

Rethinking 'need' for clinical support in transgender and gender non-conforming children without clinical classification: Learning from 'the paper I almost wrote'

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ABSTRACT

There have been ongoing debates as to how, or even whether, we should clinically classify gender diversity in children through clinical classification manuals. So-called 'depathologizing' is argued as being vital to address the stigma that these children are somehow disordered or sick. Yet one argument in favour of continued clinical classification for transgender and gender non-conforming children is that it better facilitates access to specialist psychological support. I argue that whilst continued clinical classification offers a seemingly pragmatic solution to ensuring access, it does in fact obscure our understanding of the individual needs of these children. In this paper I address fundamental issues that aim to better our understanding of need and thus why a child may benefit from specialist support. I do so by critiquing a paper I nearly wrote, which argued for the ongoing continued classification of gender incongruence in children. Ultimately, I argue that specialist psychological support and care should be driven by the needs of the individual child, as determined by the child and those involved with their care. By bettering our understanding as to why specialist psychological support may be beneficial for some, we move past the focus of such specialist support being provided because of the child's gender diversity. Methodologically the paper may be unusual, in comparison to traditional normative counter-argumentative bioethical position papers, but by presenting an argument for depathologization of gender diversity of children in this way there is also an alternative insight into the methods of bioethics.

KEYWORDS

children, clinical classification, depathologizing, gender, transgender

1 | INTRODUCTION

During the course of my philosophical enquiry and legal research on the medical treatment of transgender and gender non-conforming

(TGNC) children, it has been important to understand that the clinical classification of gender diversity in children is a complex and contentious issue to navigate. This is because there is a strong argument that clinical and diagnostic classification of TGNC children implies

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that these children and young people are somehow mentally disordered or sick.¹ Yet, one important argument in favour of continued clinical classification is that it better ensures access to specialist psychological support for children and their families within gender identity development services.²

Given that, for at least some children, specialist psychological support may be beneficial, it seemed logical to write a paper in support of the continued clinical classification within the 11th version of the 'International classification of diseases for morbidity and mortality statistics' (ICD-11).³ However, despite this seemingly logical argument there was a problem that I would be directly contributing to; by justifying clinical classification as having a pragmatic purpose, our understanding of these children's needs is obscured. Whilst this is ethically problematic, I suggest that it also has profound implications for TGNC children and the provision of specialist psychological support that should be available to them.

It is important from the outset to acknowledge that there is a worrying misconception that depathologization of TGNC identities in children should further support the case for delaying all medical gender affirming interventions until adulthood. Rather, these arguments are intended to help better understand the approach we should take in supporting TGNC children and do not reduce the legitimacy of the provision of therapeutic medical interventions.

In this paper I argue that in order to better ensure specialist psychological support for TGNC children, we need to better understand the ethical basis of the 'need' for clinical support in these children. Importantly, to do so means that we need to remove clinical classification of gender diversity⁴ in children. Nonetheless, the approach I take in this paper is slightly unorthodox, as within it I challenge my own arguments as to the importance of clinical diagnostic classification manuals through a critical commentary of a paper I almost wrote. By focussing on a paper that was almost written, I will demonstrate that there is value in challenging our own, seemingly logical and pragmatic, arguments to better understand questions that remain unaddressed.

Methodologically I appreciate that the paper may be unusual, in comparison to traditional normative counter-argumentative bioethical position papers. So, this paper therefore does two things: one

is to offer an argument for depathologization of TGNC identities in children; the other is to offer some insight into the methods of bioethics. The discipline of bioethics is an internal dialogue and a continued exercise of analysis and self-analysis. Bioethics should not be viewed as simply finding reasons for and against certain normative propositions, but it is also remaining sceptical about one's normative assumptions, even when these appear well defended and logical. Subsequently bioethics can be frustrating, but one way in which this can be methodologically addressed is to finish and then completely restart from scratch. In this paper I offer a vivid example of how this methodology works and how deconstructing finished work is imperative, particularly when dealing with such sensitive and important issues that affect healthcare provision and therefore the people's lives. Whilst I could have published a neat, clear and simple paper with a well 'wrapped up' argument, I instead demonstrate how 'unwrapping' and deconstructing our own arguments, although challenging, is necessary and important.

2 | 'THE PAPER I ALMOST WROTE'

In 2019 the World Health Organization continued with clinical classification of incongruent gender identity, albeit reclassified, within the published and revised ICD-11.⁵ Whilst primarily the ICD supports countries to collect and report health statistics using the coding system set out within it, the ICD further supports countries to identify healthcare needs and then to facilitate improved access to appropriate care and services.⁶ Hence classification is particularly important for those who may be susceptible to being marginalized as a result of a specific health issue and thus become less likely to be able to access healthcare in relation to it.⁷ Indeed, TGNC children and adults have suffered various barriers to accessing specialist support, including the inconsistent ways in which healthcare systems provide or design services and the way in which societies and cultures even consider gender diversity.⁸ TGNC people often face discrimination,⁹ which can make every day needs difficult to achieve and can cause psychological harm.¹⁰ The further harm of not being able to access specialist support is well documented as being detrimental to the mental well-being

¹Mulvey, K. L., & Killen, M. (2015). Challenging gender stereotypes: Resistance and exclusion. *Child Development, 86*(3), 681–694.

²Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender diagnosis in the ICD-11. *International Review of Psychiatry, 24*, 568–577.

³World Health Organization. (2018). ICD-11 Mortality and morbidity statistics, chapter 17. Retrieved from <https://icd.who.int/dev11/l-m/en/#/http3a%2f%2fid.who.int%2fid%2fentity%2f577470983>

⁴Throughout the paper I use the term transgender and gender non-conforming children (TGNC) to describe gender diversity that is characterized by an experienced gender identity that differs from the normative expected cis-gender identity corresponding to natal sex characteristics. I accept that it may be viewed as problematic to even use terminology to differentiate these children, but I do so to consider the experienced identities of a population who must be better supported. Whilst I also use the term gender diversity as an umbrella term in some parts of the paper, it is intentional and is used to identify a broader sense of gender diversity in respect of binary societal and clinical heteronormative expectations.

⁵World Health Organization, op. cit. note 3.

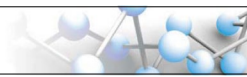
⁶Chou, D., Cottler, S., Khosla, R., Reed, G. M., & Say, L. (2015). Sexual health in the International Classification of Diseases (ICD): Implications for measurement and beyond. *Reproductive Health Matters, 23*(46), 185–192.

⁷Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., & Wylie, K. (2016). Transgender people: Health at the margins of society. *The Lancet, 388*, 390–400.

⁸Ibid.

⁹In Europe see: Council of Europe. (2009). Commissioner for Human Rights. Issue paper: Human rights and gender identity. Retrieved from <https://wcd.coe.int/ViewDoc.jsp?id=1476365>; see Section 7 of the Equality Act 2010 for an example of legislative prohibition of discrimination against transgender individuals or groups. Retrieved from <https://www.legislation.gov.uk/ukpga/2010/15/section/7>

¹⁰Ibid. Council of Europe. (2009).



and health of TGNC adults and children.¹¹ So, on this basis I would have argued that in principle, continued inclusion within the ICD seems a good thing, insofar as it facilitates access to specialist psychological support and care.

The WHO decided to place the condition, now named 'gender incongruence', in a new category called Conditions Relating to Sexual Health but I would argue that this new category is specifically inappropriate for gender diverse children. Consequently, I wanted to write a paper in which I would discuss where, instead, this condition should be placed to better support access to specialist psychological support and care within gender identity development services.

I therefore wrote a draft paper, which I now call 'the paper I almost wrote'. Within it I considered how we should classify gender incongruence in children and I explored the following issues: whether reclassification as a condition relating to sexual health was appropriate, whether we should revisit the suggested inclusion of gender incongruence being considered as a factor influencing health status and contact with health services (within so-called Z codes in the ICD) and finally whether there was actually a problem with continued mental health classification at all.

In criticizing the inclusion of gender incongruence of childhood (GIC) within the ICD-11 as a condition relating to sexual health, I argued that gender incongruence should be clinically considered as more than something related to sexual health.¹² In offering an alternative I explored the use of Z-codes (factors influencing health status and contact with health services) rather than clinical classification within the ICD, but accepted that this approach was problematic as not all health systems provide access to care for factors found within these Z-codes. Overall, it seemed to me that, when considering current clinical guidelines for the management of gender incongruence and gender dysphoria in pre-pubescent children, the main ethical issue that concerned me was GIC being classified as a condition related to sexual health, not that it was still included in the ICD. This is so, because if children need psychological support, then mental health classification can be a more straightforward way to access it. Moreover, mental health does not mean mental illness. The problem was not that it was associated with mental health classification but an inference that gender diverse children are mentally disordered in some way. To suggest that one person needs psychological support at a certain point in life is not to suggest that a person is mentally ill. Subsequently, rather than being framed as a disorder, the WHO could have developed a chapter entitled 'conditions related to

mental health', acknowledging the potential psychological impact of experiencing an incongruent gender identity, but removing any pathologized association. The importance of access to and provision of specialist psychological support and care within gender identity services could be viewed as a positive way in which gender diverse children were ensured access to what is an important aspect of clinical care. It seemed to me that clinical classification could facilitate such provision, and that removing the condition from classification and diagnostic manuals, such as the ICD-11, might result in harm to children and families, who might see themselves turned down from specialist care in absence of a clinical diagnosis.

