind of thing...It would have had an impact if he could have had it with his peers, when his peers were getting it. I mean, they do that in other countries. [P]

A trans adolescent who had been on a blocker for 5 years, but who was still waiting to be prescribed HRT commented "Testosterone should start at 14 or 15 and there shouldn't be a court date for it to be prescribed" [C]. Another adolescent, who had started Testosterone (accessed privately) after over 3 years on a blocker, shared his thoughts on the timing of initiation of HRT.

I think so I started T when I was 15, maybe 14. And there's definitely a point, kind of just before I got on T that, like, when you look at the boys around you, you're kind of, like, oh. There's definitely, a difference in terms of like voice or whatever. So, you know, I think if I'd gone on T when I was 16. I mean, I'm 16 now, and like, I think if I was still on blockers all that time and up until now. Like seeing the people around me, I think I would have been a lot more self-conscious than if I hadn't started T a while ago. I mean, ideally in my head, I probably would have started T a bit earlier just because of the side effects of kind of being on the blockers for so long. But yeah, other than that - I think I was quite lucky with the age that I managed to get on T. [C]

### 7.5.3 Discussion

The first major theme in this dataset, presented parent and child perceptions on pre-pubertal anxiety. A majority of parents in this sample described noticing their child's anxiety about puberty at a young age, even before children knew the word puberty. It is important to note here that this sample only included trans children who socially transitioned under age 11, excluding trans children who came to understand or disclose their identity at an older age. Parents in this sample described children's anxiety levels increasing as they got older, and particularly as they saw older siblings or peers progress through puberty. Several parents reported their child exhibiting acute distress, with parents realising that endogenous puberty would be intolerable for them. Parents in this sample were aware of their child's anxiety about puberty, though wider research has shown parents are likely to underestimate their trans adolescent's level of anxiety (McGuire et al., 2021). As puberty approached, many parents in this sample described their trans child bringing up the topic regularly, with the parent perceiving it as a chronic source of anxiety. A prepubescent trans girl highlighted worrying about puberty every single day. These research findings highlight the importance of managing anxiety in pre-pubertal trans children. Many parents in this sample discussed the existence of puberty blockers with their child, as a way of reducing anxiety. Several parents felt strongly that categorical reassurance of the option of puberty blockers was critical for reducing anxiety and allowing their child to "thrive in the here and now". This finding complements existing research showing trans children and adolescents have heightened levels of anxiety, when compared to cis peers (Lopez et al., 2018). It also reinforces research on how the use of puberty blockers reduces anxiety, enabling trans adolescents to learn and concentrate on other aspects of their lives (de Vries et al., 2014).

Whilst parents in this sample wanted to be able to reassure their children about the option of avoiding endogenous puberty, the parents were all clear that guaranteed access, as needed, to timely puberty blockers, was not feasible within the NHS. Only by looking to potential non-NHS options were parents able to guarantee their child they would not proceed through endogenous puberty. A number of parents, who could not look outside of the NHS, felt unable to reassure their child that blockers were definitely an option. Several parents in this situation wished they could provide their pre-pubertal trans child with this reassurance, and felt this would have helped with pre-pubertal well-being. These findings align with research from other countries like the US on family stress and fear over inaccessible healthcare, particularly where trans adolescent healthcare has become politicised, rather than based on individual need (Abreu et al., 2021).

The second major theme examined difficulties accessing blockers, with sub-themes on extensive assessments, and harmful delays. A majority of parents and several children described access to puberty blockers as their primary reason for engaging with NHS paediatric gender services, attending Gender Service appointments throughout childhood, purely to ensure timely access to blockers at the start of puberty. For these children and families, drawn out assessments were a hurdle to accessing essential medication. One adolescent interviewed within this study spoke of barriers to trans adolescent healthcare as a violation of human rights, an act of cis-dominance over trans youth's lives. This can be understood as an example of cis-supremacy in cis-dominant institutions that fail to safeguard trans rights, where trans children experience control and coercion, with harms to trans children tolerated or even expected.

In terms of the assessments required for referral for puberty blockers, parents

reported children being distressed at being expected to talk in depth, repeatedly, about their feelings about their current body, over many months or years. A number of parental interviewees questioned why trans children needed to be distressed about their current body, and why the assessment could not simply focus on a child's feelings about endogenous puberty, the factor parents felt was key in determining need for blockers. Parents also questioned why children needed to tell clinicians in depth how distressing puberty would be for them, why they could not receive healthcare without needing to demonstrate their distress to cis psychologists. One adolescent commented on the power dynamic of a cis clinician judging whether a trans adolescent is sufficiently dysphoric to access puberty blockers. Cis stakeholders holding power over trans lives, requiring trans children to prove their dysphoria to access healthcare, can be understood as cis-supremacy in action, as discussed further in chapter 8. These findings also resonate with work criticising excessive assessment of trans children (Ashley, 2019c), and with research on structural transphobia within healthcare, and its negative impacts on trans communities, and particularly trans adolescents (Hollinsaid et al., 2021; Price et al., 2021).

A number of parents shared examples of their knowledge, or their child's knowledge, about their child's stage of puberty, being dismissed by gender service clinicians. Several parents commented on what they felt were excessive barriers to getting clinicians to recognise the reality that puberty had started. Many parents spoke of psychologists wanting to themselves observe obvious pubertal changes, before referring to endocrinologists, with endocrinologists wanting to further confirm through physical examination and a suite of other tests. These accounts present evidence of testimonial injustice. Testimonial injustice occurs when a person's

account is disbelieved or distrusted, with their credibility undermined by some form of prejudice (Fricker & Jenkins, 2017). A body of literature outlines trans adults' experiences of testimonial injustice when accessing healthcare (Fricker & Jenkins, 2017; Pearce, 2018; Serano, 2016; Vincent, 2020). Other literature outlines testimonial injustice experienced by children and their carers within healthcare settings (Carel & Györffy, 2014). This existing literature reinforces trans children's vulnerability, as members of two groups, known to experience testimonial injustice.

Parents also discussed experiences of delays to accessing timely treatment, and the harms of delay. Many parents perceived delays as having contributed to high levels of short or medium-term stress for their child during the period of delay, as well as having longer-term physical and emotional consequences for adolescents who unwillingly progressed through stages of endogenous puberty. Several parents expressed frustration and felt badly let down when their child had not been able to access timely puberty blockers, despite engaging with the Gender Service for many years before puberty. Other parents talked about ableism, highlighting how demanding the expectations were for neurodiverse children, particularly children who did not readily communicate their emotions to strangers. Several parents of neurodiverse children felt their child had faced additional delays to accessing puberty blockers, in a process that was not flexible or child-centred.

The final major theme explores, for the subset of the sample who had accessed, or whose children had accessed, blockers. A majority of parents whose children had accessed blockers, spoke about immense relief once puberty was stopped. Others described blockers as anti-climactic, focusing instead on the frustration of delayed access to HRT. Parents and adolescents on blockers reflected upon the impacts of arbitrary age-based barriers to gender-concordant HRT,

referencing the social, emotional and also physical consequences of inflexible protocols. These accounts from adolescents and parents align with the perspectives of a number of clinicians from health services in other countries like US and Australia, who have written on the potential harms of inflexible protocols, that inhibit options for gender-congruent peer-concordant puberty (Rosenthal, 2021).

