Raising Awareness, Building Acceptance:

Educating Parents on Gender Diversity

by

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Abstract

The focus of this capstone is to provide an overview of how gender is defined and the journey a transgender or gender-diverse (TGD) child or youth may take. Specifically, this capstone is intended to offer insight for cisgender, heterosexual parents and caregivers or the population in general who have questions or confusion surrounding this important topic. Gender incongruence is a widely misunderstood topic for people who live life in a binary black-and-white fashion. My objective is to provide sufficient information to foster understanding of this topic, thereby reducing stigma, discrimination, and the numerous psychological challenges faced by this population. Moreover, I aim to highlight that gender-affirming care for TGD children and youth is equally as valuable and necessary as it is for cisgender children experiencing precocious puberty or adults requiring hormone supplements or sexual enhancement prescriptions. The prevalence of TGD individuals is approximately 2% around the world. There has been a noticeable increase in children and youth socially transitioning prior to seeking out gender-affirming care in the past decade. I outline the psychosocial co-morbidities of the TGD population, as well as necessary protective factors. I write about assessment and psychological and medical interventions as they relate to creating positive transition outcomes and the ethics of gatekeeping gender-affirming care. I provide information on transition and detransition as it relates to a journey of gender discovery rather than a treatment endpoint. I provide insight into how viewing our world from a binary lens is harmful and restricts the expectations of the TGD population and how gender should be expressed on an individual basis without societal pressure for what it thinks it should be. Finally, Chapter 3 contains a semi-scripted presentation that I have created for caregivers at Foundry Langley, BC, Canada.

Keywords: transgender, gender diverse, gender dysphoria, mental health, protective factors, detransition

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Chapter One: Introduction

Overview of the Topic

Gender identity has become a controversial and politicized issue. We live in a cisnormative society where gender is often taken for granted, and questioning it is rarely encouraged. This is the result of structural and political forces that reinforce binary gender norms. From an early age, we are socialized to believe that gender is fixed, tied to biological sex, and absolute. Schools, media and legal systems uphold these norms, making it difficult for anyone to conceptualize gender as fluid or self-determined. Resistance is often rooted in fear and misinformation rather than an understanding of lived experience.

For many parents, the idea of changing pronouns, altering birth names, and gender or expressing yourself outside of a cisgender, heteronormative, socially constructed framework can feel destabilizing. This discomfort is not necessarily a reflection of a lack of love but rather a reflection of a society that has not prepared them to see gender beyond rigid binaries. Parents typically want what is best for their child and would, if given the chance, choose a life unencumbered by struggle for their child and themselves. However, the real struggle often comes not from a child's gender identity itself but from the societal barriers and discrimination that make gender diversity difficult to navigate.

Who you are in terms of your gender identity is an existential question that does not plague most people in their lives. How a person identifies is often a stereotypical progression that begins by receiving a gender designation at birth based on a visual assessment of the infants' genitalia and the child growing and maturing through puberty and adulthood, resulting in a lived experience of the gender they were assigned at birth. If you identify with the sex you were assigned at birth (male genitalia means you are a boy, and female genitalia means you are a girl), you are described as cisgender (Hässler et al., 2022). However, if the feelings you have about your gender identity are incongruent with

your assigned sex at birth and you question the validity of society's expectations and assumptions of this gender, you are described as transgender or gender diverse (Bowman et al., 2022). The topic of gender incongruence and the philosophical and practical questions that arise from a discussion have answers that hold fundamental significance and have valuable real-world applications. With an estimate in the United States (US) of 0.7% of children and adolescents under the age of 18 identifying as transgender or gender diverse and more recent calculations of 2% of high school students identifying other than their assigned sex at birth, answers to how to guide and support gender-questioning children and youth are important to the individual, parents, and surrounding support systems (Cole et al., 2023; Dubin et al., 2020). Pivotal to this discussion is evidence that children as young as age five have an increased risk of suicidality when they lack support from their parents or caregivers (Turban & Ehrensaft, 2018).

What is gender identity, and how old do you have to be to understand it? At what age should an individual be allowed to seek gender-affirming care? What are the consequences of early versus late gender-affirming care and transition? Does the child or youth experiencing emotions of incongruence know best, regardless of age? How important is the weight of cisnormative oppression and discrimination? Who is responsible for overseeing a person's gender identity prior to reaching the age of consent? If there are disparities in the desired gender care trajectory between parent and child, who or what authority decides a solution? What if the child, youth, or young adult changes their mind and wants to detransition? Many questions are relevant to this important topic due to its complexity involving personal, legal, and political opinions. For the purposes of this capstone, I will be focusing on gender development, gender incongruence, gender-affirming care, both psychological and medical, and the concerns surrounding detransition. The result will be a comprehensive guide to the essential knowledge that parents require to support the health, safety, and well-being of their children and youth who experience gender incongruence. My belief that gender-affirming care is essential for providing

inclusive, life-saving, and meaningful support for our children, youth, and future generations is woven throughout this capstone.

Background of the Issue

Transgender is employed as an overarching term that includes people who identify other than their assigned gender at birth, including but not limited to transgender women (TGW), transgender men (TGM), nonbinary (NB), gender-queer, gender fluid, and agender or gender-neutral individuals (Bowman et al., 2022). Gender diverse, gender-questioning, and gender fluid refer to individuals who identify differently than their assigned gender at birth and are believed, at this point, to be terms that are inclusive and non-pathologizing (Turben & Ehrensaft, 2018). Those who experience distress from their assigned sex at birth not matching their gender experience or expression are described as suffering from gender dysphoria. The most recent definition of gender dysphoria (GD) in the 2022 edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) states that the diagnosis of gender dysphoria refers to individuals who experience clinical distress from an incongruence between their sex assigned at birth and their gender identity. More recently, the term gender incongruence has been promoted as an alternative to gender dysphoria, as not all people who identify differently from their assigned gender at birth experience dysphoria (Turban & Ehrensaft, 2018). The DSM-5-TR requires at least six months of duration manifested by at least two or more of their criteria and is "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2022. p. 512). The historical pathologization of TGD individuals is pervasive and places mental health professionals in the position of gate-keeping gender-affirming care. The necessity of a diagnosis of gender dysphoria to access gender-affirming care is a reaction to cisnormativity and negatively impacts therapeutic rapport and adds to the ongoing oppression and stigma that this population experiences (Spencer et al., 2021).

Many opinions have weighed in on the topic of children and youth transitioning from their assigned gender at birth and the appropriate age that is required to understand the ramifications of this change. The question that arises from this concern is the stability of a gender identity other than the one assigned at birth, and given the different levels of permanency of gender care, what are the consequences if the individual changes their mind and desires to detransition? The importance of understanding gender-affirmative care and its impact on the gender-diverse population is particularly relevant in today's political atmosphere, especially in the United States, due to the influx of legislation to limit access to gender-affirming care (Turbin et al., 2022). Additionally, and perhaps more importantly, it is necessary to understand the ethics of gatekeeping gender-affirming care, given the psychological and physical ramifications of withholding care (Ashley, 2019).

Purpose Statement

The purpose of this capstone is to offer a thoughtful review of the concerns held by society at large, and by parents in particular, regarding transgender and gender-diverse children and youth transitioning. The ultimate aim is to develop a resource for individuals who may not be familiar with or have access to the existing literature on the current understanding of assessment, treatment, and the gender transition process with an information session for interested caregivers through Foundry Langley, BC, Canada. This resource is designed to help parents and caregivers understand how to provide informed, positive, and affirming support to their child or youth experiencing gender incongruence.

Significance of this Capstone

Transgender and gender-diverse (TGD) individuals have a higher rate of maladaptive coping mechanisms, substance misuse, suicide attempts, and completed suicide compared to cisgender youth and non-trans LGBTQIA+ youth (DeZure, 2023). Providing gender-affirming care in the form of

psychological and optional medical care reduces the negative psychological trajectory that many gender-questioning and gender-incongruent youth experience when they are negated and pathologized for their experience. Parents and caregivers are often the first line of support for these children and youth, and providing accessible and relatable evidence-based support for them will significantly reduce the dysphoria and trauma that TGD children and youth are subjected to. The intensity of gender dysphoria (GD) experienced by children and youth is largely shaped by their environment; TGD youth who face family rejection are eight times more likely to attempt suicide, whereas those who receive family acceptance and support are three times more likely to experience happiness and have a positive outlook on the future compared to their rejected peers (Turban & Ehrensaft, 2018). Providing a summary of the recent peer-reviewed academic content on this topic will allow caregivers and parents to be primed for being supportive, self-aware, and less fearful of a concept that many people do not understand. In addition, understanding how gender-affirming care promotes well-being and psychological congruence for TGD individuals is important.

Ensuring access to gender-affirming care is essential for alleviating distress. While a small amount of TGD individuals detransition, imposing an overly complicated assessment for care is often regarded as dehumanizing, unjust, and a barrier (Ashley et al., 2023). Detransition is understood as an act of returning, in some fashion, to an identity previous to transition, often by discontinuing medications, engaging in reversal surgery, or both (Hildebrand-Chupp, 2020). A separate but sometimes connected experience is transition regret, which is defined as experiencing a negative emotion that arises when a person reflects on past decisions with a sense of personal responsibility that contributed to their undesired outcome (Jorgenson, 2022). Traditionally, detransition is rare, and it is challenging to calculate the rate of detransition or regret because of inconsistent definitions and the inability to document it accurately (Jorgenson, 2022). However, regret rates for gender-affirming interventions are

low, between 0.3% and 1% (Thorton et al., 2024). Detransition and regret may occur for several reasons, such as persistent social stigma and discrimination, the expense of medical treatment, medical risks or side effects, poor surgical outcome, and/or a different understanding of their gender outside their initial binary journey (Jorgenson, 2022; Thorton et al., 2024). Understanding that transitioning is a journey with individuals who detransition, sometimes retransitioning from binary to nonbinary or gender fluid, is beginning to take shape (Jorgenson, 2022). Ensuring informed consent is provided is a fundamental aspect of gender-affirming care that allows TGD individuals to make thoughtful, well-informed decisions about their desired medical interventions while recognizing that gender nonconformity does not necessarily equate to a transgender identity (Jorgenson, 2022).

Intended Audience

While I live and reside in Delta, BC, the intended audience of this paper is all people from all socioeconomic levels, education levels, cultures, and ethnicities. According to the Standard of Care for the Health of Transgender and Gender Diverse People version 8, created by the World Professional Association for Transgender Health (WPATH), approximately 2% of the high school population is TGD, and the likelihood that any one person knows or interacts with a TGD youth is high (Coleman et al., 2022). Learning the terminology and providing an inclusive and accepting community for this population is an important step toward dismantling the discrimination, stigma, and violence that the TGD community experiences. However, the benefits of creating space for gender diversity extend beyond the TGD community. When we challenge cisnormative values and biases, we create a society where everyone has greater freedom to express themselves without rigid expectations. Expanding our understanding of gender benefits not just TGD individuals but also cisgender people, as it allows for more authentic self-expression and reduces the pressure to conform to socially constructed norms. Additionally, it is essential to recognize that gender and sexuality are distinct and do not inherently

relate. The conflation of the two contributes to misunderstanding and marginalization. By making space for those in the margins, we ultimately make space for everyone, fostering a world where all individuals- regardless of gender identity- can exist and thrive without fear of judgment or limitation.

People need to understand how damaging cisnormative values and biases are to gender-diverse people. While explaining my capstone topic to people, I often hear, “I don’t care, it doesn’t affect me, so it doesn’t matter”; while these words are intended to convey neutrality or even tolerance, they are ultimately dismissive and lack the empathy needed to truly support the TGD community. Tolerance creates a space where people are merely allowed to exist, but it does not foster genuine inclusion or acceptance. Policy changes while necessary, are not enough on their own – true change comes from shifting cultural attitudes and actively working towards a society where TGD individuals are valued, respected, and fully embraced. My purpose is to create awareness and support for a group of people who are often stigmatized, misunderstood, and vilified. A journey of gender discovery should involve compassion, benevolence, and understanding rather than medicalization and derision. Acceptance requires more than passive indifference; it demands intentional efforts to understand, affirm and advocate for those whose identities challenge societal norms. It is important to understand that all people want to feel heard, validated, and included, and when an entire population of people are denigrated and pathologized for simply existing, it causes emotional harm to them. I recognize that our entrenched, Westernized, binary way of thinking contributes to questions and confusion about TGD individuals; however, this lack of understanding does not justify the discrimination, hate, and vitriol directed at them. Ignorance should be met with education and empathy, not harm and intolerance. By moving beyond intolerance and into true acceptance, we create a world where all individuals, regardless of gender identity, are seen, heard and supported.

Parents/Caregivers

Parents and caregivers of today's TGD children and youth are often in their 30s, 40s, and 50s. While many of them are supportive and affirmative of their offspring's gender-questioning experiences, others struggle with the concept of gender diversity, believing their children should wait until they are in adulthood to make such significant decisions. Some parents go further, rejecting their TGD youth entirely, which can create and reinforce shame, guilt and self-hatred. My goal is for parents and caregivers to learn that transgender and gender-diverse people are not to be pathologized and that the questioning of their gender and their resulting gender transition is a journey and not a treatment or finish line. Parents and caregivers are my main audience because they are the number one protective factor for a TGD child and youth against feeling negative about themselves and experiencing thoughts of suicide, depression, anxiety, and other serious mental health concerns (Turban & Ehrensaft, 2018). In fact, TGD children and youth who are rejected by their families are eight times more likely to attempt suicide, in contrast with TGD children and youth who are accepted and supported by their families and who are three times more likely to be happy and look toward the future (Turban & Ehrensaft, 2018). If my paper and the following presentation can achieve a level of psychoeducation sufficient for parents to understand the importance of being supportive of their TGD children and youth so these kids can feel acceptance externally and internally, leading to feelings of worthiness and inclusion, I will feel it has been successful.

Educators

From preschool teachers to high school instructors, educators are a tremendous influence in our young people's lives and play a huge role in helping shape their values and biases. In Canada, from approximately age four until 18, children spend approximately 25% of their waking hours with our educators (Government of Canada, n.d.). Helping our educators understand how to be supportive and

create a safe space for gender diversity and inclusion is an important aspect of this paper. Learning inclusive vocabulary, using correct pronouns and chosen names, and not shaming or dismissing people who are in the TGD community will go a long way toward providing long-lasting feelings of respect, compassion, and a sense of understanding that will decrease the chance of this population experiencing suicide, depression, anxiety, shame, and guilt.

Counsellors

Given the significant overlap between serious mental health challenges and gender dysphoria, it is crucial for this audience to understand how to provide supportive, affirmative care. The goal is to help reduce feelings of dysphoria related to gender incongruence while also addressing coexisting mental health concerns. This population must understand that the existence of comorbid mental health issues is not a barrier to accessing gender-affirming care and does not necessitate resolution unless it affects the ability to obtain informed consent. This audience is, by nature, caring and compassionate, and being supportive of this population is important. Talk therapy is important but should not be coercive toward rejecting gender diversity. Learning to follow the client's lead while supporting gender expression, name, and pronouns while scaffolding the client's decision-making related to their affirmative care is instrumental in supporting a gender-diverse child or youth (Ashley, 2019). While affirming attitudes is an important foundation, healthcare providers must go beyond affirmation by actively educating themselves, advocating for their patients, and fostering an inclusive and competent healthcare environment for TGD individuals (Rich, 2024). As counsellors, we may have beliefs on why a person wants to transition or what the theory of gender development is and how to incorporate gender diversity into this theory, but it is my opinion that our role in our client's life is to provide person-centred, compassionate care, and this capstone will aid in understanding the basics of how strengths-based support starts with gender-affirming care.

Allies and Interested People

Another intended audience for this paper is allies and interested people. People who want to support and be knowledgeable about transgender and gender diversity will find value in the content provided. People who know or have a loved one who is transgender or gender diverse will benefit from learning about how to show support for them with respect and compassion. Remembering to use correct pronouns and chosen names and not being dismissive or critical of gender expression, regardless of how many times it changes, is important. While this capstone does not provide a fulsome education, it is substantiative and topical and will have a positive impact for allies and interested people.

Policymakers

While the chances of policymakers reading this capstone are slim, they are also my intended audience. Policymakers are made up of our community and are either appointed or voted into their respective positions. Having people in these positions of power who understand what transgender and gender diverse mean and how to be supportive of this population is key to providing policy that is inclusive, equitable, and compassionate. Education is the number one format for removing biases, stigmatization, and discrimination based on fear and ignorance.

Contributions to the Field

The most significant way this capstone can contribute to the field of transgender and gender diversity is by providing an easy-to-understand guide on how to be supportive of this population. Binary cisgender beliefs dominate our Western culture and understanding that these biases are hurtful and dismissive to the TGD community is important. Research in all areas is dominated by a binary view, with groups being sectioned into men and women. Recognizing that gender can be cisgender binary, transgender binary, or gender fluid and actively including the TGD population in research ensures that study results are more inclusive, equitable, and applicable to a broader population. I believe many

people are open to understanding an incongruence between assigned sex at birth and expressed gender identity but still think in terms of binary and become confused and dismissive when gender is not expressed in a traditional heteronormative way. A person who is nonbinary may express themselves as more masculine than feminine or vice versa on different days, and some people in their life may struggle to comprehend why a binary gender is not maintained or expressed clearly. A transfeminine woman may choose not to shave their facial hair but may still identify as a woman, and a transmasculine man may choose to bind rather than surgically remove their breasts and still identify as a man. It is important to understand that each person's journey and expression of their gender is theirs alone, and placing our biases and expectations of what we think gender is on anyone is invalidating and hurtful and can cause serious mental health concerns like suicide, depression, and anxiety. It is with great hope that this capstone opens the door to conversation, understanding, and an increase in compassion for what, for many, is a difficult and confusing topic.

Reflexivity and Positionality

I was raised in a heteronormative, cisgender household, and I did not experience gender diversity while growing up. As a teenager, I met people who were potentially gender diverse, but I was not fully cognizant of transgender and gender-diverse communities until I was in my 30s. As a photographer, I got to know a family who have a transgender daughter who began her gender journey at age ten, with many signs of gender incongruence evident since she was a toddler. She was raised by incredibly understanding and compassionate parents who offered her every avenue of support and advocacy. Eventually, she became the voice of trans youth in Vancouver and participated in TV, radio, and social media shows advocating for both her and the trans youth community in general. The support she experienced was amazing. Another equally caring and loving family whom I am acquainted with has a transgender son whose gender journey began during his mid-teen years and was announced with very

few prior indicators of gender incongruence. Their experience led them to the belief that their child's expression of gender dysphoria was a feminist protest to being a woman in today's misogynistic society, and they believed he should wait until he was an adult to consider transitioning or beginning gender-affirming care. They were concerned about the permanence of many gender-affirming medical interventions and the possibility of regret or detransition, particularly in relation to typical teenage impulsivity and emotional changes. Their experience and concerns led to my first paper on transgender and gender-diverse individuals and truly opened my eyes to a community that is struggling to be heard, validated, and included. I have since learned that while the DSM-5-TR (2022) describes the diagnosis of gender dysphoria for individuals who feel distressed that their gender is incongruent from their sex assigned at birth, not all transgender individuals have feelings of dysphoria. I have learned that many people see gender transition as detrimental to children and youth, and yet, research points to gender-affirming care guided by the individual through informed consent as positive (Ashley et al., 2021). I also learned that detransition is rare, and it is likely part of a "person's lifelong psychoeducation of well-being and life satisfaction, despite eventual or transient regret" (Ashley et al., 2023. p. 2).

I hope for a future where gender holds less influence over societal beliefs and values, where labels become less significant, and where all individuals can express their gender freely without fear of violence, rejection, or discrimination. Complementing this idea is my belief that gender-affirming care provides vital support through validation, empathy, and inclusion and offers a holistic opportunity for TGD children and youth to experience congruence and gender euphoria.

Definition of Terms

Cisgender

"Non-TGD people whose gender is concordant with their sex assigned at birth" (Salomaa et al., 2023, p. 619).

Detransition

“is, in one sense, a descriptive verb that refers to the act of returning in some way to a pre-transition state. Detransition can have both medical and social components.” (Hildebrand-Chupp, 2020. p. 802)

Gender Affirmation

“Refers to the iterative process by which an individual receives validation for their gender identity, role, and expression across social, legal, medical, and psychological domains” (Todd et al., 2022. p. 100186).

Gender-Affirming Care

“Alleviate the psychological distress related to one’s body developing in ways that do not align with one’s gender identity” (Turban et al., 2022. p. 2).

Gender Dysphoria

“Marked incongruence between one’s experienced/expression gender and assigned gender, of at least 6 months duration” (American Psychological Association, [APA], 2022, p. 512).

Gender Euphoria

“Refer(s) to a range of positive feelings including but not limited to comfort, confidence, certainty, satisfaction, and joy in response to affirmation of one’s body or one’s gender identity” (Austin et al., 2022. p. 1408).

Gender Expression

“Refers to how individuals present their gender in ways that do or do not align with traditional” (Murray et al., 2017, p. 292).

Gender Identity

"Is one's psychosocial sense of being male, female, neutral or some combination thereof, and is based in one's self-conception of their gender" (Murray et al., 2017, p. 292).

Genderqueer

"Can be defined as any type of trans identity that is not always male or female. It is [also] where people feel they are a mixture of male and female" (Counselman-Carpenter & Redcay, 2023. p. 430).

Hormone Blockers & Gender-Affirming Hormone Treatment

"Pubertal suppression for younger adolescents and gender-affirming hormones (GAH, e.g., estrogen and testosterone) from adolescence onward to induce physical changes that match the person's gender identity" (Turban et al., 2022. p. 2).

Intersex

"Intersex variations, also known as differences of sex development (DSD), encompass a diverse set of congenital differences relating to gonads, chromosomes, and genitals that fall outside typical binary notions of male and female sex" (Rosenwohl-Mack et al., 2020. p. 2).

Nonbinary

"a person identifying as neither a boy nor a girl, as both boy and girl, or as a combination of genders; related terms include genderqueer and gender fluid" (deMayo et al., p. 213).

Sexual Orientation

"Is used to describe a person's sense of emotional, romantic, sexual, or spiritual attraction toward another person" (Murray et al., 2017, p. 198).

Sex Assigned at Birth/ Natal

"Birth-assigned gender" (Coleman et al., 2022. p. S59)

Transgender

"Term for binary and nonbinary gender identities that do not align with an individual's assigned sex/gender at birth" (Jackson & Bussey, 2022. p. 19).

Transman

"A person born phenotypically female (natal female), registered (assigned) female at birth, who identifies as male. Also known as female to male." (Butler et al., 2018. p. 1).

Transwoman

"A person born phenotypically male (natal male), registered (assigned) male at birth, who identifies as female. Also known as male to female." (Butler et al., 2018. p. 1).

Overview of This Capstone Paper

Chapter Two: Literature Review

Chapter two is a literature review that outlines what being transgender and gender diverse is and how gender dysphoria is currently understood and defined. It covers comorbid mental health issues of transgender and gender-diverse individuals and how gender is conceptualized around the world. First, I will explain the relevant terminology and a brief explanation of cisgender development, along with theories relating to transgender and gender-diverse development. Next, I will define gender dysphoria and its related topics and discuss gender transition for early and late transitioners and a controversial notion of rapid onset gender dysphoria. Next, I will discuss the mental health challenges TGD individuals experience, with information on countering these mental health issues. Next, I will cover the assessment of adolescents and children and affirmative care, both psychological and medical. Next, I will cover

concerns regarding the application of gender-affirmative care and detransitioning. Finally, I will summarize the literature review.

Chapter Three: Discussion and Applied Practices

Chapter three is a presentation I have created with a supplemental section of common questions and answers for parents and caregivers. The presentation is formulated to be an informational synopsis for people interested in learning more about the journey of transgender and gender-diverse children and youth in their lives. As social acceptance has made it somewhat safer for TGD individuals to live openly; many cisgender individuals are struggling to understand the notion of being transgender. I hope this presentation and the following Q & A will provide a simple yet informative resource that will lead to support and compassion for transgender and gender-diverse communities at large. I will also provide some personal reflections and commitments that I will carry into my future counselling practice.

Chapter Two: Literature Review

This literature review covers some of the major themes related to gender, gender diversity and transgender people. It will provide a better understanding of the assessment, treatment, and journey of transition that gender-variant people experience. It will cover the main treatment options, the psychological benefits of treatment, and the negative aspects of gatekeeping gender-affirming care. It will highlight some of the questions that parents and caregivers struggle with and the research that applies to these questions. And finally, a thought piece about detransition and its role in the journey of gender transition. Putting together all these pieces, this review aims to provide an overview of the journey TGD children and youth experience and how to support their unique journey to increase their emotional well-being while decreasing stigma and discrimination.

What Is Gender?

When a child is born, and sometimes even prior, one of the first questions asked is, “What is it? A boy or a girl?” Traditional, Western, heteronormative understanding of gender provides a binary essentialist view of men and women (Jackson & Bussey, 2022). Although many cultures around the world have long recognized gender as existing beyond a binary framework, Western conceptualizations of gender have lagged and are in the process of confronting their previous imposition of rigid definitions that erased the diverse and complex ways gender has been understood across cultures (Dunham & Olsen, 2016). In Western societies, gender is typically determined at birth based on a baby's visible anatomy and is generally expected that their gender identity will align with this assigned sex. A person with congruent or matching assigned sex at birth and gender identity is considered cisgender. People whose gender identity is incongruent or mismatched with their assigned sex or experience a gender identity that falls outside the traditional binary of man/woman are called transgender and nonbinary, respectively (Jackson & Bussey, 2022). Gender identity is the expression of how a person represents

themselves socially, is thought to be related to cultural and social meanings and involves a person's core sense of being a man or a woman (Kaltiala-Heino et al., 2018). Gender identity is represented through a psychosocial sense of being and is thought to be created from role models and expectations of appearance through behaviour, attire, and actions (Murray et al., 2017). Biology can shape this identity, but the way gender is expressed and understood is shaped by cultural and social contexts (Murray et al., 2017). In contrast, a person's sex is related to anatomical characteristics and biology and is increasingly understood as being "culturally entangled" (p. 19) and beginning to be recognized as neither binary nor immutable (Jackson & Bussey, 2022). A person's gender identity is not synonymous with sexuality, meaning sexual orientation is a separate concept from gender identity. Sexual orientation refers to the idea of attraction and intimacy and who a person is drawn to sexually (Turban & Ehrensaft, 2018).

