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"It felt like they were trying to destabilise us": Parent assessment in UK children's gender services

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ABSTRACT

Background: Pediatric gender clinics have a long history of analyzing and scrutinizing parents of trans children. At present, gender services in countries like the UK continue to hold clinical sessions with parents of pre-adolescent transgender children, sometimes extending over many years. Clinician viewpoints dominate the limited existing literature, with little analysis of the perspectives of parents of trans children.

Aims: The study aimed to understand the experiences that parents of socially transitioned pre-adolescent trans children have had in UK gender clinics.

Methods: Data were drawn from semi-structured qualitative interviews with 30 UK-based parents of socially transitioned trans children – children who socially transitioned, for example, changed pronoun, under the age of eleven. This article analyzed a subset of a wider dataset, focusing on data from 23 parents relating to parental engagement with UK NHS gender clinics before their child reached adolescence.

Results: Themes emerging from the dataset included parents feeling under a microscope, and parents finding gender clinic sessions judgemental, intrusive and inappropriate. Interviewees reported clinician discouragement of listening to and validating their children, as well as a lack of emotional support.

Discussion: The article presents evidence of continued pathologisation and problematisation of childhood gender diversity in parental engagements with UK children's gender clinics. It concludes by contrasting current UK practice as described in parental accounts with gender affirmative approaches to supporting parents of trans children.

KEYWORDS
Transgender; children; parent; qualitative research; clinical care

Introduction

Gender clinics have a long history of pathologising gender diversity, regarding trans and gender diverse children as failing to conform to normative expectations, having what was termed "Gender Identity Disorder" (Gill-Peterson, 2018). Under a paradigm where diversity was seen as disordered, gender clinics focused on trying to identify psycho-social factors that caused childhood gender diversity (Lev, 2006; Turban & Ehrensaft, 2018). Pathologising research on trans children and their families (as well as on gender nonconforming cis children), looked for causal links between childhood gender diversity and factors including parenting style; mother's mental health; childhood trauma, childhood family break up and other theorized causes of children developing what was considered a "disordered" understanding of their own identity (Lev, 2006; Turban & Ehrensaft, 2018). Two affirmative clinicians have noted that these approaches were grounded in "a fundamental assumption of pathology – that something has gone wrong with a child's gender development and functioning; the purpose of the assessment is to decipher what went wrong so it can be fixed" (Berg & Edwards-Leeper, 2018, p. 105). Decades of such research, psychotherapy and "medical violence" (Sullivan, 2017, p. 3) failed in its intent to erase gender diversity, instead causing deep harm to the children it attempted to treat. Children subjected to this "treatment" were taught to feel ashamed, developing low self-worth, accompanied by poor mental health and high levels of self-harm

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or suicidal ideation (Bryant, 2006; 2007; Gill-Peterson, 2018; Scholinski & Adams, 1998; Sullivan, 2017). One person, subjected to this treatment as a child, described "the shame of knowing that those I was closest to disapproved of me in what felt like very profound ways" (Bryant, 2007, p. 4)

Defining gender diversity as disordered or pathological is now widely considered outdated, prejudiced and harmful (AusPATH, 2021; Endocrine Society & Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018). Efforts to control, shame or coerce gender diverse children are condemned by a broad range of international healthcare practitioners (American Psychological Association, 2021; Ashley, 2020, 2022; Telfer et al., 2018; UN Human Rights Council, 2020). Modern healthcare consensus asserts that gender diversity is a positive part of human diversity, that should be celebrated or normalized rather than problematized or pathologized (Endocrine Society & Pediatric Endocrine Society, 2020; Telfer et al., 2018). This consensus has been ratified by the World Health Organization's International Classification of Diseases, which in 2019 changed the classification of gender diversity removing it from the section on mental health (World Health Organisation (WHO), 2018). There is growing recognition that mental health inequalities are driven by societal cisnormativity, prejudice and minority stress, and that it is our society that needs fixing and not trans people (Austin et al., 2020; Chodzen et al., 2019; Hendricks & Testa, 2012; Tan et al., 2021; Veale, Peter, et al., 2017; Veale, Watson, et al., 2017).

A conceptual shift from gender diversity as pathological, caused by family disfunction or childhood trauma; to gender diversity as a positive part of our diverse world, is a profound shift, with significant implications for the focus and purpose of gender clinics for families with pre-pubertal trans children (Pyne, 2014). Trans-positive therapeutic practice for families of younger trans children has moved away from an attempt to identify a cause of gender diversity, such as through psycho-analyzing mother-child relationships, toward an emphasis on therapy and education to help families better support their trans or gender diverse children (Coolhart, 2018; Keo-Meier & Ehrensaft et al., 2018; Oliphant et al., 2018; Riggs, 2019; Telfer et al., 2018). Research has demonstrated that family support is vital for mental health and well-being, highlighting the importance of building trans-positive family units that can provide affirmation, safety and emotional security for trans children (Katz-Wise et al., 2018; Klein & Golub, 2016; Pullen Sansfaçon et al., 2020; Simons et al., 2013; Travers et al., 2012). There is growing consensus of the benefits of what has come to be known as a "gender affirmative approach" (Keo-Meier & Ehrensaft et al., 2018). Trans children, adolescents, and families, receiving affirmative healthcare, report high levels of satisfaction (Bartholomaeus et al., 2021; Inwards-Breland et al., 2019; Pullen Sansfaçon et al., 2020; Tollit et al., 2018). A shift to affirmative support for trans children and their families has been endorsed by a wide number of global and national healthcare bodies across countries including USA, Australia and New Zealand. (Endocrine Society & Pediatric Endocrine Society, 2020; Human Rights Campaign, 2016; Oliphant et al., 2018; Telfer et al., 2018).