### 7.5.4 Conclusion

This research provides insights into puberty, from families where trans children socially transitioned in pre-adolescence. It emphasises the value of reassurance of blocker availability for reducing pre-adolescent anxiety, with relevance for parents and carers of pre-adolescent trans children, and for wider professionals concerned for trans children's well-being. The research highlights the harms in extensive assessment or barriers to eligibility for puberty blockers, demonstrating that services need to place greater emphasis on safeguarding adolescent well-being, centring the rights of trans adolescents to de-pathologised healthcare. The research reinforces the critical importance of puberty blockers in preventing the development of incongruous secondary sexual characteristics, and protecting adolescent mental health and self-confidence. It also demonstrates the harms and consequences of restrictive age-based protocols for HRT, evidencing the needs for individualised healthcare. These findings have relevance for healthcare workers supporting trans children and adolescents; for healthcare policymakers; for families with trans children; and for those supporting trans adolescents' right to healthcare.

## 7.6 Parental Decision Making on Puberty Blockers

This section informs the published article:

Horton, C. (2022). <u>"I didn't want him to disappear" Parental decision-making on access to puberty blockers for trans early adolescents</u>. *Journal of Early Adolescence*.

### 7.6.1 Research aim

Section 7.6 addresses an identified knowledge gap, examining parental perspectives and experiences navigating decision making relating to puberty blockers. This section explored the following topic specific research questions: 1) How do parents of trans children feel about puberty blockers? 2) How do they navigate decisions of providing parental consent? 3) How do parents weigh up and reflect upon the risks and benefits of puberty blockers for trans early adolescents? Whilst section 7.5 examines experiences related to applying for or accessing puberty blockers, section 7.6 zones in on the parental decision-making process.

### 7.6.2 Findings

Findings related to parental decision making are presented in three main themes 1) protecting mental health and well-being, 2) parental perspectives on consent, and 3) decision-making without certainty. Each major theme is divided into two or three sub-themes, each illustrated with parental quotations.

**Protecting Mental Health and Well-being**

Interviewees reflected on the purpose of puberty blockers, with all parents mentioning that the immediate aim of blockers was to avoid development of

secondary sex characteristics. However, the purposes parents spoke most about were the indirect impacts of puberty blockers. Two prominent indirect aims comprise the two sub-themes presented here: 1) protection of short and long-term mental health, and 2) enabling adolescent well-being and quality of life. For the purposes of this analysis a distinction is drawn between mental health, here focusing on clinically diagnosable levels of mental distress including depression, self-harm or suicidal ideation; and well-being or quality of life which herein considers whether a child is happy, whether they are able to partake in social activities, whether they attend school, whether they can join in sports, whether they are able to enjoy their adolescence. The two sub-themes are recognised as overlapping and interlinked.

### Protection of Short and Long-Term Mental Health

One parent placed emphasis on an assumption that prevention of unwanted secondary sex characteristics would be important in safeguarding her daughter's mental health in the short and long term.

> To prevent, basically, to prevent irreversible changes from happening, that she's been asking for them not to happen for many years. So, it's to prevent the changes she really doesn't want to happen. And therefore, you know, ultimately protect her mental health, isn't it? And her future life? Because being trans isn't easy. I think it probably is easier, if you don't have (Testosterone-driven) secondary sex characteristics. You know, that's, that's what she doesn't want anyway. She doesn't want to be a woman with a (Testosterone-affected) body [P].

Another parent highlighted the massive emotional toll secondary sex characteristics would take on her daughter.

> The benefit is to [Child's] mental health, to give her that, that ease that she's not going, you know, once puberty blockers are working, you know, her voice won't break, she won't develop an Adam's apple, she won't get facial hair. You know, she's told me, she's been watching videos on YouTube of - she's been doing vocal exercises, she's so paranoid about her voice…. the benefits outweigh any risks [P].

Other parents were aware of their child reacting with dread to any suggestion of incongruent secondary sex characteristics, and feared how their child's mental health would cope with endogenous puberty.

> That actually mentally mental health wise, I dread to think what would have happened with [Child], if he was already pushing down his boobs from a young age so they're not going to grow? What the hell is he going to do, if he knows they're going to grow? You know, there is all that - the self-harm [P].

> It would be depression and self-harm. For him, obviously. I would worry that he would just not be able to cope anymore [P].

The risk of acute mental health distress was a key risk factor for many interviewed parents.

> We did a for and against, if we don't take puberty blockers, what will that mean for our child? Well, it will mean they have to go through the wrong puberty, it will mean they have to suffer the consequences of a body that doesn't match who they are. And what does that mean? Well, that means

they're at higher risk of self-harm, they're at high risk of suicide, they're at

higher risk of social anxiety and mental health issues [P].

*Enabling Adolescent Well-being and Quality of Life*

Beyond the avoidance of severe mental health consequences, parents also spoke

about the impact of blockers in protecting their child's happiness and self-esteem.

This medication means that [Child] will be more happy and confident in their

presentation [P].

Many parents described access to puberty blockers as important for enabling their

child to succeed at school and allowing them to enjoy their adolescence.

Over the next five years, six, seven years, I want him to think about his

schoolwork. And I want him to think about his friendship groups, and I want

him to think about what he enjoys doing. One of the things he loves doing, he

does [sport]. I want him to engage with that and love doing his [sport]. I want

him to just enjoy being a teenager, which is hard enough for any teenager … I

just want him to enjoy his life. Without blockers, a lot of that gets wiped away.

Because, he will pass less and less as male, as his body changes. And that

would have a major psychological impact on him. So, yeah, I want him to just

get on with his life [P].

Several parents had noticed the impacts of early puberty on their child's confidence,

and felt denial of blockers would have a substantial negative impact.

As [Child] got older and then puberty did kick in, the showers weren't

happening, the almost withdrawing into himself, walking around like this (bent

over) to try and hide things. …To have delayed it would have been cruel, in

my mind, it would have been cruel… I thought if he starts his period, I'm not quite sure how he's going to manage that. It's almost then, having to be forced to tell everybody…he wouldn't have been able to continue his school, because how can you have been, from, you know, year seven, in secondary, up until he's now gone into year 10, a boy, to everybody, and then all of a sudden, because of no fault of your own, you've got boobs. He would not have gone to school. I can tell you that now [P].

A large number of parents in the sample felt their child would have refused to attend school if forced through incongruent puberty, with a large number of parents having seen this scenario in other families with trans adolescents.

I know of children, where they're not accessing school…they now don't want to go to school, because, their body, you know, doesn't equate to what they what they feel their gender is [P].

Some parents had seen the impacts of puberty on other trans adolescents' self-esteem.

I've met so many trans teenagers now who, you know, they bind, but because of the amount of chest tissue they have, they're hunched over and they're - it's like they're trying to disappear. And I didn't want that for my child. I looked at my child who was just confident, and swinging off trees and at home with their body. I didn't want him to disappear. And that was what I knew was potentially in our future, if we didn't get him blockers [P].