In recent years, the understanding of gender has become a hot topic among parents, policymakers, and medical professionals. The gender binary is considered mainstream and an expected developmental trajectory of most children and youth. Transgender was originally coined to describe people who expressed their gender opposite to what they were categorized at birth (natal male to female and natal female to male), which follows the assumption of gender being binary; however, more recent definitions have included gender identities that do not conform to this simplistic binary system (Jackson & Bussey, 2022). Several different understandings of gender have been described by children, adolescents, and adults who do not ascribe to a binary system. People with incongruent gender identity from the sex assigned at birth include a broad community, and it is impossible to describe or include all the accepted terminology, so for the purpose of this paper, I will be using the definition outlined in The World Professional Association for Transgender Health (WPATH) Standard of Care – Eighth Edition (SOC-8). WPATH uses the term transgender and gender diverse (TGD) to describe a community that "exist(s) globally of people with gender identities or expressions that differ from the gender socially attributed to

the sex assigned to them at birth" (Coleman et al., 2022. p. S5). The WPATH describes gender as a spectrum that includes people identifying their gender as matching their assigned sex and those who do not or are fluid in their gender representation and includes terms like genderqueer, genderfluid and nonbinary (Coleman et al., 2022). Although I will use the term TGD throughout this capstone, another term that emerged from individuals within these communities is genderqueer, which describes anyone who identifies and expresses themselves outside the binary of man or woman and may refer to "themselves as transgender, genderfluid, gender non-conforming, bigender, agender, Two-Spirited, gender variant, or other terms such as androgynous, mixed gender, or pangender. Many folx may also use more than one label to describe their gender identity" (Counselman-Carpenter & Redcay, 2023. p. 430). Labels are deeply personal and ever-evolving. The terms and labels folx use to describe themselves that are related to gender and sexuality are not fixed and shift as language grows. What might be affirming to one person may feel restrictive or harmful to another and it is essential to avoid making assumptions about how a person identifies. Language is a tool for self-expression and not a box to be confined within, marginalized communities often reclaim slurs and reshape language to reflect their own experiences and words that were once used as weapons may be transformed into sources of pride and empowerment (Puchala et al., 2025).

It is important to note that some people whose gender identity is different from their assigned sex at birth experience dysphoria or an experience of clinical distress at the difference of sex and gender experience. However, due to the pejorative nature of this label, the term 'gender incongruent' emphasizes that not all people experience distress at this difference (Turban & Ehrensaft, 2018). Gender is increasingly being described as multidimensional, with different aspects following different trajectories. Evidence is being found that many people do not experience gender as binary, and upward of 35% of cisgender adults feel "to some extent, like the 'other' gender" (Potter et al., 2021. p. 171). This

statistic emphasizes how this work is important to all people as it allows the freedom of authentic expression. Challenging cisnormative values and biases create space for a world where people can explore their identities without judgment which fosters acceptance, reduces stigma, and ultimately leads to a more inclusive and compassionate society.

Intersex/Differences of Sex Development (DSD)

Intersex is a term used to describe people whose biological sex is not clearly male or female (Durham & Olsen, 2016). Genetic testing has allowed the ability to make assessments easier and earlier, including in utero inclusion, and has determined that more intersex people exist than was originally understood (Durham & Olsen 2015). Intersex people are born with physiological characteristics that are outside the expected binary of male or female sex, also called differences of sex development (DSD), and include a myriad of “congenital differences relating to gonad, chromosomes, and genitals” (Rosenwohl-Mack et al., 2020. p. 2). For over 70 decades, medical care for people with DSD has included non-consensual medical interventions that created a surgical binary sex category that is irreversible and associated with long-term health challenges to treat the sex ambiguity (Rosenwohl-Mack et al., 2020). Rosenwohl-Mack et al. (2020) reported that in a study of intersex care, including 259 participants with an average age of 37, 10% stated not knowing what intersex variation they had, and over 50% had more than two intersex diagnoses and an average of age of 20 when they received a diagnosis. Thirty percent reported that their physical health was fair/poor regardless of age group, and over fifty percent reported their mental health was fair/poor, including depression, anxiety, or PTSD. This study concluded that there is an important need to expand research and intervention for those with DSD and to create interventions that include informed consent and decision-making, with the promotion of bodily autonomy that prevents harm.

Gender Around the World

As described above, Western cultures traditionally view gender and sex as discrete and binary, but outside the Western middle-class “WEIRD” (Western Educated, Industrialized, Rich, and Democratic) context, a more inclusive and diverse view is welcomed (Dunham & Olson, 2016. p. 651). The PBS (2024), through Independent Lens online magazine and in consultation with Badly Licked Bear—an educator, writer, artist, and mutual aide worker—created an interactive map that reports over 30 distinct cultures that include a third gender. The WPATH state:

> TGD people identify in many different ways worldwide, and those identities exist within a cultural context. In English speaking countries, TGD people variously identify as *transsexual*, *trans*, *gender nonconforming*, *gender queer* or *diverse*, *nonbinary*, or indeed *transgender and/or gender diverse*, as well as by other identities; including (for many identifying inside the gender binary) *male or female*. (Coleman et al., 2022. p. S18).

Dunham and Olsen (2016) describe Samoa as having the gender identity of fa’afafine, which is recognized as an alternative to male and female; the Dominican Republic and Papua New Guinea have regions where intersex births are relatively common; and the hijra of India are a third gender, similar to the Western concept of transgender and intersexed individuals. The hijra are understood to possess the power to bless or curse and often assume religious roles (Britannica, 2023). Colonization laws from 1871 categorized the hijra as criminals, and anti-hijra sentiments grew (Britannica, 2023). An ethnic group in Indonesia, the Buhis, recognizes three genders outside the binary: the Calalai, Calabai, and Bissu, which surpass other genders and epitomize a spiritual role (Britannica, 2023). In Mexico, there is a group of people who have male sexual characteristics but express a feminine identity, called muxes; they are embedded in the Indigenous culture of the Zapotec people (Britannica, 2023). People Indigenous to

Madagascar who are sexed male at birth but display feminine preferences are raised as girls, called Sakalava, and are viewed as both sacred and protected by supernatural powers (Britannica, 2023).

The Indigenous people of Turtle Island, the name of the land used to describe the Americas that originated from First Peoples' creation stories, refer to people of their community who express both male and female spirits as being Two-Spirit and are uniquely able to view life from both gender perspectives and bridge the differences between the binary (Britannica, 2023). Colonization deliberately erased Indigenous gender and sexual diversity by controlling reproductive rights and enacting a format of kinship documentation with the imposition of binary gender roles (O'Sullivan, 2021). O'Sullivan (2021) examined how the gender binary is a colonial construct imposed upon Indigenous peoples, erasing pre-existing gender diversity and enforcing European social-religious norms. The author argues that colonization sought to manage Indigenous populations by restructuring family and kinship systems to fit a Western Nuclear model, reinforcing heterosexual reproduction as a means of control. In 1990, the Indigenous people coined the term Two-Spirit as an organizing tool to opt out or challenge Western concepts of the gender binary of man/woman (Pruden & Salway, 2020).

Two-spirit represents a placeholder and not an identity, as there are currently around 130 Nation-specific terms used to describe sexuality and gender amongst the Indigenous people (Pruden & Salway, 2020). Two-Spirit identities are an integral aspect of the First Nations Peoples of Canada and represent "a diverse array of sexual orientations, gender identities, and gender expressions from First Nations across North America that exist beyond colonial and heteronormative conceptions of gender/sex and sexuality (Cameron & Stinson, 2022. p. 538). Among many Indigenous cultures is the idea of a third gender encompassing both genders of varied measures and having a special religious role, healer or spiritual worker, and despite centuries of suppression in many Western cultures, there exist remnants of a past when a third or fourth gender existed (PBS, 2024). It can be concluded that there is

global recognition of diverse gender identities that challenge the Western binary model and highlight the resilience of Indigenous and non-Western understandings of gender despite centuries of colonial suppression.

Theory of Gender Development

Gender is understood as the expression of a person's identity that represents the social, mental, and emotional state related to their sex but not necessarily associated with their anatomy and is created from one's concept of their gender (Murray et al., 2017). The term gender identity is commonly used to describe a person's "sense of their own gender as, for example, a boy, a girl or nonbinary person" (deMayo et al., 2022. p. 208). Westernized developmental science propels the concept of gender being developed in childhood by the age of three, which then becomes the basis for their sense of self and creates an outline for how the child interacts socially with peers and activities (deMayo et al., 2022). This journey, where a child aligns their gender identity with the sex they were assigned at birth, is defined as cisgender and is considered mainstream and is statistically the most common formation of gender (deMayo et al., 2022; Jackson & Bussey, 2022). However, this model ignores the development of gender-diverse children and youth. Gender is rapidly being understood to be multi-dimensional, with "different aspects of gender following different developmental trajectories" (Potter et al., 2021. p. 171). Gender-diverse people are defined as those who do not fit this definition of gender-conforming people who have matching gender identity and sex assigned at birth (deMayo et al., 2022). Those whose gender identity is incongruent with their sex assigned at birth are termed transgender, and gender identities that fall outside of the binary of man and woman are termed nonbinary (Jackson & Bussey, 2022). The importance of using a gender development theory that is inclusive and non-pathologizing toward gender-diverse children and youth is important to the research and future psychological and medical care of gender-diverse people (deMayo et al., 2022).

Most theories of gender development are entrenched in the essentialist views of binary assumptions of either man or woman, and there is a belief that cisgender children involve the acceptance of an identity already present, while transgender or nonbinary children and youth involve an active identification into an alternate gender group (Jackson & Bussey, 2022). However, research suggests that gender development is more alike than dissimilar for all formations of gender, and it is just viewed more obviously by those who identify outside of their assigned binary (Jackson & Bussey, 2022). Jackson and Busey (2022) outline that classical theories of gender development attempting to explain transgender and nonbinary gender development originate with normative binary gender assumptions and likely include implicit biases in their understanding of gender development in their explanations. A perception that gender is stable, immutable, and binary is being recognized as inaccurate, as there is a burgeoning understanding that gender as a category may be correct "at that time" (p. 21) and can potentially be subject to change across a person's experiences and growth (Jackson & Bussey, 2022). Some common gender developmental theories that have attempted to include transgender and nonbinary development are cognitive developmental theory, gender schema theory, social cognitive theory, and biological gender theory. A notable understanding is that research on gender development has traditionally focused on cisgender binary children and youth with the recent inclusion of transgender binary participants; however, the inclusion of genderqueer, gender fluid and/or nonbinary children or youth has yet to become routine (Levin et al., 2023).

Cisgender Binary Gender Development

Historically, gender development focused on cisgender children and found children aged 2.5 to three years old can distinguish their gender identity and begin to show preferences for toys and activities that match the stereotypical gendered toys and clothing associated with their binary genders, and they prefer same-gender peers (Hässler et al., 2022). By around age three to five most children

believe their gender will stay the same for the remainder of their lives, typically view themselves as the same as other similarly gendered children, and show highly stereotypical behaviours of their gender (Gülgöz et al., 2019). Gülgöz et al. (2019) explain that a prototypical girl is someone who is assigned female at birth due to having XX sex chromosomes and feminized genitalia. These attributes provide a female label at birth, and then the baby is treated like a girl, which will likely lead to her internalizing a sense of being female (gender identity). Chances are that this will lead to engaging in cognitive self-socializing and gender-stereotype behaviour, which are often directly or indirectly reinforced by parents, peers, and media, which then creates the inability to separate the role that each factor plays in the development and expression of gender identity.

A child that is assigned a gender at birth and is treated and socialized as that gender may internally feel that that gender does not make sense for them, and they may begin to identify with the opposite binary, both or neither binary gender, or even freely vacillate between the two binary genders (Gülgöz et al., 2019). These children may then seek out ways to express this gender through socializing and role models (Gülgöz et al., 2019). In the past, these children were considered late developers or were designated as having problematic behaviours, but more recently, researchers are "viewing cross-gender identification and behaviour as part of a spectrum of normal gender variating rather than clinical concern" (Gülgöz et al., 2019. p. 24481).

Cognitive Developmental Theory

This theory follows that children's idea of gender develops over time through "cognitive maturation" (p.21), with a judgement that they are a boy or girl based on physiological characteristics that lead them to become involved with behaviours that are gendered and binary and making them active agents of their development of gender (Jackson & Bussey, 2022). It is believed that children play an active role in understanding and expressing their gender rather than passively accepting it based on

societal reinforcement and then searching for clues to support their beliefs (deMayo et al., 2022). Research has demonstrated that transgender children who have changed all of their social indicators of gender to the binary opposite to their assigned sex at birth by age three to five remained consistent in this opposite expression of gender, suggesting that transgender binary development is analogous to cisgender binary peers (Fast & Olson, 2018). However, the lack of nonbinary children in this study challenges the assumption of consistency of gender, as for some children, youth, and adults, how they express or relate to gender internally and socially changes over time and is flexible (Jackson & Bussey, 2022).

Gender Schema Theory

This theory states gender schemas are created by the child's first observation of genders, and then stereotypes are created around these concepts (Jackson & Bussey, 2022). Once children can begin to assess their self-categorizing of their own gender, they can build a schema around it, and it is believed that children are reinforced to find information about their presumed gender and act accordingly (Jackson & Bussey, 2022). The assumption that schemas are created from the child’s assigned sex at birth with the connotation of a correct gender is implicit and excludes transgender and nonbinary development. This theory assumes that children are creating gender identity from the interactions within the society in which they live, and yet, nonbinary children often have no visual representation of this category yet still develop outside of the binary assumption of their visual world (Jackson & Bussey, 2022).

Social Cognitive Theory

This theory views gender as a social process of categorizing, which is acted out via gendered practices and performances and is interpreted through socially constructed systems of meaning (Klysing, 2019). This theory emphasizes that children develop their behaviour and sense of self because of the

early influences of parents and their social environment, and this direct and vicarious influence of binary gender supports children to develop their gender (deMayo et al., 2022; Jackson & Bussey, 2022). Social consequences are the motivating factor behind determining whether a behaviour or expression is appropriate for their gender. This theory asserts that transgender individuals develop their gender self-categorization later than cisgender children and is increasingly obvious only because it differs from their assigned sex at birth (Jackson & Bussey, 2022).

Biological Gender Theory

This theory states that viewing gender as biological assumes our reproductive functions as the basis of categorization and assumes the expression of the binary phenotype based on an underlying genotype (Klysing, 2019). This theory argues that genetic and hormonal factors are integral to the formulation of gender identity (deMayo et al., 2022). Studies on hormonal levels during in utero and gendered behaviour have fallen short of explaining gender development; including other valuable biological determinants is imperative but still lacks a comprehensive explanation for traditional and non-traditional gender development (DeMayo et al., 2022). Gender identity may be fixed for some, but for others, it includes a developmental process (Coleman et al., 2022). According to WPATH, “neuroimaging, studies, genetic studies and other hormone studies of intersex individuals” (p. S44) found there is a biological component to the contribution of gender identity (Coleman et al., 2022). Still, it is impossible to separate how each aspect contributes to the process or to determine which individual gender identity will be fixed or will be a developing process (Coleman et al., 2022). Research suggests that transgender individuals disclose a myriad of personal narratives that represent the heterogeneity of gender transition pathways and that when compared to their binary counterparts, nonbinary individuals have “a less linear and more flexible” transition that may start later and may have a less targeted endpoint (Tatum et al., 2020. p.380).

Other Theories

The theories outlined above have attempted to understand the development of TGD with limited success. At best, they explain the origins of gender dysphoria or incongruence, whether influenced by internal factor or external reinforcement of cisnormative binary gender roles. Meanwhile, the child learns that their gender identity is viewed as abnormal by their cisnormative peers. One theory that attempts to be inclusive of gender-diverse individuals in its gender development is the idea that gender develops through a constructivist framework through which gender is developed in four distinct aspects: biological sex, gender identity, gender role expression, and sexual orientation, and they are each on independent continuums and fluid throughout a person's lifetime (Wilson et al., 2023). This model emphasizes self-determination and agency and has been modified to include developing language by using the terms 'sex assigned at birth' and 'anatomical sex' instead of 'biological sex' (Wilson et al., 2023). However, a criticism is that this still emphasizes a binary with each axel being on a continuum with masculine and feminine opposite to each other.

It is important to note that as the current TGD population increases, they will be increasingly represented in research and theory and new, more applicable theories will come to fruition (Wilson et al., 2022). Along this thought process is the idea that individuals who are now in their teens and early adulthood and have been raised in a global community with access to inclusive vocabulary and a broader awareness of the diversity of gender and sexuality will lead to a more dynamic population of which to gather subjects for future research (Levin et al., 2023).

Gender Dysphoria

Those who experience psychological distress that causes impairments to their social, occupational, or other area of functions because their gender identity is incongruent with their sex assigned at birth are described as suffering from gender dysphoria (GD) (Kaltiala-Heino et al., 2018). The

most recent definition of GD in the 2022 edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) states that the diagnosis of gender dysphoria refers to individuals who have a “marked incongruence between one’s experience/expressed gender and assigned gender” (APA, 2022. p. 512). More recently, the term gender incongruence has been promoted as an alternative to gender dysphoria, as not all people who identify differently from their assigned sex at birth experience dysphoria (Turban & Ehrensaft, 2018). Gender dysphoria in children is outlined in the DSM-5-TR (APA, 2022. p. 512) as requiring at least six months of duration manifested by at least six of the following:

- a strong desire to be of the other gender or an alternate gender to their natal sex
- a strong desire to cross-dress opposite or alternate to their natal sex
- a strong preference for cross-gender roles during imaginative play
- preference for toys, games, or activities that are traditionally used by the opposite gender
- preference for playmates of the opposite gender
- a strong rejection of typical gender toys of their natal sex
- a strong dislike of their sexual anatomy
- a strong desire for primary or secondary sex characteristics that match expressed gender identity

Gender dysphoria in adolescents requires 6 months of distress, but only two criteria are needed from the mostly social experience of gender, such as wanting to be a gender other than assigned sex at birth, wanting to rid oneself of sex characteristics, strongly desiring the sexual characteristics of the other gender, a desire to be the other gender or be treated like the other or alternate gender, and finally, a strong conviction that one is the other or alternate gender (American Psychological Association, 2022). To be diagnosed as gender dysphoric, it is a core feature that there is clinical psychological distress; simply expressing oneself as the opposite gender does not meet the criteria. Gender non-conformity

affects children and youth of all ages and may begin as early as age two. Disruption in peer relationships; daily activities such as getting dressed, doing hair in a gendered fashion, going to school, using gender facilities or attending gendered activities or sports, dating, employment, sexual relationships; and many other ways are commonly noted (APA, 2022). The DSM-5-TR (APA, 2022) outlines that even in countries and cultures where attitudes toward gender diversity are accepted and inclusive, gender dysphoria exists, and different levels of anxiety prevail and are a relatively common symptom, even though it is unknown whether the criteria outlined for gender dysphoria would be met.

There is a vast amount of research and support for gender dysphoria, causing serious mental health issues, including depression, anxiety, suicidality, and eating/body dysmorphic disorders (Austin et al., 2022). It should be noted that gender dysphoria is separate and independent from body dysmorphic disorder (BDD), which “focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed” and has nothing to do with identifying as a different gender (APA, 2020. p. 519). If a person also meets the criteria for BDD, both diagnoses can be applied. Historically GD has been conceptualized as a single concept but its correlation with several severe psychological issues and an inability to separate causality makes it important for mental health professionals to identify “social and contextual factors that exacerbate or trigger experiences of gender dysphoria” and how the individual is affected by the (Goldbach & Knutson, 2021. P. 384). More recent understandings of GD are evolving to incorporate a broader, more diverse conceptualization of dysphoria to include the role of minority distress, discrimination and stigma (Goldbach & Knutson, 2021). While the medical model “serves as a vital framework for providing gender-affirming care” (p. 384) it limits the understanding of gender dysphoria to originating within the individual and ignores that the dysphoria may not exist without transphobic policy and social systems that promote cisnormative binary gender expression (Goldbach & Knutson, 2021).

Prevalence

Determining the prevalence of transgender and gender-diverse children and youth is difficult to calculate. Most research on this topic involves participants from gender care clinics and those seeking gender-affirming care, which is a restrictive population (American Psychological Association, 2022). An estimate of the world's population of TGD individuals from 2020 is between .4% and 1.3%, which accounts for about 25 million people (van den Brink et al., 2020). The DSM-5-TR (2022) documented gender dysphoria to be around 1/1000 for both individual-assigned males or females at birth, but it is believed this is an underestimation. Data collected from a 2021 and 2022 English GP Patient Survey, which included 1,520,547 respondents, resulted in 0.7% of people identifying as transgender (10,648) and 0.3% identifying as nonbinary (4,562) (Derman, 2024). The WPATH reported that among high school students, there are up to 1.2% identifying as transgender and up to 2.7% experiencing some level of gender diversity (Coleman et al., 2022).

Sexual and Romantic Attraction

Gender and sexual orientation are different concepts and should not be assumed based on a person's gender identity. A person's sexual orientation describes who a person is sexually, romantically, emotionally, or spiritually attracted to (Murray et al., 2017). Sexual orientation has traditionally been described in a binary fashion as either heterosexual or homosexual, with these terms originating in the early 1800s (Murray et al., 2017). However, to capture the complexities of sexuality and challenge the notion that minority sexual orientations are solely based on sexual attraction, the term affection orientation was introduced (Murray et al., 2017). It has also become apparent that sexual and affectional orientation are limited when using the binary terms heterosexual and homosexual, and employing inclusive language allows the representation of a range of possibilities. Sy and Zheng (2023) studied the stability of sexual and romantic attraction over time and use the following terms to assess

the level of sexual attraction to others: “straight, lesbian or gay, bisexual, pansexual, queer, demi-sexual, gray-asexual, asexual, and others” (p. 233) and the terms “aromantic, biromantic, heteroromantic, homoromantic, panromantic, [and] other” (p. 233) to assess for romantic orientation. In conclusion, gender should not be conflated with sexual or romantic attraction, which is as varied as gender expression.

Gender Dysphoria and Transition

According to the DSM-5-TR (APA, 2022), gender dysphoria shows up differently at different stages of life, with an onset of non-confirming gender behaviour sometimes beginning between the ages of two and four. Gender incongruence can be broken down into two categories: early-onset gender dysphoria, with onset prior to puberty, and late-onset or adolescent gender dysphoria, with onset at or after puberty (Ashley, 2020). More research has been created on early-onset gender dysphoria and the journey children traverse than on adolescent- and young adult-onset gender dysphoria. The assessment of GD in children is often discussed in terms of persistence and desistance (Kaltiala-Heino et al., 2018). Accordingly, a literature review compiled by Kaltiala-Heino et al. (2018) determined that GD in children often resolves by puberty, with about 80% of those diagnosed with early onset GD desisting and no longer meeting the criteria of GD in adolescents and many instead identifying as non-heterosexual. Factors influencing whether GD persists or desists include social environments, anticipated bodily changes, and early romantic or sexual experiences. Late-onset GD individuals who are struggling with their gender identity have not been studied as much, but research has determined that there has been an increase in this population worldwide (Zucker, 2019).

Early-Onset Gender Dysphoria

For some individuals, it is apparent from an early age that a child's gender identity is different from their assigned sex at birth, making it unsurprising to their caregivers (Coleman et al., 2022). For

others, this realization and declaration may not occur until puberty, adolescence, or even adulthood and may appear as sudden and unexpected to the individual's caregivers and loved ones (Coleman et al., 2022). The expression of gender dysphoria differs with age; therefore, different criteria have been outlined for diagnosis in prepubescent children, with an emphasis on more concrete behaviour because young children are less likely to have distress over anatomical differences than older post-puberty individuals (APA, 2022). According to the DSM-5-TR, very young children may cry when told they are not the gender they identify as; however, it may be less easy to observe if gendered behaviour is not focused on in social settings (APA, 2022). The gender-diverse child may also state they are a different gender from their assigned sex at birth and wish to wear the clothing and hairstyles that are typical for that binary opposite gender. They may also have behavioural challenges when expected to behave or enjoy stereotypical gendered activities, like wearing dresses or having long hair. Marked and persistent feelings of being a different gender than they were assigned at birth and expressing gender nonconformity are prevalent at this prepubescent age (APA, 2022).

Allowing a child to live differently than the gender they were assigned at birth is called social transition (Fast & Olsen, 2022). Fast and Olsen (2022) conducted a study to examine whether children who are socially transitioned and allowed to live according to their expressed gender identity develop similarly or differently from cisgender children. The researchers completed the study using participants aged three to five from a larger longitudinal study, focusing on socially transitioned binary transgender children, cisgender siblings of the transgender children, and gender-matched unrelated cisgender control children. Their study was an exploratory investigation and sought to compare the gender preferences, behaviour, and beliefs of young, socially transitioned transgender children in comparison to their cisgender peers. Fast and Olsen studied several variables, including gender constancy; peer, toy, and clothing preferences; and stereotype flexibility. They determined that across all the variables they

measured, the socially transitioned children did not differ significantly from their cisgender peers in any of the categories. What this means is that the socially transitioned children showed preferences for toys, peers, and clothing culturally associated with their expressed gender, dressed in stereotypical gendered fashion, and believed themselves to be more similar to their cisgender peers than to the sex-at-birth gender. In addition, they were as likely as their cisgender peers to believe their socially transitioned transgender was as stable into adulthood as their cisgender peers did. However, interestingly, the socially transitioned children were less likely to see other people's gender as stable than their cisgender peers, likely because they understood that for others, gender might be incongruent or fluid. This study, along with other research, suggests that gender is often understood by age three and stable by age seven, and underlines the importance of supporting transgender children psychologically and socially to prevent detrimental harm and prolonged suffering (Zaliznyak et al., 2021).