In other locations, however, including the UK, children's gender services have not undergone substantial restructuring or reconfiguration since they were originally established to examine and treat "Gender Identity Disorder". Services remain housed within mental health trusts, and continue to be run by psychoanalytical psychologists, with an ongoing domination of a psychoanalytical approach to working with parents of trans children (Akkermans, 2018). Continued commitment to a psychoanalytical approach is exhibited within recent publications by children's gender clinic staff, with examples of clinicians keeping "dream diaries" to analyze their own sub-conscious reflection of their encounters with parents of trans children, and accounts where clinicians examine and analyze the clothing and even the physical bodies of parents of trans children (Bonfatto & Crasnow, 2018). Pathologising clinician accounts have been criticized as "judgemental and intrusive", as trauma inducing, and as an "exercise of symbolic violence" (Pearce, 2020, p. 816).

Existing insights into clinical sessions with UK families with younger trans children predominantly come from those in positions of authority, within publications written by gender clinic staff themselves. There is some research into trans adolescents' and their families' experiences in gender clinics, with interviewees conveying a "strong dislike of the assessment process" which was described as "painful" (Carlile et al., 2021, p. 6) There is however a complete absence of literature on the experiences of parents of the younger cohort of pre-pubertal trans children within UK Gender Services. This research aims to fill that gap, drawing evidence from families whose trans children socially transitioned under the age of eleven, those with current and recent experiences engaging with UK gender clinics as parents of pre-pubertal trans children. A companion article explores the experiences of trans children within the same system (Author, forthcoming).

Materials and methods

Study design

The research presented here is a portion of a wider PhD on cisnormativity, rights and well-being of socially transitioned trans children. The PhD research explores the experiences of trans children who socially transition pre-adolescence in the UK, through interviews with trans children and with their parents. The wider PhD included insights from children as well as from parents, though this specific article deals only with data from parents. The primary inclusion criteria for parent interviewees were i) being a parent or carer of a socially transitioned trans (including non-binary) child in the UK ii) their child having socially transitioned under the age of eleven iii) their child currently being under age 16 (one child in the sample had just turned 16 by the time the interview took place). To recruit participants, details about the study were shared on closed online spaces in six UK support groups for parents of trans children. None of these six support groups are actively trans-hostile, with group moderators ensuring the groups are a safe space away from transphobic discourse. Avoidance of advertisement on trans-hostile parenting fora was judged as unlikely to affect the sample, as trans-hostile parents would by definition not support a trans child's social transition under the age of eleven, and therefore would not fall into the cohort prioritized in this research. Additional interviewees were brought in through snowball sampling (i.e., introduction from other members of these parent support groups).

Access to hard-to-reach families and children was enabled by the author's positionality as a non-binary parent of a trans child, helping overcome trust related barriers to hearing from this cohort. The author is themselves a member of four of these closed online spaces and posted there directly, with other parents sharing the posts on two other groups. The researcher had met a number of the interviewees at parent and trans child groups, although the majority were unknown prior to the research. The interviews were empathetic and open, with the explicit intent of putting interviewees at ease using active listening to provide interviewees the space to share their experiences. Researcher positionality, with aspects of being both an insider and an outsider to research participants, shapes this research, with a priority on authenticity, ensuring the research accurately represented the diverse experiences and perspectives shared by interviewees (Dwyer & Buckle, 2009). Insider researcher status offered "greater intimacy and openness" (Paechter, 2013, p. 75) whilst leaving the potential for things to be unsaid that would be spelt out to an outsider researcher. Efforts were taken to combine empathetic listening, building rapport and creating a safe space for interviewees to share their experiences, alongside effective use of prompts to ensure interviewee meaning was understood. Researcher positionality was reported by many interviewees as a critical factor in their willingness to participate in this research, as discussed further in the research ethics section. No incentive or token of appreciation was provided to interviewees, beyond the opportunity to anonymously share their experiences with broader audiences.

Ethics

The research received ethical approval from Goldsmiths Department of Education. Research

participants received a project information sheet in advance, outlining the purpose of the research, their rights, and how their data would be used, with all participants signing a consent form indicating their willingness to participate and have their data included in this research and associated publications. The research built in ethical best practices for trans-related research (Adams et al., 2017; International Transgender Health Forum (ITHF), 2019; Vincent, 2018). Given the vulnerable and small population that this research cohort is taken from, participant anonymity was a high priority, with a number of interviewees raising concerns related to the impact identification could have on their family, or on their child's access to healthcare., Many interviewees revealed that they were being interviewed for the first time, with the researcher's trans-positivity, and understanding of enhanced anonymity needs, cited as reasons for their willingness to participate. During interviewee briefing it became apparent that two interviewees within the cohort had previously participated in, and then withdrawn from, other research studies related to trans youth, over concerns around patchwork identification. This particular cohort holds important privacy and safety concerns, and a strong duty of care was upheld to respecting interviewee preferences in how their data were shared. For this reason, joint with research participants, it was agreed to go a step beyond the usual criteria for anonymity, to avoid linking individual quotes to specific pseudonyms or interviewee numbers, as well as omitting child ages from specific parental quotes. These steps were taken to prevent patchwork identification, whilst also ensuring diverse interviewee experiences are represented, both in the quotations presented and within data analysis.

