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Transgender and Gender Diverse Children: Considerations for Affirmative Social Work Practice

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Abstract Given growing public awareness about transgender and gender diverse identities, it is expected that greater numbers of children and families will seek mental health and social services, including transition-related services, from social workers and other mental health professionals. Transgender and gender diverse children have a range of transition-related needs which require the support of informed practitioners with transgender and gender diverse-specific knowledge and skills. Moreover, the needs and experiences of families and caregivers of transgender and gender diverse children will vary greatly. To date, research suggests a paucity of transgender and gender diverse-specific expertise among social workers and other mental health providers; this seems particularly evident with respect to the needs of transgender and gender diverse children. An affirmative practice framework to guide therapeutic work with transgender and gender diverse children and families is presented. In addition, key clinical practice considerations associated with engagement, assessment, psychoeducation, support and referral are provided. Finally, clinical examples illustrating use of the affirmative practice approach with transgender and gender diverse children are provided.

Keywords Transgender · Affirmative · Gender diverse · Child · Transition · Health

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Introduction

With the advent of many high profile transgender individuals coming out and sharing their stories in the media (e.g., Caitlyn Jenner, Jazz Jennings, Chris Mosier), public awareness of transgender and gender diverse (TGD) identities and experiences has grown significantly in recent years. However, understanding of contemporary transgender experiences is neither nuanced nor comprehensive. Rather, there remains a lack of awareness about transgender-specific experiences among the general public, as well as among social service, health, and mental health care providers (Shipherd, Green, & Abromovitz, 2014). This is particularly true with respect to TGD youth (Gridley et al., 2016) seeking services. Given the disproportionate mental health risks experiences by TGD youth (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Yunger, Carver, & Perry, 2004) and the likelihood that affirmative interventions can mitigate these risks, it is critical that social workers develop the knowledge and clinical skills to work affirmatively with TGD youth. In this paper I will address these gaps in the social work literature in the following ways. I will present an overview of extant research contributing to our contemporary understanding of TGD identities and experiences, as well as research defining best (affirmative) practices for working with TGD children. I will then offer practice recommendations for engaging in affirmative social work practice with TGD children and their caregivers. Finally, clinical examples illustrating affirmative clinical social work practice with TGD children with distinct needs will be provided. I use the term TGD to refer to all children whose gender identity or expression differs from binary societal or cultural expectations associated with assigned sex at birth. A conceptualization of gender that

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is multidimensional is recommended to replace current binary conceptions of gender.

Transgender and Gender Diverse Identities in Childhood

The mental health and healthcare needs of TGD children exists in a developmental context of emergent and fluid experiences of gender and may vary considerably based on many factors. A clear and considered understanding of gender identity development including the range of gender experiences among children, and associated terminology, is a pre-requisite for informed discussions of TGD specific health and social service needs. As such, I will provide a brief overview of these concepts. Biological sex refers to biological and physical anatomy and is used to assign gender at birth while gender identity refers to the attitudes, feelings, and behaviors that are associated with an individuals' innermost sense of self as male, female, both or neither. Most individuals develop a gender identity that aligns with their biological sex, however for others, gender identity and biological sex (sex assigned at birth) do not match.

It is becoming increasingly clear gender is not a binary concept (either male or female). Recent data from the 2015 Report of the United States Transgender Survey (USTS), the largest study to date of transgender adults (N = 27,715) found that over one-third (36%) of participants embrace a non-binary gender identity (James et al., 2016). Examples of gender identities beyond the male/female binary include, but are certainly not limited to, agender, bigender, genderqueer, gender creative, genderfluid, gender expansive, gender neutral, and transgender (see Austin et al., 2016 for a glossary of terms). Terms such as genderfluid and gender creative convey a broad, flexible range of gender expression. Individuals with these identities may have interests and behave in a manner not limited by restrictive boundaries of expectations of girls or boys. Moreover, genderfluidity may suggest that individuals experience themselves as both a boy and a girl at the same time. For these children gender identity may vary from day to day or across circumstances and neither "boy" nor "girl" describes them accurately (Ehrensaft, 2016; Graham et al., 2011).

According the American Pediatric Association (2015), awareness of gender identity (e.g., male, female, other) occurs relatively young, as children can typically identify themselves as boys or girls by age 3 and gender identity is generally stable by age 4. However, as a result of limited and somewhat questionable data on TGD youth, there is no consensus regarding stability of TGD identities among children and teens. For instance, while some research has suggested that a transgender identity did not persist for the majority of children presenting for care associated with gender non-conforming behaviors/identities (Levine, 2013; Zucker, 2010). However, several factors suggest that this research is flawed and may vastly underestimate the stability of TGD identities among children and teens including (1) skewed research processes, the likelihood that most study participants did not actually have TGD identities at the start of the study, as well as the possibility that participants, as a result of the implicit and explicit pressure to conform to gender-normative behavioral expectations associated with biological sex, were reluctant to share persisting experiences of gender dysphoria (Ehrensaft, 2016; Olson, 2016; SAMHSA, 2015).