I did have worries as to how this argument would be received, yet it seemed important to explain that revised classification as a condition relating to mental health was actually closer to depathologization than framing GIC as a condition relating to sexual health, potentially implying that gender incongruence is a sexual 'problem'. There is nothing inherently derogatory in suggesting that some of us have issues that may influence our mental health and importantly the classification of GIC as a condition relating to sexual health is problematic.

3 | WHY I NEVER WROTE THE 'PAPER I ALMOST WROTE'

The most significant challenge to 'the paper I almost wrote' is that the requirement for referrals to gender identity development services to be based on diagnostic criteria, in order to access specialist psychological gender identity support, is problematic. In what follows I demonstrate why this is the case, and why there should be no differentiation between other aspects of child development and experiences where psychological support can be accessed without the need to satisfy diagnostic criteria. Before putting forward my specific arguments we must understand and acknowledge that there is a well-articulated discourse within the literature between continued clinical classification and removing the clinical classification of gender diversity from diagnostic manuals, so called 'depathologization'.¹³ However, I focus on three specific arguments and I will address them individually below.

Firstly, gender diversity is not a disordered or diseased pathology, but is an aspect of personality development and expression. The fact that we are not able to fully explain why some children develop and experience gender incongruence does not imply, neither does it justify, that they should be classified as suffering from a mental health associated condition.¹⁴ Moreover, individual gender expression is protected by internationally agreed human rights

¹¹See: Meyer-Bahlburg, H. F. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behaviour*, 39(2), 461–476; Aramburu-Alegra, C. (2016). Gender nonconforming and transgender children/youth: Family, community and implications for practice. *Journal of the American Association of Nurse Practitioners*, 28, 521–527; for clinical guidelines see: The World Professional Association for Transgender Health (WPATH). (2011). Standards of care for the health of transsexual, transgender and gender nonconforming people. Retrieved from <https://www.wpath.org>

¹²Horowicz, E., & Giordano, S. (2020). Gender incongruence as a condition relating to sexual health: The mental health 'problem' and 'proper' medical treatment. *Droit Et Cultures*. In press.

¹³Suess Schwend, A., Winter, S., Chiam, Z., Smiley, A., & Grinspan, M. C. (2018). Depathologising gender diversity in childhood in the process of ICD revision and reform. *Global Public Health*, 13(11), 1585–1598; Drescher et al., op. cit. note 2; Kaltiala-Heino, R., Bergman, H., Työlajärvi, M., & Frisén, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, 9, 31–41.

¹⁴Langer, S., & Martin, J. (2004). How dresses can make you mentally ill: Examining gender identity disorder in children. *Child and Adolescent Social Work Journal*, 21(1), 5–21.

and domestic equality legislation, prohibiting discrimination on the basis of gender identity. The purpose of these legal doctrines is to promote societal equality and address unacceptable societal hostilities, on the basis that they are harmful to individuals and groups.¹⁵ Where a clinical mental health diagnosis exists in response to the present inability to understand the aetiology of gender identity formation in children and does so knowing that this potentially exacerbates societal inequality and hostility towards a specific group, then this should be regarded as discriminatory.¹⁶

Secondly, whilst discrimination is unlawful, it also contravenes the professional obligations of health and social care professionals to practice in a way that recognizes individual patient/service user diversity.¹⁷ By pathologizing gender diversity, we could suggest that doctors and other clinicians are breaching the fundamental principle of non-maleficence by failing to consider the harm of pathologizing these children. I would argue that consideration of the principle of non-maleficence within the care of TGNC children has focussed on the harm of clinical interventions.¹⁸ Whilst I am not saying that these arguments are not important, we should at least consider the psychological harm caused by clinically classifying ordinary childhood diversity.¹⁹ There is of course an argument to say that clinical classification may protect children and ensure ongoing referral if they are at risk of not being supported by their primary clinicians on the basis of the clinician's personal ideology, in respect of gender identity.²⁰ However, this argument simply confirms that doctors should not discriminate against patients and service users, particularly where the characteristic in question is protected by law. Moreover, even if we were to remove clinical classification, absence of clinical diagnosis is never grounds for a clinician to not provide support or care in some way for a patient.²¹

A further particular professional issue in the case of TGNC children is why parents may seek clinical medical support in the first instance and how this may further influence ongoing referral. Subjective ideologies as to what a child's gender identity 'should' look like may confound the problem by potentially aligning with

objective diagnostic criteria, and thus may perhaps strengthen the clinical need for ongoing referral. I will return to this point in more detail later, but here we can say that clinicians making referrals on the basis of both objective criteria being met in some way and subjective parental opinion is potentially harmful. Professionally doctors must focus on the needs of the child and act in a way that places the best interests of the child as being paramount.²²

Thirdly, there is no logic in the following position: clinical classification facilitates provision of care. There are, in fact, many ways in which children are offered specialist psychological support without them requiring diagnostic clinical classification. For example, children may benefit from specialist psychological support in coping with or processing parental separation, the provision of which does not require any form of diagnostic clinical classification.²³ Furthermore, child and adolescent mental health services have significantly shifted away from diagnostic certainty and 'labels', towards addressing behaviours and presentations.²⁴ In essence, and I will return to this argument later, psychological support is well regarded as being beneficial to the well-being of many children without it being based on any clinical diagnostic rationale.