Further research on adults and their first memory of feeling incongruence with their gender assigned at birth and experiencing gender identity was recounted at an average of age seven, with two years between the first memory and the onset of gender dysphoria or incongruence (Zaliznyak et al., 2021). Social transition is considered 100% reversible, and this simple intervention is associated with lower rates of depression and anxiety in prepubescent transgender children (Sherer, 2016). Studies show that children experiencing gender dysphoria have a persistence of gender incongruence 10-27% of the time and that support and education of this population have been shown to significantly improve quality of life and survival (Zaliznyak et al., 2021). It is important to note that gender-diverse young people may experience social or psychological challenges, but it is not necessarily associated with distress due to their gender incongruence but rather their environment and the experience of prejudice, discrimination, and even violence (Goldbach & Knutson, 2021). With reported comorbidities of

depression, anxiety, suicide, and more, supporting TGD children is important to reduce their dysphoria and the social stigma that arises because of it (Zaliznyak et al., 2021).

Late-Onset Gender Dysphoria

Late-onset dysphoria is defined as the onset of feelings of incongruence after the initiation of puberty and can begin as early as when the first signs of secondary sex characteristics develop or even into adulthood (Ashley, 2020). Adolescents who had not shown gender curiosity or incongruence as children may begin to present with higher levels of anxiety, depression, substance use, self-harm, and suicide with the onset of puberty (Bowman et al., 2022). DSM-5-TR states that for those assigned female at birth, puberty typically begins between the ages of nine and thirteen and for those assigned male at birth, between the ages of eleven and fourteen (APA, 2022). During this time, as secondary sex characteristics begin to develop, there may or may not be a desire to rid oneself of these characteristics or to gain characteristics that are not present, such as breasts, menstruation, deeper voice, and facial hair (APA, 2022). An adolescent going through puberty with beginning feelings of incongruence may develop techniques to hide their secondary sex characteristics with binding or tucking (APA, 2022). It is thought that adolescence is a pivotal time for psychosexual identity, and research suggests that persistence or desistance will be determined around ages ten to thirteen (Kaltiala-Heino et al., 2018). Youth have described their social environment, expected outcomes of puberty, and initial sexual and romantic relationships as important factors in the desistance and persistence of dysphoria (Kaltiala-Heino et al., 2018). Reports of pubertal suppression treatment in youth are considered reasonably safe and provide good outcomes; implementing them should take into consideration the best interest of the minor, the social context, and the ethics of gatekeeping care (Kaltiala-Heino et al., 2018).

Rapid-Onset Gender Dysphoria (ROGD)

I hesitated to include this category, as it is a concept promoted as theory that is created from research that included the participation of parents from right-wing transphobic websites and Facebook groups and excluded TGD children or youth and their medical teams; however, understanding it and its criticisms is important. ROGD has been promoted as a psychological theory, but notably, there is no known evidence to support its existence, thereby negating its validity as a theory. Its attempt at explaining the experience of gender dysphoria during adolescence needs to be understood in context with counterpoints from evidential research. It is a concept postulated by Lisa Littman in 2018 as an attempt to explain a perceived uptick in individuals assigned female at birth requesting gender-affirming care post-puberty in American clinics. Littman's (2018) research led to several hypotheses on why gender clinics are seeing more requests for gender care over the past few years. First, she describes social and peer contagion as a plausible explanation and suggests that vulnerable youth may misinterpret their emotions and incorrectly believe themselves to be transgender because their peers, as well as media and online investigations, imply that transitioning is the only way to be happy (Littman, 2018). She further proposes that gender dysphoria in adolescents and young adults who would not have met the criteria as children is a catch-all explanation for youth who show any kind of distress, psychological pain, and discomfort, and that transition is being touted as the solution. She uses parental reports of their child's friend groups having multiple members who came out as gender dysphoric and identified as transgender during adolescence as evidence of this phenomenon (Littman, 2018). Littman (2018) reported that parental observations state that 80% of parents felt their child's transgender identity came out of nowhere without any prior gender dysphoria. However, she also describes these youth as having several comorbidities and vulnerabilities, including psychiatric disorders, neurodevelopmental disabilities, trauma, non-suicidal self-injury, and difficulty coping with negative

emotions. Over 30% of the youth described in her research recount their trauma as sexual or gender-related, with Littman implying the choice to transition would allow the individual to avoid being sexually assaulted in the future (Littman, 2018).

Secondly, she describes child–parental conflict as a possible explanation for ROGD, claiming almost half of the youth withdrew from family life, although she does offer the viewpoint that the parent-child conflict could arise because the parents disagreed with the youth's self-assessment and were coping poorly with the thought of their child being transgender. Finally, Littman (2018) proposes that being gender diverse is simply a maladaptive coping mechanism to avoid feeling strong or negative emotions and that it might relieve the symptoms temporarily but does not address the cause of the problem and will likely cause additional negative harm. She posits that if this is true, then by focusing on GD rather than the underlying emotional trauma, the clinician is doing a disservice to the youth by delaying treatment for the actual underlying emotion (Littman, 2018).

Furthermore, proponents of ROGD argue that medical interventions are likely harmful and lack benefits for this population. Additionally, they postulate that the desire to transition from female to male is based on the devaluation and sexualization of women's bodies (Ashley, 2020). Florence Ashley (they/them) is a transfeminine jurist and bioethicist who writes extensively about issues facing transgender people in the legal and healthcare systems (Ashley, 2025). They (2020) delineate how ROGD followers justify the increase in transgender adolescents who transition from female to male as a flight from womanhood motivated by rigid gender roles, the sexual objectification of women's bodies, and sexual assault. However, Ashley (2020) states this proffered concept of internalized misogyny and response to sexual trauma is unsubstantiated. Proponents also suggested that gender-diverse individuals are pushed into transition by a higher acceptance of "straight transgender identities" rather than of cisgender LGBQ people. However, all sources indicate that transgender people are less accepted

than cis LGBQ individuals, so it is difficult to suggest that transition is motivated by the desire to be straight or a feminist protest and the devaluation of women's bodies (Ashley, 2020). Ashley argues that for this notion to have merit, it would have to offer transition as a rapid solution for any underlying mental distress rooted in mental illness, which is described as abnormally high among trans teenagers (Ashley, 2020). Ashley (2020) states that the mere notion of ROGD is not only mired in panic but is also akin to conversion therapy. Additionally, ROGD attempts to use scientific language to add legitimacy to its claims, with the goal of disproving gender-affirming care as the best care for TGD children and youth. Ashley (2020) argues that the experience of depression, anxiety, and suicide, combined with gender dysphoria, can be explained more accurately as a result of discrimination, stigma, transphobia, and incongruence exacerbated by puberty.

Challenging reactions from parents and caregivers regarding a youth expressing gender non-conformity have been shown to increase the risk of emotional distress, severe psychological outcomes, and inadequate housing (Kaltiala-Heino et al., 2018). When addressing the needs of TGD children and youth, it is crucial to consider their intersectionality because they experience challenges relating to their gender identity as well as other intersecting identities formed through their ethnicity, religion, and social class (Kaltiala-Heino et al., 2018). Collectively, these factors influence the quantity and quality of support received by these individuals (Kaltiala-Heino et al., 2018). Whether an individual shows gender incongruence prepubescently or post-puberty, it is important to highlight that the perception of having positive support from parents and caregivers is significantly associated with higher life satisfaction and fewer depressive symptoms (Kaltiala-Heino et al., 2018). There needs to be a strong emphasis for parents and caregivers that gender transition is a journey and not an end game achieved by interventions and that gender identity is often fluid rather than immutable or binary, and detransition is rare (Ashley et al., 2023).

Regardless of the age of onset, providing multidisciplinary care is optimal, including being supported via counselling on topics such as gender literacy, resilience, going beyond the binary, and making connections to medical interventions (Spencer et al., 2021). As described in Spencer et al., (2021) some mental health providers have been a huge barrier in gender-affirming care because their interventions are traditionally based on cisnormative, heteronormative, and binary definitions of gender. While informed consent is standard practice in most medical fields, gender-affirming care has historically required excessive oversight, such as compulsory psychological evaluations and medical diagnoses for insurance coverage. With a growing emphasis on informed consent, which upholds autonomy and self-determination, a shift to increasing access to hormone therapies and gender-affirming care through primary caregivers has been noted. Spencer et al. (2021) observed that despite progress, some restrictive practices remain embedded in professional standards that reinforce cisnormative and pathologizing models of care. The pathologization of TGD identities by Western culture ignores the fact that gender-diverse people have existed since the beginning of humanity, with many Indigenous, African, and Eastern European cultures recognizing more than two genders (Spencer et al., 2021). Normalizing transgender identities as natural manifestations of human gender expression is an essential first step in a broad gender-affirming approach (Spencer et al., 2021).

Mental Health Challenges

Gender Dysphoria (GD) is diagnostically perceived as an incongruence of assigned sex at birth and gender identity, with the incongruence being the mental health issue. However, it is becoming increasingly difficult to separate the emotional distress that occurs from experiencing social stigmas, discrimination, and minority stress from the experience of incongruence (Goldbach & Knutson, 2023). GD is generally understood to be nuanced, with an abundant amount of evidence of a connection to other complex mental health issues, including depression, anxiety, suicidality, eating disorders, and body

image, which are not solely caused by the individual's gender identity (Austin et al., 2022). Specifically, TGD youth have high rates of mental health issues, substance use, and completed suicide, none of which are directly attributable to being TGD (DeZure, 2023). Many factors, including “internal conflict, discrimination, stigma, and social rejection”, are very damaging to the mental health of TGD youth (DeZure, 2023. p. e616). The experience of depression and anxiety is higher amongst TGD adults than the general population, with depression reported 44-65% of the time and anxiety 35-48% of the time in comparison to just 7% and 18%, respectively (Zaliznyak et al., 2021). Exposure to high rates of stigma, discrimination, and violence is associated with “heavy episodic drinking and suicide ideation when drinking” in comparison to their cisgender counterparts (Mezo Lazaro & Bacio, 2023. p. 452). Traditionally, research has attributed the use of alcohol and tobacco as a coping mechanism for any minority stress experienced by the TGD population, but some studies are showing there is a higher rate of alcohol and tobacco use amongst transmasculine individuals due to this being seen as a gender-affirming behaviour compared to cisgender men and women (Todd et al., 2022).

While the TGD community experience mental health disorders at higher rates than their cisgender peers across the board, a more disturbing statistic is higher rates of mortality, ranging from 34% to 75% higher, than their cisgender cohort because of the risk of external causes of death (Jackson et al., 2023). Completed suicides occur three to five times more often among the TGD community than within the cisgender community (Jackson et al., 2023). Transphobic hate crimes have risen by four times over the past six years in the United Kingdom, with the murder of TGD individuals increasing globally, and 96% of murdered TGD victims are transgender women (Jackson et al., 2023). It was also noted that individuals without documented gender-affirming care had a higher risk of mortality, emphasizing a need for this population to receive empathic, person-centred, and accessible gender-affirming care (Jackson et al., 2023). This population faces a variety of physical and mental health challenges that

deserve consideration, and special notes on eating disorders, suicide, and autism spectrum disorder (ASD) are outlined below.

Eating Disorders

TGD individuals are at high risk for developing an eating disorder (ED) due to gender-based prejudice and the need to increase congruence between gender and physical characteristics (Cusack et al., 2022). Cusak et al. (2022) explain that specific behaviour may depend on the binary gender they were assigned at birth and their current gender identity, and it may include restrictive eating patterns to suppress menstruation and reduce bodily curves typical of post-puberty in transmen or increasing thinness to appear more feminine in transwomen. A complication is that recovery from the ED may increase gender dysphoria due to fear of weight gain or reemergence of secondary sex characteristics; in contrast, gender-affirming care may alleviate the symptoms of the ED. However, not all TGD individuals might pursue gender-affirming care, and ED recovery may look different within the TGD community.

Suicide

With a suicide rate of 1.4% in TG adults and 44-65% of all TD individuals suffering from depression, alleviating the distress experienced by this population is imperative (Zaliznyak et al., 2021). Evidence shows that amongst prepubertal transgender children, upward of 21% experience anxiety, with around 10% attempting suicide; post-pubertal transgender youth experience mood disorders at a rate of 30-78% and suicidal ideation between 12 and 74% (Morandini et al., 2023). Some reports have shown that there is an increased suicidality risk in clinic-referred TGD as young as age five with that risk increasing with age if their family is unaccepting (Turban & Ehrensaft, 2018). In 2015, it was found that 39% of TGD individuals experienced serious psychological distress, compared to 5% of the general US population. Additionally, 40% of TGD adults have attempted suicide at least once, which is nine times the national average (Zaliznyak et al., 2021). In a study of transmen and transwomen, it was reported

that both experience similar rates of suicidality, with similar rates of decrease in suicide ideation with gender-affirming care (Zaliznyak et al., 2021). In one study, 91% of the TGD participants had experienced at least one event of suicide risk, whether it was thoughts, plans, and/or attempts (Counselman-Carpenter, & Redcay, 2023). Among those who began social transition or gender-affirming care, suicidal ideation often persisted, but there were zero further suicide attempts post-transition (Zaliznyak et al., 2021).

The level of gender dysphoria that children or youth experience is significantly influenced and controlled by their environments, with TGD youth who are rejected by their families being eight times more likely to attempt suicide. In contrast, those who were accepted and supported by their family were three times more likely to be happy and look toward the future than those who were rejected (Turban & Ehrensaft, 2018). One model that explains suicide risk in the TGD population well is the Minority Stress Model (MSM), which explains that marginalized groups like the TGD population experience internal and external stresses that are specific to their identity, and it filters through any available protective factors to determine the level of harm experienced (Boase & McLaren, 2024). Specifically, the stress of having to conceal your trans identity, predict future discrimination, and potentially live with internalized transphobia or self-hatred is associated with heightened suicide risk among the TGD population (Boase & McLaren, 2024). In addition, structural discrimination, including but not limited to anti-trans policies, lack of access to gender-affirming care, religious trauma, and victimization in educational settings, all contribute to feelings of distress and marginalization (Boase & McLaren, 2024). In general, TGD who are supported to identify and express their gender as they desire are less likely to experience serious psychiatric distress and suicide attempts (Meza Lazaro & Bacio, 2023).

Autism Spectrum Disorder

Special attention should be taken with children and youth diagnosed with ASD or those experiencing other forms of neurodivergence, as they present additional clinical complexities (Coleman et al., 2022). Assessment of gender dysphoria should include a range of psychometric measures that determine behavioural and emotional functioning, especially for ASD, as 35% of young people referred to a UK Gender Identity Development Service show moderate to severe traits of autism (Butler et al., 2018). Among the TGD population, 5–20% have been shown to experience ASD as a comorbidity, compared to 1% of the general population (Turban & Ehrensaft, 2018). There was also a similar amount of TGD individuals found with an attention-deficit/hyperactivity disorder (ADHD) diagnosis, leading to the question of whether TGD, ASD, and ADHD are linked or simply overrepresented in the clinically referred populations. However, through testing of the hypothesis that “autistic traits are significantly associated with both current gendered behaviour and recalled gender behaviour” (p. 1462), it was determined that the more autistic traits a person self-reports, the more gender-dysphoric feelings they had expressed in the past year and the more “cross-gender” (p. 1462) behaviour they remembered from childhood (Kallitsounaki et al., 2020). This same study reported results that imply that people with low mentalizing ability, which is the ability to recognize and understand another person's mental state (social intelligence), are more likely to experience gender dysphoric feelings than those with high social intelligence and that people with ASD report increased gender dysphoric feelings, mainly because their mentalizing ability is low (Kallitsounaki et al., 2020). This study concluded that the inability to read and understand other people could be one of the main neurocognitive mechanisms that explain an increase in gender nonconformity in people with ASD (Kallitsounaki et al., 2020).

Children and youth who experience gender dysphoria or gender incongruences often experience many psychiatric comorbidities, with a “high prevalence of mood and anxiety disorders, trauma, eating

disorders and autism spectrum conditions, suicidality and self-harm” (Frew et al., 2021. p. 261). Frew et al. (2021) explored this phenomenon in a systematic review of gender dysphoria and psychiatric comorbidities and noted that some gender-affirming clinics prioritize these comorbid psychiatric conditions before addressing gender dysphoria, while others focus on gender-affirming care. The clinical implication of their review showed that no standard international approach exists to diagnosing and treating children and youth with serious mental health issues and gender dysphoria. However, the WPATH outlines that requiring treatment for comorbid mental health concerns should not be a barrier to providing gender-affirming care and recommends that mental health professionals address the treatment of these mental health issues prior to providing gender-affirming care only when it interferes with the youth's capacity to provide informed consent (Coleman et al., 2022). Mental health professionals should offer psychotherapy but not make it mandatory to receive gender-affirming care, and when therapy is accessed, it should psychologically support the youth wherever they are in their gender journey. Additionally, the WPATH states that TGD youth should be encouraged to find and build a support system while also providing patient-centred affirming care that respects autonomy and ensures appropriate attention is experienced (Coleman et al., 2022).

Countering Mental Health Distress

Protective Factors

A 2022 US Trans Survey, including 92,329 respondents from the US, District of Columbia, Puerto Rico, American Samoa, and US military bases, speaks to the need to find protective factors for resilience and the reduction of psychological distress of those with marginalized gender identities (James et al., 2024). A range of negative experiences, including but not limited to misgendering by medical professionals, harassment online, physical attacks in the community, violence within the home by family members, and homelessness, impact the lives of TGD (James et al., 2024). The minority distress

experienced by TGD is high, and the cause of much of the internalizing psychopathology experienced by the genderqueer community is caused by transphobic social systems that increase and prolong feelings of dysphoria (Goldbach & Knutson, 2023). However, sometimes positive mental transformation is gained from overcoming extremely difficult life situations and focusing on any or all transformative qualities that arise from surviving the negative experience may lead to a “greater appreciation of life, heightened awareness of personal strength and recognition of new possibilities of life” (Counselman-Carpenter & Redcay, 2023. p. 430). While it is important to determine social and contextual factors that exacerbate or trigger feelings of gender dysphoria, it is equally important to find protective factors that increase a positive protective factor (Goldbach & Knutson, 2023). Considering this perspective, some argue that the psychopathology experienced by the TGD community is socially generated rather than a consequence of their gender incongruence (Dowers et al., 2020).

Family and Social Support

A growing number of children are entering gender-affirming clinics seeking medical care after having already transitioned socially; this trend is evident in the data from an Amsterdam clinic, where the percentage of children who had fully socially transitioned before their first visit increased from 1.7% in 2000 to 3.3% in 2004 (Morandini et al., 2023). A more significant shift was observed at the Tavistock clinic in London, where the proportion of individuals assigned male at birth but having socially transitioned at their initial presentation rose from 19.8% in 2012 to 47.2% in 2015 (Morandini et al., 2023). It has been theorized that social transition reduces mental health issues for TGD. In addition, there has been a recent cultural shift in acceptance and support of the TGD community; notably, the TGD community has provided evidence that early transition has many benefits, including improved mood, enhanced peer and caregiver relationships, and being “protective for the child’s happiness and well-being" (Morandini et al., 2023, p. 1047).

TGD individuals commonly experience internalizing psychopathologies like anxiety, depression, and suicidal ideation, which are believed to be the result of external factors rather than inherent conditions (Turban & Ehrensaft, 2018). Gender dysphoria and minority stress tend to worsen with age because as TGD individuals age, they experience increasing negative interactions with society. These negative interactions can include gender misunderstandings, exclusion, and outright hostility, all of which contribute further to mental health challenges (Turban & Ehrensaft, 2018). However, it needs to be emphasized that when TGD children and youth are supported by their families, their internalizing psychopathology is not significantly different from their cisgender peers. In addition, transgender children and youth who experience parental support have significantly lower psychopathology than their unsupported TGD controls (Turban & Ehrensaft, 2018). It bears repeating that TGD children and youth who are rejected by their families are eight times more likely to attempt suicide, in contrast with TGD children and youth who are accepted and supported by their families, who are three times more likely to be happy and look toward the future (Turban & Ehrensaft, 2018). Turban and Ehrensaft have found evidence that supports the idea that it is not incongruence of sex assigned at birth that causes higher levels of internalizing psychopathology, but instead, it is caused by both society's mistreatment of TGD youth, as well as a lack of family support. Stigma, combined with the lack of affirmation experienced by TGD youth, contributes to psychiatric stress and distress, which can be combatted with early acceptance and social transition (Turban & Ehrensaft, 2018).

Support from parents and caregivers is an important factor in developing resiliency and has also been shown to reduce the negative effects of depression, anxiety, and suicide ideation that have been caused by anti-transgender rhetoric. Specifically, parent and caregiver support has been documented to produce higher levels of resiliency above and beyond support from friends and the community (Meza Lazaro & Bacio, 2023). Support from parents and caregivers can take various forms, with gender-

affirming care being a significant element of this support. Gender-affirming care has a considerable impact, as providing psychological affirmative support for TGD individuals yields overwhelmingly positive effects. Utilizing an individual's affirmed name and pronouns in multiple settings (such as home, school, work, and social environments) has been shown to reduce symptoms of depression by 71% and lower suicide attempts by 65% (Austin et al., 2022). Affirming a TGD child or youth's identity with name and pronoun changes, government ID, and advocacy with family, friends, and the public are simple yet effective ways to provide protection.

Resources for Further Education

This capstone aims to elucidate key concepts and provide a foundational understanding of TGD children and youth and their experience, but it is important to not ignore or dismiss parents and caregivers as they navigate this journey alongside their child or youth. Parents and caregivers may experience a range of emotions, including denial, grief, fear, and uncertainty regarding their child's gender journey, but acceptance of their child's gender identity often improves family relationships and strengthens the parent-child bond (Hynes Brothers, 2025). It bears repeating that supportive, positive relationships with people who care for the child or youth are a protective factor that leads to an increase in family connectedness and a reduction in negative outcomes (Turban & Ehrensaft, 2018). Given this, providing parents and caregivers with access to accurate information and guidance from professionals plays a crucial role in parents being accepting and confident in supporting their child or youth on this journey (Hynes Brothers, 2025). So, for parents, caregivers, and others seeking further depth, the following resources offer additional insights and comprehensive information on all the topics discussed in this capstone.

Trans Care BC. Provides comprehensive information on gender exploration, psychological and medical interventions, and resources for youth, parents, and families. https://www.transcarebc.ca/

Vancouver School Board. Provides talking points about gender and links to Sexual Orientation and Gender Inclusion (SOGI) policy, as well as further teaching resources. https://www.vsb.bc.ca/page/72062/trans-inclusion

World Professional Association for Transgender Health (WPATH). This is a non-profit interdisciplinary professional and educational organization devoted to transgender health. It provides open access to view and download the Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. https://wpath.org/publications/soc8/

Gender Euphoria

To ameliorate the one-sided conversation of transgender individuals' lives and experiences of gender dysphoria and distress, the TGD community created the concept of gender euphoria (Austin et al., 2022). Beishel et al. (2021) challenged themselves to find a common understanding of this term in order to take an abstract notion and legitimize it for future research purposes. They surveyed 47 participants identifying with a variety of gender and sexual identities and determined that gender euphoria relates to a sense of confidence, attractiveness, and affirmation, with a focus on joy and happiness. Moreover, gender euphoria refers to a person's powerfully positive experience of gender and a unique sense of pleasure that comes from being treated as the gender the person identifies with, and it is associated with distress relief and feelings of wellness (Beischel et al., 2021). It has been found that it describes an overwhelming sentiment of positive emotion, with "a constellation of feelings related to authenticity, rightness or being at home" (Beischel et al., 2021. p.286). This term is mostly found within the gender minority communities, specifically related to transgender and nonbinary members, although a form of this feeling termed "gender pleasure" could be used to refer to all gendered experiences that are positive (Beischel et al., 2021. p. 287). It should be noted that the term gender euphoria is not simply the opposite of gender dysphoria but involves a more nuanced relationship to gender that deserves

more attention, as it represents an important aspect of the gender-diverse community (Austin et al., 2022).

Gender-Creative Parenting

Since the 1980s, a new gender-creative parenting style has emerged that involves removing binary pronouns and gender norms while raising their children (Savage, 2022). The practice of raising children without a binary gender is an unconventional and niche concept that emerged within queer communities during the second wave of feminism, driven by a desire to challenge gender stereotypes, power structures, and discrimination (Savage, 2022). Documented case stories flooded social media in the 2000s describing how to raise a child without gender references. As described by Savage (2022), a preschool in Sweden purposely avoids the use of gender pronouns when referring to the students under a gender-neutral ideology, hoping to decrease the conscious and unconscious biases that affect all genders. Only preliminary research on this topic exists. A master's thesis written in 2022 used Facebook groups as a source of study for this style of parenting (Martinez, 2022). From this limited scope of reference, Martinez reports that gender-neutral parents focus on changing the binary by developing a novel cultural and social way to raise their children (2022). Its intention is to remove the values and biases placed on genders and separate gender expression from sex assigned at birth, simultaneously rejecting the boundaries provided by the gender binary (Martinez, 2022). Martinez found that there was very little difference between gender-creative, gender-neutral, and gender-affirming parents, all attempting to provide an expansive and unbiased form of gender development, including but not restricted to raising "theybies" without any gender to simply providing toys and social activities that cross the binary (2022, p.27).

Assessment

Gender assessment is a required process for individuals seeking gender-affirming care, serving as a safeguard to ensure appropriate treatment (Coleman et al., 2022). Ashley et al. (2023) report that clinicians typically use four different ways to assess for gender and potential regret following gender-affirming care. They are the application of the DSM-5-TR to diagnose gender dysphoria, gender history, standardized questionnaires, and regret correlates. The researchers summarized how each of these formats is unreliable, irrelevant, and based on stereotyping, and they are considered formal versions of self-report. While none of these methods is considered a gold standard of assessment, the WPATH requires a history or intake of the person's gender development to document persistent and established gender dysphoria (Coleman et al., 2022). It is seen as a compromise between providing necessary care for TGD individuals and addressing concerns about those who may later regret their transition and choose to detransition (Ashley et al., 2023). However, it is argued that this process is “predicated on the assumption that gender assessments can reliably distinguish between trans people who will be benefited by gender-affirming care and detransitioners who would regret the interventions” (Ashley et al., 2023. p. 1). They also determined in their review that there is little evidence to suggest that gender assessments can reliably answer the question of regret that leads to detransition. Ashley et al. (2023) conclude that there should be a focus on supporting the client in decision-making and improving informed consent regarding the benefits and realities of affirmative care. Regret and detransition will be discussed in more detail further on in this paper.