To date, the correlates of persisting (stability of TGD identity into adolescence and adulthood) or desisting (TGD feelings/experiences dissipate as a child approaches adolescence) gender non-conformity remain unknown (Levine, 2013), but emerging research suggests a complex interplay between biological, environmental and psychological factors (Steensma, Kreukels, deVries, & Cohen-Kettnis, 2013). Research suggests that stability of TGD identities is more likely for children whose gender dysphoria (emotional distress associated with a gender identity that is not aligned with biological sex) is more severe and whose cross-gender identity and expressions of self (e.g., play, activities, appearance,) are insistent, persistent, and consistent across time, circumstance, or developmental stage (Forcier & Haddad, 2013). In addition, it appears that TGD children who *believe* themselves to be the "other" gender rather than *wishing* they were the "other" gender may distinguish persisters from desisters (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). Nevertheless, existing data suggests that gender dysphoria that arises during childhood and intensifies during adolescence is very unlikely to abate, and that TGD identification during puberty (10–12 for natal females and 12–14 for natal males) is likely to remain throughout the lifespan (Spack et al., 2011; Steensma, Kreukels et al., 2013, Steensma, McGuire et al., 2013).

Importantly, many studies have primarily focused on TGD children with binary transgender experiences. Burgeoning clinical experience and research data suggest notable within-group diversity among TGD individuals (Ehrensaft, 2016; James et al., 2016) highlighting the possibility of an array of identity-related developmental trajectories for TGD children and teens. As practitioners and theorists continue to produce work which enriches our understanding and knowledge about the emergence of gender identity among children (Ehrensaft, 2016), it becomes clear that existing frameworks for discussing gender awareness and stability may not be adequate. Because existing frameworks are rooted in cisgender, binary conceptions of gender, they fail to account for the reality of non-binary, fluid and evolving experiences of gender identity and expression. This is

an area which requires further attention in research and clinical practice with TGD children.

Considerations in Transition-Related Care for TGD Children

As the diversity of TGD identities and experiences is acknowledged, along with the recognition that identity emergence is an evolutionary process, it is important to consider the corresponding variation in transition-related needs among TGD youth across development phases. I recommend that an inclusive and flexible understanding of transition-related services should be embraced. For instance, a useful definition of transitioning is: the processes (social, legal, and/or physical) of modifying one's external indicators of gender (e.g., name, behavior, expression and/or body) to more accurately reflect one's gender identity. This conceptualization of transitioning focuses on various processes associated with living authentically, creating room for both binary (e.g., male to female, female to male) and non-binary (e.g., female to genderqueer, male to gender creative) transitions. As such, for some non-binary TGD children changing their name (e.g., Sabrina to Sam), personal pronouns (e.g., she/her/hers to they/them/theirs), hair and clothing (e.g., gender neutral style) may represent a sufficient transition. For other TGD youth a transition that includes physical changes (e.g., hair, clothing, accessories), medical intervention (e.g., hormones and eventually surgery) as well as, legal components (e.g., name, gender marker and document changes) may be necessary to achieve a sense of alignment.

While the importance of transitioning for adults has been recognized in activist, medical, mental health, and social work communities for decades, mounting empirical research indicates the positive impact of social, medical, and legal aspects of transitioning on mental health and overall wellbeing among transgender children (Ehrensaft, 2016; Olson, Durwood, DeMeules, & McLaughlin, 2016) and teens (Simons, Schrager, Clark, Belzer, & Olson, 2013; Tishelman et al., 2015). Olson et al. (2016) conducted the first study of prepubescent, transgender children ($n=73$) who were supported in their social transitions and found evidence of positive mental health outcomes similar to those of their cisgender counterparts ($n=73$). Similarly, a study exploring parental support for TGD youths' medical transitions indicated that increased transition-related support was associated with lower rates of depression and better quality of life among (Simons et al., 2013). Given previous research demonstrating elevated rates of mental health problems among TGD youth (Cohen-Kettenis et al., 2003; Yunger et al., 2004), these studies provide important support for transition-related care for TGD youth.

The timeline for transition-related medical care among youth is often determined by developmental factors. For example, while reversible pubertal suppression (i.e., hormone blockers) is identified as an important and often critical medical intervention for TGD youth, this intervention must be initiated during but not prior to onset of puberty (Hembree et al., 2009; Spack et al., 2011). Importantly, this often requires the development of relationships with TGD competent mental health providers (to provide gender assessments and letters of support) and pediatric endocrinologists well before the onset of puberty. For adolescents interested in transitioning physically, hormone therapy to regulate pubertal development of the desired gender is often a primary need; this intervention can be initiated during adolescence, but never prior to pubertal onset. The recommended age for hormone initiation has been 16 years old (Edwards-Leeper & Spack, 2012; Hembree et al., 2009), however this varies by provider. In fact, with growing evidence demonstrating the positive mental health impact of transition-related care for children and youth (Olson et al., 2016) and the negative mental health consequences of delaying transition-related treatment, including pubertal blockers and subsequent cross-sex hormones (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011), providers are recognizing the importance of early intervention (Forcier & Haddad, 2013). As such, social workers and other mental health care providers must be prepared to provide the necessary support and services to TGD youth and families in need of transition-related care.