In shifting away from this position, I had to confront the original concern that inspired 'the paper I almost wrote', that TGNC children are vulnerable and therefore clinical care must be available to support these children and to further the understanding of gender diversity in children.²⁵ However, I failed to acknowledge that clinical classification may even do the opposite. As Karter and Kamens argue, diagnostic and statistical manuals might disadvantage individuals and groups experiencing poor mental health and well-being by focussing the emphasis on addressing diagnostic criteria as symptoms to alleviate, rather than focussing on individual needs.²⁶

I had planned to argue that classifying and terming GIC broadly as a condition relating to mental health does not need to be considered as detrimental; some TGNC children may need specialist psychological support because they may be confused about their identity or may be trying to manage social responses that may be ambivalent or hostile or both. This is not to say that the child is deviant, is ill or is mentally disordered and as such this is where diagnostic classification criteria had an advantage in that, if rewritten, they could reflect this position. Yet, if one accepts my arguments

¹⁵Winter et al., op. cit. note 7.

¹⁶Moleiro, C., & Pinto, N. (2015). Sexual orientation and gender identity: Review of concepts, controversies and their relation to psychopathology classification systems. *Frontiers in Psychology*, 6, 1511.

¹⁷General Medical Council. (2013). Good medical practice: Establish and maintain partnerships with patients. Retrieved from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-3---communication-partnership-and-teamwork#paragraph-46>

¹⁸See: Priest, M. (2019). Transgender children and the right to transition: Medical ethics when parents mean well but cause harm. *The American Journal of Bioethics*, 19(2), 45–59; Harris, R. M., Tishelman, A. C., Quinn, G. P., & Nahata, L. (2019). Decision making and the long-term impact of puberty blockade in transgender children. *The American Journal of Bioethics*, 19(2), 67–69; Priest, M. (2019). Response to commentaries on "Transgender children and the right to transition". *The American Journal of Bioethics*, 19(6), 10–15.

¹⁹Capous-Desyllas, M., & Barron, C. (2017). Identifying and navigating social and institutional challenges of transgender children and families. *Child and Adolescent Social Work Journal*, 34(6), 527–542.

²⁰Allen, B. J. (2019). Primary care of transgender children and adolescents. *Transgender medicine*. In L. Poretsky & W. Hembree (Eds.), *Transgender medicine. Contemporary endocrinology* (pp. 69–92). Cham: Humana Press.

²¹Stanley, D. E., & Sehon, S. R. (2019). Medical reasoning and doctor-patient communication. *Journal of Evaluation in Clinical Practice*, 25(6), 962–969.

²²General Medical Council. (2007). 0-18 years: Guidance for all doctors. Retrieved from https://www.gmc-uk.org/-/media/documents/0_18_years_english_0418pdf_48903188.pdf?la=en&hash=3092448DA3A5249B297C4C5EAEF1AD7549EEB5C7

²³D'Onofrio, B., & Emery, R. (2019). Parental divorce or separation and children's mental health. *World Psychiatry*, 18(1), 100–101.

²⁴Callaghan, J. E., Fellin, L. C., & Warner-Gale, F. (2017). A critical analysis of child and adolescent mental health services policy in England. *Clinical Child Psychology and Psychiatry*, 22(1), 109–127.

²⁵Drescher, J., Cohen-Kettenis, P., & Reed, G. (2016). Gender incongruence of childhood in the ICD-11: Controversies, proposal, and rationale. *The Lancet Psychiatry*, 3(3), 297–304.

²⁶Karter, J. M., & Kamens, S. R. (2019). Toward conceptual competence in psychiatric diagnosis: An ecological model for critiques of the DSM. In S. Steingart (Ed.), *Critical psychiatry* (pp. 17–69). Basel, Switzerland: Springer.

as being valid and thus is open to there being no basis to support continued clinical classification, we are left with a much more profound problem. Whilst clinical diagnostic and classification manuals give us seemingly measurable and identifiable presentations of those who experience an incongruent gender identity, another way we could view them is to say that they could potentially distort our ability to truly understand the needs of individual TGNC children. However, without clinical diagnostic classification, who should decide that a child needs support and on what basis? To address this, we must understand in the first instance how we even consider what it is that a child displays or expresses to warrant consideration of 'need' or 'needing' specialist psychological support.

4 | WHAT IS IT THAT MAKES A CHILD GENDER DIVERSE?