Data collection

Interviews were conducted remotely via Microsoft Teams during the period November 2020 to August 2021, with interviews ranging from one to three hours in length. Semi-structured interviews followed the topics and themes parents chose to speak about, loosely structured around three broad areas 1) family 2) school 3) healthcare. Parents (whose data are reported here) opted in to the study and were interviewed first, with no requirement for their child to participate (children's data are not included in this article).

Analytical approach

The data presented here stemmed from portions of the interviews discussing healthcare, especially in-depth discussions on parental experience initiated with the question: "Can you tell me about your experiences attending a UK gender clinic". Following each initial answer, prompts were used flexibly to elicit further responses, listening to the experiences that interviewees wanted to talk about. Under a constructivist grounded theory approach, prompts also enabled refined exploration of experiences, steering away from themes and sub-themes that had reached saturation, and gaining deeper insights into themes and sub-themes that were up to that point of time under-explored. Interviews were recorded, stored securely on an encrypted platform, with anonymised transcripts analyzed in NVivo. Following a constructivist grounded theory approach, transcripts were coded, organizing data into key themes emerging from the dataset (Charmaz, 2005, 2006). Data relating to parental engagements with children's gender clinics pre-puberty emerged as an important topic, which was further analyzed to identify pertinent themes and sub-themes. These are presented in the results section, with illustrative quotations and interpretation, alongside reflections on how these data correspond to existing literature. Efforts were made to include a range of quotations in this article, responding to interviewee requests to have their voices shared directly. A majority of this cohort are limited in their ability to share their experiences in other fora, given privacy and safety concerns. The analysis accompanying the quotations is recognized as the author's interpretation, acknowledging the role of any researcher in actively interpreting data (Charmaz, 2006).

Participants

Thirty parents were interviewed from across England, Scotland and Wales. Exact demographic

information is not presented, responding to participant requests for additional privacy, in a small, vulnerable and potentially identifiable cohort. 100% of interviewees were cis; 90% were white; 93% were female and 23% were disabled. 70% were aged 40–50 years old, and 10% were immigrants to the UK. Interviewees had a wide range of levels of household income, and a range of levels of education, with 20% reporting secondary education as their highest qualification, whilst 37% reported a graduate degree and 43% a post-graduate degree as their highest qualification. In terms of sexual orientation, the cohort was diverse; 60% of parental interviewees were heterosexual, 7% gay or lesbian, 10% bisexual and 23% pansexual. A majority of interviewees were white cisgender women. The parents interviewed shared experiences of 30 socially transitioned trans and/or non-binary children. These children socially transitioned at an average age of 7 (range 3–10 years old). At time of parental interview, the trans children of these parents were on average age 11 (range 6–16 years old).

Out of the 30 parents (of 30 trans children) who were interviewed, 23 had attended NHS children's gender clinics, and insights from these 23 parents form the dataset used in this article. NHS children's gender clinics comprise the Gender Identity Development Services (GIDS) at the Tavistock and Portman covering England and Wales, and the Sandyford covering Scotland. Four of the interviewed parents were still waiting for their first contact with the NHS gender service. Three of the interviewed families had accessed private gender services instead of NHS gender services, with two explicitly choosing to avoid NHS gender services to avoid negative practices that they had heard about from other families, whilst one had accessed private services primarily due to the length of the NHS waiting list. A majority of the children within this sample had socially transitioned prior to their first session at a UK gender clinic, in part due to the long waiting list for a first appointment. In many cases, parental sessions at gender clinics had continued over many years; initially sessions tended to focus on parents, with their children engaging more directly, alongside their families, as they approached puberty.

Results

Findings were grouped under two broad themes, "families under a microscope"; and "a lack of trans-positive support for parents of trans children". Each theme was broken into two or three sub-themes, each illustrated with quotes, all from parents of trans children who socially transitioned under the age of eleven.

Families under a microscope

The first theme considers how parents of young trans children reflect upon their own experiences with children's gender clinics, which can be described as feeling under a microscope. This theme is sub-divided into three sub-themes that capture parents' experience of family assessment, with many families perceiving it as 1) Judgemental, pathologising and outdated; 2) Intrusive and Irrelevant 3) Insensitive and Inappropriate

Judgemental, pathologising and outdated

A common theme shared across many interviews was a perception of being judged during parental sessions, as one parent described:

> I was being grilled about how we'd dealt with the situation. There were times where I felt a little bit like I might be being judged.