The Practice Context for TGD Children

Barriers to Affirmative Care for TGD Children

While safe and identity-affirming clinical services can be pivotal in supporting the long-term health and well-being of TGD youth (Forcier & Haddad, 2013; Olson, 2016; Simons et al., 2013), at present few eligible TGD youth receive the support or transition-related care they need (Gridley et al., 2016). In fact, research suggests multiple and pervasive barriers to TGD affirmative care. Affirmative care refers to a non-pathologizing approach to practice which accepts and validates all (binary and non-binary) experiences of gender. Providers engaging in affirmative care support each child as they strive to openly express and embody their authentic gender.

Barriers to affirming care may include overt bias, lack of practitioner knowledge regarding TGD-specific healthcare needs, and structural oppression toward TGD clients in healthcare systems (Grant et al., 2011; Gridley et al., 2016; James et al., 2016; Shipherd et al., 2014). A recent qualitative study of TGD youth ($n=15$) and caregivers ($n=50$),

conducted by Gridley et al. (2016) found the following six specific barriers to TGD affirmative care for youth: (1) few accessible pediatric providers are trained in gender-affirming health care; (2) lack of consistently applied protocols; (3) inconsistent use of chosen name/pronoun; (4) uncoordinated care and gatekeeping; (5) limited/delayed access to pubertal blockers and cross-sex hormones; and (6) insurance exclusions.

These barriers likely reflect several factors. Knowledge about and attention to TGD identities has grown exponentially over the last decade, well after many practitioners were trained. Moreover, evidence suggests graduate programs do not adequately train students to work affirmatively with TGD youth. For instance, research indicates that social work programs dedicate very little attention to transgender issues in their curricula (Austin, Craig, & McInroy, 2016), resulting in graduating practitioners unprepared to engage in affirmative practice. It is also important to recognize that until 2013, when changes were made to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), individuals of transgender experience were classified in the DSM-IV with a mental disorder known as gender identity disorder (American Psychiatric Association, 2000). This pathologizing framework for understanding transgender identities and engaging in clinical practice with TGD individuals continues to impact TGD clients' access to informed and supportive care which facilitates (rather than impedes) access to transition-related care.

Children with non-conforming experiences of gender continue to be pathologized or have their experiences of gender minimized by parents and providers. Children often receive treatments which reject their true experience or expression of gender, discouraging them from living in a manner consistent with their gender identity. Instead TGD children are often coerced to present and behave in a manner consistent with binary gender norms associated with their anatomical sex (Spiegel, 2008). In fact, the utilization of pathologizing "reparative" approaches has been perpetuated by some of the most well-known and widely cited professionals working with TGD children (Spiegel, 2008; Zucker, & Bradley, 2005). Such practices are contrary to interdisciplinary practice guidelines (APA, 2000; NASW, 2015; SAMHSA, 2015) which repudiate all coercive mental health and health care practices targeting sexual and gender minority identity and expression among youth. Furthermore, it should be noted that in 2015 Dr. Zucker was dismissed from his position as the medical director of Child Youth and Family Gender Identity Clinic in Toronto as officials investigate and reconsider their recommended practices (which have been equated with reparative therapy) for intervening with TGD children (Beyer, 2015; Singal, 2016). Although not without controversy, Zucker's dismissal and the clinic's closure came as a relief to many affirmative practitioners, researchers and transgender activists concerned about the wellbeing of TGD children (Beyer, 2015). At present six states in the U.S. (California, Illinois, New Jersey, New Mexico, Oregon, Vermont) as well as the District of Columbia have laws which ban conversion therapy for minors and advocacy efforts aim to add more to this list (Movement Advancement Project, 2017).

The Role of Social Workers in Promoting TGD Affirmative Care

Affirmative approaches to social work with TGD children, teens, and adults are markedly different than damaging and unethical practices which try to change sexual orientation and gender identity. Affirmative practices, which support and validate the identities, strengths, and experiences of TGD populations are increasingly important in the provider landscape (Craig & Austin, 2017; Ehrensaft, 2016; Sevelius, 2013). Such interventions can counter experiences of transphobic stigma and/or bullying and promote the health and wellbeing of TGD individuals (Austin & Craig, 2015; Craig, Austin, & Alessi, 2012; Crisp & McCave, 2007). Moreover, a TGD affirmative framework is consistent with core social work values, in particular those which foster integrity, uphold dignity and worth of the person, and promote social justice (NASW, 2008). In addition to embracing an overarching approach to TGD identities that is validating, inclusive, and supportive, TGD affirmative practice requires TGD-specific competency in areas of particular relevance to TGD youth wellbeing, specifically, engagement, clinical assessment, support, and linkage.