GIC is defined in the ICD-11 as being

characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years and cannot be diagnosed before age 5. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.²⁷

Distress is not directly referred to in the GIC definition, but there is an emphasis on dislike of natal genital anatomy with a desire for alignment to match this to the secondary sex characteristics of the experienced gender. Alternatively the 'US diagnostic and statistical manual of mental disorders' (DSM-V) is more concise in focussing on the associated distress as gender dysphoria, defining it as 'a strong desire to be of the other gender or an insistence that he or she is the other gender'.²⁸ To support diagnosis the DSM-V highlights that children should have 'Clinically significant distress or impairment in social, occupational, or other areas of functioning'.²⁹

Previously, I would have had to accept that these descriptors would need to exist and that children who match these descriptions, or fulfil these criteria, are in principle eligible for care. However, there are problems in setting diagnostic criteria for gender diversity, already well illustrated in the literature both concerning adults and children.

One important criticism of the GIC definition and diagnostic criteria in the ICD-11 is the uniform definition of GIC presentation that is expected to fulfil this objective criteria. Whether it be that a child is expected to be playing with toys not associated with the gender expected from sex assigned at birth or the requirement to experience the gender incongruent feelings for at least 2 years, the result may be that without fulfilling these criteria there may be restrictions on access to gender identity development services. This may lead to parents, or even children, over-emphasizing behaviours and distress as they realize that these are the 'gateways' to support and treatment. The concern is that with objective criteria, parents and children are forced into portraying a certain position, which may not truly align with their lived experience. For example, a child may experience an incongruent gender identity and wish to seek support with the aim of transitioning in some way, but does not experience distress associated with this. Thus, the net might be too wide, leaving children in need out of the radar, or too narrow, medicalizing children who are perfectly fine. Nonetheless, in accepting the necessity of these criteria, however broad or admittedly imprecise, the alternative of there being no clinical diagnostic classification would be more problematic and detrimental to children. Yet, the term incongruence simply reflects binary norm expectations and does not consider the spectrum of gender identity, which may not correspond with incongruence towards genitalia or other physical sex characteristics.³⁰ Objective criteria may thus be unhelpful in facilitating access to care for those who do not demonstrate this yet may benefit from specialist psychological support. We must then consider what the alternative is.

Some parents might seek medical and psychological support because in their view their child does not conform to their gender identity ideals and expectations, regardless of the subjective experience of the child. Perhaps children might come to the attention of clinical services because parents may hope that doctors will give them advice on how to 'reconnect' their child within their heteronormative standards, perhaps parents may even be motivated by a wish to protect children from anticipated difficulties later on in the child's life. Conversely, other parents might be relaxed about gender diversity, and might accept a child's gender expression, yet might miss the opportunity to seek specialist support that the child might in fact need or benefit from. The problem in either case here is that parental subjective identification of TGNC children may not reflect the needs of the individual child but has the potential to influence how a

²⁷World Health Organization, op. cit. note 3.

²⁸American Psychiatric Association. (2015). Diagnostic statistical manual of mental disorders - 5 Gender dysphoria (in children). Retrieved from www.dsm5.org

²⁹Ibid.

³⁰Moser, S. (2017). ICD-11 and gender incongruence: Language is important. *Archives of Sexual Behaviour*, 46, 2515–2516.

child is identified as 'needing' or 'not needing' specialist psychological support.

If on the one hand we accept that some TGNC children might benefit from psychological support, on the other hand we need to admit that in individual cases identifying a child as being different and in need may be detrimental. In other words, it is not helpful to simply identify TGNC children, as this perpetuates the problem of them being in 'need'. However, in order to argue this, we would have to better approach how we determine who could benefit from specialist psychological support. This requires us to explore the basis of 'need' and 'needing'.

5 | ON WHAT BASIS DOES A GENDER DIVERSE CHILD NEED SUPPORT?

If we are to argue that some TGNC children may benefit from specialist psychological support, we must accept that the provision of this should consider the needs of each child. There is however a tension here from the outset when considering and even meeting a child's needs, which is that a child may need something without knowing it. Generally, we expect parents to meet a child's needs, these include health, educational and well-being issues that although may not be causing a child distress or discomfort may still potentially harm the child in some way if not addressed. There are ways in which we measure children's needs, for example through exhibiting suffering, which often forms the basis of child neglect indicators within government policies.³¹ However, as Giordano argues, there may be times that a child does not exhibit suffering but is in fact potentially being neglected in some form because needs are not met.³²

The fundamental issue is that when considering a child's needs, we must in a broader sense consider how children's needs ought to be understood and framed. This tension spans all considerations of children's welfare and is far beyond the scope of this paper, but at the very least we should be sensitive to it when applying this to understanding how we consider the needs of individual TGNC children.

The current situation is that clinical guidelines focus on objective diagnostic criteria of gender dysphoria or gender incongruence in determining need for access to specialist support. The World Professional Association for Transgender Health (WPATH) 'Standards of care' highlight the importance of psychological and psychotherapeutic assessment and support in the management of children and adolescents who experience the diagnostic criteria for gender incongruence and dysphoria.³³ However, even if there are no identified feelings of distress or even if a child's presentation does

not meet the diagnostic criteria, we should accept that psychological support may still be beneficial for at least some TGNC children.

