

Role of Family Environment on Recognition of Diverse Gender Identities and Presentation to Care

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In 2018, the American Academy of Pediatrics recommended that all transgender and gender-diverse (TGGD) youth “have access to comprehensive, gender-affirming, and developmentally appropriate health care.”¹ In its position statement, The American Academy of Pediatrics acknowledges mounting evidence that gender-affirming medical care (GAMC) for TGGD youth improves health and developmental outcomes^{2,3} and describes the critical role that pediatricians play in diagnosing, supporting, and facilitating access to care for TGGD youth. Furthermore, the timing of presentation to care for peripubertal youth is critical because delays in care impact whether and to what extent a youth can benefit from treatment with pubertal suppression. Access to puberty suppression may have an impact not only on mental health outcomes, but also on the need for or type of future surgical interventions.^{4,5} It is vital that providers who care for youth understand the factors that impact youth’s timing of presentation to gender-affirming care so that we may facilitate timely access to GAMC for all youth, particularly those with intersectional identities that have an additional impact on access to health care.

In this issue of *Pediatrics*, Sorbara et al⁶ present a sequential mixed methods study, in which they explored and compared the care-seeking experiences of youth aged <18 years who

presented to gender-affirming care at an older age (≥ 15 years) with those who presented at a younger age (<15 years). Semistructured interviews with both youth and caregivers explored youth’s journeys to GAMC and familial and sociocultural supports and influences. The authors used qualitative themes to identify possible areas of discrepancy between the older and younger presenting youth; these themes were then translated into survey questions, which were administered to youth and caregivers. In the analysis, the authors found that family religious affiliation was associated with age of presentation to GAMC, and that, across all ages, there was asynchronous youth and caregiver recognition of TGGD identity, among other important findings.

Youth presenting at older ages were more likely to endorse a familial religious affiliation and cite their family’s religion as a reason for waiting to come out and were less likely to have a family member who identified as lesbian, gay, bisexual, transgender, queer, etc (LGBTQ+). The authors theorize that youth from more religious backgrounds may feel more tension between familial norms and their emerging diverse gender identities, whereas the presence of a family member who identifies as LGBTQ+ may facilitate communication and recognition of gender diversity. Curiously, the older-presenting youth were not only more likely to come out at a later age, but also to recognize their

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own gender incongruence at a later age, suggesting that the family environment may have an impact on the evolution of a youth's own identity formation. Because the authors note that previous literature has described an association between religiosity and transphobia,^{7,8} we wonder whether internalized transphobia could be the mediating factor between the family environment and the delay in a youth's own recognition of gender incongruence. Dialogue and partnerships between professionals serving transgender youth and communities of faith could help to forge relationships, normalize gender diversity as a phenomenon that occurs in all cultures, religions, and walks of life, and promote messages of acceptance.

In this study, the authors also provide us with a deeper understanding of timing of events in a youth's acknowledgment of their gender incongruence and disclosure of that incongruence ("coming out") with caregivers. Youth in both age groups experienced a median delay of nearly 2 years between their own recognition of gender incongruence and coming out to caregivers; in contrast, caregivers tended to view these events as occurring simultaneously. Both in clinical practice and in public discourse, we have heard caregivers report that their child's disclosure of gender incongruence was precipitous or "out of nowhere." Here we see evidence that this perceived abruptness is not a reflection of the youth's identity formation, but rather the timing of caregivers' insight into the youth's experience. This caregiver-youth disconnect illustrates why it is essential that research on the natural history of gender incongruence is not limited to caregiver report alone. Family religion was cited by many

youth as a reason for waiting to come out. If indeed family religiosity contributes to the delay between youth recognition and coming out to caregivers, this would further point to the importance of dialogue with communities of faith.

In this study, in which the authors seek to understand barriers to early presentation for GAMC, the most sobering findings pertain to what we can extrapolate about the youth who are not receiving care at all. As the authors recognized, their sample was predominantly white and of high socioeconomic status. Like in many other pediatric gender clinics at tertiary medical centers (our own included) Black people, indigenous people, and people of color are underrepresented. Those with intersectional identities, who are transgender and Black, indigenous, and/or of color, face particularly high rates of adverse health outcomes,^{9,10} and delaying GAMC until adulthood may further exacerbate these disparities. Further work is needed to better understand the barriers facing the most vulnerable individuals and to identify opportunities to improve access to care.

ABBREVIATIONS

GAMC: gender-affirming medical care

TGGD: transgender and gender-diverse

LGBTQ+: lesbian, gay, bisexual, transgender, queer, etc

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