Creating a TGD Affirming Clinical Context

A social worker may be among the first points of contact for families as they attempt to identify and understand their children's TGD identities and experiences. As such, the adoption of an affirming clinical position which acknowledges the diversity of gender and provides unconditional positive regard for all gender identities and expressions is critical (Austin & Craig, 2015). Affirmative social work practice must acknowledge and counter the oppressive contexts in which children and families may have previously experienced services by creating an affirmative culture at the onset of the clinical relationship (Craig et al., 2012; Craig & Austin, 2017). At the organizational level, attending to structural and policy-related components of the therapeutic environment is necessary. Social work practitioners should consider creating visibly affirming offices by including posters, brochures, and children's and parents' books that embrace diverse TGD identities. In addition, the use of inclusive intake/referral forms that allow for the

use of chosen names, as well as, a diverse and inclusive range of gender identity options is recommended (Levine, 2013). Practitioners should ensure that TGD youth can take part in programming based on gender identity rather than assigned sex at birth (e.g., support groups consistent with gender identity). Similarly, practitioners should replace sex segregated spaces with gender inclusive spaces whenever possible (e.g., gender neutral restrooms). Finally, adopting agency and organizational policies that prohibit identity-based discrimination against clients and staff contributes to an organizational culture that values and supports affirmative care.

At the clinical practice level an important first step toward helping children and families overcome reticence or distrust is to establish a gender inclusive stance during the first session. Doing so in clear, uncertain terms is important. Table 1 provides examples for TGD affirmative communication with both TGD children and their caregivers. Allowing children to self-identify is important to establishing an affirmative context and building rapport early on. Clearly explaining the social work practitioner's role as collaborator, rather than driver of the therapeutic process and resulting outcomes, can empower TGD children and families and increase their trust. Finally, demonstrating a client-centered approach that acknowledges the child as the expert of her/his/their own experiences of gender is a key to creating a safe and affirming therapeutic setting (Ehrensaft, 2016). This approach has been described as facilitating "the child's authentic gender journey" (Ehrensaft, 2012, p. 339), allowing the child to drive the process of identity emergence and expression in a manner consistent with their developmental stage (early childhood, pre-puberty, adolescence). The benefits of a client-centered approach to TGD affirmative practice for promoting child wellbeing are deftly described in the ensuing quote by Ehrensaft (2012).

> Repeatedly, the children I work with tell me, in words and actions, that when allowed to express their gender as they feel it rather than as others dictate it, they become enlivened and engaged; when prohibited from that expression, they show symptoms of anxiety, stress, distress, anger, and depression (p. 338).

Conducting a TGD Affirmative Assessment

Explore Gender Experiences The DSM-5 (American Psychiatric Association, 2013) provides for an overarching diagnosis of gender dysphoria with specific criteria for children that differ from the criteria for adolescents and adults (See Table 2). While a diagnosis of gender dysphoria may be important for guiding some aspects of care (e.g., making decisions about social and/or medical transitioning) and/or getting services covered by insurance, it is not designed to elucidate the full array of gender diverse experiences among children. As such, I recommend engaging in a comprehensive gender assessment aimed at gathering a complete and nuanced understanding of each TGD child's unique experience.

Assessments for TGD children include careful and thorough exploration of a range of gender identity related experiences. Screening questions should be developmentally appropriate for exploring TGD identity and experiences among children of all ages (Sherer, Baum, Ehrensaft, & Rosenthal, 2015). As some children, particularly those younger in age, communicate better through drawing or art (Landreth, 2012; Oaklander, 1988), it may be helpful to integrate art into the gender assessment process as well. Verbal responses, as well as pictures can be used to facilitate understanding of each child's gender identity and gender-related experiences in the world. In Table 3 I provide examples of important assessment domains, as well as sample questions associated with each domain.

Flexibly employing methods that facilitate client expression and articulation of gender experiences, practitioners should assess gender identity across several dimensions. Specifically, practitioners need to: tune in to each child's articulation of their gender identity (non-binary and binary expressions); listen for the child's expressions of *being* versus *wishing* (e.g. I am a girl versus I wish I was a girl because things would be easier); attend to distinctions between cross-gender interests and play (e.g., liking boy toys and games) versus TGD identification (e.g., I play with boy toys because I am a boy); evaluate for the existence of gender dysphoria using DSM-5 criteria; explore the ways in which the child would like to present to others (be seen and recognized by); and note the importance of being perceived "accurately" by others for the child (Bockting, Knudson, & Goldberg, 2006; Forcier & Haddad, 2013). It is critical to recognize that there is no typical or single way in which a child presents as TGD, so an affirming an comprehensive assessment should focus on trying to understand each child's authentic experience of gender as well as what each child needs to feel supported and affirmed in that identity.