Other parents were concerned about how adolescents could manage schoolwork whilst going through incongruent puberty.

(If they didn't have access to blockers) there's just - they won't be able to do their work. It's like, secondary school, it is actually important. They're gonna spend all their time being really, really miserable about all the changes that are in their body. It's not like I haven't said to them, are you sure it wouldn't be okay to just go through your puberty, and they just looked me and they were like 'Yes. But that's not my gender' [P].

The findings across this theme draw attention to parental perspectives on blockers as preventative and protective, safeguarding mental health, self-confidence and adolescent quality of life. The parents in this sample felt puberty blockers were critical for providing trans youth with a good quality of life, emphasising the importance of bodily autonomy, of trans youth feeling they have control over their lives and bodies, of trans youth feeling understood, affirmed and supported. Parents interviewed within this research wanted to protect trans children from the high levels of mental health distress commonly found in trans youth, but also outlined a higher ambition, for their children to have a happy, secure, fulfilled adolescence.

## Parental Perspectives on Consent

The second major theme examined parental perspectives on their child's consent to taking puberty blockers. These interviews were all conducted in the period after the original December 2020 *Bell vs Tavistock* court judgement and before that court judgement was overturned on appeal in September 2021. All interviewed parents within the sample were aware of that judgement and its emphasis on consent, and reflected upon aspects of child consent in their interviews. This theme is divided into

three sub-themes on 1) Inappropriate consent 2) Appropriate consent and 3)
Consideration of fertility.

### *Inappropriate Consent*

Parents talked about aspects of the current consent process that they felt were
inappropriate, in particular a focus on genital surgery. Parents were frustrated that
children who were consenting for puberty blockers were asked to discuss and
consent to things unrelated to puberty blockers, like the potential impacts of future
HRT or genital surgery. A parent who had experience of attending a pre-surgical
consultation with a trans adult, felt it was entirely inappropriate to cover any such
topics with trans early adolescents who were just deciding on accessing puberty
blockers.

> I've sat in on these like preassessment meetings with a surgeon and a trans
> friend of mine, and they cover all that kind of stuff, complications in surgery,
> loss of function. And they share lots of statistics on it. And, you know, those
> are adult conversations, and they should be, I don't really see why you would
> tell a nine-year-old that they might have an impact on their sex life, if they go
> for surgery (as an adult) [P].

Other parents shared similar thoughts on the inappropriateness of asking pre-teens
to discuss surgery that would not occur until adulthood, if at all.

> I think these decisions about surgery are huge. Absolutely huge. And I don't
> think that that really has any bearing on my 11-year-old's life right now. It
> doesn't feel appropriate for her to think about that. Obviously, she might think
> about it by herself.

Others pointed out that children being expected to provide consent for other interventions gave an unhelpful message that blockers were a direct path to HRT and surgeries, when parents felt it was important for their child to know each intervention is separate [P].

> It's like, almost as if they think it's an inevitability that a child will go on to blockers, then they'll go into sex hormones, and then of course they'll have surgery. So, they need to understand all that. But it's like, you can go onto blockers and hormones, and still not have surgery. That's a possibility, too. You know, that's an individual choice. It's not a pre-determined pathway. I don't get it [P].

One parent found the seriousness and weight placed on the decision to take reversible puberty blockers, gave an unhelpful impression that it was a uniquely huge decision to take. A parent found it unhelpful to expect a child to express certainty about their future needs, with the parent instead wanting their child to have space to find what they need gradually, taking each step at a time, without pressure or commitment to a pre-defined final destination.

> For me, it's like trying on clothes, you try them on, does it look good? You can't tell when it's on the hanger. You have to try it on. And go, yeah, this feels good... So, I feel it's really important that she is allowed to take one step at a time. Without this kind of, you have to buy the whole package, like you're in or you're out, you know, you're trans full surgery, or you're not trans. I don't want her to feel like that [P].

*Appropriate Consent*

Parents talked about the approach to consent they would like for their child, wanting the consent process to focus specifically on the impacts, risks and benefits of puberty blocking medication. One parent felt it was important to simplify decision-making about blockers, not to over-complicate it.

> She needs to understand that taking this medication will stop her body from producing hormones. She can learn the word Testosterone; she already heard this word. She can know exactly what Testosterone does, it will do this, this, this. Puberty blockers are going to stop all that. That's it. That's all you need to know. And she should also know that if she changes her mind, she can stop taking them, and her body will continue doing what it was always going to do. I mean, what more do they need to know? [P].

Parents described high expectations of child consent within NHS gender services (Tavistock), with it treated as a test of a child's knowledge of a wide range of associated issues.

> What they do, why she would need them, and what they were going to stop that she didn't want, and any possible side effects. I think Tavistock do go through that very thoroughly. You know, they kind of almost test her really. Those meetings we had last year, that she would be tested on, you know, what vitamins you should be taking, and bone density and all that. I think she had a good understanding of all that [P].

For another parent, the key aim of a consent process should be for their child to have his questions answered, and to make clear what a child's options are.

I think that he should just have his questions answered. Whatever information he's seeking, he should be given, in the most factual, well-informed way possible, I just want him to know what his options are [P].

Several parents described a decision to take puberty blockers as being a potentially less significant decision than for a trans child to decide to go through endogenous puberty, and wanted the consent process to acknowledge that.

There's no such thing as doing nothing. If you don't give a child puberty-blockers there is a consequence - it's not that nothing happens. There's a massive consequence… If they don't have the capacity to decide that they shouldn't go through (endogenous) puberty, how do they have the capacity to decide that they should go through (endogenous) puberty? That doesn't make sense. Either they have the capacity to have an opinion about that, or they don't [P].

Unanimously, interviewed parents recognised the importance of being guided by their child's needs and wishes, regardless of their level of ability to formally consent.

It was his choice. As much as you can allow a 10-year-old to choose this sort of decision. We never said that you need to have blockers, we asked him. We even talked about the downsides with him [P].

A number of parents expressed concerns on how fertility discussions were brought into the process of consenting for puberty blockers. One parent describing finding it hard to have conversations on fertility with a young adolescent.

> We said you deciding to have blockers now might mean you can't carry a child. Now, if you ask him right now, there's no way he wants to carry a child, because (he thinks) that's what women do. And he's not a woman. But he's 11. I didn't want children at 11 necessarily [P].

Some parents felt gender service clinicians holding a dual role of gate-keeper, taking the decision to refer an adolescent for puberty blockers, and fertility counsellor, was problematic.

> They expected to have a conversation around fertility. When I was like, at the end of the day, he's just gonna say whatever it is, that makes you shut up, so that he can get the blocker… [Child] is emotionally intelligent enough, and articulate enough, to be able to see … I think in his head, he was like, I'm gonna say this, this and this, because that's what they want to hear [P].