A number of parents felt they were being treated as research objects in sessions that focused almost exclusively on the past, for example, concentrating exploration on infancy and early childhood without any discussion on challenges or needs in the present and future. Another parent felt mothers, in particular, were placed under judgment "You do feel, particularly as a mother, that you are very much under scrutiny". Many perceived these sessions to be grounded in pathologisation of gender diversity. A parent commented on the ways that clinicians appeared to be problematizing gender diversity:

> I think the implication is "why is this happening?" "We don't want this to happen". That it's definitely a problem. My sense was (the clinicians believed) it's rooted in the family, you know, something that's happened.

These perceptions resonate with existing literature criticizing non-affirmative approaches to working with trans children and families. Affirmative children's service clinicians from other countries have critiqued approaches that problematize gender diversity based on an assumption that it represents something that has gone wrong (Berg & Edwards-Leeper, 2018). A mismatch between affirmative practice in other countries and the UK's approach was also revealed within this research. Two families who had experienced children's gender services in (two) different countries before coming to the UK, noted a significant difference in approach, with services in other countries having only briefly asked about their child's gender history before focusing on the present and the future, whilst in the UK families were required and expected to speak about the past for sessions spreading over several years. One of these parents preferred their experience in another country where a gender affirmative approach was mainstream:

> They're much more like, okay, so you're trans, tell me about it, tell me what you want for your future… there's no "what's caused this?"

Most parents in this sample had heard or read about there being differences in approach between the UK and countries where gender affirmative healthcare is common, and described the UK's approach as pathologising and outdated. One parent elaborated their concerns:

> That kind of Freudian psychoanalytic background … the higher ups are still working within that framework, and, are years behind the rest of the world on their thinking…it's allowed the narrative in the media to build of it being this psychological disorder, because that's what it's still treated as by the experts who are supposed to be caring for our kids.

The parents in this sample did not think that gender diversity should be problematized, and found encounters with pathologising approaches troubling and out of alignment with their own view on gender diversity, as one parent described:

> You know, like I was causing it, rather than it's just a naturally occurring thing. Perhaps it's just part of her, perhaps she was like that, and I responded to it, rather than because I've parented in a particular way.

Several parents described their personal journey from trusting in the UK NHS (National Health Service) process, to questioning it, and then challenging it, as illustrated by this parent:

> They were the very first few sessions until I kind of wised up and kind of saw where they were going with it. It was very much about picking us apart as a family and trying to psychoanalyse what had made her trans and it took a couple of sessions of us kind of standing up to them and saying well actually, we don't think - why is that relevant? Why are we talking about that?

A focus on problematizing trans identities, and trying to identify a causation of a trans identity, aligns with the experiences noted by trans adolescents in the same children's gender clinics, who were asked "whether their gender identity has come about due to some sort of trauma or parental pressure" (Carlile et al., 2021, p. 6). This research provides additional insights into how pathologising assumptions about gender diversity are encountered and experienced by parents of younger trans children.

Intrusive and irrelevant

The second sub-theme reflects upon areas of gender clinic questioning that parents described as intrusive or irrelevant. A number of parents spoke about their experience of being asked details of their child's birth, for example:

> In our first appointment. I remember when they were asking me about like CHILD's NAME's delivery and like CHILD's NAME was induced, because I had pre-eclampsia…. And I was like, What the hell's that got to do with it - like, seriously?

Another parent described such questions as "invasive, and I feel, unrelated at all to my child's gender". Many parents were told that the sessions' aim was "to find out how we got to here" or "to understand your full family history". Parents felt this overly broad aim gave clinicians a carte blanche to ask any questions they saw fit, including those unrelated to the families' current needs. Parents described a particular focus by clinicians

on gender roles within the family, which they viewed as unnecessary and troubling, as one parent described:

> They said something about how there's really strong female role models in my family. And it made me feel like that was something that they can grab onto as a reason.

Other parents felt uneasy about the assumptions underpinning the questions they were being asked. One parent stated "it's very much, they're still trying to look for cause". This perception of clinicians looking for a cause, and delving into topics that parents perceived as irrelevant to their child's current needs, was emphasized by numerous parents, each highlighting a slightly different focus:

> It's like they were literally trying to find any other reason to pin it on. You know, it's because I'd had mental health issues in the past. And her older brother is autistic.

Parents were asked to speculate on how the gender of the primary care giver impacted on their child's gender identity. Parents reported being asked many questions about gender roles in their own home, about gender roles of their parents and grandparents, about how household tasks were divided, questions that were irrelevant to their child's gender identity and current needs. Another parent commented:

> It's always felt like that of kind of like, are we ticking off every single reason why there might be some other reason why this is happening. And that was over a good few years. That's what it felt like we were doing, like, it was just exploration of every single thing in the past that could be a reason why this had happened.

Some parents challenged clinicians on questions they perceived as unrelated to their child's current needs:

> It felt a bit sometimes, almost looking for a reason to be trans and the whole can you draw out your family tree and tell us what roles different people in your family have? And that felt a bit well hang on gender roles and gender expression don't mean anything. We're talking about gender identity here. Where are we going with this?

These themes of irrelevant or intrusive questioning of parents of younger trans children align with literature on trans adults' and older teens experiences in gender clinics (Carlile, 2020; Carlile et al., 2021; Pearce, 2018; B. Vincent, 2020). Carlile et al. (2021, p. 7) notes trans adolescents being asked "intrusive and irrelevant questions". This research complements the research on trans adults and teenagers, demonstrating the scope of family assessment and how it is perceived by parents of younger trans children.

