Learning to Listen to Trans and Gender Diverse Children: 


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Abstract:

The authors answer recent responses by Steensma & Cohen-Kettenis (2018) and Zucker (2018) to our critical commentary on “desistance” stereotypes and their underlying research on trans and gender diverse children (Temple Newhook et al., 2018). We provide clarification in the following areas: (1) the scope of our paper; (2) our support of longitudinal studies; (3) consequences of harm to trans and gender diverse children; (4) clinical practice implications; (5) concerns about validity of research methodology; and (6) the importance of learning to listen to trans and gender diverse children.

Keywords
adolescents; children; desistance; dysphoria; transgender
Learning to Listen to Trans and Gender Diverse Children:

A sincere thank you to the authors who took time to provide commentary on our critique (Temple Newhook et al., 2018). We appreciate the opportunity to clarify the following points:

Critical Commentary

Our paper is “a critical commentary,” as we stated in our title and abstract, rather than an exhaustive literature review. This is an important distinction because key research publications have bolstered the hypothesis of 80% “desistance” of transgender identity in childhood in the medical and public worlds. We focus on four formative publications, from the Clarke Institute of Psychiatry (now the Centre for Addiction and Mental Health, CAMH) in Canada and Vrije Universiteit (VU) Medical Centre in the Netherlands, that have been most influential in propagating the 80% ‘desistance’ axiom into policy and public consciousness. Our article describes limitations of this research and cautions “against using these studies to develop care recommendations for gender-nonconforming children.” We present the case that these studies fall short of their burden of evidence and reason to establish the validity of the 80% "desistance" claim.

Healthy Scientific Debate

We have great respect for the contributions of Drs. Cohen-Kettenis, Steensma, Wallien, and the other VU staff, and agree wholeheartedly that a) the historical and ethical context of care for trans and gender non-conforming children is quite different today than it was two decades ago when they began their groundbreaking work; b) the well-being of trans and gender non-
conforming children is the foremost priority; and, (c) progress in the field is being made through collaboration, including respectful academic dialogue as an essential component (Steensma & Cohen-Kettenis, 2018). We add that posing methodological, theoretical, ethical and interpretive queries is part of healthy scientific debate and indeed contributes to improved knowledge over time.

**Longitudinal Studies**

We clarify that we do not call for the abandonment or erasure of longitudinal studies with trans and gender diverse children. In fact, four of our authors (Temple Newhook, Pyne, Holmes, and Feder) are currently involved in the largest longitudinal studies ever conducted with transgender children in clinical care in Canada, including 8 clinics from 6 provinces, funded by the Canadian Institutes for Health Research (CIHR). One of our authors (Pyne) co-led a 2013 CIHR-funded Research Planning Grant which fostered these research partnerships.

It matters a great deal whether these young people are doing well as they grow up and whether they are getting the care that they need. Our call is specifically to move away from the disproportionate focus on using these studies to predict children’s identities as they grow up. This focus, and expectation of “desistance,” risks having professionals and parents neglect the child’s experienced gender identity, rather than prioritizing the well-being of the child and the reduction of the distress of dysphoria, where it exists. Our intention is also to raise questions

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1 This grant was co-led with Loralee Gillis and held at Rainbow Health Ontario (RHO). RHO is a knowledge translation unit funded by the Ontario Ministry of Health and Long-Term Care with a mandate to ensure that high quality evidence is used to inform clinical practice with LGBTQ communities in Ontario.
about policies and practices that prioritize speculation about future identity outcomes over the present needs of children. We recommend that WPATH and other medical authorities re-examine policies and practices based on the 80% desistance axiom in light of these concerns about its validity and usefulness.

Shame: Lessons from History

Dr. Zucker (2018) writes that we were mistaken to omit Green’s 1987 study. However, modern understanding and social context of human diversity in gender identity and sexual orientation have evolved greatly from the mindset of "prehomosexuality," pretranssexualism," and the "treatment" of either in the 1980s (Green, 1987). In our view, the "Sissy Boy" studies are fading in relevance to policy discourse. The dramatic events of the queer and transgender movements of the 1990s had yet to occur. The language of self-identification with respect to gender identity, gender dysphoria, and transgender social identity was not available to children then, as it is today. This is a case in which medical understanding and social change can outpace the span of longitudinal studies. We note however, that Green’s study does indeed hold an important lesson for today, in that at least one of Green’s original child research participants, Dr. Karl Bryant, has spoken publicly as an adult about the effects that this research and treatment had on his life:

The study, he [Dr. Karl Bryant] says, gave him the lasting impression that “the people closest to me, and that I trusted the most, disapproved of me in some profound way.” He says it’s hard to overstate the harm that such knowledge can inflict: “The study and the therapy that I received made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for
Clinical Implications

Dr. Zucker juxtaposes two treatment models that he refers to as a “psychotherapeutic approach” and a “gender social transition treatment approach.” Yet clinicians who will support pre-pubertal social transition do not practice “gender social transition” as their clinical approach, but rather an Affirmative Model, because it encompasses affirmation for how young people self-identify. Only sometimes does this involve one or more elements of a “social transition,” according to the needs of the individual child. In addition, availability of client-centred supportive counselling can be an important part of care in an affirmative model. Further, what is referred to here as the “psychotherapeutic model” seems to in fact be a gender-conversion approach, which is illegal in numerous jurisdictions (e.g., Legislative Assembly of Ontario, 2015) and noted as harmful by professional organizations such as the Canadian Professional Association for Transgender Health (2015), and the Canadian Association of Social Workers (2015). According to a recent statement by the American Academy of Child and Adolescent Psychiatry (2018), the existence of an a priori goal for a child’s gender identity, is considered “conversion therapy” and is stated to “lack scientific credibility and clinical utility.”