> It's like, how do I think you want me to answer this? How do I think I should answer this, to get the outcome that I want? And that is not any kind of, you know, therapeutic exploration … it's nonsensical to consider that that's actually going to produce or inform someone's choice, when actually there's such a power dynamic at play really, particularly in a child [P].

An overarching question raised by parents in this sample, was whether trans adolescents need to discuss fertility at the point of starting puberty blockers, given puberty blockers themselves do not impact on fertility.

**Decision-Making Without Certainty**

A third major theme relates to decision-making without certainty, with two sub-themes on 1) Quality of evidence and 2) Parental confidence in decision-making.

*Quality of Evidence*

The interviews took place at a time of scrutiny on the evidence base underpinning use of puberty blockers for trans early adolescents. In particular, parents were aware of an NHS NICE study that critiqued the evidence base underpinning blockers (National Institute for Health and Care Excellence - NICE, 2021). Many parents shared their thoughts on the evidence underpinning blockers, including evidence of decades of use by cis children, finding this evidence reassuring.

> I know the research into blockers, and how many years they've been used for
>
> precocious puberty. The safety of them in that field was reassuring [P].

Parents felt there was clear evidence of the negative implications of denying blockers, weighing that significantly in their decisions.

> The evidence is that if you don't have them, it's very clear that it creates huge,
>
> huge problems for kids. That's my main evidence, you know, is the absence of
>
> them, is deeply damaging [P].

A number of parents raised their frustrations in people who are not trans, and not trying to make effective healthcare decisions for trans children, asking for evidence like Randomised Control Trials (RCT). Where interviewees brought up the topic of RCTs they were prompted to consider "would you like your child to participate in a

RCT?" All interviewees who shared thoughts on this topic raised serious concerns about the ethics of RCTs for puberty blockers, with several parents making it clear they would never give consent for their child to be part of such an RCT.

> I can understand the thought behind it, but not a chance in hell would I put my child up to that…With blockers, if you have a bunch of 12 or 13-year-olds, let's say, one in the hormone blocker group, one in the psychotherapy group. The ones that are in the psychotherapy group, well by the time you've done the trial, if the psychotherapy hasn't worked, then you now have a child who is 14, 15. And puberty's hit, it's happened…You know, how do you correct the damage of a (Testosterone-driven) puberty on a trans girl? That's my first problem with it. My second problem with it is, if we're talking about either hormone blockers, or therapy, psychotherapy. That suddenly starts to feel very much like conversion therapy [P].

Another parent articulated their ethical concerns with applying RCTs to this cohort.

> I'm just really struggling with the medical ethics of this, because you can't. I mean, that's just some very difficult, dark, territory there. You can't really do that. Can you? There has to be a neutral setting – That is not neutral - the default control group has to be neutral [P].

Other parents were forthright in their view on the inappropriateness of suggesting RCTs on trans adolescents that included denial of puberty blockers:

> (That's) conversion therapy. No thanks. I mean, I just think that is ethically completely flawed. No. Not in a million years [P].

> I'm sorry, that is eugenics level [P].

*Parental Confidence*

Parents varied in how confident they felt about giving parental consent for their child to access blockers. Several parents described feeling well informed and confident that it was right for their child:

> We felt quite well informed about the process. The negative aspects were sort of negligible, in comparison to the positive aspects of being on blockers, to help affirm her identity, but to also stop her body changing in ways that she just didn't recognise, or accept, or understand [P].

> 100% confidence.  Yeah, no doubt in my mind [P].

Several parents felt that there wasn't a choice, that puberty blockers were the only viable option for their child.

> I think blockers are crucial [P].

> There didn't seem to be any option really, if he was going to be happy [P].

One parent spoke about how her views on risk had evolved over time.

> If I'd been making that decision when I was reading desistance studies, I'd have been quite anti them. But as we've moved along as a family and taking a holistic view, yes, there are risks. But for me, the benefits outweigh the risks. And most of the risks can be mitigated with vitamin supplements, healthy diet, you know. There are things that you can do. So, parental consent was very easy. Because this is about, again, a fixed point in time saying, what is it that we need, right here and right now…Because I want my kid to be happy and healthy. It's about weighing up the risks and benefits and being informed [P].

Some parents found the process of having to make decisions about puberty and puberty blockers isolating and stressful, though those parents also emphasised understanding the importance of access to puberty blockers for their child's well-being:

> The idea of puberty and of hormone blockers makes me feel overwhelmed, at times, like completely overwhelmed, and really, really worried and stressed and alone and isolated… (Blockers) prevent irreversible changes from happening, that she's been asking for them not to happen for many years. So, it's to prevent the changes she really doesn't want happening...  I feel like I just have to do what is right for my child. Which is to find a way for her to have hormone blockers [P].

One parent emphasised that they would much rather their child did not need to take puberty blockers, but emphasised that blockers would be an important safety net if their child was distressed at the idea of incongruent pubertal changes:

>  I don't think we'd want to access blockers unless we felt there was a need to. And that would be if, if there's a need to - you know if there was distress and that was - it's really our last option. It is the safety net. So, we would get that from wherever we'd need to [P].

Another parent emphasised their own emotions about puberty blockers, seeing them as important for their child's well-being and dysphoria, whilst also expressing concern about the amount of time their child might be on blockers (in an NHS system that does not allow HRT until age 16).

> You know, if it's up to me, and if I'm thinking of my happiness, then he wouldn't have any medical intervention whatsoever. But this isn't about my

happiness, this is about his happiness. So, I certainly would give consent, if

that's what will make him happy, not just - not just happy, though, like actively

non-dysphoric. My fear is if he has an early puberty - How long does he spend

on blockers? Like, if he starts puberty at 10? Is he on blockers for four years?

Six? An awfully long time [P].

Some parents wanted greater certainty, but after careful consideration of available

options judged puberty blockers the best option for their child.

When it comes to blockers... you are gambling on the blockers and any

consequences of the blockers being better, being preferential, to the damage

and impact of puberty on your child. That's what you're counting on. And it is a

gamble and it's not perfect, but it's the only option available. So yeah, I'm, I'm

hedging my bets. And I'm making an informed judgement. That that is the

least damaging course of action for my child [P].

### 7.6.3 Discussion

This section explored parental views on puberty blockers, aiming to understand how

supportive parents of socially transitioned trans children view puberty blockers, how

they consider risks and benefits, and how they approach decision making. Three key

themes were presented, relating to the purpose of puberty blockers, parental

perspectives on consent, and parental approaches to decision making without

certainty.