Studies of untreated GD in adults show that individuals who have not accessed any gender-affirming interventions, including social transition and hormonal or surgical interventions, have high rates of comorbid mental health issues and decreased quality of life (Zaliznyak et al., 2021). Robust evidence suggests gender-affirming care produces an improved quality of life and mental health (Ashley

et al., 2023). The earlier children are identified as gender dysphoric or incongruent and subsequently supported psychologically and socially, the better the chances of reduced comorbid mental health issues (Sherer, 2016). Social and medical transition, in combination with meeting the individual's desired outcomes, has been shown to reduce suicide ideation and significantly improve the development and quality of life; therefore, proper assessment and concurrent gender-affirming care are necessary to provide inclusive, safe, and equitable care for this community (Turban & Ehrensaft, 2018). Children and youth fearing discrimination and stigma by parents, caregivers, surrounding family, and medical practitioners is a barrier to evidence-based gender-affirming care (Sleeman et al., 2017). TGD individuals often require multiple care providers and interventions, which increases the chance they will experience non-inclusive and challenging medical professionals, which often leads to avoidance of medical care for concerns unrelated to gender (Sleeman et al., 2017).

Adolescents

The WPATH outlines several necessary and sufficient guidelines for the assessment of youth requesting gender-affirmative care (Coleman et al., 2022). First, an assessment should be completed by someone licenced by their statutory body who has theoretical and evidenced-based training and expertise in gender identity development and gender diversity with accompanying expertise in neurodivergence and other developmental disabilities. Understanding neurodevelopmental differences is important because some aspects of these conditions may challenge the assessment process and these youth may require extra support and psychoeducation on forward-thinking and the risks and benefits. It is recommended that the child or adolescent undergo a comprehensive biopsychosocial assessment, including but not restricted to gender identity concerns, medical and surgical-related concerns, and reproductive effects—including infertility—and that caregivers be involved in the assessment and treatment process. The WPATH provides details on the necessary requirements to be met for gender-

affirming care to proceed, which includes meeting the diagnostic criteria of gender incongruence as per the International Classification of Diseases – 11 (ICD-11) (Coleman et al., 2022). Additional requirements are that the experience of gender incongruence is marked and sustained, the adolescent demonstrates the cognitive and emotional maturity to provide consent, and the adolescent is at Tanner stage 2 of puberty prior to puberty blockers/suppression. The Tanner stages refer to five levels of pubertal development from prepubertal to post-pubertal; Tanner stage 2 is described as pubertal onset, such as breast budding, in those assigned female at birth and achievement of “testicular volume greater than or equal to 4ml” (p. S64) for those assigned male at birth (Coleman et al., 2022). The timing of puberty is an important qualifier for beginning puberty blockers, and decisions regarding its implementation should be shared with a multidisciplinary team that includes the adolescent and caregivers. Finally, there is a requirement that the adolescent has been treated for at least 12 months with gender-affirming hormones before surgical treatment can commence unless otherwise contraindicated.

An important part of this process, as mentioned above, is that the youth should be cognitively and emotionally mature enough to participate fully in the assessment and transition journey. The WPATH describes the skills necessary to consent to treatment as having a comprehensive understanding of the treatment, including risks and benefits; fertility consequences; the ability to appreciate the nature of the decision, including the limits and unknowns of the treatment; and the ability to communicate choice since some youth decide to stop treatment because it is no longer a good fit for them. It should be noted that the ability to provide this consent cannot be measured at any particular stage or age and must be assessed for each gender-related treatment step. It is hoped that the youth’s caregivers be a part of the affirmative care journey; however, when the situation arises that the youth is seeking treatment without parental permission, “extra care must be taken to support the adolescent’s informed decision-making” (Coleman et al., 2022. p. S62)

Transcarebc.com provides pathways for accessing gender-affirmative care in three different ways: “Your general practitioner, Endocrinologist or at a trans-specific clinic or care provider” (Trans Care BC, 2024, para 4). Receiving a hormone readiness assessment is important and should be conducted by a qualified professional. Assessments may take longer if the person has physical or mental health issues or has a substance use disorder, although they are potential concerns, not barriers. As described on the transcarebc.ca website, the focus of these assessments is supporting the youth and will explain the effects of hormone blockers and affirmative hormone treatments. Considerations taken under advisement are how the youth understand their gender, the length of time they have felt this way, how they want to express their gender, their emotions, support systems, and many more factors.

Children

The WPATH employs the term gender diverse for this age group because the prepubescent gender journey cannot be predicted and may change over time (Colemen et al., 2022). Gender diversity in childhood is an expected aspect of development and should not be considered pathological or a mental health disorder. The WPATH notes that gender diversity may not be a reflection of transgender identity or gender incongruence. An assessment or care from a professional in gender care is a helpful psychosocial option because gender diversity in prepubescent children may be fluid, and there is no reliable way of determining or predicting each child’s gender journey (Coleman et al., 2022). As described above, it is required that the youth be at Tanner stage 2 to begin medical treatments such as hormone suppressions; therefore, prepubescent children are not eligible for medical interventions. However, while medical treatment such as hormone blockers and affirmative hormone care is not available for this age group, providing psychosocial support for these children is imperative given the prolific destructive and traumatic experiences from “gender-related rejection and other harsh, non-accepting interactions” (Coleman et al., 2022. p. S67).

Gender assessment is not necessary for all gender-diverse children, but it is often a stepping-off point to support children and families with the knowledge of how beneficial acceptance and support are to the mental well-being of the child and understanding that "fostering well-being and quality of life" (p. S68) for a child is in their best interest (Coleman et al., 2022). It is imperative that throughout an assessment of gender-diverse children, as well as for the postpubescent youth, many factors are taken into account, including racial, religious, geographic, and socio-economic identities, as well as ethnic and immigrant/refugee status (Coleman et al., 2022). The WPATH emphasizes the importance of being respectful and sensitive to cultural and religious beliefs and the degree to which gender diversity is accepted, given that "intersections between gender diversity, sociocultural diversity, and minority statuses can be sources of strength, social stress or both" (Coleman et al., 2022. p. S69).

If an assessment is warranted, it is key to keep in mind the child's development across a myriad of domains like cognition, social-emotional, and physiological (Cole et al., 2022). Considering the child may be as young as preschool age, determining the child's relative and expressive language skills as well as cognitive levels may need to be assessed by consulting a specialist. Assessment may include understanding the child's psychological environment, and psychotherapy may be recommended for all involved to help support the family and child in a way that promotes the best interest of the child. The WPATH highlights supporting protective social and emotional coping skills to promote resilience, problem-solving social challenges related to reducing gender minority stress, strengthening environmental supports for the child and family, and providing opportunities for the child to understand their gender experience (Coleman et al., 2022).

Gender-Affirming Care

Many opinions have been weighed in on the topic of children, youth, and young adults transitioning from their assigned sex at birth and the appropriate age that is required to understand the

ramifications of this change. The question that arises from this concern is the stability of gender, specifically if it is different than the one assigned at birth. Given the different levels of permanency of gender-affirming care, what are the consequences if the individual regrets their decision and desires detransition? The importance of understanding the different levels of gender-affirming care and its impact on the gender-diverse population is particularly relevant in today's political atmosphere, especially in the US, due to the influx of legislation to limit access to gender care (Turbin et al., 2022). Additionally, understanding the ethics of gatekeeping gender-affirming care is essential, as restricting access can have serious psychological and physical consequences, particularly in light of its well-documented benefits Both medical and psychosocial gender-affirming care have been shown to reduce adverse mental health challenges, build self-esteem, and increase the overall quality of life for TGD individuals (DeZure, 2023). A variety of gender-affirming care exists and can be categorized into different levels of psychosocial and medical support, beginning with interventions that are 100% reversible, semi-reversible, and permanent (DeZure, 2023).

The WPATH outlines that the standard of care for hormone therapy and chest surgery requires a mental health assessment by one professional, and two professional mental health assessments are required for genital surgeries, the idea being that decision-making is flexible (Westmacott et al., 2024). Across Canada, there exists a variety of referral pathways to gender-affirming care, with current rules in British Columbia being that hormone therapy requires a readiness for hormone assessments, and surgery requires a surgical readiness assessment (Trans Care BC, 2024). Many healthcare jurisdictions have begun using an informed consent approach for the prescription of hormones, with the roles of the care provider being “to provide information about risks, side effects, benefits, and potential consequences of participating in gender-affirming medical care, and to obtain informed consent from the patient” (Westmacott et al., 2024. p. 2). This was developed to meet the needs of TGD individuals

and providers who believed the current practice to be a barrier to receiving appropriate care and requires the patient to have the cognitive capacity and ability to make informed medical decisions rather than prove distress as a prerequisite for gender-affirmative care (Westmacott et al., 2024).

Psychological Care

Gender-affirming care begins with psychological support for the gender-questioning individual, which includes, but is not limited to, counselling and social support. Social support involves cooperating with pronouns and name changes in all aspects of the person's interactions, permission and acceptance of dressing in a manner different from their assigned gender, and changing hairstyles (Ashley, 2019). While prepubescent gender-affirmative care includes being socially accepting of the child's gender diversity, providing acceptance and support of adolescents' experiences of gender diversity is also an effective way to support TGD youth and is 100% reversible. These actions include birth certificate and passport name changes, school and medical documents, participation in gendered programs that match their identity, bathroom and locker use, and communication of affirmed gender to others, including extended family, schools, and programs the youth is associated with (Coleman et al., 2022). Other types of non-medical supports that are optional to TGD youth and are 100% physically reversible and related to the distress of the youth’s body not matching their gender identity are chest binding, chest padding, genital tucking, and genital packing (Coleman et al., 2022).

Making allowances for these physical and psychological changes results in increased well-being with fewer depressive symptoms and less suicidal ideation and behaviour (Dubin et al., 2020). This suggests that some of the psychosocial burdens of being gender-questioning may be reduced with non-medical interventions (Dubin et al., 2020). Research has found that children who have socially transitioned have depression and anxiety rates comparable to their cisgender peers, which is significantly lower than non-socially transitioned gender-dysphoric children (Sherer, 2016). Ashley

(2019) suggests a policy of respecting a youth's preferences for gender identification regardless of how often they change gender pronouns and that chosen names will promote gender exploration as a process rather than a binary endgame with permanent identification.

Medical Care

Gender-affirmative medical care involves three levels, with varying degrees of permanency within each treatment option. According to Dubin et al. (2020), the first step to gender care is hormone blockers, which are considered 100% reversible. However, long-term research into their usage is in its infancy, so the consequences of their application are not fully known (Ashley, 2019). Current research suggests that the use of gonadotropin-releasing hormone (GnRH), which prevents the advancement of secondary sex characteristics starting at the beginning of puberty, has been shown to improve quality of life (Dubin et al., 2020). It is understood that puberty blockers allow for wide-open exploration of gender without the timetable of biological sex characteristics developing, which can cause psychological harm via incongruence (Ashley, 2019). Puberty blockers have been used safely for decades to treat precocious puberty and once stopped, will allow puberty to resume (Trans Care BC, 2024).

The next level of gender care involves gender-affirming hormone therapy (GAHT)—estrogen for transwomen and testosterone for transmen (Dubin et al., 2020). GAHT has well-documented positive effects and is considered semi-reversible. GAHT has been shown to decrease internalizing psychopathology, improve well-being, and decrease suicidality, with overall access, regardless of age, being associated with favourable mental outcomes in comparison to individuals who would have liked access but could not access GAHT care (Turbin et al., 2022). Specifically, in a study of 21,598 transgender adults who had desired gender-affirming hormone treatment, it was determined that those who desired GAHT and received it had significantly lowered psychological distress, past-year suicidal thoughts, past-month binge drinking, and lifetime illicit drug use. Additionally, access to GAHT prior to adulthood (ages

14–18) significantly lowered the odds of experiencing these distressing variables (Turbin et al., 2022). However, it is noteworthy that with GAHT, the body changes, in part irreversibly, and after a certain amount of GAHT, an individual will not be able to live an uncomplicated cisgender identity (Ashley, 2019). Also important are the effects GAHT has on spermatogenesis and ovulation; concerns for preserving future fertility need to be assessed, as these options can be expensive. Additionally, for those who use gender blockers followed directly by hormones, an added complication arises for those who also want surgical therapy (Dubin et al., 2020).

The final step following puberty blockers and hormone replacement therapies is an assessment for surgical intervention, which can include chest surgery (i.e., breast augmentation and chest reconstruction surgeries) and genital surgery (i.e., orchiectomy, vaginoplasty, hysterectomy, bilateral saplingo-oophorectomy, metoidioplasty, and phalloplasty) (Tomita et al., 2019). Gender-affirming surgery is permanent and, in most countries, cannot be accessed prior to age 16, although the required age is often 18 or older (Dublin et al., 2020). In some instances, age 14 is an upper age limit for double mastectomy, as there is evidence of the psychosocial benefits of masculinizing the chest before the individual becomes an adult (Dublin et al., 2020). It is important to note that surgery is not always desired by gender-questioning individuals, and how each person chooses to express their identity is different; it is not necessarily in a binary fashion but rather a journey of the fluidity of gender (Durwood et al., 2022).

Challenges Accessing Gender Care

Several obstacles have been documented that create challenges with accessing gender-affirming care, such as safety concerns surrounding medical care, lack of access to appropriate medical and mental health services, and limited availability of competent and available clinicians (DeZure, 2023). Kimberly et al. (2018) wrote:

> Ethical considerations in gender-affirming care for [transgender and gender-nonconforming] TGNC youth span concerns about meeting the obligations to maximize treatment benefit to patients (beneficence), minimizing harm (nonmaleficence), supporting autonomy for pediatric patients during a time of rapid development, and addressing justice, including equitable access to care for TGNC youth. (p. 1)

Despite advances in novel treatments for the TGD population and evidence for their effectiveness in reducing negative psychological consequences of gender dysphoria and the inherent risk in not treating the dysphoria, there are little long-term data on the effects of both hormonal and surgical interventions (Kimberly et al., 2018). Currently, gender-affirmative care requires an assessment and/or a referral letter from a mental health professional, and some have argued that this process is dehumanizing and unethical and promotes mistrust of transgender people (Ashley, 2019a). Informed consent models do not require a letter from a medical professional and instead rely on autonomy and patient-centred care. They range from “exclusively relying on the patient’s decisional autonomy to exclusively relying on a thorough, independent assessment of the patient’s gender identity and/or gender dysphoria in determining eligibility for hormones” (Ashley et al., 2021. p. 543).

Current Models of Care

Current models of care that are implemented for addressing the needs of TGD children and youth are based on contemporary models of gender development, with varying differences between them (Ehrensaft, 2017). Ehrensaft (2017) describes the “live in your own skin model” (p. 61), which assumes that children have flexible gender brains, and interventions should include supporting the child to accept the gender that matches their assigned sex at birth as best practice because it will enhance psychological and social well-being until they experience puberty. Using behaviour modification, interventions, and family restructuring, the child is encouraged to remain as their assigned sex at birth

gender. If the child experiences puberty and continues to feel dysphoric, then transitioning should be supported. Another model described is the "watchful waiting model" (p. 61), which supports children who have incongruent gender identity as valid but feel waiting until puberty for intervention is important, along with the implementation of pubertal blockers as a pause on the growth of secondary sex characteristics. The difference between this model and the previous model is that no interventions to prevent the incongruences are implemented, and the child is simply observed. The final model described is the "gender affirmative model" (p.62), believed that children of any age are capable of understanding their authentic gender and that social transition is beneficial to the child. It is understood that children can speak for themselves and are self-aware of their gender identity and how they would like to express it. This model emphasizes supporting social transition at any age because of it benefits on mental health outcomes. These approaches range from encouraging a child to conform to the gender that matches their sex assigned at birth until gender dysphoria becomes undeniable to fully supporting their gender diversity by affirming that the child is the expert of their own identity.

I resonate strongly with this final approach of gender-affirming care for TGD children and youth. I firmly believe that providing psychological support for children, and both psychological and medical gender-affirming support for youth, is the most psychologically sound and evidence-based approach available. I am passionate about the belief that this community deserves a compassionate and person-centred approach involving informed consent to ensure they receive non-stigmatizing and empathic gender-affirming care, as it is an essential component of their survival.

Concerns With Transition

Concerns with social transition at prepubescent ages are rationalized by suggesting that children cannot possibly know their own gender at such an early age and that supporting these children will lead them to seek out gender-affirmative medical care that has varying degrees of permanency (Sherer,

2016). However, Sherer (2016) notes that those who seek out transition at a later age often experience greater gender dysphoria and have three times higher levels of internalizing psychopathology like depression and anxiety (Sherer, 2016). This suggests that early transition does not provide additional harm and may provide a protective factor for transgender children. Many view transition as a form of gender exploration rather than an endpoint or final treatment (Ashley, 2019). Clinicians often encourage families to remain flexible to the possibility that an initial transition may not be permanent (Durwood et al., 2022). Discussions with caregivers, children, and youth about potential detransition and retransition—without framing it as a failure or source of shame—are essential to a supportive, gender-affirming approach (Durwood et al., 2022).

The notion that some parents feel that their child's gender dysphoria is sudden and unexpected and related to peer pressure and social media was put forth by Littman (2018), but her results were criticized by several others (Ashley, 2020). Parents may feel that their children should wait until they are 18 years old to make a medical decision about their body and gender, but research has repeatedly confirmed that social transition with support from parents, along with informed consent, is key to reducing psychological distress caused by outside factors (DeZure, 2023). As noted by Turban & Ehrensaft (2018), "rejection and family acceptance are key factors in both physical and mental health outcomes for transgender youth" (p. 1235), with positive relationships from adults being the key protective factor for TGD youth when faced with societal discrimination and adversity. A further concern with children and youth seeking gender-affirming care is a fear they may later regret their decision, potentially leading to detransition. There is also a worry that gender-affirming care may not address the comorbid psychological challenges and that semi-permanent or permanent physical changes, such as infertility, unrealistic physical expectations, and surgical modification of the body, will be regretted (Dubin et al., 2020). Amelioration of these concerns includes employing an informed consent model that

attempts to balance non-maleficence and autonomy and should be required from all levels and prescribers of gender-affirming care (Ashley et al., 2021). The WPATH outlines that the legal guardian is integral to the informed consent process, but an assessment of the emotional and cognitive maturity of the youth is a necessary step (Coleman et al., 2022). Assessing for mature minor status involves determining whether the child or youth that is under the age of 19 can “understand the issues at hand, express a choice, appreciate and give careful thought, regarding the wish for medical-affirming treatment” (Coleman et al., 2022. p. S67). This is identified as a youth’s understanding of the interventions being suggested and the risks they involve—both temporary and permanent—and is employed as an ethical principle (Dubin et al., 2020).

Retransition and Detransition

Retransition is described as returning to identify as the gender that is congruent with the assigned sex at birth and may be temporary, and it does not necessarily mean that the initial transition was inherently undesirable (Ashley et al., 2023). Detransition is an act of returning in some form to a state prior to transition, which can be achieved socially and sometimes medically (Hildebrand-Chupp, 2020). Studying these concepts is “inevitably political and value-laden” (p. 800) and makes assessing their rates challenging (Hildebrand-Chupp, 2020). TGD individuals detransition for a variety of reasons, including but not limited to medical challenges with the interventions, the intervention results do not meet their needs, the side effects are problematic, or due to acquiring an understanding that their gender is fluid and a binary gender identity is no longer the intended outcome (Ashley et al., 2023). Understanding the process of detransition or retransition is studied under the belief that this knowledge can mitigate or prevent transition regret while still providing gender-affirmative care to those who would benefit from it (Ashley et al., 2023). Determining the number of individuals who detransition due to regret is challenging. This difficulty arises because individuals may regret specific aspects rather than

the entire process, or their feelings about the transition may evolve over time. Additionally, it is complicated to distinguish between personal and societal expectations for passing as their identified gender, as well as the associated shame and stigma from the initial transition (Ashley et al., 2023). Ways to determine regret and detransition rates include reviewing documented surgery reversal requests, the prevalence of formal cancelling of gender care, retrospective documentation review of charted regret, and reinstatement of sex assigned at birth (Jorgensen, 2023).

Historically, gender care was initiated after a lengthy assessment and psychological workup, along with an evaluation for transition regret, before offering gender-affirming care; this has resulted in a low transition regret of less than 1% (Jorgenson, 2023). The regret rate of the recent younger generation of children and youth presenting with gender dysphoria and being provided gender-affirming care accompanied by informed consent will take time to ascertain (Jorgensen, 2023). However, early results from a longitudinal study by Durwood et al. (2022) of 317 socially transitioned binary transgender children from Canada and the US ages three to twelve years at the times of initial participation showed low retransition rates just four years later. Of the total who retransitioned, 2.5% retransitioned to their sex assigned at birth, and 3.5% detransitioned to a nonbinary gender identity. Factors involved in detransition and retransition ranged. Some youth began identifying other than in a binary way, others learned new vocabulary, such as the word 'gay', and realized they were not transgender, or they experienced discrimination and transphobia and identifying as their sex assigned at birth appeared less emotionally distressing. None of the youth indicated regret of their initial social transition, and parents who were interviewed expressed the importance of following the children's lead. Attempting to understand levels of regret of gender-affirming care and transition led to a fascinating systematic review by Thornton et al. (2024) of regret of medical interventions and major life decisions, including gender-affirming interventions. They concluded that regret rates for gender-affirming care

were low, between 0.3% and 1%. Regret was defined and categorized into true regret (regretting gender-affirming care), social regret (regret of transition caused by loss of family or a job), and dissatisfaction with surgical results or no longer feeling binary gender, all of which were documented approximately ten years post-transition. Gender-affirming care regret was compared to other major life decisions and surgical care, and it was noted that people regret having children at higher rates (7–13%), getting a tattoo (16.2%), getting married to their current spouse (31%), having gastric bypass surgery (5.1%), and having treatment for prostate cancer (30%).

According to Hildebrand-Chupp (2020), there "is no value-neutral apolitical way to study [detransition]" (p. 803), and they suggest that everybody should be skeptical of studies that look for results to justify "external constraints on decisions about transition or detransition" (p. 804) and should rather be focused on seeking a larger understanding of the assessment and intervention processes. This article considers most detransition literature as having one of two concerns: preventing detransition or supporting detransition. Each one encompasses a set of ideologies, value judgements, and a range of interventions. They are vastly different ideologies, with research on preventing detransition ensconced in the idea that detransition is a failure, harmful, and should be avoided, and it includes the goal of reducing detransition with interventions. Supporting detransition research includes believing detransition is a viable option, it is an important part of the process, and post-detransition life is livable and includes a research goal of helping people through the detransition process in various ways.

The process of detransition is often framed within a binary understanding of gender, assuming a fixed outcome. However, for many individuals, gender is fluid or nonbinary, and transitioning, followed by a potential detransition to a nonbinary identity or a retransition to their sex assigned at birth, can be a necessary and integral part of their gender exploration. As researchers learn more about retransition and detransition, it may come to fruition that it is a new self-conceptualization, and "detransitioning

individuals will very likely require compassionate therapeutic and community support as they process a range of emotions, such as regret, confusion, shame, and anger while facing detransition-related stigma” (MacKinnon et al., 2023. P.10).

Summary

Transgender and gender-diverse youth and children are accessing mental health resources at increasing rates and seeking gender-affirming care. These kids experience high rates of severe psychological challenges from a variety of situations, including but not limited to their incongruence, stigma, possible shame and self-hatred, and social discrimination. However, it is challenging to separate the distress caused by incongruence or dysphoria from the distress experienced by being a marginalized group in society. Finding ways to support this population socially and with psychological and medical treatment will benefit them in a myriad of ways. There are a variety of reversible, semi-permanent, and permanent interventions for this population, and it is important to find ways to provide treatment options through informed consent in an ethically humanizing way. Repeatedly, it has been shown that socially supporting TGD children and youth through preferred pronoun usage, chosen name, and acceptance of changing appearance benefits their psychological outlook, and further medical care may not be necessary. Countering the mental distress experienced by society can be ameliorated by support from parents and families due to this being the main protective factor for creating resilient, psychologically sound children while also saving lives. Several factors play a role in the consideration and application of gender-affirming care. Recognizing that medical gender affirmation is a step within the broader process of gender exploration and treatment rather than an endpoint is crucial for providing ethical and comprehensive care to gender-diverse individuals. Making allowances for curiosity and detransition as a part of the process rather than as a shameful mistake will go a long way to allowing humanity into gender-affirming care (Ashley, 2019). An important lesson for all is that an individual's

experience of their gender cannot be replicated, and placing any expectations of what gender is or what binary genders of man or woman should be is limiting and the basis for psychological distress and gender discrimination. Providing support, psychological openness, and humanity for this marginalized population will go far in reducing gender dysphoria, severe psychiatric symptoms, and suicide.

Chapter Three

The previous chapter outlines the challenging mental health concerns that transgender and gender-diverse children and youth experience. It outlines assessment, interventions, transition, and detransition. The arch of the capstone is that TGD children and youth experience severe emotional distress from both their potential dysphoria and societal discrimination and stigma. While it is challenging to distinguish between these interrelated factors, the conclusion is that gender-affirming care, combined with additional support for psychiatric comorbidities, is optimal for this population. Best practice suggests that providing social, psychological, and medical support to this community will significantly reduce the emotional distress experienced by TGD children and youth, aligning their well-being with that of their cisgender peers. Determining which psychological and medical interventions are desired and would be beneficial while engaging informed consent allows for person-centred, empathic, and respectful gender-affirming care. Emphasis should be placed on parents and caregivers providing supportive, unconditional love and safety, as they are the number one protective factor for increasing psychological resilience and emotional well-being. Equipping parents and caregivers with evidence-based information about gender-affirming care will increase acceptance and support by this group. An important takeaway from this capstone is comprehending transition as part of an evolution of gender identity and not as an endpoint. Additionally, viewing detransition as potentially part of the process rather than a failure provides a safety net for those who realize their gender is fluid or that the interventions and experience of transition were not exactly the results they wanted. Everybody's experience is unique and individual. Optimally, regret is not an outcome that anybody wants, but gatekeeping gender-affirming care in fear that TGD individuals will experience regret is considered dehumanizing, pathologizing, and dangerous.

