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Cal Horton

**To cite this article:** Cal Horton (2024) The importance of child voice in trans health research: a critical review of research on social transition and well-being in trans children, International Journal of Transgender Health, 25:3, 389-406, DOI: [10.1080/26895269.2023.2295381](https://doi.org/10.1080/26895269.2023.2295381)

**To link to this article:** <https://doi.org/10.1080/26895269.2023.2295381>



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Published online: 26 Dec 2023.



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## The importance of child voice in trans health research: a critical review of research on social transition and well-being in trans children

Cal Horton 

Centre for Diversity Research Policy and Practice, Oxford Brookes University, Oxford, England

### ABSTRACT

**Background:** Trans healthcare has traditionally been dominated by the perspectives of cis clinicians, with trans and service user voices side-lined. The voices and perspectives of trans children are rarely centered in clinical literature, with potential consequences for the design, delivery and evaluation of pediatric trans healthcare services.

**Aim:** This article examines literature on the association between social transition and mental health in trans children, exploring the inclusion or exclusion of child reported data.

**Methods:** Modern research studies on the relationship between social transition and well-being in trans children are examined, investigating what data sources underpin each analysis. A recent clinician authored article on the relationship between social transition and mental health is then reviewed in greater depth. This article is evaluated, drawing attention to data limitations and reflecting on the implications of the study's approach to data.

**Results:** Data limitations related to social transition are identified, exploring the omission of trans child perspectives on 1) social transition 2) name change and 3) ease of social transition. Mental health data limitations are reviewed considering 4) the combination of research with clinical assessments. Additional limitations relate to the absence of 5) child or family perspectives on mental health 6) data on euphoria and 7) data on gender minority stress.

**Discussion:** The reviewed article's approach to data is critiqued, highlighting the limitations of a reliance on clinician reported measures and the consequences of the exclusion of child reported measures. The article calls for greater prioritization of child and service user perspectives in healthcare research.

### KEYWORDS

Children; clinical care; mental health; PROMS; qualitative research; research; social transition; transgender

### Introduction

Within trans healthcare there is increasing research on the experiences trans children, including on the topic of 'social transition' (de Castro Peraza et al., 2023; Galman, 2020; Olson & Gülgöz, 2018). Trans is an umbrella term for people whose gender identity does not correspond to the identity they were assigned at birth, with the adjective cis its antonym (Tompkins, 2021). In this article the term child encompasses all ages under 18 years old, the term adolescent is used when referring to children over the age of 12, and the term youth is used to encompass adolescents and young adults under the age of 25. Social transition is understood as signifying social acceptance or affirmation of a child's identity, commonly accompanied by a change in pronoun (Ehrensaft, 2020). Ashley (2019a, p. 679)

emphasizes that "social transition involves something beyond gender non-conformity and speaks to a shift in lived gender identity". Research on social transition conducted in the last decade comprises a collection of community-centered quantitative studies, predominantly from North America (Durwood et al., 2017, 2021; Gibson et al., 2021; Olson et al., 2016); qualitative studies from Spain (de Castro Peraza et al., 2023), the UK (Horton, 2022b, 2023b, 2023a; Whyatt-Sames, 2017) and the USA (Kovalanka et al., 2014); retrospective studies with trans adults (Kennedy, 2020; Turban et al., 2021), and a small number of studies embedded in gender clinics in the UK (Morandini et al., 2023) and Germany (Sievert et al., 2021). Parents and clinicians look to existing literature for evidence-based guidance on effective care and support for trans children

**CONTACT** Cal Horton  [chorton@brookes.ac.uk](mailto:chorton@brookes.ac.uk)  c/o Centre for Diversity Research Policy and Practice, Oxford Brookes University, Oxford, England

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(Horton, 2023b). The majority of studies report overwhelmingly positive findings related to social transition, whilst two clinic-based studies (Morandini et al., 2023; Sievert et al., 2021) find neither positive nor negative impacts. This apparent divergence between articles reporting positive or neutral impacts merits further consideration, as prioritized in this article.

The modern literature introduced above, reporting positive or neutral impacts of social transition, contrasts strikingly with the conclusions of older research that warned against social transition as likely harmful (Steensma & Cohen-Kettenis, 2011). There are several reasons for exercising caution in the application of older research to guide modern clinical practice in trans healthcare (Ashley, 2019b). A majority of published clinical research studies on gender diverse children conducted from the 1950s through to the removal of the diagnosis of gender identity disorder in 2013 took place in clinics that sought to cure, control or prevent gender diversity (Bryant, 2006). Such research and clinical practice was grounded in a pathologising paradigm that saw being trans as a disorder (Marrow, 2023). Older research on social transition has been heavily criticized (Ehrensaft et al., 2018; Priest, 2019; Temple Newhook et al., 2018; Temple Newhook et al., 2018), with authors raising “methodological, theoretical, ethical, and interpretive concerns” (Temple Newhook et al., 2018, p. 1). Past clinical literature is also critiqued for cis clinician dominated studies that delegitimise, pathologise and misgender trans children, in work where trans children’s voices are rarely heard, let alone respected and centered (Ansara & Hegarty, 2012; Tosh, 2011).

Three distinct agendas call into question the historic approach of sidelining trans child perspectives in research on trans children (Sitas et al., 2023). Firstly, at a global level there is increased commitment to depathologisation of trans identities, as recognized in the World Health Organisation’s ICD-11 (World Health Organisation, 2021). This global commitment to depathologisation aligns with and builds upon long-standing trans community calls for trans accountability and depathologisation (Horton, 2022a; Suess Schwend, 2020; Tosh, 2011). The movement for

trans depathologisation has championed the importance of research and clinical practice that respects the autonomy and dignity of trans children, challenging harmful clinical and research practices, and drawing attention to trans children’s voices, rights and perspectives (Ashley, 2019a; Davy et al., 2018; Suess Schwend et al., 2018). Secondly, there is a growing movement for respecting children’s rights in research, as expressed in the UN Convention on the Rights of the Child (Byrne & Lundy, 2015). Child rights include the right of children to be heard, and to have influence over policy and decision making including in research and healthcare (Jørgensen et al., 2022; Lundy, 2018). Thirdly, in wider healthcare discourse there is increasing recognition of the importance of listening to patient experiences and perspectives, including investment in Patient Reported Outcome Measures (PROMs) (Krogsgaard et al., 2021). Patient voice is regarded as especially vital when measuring concepts such as well-being and quality of life (Gagnier et al., 2021). In combination, the three agendas of depathologisation, child-rights and patient voice have the potential to come together in the field of pediatric trans healthcare, shifting the field toward greater inclusion of child-voice in healthcare design, delivery, evaluation and accountability.