Inappropriate, insensitive and not trauma informed

This sub-theme has overlaps with the previous sub-theme; in both, questioning by clinicians was perceived by interviewees as intrusive and irrelevant. This sub-theme is distinct due to its perceived impacts in terms of parental distress. Interview segments were categorized into this sub-theme where questioning was upsetting for the parent, with this inference drawn both from the language interviewees used about their experience, as well as emotional responses observed at interview, with reflection on some aspects of gender service questioning visibly provoking parental emotion.

A number of parents experienced questioning that they found upsetting; questions that they felt were inappropriate or insensitive. Parents with multiple children were asked to consider whether their trans child was copying or jealous of their cis sibling(s). Parents were asked to consider if their trans child was asserting a trans identity to gain parental affection. Where families had experienced parental separation (regardless of how amicable), this became a focus of parental gender clinic sessions as one parent shared:

> They asked me stuff like …when did she talk to you first about her gender? was that before or after dad left the home? You know, as if there was a link to him leaving.

Some parents were particularly concerned about how clinicians focused on family bereavement.

> They talked about the fact … that my mother died shortly after they were born…Like, I don't think that if my mother hadn't died, my child wouldn't be trans. It felt like they were looking for ways to discredit our child.

One parent who had experienced the death of a child, found gender clinicians continually asking her to focus on this topic:

> They were obsessed, obsessed, with the fact that I'd had a stillborn baby before (CHILD was born). And they were obsessed and like for ages every report was CHILD expresses, you know, great fear and great sadness around the brother that she had who died … and it's like, well, yeah, cos that's a sad thing to think about…Nothing to do with her identity.

Another parent found gender clinicians wanted to keep talking about their child's father, who had died many years earlier, speculating links between the child's father's death and the child's identity:

> Is CHILD's NAME trying to be the man in the house because their father has died - you know when you're just like, - pardon? like you're asking a 10-year-old, like, if you think they're trying to pretend to be their Dad?

Several families felt strongly that gender clinic sessions focusing on family bereavement was inappropriate, that discussions were not trauma informed, that questions were potentially trauma inducing, and that prompting parents to speculate on the impact of bereavement on a child's identity was not helpful, evidence based or prioritizing family or child well-being. This theme of inappropriate or insensitive parental questioning resonates with accounts from trans teens, who reference clinicians attempting to establish links between identity and trauma (Carlile et al., 2021, p. 6).

A Lack of trans-positive support for parents of trans children

A second major theme in the interviews relates to a lack of trans-positive support for parents of trans children in the UK. This theme contains two sub-themes 1) discouragement of parental support for trans children 2) Services not meeting family needs.

Discouragement of parental support for trans children

A majority (but not all) parents encountered trans negative attitudes at UK Gender Services, especially when attending with younger trans children. Many clinicians inferred (or stated) that a trans child growing up to be a trans adult was a negative, undesirable and avoidable outcome as described by two parents:

> Seems to be the whole focus of the way (Gender Clinic) approaches it, you know, we definitely want these kids to be cis when they grow up. Because Ooh, trans.

> It does feel like, you know, the worst possible outcome would be that your child is trans. And it's like, well, no, not really, the worst possible outcome is that my child is dead, because you didn't give them the, the medical care that they needed. That's the worst possible outcome - there's nothing wrong with being trans.

These experiences align with wider literature on negative healthcare professional attitudes toward trans people evidenced across diverse fields (Brown et al., 2018; Stroumsa et al., 2019). A large number of families were given outdated and widely refuted statistics particularly around the much critiqued concept of "desistance". Clinicians quoted these statistics to advise parents not to support or affirm their child.

> We had a very, very conservative therapist who spouted the 80% desistance nonsense at us at our very first appointment.

These statistics and indeed the concept of desistance are much critiqued in the literature, with a number of articles challenging both the validity of older research, and its relevance for socially transitioned trans children today (Ehrensaft et al., 2018; Temple Newhook, Pyne, et al., 2018; Temple Newhook, Winters, et al., 2018; Turban & Ehrensaft, 2018). Several families in this sample were aware of the recent literature critiquing this interpretation, and were unhappy that they had been presented these statistics as applicable to their child, without highlighting the critiques, and without provision of contrasting research on the benefits of affirmation, as one parent commented:

> I remember clearly her saying, you know, 80% of children, basically de-transition, and don't go on. And I just was like, I don't think that's true. …my main memory of that first appointment is feeling really angry.

For some hesitantly supportive parents in this sample, gender clinician advice served to actively undermine their confidence in supporting their child, giving what one parent described as "reassurance" that their child would grow out of their trans identity.

> This was the very first session we had, so he was, CHILD was, he would have been about five or six at that point. At the time, I think, because it was our very first session, we were still getting our heads around what was going on. So when she said that initially, I must admit, we probably felt a bit of a sense of relief…I don't know, in some ways, it gave us hope …(that our child wouldn't) have a much more difficult life.