Explore Experiences of Transphobic Stigma and/or Bullying Assessment clarifies the client's needs and experiences, as well as informs the direction of the therapeutic work. Considering the deleterious impact of anti-transgender discrimination and the accompanying minority stress on mental health outcomes (D'Augelli, Grossman, & Starks, 2006; Goldblum et al., 2012; Toomey, Ryan, Diaz, Card, & Russell, 2010), it is imperative that social work practitioners assess for discrimination and anti-TGD messaging in the lives of TGD individuals (Austin & Craig, 2015; Austin, Craig, & Alessi, 2017; Craig et al., 2012; Langdridge, 2007). Instead of waiting for TGD youth to disclose experiences of

Table 1 TGD Affirmative communication with children and caregivers

Topic	Child	Caregiver
Create a welcoming and gender inclusive context during the first session	Welcome, I want to let you know that we work with many children here, including some children who feel a little bit different than other boys or girls their age. For example, some kids feel like girls, boys, both, or something else. What would you like me to know about you?	Welcome, I want to let you know that we work with children across the spectrum of gender identities, expressions and experiences. What is important that I know and understand about your child?
Encouraging self-identification	Hello, my name is Dr. Ashley Austin, but I like to be called Ashley, what would you like me to call you during our time together	It is important that your child feel as comfortable as possible while in these sessions, part of that includes being called the name and gender pronouns that fit for them
Adopt and share a TGD affirming clinical position	I want you to know that I believe that any way that you experience being a girl, boy, or something else is absolutely ok. Everyone experiences their gender in unique and special ways. I will not pressure you to act in any way that is not comfortable to you	Like many children, your child is still understanding their own identities around gender. It is best to remain open to these explorations and the evolution of their emerging identity. If you find this difficult to do, I can provide support and resources that you might find helpful
Clearly explaining the practitioner's role	As your practitioner, I am here to learn more about you so that I can help you to feel more safe and comfortable expressing yourself—as a boy, girl, both, or something else. Part of this might include helping the grown-ups in your life, parents, grandparents, teachers, doctors, learn how to support you better	As your child's practitioner, I am here to learn more about your child so that I can help them feel safe and comfortable identifying and expressing their gender identity—as a boy, girl, both, or something else. Part of this process might include helping you navigate this journey, as well as providing any necessary advocacy related to garnering support from the other folks in your child's life (e.g., grandparents, teachers, doctors)
Demonstrating a client-centered approach that acknowledges the child as the expert of her/his/their own life and experiences	I have worked with many kids and families, and everyone is different. You are the expert on your own feelings and expeeriences. The more I learn about your unique experiences and needs, the better I will be able to help you	While I have worked with many kids and families, every child is different. You and your child are the experts on your own family's needs and experiences. The more I learn about your child's unique experiences of gender and their expressed needs, as well as your needs as parents, the better able I will be to provide the specific guidance and services necessary to support each of you through this process
Encourage open expression of identity-based discrimination and/or negative messages about being TGD	Sometimes kids I work with hear people say things that are not very nice about TGD people (or about people who dress or behave in a way that may be different than what they are used to). That can make us feel pretty upset. Have you heard anyone say things like this? If so, would you mind telling me a little bit about it?	Sometimes families of TGD children are exposed to anti-transgender attitudes, beliefs, and behaviors from individuals in their personal, social, religious, and work lives which can be very difficult. Is this something you have had to deal with?

Table 2 DSM 5 criteria for a diagnosis of gender dysphoria in children

1	A strong desire to be of the other gender or an insistence that one is the other gender
2	A strong preference for wearing clothes typical of the opposite gender
3	A strong preference for cross-gender roles in make-believe play or fantasy play
4	A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
5	A strong preference for playmates of the other gender
6	A strong rejection of toys, games and activities typical of one's assigned gender
7	A strong dislike of one's sexual anatomy
8	A strong desire for the physical sex characteristics that match one's experienced gender

A gender dysphoria diagnosis for children requires at least six of the above criteria and an associated significant impairment in function, lasting a minimum of 6 months