This article takes stock of the inclusion of child-voice and child perspective in recent studies on trans children and social transition. It presents a critical review of modern literature on the relationship between social transition and well-being, exploring the inclusion or exclusion of child voice and child-reported outcome measures. The article examines the inclusion of child voice in existing research, reflecting on current practice and considering areas for future research prioritization. In section one this article presents a stock-take of evidence on the impact of social transition on trans children’s mental health, happiness and well-being. This stock-take draws attention to the measures and data sources that are prioritized in recent research studies, highlighting the data underpinning each analysis. In section two this article then selects one recently published article on trans children and social transition for a more in-depth review, analyzing what measures,

perspectives and data sources are prioritized, paying particular attention to the inclusion or exclusion of child voice or child-reported data. This article reflects upon the reviewed study's approach to data, examining methodological, ethical and interpretive implications.

## Materials and methods

### Study design

This study applies a critical review methodology (Grant & Booth, 2009), exploring and evaluating the key literature published in the last decade on the link between social transition and well-being in trans children. A critical review methodology helps assess and evaluate a body of literature, drawing attention to weaknesses in the existing evidence base, assessing what is significant and highlighting areas for further research (Paré et al., 2015). This critical review builds on similar work in pediatric trans healthcare that appraises the strengths and weaknesses of existing literature to better inform policy and practice (Temple Newhook et al., 2018). A critical review emphasizes interpretation of the evidence base, and is inherently and intentionally subjective (Grant & Booth, 2009). In this article I engage with the existing literature with a specific focus on the inclusion or exclusion of child perspectives and child-reported data, interpreting and evaluating the implications of existing approaches to data collection and analysis.

The first part of this article examines an extensive collection of articles published post 2016 on trans children and social transition, addressing research question one (RQ1) (see Table 1). A wide range of articles are included in this initial stock-take (see Table 2), following a purposive sampling strategy to ensure analysis of a range of types of study including community-centered quantitative, qualitative, retrospective, clinic-embedded quantitative, and comparative studies. The second part of this article selects one recent article on trans children and social transition for a deeper analysis. The selected article is analyzed through deductive and inductive reflexive thematic analysis (Braun & Clarke, 2019), addressing three prioritized research questions (see Table 1). The study examined in the second part of

**Table 1.** Research questions.

RQ1: What measures are included in the analysis, where did data come from, and are child or service user perspectives included?
RQ2: Do the selected measures effectively assess the concepts of concern (social transition and well-being)?
RQ3: What are potential limitations of the selected measures, what relevant data sources or measures are excluded from the analysis, and what are the consequences and implications of the reviewed study's approach to data?

**Table 2.** Reviewed articles.

Type of study	Articles included
Community centered quantitative studies	Olson et al. (2016); Durwood et al. (2017); Gibson et al. (2021); Durwood et al. (2021); Pollitt et al. (2021); Russell et al. (2018)
Qualitative studies	de Castro Peraza et al. (2023); Horton (2022b, 2023a, 2023b); Kuvalanka et al. (2014); Whyatt-Sames (2017)
Retrospective studies	Turban et al. (2020); Kennedy (2020)
Clinic-embedded quantitative studies	Sievert et al. (2021); Morandini et al. (2023)
Comparative studies	Wong et al. (2019)

this article (Morandini et al., 2023) is reviewed in order to draw attention to the inclusion or exclusion of child voices, with reflections on the limitations and implications of the identified approach. The article under review, "Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?" was selected for three reasons. Firstly, it is a recent 2023 article drawing upon a clinical sample, providing insights into how child voice is included in current clinic-embedded research. Secondly, the article focuses upon measuring the outcomes of social transition, a topic that cannot be assessed by laboratory tests, radiological results or medical examination (Krogsgaard et al., 2021), where child and family experience and perspective are important. Thirdly, the article concerns a clinical population with whom I have insider insight (see section below on positionality).

### Positionality and ethics

Noting the subjectivity at the heart of a critical review methodology (Paré et al., 2015), provision of information on author positionality is important. My approach to this topic is informed by a commitment to trans-emancipatory research (Noel, 2016), recognizing that being trans is neither a pathology nor a problem, acknowledging that trans lives are equal to cis lives, and being attentive to

cisnormativity or pathologisation of gender diversity. I approach the topic as a non-binary researcher and as a parent of a trans child. I am close to trans community groups and parent of trans child community groups in the UK. The second section of this article reviews one study in detail, examining the measures underpinning the study's analysis and conclusions, and critiquing and reflecting upon potential limitations in the selected data. Limitations are presented from my experience and knowledge. I draw upon a combination of experience interviewing trans children within formal research (some of which is summarised in section one of this article), and from informal connections and conversations with trans children and families as a member of parent-of-trans-child support communities. I draw upon my in-depth knowledge of existing literature, from my first-hand experience as a research participant, and from my own experience as a parent service user of the children's gender clinic where the reviewed article is drawn from. This knowledge and positionality provides insider insight that can enrich my understanding and analysis. I also acknowledge my own outsider status compared to the trans children at the heart of this article, as an adult, and as a trans person who did not socially transition in childhood. As intended in my adopted methodological and analytical approaches, my findings are subjective and influenced by my knowledge and life experiences (Ruokonen-Engler & Siouti, 2016).

### Section one - child-voice in literature on trans children and social transition

This section examines modern literature on the association between social transition and

well-being or mental health in trans children. It synthesizes and analyses a range of studies including community centered quantitative studies, qualitative studies, retrospective literature, clinic-embedded quantitative studies and comparative studies. It highlights key study findings, alongside an examination of the underpinning data sources, with a particular interest in the inclusion or exclusion of child reported data.