When discussing the purpose of blockers, parents mentioned the importance

of avoiding incongruous secondary sex characteristics, but also emphasised that

avoiding unwanted puberty was vital for trans children to have the opportunity to

enjoy their adolescence, focusing on protection of mental health, quality of life, and

well-being. These findings reinforce existing quantitative research on the mental

health benefits of access to affirmative healthcare (Achille et al., 2020; Miesen et al.,

2020; Tordoff et al., 2022). It is noteworthy that for the parents in this sample, whose

children had socially transitioned at an average of 7 years old, time to think about

identity was not raised as a significant purpose of blockers, despite this being a

common narrative in clinician accounts (Brik et al., 2020). Some parents did see

puberty blockers as providing time to reflect upon their options for medical

intervention, in particular, how and when, to proceed through endogenous or

exogenous puberty. Parents in this sample made a distinction between time to

explore identity, and time to explore options for medical transition, seeing the latter

as much more significant. These findings mirror the findings of one of the only

qualitative studies to engage with trans adolescent perspectives on puberty blockers,

which found that "most adolescents did not use puberty suppression for further

exploration of their gender identity" (Vrouenraets et al., 2021b, p. 8). Similarly, trans

adolescents interviewed by Riggs et al. (2020) emphasised that blockers were not

critical to affirming their identity, but rather were important in preventing incongruent

puberty. These parental and adolescent views on the purpose of puberty blockers

stand in contrast to the identity-centred rationale for blockers commonly seen in

clinician accounts, media discourse or legal proceedings. Indeed the 2020 *Bell vs*

*Tavistock* court case described puberty blockers as "treatment that goes to the heart

of an individual's identity, and is thus, quite possibly, unique as a medical treatment"

(2020, para. 134). These findings highlight the importance of any discussion, court

case or policy review incorporating an accurate experience-informed perspective on

the purpose of puberty blockers. These findings also hold relevance for healthcare

research, demonstrating the importance of centring quality of life outcomes in any evaluation of blocker effectiveness.

A second key finding relates to parental views on consent for puberty blockers, highlighting parental concerns about the appropriateness of current approaches to consent. Parents perceived a divergence between what they considered medically necessary aspects of consent, and current clinical practice. Parents in this sample considered a decision for a trans child to proceed through endogenous puberty to be no less significant a decision, than a decision to proceed through exogenous puberty. Several parents raised concern about the politicisation of trans adolescent healthcare, feeling the consent process was shaped by factors other than adolescent need, a finding that aligns with recent literature from other countries critiquing the politicisation of trans adolescent healthcare (Abreu et al., 2021). These parental concerns on consent also align with some published perspectives from healthcare professionals. Research by Vrouenraets et al. (2015) included a perspective from a paediatrician who questioned why consent for puberty blockers is deemed as unique and controversial, when more complex paediatric interventions are frequently prescribed with simpler and more streamlined approaches to either parental or child consent. The one study to focus on trans adolescent ability to consent demonstrated that the vast majority of trans adolescents are able to consent to puberty blockers (Vrouenraets et al., 2021a). These findings reinforce a recent editorial on Child and Adolescent Health by the Lancet journal (2021, p. 385) that critiqued politicised discourse on children's consent for puberty blockers, concluding that "disproportionate emphasis is given to young people's inability to provide medical consent".

This study explored parental perspectives on the current evidence base for puberty blockers. For a large majority of parental interviewees, the risks of trans children being denied access to blockers outweighed any known risks of blockers, and in the absence of certainty informed a decision to support blockers. Parents evaluating evidence on puberty blocker effectiveness are informed by the histories and perspectives of trans adults who did not access puberty blockers, incorporating into any assessment consideration of the costs of not providing puberty blockers. This approach aligns with global healthcare bodies including the Endocrine Society and WPATH, who in response to the initial Bell vs Tavistock court case, released statements and submitted evidence to the appeal arguing the original verdict had "overlooked the harms of not providing puberty blockers", emphasising that restrictions on access to blockers "will have a significantly adverse impact upon gender diverse youth" (WPATH, 2020, pp. 1–2). Parents also refer to the multi-decade evidence base of safely providing blockers for precocious puberty (Kim, 2015), not seeing compelling evidence to exclude this evidence base. Finally, parents raised significant concerns at an implied NICE recommendation of Randomised Control Trials for puberty blockers where a control arm would progress through incongruent puberty (Eckert, 2021). A number of interviewees felt a randomised trial in which some trans adolescents would be offered psychological therapy with an incongruent puberty instead of affirmative healthcare, was an approach that would amount to "conversion therapy". This view aligns with a 2020 UN report on conversion therapy that named "preventing trans young people from transition" as part of conversion practices (UN Human Rights Council, 2020, p. 11). Existing literature has described such puberty blocker RCTs for trans adolescents as infeasible, noting trans adolescents distressed about puberty would not be willing to

take part in a study where the control arm would progress through incongruent

puberty (Brik et al., 2020; de Vries et al., 2011; Giordano & Holm, 2020). Existing

literature has also described RCTs where the control arm unwillingly progresses

through incongruent puberty as unethical (Giordano, 2008; Giordano & Holm, 2020).

As Brik (2020, p. 6) notes "many would consider a trial where the control group is

withheld treatment unethical, as the treatment has been used since the nineties and

outcome studies, although limited, have been positive". This current study reinforces

the practical concerns already documented in the literature, highlighting significant

levels of parental unwillingness to participate in such a trial. Cis healthcare

stakeholders calling for unobtainable or unethical standards of evidence in order to

continue delivery of routine healthcare provision, can be understood as an act of cis-

supremacy in healthcare, in cis dominant institutions lacking in trans leadership or

trans accountability.

This study also explored parental confidence and parental approaches to

decision making without certainty. A majority of parents described a careful process

of weighing up the potential pros and cons of supporting access to puberty blockers.

Given current evidence, parents in this sample were unanimous that having access

to puberty blockers was the best option for their child after considering all known

risks, including what they saw as the significant risk of a trans child being forced

through an incongruent puberty. Whilst some parents agreed with the NICE review

on the desirability of better evidence, parents highlighted concerns on how the

limitations of the current evidence base were being used to deny healthcare. Indeed,

many parents in this sample felt very strongly that given existing knowledge, denial

of access to blockers required greater justification and burden of proof than

supporting access to blockers, a finding that adds to the literature. For clinical policy

to hold stakeholder confidence, policy makers need to engage with experience-informed perspectives such as those outlined here.

Several parents noted how their own views on risks and benefits had evolved over time, and especially how their perception of the risks of not supporting access to puberty blockers evolved as they grew in knowledge of, and connection to trans communities. It is speculated that the level of support for puberty blockers found here is related to the length of time parents in this sample have had to understand their child's identity and build knowledge of trans communities, with interviews conducted an average of 4 years since their child's social transition. Existing literature has highlighted the support that parents require to understand and advocate for their trans children (Pullen Sansfaçon et al., 2015; Riggs, 2019a; Riggs et al., 2020). The findings presented here call attention to the support parents may need in navigating decisions related to puberty blockers, especially where parents do not benefit from connection to trans communities, or where parents have had less time to understand their child's identity pre-adolescence. This aligns with recommendations from Ashley (2019a) who calls for support and education for parents to help them understand and support their children through trans adolescent healthcare decisions. Further research can expand understanding of how parental views towards trans healthcare evolve, including effective ways of building parental confidence in decision making without certainty.