Table 3 TGD affirmative assessment domains

Topic	Examples
Explore TGD identity and experiences	1. Some clients wonder if they are more like a girl or boy or something else on the inside. What has it been like for you? 2. Do you ever feel the people around you have got it wrong about you being a boy?/girl? Can you tell me about that? 3. Can you draw/paint a picture of how you see yourself?
Explore how TGD clients would like to be perceived by others	1. How would you like other people (family, friends, teachers, strangers) to see you? 2. Can you draw a picture/paint of how you would like to be seen by others?
Explore preferences for clothing and hairstyle	1. What kinds of clothes or outfits do you like? Do you have a favorite outfit? What's so special about it? 2. How do you like to wear your hair? Do you like it now? Or do you wish it were different in some way? How?
Explore play preferences	1. What kinds of games do you like to play? 2. When you play pretend, who is your favorite character to play? 3. Can you draw me a picture of you playing with your favorite toys?
Explore thoughts and/or hopes about future self	1. What do you imagine you will be like when you grow up? 2. When you imagine your future, what do you hope it will be like? 3. Can you draw me a picture of yourself in the future?
Explore experiences with stigma or discrimination related to expressed gender identity	1. Has anyone made fun you for the clothes you like to wear or the games you like to play? Can you tell me about this? 2. Some clients tell me about other kids or adults who bully or pick on them. Is this something that has ever happened to you? 3. Can you draw me a picture of what it was like for you that day? 4. Can you draw a picture of how that experience made feel?

victimization, bullying or marginalization, these should be standardized components of a TGD affirmative assessment (See Table 3). As with other components of assessment, it may be helpful to allow younger clients to use art to express their experiences with bullying. Part of affirmative assessment is validating clients' self-reported experiences of discrimination. For example, when a child reports an incident of discrimination, the practitioner should not automatically universalize it (e.g., all kids have a hard time getting along with their classmates), search for alternative reasons for the bully's behavior (e.g., doesn't he tease everyone?), or blame the child (e.g., perhaps you are being overly sensitive). Instead, an affirming and validating response should be provided (e.g., he is using your old name to tease you; it really hurts). It is critical to not dismiss the discrimination or accept it. It is important to let the child know that you are sorry it is happening and they are not to blame.

Identify Needs for Transition-Related Care Given the range of transition-related services (social, medical, and legal) that may be relevant and necessary for TGD youth, it is important that the social worker be able to adequately explore the child's individual needs as well as the family's level of awareness about and understanding of these services. It is important that assessment questions be asked in a normalizing and nonjudgmental manner. TGD children and their family members may interface with many health care providers (e.g., primary care, school nurse, endocrinologist) and other professionals (e.g., school administrators, religious leaders) with vary-

ing levels of trans-specific knowledge and compassion. Having an informed social worker serve as an affirmative source of support while exploring and/or processing challenging experiences is beneficial.

With younger children, the social transition is often the most immediate area of concern. The assessment may include an exploration of the following issues (both what is happening currently and how they wish things could be): clothing, hairstyle, pronouns, name, bedroom and toys, as well as extracurricular activities (e.g., ballet versus football, or playing on the girls' soccer team versus the boys' soccer team). Once the child has been able to express their needs, it is important to explore any caregiver ambivalence about the child's social transition, as well as needs for advocacy (e.g., working with the school to ensure a safe and supportive climate for the client; family sessions with grandparents to help them understand the needs of TGD children).

Exploring the child's and family's feelings about and/or plans related to legally changing the child's name is another important area of assessment. This may also be an opportunity for psychoeducation. While not all families will be ready to take this step during childhood (versus adolescence or adulthood), some will. Legal name changes are often important to children who have already socially transitioned and are living as their authentic gender across all spheres of life. Legally changing a child's name to match his/her/their identity and gender presentation can often make the child more comfortable in school, recreation and medical settings where legal names are documented and often called aloud. The use of a child's legal name and/or the incorrect pronouns may feel like an emotional assault to TGD children and can be a source of notable anxiety and distress.

Puberty can be a particularly distressing time for TGD youth who may feel that their bodies are betraying them by developing in the "wrong" direction. As puberty is occurring earlier than ever (in some instances in children as young as 7 or 8 years old) (Sherer et al., 2015), it is important that social workers explore transition-related medical needs with young children and their caregivers. When exploring a child's transition-related medical needs, it is important that the social worker be aware of the developmental considerations (discussed above) associated with various aspects of medically transitioning, the reversible (pubertal blockers) and non-reversible aspects of medically transitioning (e.g., hormone therapy, surgeries) as well as current research associated with medical transition-related care for children. Moreover, social workers should have a list of appropriate, affirming medical providers (e.g., pediatric endocrinologists) to share with the family.

Providing TGD Affirming Family Education and Support

Family acceptance and support for TGD identities and transition-related care are increasingly recognized as key contributing factors to positive development among TGD children and teens (Olson et al., 2016; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Simons et al., 2013). However, it is well-established that many parents struggle (especially initially) with their child's TGD identity (Menvielle & Rodnan, 2011) and are often ill informed regarding best practices (Riley, Sitharthan, Clemson, & Diamond, 2013). As such, providing psychoeducational information to parents is an integral component of helping families to better accept and understand their children (Ryan et al., 2009, 2010). Specifically, affirmative education might include information about TGD identity development, the spectrum of TGD identities, transition-related options and resources, and the impact of family acceptance and support on health outcomes (Riley et al., 2013; Ryan et al., 2009, 2010). Exploring parents' feelings of confusion, shame, guilt, fear, and/or anger about their child's TGD identity and correcting any misconceptions are also important tasks (Forcier & Haddad, 2013; Menvielle, & Rodnan, 2011).