### Community centered quantitative studies

Four community centered studies (Durwood et al., 2017, 2021; Gibson et al., 2021; Olson et al., 2016) are led from the same research center, though with differing samples and different measures (see Table 3 for details). A community-centered study by Olson et al. (2016) (see Table 3) found that trans children who were supported and affirmed in pre-adolescence (under age 12), had good levels of mental health. The study focused on parental measures of anxiety and depression. In terms of depression, transgender children's symptoms ( $M=50.1$ ) did not differ from the population average. Mean anxiety symptoms of transgender children were slightly higher (54) than the population average (50) but still substantially below the clinical (>63) or even pre-clinical (>60) range. The authors contrasted this to previous literature on trans children and adolescents who had not been supported and affirmed in pre-adolescence, that reported high levels of anxiety and depression.

A study by Durwood et al. (2017) looked at anxiety, depression and self-worth in a non-clinical sample of socially transitioned trans children (see

**Table 3.** Study sample characteristics.

Study	Country	Sample Size	Sample description	Age
Olson et al. (2016)	USA and Canada	73	Socially transitioned trans children	3-12 years old, mean age 7.7
Durwood et al. (2017)	USA and Canada	63 and 116	Socially transitioned trans children	6-14 years old, mean age 10.8
Gibson et al. (2021)	USA and Canada	148	Socially transitioned trans children	8-14 years old, mean age 10.1
Durwood et al. (2021)	USA and Canada	265	Socially transitioned trans children	3-15 years old, mean age 9.4
Pollitt et al. (2021); Russell et al. (2018)	USA	129	Trans youth	15-21 years old
de Castro Peraza et al. (2023)	Spain	8	Trans children	5-15 years old, mean 10.1
Horton (2022b, 2023a, 2023b)	UK	30	Socially transitioned trans children	6-16 years, mean 11.
Whyatt-Sames (2017)	UK	1	Trans child	Age 11 years old
Kuvalanka (2014)	USA	5	Transgender children	8-11 years old, mean age 9.5
Turban et al. (2020)	USA	27,715	Trans adults	Mean age 31 years
Kennedy (2020)	UK	16	Trans young adults	18-26 years old
Sievert et al. (2021)	Germany	54	Gender clinic referred children	5-11 years old
Morandini et al. (2023)	UK	208 and 357	Gender clinic referred children diagnosed with gender dysphoria.	4-17 years old, mean age 14.3

Table 3 for details). It found that trans children's levels of depression and self-worth matched national averages, whilst their levels of anxiety were marginally higher. This study surveyed parents and children, noting the similarity between child and parent reported data. Depression in a clinical range was self-reported by 6% of children and in 5% of parental reports. Anxiety in a clinical range was self-reported by 5% of children and in 19% of parental reports.

A study on socially transitioned trans children by Gibson et al. (2021) (see Table 3) examined child and parent reported data on anxiety and depression, finding good levels of mental health. Data from child self-report found no difference in anxiety or depression to a control group. Data from parent report found no difference in depression. Parent reported levels of anxiety were higher than in the control group though still below clinical levels. The article concludes that “whether their generally strong mental health is because of their early social transition, the high levels of support they receive, or other factors is as yet unknown” (Gibson et al., 2021, p. 3).

Another study (Durwood et al., 2021) focused on parent reported anxiety and depression in socially transitioned trans children (see Table 3). For this study they included variables on social support status, hypothesizing that social support from families, peers, schools, laws and policies would impact on well-being. They also included variables on gender-related victimization, again hypothesizing that victimization would negatively impact on well-being. The parental sample overall reported high levels of support for their children's gender identities and low levels of gender-related victimization. In analyzing the link between well-being and social support, family support, peer support and school support were all found to be associated with lower levels of anxiety and depression. In considering the impact of gender victimization, high levels of peer and school support moderated the impact of gender victimization on depression and anxiety, protecting trans children's well-being.

Two articles drawn from one study focused on the relationship between use of chosen name, a common step in social transition, and mental health in trans youth (Pollitt et al., 2021; Russell

et al., 2018). Chosen name use was assessed by asking trans youth whether they had a preferred name different from the name they were given at birth, with 74 out of 129 youth reporting that they had a different preferred name. They were also asked “are you able to go by your preferred name” at home, at school, at work, or with friends. After adjusting for personal characteristics and social support, chosen name use in more contexts was associated with lower depression, suicidal ideation, and suicidal behavior. Depression, suicidal ideation, and suicidal behavior were lowest when chosen names could be used in all contexts.

### **Qualitative literature**

A body of qualitative literature has emphasized the positive or protective impacts of social transition. Qualitative studies typically collect data from listening to trans children and their parents, centering current and retrospective reports on happiness and well-being. A small number of qualitative studies focus directly on trans children's perspectives on social transition. One such study from the UK (Horton, 2023a) highlighted the importance of social transition for children's happiness or ‘euphoria’. A study from Spain focused on parental perspectives on social transition (de Castro Peraza et al., 2023). It concluded that social transition had positive and immediate benefits on trans children, leading to a reduction in anxiety, alongside improvements in mood, self-esteem, and social and family relationships. UK research on parental perspectives emphasized both the harms of delaying social transition (Horton, 2022b) and the positive impacts of supporting social transition (Horton, 2023b). Parents in the latter article described social transition as protective for child mental health and well-being. Qualitative research with families in the US described significant changes in children's confidence and happiness associated with social transition (Kualanka et al., 2014). Work by Whyatt-Sames (2017) provides a clinician's positive reflections on the social transition of a child in foster care.

### **Retrospective literature**

A body of retrospective research with trans adults has emphasized the negative impacts of efforts to

deny childhood affirmation or social transition. Research by Turban et al. (2020) investigated the relationship between trans adult mental health and past experiences of conversion therapy or conversive practices. They found that recalled exposure to gender identity related conversive practices was associated with increased odds of severe psychological distress and lifetime suicide attempts. There was particularly raised lifetime odds of suicide attempts amongst those who recalled conversive practices in childhood (under age ten). Other retrospective research by Kennedy (2020) provides insight into ‘coming out’ or disclosure timelines. Trans adults reported significant delays and a significant period of distress before sharing their identity with families or clinicians in advance of a social transition. External efforts to deny or delay social transition are recognized as a form of conversion therapy (UN Human Rights Council, 2020). This retrospective research highlights potential dangers and harms of not supporting a child’s social transition.