## 7.6.4 Conclusion

This research provides a valuable parental perspective on puberty blockers, with insights into parental decision-making from parents of socially transitioned trans

children who are in, or approaching, adolescence. Parents viewed puberty blockers as critical to protection of their children's mental health and quality of life. Parents raised concerns relating to how adolescent consent is taken for puberty blockers, questioning whether the consent process was tailored towards individual needs. Parents also spoke about decision-making without certainty, and the lengths parents had gone to understand and weigh up the evidence base. Despite some uncertainty, all parents who participated in this study considered puberty blockers an important option for trans adolescents. Parents expressed frustration on limitations in the evidence base being used to advocate for withdrawal of essential healthcare, with several parents challenging the ethics of RCTs for puberty blockers. These findings hold relevance for healthcare professionals working with trans children and their families, for those designing future longitudinal research studies, for healthcare policymakers, for families with trans children, and for those advocating for adolescents' right to healthcare.

The research presented across chapters 5-7 of this thesis has explored parent and child experiences in schools, families and healthcare. The next chapter (chapter 8) brings together these findings, examining them collectively in terms of this thesis' overarching theory of cis-supremacy (as was introduced in chapter 2).

# Part III – Conclusion

# 8 Cis-supremacy and Trans Liberation

"Recently I learned that cis kids are prescribed over the counter puberty blockers. It turns out, my sister is going through puberty early, and she's having blockers prescribed to her immediately. I had to wait 3 years for blockers. I'm so fed up with cis supremacy" (@personal_amber, 2021).

The above was posted on Twitter in 2021, highlighting one young trans person's frustration with experiences of cis-supremacy and injustice. The tweet stuck with me, resonating with themes uncovered within this thesis. Every chapter of this thesis has documented the injustices trans children and adolescents continue to face in the UK. Each section of this thesis has shone light on the impacts of cisnormativity and cis-supremacy across different spheres of trans children's lives, limiting and constraining their life chances. As I have evidenced, trans children continue to be subject to explicit double standards and systemic discrimination across diverse institutions and areas of policy and practice.

Across chapters 5-7 I have addressed the thesis' broad research questions, examining the external factors that shape the experiences of socially transitioned trans children under the age of twelve in the UK. The thesis' main chapters have approached this according to three key spheres of a child's life, examining trans children's experiences at home (chapter 5), at school (chapter 6) and in healthcare (chapter 7), with each chapter providing significant contributions to knowledge about

the experiences of trans children and their families. In each sphere these chapters examined and addressed a series of topic specific research questions (summarised in tables 1-3 in section 1.7). In this conclusion, I pull together all my research to examine and respond to two overarching theory-driven research questions (as introduced in section 2.4.5):

- How do cisnormativity, pathologisation and gender minority stress impact on trans children's experiences in the UK?

- How does cis-supremacy in key systems and institutions including schools, families and healthcare shape trans children's lives?

In section 8.1 I examine how cis-supremacy operates across each domain of the research (families, education, healthcare), synthesising the research presented in chapters 5-7, and reviewing research findings against the theory-driven research questions listed above. In section 8.2 I conclude this chapter by calling for commitment and action to tackle cis-supremacy and demand trans equality.

## 8.1 Cis-supremacy in Action

The impact of cisnormativity and cis-supremacy is a cross-cutting theme across the chapter on experiences in families. Sections on experiences of social transition (Section 5.2) and on parental decision making on social transition (Section 5.3) highlighted the influence of cisnormative parental attitudes, assumptions, fears and norms on parental responses to trans children. The section on 'delaying transition' (Section 5.4) revealed the ubiquity of parental approaches to deter or delay acceptance and support for a trans child, with interviewees providing important insights on the harms of such delay. It is important to note here that missing from this thesis are the voices and perspectives of trans children in unsupportive or actively abusive households, in spaces where cis-supremacy is violently enforced within the home, where unconstrained cis-supremacy denies trans children basic freedoms to exist, to be seen and respected, to grow up with self-esteem, self-confidence, safety and security.

In the UK there is currently no institutionalised endorsement of affirmative approaches to supporting trans children, with no clear affirmative guidance for parents of trans children (in contrast to other countries like the USA and Australia where national health bodies emphasise the vital importance of childhood affirmation (Murchison et al., 2016; Telfer et al., 2018)). In the UK there is no institutionalised support or protection for parents who affirm their trans children, and no institutionalised support or protection for trans children facing rejection and conversion practices at home. In spite of clear and growing evidence of benefits of affirmation for trans children's mental health and happiness (Durwood et al., 2017, 2021; Olson et al., 2016; Simons et al., 2013), institutions, media and healthcare professionals in the UK continue to endorse or accept efforts to delay social

transition, presenting childhood affirmation as more radical and more in need of evidence than childhood rejection (Cass Review, 2022). Within a world where cis stakeholders hold institutional power, rejection of trans children is seen as an acceptable or even the default position. UK toleration or legitimisation of efforts to reject trans children, combined with institutional reluctance to embrace an affirmative approach can be seen as an example of cis-supremacy in action. Trans voices, trans experiences, and trans children's right to a happy and supported childhood continues to carry little weight in UK influencing institutional policy.

The impacts of cisnormativity, pathologisation, gender minority stress and cis-supremacy were also seen within the chapter on education. The first section (Section 6.2) examined how cisnormative schools create unsafe environments for trans pupils, emphasising the impacts on trans children's lives, with evidence of school drop-out and institutionalised trauma. The second section (Section 6.3) examined the gender minority stress trans children face in cisnormative schools, illuminating the range of stresses that weigh upon trans pupils, with cumulative negative impacts on mental health and well-being. The final section (Section 6.4) introduced a staged-model for trans inclusion in schools, making explicit the ways in which cis-supremacy enforces the subjugation of trans pupils, forcing trans pupils into positions of vulnerability. This model draws attention to the power structures underpinning different approaches to trans inclusion, distinguishing between cis-supremacy in full dominance, cis-supremacy with exceptionalism, benevolent cis-supremacy or gender justice and trans liberation. Trans hostile schools are framed as spaces where cis-supremacy is enabled in full dominance, with no care for the rights or well-being of trans pupils. Trans assimilationist schools are framed as upholding cis-supremacy with exceptionalism, allowing limited and conditional escape from the full force of

trans hostility for those trans pupils who hold most power or who least challenge the cis-dominant status quo. Trans accommodative schools are framed as practicing benign cis-supremacy, taking steps to make (some) trans pupils welcome, but never as genuine equals. In such schools the underlying power of cis-supremacy remains uncontested; accommodation needs to be requested and can be denied.

Chapter 6 ended with an examination of power and cis-supremacy, acknowledging the ways in which non-emancipatory approaches to trans inclusion may aim to assimilate or accommodate a trans pupil whilst leaving underpinning structures, processes and systems of cis-supremacy unchallenged. The final sub-section of the chapter on education prompted us to look to the future and question: what could trans emancipatory schools look like? What might schools look like if trans pupils were genuine equals to their cis peers? What would education be like if schools proactively examined and took account of institutionalised cis-supremacy? What could education look like if schools took active responsibility for dismantling cis-supremacy across education? The chapter on education highlighted the need for increased recognition of cis-supremacy, with commitment to emancipatory approaches to trans inclusion essential for equity and gender justice in our schools.