We disagree with the assertion that "encouraging social transition is itself an intervention" (Zucker, 2018). Childhood social transition is not about encouraging a child towards any particular path, but about removing the obstacles that have been preventing them from living fully and freely. Accepting and affirming non-birth-assigned gender identities with respectful, congruent names, pronouns, and documentation is a matter of basic human dignity (Grinspan et
and no more a medical intervention than affirming and respecting birth-assigned gender identities of cisgender children.

Once again, we do not question the intentions of the staff at VU University Medical Centre in Amsterdam, the Netherlands. However, we have concerns about the longstanding "Dutch Approach" of advising parents that "young children not yet make a complete social transition (different clothing, a different given name, referring to a boy as 'her' instead of 'him') before the very early stages of puberty" (de Vries & Cohen-Kettenis, 2012, p. 308). We are troubled by the misgendering language in this statement. This advice is unequivocally rooted in the 80% "desistance" axiom (p. 308; Steensma & Cohen-Kettenis, 2011, p. 649), and disregards evidence that intensity of gender dysphoria, "expressed cross-gender identification," and childhood social transition itself are significant predictors of “persistence” (Steensma, et al., 2013, pp. 587, 589). Most importantly, it dismisses children’s profound internal experiences of their own gender. Though labelled as "watchful waiting and carefully observing," such discouragement of congruent gender expression and authentic participation in childhood life experience is not a neutral clinical choice. In our experience, childhood closets can have lifelong consequences.

**Methodological Clarifications**

We did not speculate here about the outcomes of Drummond’s subjects who were not directly determined to have "desisted" at follow up. Instead, Table 1 illustrates the discrepancy between the desistance claims in these four papers and the much lower figures of "desistance" that these researchers actually determined by re-evaluation at follow up. The remaining subjects who were
found “persistent,” reported second-hand by third parties, or non-participants at follow up, are accounted for in the table.

We stand by our statement that "Evidence of the actual distress of gender dysphoria, defined as distress with physical sex characteristics or associated social gender roles (Fisk, 1973), was dropped as a requirement for GIDC diagnosis in the DSM-IV (American Psychiatric Association, 1994; Bradley et al., 1991)" (Temple Newhook et al., 2018, p. X). Criterion A for Gender Identity Disorder of Childhood (GIDC) in the prior DSM-III-R had required, "Persistent and intense distress about being a girl, and a stated desire to be a boy..., or insistence that she [sic] is a boy" (American Psychiatric Association, 1987, p. X). The corresponding wording for children assigned male at birth was roughly equivalent, but specified "intense" instead of "stated" desire. Such evidence of distress of gender dysphoria was reduced in the DSM-IV to a subcriterion, 1A, which was merely optional to meet Criterion 1: "Repeatedly stated desire to be, or insistence that he or she is, the other sex" (American Psychiatric Association, 2000, p. X). Instead, Criterion 1 only required that four of the five subcriteria be met, and the other four described gender role nonconformity rather than distress of gender dysphoria. The DSM-IV Subcommittee on Gender Identity Disorders acknowledged their intent to "eliminate the pivotal role that the verbalized wish to change sex plays in the DSM-III-R criteria" (Bradley et al., 1991, p.337), and this set the stage for conflation of gender nonconformity and distress of gender dysphoria in subsequent research. This omission was reversed once again for the Gender Dysphoria of Childhood category in the DSM-5, which currently requires subcriterion 1A (American Psychiatric Association, 2013). Criterion B, the generic clinical significance criterion added to virtually all categories in the DSM-IV, is not a direct substitute for the omission of
evidence of distress of gender dysphoria in the DSM-IV GIDC diagnosis that was used for sample selection in "desistance" studies.

We did not claim that "Onlypersisters [in the desistance studies] were truly gender dysphoric in childhood," (ref, p. x) nor did we attempt to define childhood gender dysphoria ad hoc by future outcomes of "persistence." Rather, we raised specific concerns about false-positive bias in the DSM-IV GIDC criteria that dropped the prior requirement for direct evidence of distress of gender dysphoria and allowed diagnosis based on nonconforming gender expression. We are not surprised by Dr. Zucker's assessment of low specificity rate, 42%, for subthreshold diagnosis at assessment associated with findings of "desistance" at follow-up, in aggregated data from Drummond (2008), Wallien (2008), Steensma (2013), and Singh (2012). This is consistent with our concern that a large number of "desisters" who previously met the full GIDC criteria may reflect sample bias introduced by flawed, false positive diagnosis, with respect to distress of gender dysphoria. From our perspective, children’s experiences of dysphoria and of identity can be complex, and changes and developments are to be expected (and celebrated) and not seen as destiny of their future identities.

Learning to Listen

Finally, Dr. Zucker provides an insightful example of a child, who when asked whether they wanted to be a girl or a boy, deferred to the parent in saying, “Who do you want me to be?” What led this child to believe that there was only one version of themselves that would be “wanted,” accepted, and embraced? Why did this child not feel comfortable or perhaps safe enough to express their inner feelings about their gender? What consequence did they fear from
allowing their hearts to speak truthfully? The affirmative approach strives to create an environment within which the child does feel free to use the "I" word in expressing their gender and have the security of knowing that the adults in the room will listen. As the field of care for gender diverse children progresses, we look forward to a time when we not only ask children who they are, but truly learn to listen.

Declaration of Conflict of Interest

The authors declare that they have no conflict of interest.
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