### ***Clinic-embedded quantitative literature***

A study by Sievert et al. (2021) examined parental data on children referred to a gender clinic in Germany. The clinic in question is described as following a “watchful waiting approach” (Sievert et al.,

2021, p. 83). The sample overall is described as comprising children who have “a wish to transition” (Sievert et al., 2021, p. 90). At the point of data collection, 16 out of 54 children had not transitioned socially, 17 had partially transitioned and 21 had fully socially transitioned. Parents reported data on internalizing problems (anxiety and depression), externalizing problems (aggression), poor peer relations and general family functioning (see Table 4 for details). According to a measure that does not consider trans specific family support only 2 parents (4% of sample) reporting problematic general family functioning. Parents reported raised levels of both internalizing and externalizing problems in the sample, compared to the national norm. 23 parents (43% of the sample) reported that their child had poor peer relations (see Table 4), with more than a third reporting their child “doesn’t get along with other kids” and “gets teased a lot”. Within the study analysis, social transition status did not predict internalizing or externalizing problems. Instead poor peer relations were a key predictor of both internalizing and externalizing problems. The study authors conclude that clinically referred children in Germany have high levels of emotional and behavioral problems. The authors contrast these findings with the higher levels of positive mental health reported in North American studies of socially transitioned trans children with family support. It needs to be

**Table 4.** Study data sources and findings.

Study	Data Sources	Measures (see Table 5 for details)	Findings
Olson et al. (2016)	Parent	PROMIS short form measures for anxiety and depression.	Positive
Durwood et al. (2017)	Child and parent	Global Self-Worth Subscale & PROMIS short form measures for anxiety and depression	Positive
Gibson et al. (2021)	Child and parent	PROMIS short form measures for anxiety and depression	Positive
Durwood et al. (2021)	Parent	PROMIS short form measures for anxiety and depression & data on social support and gender victimisation	Positive
Pollitt et al. (2021); Russell et al. (2018)	Youth	Beck Depression Inventory for Youth, the Self-Harm Behavior Questionnaire, and the Child and Adolescent Social Support Scale.	Positive
de Castro Peraza et al. (2023)	Parent	Qualitative	Positive
Horton (2023a)	Child and parent	Qualitative	Positive
Horton (2022b, 2023b)	Parent	Qualitative	Positive
Pullen Sansfaçon et al. (2022)	Parent and child	Qualitative	Positive
Whyatt-Sames (2017)	Psychologist	Qualitative	Positive
Kuvalanka (2014)	Parent	Qualitative	Positive
Turban et al. (2020)	Adult	Kessler psychological distress scale	Positive (negative impacts of barriers to affirmation)
Kennedy (2020)	Adult	Qualitative	Positive (negative impacts of barriers to affirmation)
Sievert et al. (2021)	Parent	Child Behavior Checklist and General Family Functioning assessment.	Neutral
Morandini et al. (2023)	Clinician	Clinical assessment records	Neutral

**Table 5.** Measures used within the reviewed articles.

Measurement tool	Details on the measures
PROMIS short form for anxiety and depression (Varni et al., 2012),	This form can be completed either using the pediatric version, to be completed by a child, or the proxy version, to be completed by a parent or carer. This form includes six questions about depression and eight about anxiety. Scales assessed items like "I felt nervous", "my child felt scared", "I felt sad", "I felt worried", "my child felt unhappy". Respondents highlight how often they or their child felt that way in the past week, selecting either "never", "almost never", "sometimes", "often" or "almost always". The scales measure depression and anxiety on a 100-point scale where 50 is the population mean.
Global Self-Worth Subscale from the Harter Self-Perception Profile for Children (Harter, 2012)	This presents 2 kinds of children, those who "like the kind of person they are" and those who "wish they were different", asking children which kind of child they are most like, and whether this is "sort of true" or "really true".
Social support (Durwood et al., 2021)	For social support parents rated on a scale of 1-7 how accepting different people or institutions in their child's life were of their gender or gender presentation. They rated family support, and peer support, to include close friends and peers, other peers, and peers' parents. Parents also rated the levels of school and policy support, and parental satisfaction with their school. This parental data was combined with researcher calculated variables on state level legal protection (for a US sample) to assess the social support around trans children.
Gender victimization (Durwood et al., 2021)	For gender victimization parents were asked whether their child had ever experienced gender-related bullying, with responses including "never", "seldom", "sometimes", "often" and "I don't know." Parents were also asked whether their child has ever experienced gender-related discrimination ("treated unfairly") at school with "yes" and "no" response options.
The Beck Depression Inventory for Youth (Beck et al., 2001)	The 20-item Beck Depression Inventory for Youth scale measures depressive symptoms. Sample items included "I hate myself" and "I think my life will be bad." Higher scores represent higher levels of depressive symptoms.
The Self-Harm Behavior Questionnaire (Gutierrez & Osman, 2008)	Measures suicidal ideation and behavior considering multiple dimensions of suicide (ideation, threat, attempt) and self-harm. Dichotomous yes/no questions assess severity of ideation (method, whether other events precipitated ideation, suicide plan, reactions of others, preparation) and behavior (method, frequency, risk, medical treatment necessity, whether other events precipitated behavior, intent to die) on an ordinal scale from 0-22.
The Child and Adolescent Social Support Scale (Kerres Malecki & Kilpatrick Demary, 2002)	Comprises five scales of twelve items each that assess supportiveness from parents, close friends, classmates, teachers, and their school.
Child Behavior Checklist "internalising problems" (Achenbach, 1991)	Internalizing problems assesses 31 items including anxiety and depression, somatic complaints and withdrawal problems.
Child Behavior Checklist "externalising problems" (Achenbach, 1991)	Externalizing problems combines 33 items assessing for example aggressive and rule breaking behavior.
Child Behavior Checklist "poor peer relations" (Achenbach, 1991)	'Poor peer relations' combines responses to questions on whether a child "doesn't get along with other kids", "gets teased a lot", and "is not liked by other kids".
General Family Functioning (GFF) Index (Byles et al., 1988)	12 item index of general family functioning. Six of the items are worded to describe healthy functioning of the family and the other six items describe unhealthy functioning, with response categories of "Strongly Agree," "Agree," "Disagree," and "Strongly Disagree." These include "Planning family activities is difficult because we misunderstand each other"; "In times of crisis we turn to each other for support"; "We cannot talk to each other about the sadness we feel"; "Individuals are accepted for what they are"; "We avoid discussing our fears and concerns"; "We express feelings to each other"; "There are lots of bad feelings in our family"; "We feel accepted for what we are"; "Making decisions is a problem for our family"; "We are able to make decisions about how to solve problems"; "We don't get along well together"; "We confide in each other".

noted that although this German study uses the term 'social support', it did not include measures of family or social support of a child's gender identity.