The first section in the pathologisation and healthcare chapter (section 7.2) examined the continued impacts of pathologisation across all spheres of trans children's lives, questioning where responsibility for depathologisation lies. Across the UK, pathologisation has long been actively upheld and perpetuated across national institutions and policies (Murray, 2019b). Yet, at a time of global medical consensus that transitude is a healthy and expected part of human diversity (World Health Organisation, 2021), the UK holds no plan, commitment or institutional responsibilities for tackling embedded pathologisation of trans children. The current

'Cass Review' has demonstrated embedded pathologisation across outputs produced as of late 2022, with no recognition of the harms of such pathologisation (Horton, 2022f). Nations and systems that have for decades allocated resources, policies, and professional responsibilities to upholding the pathologisation of gender diversity are unable or unwilling to allocate resources to actively promote and facilitate depathologisation. This resource and responsibility gap, and the continuance of pathologising practices embedded in processes such as the Cass Review (Horton, 2022f), highlights continued cis-supremacy in healthcare practice. Cis-dominant systems are unobservant of the ongoing harms of pathologisation, unconcerned by the negative impacts on trans children, and unaccountable to trans communities experiencing direct harm. This lack of accountability to trans communities is at the root of cis-supremacy in action, with power wielded by cis decision-makers, in cis-dominant systems where trans communities, and particularly trans adolescents and children, hold little institutional power.

The impact of cis-supremacy also cuts across the chapter on healthcare. Within sections on parents' (section 7.3) and children's (section 7.4) experiences in gender clinics, I have highlighted experiences of coercion and powerlessness with trans children and families controlled in cis-dominant systems where they are forced to prove themselves and make themselves intelligible and acceptable to gain access to wider healthcare. Families described enduring clinical appointments that did not meet their needs, within assessments that some experienced as inconvenient, outdated and boring, that others experienced as painful, intrusive and traumatic. Gender clinicians and wider NHS authorities continue to wield substantial power over trans children, without emphasis on safeguarding trans children's rights, dignity, bodily autonomy or well-being. The current system includes limited mechanisms for

holding clinicians to account for pathologising, transphobic or abusive practices. Moreover, the current system codifies and reinforces power structures of dominance where children and families are compelled to cooperate with and submit themselves to potentially abusive regimes as a requirement for accessing healthcare. Power and cis-supremacy is explicit in many aspects of trans healthcare, perhaps best encapsulated by the following quote from a young adolescent:

> "Gender clinics are a bunch of cis people sitting around and deciding if we get human rights. I am not okay with that. We deserve human rights. It is not up to a doctor, or a clinician or a therapist to decide if we get human rights" [C].

Across trans healthcare cis-supremacy is visible in experiences of pathologisation, control and coercion. Sub-sections on puberty blockers (sections 7.5 and 7.6) have highlighted the inequalities and injustices in trans adolescent healthcare, with high barriers to access, and continued pathologisation. Those sections also emphasised inequities in whose voices are heard or believed, with examples of testimonial injustice where trans children or family accounts are questioned or doubted. Those sections also noted the double standard in evidence, where medications that are considered safe and non-controversial when used to delay puberty in cis children, are extensively challenged as experimental or 'low quality' when used in trans children (Giordano & Holm, 2020).

Missing from this chapter (as discussed further in section 3.9) is the impact on trans children and adolescents when access to puberty blockers is denied, including through politicised interference in healthcare such as the original *Bell vs Tavistock* court case (*Bell vs Tavistock*, 2020). Interviewees shared examples of trans children

and adolescents devastated by the impacts of the original court verdict, the case's immediate and pre-emptive interpretation into policy by NHS England, and the raising of additional barriers to access that remain in place as of 2022, despite the case being over-turned at appeal. These restrictions on access to essential healthcare, with acute short and long-term consequences for trans adolescents (as shown in my data, discussed in section 3.9) constitute extreme examples of cis-supremacy in action. Trans adolescents' bodily autonomy, rights, and physical and mental health count for little in a cis-dominant healthcare system where extensive trans suffering is tolerated and where trans lives are systematically valued less than cis lives. The findings summarised in this thesis highlight the scale of the challenge facing trans children and adolescents in the UK, with cis-supremacy embedded across diverse institutions and spheres.

One significant area where further research would be valuable, as discussed in section 3.8, is an intersectional analysis of cis-supremacy in action. This research has achieved limited intersectional analysis of the ways in which cis-supremacy impacts on trans children or families who are Black, disabled, immigrants, members of religious or ethnic minorities, or otherwise minoritised. Further research could meaningfully build upon this thesis, examining how cis-supremacy operates and is experienced by those experiencing intersectional axes of oppression, including the ways in which cis-supremacy specifically intersects with ableism and white-supremacy.

**A note on palatability**

In Spring 2022 I was talking about my research on a virtual seminar with educators from New York. One participant asked me a question about how palatable the word 'supremacy' is to mainstream cis people, and if I would use different words with different audiences. I replied that talking about cis-supremacy may not always be the right tactic, that cis people may feel more comfortable with us talking about cisnormativity rather than the stronger concept of cis-supremacy. Yet the word cis-supremacy for me is an essential term to have within our reach, even if just for ourselves (here I'm talking to anyone who is actively working to build a better world for trans children).

There have been many times as an advocate for trans children's rights when change has been so hard, when those with power have been so reluctant to listen or to learn. Naming the problem as one rooted in societal and institutional cis-supremacy, for me is crucial in helping make sense of the areas where reform is intolerably slow, where the barriers to trans equality are being reinforced by those invested in the status quo. We are not only up against the anti-trans activists who want to fundamentally roll back trans rights or morally mandate us out of existence. We are also up against the middle ground establishment who has accepted the status quo of trans subordination as being both the way things are and the way things should be - for whom cis domination is so deeply entrenched in their upbringing and experience that they cannot see another way, and for whom cis domination is so deeply normalised that they do not even recognise it as such. For these reasons, I find it useful to name the obstacle that is in front of us: cis-supremacy (alongside white supremacy, ableism & patriarchy).

## 8.2 Towards Trans Liberation

Section 8.1 built upon a theory of cis-supremacy (as introduced in section 2.4), examining how cis-supremacy shapes trans children's experiences in families, education, healthcare, and across UK society. A similar analysis could be provided specific to the media outputs of a particular newspaper, or to specific reports like the Cass interim report, to the work of a specific institution like the EHRC, or to a specific policy process like the UK consultations on GRA reform. I propose examination of cis-supremacy as a useful theoretical framework from which to understand dynamics of power and domination over trans children (and over trans communities more broadly). Analysis within a framework of cis-supremacy facilitates understanding of the conditions of trans childhood in the UK, drawing attention to systemic and powerful barriers to trans liberation. These barriers go beyond either transphobia[3] or cisnormativity (as reviewed in chapter 2). Cis-supremacy allows and enables continued control and coercion, problematisation, toleration of trans harm, and institutional cis-dominance, with devastating impacts on trans children in the UK. To understand barriers to trans liberation we need to grapple with the forces of power and cis-supremacy that hold back trans rights and perpetuate and reinforce a status quo of cis-dominance. Here I echo back to scholarship on white supremacy, recalling the words of bell hooks:

> "…racism is oppressive not because white folks have prejudicial feelings about blacks (they could have such feelings and leave us alone) but because it is a system that promotes domination and subjugation" (hooks, 2009, p. 12).