Many families can benefit from being connected with others navigating similar experiences (Riley et al., 2013). As such, social work practitioners should be aware of local and national resources that offer support. Connecting families with local chapters of the national advocacy and support organizations PFLAG and Trans Youth Family Allies can enable family members to learn from others how to better support their child. Encouraging families to find online information and support may also be beneficial, such as directing parents of TGD children to YouTube videos that document (1) stories of families with TGD children (e.g., Whittington Family), (2) experiences of TGD young people with a range of identities and who fall within various stages of the transition process (e.g., pre-hormone replacement therapy, changes related to hormone usage, post-surgery), as well as (3) narratives of nonbinary or agender youth. There are also transgender specific websites and conferences that specifically provide support to family members of TGD children (e.g., Genderspectrum, Gender Odyssey Family). Research suggests that providing advocacy for families is also an important role for the trans-affirmative social worker, including offering support for families navigating transition-related health services (Gridley et al., 2016) as well as schools and other community organizations, such as sports leagues, dance studios, or camps (Riley et al., 2013).

Clinical Examples

There are several factors to attend to when striving to engage in competent and affirmative clinical care with TGD children and their families. When assessing a TGD child's clinical needs, it is important to consider the client's age and developmental stage, the persistence and consistence of experiences of gender non-conformity, as well as any social, cultural, or familial pressures to conform to the behaviors, attitudes, and expressions associated with assigned sex at birth. Moreover, TGD affirming practitioners must be aware of the importance of practicing from a framework that acknowledges and affirms non-binary experiences of gender, and helps adults support children's non-binary, fluid, and/or evolving expressions of gender (Ehrehnsaft, 2016). The following clinical examples were developed from a constellation of experiences of TGD children/parents who were seeking transgender-specific therapeutic services in a private practice setting. As such the examples do not reflect the experience of any single client, rather they highlight several salient clinical considerations that may be relevant to providing affirming care to TGD children in a variety of social work practice settings.

Taylor

Taylor is a 9-year old who was assigned female at birth and expresses a gender identity that is non-binary and fluctuates. Taylor is brought in for therapeutic services by her single mother who is "confused" by Taylor's shifting expressions of gender and wants support to help Taylor get through "this phase". An in-depth gender assessment reveals that Taylor has preferred wearing gender non-conforming clothing (e.g., clothing more typical of biological male children) since a relatively young age (3-years old), although there are still many instances where Taylor likes to wear stereotypically feminine clothing (e.g., t-shirts with glitter, sparkly shoes) and play with stereotypically female toys (e.g., dolls, baking) even at home alone. From a young age, Taylor begged to wear her hair short, and if it was long would always wear it pulled back in a low ponytail. While Taylor generally prefers a physical gender presentation that is more typical of a young boy (e.g., short hair, baseball caps), unlike some transgender children Taylor has never stated "I am a boy". Rather, when Taylor is asked about gender identity (e.g., how do the words boy or girl fit for you?), Taylor describes it as follows: I mostly feel like a boy, but not always. Sometimes I like to be girly too. Maybe I am two things—boy and sometimes girl. Taylor appears to have little dysphoria associated with sex organs (e.g., no expressions of distress, disgust, or shame about having a vagina, although she has stated that she would rather not grow breasts). Taylor is not bothered by female pronouns (which are used at both school and at home), but is also comfortable with male pronouns (which often happens in public places). Taylor does express significant distress over being teased by kids about being gender non-conforming or stared at in public (which reportedly happens while shopping for clothes or toys). These experiences are very upsetting for both Taylor and her mother. Because Taylor does not explicitly reject her female identity or exclusively claim a male identity, feels little gender dysphoria associated with her body, and demonstrates some gender fluidity, Taylor's experience of gender appears to be non-binary and one that may further evolve as she approaches puberty.

Given existing research on identity emergence and best practices, the specific strategies necessary to support Taylor should focus on supporting Taylor's current and potentially evolving experiences of gender, provide psychoeducation to facilitate her mother's ability to understand, affirm and support Taylor's non-binary experience of gender, provide resources (e.g., coping skills, support services) and/or advocacy to Taylor and her mother to address the impacts of bullying and stigma associated with negative attitudes and responses to Taylor's gender nonconformity. It is important to validate and support Taylor's mother's efforts to get her the care and services she needs, while simultaneously educating her about: (1) non-binary experiences of gender; (2) research regarding the evolution of gender identity and experiences for some children/teens; and (3) age/developmentally appropriate intervention strategies that can support Taylor's authentic expression of self. In addition to psychoeducational interventions, supportive interventions may be important for youth and family members dealing with stigmatizing experiences associated with TGD identities. For instance, Taylor may benefit from supportive individual or group counseling if she is teased or ostracized at school, while her mother may need support from a practitioner when trying to help family and friends understand that Taylor is not confused about her gender identity, but rather that her sense of gender is more fluid or diverse than some.