A study by Morandini et al. (2023) examined data on children referred to a UK children's gender clinic. In contrast to all the research reviewed above, this study does not include child or parent reported data. This study, its data sources, findings and limitations will be examined in closer detail in section two of this article.

### Comparative literature

A comparative analysis by Wong et al. (2019) contrasted levels of internalizing and externalizing problems in gender non-conforming cis children and socially transitioned trans children. Data on trans

children were taken from the North American community centered quantitative studies introduced earlier in this article. The comparative analysis found similar levels of internalizing and externalizing problems, and poor peer relations (including bullying). The authors interpret this as evidence that social transition alone is insufficient to safeguard against bullying, poor peer relations, anxiety and depression. They conclude that socially transitioned trans children, like gender non-conforming cis children, may face a difficult external environment, with consequences for their well-being.

### Section two – examination of a clinical study on social transition

This section presents a critical appraisal of one recent clinic embedded study (Morandini et al.,



2023). The selected article concluded that “social gender transition is not associated with mental health status in children” (Morandini et al., 2023, p. 1058). This study is closely reviewed, scrutinizing the data that underpins its analysis and conclusions. The first subsection analyses the study’s chosen measures of social transition. It examines what is measured, what data sources are used, and how child voice is included or excluded. This analysis enables exploration and reflection upon the limitations of the study’s approach to data on social transition. The second sub-section examines the study’s chosen measures of mental health and well-being. It summarizes what is measured, what data sources are used, and how child voice is included or excluded. This evaluation enables consideration of the limitations of the study’s approach to measuring mental health. The third sub-section examines the study’s stated conclusions, evaluating and reflecting upon the implications of the identified limitations.

### Measures of social transition

Two measures of social transition are included in the analysis. ‘Name change’ captures whether a child has changed their first name. ‘Living in role’ assesses whether a child is living in their affirmed gender. Children in the sample are categorized as ‘not’, ‘fully’ or ‘partially’ transitioned for each variable (see Table 6). How ‘living in role’ is defined, and by who, is not clarified in the article. Data on living in role or name change status are taken from records completed by clinicians at the end of an assessment period. Whether children or parents

are provided an opportunity to review and correct the record is not stated in the article.

There are three major limitations of the study’s approach to measuring social transition. These limitations will be introduced and explored here, considering 1) the absence of trans child perspectives on ‘living in role’ status, 2) the absence of trans child perspectives on name change status and 3) the lack of information on trans child perspective on ease of social transition.

### *The absence of trans child perspectives on living in role*

The reviewed study does not provide any information on how trans children feel about their current social transition status, a factor that could be considered relevant to their current mental health and well-being. I know trans children for whom a lack of a social transition, or a partial social transition (transitioning only in affirming or safe spaces) meets their current needs, desires and preferences. Trans children have a right to approach social transition at a pace and on a timeline that suits their individual preferences, there is no single ideal or correct timeline. Contrastingly, I also know trans children who would like to be fully socially transitioned, but whose transition has been blocked by those with power over them. Trans children can face delays to affirmation and social transition, even within otherwise supportive families (Horton, 2022b). Trans children in actively trans hostile families can face severe barriers to social transition, and are at risk of familial abuse, conservative practices, control and violence (Riggs & Bartholomaeus, 2018b). Trans children in care face additional barriers to social transition (Kovalanka et al., 2019). Trans children with an unsupportive secondary parent can face barriers to full social transition even when affirmed in their primary residence (Kovalanka et al., 2019). Barriers can be informational, with trans children and families lacking awareness of the options for social transition, including those who are waiting for medical ‘permission’ to socially transition (Horton, 2023b). Outside of the home, schools in particular, can impose restrictions or barriers to social transition, regardless of a child’s wishes (Riggs &

**Table 6.** Sample data per key analysis category in the reviewed study.

Variable	Sample data per category
Living in role	Analysis of the impact of ‘living in role’ looked at available data on 288 children and adolescents. 59.4% of these were categorized as ‘fully living in role’, 13.5% as ‘partially living in role’ and 27.1% as ‘not living in role’. For ease of analysis data on those living fully or partially in role were combined, with the analysis comparing the 73% living fully or partially in role with the 27% who were not living in role.
Name Change	Analysis of the impact of name change looked at available data on 357 children and adolescents. 60% of these had partially or fully changed their name. For ease of analysis those categorized as having partially changed their name (approximately 2% of the sample) were merged with those who have fully or in all domains changed their name.

Bartholomaeus, 2018a). Within the reviewed study's approach, those who have transitioned to the degree to which they are comfortable, with autonomy and control over their transition timeline, are conflated with those who have faced severe or abusive external barriers to social transition.

### ***The absence of trans child perspectives on name change***

For name change, trans children within the study are divided into binary categories of 'name changed' or 'name unchanged'. Child perspectives on name change are omitted. There is no information collected or analyzed on what name change means for a specific child, whether they want to change their name, and whether name change is for them an important part of gender affirmation and social transition. There are several limitations of this approach.

Firstly, the research assumes that children who have not changed their name have not fully socially transitioned. There are a number of trans youth for whom name change is not part of their desired social transition pathway (Pollitt et al., 2021). I know trans children who have a gender-neutral name that they do not see as conflicting with their gender, for whom there is no reason to change their name. I know trans children who are happy with an abbreviation of a given name. I know other trans children who have a name that is coded or associated with their assigned gender, and yet see that name as their name, do not see it as invalidating their identity, and do not wish to change their name. For all of these children, the lack of a name change does not indicate a lack of social transition. Indeed, presuming such children have not socially transitioned is an act of trans-normativity (Riggs et al., 2019) and cis-dominance over service users, overruling and negating their own self-knowledge. It is worth revisiting here the research studies introduced earlier in this article, that asked trans youth about their 'chosen name'. This research (Pollitt et al., 2021; Russell et al., 2018) found that 57% of trans youth (74 out of 129) had a chosen name that differed from their originally assigned name. The remaining 43% of

trans youth were happy to use the name they were given at birth.