Educational Presentation: Vision and Development

My presentation was held at Foundry Langley, a community-based setting approximately 50 km outside of Vancouver BC, Canada, for parents and caregivers. While this presentation was about TGD children and youth, they were not the target audience and were not invited to attend. This presentation was aimed at parents and caregivers and hoped to provide this population with the basics of gender-affirming care and its mental health benefits. Parents and caregivers are the number one protective factor for TGD children and youth, and providing them with a safe environment to be curious and vulnerable to the challenging topic of gender is fundamental to removing the stigma and discrimination these kids experience. It was the goal of this presentation to provide information on gender, gender dysphoria, assessment and gender-affirming care, and transition and detransition. Specifically, its goal was to provide parents and caregivers with concrete actions on how to support their children and youth.

The presentation included a 25-slide PowerPoint presentation that lasted approximately 45 minutes (see Appendix A). I had talking points for each slide and added pertinent information to each slide to emphasize the necessary learning. The presentation was offered during a caregiver social from 5 pm to 7 pm on March 11th, 2025, at Foundry Langley, BC, Canada. I provided a brief overview of each of the main topics but focused on explaining gender, gender dysphoria, assessment, psychological support, and detransition to highlight the importance of psychological support for TGD individuals. An advertisement on the Foundry Instagram page for parents and caregivers with information about the representation was sent out (see Appendix B).

My focus was to examine the fundamentals of gender diversity and gender-affirming care while highlighting the importance of acceptance and support by parents and caregivers for TGD children and youth. As people settled in and we waited for latecomers, I explained my positionality and the impetus for my passion for this topic, including sharing the stories of two families with transgender children. My

presentation began with a land acknowledgment highlighting the erasure of Two-Spirit peoples through colonization. I wanted to emphasize that gender is a social construct, so I introduced Jamie, an individual with many passions and hobbies that prevented assumptions about their gender. I then questioned the audience if they had enough information to decide if they would like to be Jamie's friend (see slide 3 in Appendix A). The goal of this was to underscore that passions, hobbies, and personality are gender-free, and liking or respecting someone is more important than knowing their gender.

I provided a few key definitions and then explained in detail an understanding of the concepts of gender, transgender, and intersexed. A note on the difference between gender and sexuality was included because I believe it is important for people to avoid conflating the two concepts. Then, I focused on how gender is understood globally, with an emphasis on how the erasure of the experience of gender diversity by Indigenous Peoples occurred through colonization, and explained the birth of the term Two-Spirit by the Indigenous Queer Community as an umbrella term that encompasses a range of sexual and gender identities. My written capstone provided research on gender development theories; however, I decided that this was not integral to educating parents and caregivers on how to support their TGD child or youth.

Then, I provided a more detailed description of what it means to be transgender and a DSM-5-TR description of gender dysphoria. I provided information on the mental health issues that are frequently experienced by TGD children and youth and how supporting these kids socially and psychologically promotes resiliency and increased emotional well-being. I emphasized how many of these comorbid mental health issues are due to discrimination and stigma from society rather than gender incongruence. From here, I showcased how affirming gender identity reduces psychological distress, and by supporting gender-affirming care and transition, there is a resulting increase in emotional well-being. The next slide provided a definition and some examples of reversible non-medical

social gender-affirming care. From here, I outlined the difference between gender-affirming care for prepubescent children and post-pubescent adolescents, specifically highlighting reversible and non-reversible interventions. I touched on the concept of gender euphoria but omitted the topic of gender-diverse parenting because I feel time only supported discussing the best way to support children and youth. I provided more depth to the topics of assessment, informed consent, and gender-affirming care, then ended with how to support children and youth through transition and possible detransition. Finally, I shared the comparison of regret rates for gender-affirming care and other medical procedures and major life decisions. From here, I provided concrete steps on how to support TGD children and youth while emphasizing that parents and caregivers may experience fear and concerns about transition. To support parents and caregivers with these concerns, I provided handouts with more detailed information and resources about all the topics covered (see Appendix C).

I ended my presentation with the main takeaways I have identified from the compilation of this capstone. I followed this slide with an invitation for questions and discussion and provided the audience with a brief anonymous satisfaction survey (see Appendix D). My goal was to assess the audience's satisfaction with the material and to request feedback on the content provided in my presentation, specifically on whether my goal of providing concrete steps on how to support TGD children and youth was achieved.

Applications

The objective of my presentation was to offer parents, caregivers, and other interested parties a fundamental framework for supporting TGD children and youth through transition, both socially and medically. The target audience of the presentation was parents and caregivers rather than transgender and gender-diverse children or youth to foster a safe environment where parents and caregivers can pose inquiries and express their concerns with confidence and feelings of safety. By providing clear,

research-based information about gender identity, gender incongruence, assessment, and gender-affirming care, I attempted to reduce confusion and misconceptions about the types of gender-affirming care provided and how decisions are made through informed consent, hormone readiness assessments, and surgical readiness assessments. To supplement these concepts, I provided my audience with resources from TranscareBC to increase the depth of their education on these topics and to encourage open, supportive communication with their children and youth (see Appendix C). The location of my presentation was Foundry Langley, BC, Canada, which employs an experienced caregiver support worker with lived experience. I emphasized that she could meet with them to provide a supportive, open conversation about their concerns or questions about parenting their TGD child or youth.

The focus of creating awareness about gender diversity was informing parents and caregivers that they are the number one protective factor for ameliorating severe emotional distress caused by societal discrimination and stigma resulting from gender incongruence. Providing examples of the types of support TGD children and youth require was an important part of this presentation. I chose to outline support that resembles accepting your child unconditionally, with love, while they navigate their gender identity through gender-affirming care and transition. Highlighting the positive impact of gender-affirming care on the reduction of anxiety, depression, and suicide risk amongst TGD children and youth was an imperative part of this education. Emphasizing the concept that gender identity is a journey rather than an endpoint and that detransition is not a failure but part of the process was key to summarizing the information provided.

Anonymous satisfaction survey

At the end of the presentation, I requested everyone in attendance answer four questions assessing the level of comprehension achieved (via a 10-point scale) and provide feedback for future presentations (via written comments) (see Appendix D). The survey asked the 14 participants to rate

their understanding of various topics related to gender on a scale from 1 to 10 (1 being fully disagreed and 10 being fully agreed). The results indicated that 13 (93%) respondents agreed that their understanding of gender was at 100%. Eleven of the respondents (78%) reported they fully agreed that they learned more about gender-affirming care, with three people agreeing between 70% and 90% with this statement. This might be because several of the audience members reported they had been through gender-affirming care with their children and were very aware of the various interventions, so could not say they learned more. Only 50% of the respondents stated they fully agreed they understood what informed consent is and how it is included in gender-affirming care. Nine out of the fourteen members (64%) fully agreed that they understood how to support TGD children and youth. Based on the written comments provided, audience members felt that the presentation was well researched, provided at a great pace, and easy to follow. Other comments stated that the definitions provided clarity, that the importance of supporting TGD children and youth was helpful and reassuring and made clear in an empathic, supportive way, and that the statistics on regret rates were eye-opening. Topics that the audience would have liked a deeper understanding of included informed consent, gender and mental health crossover, and a further understanding with more examples of how to be respectfully curious while still supporting your TGD child and youth. Several people would have liked more discussion.

Suggestions for Future Development

Based on comments from the survey, the presentation appeared to achieve its goal of raising awareness while building acceptance and educating parents and caregivers on gender diversity. The comments on suggestions for improvement focused on informed consent, gender, and mental health comorbidities, as well as providing further information on how to support your TGD child and youth respectfully and with curiosity.

The audience appeared to appreciate learning about informed consent but would appreciate a deeper dive. Perhaps providing real-world scenarios or case studies would bring this topic some clarity and illustrate how informed consent, especially with minors, is applied in gender-affirming care. The interest in the intersection of gender and mental health suggests that providing a deeper understanding and overview would have been welcomed. Providing more details on the comorbidities as outlined in the written portion of this capstone would be beneficial for further presentations. Additionally, providing strategies for parents and caregivers on how to support TGD children and youths' mental health could be outlined. Along this vein, more guidance on how to ask questions of their TGD children and youth in a supportive way would be beneficial. Perhaps adding specific scripts or role-playing exercises would help illustrate how to balance curiosity with affirmation. Since several people requested more discussion, future presentations could include small group breakouts or specific discussion prompts to engage the audience and increase comprehension of some of the more challenging topics. Concurrently, more detailed, concrete, real-life examples of the presentation of gender incongruence, gender-affirming interventions, and detransition might make the concepts more relatable and meaningful. Finally, given that the regret rates were incredibly impactful, perhaps a further exploration of why regret rates are low and what factors contribute to positive outcomes in gender-affirming care could be better outlined.

Limitations of this Capstone and Presentation

I have always identified with my gender assigned at birth; therefore, this capstone is written from a cisgender, heteronormative perspective. This perspective inherently presents a challenge, as my binary experiences may be perceived as condescending or as stemming from a saviour complex. However, I strongly advise that this capstone is not meant for individuals experiencing gender diversity but rather for the people in their lives who have questions like I did. I hope, at its core, it provides the

groundwork for curiosity with a positive rather than a dismissive “not my problem” ideology. In alignment with this notion is a need to emphasize that my presentation is meant to be a brief overview of these concepts and not a fulsome education. It is my genuine hope that I inspire parents, caregivers, and families to access additional resources (e.g., TranscareBC.com), to be curious with compassion, and educate themselves further.

I approached the topic of gender-affirming care from the perspective of a cisgender white, heterosexual woman in my fifth decade, born and raised in Vancouver, BC, Canada. My experiences with gender have been shaped within a Canadian and North American context, where heteronormative and cisnormative cultural narratives have historically influenced my understanding of gender. My engagement and passion for this topic is also situated within the framework of Western medicine, particularly through the lens of the DSM-5-TR, which continues to evolve in its recognition of gender diversity. Further, my education at City University has been instrumental in helping me explore my privilege and intersectionality. It has deepened my understanding of how societal structures impact marginalized communities, including TGD children and youth. Additionally, I recognize that my academic understanding of this subject is shaped by a secular, research-based approach while also valuing personal experience as meaningful and compelling proof that gender identity exists beyond the binary. In my work at Foundry, an organization that actively supports youth of all genders, I have further developed my knowledge of how gender-affirming care is essential to the mental and physical health of gender-diverse youth. The lived realities of TGD children and youth demonstrate the importance of moving beyond rigid definitions of gender to embrace a more inclusive and affirming approach. By acknowledging my own social location, educational background, and the broader cultural forces at play, I strive to advocate for gender-affirming care in a way that is both informative and supportive, ensuring that TGD children and youth receive the respect, recognition, and care they deserve.

There is a voluminous amount of information about gender dysphoria and gender-affirming care available for study; however, there is very little information regarding the long-term effects of the medical interventions provided and the process of transition and potential detransition. Most research is created to determine how to avoid transition regret but stems from a fundamental bias of binary heteronormative gender theory. The future of gender research should include a conceptualization of gender as a journey without the bias of a gender binary and should include a “meticulous examination of the data that are available, as well as a willingness to change practice in the face of new evidence” (Jorgensen, 2022. p. 2180). My presentation was created to inform parents about the current ideology behind gender-affirming care, its motivations, and its benefits for TGD children and youth. It is promoted by my bias that social and psychological support for this demographic is imperative for emotional well-being and that gatekeeping gender-affirming care is more detrimental than the risks of psychological or medical interventions. It was my goal to answer parents’ and caregivers’ questions in a supportive, honest way, allowing for discussion without judgment, shame, or ridicule. Writing this capstone was informative and emotionally validating, but the vastness of information on some of these topics has left me feeling that I have only scratched the surface of information.

Personal Reflections

I feel I could have written so much more on each aspect of the topics presented in Chapter Two. It was my goal to provide an overview of the process of transition for people who have no idea about it and are curious and/or have negative thoughts about transgender and gender-diverse individuals. From this perspective, I began collecting articles that covered the topics I felt were relevant to creating awareness and acceptance through education on gender diversity—I quickly amassed over 180 articles. While reading the articles and assessing their level of relevance, I found several topics that were interesting but would dilute my preferred topic. Some of these topics included the care and

pathologizing of intersexed individuals, the history and global understanding of gender diversity and the erasure of it by colonization, transgender athletes, and the politicization and consequences of gender as an ideology on policy. I was surprised at the dearth of research on TGD children and youth, with the resulting lack of concrete agreed-upon steps for gender-affirming care. An attempt was made to focus my gender-affirming care results on Canada since a cohesive, holistic pattern of care has yet to be agreed upon globally. This has contributed to the collective misunderstanding of gender-affirmative care and its benefits promoted by social media, politicians, and the uninformed.

As I reflect on delivering my presentation at Foundry, I am encouraged by comments left on my anonymous survey that suggest my passion and empathy were evident and welcomed. My casual yet academic presentation of facts with supplemental evidence supporting the content was well received. The concept that was most important for me to share and emphasize is that gender transition is a journey and not an endpoint, and detransition is not a failure but a part of the process; this was received loudly by one audience member who stated that this was monumentally helpful in understanding their young adult child. Another audience member stated that this information would have been valuable for them and their child about a decade earlier. This topic is both academically interesting and emotionally significant, and I was overcome with emotions, causing difficulty speaking, at least five times throughout my presentation, starting with my personally written land acknowledgement through to the slide stating the regret rates of gender transition. Understanding the importance of this topic has fueled my motivation to capture the pertinent aspects of the more academic content into an engaging, thought-provoking presentation, and it was rewarding to see a transmale Foundry youth worker sitting in the corner encouraging me along the way. His bright pink hair, charismatic smile, and nodding head kept me going, supporting the notion that I was providing valuable information that could save lives.

Transgender and gender-diverse children and youth are entering gender-affirming clinics at increasing rates every year, and I aim to continuously increase my knowledge of all the sections from my literature review, never becoming stagnant in my education. I would be honoured to work with both children and youth experiencing gender incongruence and their respective caregivers and families. There are copious amounts of information and resources that will allow me to become more informed and fluent in these topics. My goal will always be to provide client-centred, strength-based, empathic, gender-affirming care for TGD children and youth. As both a parent and an aspiring registered clinical counsellor, I found the topic of gender dysphoria and gender-affirming care to be highly insightful and essential for shaping my daily personal and professional perspective. It has provided me with confidence and a passion for supporting both children and youth experiencing gender diversity and the parents and caregivers who support them.

Conclusions

It is essential to highlight that for parents and caregivers who encounter difficulties in understanding gender diversity, their support plays a crucial role in the well-being of their child. Chapter Two's literature review brought clarity to the notion of gender incongruence, informed consent, gender-affirming care, and detransition. Ignorance breeds fear, and fear leads to an increased need for control. This fear has entered the political arena, and through the politicization of gender, inherently transphobic policy is negatively affecting the mental health of children and youth and their access to gender-affirming care. The alarming rates of suicide among transgender individuals, particularly youth, underscore the direct harm caused by this hostile environment. Studies consistently show that rejection and discrimination significantly increase the risk of mental health struggles and suicidality in the trans population (The Trevor Project, 2024). The recent surge in anti-trans legislation, alongside increased media hostility, has only intensified these risks. Knowledge and education reduce fear and ignorance, so

it is essential to provide TGD children and youth and their parents and caregivers with the most up-to-date and comprehensive outline of gender-affirming care. In general, creating safe, inclusive environments for this population while also educating and informing the broader public about the concerns TGD children and youth face represents a significant step toward mitigating the stigma, discrimination, and fear that arise from ignorance. Ensuring access to gender-affirming care is not just a medical necessity but a fundamental human right. Educating parents and caregivers is a crucial component in fostering understanding, support, and access to inclusive and compassionate healthcare. Specifically, it is vital to provide resources to parents and caregivers, as they play a pivotal role in safeguarding the well-being of TGD children and youth.

Presentation

Slide 1 – Title

This slide states the title, my name, pronouns and how this presentation is in partial fulfilment of a master's degree of Counselling through City University.

Slide 2 – Land Acknowledgment

This slide was created in part from the Foundry Langley land acknowledgement and a personal reflection on the Two-Spirit Indigenous Peoples' experience by colonization.

Slide 3 – Jamie

This slide attempts to outline how gender is a social construct by creating a character with vastly different interests and hobbies, making it challenging to define their gender but allowing enough information to assess for likeability and friendship.

Slide 4 – Terminology

This slide provides basic definitions that are necessary to understand the concepts brought forth in the presentation.

Slide 5 – What Is Gender?

This slide explains that gender is a collection of characteristics historically used to define what constitutes a man and a woman. Examples were provided of stereotypically gendered expressions that have shifted between binary genders over time. These examples included gender expression through clothing, wigs, shoes, and makeup.

Slide 6 – What Is Transgender?

This slide provides definitions of what being transgender is, and that gender is often understood by age two. The content is superimposed on the Transgender Flag. The terminology that transgender individuals may use to describe themselves is presented.

Slide 7 – Intersexed and Sexual Orientation

The concept of being intersexed with ambiguous genitalia is presented. Also presented is how sexual orientation is different from gender identity.

Slide 8 – Gender Around the World

This slide provides more information on cultures globally that are inclusive of more than two genders. Specifically, I highlighted content that colonization erased the diversity once experienced by the Indigenous Peoples of the Americas and how in 1990, the Queer Indigenous Community created the term Two-Spirit as an umbrella term for a range of genders and sexualities.

Slide 9 – Transgender

This slide provides further understanding of being transgender, the prevalence and the age at which gender is often understood, and the difference between gender dysphoria and gender incongruence.

Slide 10 – Gender Dysphoria (GD)

This slide defines gender dysphoria according to the DSM-5-TR and its association with severe psychological distress and its onset. Both early and late onset were described, with examples of behaviour for that age of onset.

Slide 11 – Mental Health Comorbidities

This slide defines comorbidity, with an added picture of a cat, because the statistics on this slide are sad. The rates of experienced anxiety, depression, and risk of suicide are separated into three sections representing children, adolescents, and adults. I highlighted the risk of suicide at each age group and brought in evidence that the risk of suicide has shown up as early as age five for transgender children without support. I provided evidence that it is challenging to separate the emotional distress of being gender incongruent or dysphoric from the distress of societal discrimination and stigma and that when TGD children and youth are supported by their parents or caregivers, they have similar rates of mental health issues to their cisgender peers. I highlighted that 91% of transgender adults who waited until adulthood for gender-affirming care had experienced a suicide risk.

Slide 12 – Reducing Psychological Distress

This slide highlights the critical role of parents and caregivers as the primary protective factor for TGD (transgender and gender-diverse) children and youth in mitigating psychological distress. It emphasizes the necessity for TGD children and youth to have a safe space where their gender identity

can be affirmed. Examples were provided on how to reduce psychological distress by supporting transition and gender-affirming care. The transition process can be social, involving changes in names, pronouns, hairstyles, and government identification, or it may include medical interventions such as hormone blockers, affirming hormones, and surgery. It was noted that transition is a journey rather than an endpoint. Additionally, the need for parents and caregivers to receive support was underscored, and they were encouraged to seek assistance if they experienced feelings of fear, concern, or curiosity.

Slide 13 – What Is Gender-Affirming Care?

This slide provides more details on what gender-affirming care looks like and explains social transition. I provided examples of gender expression and how it may not look the way a parent or caregiver expects. Often, society expects gender to be expressed in a binary (man or woman) way and struggles with non-conforming gender expression. I emphasized that gender can be fluid and is unique and novel to each person. I outlined and described several actions that TGD children and youth may initiate that are easy, reversible, and non-medical.

Slide 14 – Gender-Affirming Care – Pre-Puberty

This slide explains that there are no medical options in Canada for prepubescent individuals, and all transitions are considered social and 100% reversible. It compares socially transitioned transgender children with their cisgender peers and finds they have similar developments and preferences in toys, activities and clothing. It highlights that gender-incongruent children persist with their incongruence past puberty 20% of the time.

Slide 15 – Gender-Affirming Care – Post-Puberty

This slide provides information on beginning medical gender-affirming care and at what stage of development it can be initiated (Tanner stage 2). Information is provided that informed consent is

required to proceed with medical care, which reduces barriers. It explains the different levels of reversible to irreversible gender-affirming interventions that can be accessed, all of which are optional (hormone blockers, affirmative hormones, and surgical care). Not all TGD youth will want medical care, but all who are interested will require a hormone readiness assessment and a surgical assessment.

Slide 16 – Informed Consent

This slide describes what informed consent is and how it is assessed. I explain how, whenever possible, parent and caregiver support and consent should be included, but for a variety of reasons, this may be harmful or not feasible. Informed consent is understood as assessing the emotional and cognitive maturity of the youth, their comprehension of treatment effects, ability to be forward-thinking, comprehension of possible loss of fertility, and their potential changing gender needs. The youth must also understand the risks and benefits of the interventions, the limits of what is known about the treatments, and that they have a choice. It is emphasized that informed consent must be assessed at every level of care sought.

Slide 17 – Comorbid Mental Health and GD Interventions

This slide explains that mental health comorbidities can be an added complication to accessing gender-affirming care, but they should not be a barrier. Assessment of safety is always a priority, but the youth's mental health concerns do not need to be resolved before proceeding with gender-affirming care because they are often a result of family and societal rejection and not their gender incongruence. Symptoms that affect informed consent, such as psychosis and cognitive challenges, need to be addressed prior to accessing care.

Slide 18 – Common Concerns About Gender-Affirming Care and Transition

This slide breaks down common concerns and fears about gender transition and access to the different levels of medical gender-affirming care, given some of their levels of permanence. I highlighted that children and youth are considered impulsive, and they may regret their transition and any of the more permanent medical treatments, like affirmative hormones and surgery.

Slide 19 – Detransition & Retransition

This slide defines detransition and retransition as the act of returning to some form prior to transition or identifying as a gender that is congruent with their sex at birth. It highlights that TGD individuals transition for a variety of reasons, from dissatisfaction with the results of gender-affirming care to discrimination and stigma from society and family members.

Slide 20 – Regret Rates

This slide provides a comparison of regret rates of gender transition with other major life decisions and major surgeries like having children, marriage, and gastric bypass. On this slide, I asked the audience to guess what the regret rate for having children is (13%) and ended with providing the regret rate for gender transition (1%).

Slide 21 – How Can I Support my TGD Child or Youth?

This slide provides ways to support their child or youth, including accessing TranscareBC, being curious and not dismissive, and making sure their child or youth knows they are loved and accepted. This slide also provides many different ways to psychologically and socially support TGD children and youth, emphasizing advocating for their child with family, friends, and society. It also repeated that if, as parents or caregivers, they were struggling emotionally to support their youth, they should seek help.

Slide 22 – Takeaways

This slide outlines the intended takeaways from the presentations. These include that TGD children and youth are on a journey, and transition is not an endpoint, support is necessary for survival, assessment includes informed consent, and interventions that can be accessed are 100% reversible, semi-reversible, and irreversible. Additionally, detransition should be understood as part of the process and not a failure. Gender identity is a journey.

Slide 23 – Questions and Discussions

The audience asked questions, and I provided answers based on my research.