In some cases, clinicians used language that was perceived by parents to be emotionally manipulative. A parent of a young socially affirmed trans boy, was told by a clinician "don't give up on your daughter". This emotionally charged advice, using gendered terms that were not being used by the parents or the child, caused distress for the parent, at a point when they were still learning how to support their son. A large number of families felt their clinicians discouraged supportiveness, and criticized their affirming approach. A number of parents reported having been explicitly told by gender clinicians that they should not have supported their trans child's social transition (i.e., that they should have continued using the child's original pronoun, and should not have recognized or supported their child's identity). One such parent elaborates:

> When I first saw them, they did basically say, it was my fault. That because I'd allowed her to socially transition in terms of clothes and using a different name. Therefore, now she's more likely to be trans because of that.

A number of parents expressed concern about negative clinician attitudes toward transitude. One parent was frustrated that gender clinics were staffed with

> "professionals working with trans children that don't have any trans friends and aren't trans or non-binary".

Parents reflected on the journey they had needed to come on to become trans-positive, and were frustrated at clinician transphobia or cisnormativity. Several parents discussed the fact that only with the benefit of hindsight (coming, now, from a position of trans-positivity), did they recognize the cisnormativity and transphobic prejudice inherent in, for example, a clinician reassuring a parent that their child will not be a trans adult.

Within this sample, several parents described the negative consequences that stemmed from their experiences in gender clinics. Several parents stated that clinician dismissiveness and discouragement had delayed the time it took for them, or their co-parent, to fully support and embrace their child's identity. Where a supportive parent had a less supportive co-parent or extended family member engage with the service, supportive parents felt gender clinic staff encouraged and reinforced existing skepticism or unsupportiveness, with a parent commenting: "*it felt like they were trying to, like destabilise us*". Several parents worried about the negative consequences the approaches they had encountered could have on other families and their children. Parents within this sample were concerned that clinician discouragement could prevent a parent lacking certainty from supporting a trans child, and could reinforce or legitimize parental transphobic abuse and rejection.

Services not meeting family needs

A second sub-theme emerging from these data was a service not meeting family needs. A review of the accounts of the 23 parents of trans children with experience attending NHS children's gender services reveals a high level of dissatisfaction with those services. 15 parents (65%) provided feedback that was overwhelmingly negative on their experience, six parents (26%) provided mixed feedback and two parents (9%) provided predominantly positive feedback.

A number of parents who had been attending appointments with the gender service for years, were unclear what was the purpose or intended benefit of the sessions as outlined below:

> Interviewer: What do you think the purpose of the sessions was?
>
> Parent: To make my life difficult? To be honest with you I really, I don't know, I, I'd say, we both come out of there. And we just think, what was the benefit? We've had no benefit, all this cost and time, because for CHILD'S NAME it's a whole day out of school - for nothing.

Another parent highlighted their frustration at a service that was not providing emotional support for them or their child:

> One of pointlessness, really. It baffles me. What the point of [Gender Clinic] is because there was - we've never had any psychological support. There's never been a kind of counselling aspect centred around CHILD's emotional well-being. It was always a hoop jumping, box ticking, evidence gathering, prove yourself trans enough"

Some parents arrived at the gender clinic with expectations of support, and expectations of a trans-positive safe space to receive emotional support, and felt disappointed with the service on offer. This parent described their initial experience:

> He was just incredibly dismissive and rude. I came out feeling very deflated. Because we were really excited. I don't know why, but we were. And we came out feeling really deflated. There was no support offered.

Another parent was visibly exhausted and depressed when asked about the benefits of attending years of parental sessions.

> Interviewer: Did you gain anything from those sessions?
>
> Parent: No. No. Nothing. Never have. Never have

In terms of the six parents who shared mixed feedback, three parents shared negative feedback on their experience of the system, alongside positive feedback on their clinicians as warm and kind individuals. Three parents described a neutral experience at gender clinics, neither useful nor harmful, whilst describing their clinician as likeable.

> "We endured - however much we like our clinicians, we endure the appointments, we're jumping through hoops, we're ticking boxes".
>
> "I mean, the therapists are lovely. And, you know, I really can't speak highly enough of them, but I'm not sure really what their role is … You know, it's a, it's an extra medicalization of it. Isn't it?"

In terms of positive feedback, two parents felt their experience at NHS gender clinics was positive. One parent described the process overall as having been helpful for them, providing a space for them to process their feelings.

> "My experience of the [Gender Clinic] has been overwhelmingly positive - over the years that I've been going there, sometimes I would go my own to see [Clinician]. It was a chance for me to process and understand what was going on".

A parent who provided positive feedback on their clinician and their experience commented:

> "It's very important to have a trans positive clinician. I think, how can you work with trans kids if you're not trans positive? I think you have to be to really, don't you? Well, I think you should be… I mean, if you're trying to help these children… I'm so relieved that we've got her because I've actually seen her fighting for trans rights outside of Tavistock. And that, that really proves to me that she cares".

Parents were aware of diverse experiences in children's gender clinics and were frustrated in a lack of consistency, and a lack of institutional commitment to trans-positive approaches. Supportive cis parents wanted to receive support and advice from trans-positive clinicians who really understood the experiences that their family and their child was having.