Secondly, the research seemingly presumes that children who have changed their name have done so for reasons of self-actualization and affirmation. Yet name change is not always driven by trans children and does not always indicate gender affirmation. Through my research (unpublished) I know trans children who have been told by UK gender clinicians that they must change their name in order to be classified as fully socially transitioned, in order to be eligible for medical interventions. For these children, name change can be interpreted less as an indication of self-directed gender affirmation, and more as an indication of coercion and powerlessness in healthcare systems where clinicians hold power, including the power to define what names are 'appropriately gendered'. Exclusion of child voice means the reviewed study risks merging youth who might have been forced to change their name through healthcare coercion and institutional violence, with youth for whom name change was a self-asserting act of self-determination and euphoria. Exclusion of child voice means the reviewed study risks merging trans children who do not ever wish to change their name, with trans children who have, through external pressure and control, been prevented from changing their name. Clarity on what a name means for an individual child can only come from research that places the voices of trans participants at its center.

### ***The absence of information on ease of social transition***

The reviewed article does not provide any data on a child's pathway to social transition, excluding potentially relevant information on how much resistance a child has faced. Two children who have both socially transitioned, may have had very different pathways to that social transition. Some children may have felt in control of their transition timelines, and felt safe, supported and loved through that pathway to transition. Other children can have faced extended rejection, humiliation, bullying, violence or abuse before being able to socially transition. A recent article

interviewing parents of trans children from Australia (Belmont et al., 2023) makes effort to recognize different pathways to support. It distinguishes between children whose social, legal or medical affirmation was i) controlled (their child wanted to affirm their gender but there were barriers to doing so); ii) denied (their child wanted to affirm their gender but was prevented by someone else); (c) delayed (their child wanted to affirm their gender but had to wait longer than they wanted to); and (d) supported (their child was able to affirm their gender socially at the time and manner they wished to). From that research over 60% of parents reported that their child had faced barriers to social transition, with their social affirmation controlled, denied, or delayed (Belmont et al., 2023). Some trans children find support straight away, while other children endure years of delays and denial before being able to socially transition (Horton, 2022b; Riggs & Bartholomaeus, 2018b). Categorizing both groups as having socially transitioned erodes critical information on how much resistance they faced on their pathway to social transition, a factor that may influence individual mental health and well-being.

### Measures of mental health

The study's data on mental health is drawn from clinical records completed at the end of an assessment period. The gender clinic's assessment involved "a minimum of three one-hour assessments with two mental health clinicians (psychiatrists, clinical psychologists, or registered psychotherapists)" (Morandini et al., 2023, p. 1049). At the end of the assessment period, clinicians complete an 'associated difficulties' form. Whether trans children or their families were provided an opportunity to review, verify or correct the clinician completed data on these forms is not stated in the article. The form captures data on 18 'associated difficulties' namely Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Mood, Anxiety, Psychosis, Eating Disorder, Bullying, Abuse, Domestic Violence, Family Break Up, Mother Depressed, Father Depressed, Sibling Mental Health, Parents' Alcohol or Drugs, Self-Harm, Suicide Attempt, Suicidal

Ideation, Family Support. The reviewed study chooses to look at data for just three of these associated difficulty measures: diagnosis of a mood disorder, diagnosis of an anxiety disorder, and recorded suicide attempts. The three selected measures of mental health are based on clinical diagnosis or recorded suicide attempts, with no inclusion of child or parent reported measures of mental health.

The recorded measure for 'mood' assesses the presence or absence of a full clinical diagnosis of a DSM-5 mood disorder (e.g. major depressive disorder or persistent depressive disorder). Children are divided into binary categories based on whether they have ever had such a clinical diagnosis. The measure for 'anxiety' captures the presence or absence of a full clinical diagnosis of a DSM-5 anxiety disorder (e.g. social anxiety disorder, panic disorder, generalized anxiety disorder). Children are again categorized based on whether they have ever had such a clinical diagnosis. The measure for 'suicide attempts' is a binary variable noting whether or not a child has a recorded suicide attempt in their history. 49.3% of the sample (303) had been diagnosed with a mood disorder; 33.2% (204) of the sample had been diagnosed with an anxiety disorder; 10.7% (66) of the sample had a recorded suicide attempt.

Four major categories of data limitation are identified that are relevant to assessing mental health status. These include 4) combining research with clinical assessments 5) the absence of child or family perspectives on mental health 6) the absence of data on euphoria and 7) the absence of data on gender minority stress. These limitations may curtail the ability of the reviewed study to effectively assess the relationship between social transition and mental health.

### Combining research with clinical assessments

The reviewed research study extracts data on mental health from assessment forms that are completed as part of a clinical assessment pathway. The conflation of clinical assessments with data collected for research purposes raises two concerns. Firstly, there is a potential for individuals to provide inaccurate reporting on

mental health in clinical assessments. Within trans communities there is an understanding that, in order to be eligible for medical transition pathways, trans youth need to demonstrate at assessment a certain amount of distress—the ‘Goldilocks’ level of distress (Pearce, 2018). Too little distress and an individual may be deemed un-needing and therefore ineligible for medical transition. Too much distress and an individual may be deemed to have acute mental health issues and therefore either ineligible for medical transition, or subject to additional delays (Ashley, 2019c). In my experience service users are very well aware of this pressure to present a medium level of distress, providing an incentive to misreport or selectively omit information from their introductory assessment. For this specific assessment, trans children and families may have an incentive to down-play clinical levels of depression or anxiety, in order to ensure eligibility for medical transition. Likewise, there is a potential for trans children and families to avoid disclosure of suicide attempts, lest such a record creates a barrier or delay to accessing medical transition. Utilizing clinical assessment data for wider research purposes raises the potential for inaccuracy. Data is arguably more reliable in research where participants know with confidence that sharing accurate information with a researcher will not impact on their access to healthcare. Data accuracy alone is a reason to scrutinize research claims drawn from clinical assessment data. A second concern with merging clinical assessment with research is ethical, raising questions of research ethics, research coercion and informed consent for research. Participation in ethical research ought to be based on informed consent (Hopwood, 2021). Where participation in research is compulsory for access to healthcare, or where clinical data is routinely used for research purposes, individuals are not able to provide informed consent for participation in such research (Adams et al., 2017). Conflation of clinical assessment with research raises significant concerns, with repercussions for data accuracy, research ethics, informed consent and child and service user healthcare rights.