Slides 24 & 25

References.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Ashley, F. (2019). Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth. *Clinical Child Psychology and Psychiatry*, *24*(2), 223–236. doi:10.1177/1359104519836462

Ashley, F. (2019a). Gatekeeping hormone replacement therapy for transgender patients is dehumanising. *Journal of Medical Ethics*, *45*(7), 480–482. https://doi.org/10.1136/medethics-2018-105293

Ashley, F. (2020). A critical commentary on 'rapid-onset gender dysphoria.' *The Sociological Review*, *68*(4), 779–799. https://doi.org/10.1177/0038026120934693

Ashley, F. (2025, March 1). *About*. Florence Ashley. https://www.florenceashley.com/about.html

Ashley, F., Parsa, N., kus, t., & MacKinnon, K. R. (2023). Do gender assessments prevent regret in transgender healthcare? A narrative review. *Psychology of Sexual Orientation and Gender Diversity*, *11*(4), 553-562. https://doi.org/10.1037/sgd0000672

Austin, A., Papciak, R., & Lovins, L. (2022). Gender euphoria: A grounded theory exploration of experiencing gender affirmation. *Psychology & Sexuality*, *13*(5), 1406–1426. https://doi.org/10.1080/19419899.2022.2049632

Bowman, S. J., Casey, L. J., McAloon, J., & Wootton, B. M. (2022). Assessing gender dysphoria: A systematic review of patient-reported outcome measures. *Psychology of Sexual Orientation and Gender Diversity*, *9*(4), 398–409. https://doi.org/10.1037/sgd0000486

Bowman, S. J., Hakeem, A., Demant, D., McAloon, J., & Wootton, B. M. (2024). Assessing gender dysphoria: Development and validation of the gender preoccupation and Stability Questionnaire – 2nd edition

(GPSQ-2). *Journal of Homosexuality*, *71*(3), 666–690. https://doi.org/10.1080/00918369.2022.2132440

Butler, G., De Graaf, N., Wren, B., & Carmichael, P. (2018). Assessment and support of children and adolescents with gender dysphoria. *Archives of Disease in Childhood. 103*, 631–636. https://doi.org/10.1136/archdischild-2018-314992

Cameron, J. J., & Stinson, D. A. (2022). Ethical gender/sex measurement in Canadian research. *Canadian Psychology, 63*(4), 536–544. https://doi.org/10.1037/cap0000334

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., . . . Sabir, K. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Counselman-Carpenter, E., & Redcay, A. (2023). Deepening understanding of nuanced identity within the transgender community through an exploration of posttraumatic growth. *Psychology of Sexual Orientation and Gender Diversity*, *10*(3), 429–439. https://doi.org/10.1037/sgd0000415

Cusack, C. E., Iampieri, A. O., & Galupo, M. P. (2022). “I’m still not sure if the eating disorder is a result of gender dysphoria”: Trans and nonbinary individuals’ descriptions of their eating and body concerns in relation to their gender. *Psychology of Sexual Orientation and Gender Diversity*, *9*(4), 422–433. https://doi.org/10.1037/sgd0000515

deMayo, B. E., Jordan, A. E., & Olson, K. R. (2022). Gender development in gender diverse children. *Annual Review of Developmental Psychology*, *4*(1), 207–229. https://doi.org/10.1146/annurev-devpsych-121020-034014

Derman, C. (2024, February 1). *Transgender, gender diverse people more likely to have unmet mental health needs*. ProQuest One Academic. https://www.proquest.com/trade-journals/transgender-gender-diverse-people-morelikely/docview/2921035539/se-2?accountid=1230

DeZure, C. (2023). Gender-affirming care in children. *Pediatric Annals*, *52*(5). https://doi.org/10.3928/19382359-20230307-03

Dowers, E., White, C., Cook, K., & Kingsley, J. (2020). Trans, gender diverse and non-binary adult experiences of social support: A systematic quantitative literature review. *International Journal of Transgender Health*, *21*(3), 242–257. https://doi.org/10.1080/26895269.2020.1771805

Dubin, S., Lane, M., Morrison, S., Radix, A., Belkind, U., Vercler, C., & Inwards-Breland, D. (2020). Medically assisted gender affirmation: when children and parents disagree. *Journal of Medical Ethics, 46*(5), 295-299. https://doi.org/10.1136/medethics-2019-105567

Dunham, Y., & Olson, K. R. (2016). Beyond discrete categories: Studying multiracial, intersex, and transgender children will strengthen basic developmental science. *Journal of Cognition and Development*, *17*(4), 642–665. https://doi.org/10.1080/15248372.2016.1195388

Durwood, L., Kuvalanka, K. A., Kahn-Samuelson, S., Jordan, A. E., Rubin, J. D., Schnelzer, P., Devor, A. H., & Olson, K. R. (2022). Retransitioning: The experiences of youth who socially transition genders more than once. *International Journal of Transgender Health*, *23*(4), 409–427. https://doi.org/10.1080/26895269.2022.2085224

Ehrensaft, D. (2017). Gender nonconforming youth: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, *8*, 57–67. https://doi.org/10.2147/ahmt.s110859

Fast, A. A., & Olson, K. R. (2018). Gender development in transgender preschool children. *Child Development*, *89*(2), 620–637. https://doi.org/10.1111/cdev.12758

Frew, T., Watsford, C., & Walker, I. (2021). Gender dysphoria and psychiatric comorbidities in childhood: A systematic review. *Australian Journal of Psychology*, *73*(3), 255–271. https://doi.org/10.1080/00049530.2021.1900747

Goldbach, C., & Knutson, D. (2023). Gender-related minority stress and gender dysphoria: Development and initial validation of the Gender Dysphoria Triggers Scale (GDTS). *Psychology of Sexual Orientation and Gender Diversity*, *10*(3), 383–396. https://doi.org/10.1037/sgd0000548

Government of Canada. (n.d.). *Education in Canada: Elementary and secondary school*. Immigration, Refugees and Citizenship Canada. Retrieved February 7, 2025, from https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/education/types-school/elementary-secondary.html

Gülgöz, S., Glazier, J. J., Enright, E. A., Alonso, D. J., Durwood, L. J., Fast, A. A., Lowe, R., Ji, C., Heer, J., Martin, C. L., & Olson, K. R. (2019). Similarity in transgender and cisgender children's gender development. *Proceedings of the National Academy of Sciences*, *116*(49), 24480–24485. https://doi.org/10.1073/pnas.1909367116

Hässler, T., Glazier, J. J., & Olson, K. R. (2022). Consistency of gender identity and preferences across time: An exploration among cisgender and transgender children. *Developmental Psychology*, *58*(11), 2184–2196. https://doi.org/10.1037/dev0001419

Helsen, V., Enzlin, P., & Gijs, L. (2022). Mental health in transgender adults: The role of proximal minority stress, community connectedness, and gender nonconformity. *Psychology of Sexual Orientation and Gender Diversity*, *9*(4), 466–477. https://doi.org/10.1037/sgd0000530

Hildebrand-Chupp, R. (2020). More than 'canaries in the gender coal mine': A transfeminist approach to research on detransition. *The Sociological Review*, *68*(4), 800–816. https://doi.org/10.1177/0038026120934694

Hynes Brothers, K. (2025). Experiences of parents and caregivers with transgender children: A critical review. *Families in Society: The Journal of Contemporary Social Services*. https://doi.org/10.1177/10443894241300629

Jackson, E. F., & Bussey, K. (2022). Broadening gender self-categorization development to include transgender identities. *Social Development*, *32*(1), 17–31. https://doi.org/10.1111/sode.12635

Jackson, S. S., Brown, J., Pfeiffer, R. M., Shrewsbury, D., O'Callaghan, S., Berner, A. M., Gadalla, S. M., & Shiels, M. S. (2023). Analysis of mortality among transgender and gender diverse adults in England. *JAMA Network Open, 6*(1), 2253687. https://doi.org/10.1001/jamanetworkopen.2022.53687

James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). Early Insights: A Report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality, Washington, DC.

Jorgensen, S. C. (2023). Transition regret and detransition: Meanings and uncertainties. *Archives of Sexual Behavior*, *52*(5), 2173–2184. https://doi.org/10.1007/s10508-023-02626-2

Kallitsounaki, A., Williams, D. M., & Lind, S. E. (2020). Links between autistic traits, feelings of gender dysphoria, and mentalising ability: Replication and extension of previous findings from the general population. *Journal of Autism and Developmental Disorders*, *51*(5), 1458–1465. https://doi.org/10.1007/s10803-020-04626-w

Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisen, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, *Volume 9*, 31–41. https://doi.org/10.2147/ahmt.s135432

Klysing, A. (2019). Exposure to scientific explanations for gender differences influences individuals' personal theories of gender and their evaluations of a discriminatory situation. *Sex Roles*, *82*(5–6), 253–265. https://doi.org/10.1007/s11199-019-01060-w

Levin, R. N., Schudson, Z. C., Raphel, K., Takahashi, A. N., Franks, J., Fiastro, A., Greene, J., Hamilton, E., & Hannigan, I. (2023). Gender identity, sexual orientation, and the prenatal androgen theory: Reevaluating definitions, cognitive tests, and somatic markers. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000671

MacKinnon, K. R., Kia, H., Gould, W. A., Ross, L. E., Abramovich, A., Enxuga, G., & Lam, J. S. (2023). A typology of pathways to detransition: Considerations for Care Practice with transgender and gender diverse people who stop or reverse their gender transition. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000678

Martinez, T. (2022). *Gender neutral parenting: Raising a generation outside the gender binary* [Unpublished master's thesis]. University of California. https://scholarworks.uark.edu/etd/4620

Meza Lazaro, Y., & Bacio, G. A. (2023). Determinants of mental health outcomes among transgender latinas: Minority stress and resilience processes. *Psychology of Sexual Orientation and Gender Diversity*, *10*(3), 451–460. https://doi.org/10.1037/sgd0000545

Morandini, J. S., Kelly, A., de Graaf, N. M., Malouf, P., Guerin, E., Dar-Nimrod, I., & Carmichael, P. (2023). Is social gender transition associated with mental health status in children and adolescents with gender dysphoria? *Archives of Sexual Behavior*, *52*(3), 1045–1060. https://doi.org/10.1007/s10508-023-02588-5

Murray, C., Pope, A., & Willis, B. (2017). Gender identity and affectional/sexual orientation. In *Sexuality Counseling: Theory, Research, and Practice, 0*, 191–226. https://doi.org/10.4135/9781071801116

O'Sullivan, S. (2021). The colonial project of gender (and everything else). *Genealogy (Basel), 5*(3), 67. https://doi.org/10.3390/genealogy5030067

Potter, A., Dube, S., Allgaier, N., Loso, H., Ivanova, M., Barrios, L. C., Bookheimer, S., Chaarani, B., Dumas, J., Feldstein-Ewing, S., Freedman, E. G., Garavan, H., Hoffman, E., McGlade, E., Robin, L., & Johns, M. M.

(2021). Early adolescent gender diversity and mental health in the Adolescent Brain Cognitive Development Study. *Journal of Child Psychology and Psychiatry*, *62*(2), 171–179. https://doi.org/10.1111/jcpp.13248

Pruden, H., & Salway, T. (2020). "What and who is Two-Spirit" in health research. *CIHR Institute of Gender and Health*. https://cihr-irsc.gc.ca/e/documents/igh_two_spirit-en.pdf

Public Broadcasting Service (PBS). (2024, March 14). *Interactive map: Gender-diverse cultures*. PBS. https://www.pbs.org/independentlens/content/two-spirits_map-html/

Puchała, D., Bilewicz, M., & Świderska, A. (2025). Reclaiming derogatory language: Self-reports and interbeat intervals. *Journal of Language and Social Psychology, 44*(1), 38-56. https://doi.org/10.1177/0261927X241299791

Rich, H. (2024, January 15). *Affirming care is not enough!* Rainbow Mental Health. https://www.rainbowmentalhealth.co/blog/affirming-care-is-not-enough

Rosenwohl-Mack, A., Tamar-Mattis, S., Baratz, A. B., Dalke, K. B., Ittelson, A., Zieselman, K., & Flatt, J. D. (2020). A national study on the physical and mental health of intersex adults in the U.S. *PLOS ONE*, *15*(10). https://doi.org/10.1371/journal.pone.0240088

Salomaa, A. C., Livingston, N. A., Bryant, W. T., Herbitter, C., Harper, K., Sloan, C. A., Hinds, Z., Gyuro, L., Valentine, S. E., & Shipherd, J. C. (2023). A bottom-up approach to developing a unified trauma-minority stress model for transgender and gender diverse people. *Psychological Trauma: Theory, Research, Practice, and Policy*, 15(4), 618–627. https://doi.org/10.1037/tra0001373

Savage, M. (2022, October 3). The parents raising their children without gender. *BBC*. British Broadcasting Corporation. Retrieved from https://www.bbc.com/worklife/article/20220929-the-parents-raising-their-children-without-gender

Seelman, K. L., Colón-Diaz, M. J. P., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health*, *2*(1), 17–28. https://doi.org/10.1089/trgh.2016.0024

Sherer, I. (2016). Social transition: Supporting our youngest transgender children. *Pediatrics*, *137*(3). https://doi.org/10.1542/peds.2015-4358

Spencer, K. G., Berg, D. R., Bradford, N. J., Vencill, J. A., Tellawi, G., & Rider, G. N. (2021). The gender-affirmative life span approach: A developmental model for clinical work with transgender and gender-diverse children, adolescents, and adults. *Psychotherapy*, *58*(1), 37–49. https://doi.org/10.1037/pst0000363

Tatum, A. K., Catalpa, J., Bradford, N. J., Kovic, A., & Berg, D. R. (2020). Examining identity development and transition differences among binary transgender and genderqueer nonbinary (GQNB) individuals. *Psychology of Sexual Orientation and Gender Diversity*, *7*(4), 379–385. https://doi.org/10.1037/sgd0000377

The Editors of Encyclopaedia Britannica (2023, January 12). *6 Cultures That Recognize More than Two Genders*. *Encyclopedia Britannica*. https://www.britannica.com/list/6-cultures-that-recognize-more-than-two-genders

Thornton, S. M., Edalatpour, A., & Gast, K. M. (2024). A systematic review of patient regret after surgery- A common phenomenon in many specialties but rare within gender-affirmation surgery. *The American Journal of Surgery, 234*, 68–73. https://doi.org/10.1016/j.amjsurg.2024.04.021

Todd, K. P., Thornburgh, S., Pitter, R., Gamarel, K. E., & Peitzmeier, S. (2022). Masculine identity development and health behaviors in transmasculine individuals: A theory of gender and health. *SSM - Qualitative Research in Health*, *2*, 100186. https://doi.org/10.1016/j.ssmqr.2022.100186

Tomita, K. K., Testa, R. J., & Balsam, K. F. (2019). Gender-affirming medical interventions and mental health in transgender adults. *Psychology of Sexual Orientation and Gender Diversity, 6*(2), 182–193. https://doi.org/10.1037/sgd0000316

Trans Care BC Provincial Health Services Authority (2024, Dec 28). *How to start.* https://www.transcarebc.ca/

The Trevor Project. (2023). *2023 National survey on LGBTQ youth mental health*. https://www.thetrevorproject.org

Turban, J. L., & Ehrensaft, D. (2018). Research review: Gender identity in youth: Treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228–1243. https://doi.org/10.1111/jcpp.12833

Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLOS ONE, 17*(1), e0261039. https://doi.org/10.1371/journal.pone.0261039

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Wilson, J., Sargeant, C., Jago, N., & Wright, S. (2023). Co-creating a new theory of gender beyond the binary: A Delphi study in the United Kingdom. *Journal of LGBT Youth*, *21*(3), 549–573. https://doi.org/10.1080/19361653.2023.2202664

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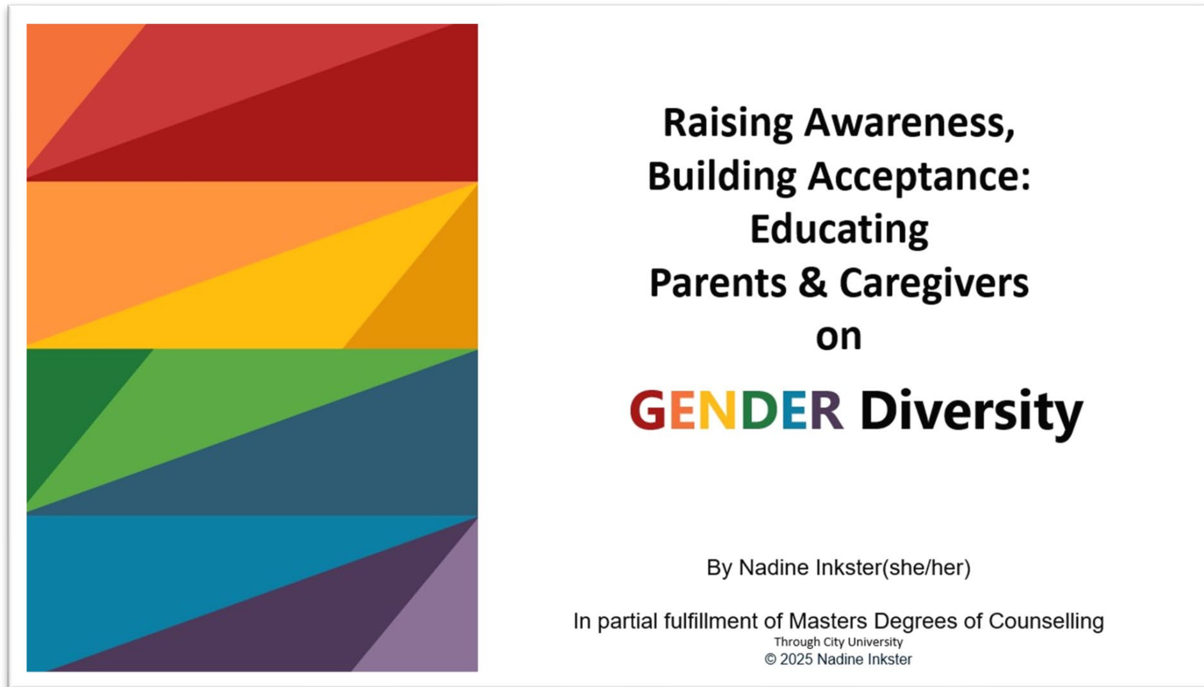
Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior, 48*(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8

Appendix A

Slide 1



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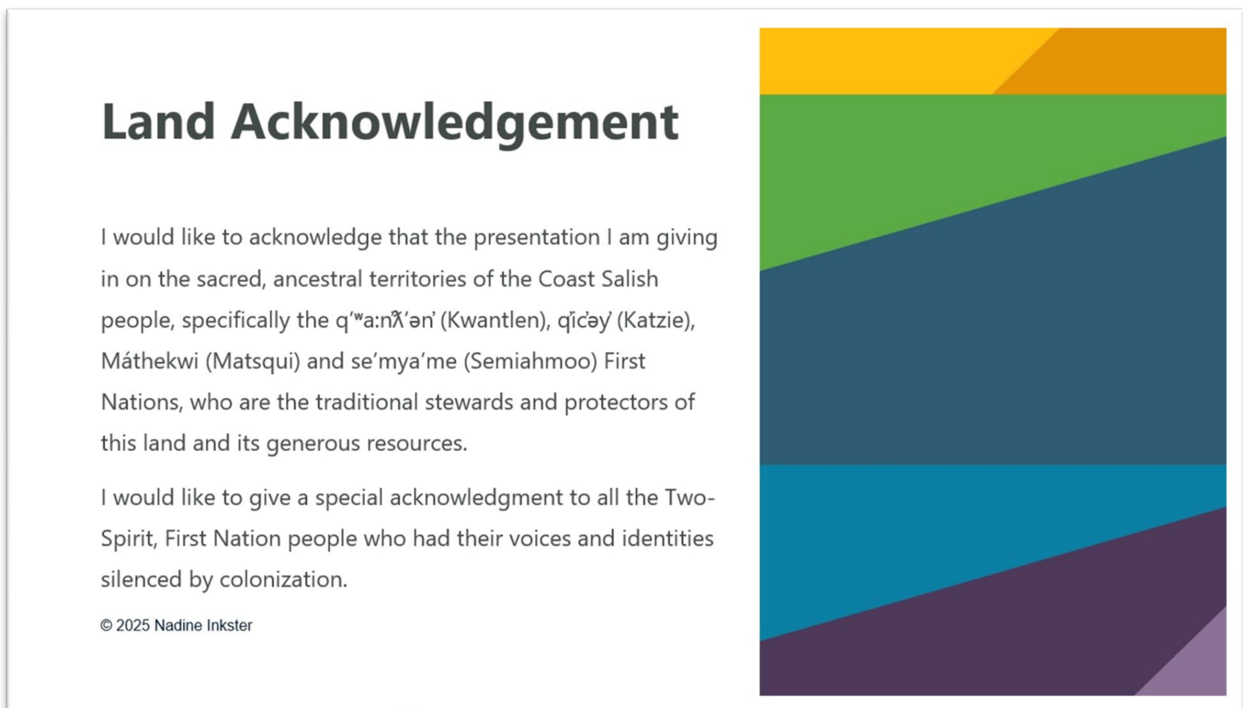

Slide 3

Jamie

Jamie is an avid gym attendee; Jamie likes to do all the pushing and pulling of the heavy things; Jaimie is also an amazing baker and makes the most delicately designed tasty cakes; Jamie is a manager at a bank and regularly attends trivia nights at the local bar and loves a good lager; Jamie also loves to sit down with a glass of wine and complete puzzles; Jamie also owns a 1969 Camero and is slowly rebuilding its engine and will soon have it up and running with a custom paint job; Jamie also has a small vegetable garden and grows seeds inside with a hydroponics set; Jamie recently learned to crochet and has donated hats to the local newborn-preemie hospital ward; Jamie has an amazing sense of dark humour and loves a good debate about politics.

Have I given you enough information to know Jamie's Gender?

Have I given you enough information to know if you would like to be friends with Jamie?

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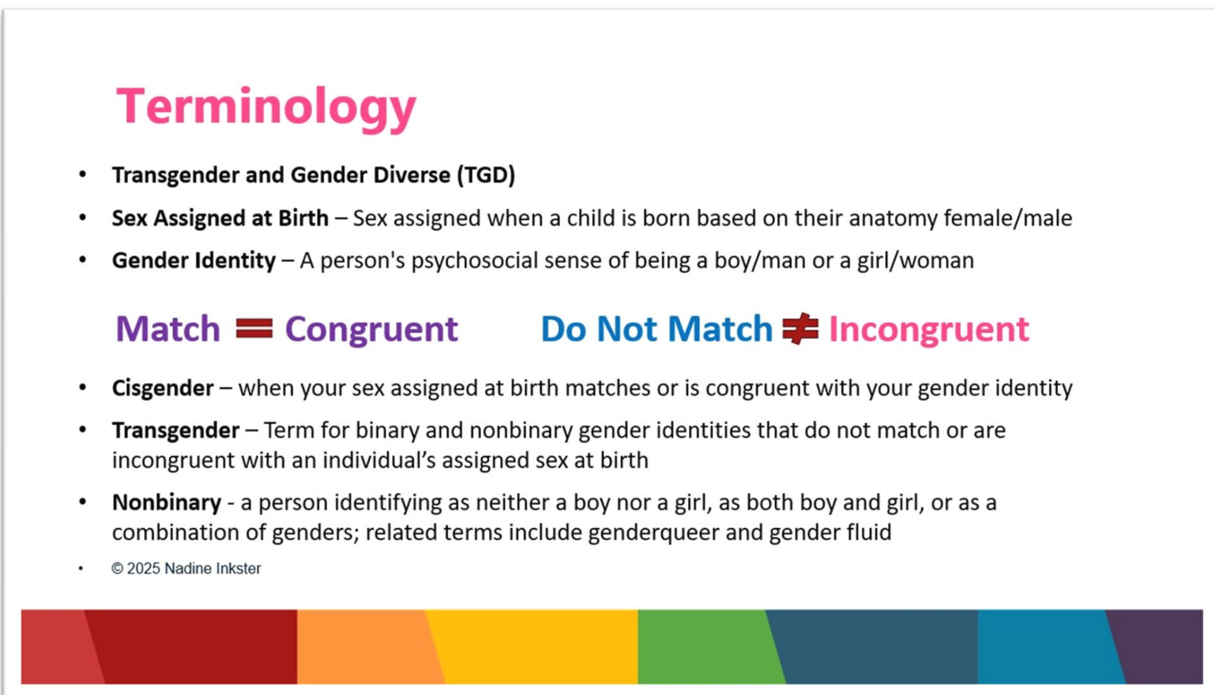
Slide 4



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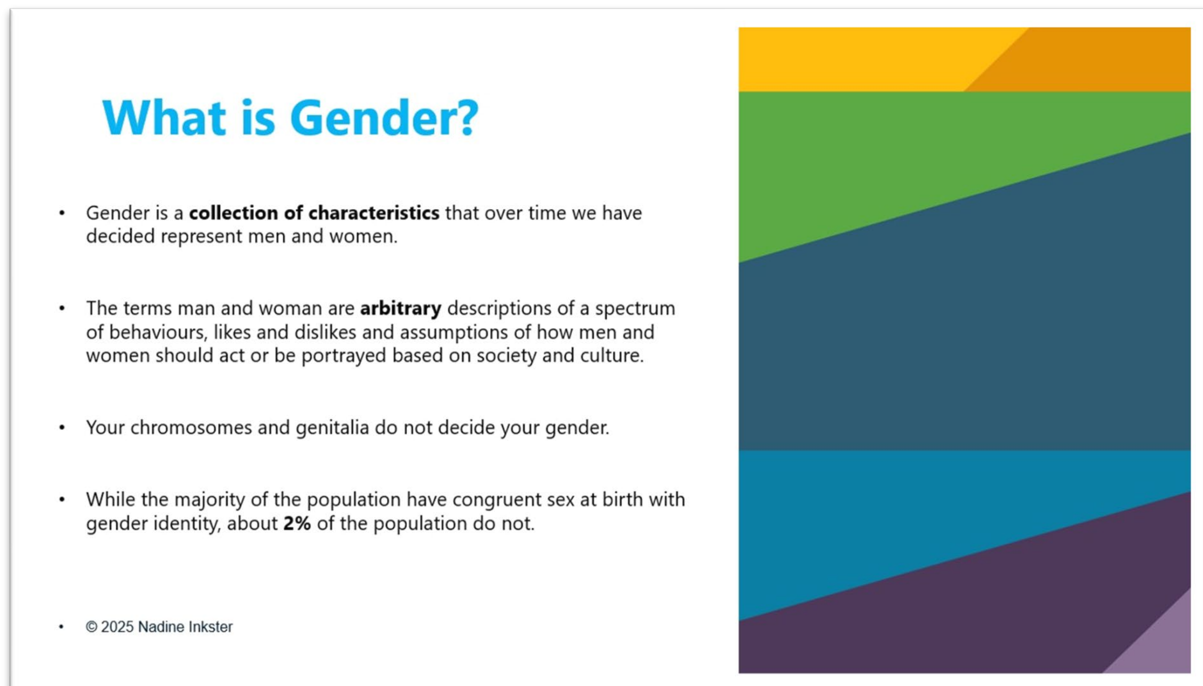

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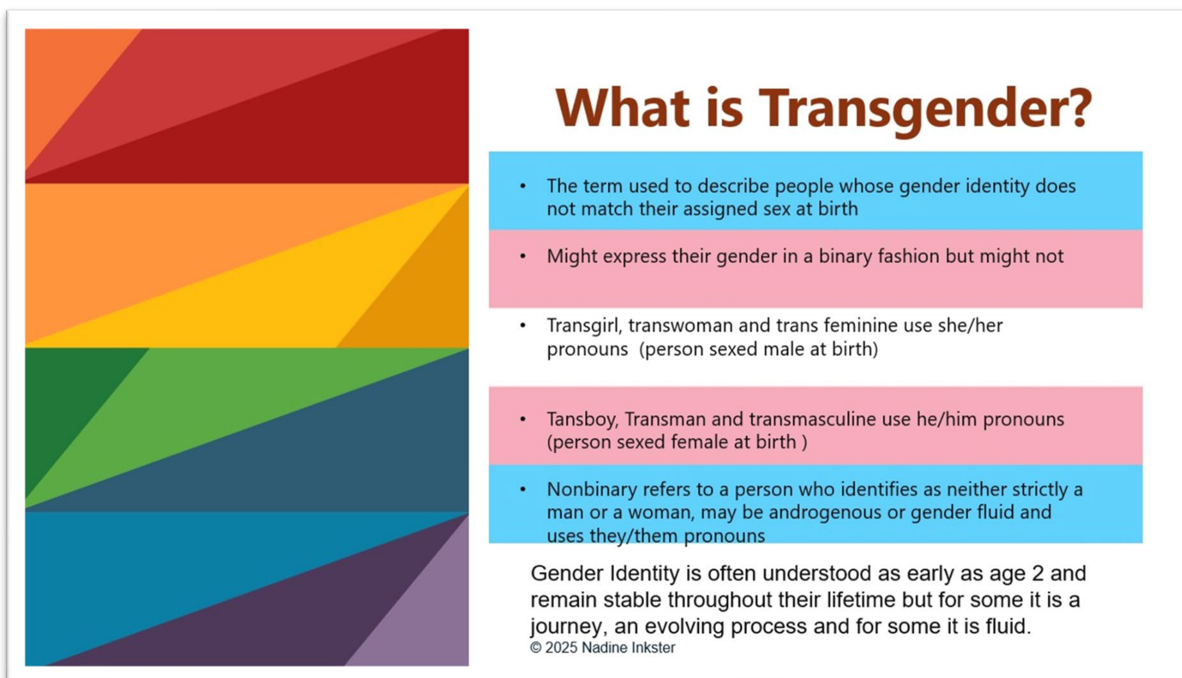

Slide 7

Intersexed

- People born with physiological characteristics that are **ambiguous** that do not fit the typical definitions of male and female anatomy

Sexual Orientation

- A person's sexual orientation describes who a person is sexually, romantically, emotionally or spiritually attracted to
- Sexual orientation is distinct from gender identity, and traditional binary terms like heterosexual and homosexual have expanded to include more fluid and inclusive identities such as pansexual, asexual and demisexual.