It could be argued that because gender identity requires some introspection, adaptation, discovery and self-discovery, this can be better facilitated for all TGNC children with appropriate psychological support.³⁴ Levine, for example, argues that it is important for all children who experience gender incongruence to receive psychological support, including those who are functioning without experiencing distress, 'to ensure that they have the necessary support they need and a safe place to explore identities and consider any transitioning experience'.³⁵ However, the argument that all of these children should and can benefit from access to specialist psychological support within gender identity services is problematic because it discounts the notion of diversity and considers children expressing gender diversity as a homogenous population. We must accept that for some children who are comfortable in their identity and do not seek support, there is no basis for them to do so.

A further reason to consider psychological support is to facilitate and improve relationships within the wider family group in which the child is embedded in. Indeed, an important part of specialist psychological support in gender identity services is to support parents and families, which has been found to be beneficial.³⁶ Thus, understanding the needs of parents and families could potentially better help understand the needs of the child.³⁷ By doing so, as Newbould argues in the context of intersex children, it could be legitimate to consider the interests of those who care for the child and that these may be taken into account when children are viewed in the context of the wider family.³⁸ However, when clinicians consider the needs of parents to be supported we should understand two points. Firstly, we do not pathologize these parents and families as being 'disordered' because of their experienced concerns and secondly, in the same way that I have argued for TGNC children above, we must appreciate that not all parents and families 'need' specialist support.

A more appropriate way of approaching how we should understand the needs of children is to suggest that needs can only be identified through a robust and individualized approach to assessing them. In shifting away from the need for clinical classification and by addressing these fundamental questions, what becomes apparent is that the need for specialist psychological support accessed by an individual child must then be clinically and societally reconceptualized. However, there is a barrier to this and that is the reported relationship between TGNC children and concomitant mental health conditions. Therefore, next I will explain why the perceived relationship

³⁴Kaltiala-Heino et al., op. cit. note 13.

³⁵Levine, D. A. (2013). Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, 132(1), 297–313.

³⁶Aramburu Alegria, C. (2018). Supporting families of transgender children/youth: Parents speak on their experiences, identity, and views. *International Journal of Transgenderism*, 19(2), 132–143.

³⁷Ibid.

³⁸Newbould, M. (2016). When parents choose gender: Intersex, children, and the law. *Medical Law Review*, 24(4), 474–496.

³¹National Institute for Health and Care Excellence. (2017). Child abuse and neglect: early help, recognition, assessment and response to abuse and neglect of children and young people. Retrieved from <https://www.nice.org.uk/guidance/ng76/documents/child-abuse-and-neglect-final-scope3>

³²Giordano, S. (2015). The fifth commandment: Reflections on the right to contact, child neglect and parental child abduction. *The International Journal of Children's Rights*, 23(1), 27–51.

³³WPATH, op. cit. note 11.

between gender diversity and mental health conditions must be addressed.

6 | DOES MENTAL HEALTH CONCERN JUSTIFY NEED?

A significant argument for accessing specialist psychological support is that some TGNC children experience distress and these children are at greater risk of experiencing poor mental health in comparison to their cisgender peers,³⁹ which was something I had planned to use to support my suggested form of continued mental health classification. Nevertheless, a significant consideration in the first instance is how we should contextualize and understand the relationship between gender diversity and concomitant mental health disorders reported in some of these children.

There are two broad theoretical approaches in understanding why TGNC children are at seemingly greater risk of experiencing mental health disorders. Whilst I am not suggesting that these two approaches are mutually exclusive, I will address them individually.

The first is that mental health issues are co-occurring comorbidities and therefore intrinsic, as a result of the gender incongruence in some way.⁴⁰ In response to whether these conditions are intrinsic and as such concomitant with TGNC children, we should be extremely cautious. We must remind ourselves again that TGNC children, like all children, are not homogenous and therefore it becomes entirely unconvincing that there can be a predictive and set presentation of mental health conditions as part of gender diversity. Furthermore, there is increasing evidence that when TGNC children are supported in expressing their experienced identities, that the reported concomitant mental health comorbidities are vastly reduced.⁴¹

The second approach is that mental health disorders are concomitant and occur as a response to extrinsic social, cultural, familial, educational and even healthcare experiences, which of course are interrelated.⁴² Perhaps the most significant form of hostility for gender diverse people is stigma, a form of social control to cope with abnormality.⁴³ As Winter et al. highlight, TGNC people, including children, are marginalized through stigma as a result of expressing their experienced gender identity and being widely considered by society as having some form of mental health disorder.⁴⁴ Despite the arguments for depathologizing gender diversity in TGNC children

hoping to reduce the breadth of such stigma and other extrinsic hostile influences, there have been arguments that this will not be achieved, for example Drescher et al. argue that they are 'neither compelling or persuasive'.⁴⁵ Therefore, one way we could argue that gender diverse children need access to specialist support and care is as a result of stigma and other social hostilities, when it is well established that poor mental health adversely affects overall health and well-being.⁴⁶ This was in fact similar to the conclusion I had planned in 'the paper I almost wrote'. However, where I was wrong was in arguing that in order to offer mental health support, we need clinical classification and a diagnosis.