### ***The absence of child or family perspectives on mental health***

The reviewed study does not include any self-reported child or family perspectives on current mental health, an omission that brings with it a number of limitations. Firstly, the study design chooses to center whether or not a child has had a clinical diagnosis of anxiety or depression. This could mean that a child who has in the past received a diagnosis of depression is classified as having poor mental health, even if their current mental health has improved, as the earlier diagnosis will not disappear from the clinical record. An individual who has historically experienced and been diagnosed with anxiety or depression, could be inflexibly grouped alongside those with current anxiety or depression. This limitation is a consequence of the study’s design elevating clinical assessment and diagnosis above patient self-report, entirely erasing patient voice or patient perspective on current mental health. Secondly, the study does not capture any data on sub-clinical-diagnosis levels of mental health, narrowing the focus to only consider clinical levels of mental health distress. The study also excludes data on suicidal ideation, focusing only on recorded suicide attempts. Based on this design, a reduction in suicidal ideation would not be counted as an improvement in mental health. Finally, the study takes a static view of mental health, without consideration of relative mental health over time. This is a significant limitation, excluding perspectives on how mental health has changed pre or post social transition, issues that are of significant interest for those studying the relationship between social transition and mental health.

### ***The absence of data on euphoria***

The reviewed study only considers three measures of mental health, all of which measure negative aspects of mental health (depression, anxiety and suicide attempts). The reviewed study does not give space to any consideration of positive areas of mood or mental health, excluding any focus on happiness. Within trans communities, euphoria is increasingly talked about as a key driver and

benefit of social transition, with trans people emphasizing the joy and happiness that can come with living authentically in your affirmed gender (Horton, 2023a). The decision to only focus on clinically acute levels of mental health distress or suicide attempts centers a cisnormative framing, assuming social transition must be justified as an escape from extreme distress, rather than a positive step toward happiness and self-actualization. Within trans communities this negative framing of trans lives is being challenged, calling for greater consideration of trans joy and gender euphoria (Shuster & Westbrook, 2022).

### ***The absence of data on gender minority stress***

The reviewed study examines mental health status without including any data on gender minority stress (GMS). The gender minority stress framework acknowledges the specific stressors that trans people experience when navigating a cisnormative and cis-supremacist world, with these stresses known to contribute to mental health differentials (Hendricks & Testa, 2012). Research on trans child mental health needs to take into account experiences of gender minority stress as an important variable (Chodzen et al., 2019; Hatchel et al., 2019; Hunter et al., 2021). Research, such as the reviewed study, that fails to account for gender minority stress is arguably limited in its ability to speculate on links between social transition and mental health. Within the gender minority stress framework, ‘disaffirmation’ is recognized as a specific stressor, acknowledging the stresses and related mental health burden of trans people whose gender is not being affirmed. ‘Disaffirmation’ is a stressor affecting trans people who have not disclosed their identity, trans people who are misgendered and trans people who face barriers to being able to socially transition (Testa et al., 2015). Under the GMS model it is recognized that experiences of disaffirmation, including chronic disaffirmation over a prolonged period, or disaffirmation from critical caregivers, impacts on mental health. Research on the relationship between social transition and mental health would be wise to consider experiences of disaffirmation as a pertinent aspect of gender minority stress.

An additional concern relates to the potential for misdiagnosis of mental health conditions. There is the potential for stresses related to non-affirmation or gender minority stress to be mis-diagnosed as broader anxiety or mood disorders. A growing body of literature has critiqued the potential for bias in the mental health diagnoses applied to minoritised groups (Asadi et al., 2023; Rodriguez-Seijas et al., 2021; Rodriguez-Seijas, Morgan, et al., 2023; Rodriguez-Seijas, Rogers, et al., 2023). Researchers have argued that mental health, mood or personality disorders can fail to recognize the impacts of the minority stress that marginalized populations face, “labelling... arguably expectable reactions to structural inequities and stressors as blemishes of individual character” (Rodriguez-Seijas, Rogers, et al., 2023, p. 29). Analysis that focuses only on anxiety and depression, without consideration of minority stress, may fail to effectively understand the drivers and triggers of distress. Research that incompletely understands distress may be unequipped to take effective action to improve mental health. Efforts that seek to tackle distress at an individual level can be ineffective where drivers and triggers of stress operate at a group and societal scale, as is the case for many aspects of minority stress (Ashley & Domínguez, 2021).

### ***Study conclusion on the link between social transition and mental health***

The reviewed study conducts statistical analysis to see whether social transition status or name change is significantly correlated with the three prioritized measures of mental health (holding a diagnosis of an anxiety or mood disorder or having a recorded suicide attempt). The reviewed study finds no significant correlations, concluding that “social gender transition is not associated with mental health status in children and adolescents” (Morandini et al., 2023, p. 1058). This conclusion contrasts strongly with the findings of studies that centered child voice and child and parent reported data, where positive mental health benefits are reported.

Within this critical review article a range of study limitations have been identified, which call into question the reliability of the stated

conclusion. Several of the identified limitations relate to a reliance on and prioritization of clinician perspective and clinician reported data. Focusing only on possession of a clinical diagnosis at point of clinical assessment adds a significant limitation to the research's ability to assess current mental health and well-being. Combining clinical assessment with research data collection brings in a potential for bias, whilst also raising questions on research ethics. Concerns about research ethics are particularly weighty for trans children, a group with a long history of clinical abuse and medical coercion (Horton, 2022c), and a group who currently face high levels of institutional violence and discrimination (Abreu et al., 2022). In the reviewed study, the authors claim their study adds value explicitly because of the absence of child and parent report, reducing "the risk of social desirability bias" (Morandini et al., 2023, p. 1048). This claim highlights potential clinician paternalism, proposing that individual self-knowledge and self-reported well-being is less valid or more biased than clinician measured mental health.