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Slide 8

Gender Around the World

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- Western cultures traditionally view gender and sex as discrete and binary but outside the Western middle-class "**WEIRD**" (Western Educated, Industrialized, Rich and Democratic) context a more inclusive and diverse view is welcomed
- The following are some countries from around the worlds that recognize more than two genders.

India	Samoa	Mexico	Madagascar	First Nations
Hijra	**Fa'afafine**	**Muxes**	**Sakalava**	**Two Spirit**

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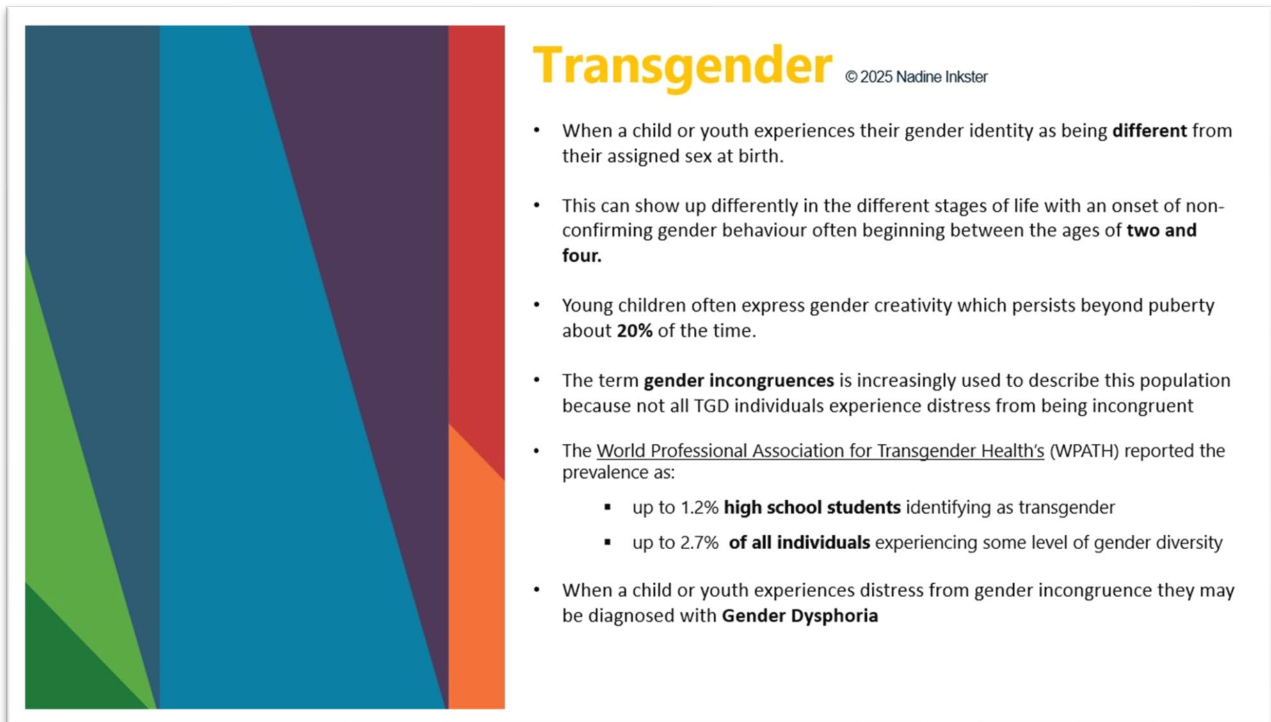

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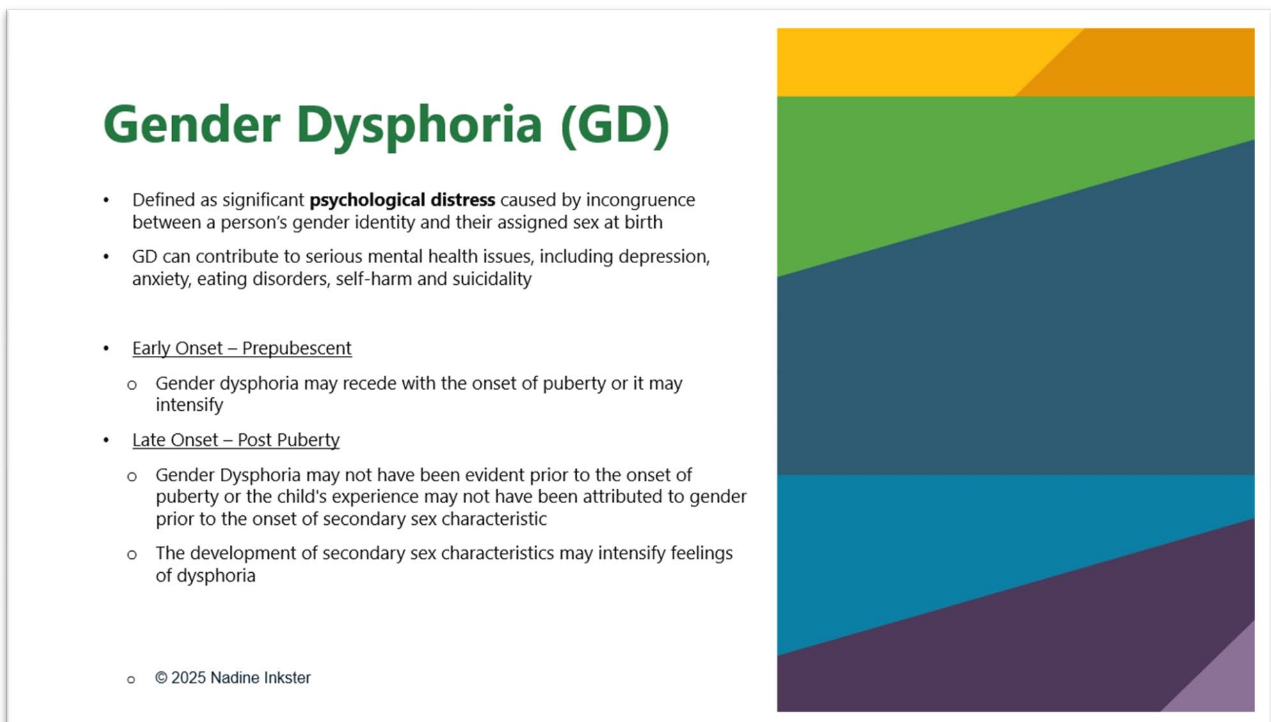

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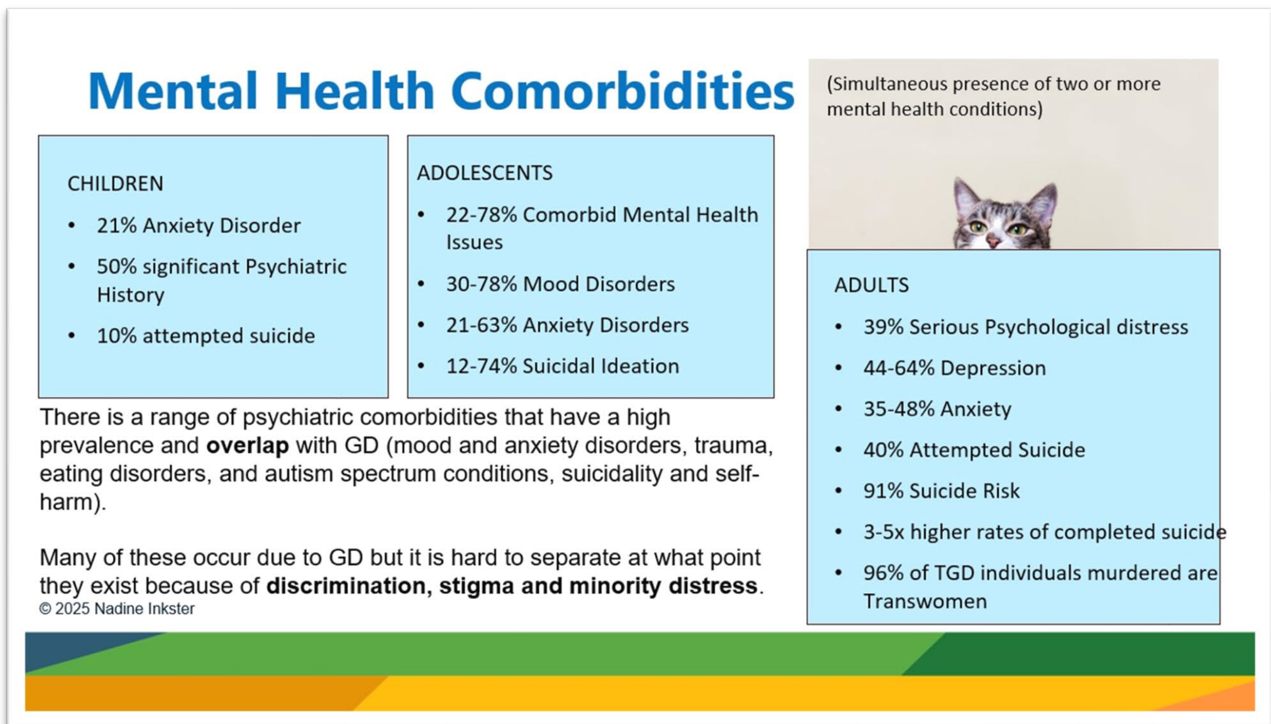

Slide 12

Reducing Psychological Distress

- Parents and Caregivers are the **NUMBER ONE PROTECTIVE FACTOR** in supporting the emotional well-being of TGD children and youth and play an crucial role in reducing psychological distress.
- Affirming your child's gender identity may involve name changes, hair, make up and government ID.
- TGD children and youth need access to safe spaces, lots of love and acceptance.
- Support **gender – affirming care and transition.**
- Transition is an **evolving process** and not an end point.

❖ TGD children and youth who **have** the support from parents or caregivers are **3 times** more likely to be happy and look forward to the future.

❖ TGD children and youth **without** support have **8 times** higher rates of risk of attempted suicide.

➢ **Parents and Caregivers need support too – feelings of fear, uncertainty, grief, and curiosities are normal. Seek support for yourself as needed.**

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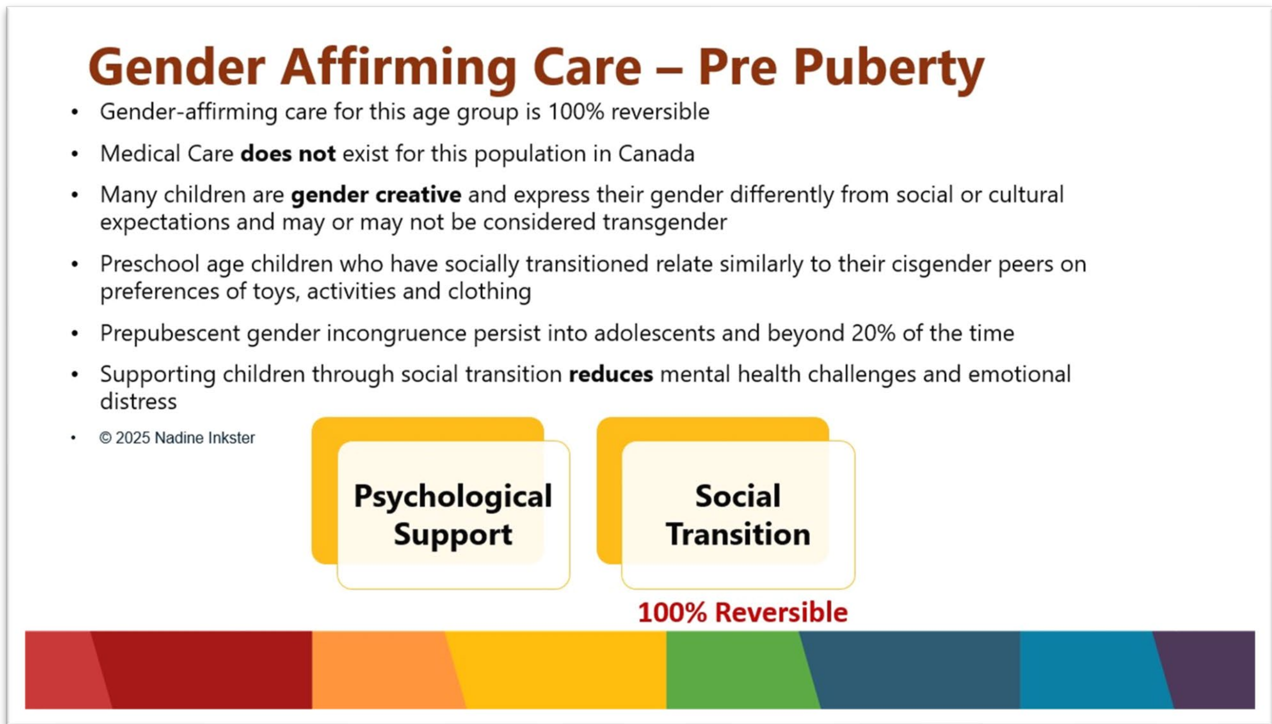

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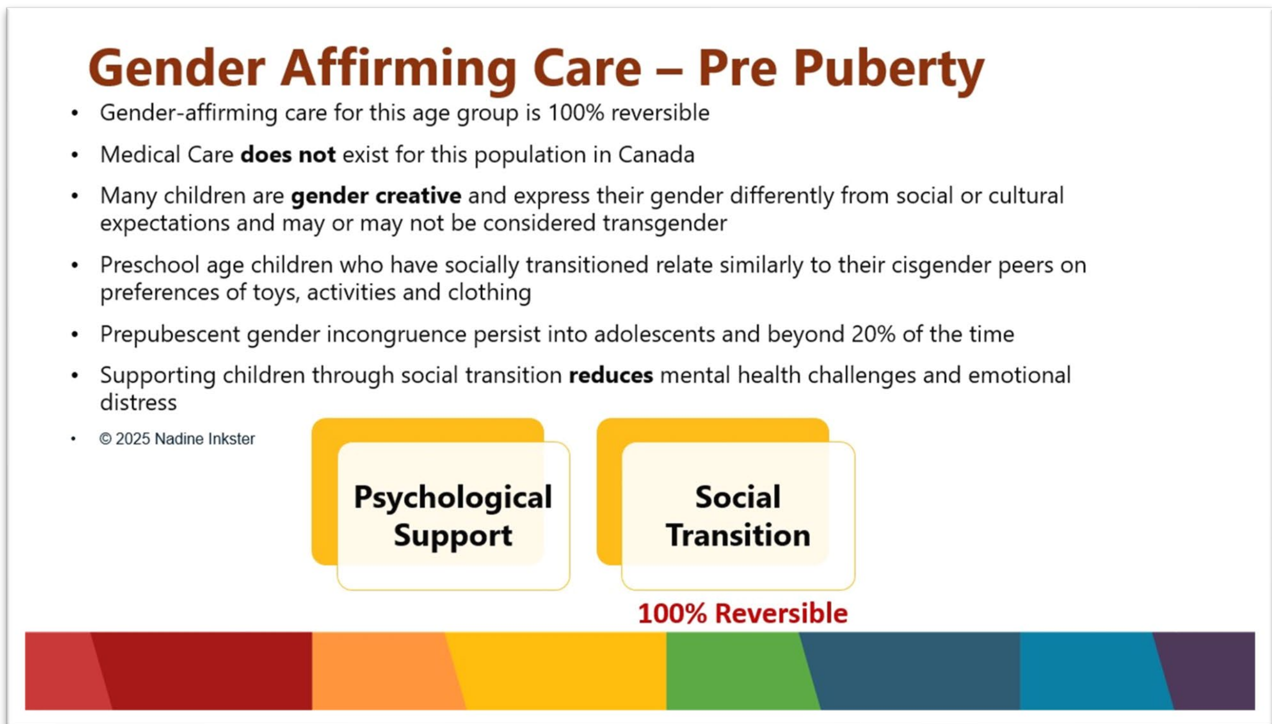

Slide 15

Gender Affirming Care – Post Puberty

- Gender-affirming care ranges from 100% reversible to permanent physical changes
- Hormone blockers cannot be started until **Tanner stage 2** has begun
- Gender-affirming care **reduces** mental health challenges and emotional distress
- **Informed Consent** reduces barriers of care
- Hormone readiness Assessment and Surgical Readiness Assessment are required

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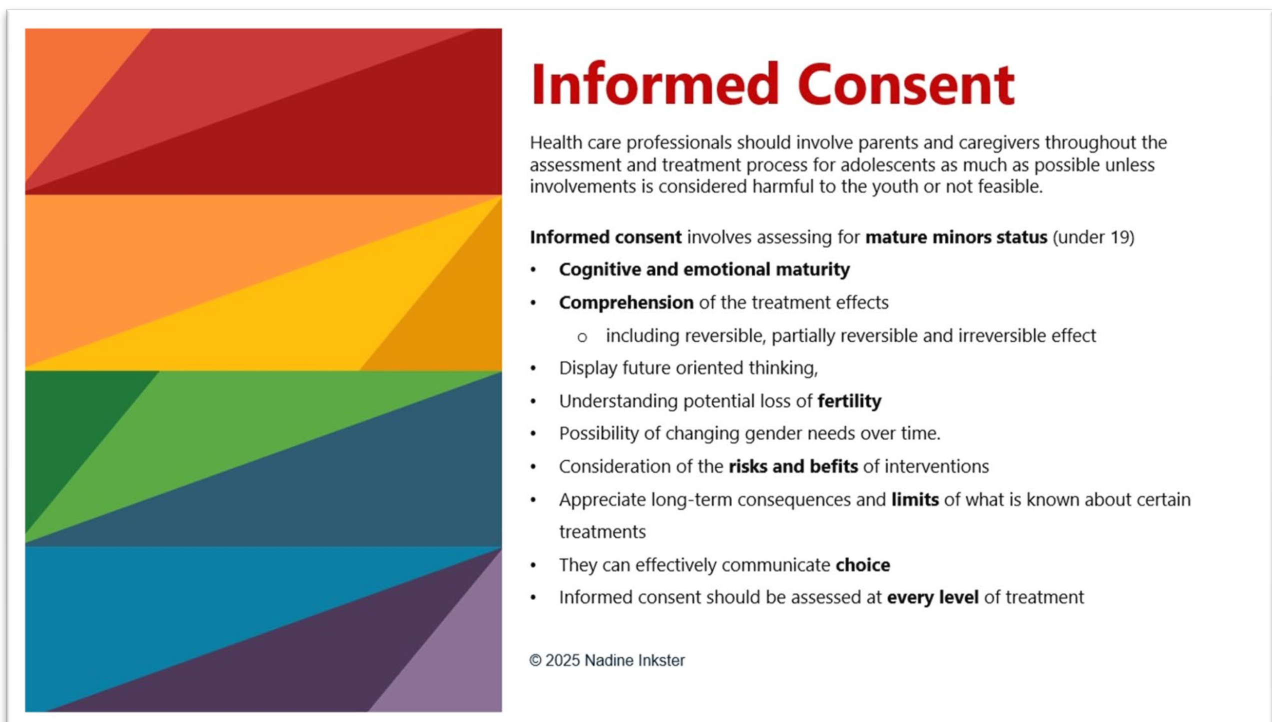
Social Transition	Hormone Blockers	Affirmative Hormone Therapy	Surgical Care
100% Reversible	Reversible	Semi Reversible	Permanent

Slide 16



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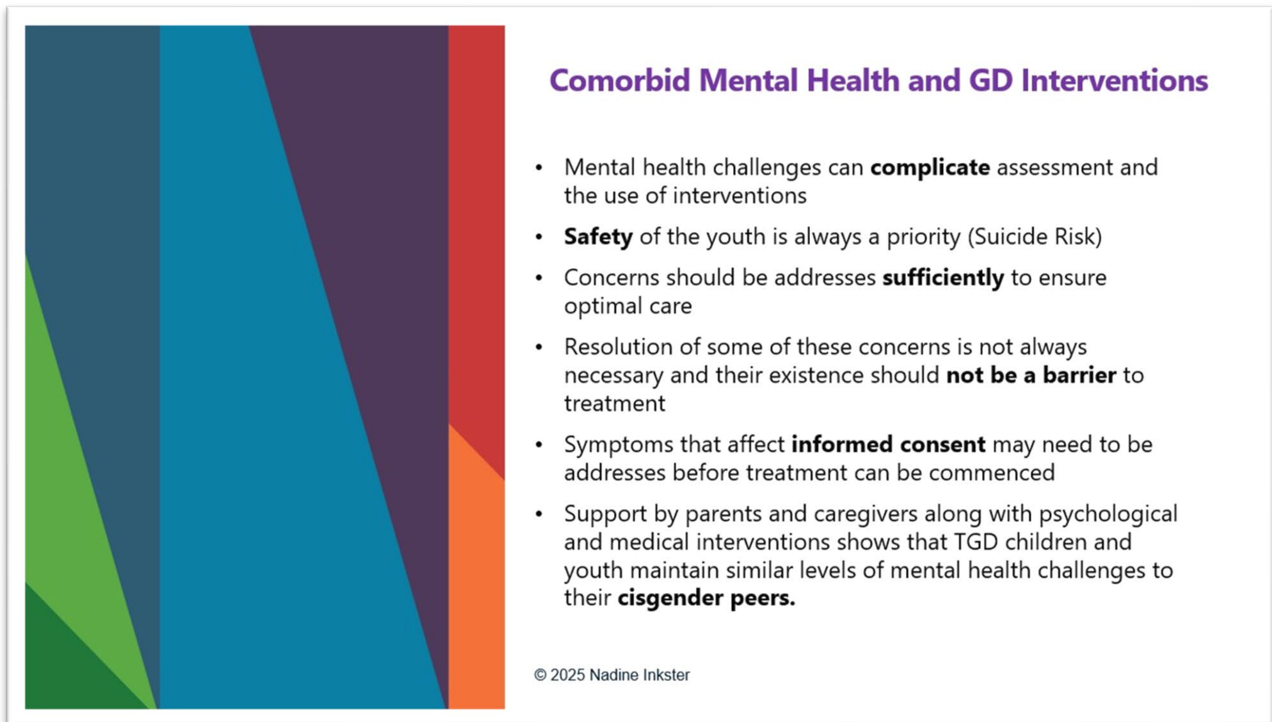

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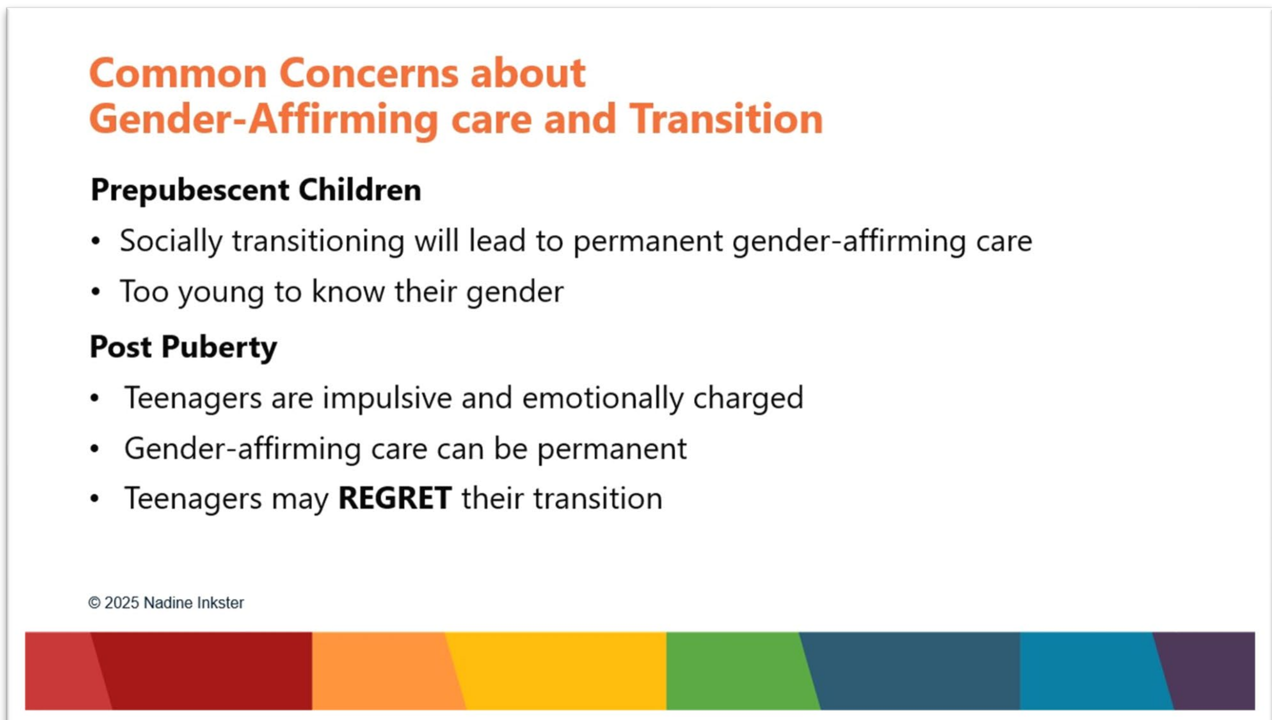