Parents also expressed concern at the service failing to meet their needs. A number of parents expressed frustration or concern that they had not been told anything on the importance of family affirmation, or on the positive mental health of socially transitioned trans children who are supported at home. Parents described finding such evidence, including studies by Olson et al. (2016), through their own research, and were upset that gender clinicians had not shared or discussed this research with them, or helped educate and support them to affirm and advocate

for their child. Parents also spoke at length at the many challenges they were facing across different spheres of their and their children's lives (issues discussed in other articles and the author's wider PhD). Many of those interviewed wished gender clinic sessions could have been a positive experience for them, a source of practical advice, a safe space of trans-positivity, and an emotional support to help them cope with transphobia and minority stress. Instead, the vast majority of parents in this sample described UK gender clinics as not meeting their needs, with many describing the sessions as actively distressing and harmful to their emotional well-being.

Discussion

This research gives an insight into the experiences of supportive parents of trans children in pre-pubertal children's gender services in the UK. Parents reported frustration, distress or disappointment stemming from encounters with trans-negativity; feeling judged, under-supported and under a microscope. Many parents found extended questioning intrusive and invasive, and did not understand why clinicians felt they had a right to delve into all aspects of a family's history, simply because they had a trans child. For many supportive parents, clinician discouragement or even rebukes for supporting their trans child, added difficulties to an already stressful time. Parents found clinician trans-negativity and discouragement made them question their own support for their child. Supportive parents worried that interactions with trans-negative clinicians could reinforce and legitimize transphobic approaches in unsupportive households, and worried for the well-being of trans children in trans-hostile households. Parents questioned the purpose of extended family sessions, querying if the service was fit for purpose in a modern healthcare system.

A cross-cutting issue that is not directly explored in this article is the power imbalance between UK pediatric gender clinics and parents of trans children. Many parents within this sample spoke of the potential consequences of disengagement from the gender service, mentioning a wide range of potential repercussions for a trans child and their family, including potential social services involvement, potential problems with schools and GPs, denial of access to healthcare at puberty, and even potential custody issues for children in separated families (author, forthcoming). Parents felt compelled and coerced into continuing with assessments and clinical sessions that they disliked or found upsetting, due to the unbalanced power dynamics inherent to the system.

This research also highlighted gaps in service provision for parents, with parents criticizing a lack of emotional support, trans-positive education, or practical advice on dealing with minority stress, transphobia or cisnormativity. The research highlights that resources and services instead appear to be embedded in outdated and unevidenced psycho-analysis and problematisation of gender diversity. These findings should prompt further scrutiny on the effectiveness of NHS healthcare for trans children and their families, with GIDS in England and Wales recently assessed as "inadequate" by the NHS's Care Quality Commission (2021). This research takes place at a time of growing global support for affirmative approaches that celebrate rather than problematize gender diversity (AusPATH, 2021). In 2019 the World Health Organization took gender diversity out of classification as a mental health disorder in the eleventh version of the International Classification of Diseases (ICD-11), with implications for the ways in which trans healthcare is delivered globally (World Health Organisation (WHO), 2018). NHS trans healthcare services will also need to align with the upcoming World Professional Association for Trans Health Standards of Care Version 8 (WPATH SOC8), the latest global trans healthcare guidance, which will likely, as with AusPATH, highlight the growing evidence base supporting the benefits of affirmative approaches, including for trans children (AusPATH, 2021). These global shifts toward affirmative care, alongside growing evidence of the harms of approaches that pathologise and problematize gender diversity, present a challenge for UK children's gender services.

Implications for practice

Parents within this sample highlighted concerns, frustrations, and distress linked to their

engagements with UK NHS Children's Services, with a majority reporting a negative experience. Parents not only criticized the UK's service, but contrasted it with what they had heard or read about gender affirmative services in other countries, wanting UK services to provide evidence based, trans-positive, affirmative support for parents with trans children. A literature review of gender affirmative clinical and therapeutic approaches to with parents of trans children reveals six components that contrast to the parental experiences described in this research.

Parental education on gender diversity (also called gender literacy) is the first component prioritized by gender affirmative clinicians or counselors, ensuring parents and carers understand the basics of gender identity and gender expression; providing parents with a broad range of diverse trans representation; enabling parents to move toward a trans-positive outlook (Coolhart, 2018; Ehrensaft, 2016; Riggs, 2019; Tando, 2016). This component also includes education on cisnormativity and transphobia, and on the importance of cis parents reflecting on their own assumptions, biases, and prejudices, considering how to make their home a safe space for a trans child. Riggs (2019) describes how conversations about gender with parents (discussing their child's gender and the parent's own relationship to gender) "can be a useful way of identifying barriers to parents affirming their children" (Riggs, 2019, p. 19). In contrast to the questioning parents experienced in the UK, this type of parental gender questioning has a clear aim; to build parental gender literacy, in order to help parents accept and affirm their child.

A second component supports parents to learn to listen to their child, and to have confidence to affirm their child and follow their child's lead (Coolhart, 2018; Ehrensaft, 2016). This includes educating parents on the protective impact of affirmation; sharing with parents current research on the importance of family support and the protective impact of social affirmation. Coolhart (2018) notes the importance of highlighting to parents words and actions that qualify as rejecting behavior, explaining the negative impact this has on a child's long-term well-being. Where one or more parents are not learning or adapting toward trans-positivity and affirmation, this element could shift toward protection of trans children. Where parents are divided, unsupportive, or causing harm, clinician responsibility could shift toward child safety, prioritizing actions to reduce "threats to the child's healthy attachments, social and emotional stability and gender health" (McLaughlin & Sharp, 2018, p. 157). This component stands in stark contrast to parent experiences in the UK, where parents criticizing the NHS service for failing to provide this support and education.

