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Debate: Different strokes for different folks

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A gender social transition in prepubertal children is a form of psychosocial treatment that aims to reduce gender dysphoria, but with the likely consequence of subsequent (lifelong) biomedical treatments as well (gender-affirming hormonal treatment and surgery). Gender social transition of prepubertal children will increase dramatically the rate of gender dysphoria persistence when compared to follow-up studies of children with gender dysphoria who did not receive this type of psychosocial intervention and, oddly enough, might be characterized as iatrogenic. Parents who bring their children for clinical care hold different philosophical views on what is the best way to help reduce the gender dysphoria, which require both respect and understanding.

Keywords: Gender identity; gender dysphoria; psychosocial treatment

The proverbial saying 'Different strokes for different folks' (The Oxford Dictionary of Phrase and Fable, 2006) reflects well the contemporary clinical debate on best-practice therapeutics for children with gender dysphoria. It reflects not only the variation in the philosophical and theoretical perspectives of front-line clinicians, but also variation in the philosophical belief systems of parents who bring their children to mental health professionals for clinical advice and care.

For prepubertal children with gender dysphoria, I would argue that there are three main approaches to therapeutics, which I list here in chronological/historical order: (a) active psychosocial treatment to reduce gender dysphoria so that the child's eventual gender identity is more congruent with her or his biological sex (thus obviating the necessity for what some now call 'gender-affirming' hormonal and surgical treatment); (b) 'wait-and-see' or 'watchful waiting', which makes the assumption that it is difficult to predict what the long-term outcome will be and so, well, the clinician should not recommend very much one way or the other; and (c) gender social transition, in which the child's 'social' gender identity is shifted from the gender assigned at birth to the putative desired gender (e.g., change in name, change in pronoun usage, and change in other phenotypic social attributes, such as hair-style and clothing-style that mark one's gender to significant others). Dreger (2009) characterized the first approach the 'therapeutic' model and the third approach the 'accommodation' model.

These rather marked variations in the type of psychosocial treatment considered to be in the best interest of the child reflect deep structure variations in theoretical perspectives on the nature and nurture of psychosexual differentiation (see the edited volume by Drescher & Byne, 2012). On the one hand, the first approach assumes that, for young children with gender dysphoria, gender identity is not fixed or 'locked in' at an early age and that there is a much greater degree of malleability and plasticity than might be the case for both adolescents and adults with gender dysphoria. On the other hand, the third approach assumes that gender identity is fixed and locked in at a very early age because of underlying biological mechanisms. One of the most well-known children with gender dysphoria, 'Jazz Jennings', has promulgated this view in her book, written for children, 'I Am Jazz' (Herthel & Jennings, 2014) where Jazz writes 'I have a girl brain but a boy body….I was born this way!'

As noted in several guideline reviews on clinical practice for the treatment of children with gender dysphoria (AACAP Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 2012; American Psychological Association, 2015; Byne et al., 2012), the field suffers from a vexing problem: There are no randomized controlled trials (RCT) of different treatment approaches, so the front-line clinician has to rely on lower-order levels of evidence in deciding on what the optimal approach to treatment might be. One quote is sufficient to document this point: 'Different clinical approaches have been advocated for childhood gender discordance…. There have been no randomized controlled trials of any treatment….the proposed benefits of treatment to eliminate gender discordance…must be carefully weighed against… possible deleterious effects' (AACAP Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 2012, pp. 968–969). Given the cautious conclusions that these types of reviews have reached, it is of interest how, in recent years, so many clinicians have embraced the treatment approach that recommends an early gender social transition. Chen, Edwards-Leeper, Stancin, and Tishelman (2018) observed that 'Over the last decade, we have seen a sea change in approach to pediatric transgender care, with the gender affirmative model now widely adopted as preferred practice' (p. 74).

In my view, there are reasons to be skeptical about the merit in recommending an early gender social transition as a first-line treatment. One should recognize that if one peruses carefully the follow-up studies of young children with gender dysphoria (or traits of gender dysphoria), the majority of such children do not have gender

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dysphoria when followed up in adolescence or adulthood (Zucker, 2018). In these studies, one can say with reasonable confidence that when these children had treatment (and not all did), the one type of treatment they did not receive was in the form of a prepubertal gender social transition. As I argued elsewhere (Zucker, 2018), if one conceptualizes gender social transition as a type of psychosocial treatment, it should come as no surprise that the rate of gender dysphoria persistence will be much higher as these children are followed into their adolescence and young adulthood (see Rae et al., 2019). If this is, in fact, the case, one might ask why would one recommend a first-line treatment that is, in effect, iatrogenic.

Even if there was a team of researchers motivated to design an RCT, the implementation of such a study would be formidable. For example, some parents would decline to place their child into a psychosocial treatment arm that would attempt to reduce the child's gender dysphoria so as to be more congruent with the gender assigned at birth; other parents would decline to place their child into a psychosocial treatment arm that would attempt to reduce the child's gender dysphoria by 'affirming' their felt gender vis-a-vis a social transition. Perhaps parents who prefer one of these two approaches would agree to 'wait-and-see' at least for a while, before deciding on a more intensive therapeutic approach. This variation in parental preferences reflects, as noted earlier, differences in underlying theoretical and philosophical perspectives which need to be respected. As the field moves forward and more follow-up data become available, we will learn more about the developmental course of gender dysphoria in particular and well-being and mental health in general.

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