Irrespective of clinical classification, the above arguments consider the need for provision of specialist psychological support in response to specific potential mental harm or distress as somehow part of what gender diverse children experience. However, the argument I put forward in separating the relationship between psychological support and mental health care for TGNC children is this; we have framed the two as being conjoined and they should not be. Some TGNC children may experience poor mental health but others may not, whilst facing the same hostilities in relation to gender identity expression. Need must therefore not be understood from the position of anticipated or even expected mental health concerns. The provision of appropriate clinical mental healthcare should be available as it would for any child needing this, regardless of experienced gender identity.

It is not to say that specialists involved in psychological support for TGNC children do not also have expertise in the management of concomitant mental health conditions, but this support should be considered in the context of the mental health issue and not simply on the basis of the child being TGNC. The focus of specialist support should be on psychological well-being. Given my arguments that we need to remove the relationship between the need for mental health care and that need for access to specialist support should therefore be reconceptualized to focus on the individual child, we must now consider whether clinicians are best placed to identify the needs of TGNC children.

7 | SHOULD CLINICIANS IDENTIFY NEED?

Currently the Gender Identity Development Service in the UK is subject to ongoing public and professional criticisms in relation to the provision of clinical interventions for gender diverse children, as part of supporting them in exploring their gender identity.⁴⁷ However, perhaps there are underlying problems linked to the arguments that I have set out in relation to need that contribute to these criticisms. It may be that because gender diverse children are subject to diagnostic classification 'labels', the criticisms of gender identity

³⁹Langer & Martin, op. cit. note 14.

⁴⁰Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics*, 137(3), e20153223.

⁴¹For example, see: Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(2), 116–123.

⁴²Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, 28(1), 13–20.

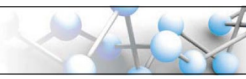
⁴³White-Hughto, J., Reisner, S., & Pachankis, J. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms and interventions. *Social Science and Medicine*, 147, 222–231.

⁴⁴Winter et al., op. cit. note 7.

⁴⁵Drescher et al., op. cit. note 2.

⁴⁶Ibid.

⁴⁷See: Holt, A. (2020, March 1). NHS gender clinic 'should have challenged me more' over transition. Retrieved from <https://www.bbc.co.uk/news/health-51676020>



services, in part, exist as a result of these 'labels' implying that this group and their needs are homogenous. In no way do I suggest here that this how clinicians within these services approach this, rather that diagnostic classification implies this. Consequently, any arguments that psychological support and care within these services is potentially harmful do not consider the children who experience benefit. This is not to discount or ignore criticisms from individuals who argue that they have been harmed but again even these cases highlight that we cannot consider need in any other way than on an individual basis. Removing diagnostic classification is only one element of addressing the needs of individual children but doing so compels us to question the notion of need for these services, focusing on those who may individually benefit from them and how they may do so. Even so, a problem that remains is who is the best arbiter of those needs across a child's development?

Currently, in the UK for example, there are public health and primary care services that monitor certain aspects of a child's health, such as weight or dental health, as preventative measures. However, there is no such preventative approach whereby children regularly access clinicians to review their psychological well-being using the same preventative approach. In fact, the current approach is that such professionals are only accessed when a potential 'problem' or issue is identified. One possible alternative to the objective or parentally subjective dichotomy is a model of individually focussed psychological support and monitoring from clinicians across a child's development. This approach would provide an ongoing developmental commitment, through a positive and proactive approach, to understanding the individual psychological needs of each child. Furthermore, it would be provided for all children and encapsulate all aspects of a child's psychological development. Importantly, this approach would not be reliant on any diagnostic classification or subjective parental bias to the notion of a child's needs.

If we accept that clinicians involved with child development may be well placed to understand the needs of a child, there is still a further question to address. How would referral to specialist psychological support within gender identity services be framed as being beneficial for TGNC children?

8 | DOES POTENTIAL BENEFIT IDENTIFY NEED?

Specialist psychological support may be beneficial for some children and access to this must be ensured. In now arguing that this specialist psychological support should not be based on clinical classification of TGNC children but the needs of individual children, I must explain how we can understand it as being beneficial.