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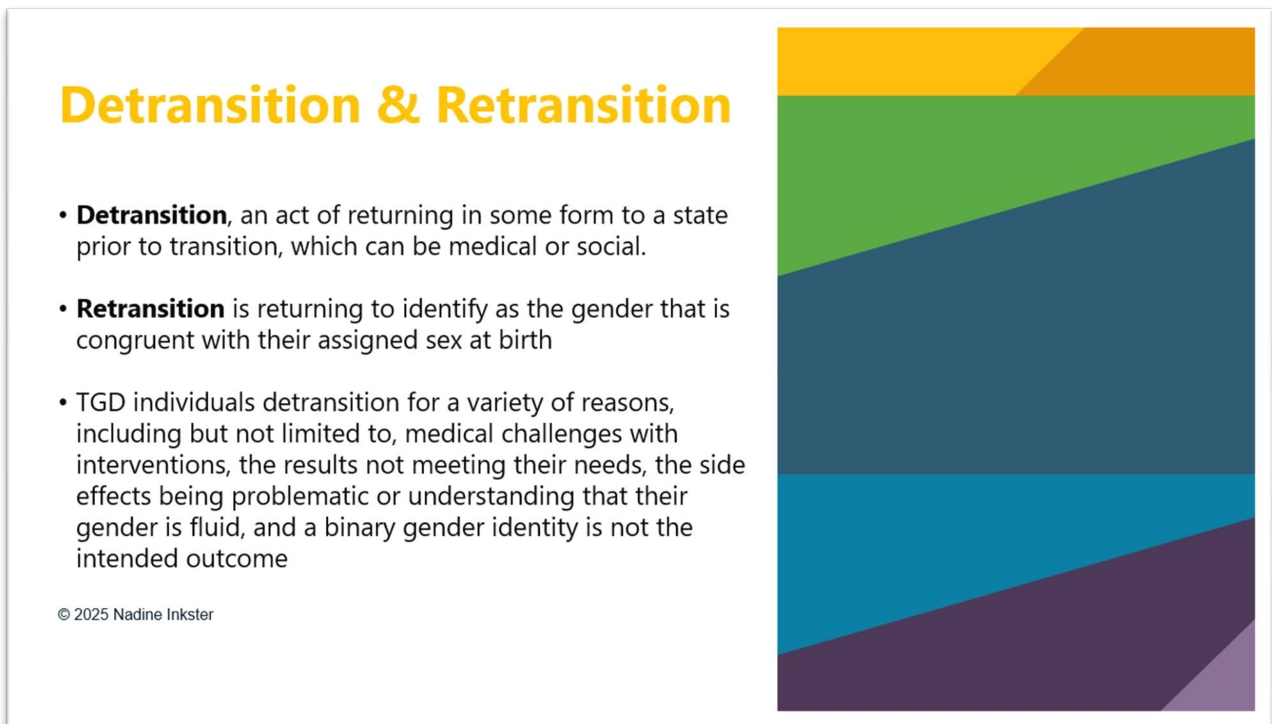

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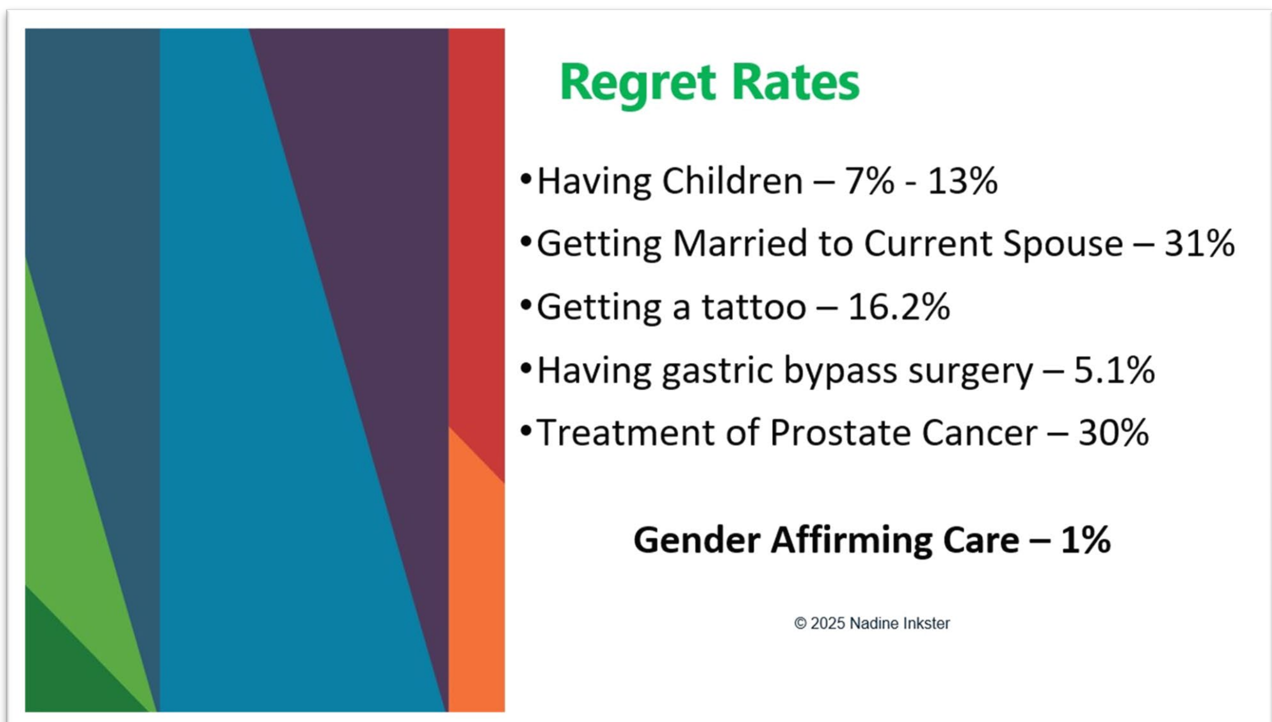

Slide 21

How can I support my TGD child or youth?

- Access **TranscareBC**
- Be curious, not dismissive
- Use **correct pronouns** (encourage family and friends)
- Support picking a new **name**
- Clothe **shopping**
- **Style** - Hairstyles/make-up/piercings
- Voice training
- Support with changing government **ID**
- Collaborate with child **what** and **when** information shared with family, friend and the outside world
- **Advocate** for your child or youth with their school, extracurricular activities and with family and friends

If you are struggling with this journey, seek help – Come to Foundry!

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Slide 22

Take Aways

- TGD children and youth are on a **journey** and transition is not an endpoint
- Psychological support is **imperative** to their emotional well-being and survival
- Assessment includes evaluation of mature minor status and treatment includes **informed consent**
- **Interventions** include 100% reversible, semi-reversible and permanent surgical treatment.
- Detransition or identifying differently from initial transition is **not a failure** but part of the journey.

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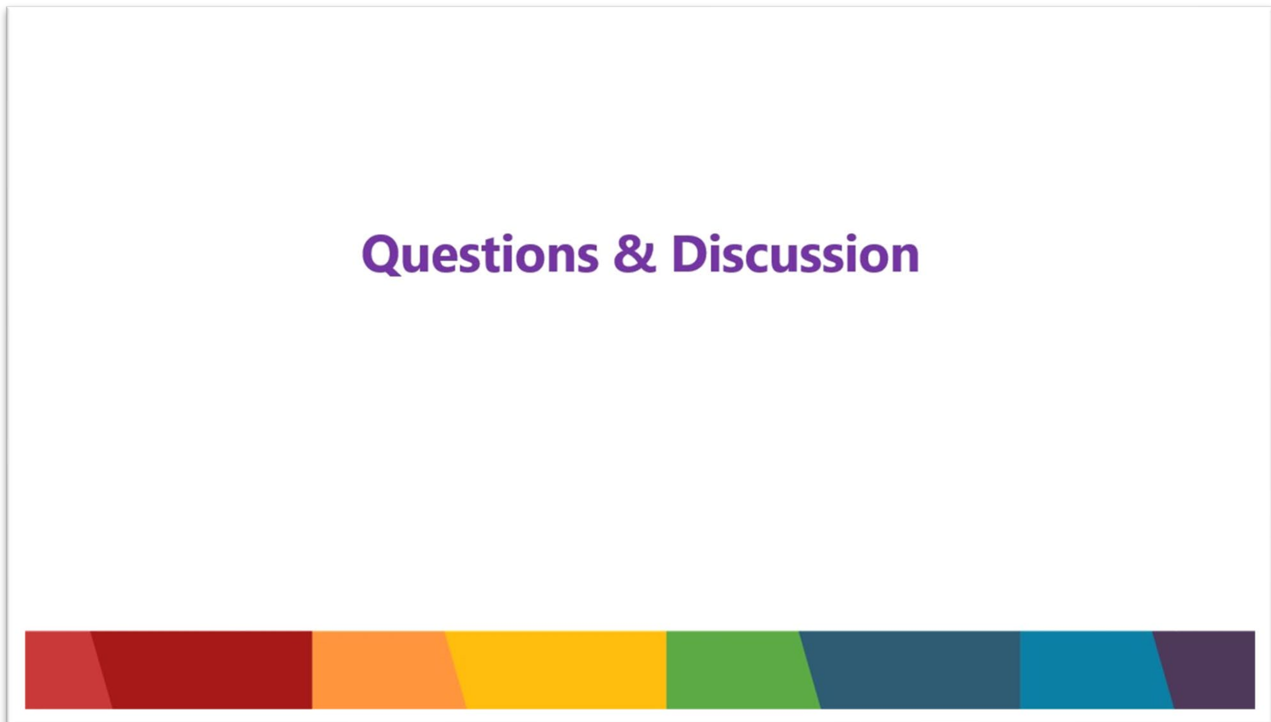
Slide 23



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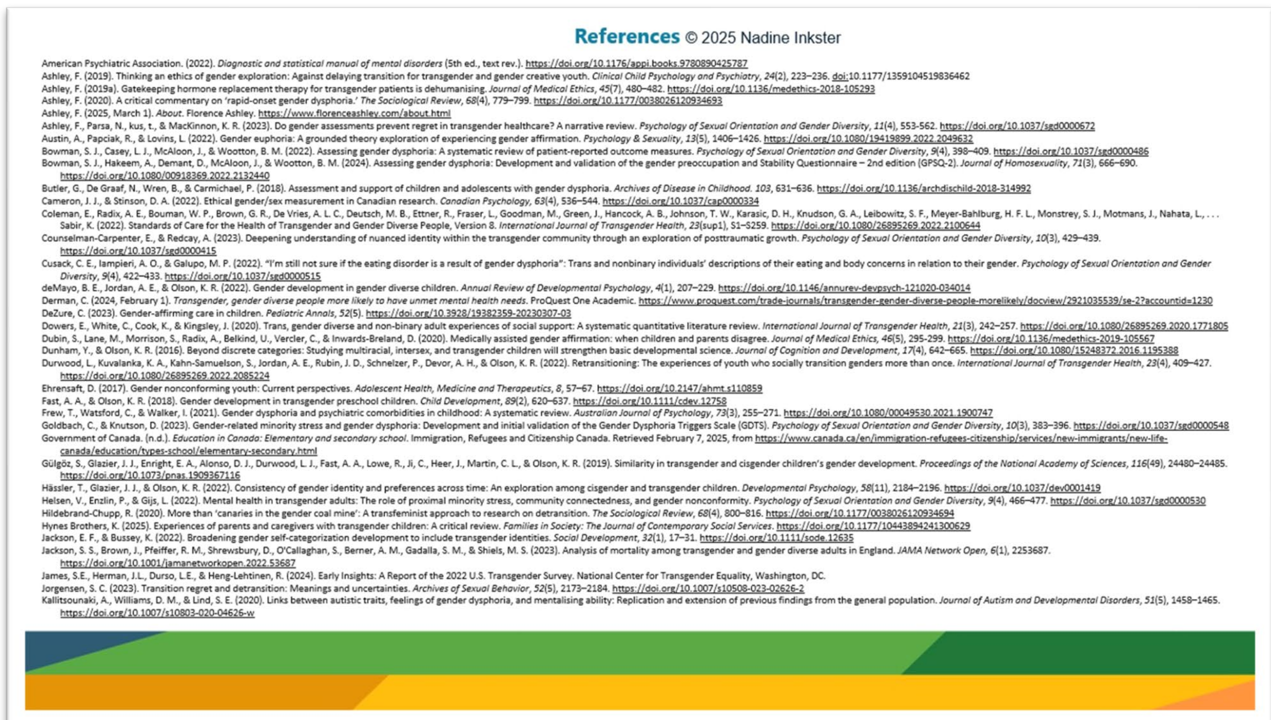

Slide 25

Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisen, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics, Volume 9*, 31–41. https://doi.org/10.2147/ahmt.s135432

Klysing, A. (2019). Exposure to scientific explanations for gender differences influences individuals' personal theories of gender and their evaluations of a discriminatory situation. *Sex Roles*, *82*(5–6), 253–265. https://doi.org/10.1007/s11199-019-01060-w

Levin, R. N., Schudson, Z. C., Raphel, K., Takahashi, A. N., Franks, J., Fiastro, A., Greene, J., Hamilton, E., & Hannigan, I. (2023). Gender identity, sexual orientation, and the prenatal androgen theory: Reevaluating definitions, cognitive tests, and somatic markers. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000671

MacKinnon, K. R., Kia, H., Gould, W. A., Ross, L. E., Abramovich, A., Enxuga, G., & Lam, J. S. (2023). A typology of pathways to detransition: Considerations for Care Practice with transgender and gender diverse people who stop or reverse their gender transition. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000678

Martinez, T. (2022). *Gender neutral parenting: Raising a generation outside the gender binary* [Unpublished master's thesis]. University of California. https://scholarworks.uark.edu/etd/4620

Meza Lazaro, Y., & Bacio, G. A. (2023). Determinants of mental health outcomes among transgender latinas: Minority stress and resilience processes. *Psychology of Sexual Orientation and Gender Diversity*, *10*(3), 451–460. https://doi.org/10.1037/sgd0000545

Morandini, J. S., Kelly, A., de Graaf, N. M., Malouf, P., Guerin, E., Dar-Nimrod, I., & Carmichael, P. (2023). Is social gender transition associated with mental health status in children and adolescents with gender dysphoria? *Archives of Sexual Behavior*, *52*(3), 1045–1060. https://doi.org/10.1007/s10508-023-02588-5

Murray, C., Pope, A., & Willis, B. (2017). Gender identity and affectional/sexual orientation. In *Sexuality Counseling: Theory, Research, and Practice, 0*, 191–226. https://doi.org/10.4135/9781071801116

O'Sullivan, S. (2021). The colonial project of gender (and everything else). *Genealogy (Basel)*, *5*(3), 67. https://doi.org/10.3390/genealogy5030067

Potter, A., Dube, S., Allgaier, N., Loso, H., Ivanova, M., Barrios, L. C., Bookheimer, S., Chaarani, B., Dumas, J., Feldstein-Ewing, S., Freedman, E. G., Garavan, H., Hoffman, E., McGlade, E., Robin, L., & Johns, M. M. (2021). Early adolescent gender diversity and mental health in the Adolescent Brain Cognitive Development Study. *Journal of Child Psychology and Psychiatry*, *62*(2), 171–179. https://doi.org/10.1111/jcpp.13248

Pruden, H., & Salway, T. (2020). "What and who is Two-Spirit" in health research. *CIHR Institute of Gender and Health*. https://cihr-irsc.gc.ca/e/documents/igh_two_spirit-en.pdf

Public Broadcasting Service (PBS). (2024, March 14). *Interactive map: Gender-diverse cultures*. PBS. https://www.pbs.org/independentlens/content/two-spirits_map-html/

Rosenwohl-Mack, A., Tamar-Mattis, S., Baratz, A. B., Dalke, K. B., Ittelson, A., Zieselman, K., & Flatt, J. D. (2020). A national study on the physical and mental health of intersex adults in the U.S. *PLOS ONE*, *15*(10). https://doi.org/10.1371/journal.pone.0240088

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Savage, M. (2022, October 3). The parents raising their children without gender. *BBC*. British Broadcasting Corporation. Retrieved from https://www.bbc.com/worklife/article/20220929-the-parents-raising-their-children-without-gender

Seelman, K. L., Colón-Diaz, M. J. P., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: Connections to general health and mental health among transgender adults. *Transgender Health*, *2*(1), 17–28. https://doi.org/10.1089/trgh.2016.0024

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The Editors of Encyclopaedia Britannica (2023, January 12). *6 Cultures That Recognize More than Two Genders. Encyclopedia Britannica*. https://www.britannica.com/list/6-cultures-that-recognize-more-than-two-genders

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Trans Care BC Provincial Health Services Authority (2024, Dec 28). *How to start*. https://www.transcarebc.ca/

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Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLOS ONE, 17*(1), e0261039. https://doi.org/10.1371/journal.pone.0261039

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Appendix B

·FOUNDRY·
LANGLEY
Hosted by Encompass Support Services Society

CAREGIVER EVENT

Parenting gender-diverse, transgender & gender questioning youth

Curious about how to better support transgender and gender-diverse children and youth?

Join Nadine Inkster, Foundry Clinical Counselling Intern, as she presents her master's degree capstone on gender, gender dysphoria, assessment and gender-affirming care – including both transition and detransition. This engaging and informative session will provide a welcoming space to explore your questions, curiosities and concerns, ensuring a deeper understanding of how to offer meaningful support. Don't miss this opportunity to learn and connect in a safe, inclusive environment!

Drop-in Tuesday, March 11th, 5:30-7pm @ Foundry Langley

E: Foundry@encompass-supports.com P: 604-546-2700 A: 20616 Eastleigh Crescent, Langley BC

Appendix C

Gender-Affirming Parenting Guide
Taking care of your child

Listen & affirm

You can be your child's most important listener.

Listen to what your child is telling you about their gender through words and actions.

Ask questions! This is a great way to hear your child's ideas about gender.

Affirm, value, and love your child for who they are today.

Create space

Create an affirming space at home to explore gender through conversation, books, and play.

Support your child's exploration of gender identities and expression.

Allow conversations to unfold over time, as your child is ready.

Talk & teach

Teach children the language they need to talk about gender.

Talk about the many ways people identify and express their gender.

Show your child that gender diverse communities exist all around the world.

Advocate & find support

Advocate for affirming environments, safety, and supports for your child at school and in your community.

Ensure you and your child have access to accurate information.

Find the peer and professional supports you and your child need.

www.transcarebc.ca

Gender-Affirming Parenting Guide
Taking care of yourself

Find information

Getting your questions answered can relieve a lot of anxiety and help you plan for your child's needs.

Access supports

Work through your feelings. Connect with other parents through a peer support group or online network. Talk with a professional to process your emotions.

Self-care

Take care of yourself so that you can be ready to support your child.

Remain open to all possibilities for who your child will become. Your affirmation, acceptance and love are crucial for healthy development.

Your child is on their own journey to figure out who they are and how they will live in the world. Love and support them as they explore who they are. Follow their lead and help them through challenges. Let them know you will be there for them wherever life takes them. This will have lasting effects on their health and relationships.

www.transcarebc.ca

Resources for parents and caregivers

Here are a few resource ideas to support parents and caregivers. For more ideas, details, and updates, check out the **Support for Families** section at **www.transcarebc.ca**.

Information commonly searched for by parents & caregivers

- Parenting gender creative children and trans youth
- General gender and trans information
- Supports for gender creative children, trans youth, and parents
- Social and school transition
- Gender-affirming healthcare and service providers
- Gender-affirming medical care options (ie. puberty blockers, hormone therapy, etc.)

Peer & professional supports

- Gender-affirming health care providers
- Facebook groups for parents
- Local peer support groups (e.g., PFLAG)
- Trans communities / trans adults

Online resources

- Trans Care BC and Peer Support Directory
- BC Childrens Gender Clinic
- Gender Creative Kids
- Gender Spectrum
- Kids in the House (J. Olson, MD)
- Family Acceptance Project
- Transforming Family
- Rainbow Health Ontario
- Sherbourne Health Centre
- Center of Excellence for Transgender Health
- Trans Rights BC
- Human Rights Campaign

Conferences

- Gender Odyssey
- Gender Spectrum

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Book ideas for children, youth, parents and caregivers

Here are a few book ideas to support children, youth, and families. For more ideas and details, check out the **Articles, Books & Movies** section at **www.transcarebc.ca**.

For children

- 10,000 Dresses (Ewert)
- Backwards Day (Bergman)
- Be Yourself (Swirsky)
- The Boy and the Bindi (Shraya)
- I Am Jazz (Herthel)
- Introducing Teddy (Walton)
- Jacob's New Dress (Hoffman)
- Morris Mickelwhite and the Tangerine Dress (Baldacchino)
- My Princess Boy (Kilodavis)
- Neither (Anderson)
- One of a Kind, Like Me (Mayeno)
- Sex is a Funny Word (Silverberg)
- Sparkle Boy (Newman)

For middle readers

- George (Gino)
- Gracefully Grayson (Polinsky)
- Lizard Radio (Schmatz)
- The Pants Project (Clarke)
- Riding Freedom (Muñoz)
- Helping Your Transgender Teen (Krieger)

For youth

- The Art of Being Normal (Williamson)
- Almost Perfect (Katcher)
- Every Day (Levithan)
- I Am J (Beam)
- If I Was Your Girl (Russo)
- My New Gender Workbook (Bornstein)
- One in Every Crowd (Coyote)
- Parrotfish (Wittlinger)
- Symptoms of Being Human (Gavin)
- Trans Bodies, Trans Selves (Erickson-Schroth)
- Wandering Son: Book 1 & Book 2 (Takako)

For parents & caregivers

- The Gender Creative Child (Ehrensaft)
- The Transgender Teen (Brill & Kenney)
- The Transgender Child (Brill & Pepper)
- Raising My Rainbow (Duron)
- Raising Ryland (Whittington)
- Becoming Nicole (Nutt)
- Transitions of the Heart (Pepper)

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Youth gender-affirming medical options

The following provides an overview about medical options that are available for youth and adults, and may be needed by some trans youth as they age.

While children do not access medical interventions before puberty, and many will not require this level of care as they grow older, many children and families find it helpful to have access to this information so they can understand their options and plan for the future.

Knowing that there are medical options to align one's body with one's gender can help prevent or relieve anxiety about pubertal changes.

Gender goals

Each person's relationship to their body and their need for gender-affirming care is unique. Beyond social affirmation, three gender-affirming medical options are available that may be necessary for gender affirmation or transition. These are puberty blockers, hormone therapy, and gender-affirming surgeries. People may access all, some, or none of these options according to their gender goals.

Health care providers

Youth and families interested in learning more about puberty blockers, hormone therapy, or gender-affirming surgeries should talk to a health care provider who is trained in providing this care. They can learn more about their options and create a care plan that will help them meet the youth's individual gender goals.

Youth gender-affirming medical options

Puberty blockers

The changes that happen in the body during puberty can be distressing if they are not in line with a young person's gender. Puberty blockers can help relieve this distress by delaying puberty. Puberty blockers can be started once puberty begins, but may also be prescribed for youth who are already part way through puberty.

Puberty blockers give youth more time to explore their gender identity, before changes happen to their body that can't be reversed. It can allow more time for a youth and family to carefully consider future care. Using puberty blockers does not mean that a youth has to start hormone therapy later on.

Hormone therapy

For someone who experiences discomfort or distress because their gender and the sex they were assigned at birth are different, hormone therapy may provide significant comfort by helping them to feel more at ease in their body.

Hormone therapy is used to make secondary sex characteristics more masculine, more feminine, or more androgynous. The hormone estrogen (often combined with other medications) can be used to feminize the body. The hormone testosterone can be used to masculinize the body. Either can be used in lower doses or temporarily to achieve a more androgynous effect.

Medications used by youth are generally the same ones used by adults. Hormone therapy can be considered whether they have used puberty blockers or not. There is no specific age at which hormone therapy is started in British Columbia. This is determined based on the individual needs of each youth.

Youth gender-affirming medical options

Gender-affirming surgeries

Some people do not need surgery, others may need one or more. This depends on each person's gender health goals. Most surgeries are performed after someone turns 18. However, there are youth who are ready for chest surgery before they turn 18.

There are many kinds of gender-affirming surgeries. Some change the appearance of the face, neck, (tracheal shave or facial feminization surgery), the upper torso (breast or chest surgery), or the lower body (vaginoplasty, metoidioplasty, phalloplasty). Some of the lower body surgeries involve removing organs necessary for reproduction, such as the ovaries, uterus, or testes.

Further Information:

For further information, visit the Trans Care BC **website** or connect with a Trans Care BC **health navigator** about resources, services, and gender-affirming care providers who can help answer your questions.

Website: www.transcarebc.ca

Health Navigation Team:

- **Phone:** 604-675-3647
- **Toll-free (within BC):** 1-866-999-1514
- **Email:** transcareteam@phsa.ca

Appendix D

Anonymous satisfaction survey

On a scale of 1-10 please answer the following questions.

1. I understand what gender is.

   1 2 3 4 5 6 7 8 9 10

   Fully Disagree – Fully Agree

2. I learned more about transgender and gender-diverse gender-affirming care.

   1 2 3 4 5 6 7 8 9 10

   Fully Disagree – Fully Agree

3. I understand what informed consent is and how it is used in gender-affirming care

   1 2 3 4 5 6 7 8 9 10

   Fully Disagree – Fully Agree

4. I understand how to support TGD children and youth.

   1 2 3 4 5 6 7 8 9 10

   Fully Disagree – Fully Agree

Please comment on what you liked about the presentation and how it could be improved for future audiences. (Two stars and a wish).