Madison

Madison is a 6-year old child assigned male at birth whose expressed gender identity is female. Madison's father is Non-Hispanic White and her mother was born in the United States but is of Cuban descent. Madison is the client's chosen name (although it has not yet been legally changed) and she experiences notable distress when her legal name Rodrigo (a clearly masculine name) is used by others. When asked about this, she said "it embarrasses me", and "makes me really sad". "It makes me feel like I'm not who I am". Madison has expressed attitudes, behaviors, play and preferences for toys and clothing typical of female children

since she was 2 years old. As soon as she was able to speak she began emphatically and consistently expressing "I am a girl" to her parents. Her mother and father initially rejected these claims, but as Madison did not stop, and instead grew more insistent about her gender identity, her parents have been allowing her to dress in female clothes and use her preferred name at home. Her parents indicate that this is helpful, but acknowledge that it does not seem to be sufficient. An in-depth assessment with Madison indicates that she knows she is a girl and cannot wait to begin to grow her hair long like Princess Jasmine's and wear her dresses and sparkle shoes to school. Madison expressed notable distress about her penis and said she wants it to go away. She also indicated that something that really scares her is the idea of getting a beard or mustache. Madison indicated that at school her best friends are girls but she gets very sad when the class lines up because there is a boys' line and a girls' line and they make her go in the boys' line. She indicated that sometimes she cries or doesn't want to go to school. Madison expresses very clearly that she would like to grow up to be a beautiful woman. Madison's parents would like to learn to support Madison, although they are not sure how. They face a great deal of pressure from Madison's grandparents and some of their friends at church to put a stop to what others see as Madison's outrageous and attention seeking behavior.

Best practice strategies for working with Madison and her family should be rooted in the existing research which points to the importance of insistent, persistent, and consistent expressions of gender dysphoria as indicators for a transgender identity that remains through adolescence and adulthood, as well as research illustrating the protective impact of transition-related care and parents who support and facilitate this process (Olson et al., 2016; Simons et al., 2013) There are specific strategies necessary to support Madison. One important step is to affirm Madison's identity and work with the family to help create safe and affirming spaces for Madison outside of the home and clinical setting. In addition, the practitioner should offer psychoeducation focused on developmentally relevant transition-related care and research on the protective impact of family support. While puberty is not rapidly approaching for Madison and medical interventions associated with transitioning (e.g., hormone blockers) are premature at this developmental stage, it may be helpful for the provider to help the family plan for the future by locating and establishing a relationship with a TGD-friendly endocrinologist. As a result of the paucity of TGD affirmative healthcare providers, this can often be a complex process. Supportive interventions may be important for Taylor and her family given that they are experiencing rejection and hostility from their extended family and their church family. Providing referrals to TGD specific support groups and/or conferences (e.g., PFLAG, Gender Odyssey) may help Madison and her family manage these stressors and teach her parents to become effective advocates.

Finally, practitioners may want to provide the families of both children with various advocacy oriented resources aimed at ensuring that the children are supported in school. Such resources might include linkages to local, state or national organizations that support TGD students in school (See Schools in Transition: A Guide for Supporting Transgender Students in K-2 Education); resources that help parents support and advocate for their children (e.g., Genderspectrum); or local, regional, or national legal support aimed at creating safe school climates for TGD children and adolescents (e.g., Human Rights Campaign: Welcoming Schools, Lambda Legal, National Center for Transgender Equality).

Conclusion

As TGD children have a range of gender experiences that may evolve over time, corresponding clinical support and transition-related needs will also vary widely. TGD affirmative practitioners must be capable and prepared to play several distinct roles depending on each client and family's unique set of needs and circumstances. Practitioners should develop the TGD-specific knowledge and expertise required to engage in a comprehensive gender assessment, offer psychoeducation, refer clients to local and online resources, competently discuss developmentally relevant transition-related care options, and provide affirmative therapeutic support. Moreover, when necessary, TGD affirmative practitioners should be able and willing to support TGD children and families through advocacy efforts targeting schools, other providers, as well as the community at large. Practitioners must have the ability to offer affirmative support to each child as they navigate their unique gender journey. This requires embracing an open and inclusive stance toward gender diversity and the recognition that a child's ability to authentically express and inhabit his/her/their true gender may evolve over time. Finally, social workers' practice must be rooted in a TGD affirmative framework, a clinical stance which honors and supports the integrity, diversity, and worth of each child as well as the right of all individuals to live authentically.

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Compliance with Ethical Standards

Conflict of interest The author declares that the author has no conflict of interest.

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