Briefly returning to my earlier arguments, understanding stigma highlights the potential benefit of psychological support for some gender diverse children. In particular those children who are trying to express or explore their gender identity but may be subject to psychological harm through the process of seeking acceptance. Therefore there is a legitimate aim to reduce this. Moser for

example, suggests that therapeutic psychological intervention enables children to explore their gender identity in a safe environment.⁴⁸ Furthermore, it is logical to consider gender identity exploration as being entirely separate to and long before any consideration of gender affirming treatment.⁴⁹ The key point to focus on here is the role of specialist psychological support in benefitting mental health and well-being, in the same way that I have suggested psychological care does for many other experiences that people encounter in their lives.

A further argument is that psychological support may seek to address potential frustration that some TGNC children may experience as a result of being unable to access clinical interventions under current clinical guidelines.⁵⁰ Interventions for pre-pubescent children experiencing GIC or gender dysphoria within current clinical guidelines only include psychological management, which is strongly influenced by the high reported recordings of discontinuation or 'desistance' of GIC and gender dysphoria upon reaching, during and after puberty reported within the literature.⁵¹ Whilst the studies in relation to so called 'desistance' and 'persistence' are the subject of recent criticism, both ethically and in respect of their validity and generalizability,⁵² there remains a cautious and non-interventional approach within current clinical guidelines. So perhaps we could suggest that as well as psychological support potentially being beneficial for some TGNC children coping with frustration, this support could also help some TGNC children understand how future gender affirming interventions could be recognized as being in their best interests.

Supporting a child to understand, and if appropriate explore, gender affirming interventions and supporting the mental health and well-being of TGNC children are two pragmatic examples of potential benefit that may justify a need for access to specialist psychological support. However, I suggest a broader approach to understanding how potential benefit can identify need for some TGNC children; gender identity is complex and we don't know what a healthy gender looks like, but we can say that gender variance is normal human diversity. For this reason, depathologization is in principle the best approach and classification of gender variance as pathology is extremely challenging. However, some children and families approach clinical services, some children struggle, some children need help in finding the right psychosexual trajectory, whilst others are clearer, and some children and families need support in navigating social difficulties. For all these reasons, it is important to be prompt and offer easy routes to health services that are competent in the provision

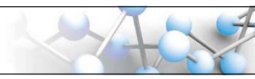
⁴⁸Moser, op. cit. note 30.

⁴⁹Ibid.

⁵⁰Ehrenschaft, D. (2017). Gender nonconforming youth: Current perspectives. *Adolescent Medicine and Therapeutics*, 8, 57–67.

⁵¹WPATH, op. cit. note 11.

⁵²Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., ... Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, 19(2), 212–224.



of specialist support and that this is distinguished from support for other mental health conditions.

Fundamentally, the way in which we must reconceptualize specialist psychological support is that we should base this on the needs of the individual child, just as we do in other areas of supportive psychological care. The needs of a child cannot be understood in the context of diagnostic classification criteria but have to be understood on the basis of how they may benefit, with clinicians having an important role to play. Moreover, we should appreciate that when TGNC children are empowered as agents, they should not be dogged by a rhetoric of psychological specialist support and care being unnecessary or by its nature damaging because of a misrepresented relationship with mental health.

9 | CONCLUSION

The arguments that I have set out in this paper conclude with the same argument I wanted to make in 'the paper I almost wrote'; TGNC children should be ensured access to specialist psychological support within gender identity development services. Yet far from the argument I had planned previously, that mental health classification is best placed to ensure access to this specialist psychological support, I would now argue that what I have set out in this paper does far more to ensure this. There are no compelling reasons for gender diversity in children to require diagnostic classification to improve or support access to specialist psychological support. In removing this diagnostic classification, we are left having unveiled the real problem of the importance of understanding how we frame need in providing clinical support.

In the first instance we must understand that there is no broad appropriate or necessary way to identify these children and therefore justify a need for psychological care through application of objective or even subjective criteria. By accepting this, we are left with ultimately recognizing that some TGNC children and some families may benefit from specialist psychological support or care. Importantly, we should be clear that this specialist support is not provided with the intention to treat or 'cure' TGNC but with the aim of supporting individual TGNC children and potentially their families. However, this specialist support and care should be driven by the needs of the individual child, as determined by the child and those involved with their care, rather than diagnostic criteria or subjective individual attitudes towards a child's gender expression. This requires us to recognize that the historical clinical construction of the relationship between mental health and TGNC children

must be reconceptualized. It is only by bettering our rationale as to why specialist psychological support may be beneficial for some TGNC children that we can promote access based on individual need. Part of the basis of this need should be psychological support being provided not on the basis of being TGNC but as part of supporting each child's development through childhood and on into adulthood.

As researchers, academics or clinicians we have to be open to challenging our own positions, assumptions and enquiry of normative prepositions. Writing a draft paper and then starting again has been a demanding but valuable endeavour to understand what is important when our aim is to better support TGNC children. Methodologies and approaches should evolve and must do so in order to broaden the way in which we frame philosophical enquiry into these most important issues. Perhaps the best way many of us can do this is to learn from papers that we almost wrote.

CONFLICT OF INTEREST

The author declares no conflict of interest.

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