A third component supports parents to process their own emotions about their child's identity (Riggs, 2019; Tando, 2016). Coolhart (2018) emphasizes that clinicians have to find ways to support and validate parents' emotional processes, without those emotions negatively impacting on their child. Riggs (2019) emphasizes the role that cisgenderism plays in parental emotions of loss, and the importance of shifting the locus of such emotions from being related to the child, to being a product of ingrained cisgenderism. Heightened emotional responses to a child's transition (like loss or grief) are rooted in societies, and parental worldviews, without trans possibilities; accepting a trans child therefore forces a fundamental shift of long-held assumptions and expectations (Coolhart et al., 2018). Tando (2016) distinguishes between a child's alignment (when a child is affirmed in their identity) and a cis parent's experience, that she describes as more of a transition. Particularly for younger trans children, a social transition can be simple and positive, a break from rejection, rather than a change in lived identity; whereas for cis parents a child's transition can be a more substantial shift. She argues that "parents are the ones who have to fully transition, from an idea they have about who their child is, to something different" (Tando, 2016, p. 99). Clinicians and counselors can provide a safe space for parents to process their emotions, whilst protecting trans children from shouldering that burden, ensuring homes are safe and trans-positive. UK research showed mixed experiences on this component. The minority of parents who reported a positive experience in NHS children's gender services highlighted the support they had received to help them process their own emotions.

The fourth component supports parents to manage their own experiences of minority stress,

helping parents cope with the isolation, criticism and abuse that many supportive parents of younger trans children encounter (Coolhart, 2018; Malpas et al., 2018; Tando, 2016). The fifth component includes the provision of practical advice and support to help parents navigate the challenges of supporting a younger trans child (Coolhart, 2018; McLaughlin & Sharp, 2018; Tando, 2016). This can include advice on engaging with schools, with co-parents, with siblings and extended family. It can include advice on how to talk with trans children about topics like disclosure, puberty, dysphoria or dealing with transphobia. The sixth component includes education, advice and support on how to stand up for trans children's rights, with advice on legal protections, and advice on how to safely challenge discriminatory practices (Horton, 2021; Riggs, 2019). Riggs (2019, p. 100) talks of increasingly encountering parents who do not require advice or support to embrace and affirm their trans child, instead they ask for "help to advocate for their children, and …ways to … challenge cisgenderism". These final three components of affirmative support for parents of trans children were not found to be offered within the NHS service. The parents within this sample instead relied on peer support from other supportive parents of trans children, accessed through parent support groups and networks. A number of parents expressed frustration and regret that these important supports were not prioritized within the UK service.

These six areas of intervention are referenced across a wide range of guidance documents for affirmative therapeutic practice with parents of trans children. These six areas can be vital for ensuring parents and carers of younger trans children are equipped to safeguard their children's emotional well-being, helping parents provide a safe and affirming home for all trans children.

Limitations

The insights from this rich qualitative dataset need to be understood in context of the sample from which they were derived. The sample explicitly focused on parents of trans children who had socially transitioned under the age of eleven years old, contacted via support groups for parents of trans children. This sample is therefore likely to represent the views and experiences of parents of trans children who are (or who have become) to some degree, supportive or trans-positive. These experiences cannot be assumed to apply to parents who are not supportive of their trans child, and nor can it be assumed to apply to those parents who might accompany a trans teenager to the same gender clinics. It is also worth reiterating that this article has also focused on the experiences and perspectives of parents of trans children, trans children's perspectives are explored in other complementary publications (Author, forthcoming).

Conclusion

The findings discussed above demonstrate an ongoing impact of pathologisation and trans-negativity on supportive parent's experiences in UK children's gender clinics. Parents shared multiple examples where they perceived gender diversity to be problematized, where they felt judged and scrutinized rather than supported, or where they felt clinicians discouraged supporting their trans child. This research takes place at a time of growing societal trans-positivity, with medical bodies recognizing trans lives as a valued part of human diversity, to be celebrated and supported (Telfer et al., 2018).

In a world and healthcare system where gender diversity is no longer considered a problem or a pathology, this research raises questions on the purpose, harms and benefits of UK children's gender services' engagements with parents of pre-pubertal trans children. This research highlights concerns about the degree to which the service has adapted or reformed since ICD-11, to depathologise healthcare for trans children and their families (World Health Organisation (WHO), 2018). It emphasizes the road still to travel and the need to acknowledge and proactively address the legacy of decades of problematisation of gender diversity that continue to be embedded in children's gender clinic systems, attitudes and approaches. Those responsible for children's gender services, and those reviewing trans healthcare in the UK, would do well to listen to the experiences of pathologisation and problematisation

of gender diversity shared by parents who are recent and current service users, understanding the multiple negative impacts on the lives of those interviewed. NHS children's gender services need to review their aims, approaches and assumptions, to actively challenge a legacy of pathologisation of diversity, and to better meet the needs of trans children and their families.

Informed consent

Informed consent was obtained from all interviewees.

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