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[3] I take my definition of transphobia from TransActual (n.d.) for whom it includes 1) attempting to remove trans people's rights 2) misrepresenting trans people 3) abuse 4) systematically excluding trans people from discussions about issues that directly affect them 5) other forms of discrimination.

The parallels between white supremacy and cis-supremacy are strong. Cis-supremacy is successful, all-encompassing and life-constraining not because a minority of cis people hate or want to eradicate trans people. Extremes of transphobia alone are not at the heart of the current barriers trans well-being. Cis-supremacy is oppressive and life-constraining because it is a system of power and domination over trans people that has become normalised and accepted and reinforced by a majority of our society, including those who otherwise wish happiness and well-being for trans folk.

UK philosopher Abigail Thorn has similarly written about forces of power and domination that cis people wield over trans people:

> "Trans people demand the same freedoms that cis people take for granted like the right to healthcare, the right to get married and start a family without having to ask the government permission first, the right to go where we please free of harassment, the right to participate in recreational activities like sport in the correct gender, and in some cases even the freedom to live free from violence – freedoms that we do not currently have secure access to because cis people structured this country in a way that we are systematically denied them" (Thorne, 2022).

Cis-supremacy provides a framework to help us grapple with the forces that keep trans children in a position of subjugation and harm. Cis-supremacy puts at the centre of our analysis the mechanisms of power that exist to perpetuate cis-dominance over trans children. Such a power analysis can help us articulate and identify mechanisms to claim trans power, especially trans children's power. The American slavery abolitionist Frederick Douglass (2000, p. 367) said in 1857 "power

concedes nothing without a demand. It never has and it never will". Trans power

need not only be claimed on an individual basis, but on a systematic and societal

basis. We need to raise our ambitions (and our demands) of what equality looks like

for trans children in the UK. We need trans allies to not only recognise and challenge

transphobia and cisnormativity, but to also recognise and dismantle features of cis-

supremacy that have been embedded and normalised into our societal status quo.

We need to individually and collectively raise our expectations for what trans justice

looks like for our trans children, and we need to more emphatically demand & claim

our right to genuine equality.

This thesis demonstrates the importance of focusing on power, on rights, and

on accountability of institutions, processes and policies towards trans communities,

and particularly towards trans children. Cis-supremacy currently holds significant

power, perpetuating systems, policies and approaches that harm trans children. We

need to build communities of trans power, of trans solidarity and trans liberation,

enabling a shift from cis supremacy to a world of egality, safety and justice for trans

children.   Recognition of cis-supremacy and its impacts on trans children is an

essential piece of any movement for trans liberation.

# 9 Annexes

## Annex 1: Published Articles Related to this thesis

**Education-focused**

Horton, C. (2020) Surviving or Thriving? Raising our ambition for trans children in primary and secondary schools, *Frontiers in Sociology*. 5.

Horton, C. (2022). Institutional cisnormativity and educational injustice: Trans children's experiences in primary and early secondary education in the UK. *British Journal of Educational Psychology.*

Horton, C. (2022). Reducing Gender Minority Stress – Support for trans pupils in our schools. *International Journal of Transgender Health*.

Horton, C. and Carlile, A. (2022) "We just think of her as one of the girls" - Applying a Trans Inclusion Staged-Model to trans children's experiences in UK primary and secondary schools. *Teachers College Record*.

Horton, C. (2022) Being an ally to trans pupils in early years, primary and secondary schools in *Diverse Educators: A Manifesto* Kara, B. & Wilson, H. (Eds.) University of Buckingham Press.

**Family-focused**

Horton, C. (2022). "Euphoria": Trans children and experiences of pre-pubertal social transition. *Journal of Family Relations*.

Horton, C. (2022). "I was losing that sense of her being happy" - Trans children and delaying social transition. *LGBT+ Family Studies*.

Horton, C. (2022). "I never wanted her to feel shame": Parent reflections on supporting a transgender child. *Journal of LGBT Youth*.

Horton, C. (2021) Parent Advocacy Groups for Trans Children In *The SAGE Encyclopaedia of Trans Studies* A. E. Goldberg & G. Beemyn, Eds. SAGE Publications, Inc DOI: 10.4135/9781544393858.n201

**Healthcare-focused**

Horton, C. (2021) "It felt like they were trying to destabilise us":  Parent assessment in UK Children's Gender Services, *International Journal of Transgender Health*

Horton, C. (2022). "Of Course, I'm Intimidated by Them. They Could Take My Human Rights Away": Trans Children's Experiences with UK Gender Clinics. *Bulletin of Applied Transgender Studies.* 1(1-2):47-70

Horton, C. (2022). Experiences of puberty and 'puberty blockers' – Insights from trans children, trans adolescents and their parents. *Journal of Adolescent Research*.

Horton, C. (2022). "I didn't want him to disappear" Parental decision-making on access to puberty blockers for trans early adolescents. *Journal of Early Adolescence*.

Horton, C. (2022). De-pathologising diversity: Trans children and families' experiences of pathologisation in the UK. *Children and Society*.

# Annex 2: Details of Children of Interviewed Parents

| Trans children in the interviewed families | Age at time of social transition | Current age | Years since social transition | Gender |
|---|---|---|---|---|
| 1 | 6 | 9 | 3 | girl |
| 2 | 5 | 11 | 6 | girl |
| 3 | 6 | 11 | 5 | boy |
| 4 | 7 | 12 | 5 | girl |
| 5 | 7 | 12 | 5 | girl |
| 6 | 10 | 15 | 5 | boy |
| 7 | 10 | 16 | 6 | boy |
| 8 | 4 | 11 | 7 | girl |
| 9 | 7 | 14 | 7 | girl |
| 10 | 5 | 9 | 4 | girl |
| 11 | 10 | 15 | 5 | girl |
| 12 | 6 | 12 | 6 | girl |
| 13 | 8 | 12 | 4 | boy |
| 14 | 9 | 12 | 3 | non-binary |
| 15 | 9 | 10 | 1 | girl |
| 16 | 9 | 11 | 2 | girl |
| 17 | 5 | 12 | 7 | boy |
| 18 | 7 | 13 | 6 | non-binary |
| 19 | 8 | 13 | 5 | girl |
| 20 | 6 | 9 | 3 | boy |

| 21 | 9 | 15 | 6 | boy |
| 22 | 6 | 8 | 2 | non-binary |
| 23 | 8 | 9 | 1 | boy |
| 24 | 9 | 11 | 2 | boy |
| 25 | 4 | 6 | 2 | girl |
| 26 | 5 | 10 | 4 | boy |
| 27 | 3 | 9 | 6 | girl |
| 28 | 6 | 12 | 6 | boy |
| 29 | 8 | 10 | 2 | boy |
| 30 | 7 | 10 | 3 | girl |

# Annex 3: List of Tables and Figures

# 10 Bibliography

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