A larger group of limitations relate to the exclusion of child perspective and the omission of child or parent reported data. The reviewed study lacks child or parent voice, avoiding children's views on social transition or name change, and omitting child or parent insights on mental health and well-being. It does not value child perspectives on social transition, failing to listen to their experiences. This exclusion leaves the study uninformed on issues such as a child's ease of social transition, how safe and supported they felt before or during social transition, or their experience post social transition. The study does not inquire about trans children's experiences of gender minority stress or euphoria. Ignoring child voice erodes aspects of social transition that are commonly raised in child-centered qualitative research, important context that is likely to be relevant to mental health and well-being. Each of these limitations hold consequences for the research, narrowing and restricting the capacity of research to authentically understand factors influencing trans child health and well-being.

## Discussion

Within healthcare, patient reported outcome measures are designed to effectively capture patient experiences and perspectives (Krogsgaard et al., 2021). Research relying exclusively on clinician recorded data, in studies exclusively designed and managed by clinicians, carries a risk of misunderstanding or misrepresenting service user experiences. Within trans healthcare there is a long and painful history of cis clinicians misunderstanding, speaking over, or outright contradicting trans service users in research conducted on, but not with, for or by trans communities (Ansara & Hegarty, 2012; Bryant, 2006). Trans children have long experienced pathologisation, bigotry, bias and abuse under the banner of research (Marrow, 2023; Pearce, 2018; Sitas et al., 2023). There is arguably an even bigger duty of responsibility in pediatric trans healthcare to ensure reported research findings align with, and do not misrepresent trans children's experiences. In data of this nature, on the link between social transition and mental health, erasure of child voice increases the risk of research presenting conclusions at odds with participant perspectives. In this context it is even more important that research is designed to value and prioritize trans children's views.

Researchers and clinicians working with trans children also need to recognize and take into account the context in which they are publishing and disseminating research findings (Ashley & Domínguez, 2021). Pediatric trans healthcare, and trans children's rights more broadly, are under pressure around the world (Abreu et al., 2022). Trans people, and particularly trans children are facing increasing political, media and legislative attacks on trans rights in a growing 'moral panic' and 'culture war' (Pearce et al., 2020). The topic of social transition has become an area of significant anti-trans focus, with politicized efforts to deny trans children's right to social transition (Wakefield, 2022; Williamson, 2023). Arguments against social transition are undermined by the existing evidence base, the majority of which reports positive benefits of social transition, as outlined in part one of this article. The study examined in part two of this article, is one of two studies that report neutral

impacts of social transition. This study (Morandini et al., 2023), and its reported conclusions, has already had a powerful impact on policy and discourse toward trans children in the UK. It was cited as the key evidence that social transition has no mental health benefits in a briefing produced to advocate against support for trans pupils in schools (Transgender Trend, 2023). That briefing in turn provided a key reference in a major newspaper editorial arguing against a ban on conversion therapy (Observer Editorial, 2023). In a trans-hostile political, legislative and media context it is even more important that ethical researchers, reviewers and editors ensure research conclusions are accurately supported by data. This needs to encompass effective scrutiny of the data underpinning the analysis, and careful reflection on study limitations, with identified study limitations directly influencing the way study conclusions are communicated. In this case, the research design excluded child and service user voice, and the study's conclusions diverged from the findings of studies based on child and parent reported data. In this situation, there is arguably greater ethical cause for reflection on study limitations, and scrutiny of the potential validity of research conclusions. Within the current context of politicized attacks on trans healthcare, ethicists have argued that researchers, editors and publishers have a duty of care to trans communities, ensuring research conclusions clearly acknowledge study limitations, reducing the risk of research being weaponised to harm vulnerable populations (Ashley & Domínguez, 2021).

### **Implications for practice**

This article challenges the omission of child voice in pediatric trans healthcare research and publications. It calls for a collective raising of ambition and expectations of acceptable research practice. Many of the limitations of the reviewed study can be overcome very simply—by listening to trans children on their thoughts on name change and social transition, by centering the measures of well-being, social transition and affirmation that are important to them. This

requires a power shift in clinical research toward research that values, respects and centers child voice. This paradigm shift toward approaches that listen to trans children also presents opportunities. There is a significant opportunity for active child engagement in healthcare research design, delivery and evaluation. This includes being accountable to trans children on what clinical research questions are important, on what outcome variables matter, and on what data sources effectively enable researchers to understand trans child experiences of health and well-being. There are opportunities to learn from initiatives in Patient Reported Outcome Measures (PROMs) that are underway in other areas of healthcare, with scope for innovation and excellence in pediatric trans healthcare. There is also potential to actively challenge and turn on its head trans healthcare's legacy of clinician coercion and abuse of trans research participants. This can be addressed through a high commitment to ethics, learning both from trans research ethics, and from best practices in child rights centered research (Adams et al., 2017; Alderson & Morrow, 2022; Lundy & McEvoy, 2012; Vincent, 2018).

The study reviewed in this article highlights the limitations and consequences of research that erases, omits or disregards child and service user voice. Within pediatric trans healthcare research we need as a field to acknowledge the unacceptability of clinical research that omits or marginalizes child perspectives. We need to raise our expectations and commitment to trans healthcare research that is accountable to trans children. Pediatric trans healthcare needs to prioritize effective and trustworthy listening to trans children across all areas of healthcare design, research and delivery.

### **Limitations**

This critical review article presents one perspective on the limitations of clinician reported data. Further research in partnership with trans children would be valuable to explore what outcome measures related to social transition are considered most salient and informative by trans children.

## Conclusion

This article provides a critical review of existing literature on the relationship between social transition and mental health in trans children. Existing research from community based quantitative studies, qualitative studies, retrospective studies and comparative studies reports important mental health benefits. Research from two clinical studies reports neutral impacts of social transition on mental health. Critical examination of one of these clinical studies highlights a range of study limitations linked to the omission of child and parental voice. This article highlights the importance of critical reflection on the consequences of erasure, omission or side-lining of child and service user reported data. It calls for a paradigm shift toward child-rights centered research, where trans child perspective, voice and self-reported data are seen as essential to the effective design and delivery of service user-centered healthcare research.

## Disclosure statement

No potential conflict of interest was reported by the author.

## Funding

The author(s) reported there is no funding associated with the work featured in this article.

## ORCID

Cal Horton  <http://orcid.org/0000-0003-1944-4122>

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