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An examination of power in a triadic model of parent–child–pediatrician relationships related to early childhood gender development

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Abstract

In this paper, the authors introduce the Triadic Model of Pediatric Care, an innovative conceptual framework for pediatric practice with transgender and gender diverse children. The Triadic Model of Pediatric Care consists of three experts—pediatricians, primary caregiver(s), and children—who each possess unique insights, knowledge, and decision-making power. This model guides pediatricians to provide gender-affirming care that acknowledges children as experts of their own experience and worthy of bodily autonomy, while also working to ensure primary caregiver(s) have the information and support necessary to provide a safe and nurturing developmental environment for their child. The authors provide a recommendation for how the Triadic Model of Pediatric Care might be applied in a pediatric healthcare setting and conclude with a summary of the model's implications, limitations, and future directions.

KEYWORDS

child development, gender-affirming care, pediatrics, prepubescent, shared decision-making, transgender

INTRODUCTION

Numerous legislative attacks against trans youth rights in Texas, Oklahoma, Florida, and elsewhere across the United States position transgender and gender diverse children as objects to be controlled and subjugated by caregivers, medical systems, school systems, and legislative

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governing bodies. Articles in purportedly liberal media outlets including *The Atlantic*, *The New York Times*, and *The New York Times Magazine* also deny trans youth's agency by questioning whether they should have access to gender-affirming care (e.g., Bazelon, 2022; Hartocollis, 2015; Singal, 2018), whether puberty suppression is "safe" for youth (e.g., Twohey & Jewett, 2022), and whether teens should be allowed to explore their gender and sexual identities at school without parent or guardian knowledge or permission (e.g., Baker, 2023). Transgender and gender diverse children are at the mercy of the adults in their lives to determine whether and how they engage with their gender identity. The discourse that questions the very existence of trans children and if anything should be done to support them is harmful (Ehrensaft, 2016; Gill-Peterson, 2022). The medical system in the United States assumes that children, including transgender and gender diverse children, are developmentally incapable of steering their treatment and care (Gill-Peterson, 2018), leaving decisions related to gender-affirming care in the hands of a child's primary caregiver and pediatrician until the child reaches the legal age of medical informed consent in their state of residence.

In this paper we examine the constructed powerlessness of the transgender and gender diverse child. We propose reconceptualizing interactions in the pediatric healthcare context as a triadic child-primary caregiver-pediatrician relationship to facilitate early childhood gender exploration and shared decision-making related to social transitions. First, we review the current landscape of gender-related pediatric experiences for young children and their families. Next, we provide a conceptual framework for understanding interactions between the young child, their primary caregiver(s), and their pediatrician. We consider the influence of these respective roles on the triadic dynamic. Finally, we discuss the model's potential implications for gender-affirming pediatric practice.

TERMS AND POSITIONALITY

We use the language *transgender and gender diverse (TGD)* acknowledging that there are many terms (e.g., trans; transgender; gender expansive; genderqueer; gender fluid; gender non-conforming; nonbinary) used to describe gender identities that are expansive and subvert the oppressive, heteronormative gender binary. TGD is the term used by the World Professional Association of Transgender Health in their Standards of Care 8 (WPATH SOC 8; Coleman et al., 2022) and by the American Academy of Pediatrics in its publications and briefs (Rafferty, 2018). *Anti-trans*, or *transmisia*, refers to behaviors, attitudes, and beliefs that stigmatize and harm transgender and gender diverse people by denying their identities, existence, and worth (Planned Parenthood, 2023).

Gender identity is one's socially constructed (Butler, 1990) and felt sense of femaleness, maleness, neither, or both (Menvielle, 2009). *Gender expression* refers to how one performs their gender identity (Rafferty, 2018). *Gender role* refers to how others perceive one's gender (Reilly et al., 2019). A *gender transition* refers to a change in one's gender expression so that one's appearance and role align with one's gender identity (Priest, 2019). A gender transition may include a social, legal, and/or a medical transition.

A *social transition* refers to a change someone makes from living socially as the gender that aligns with the sex they were assigned at birth to another gender (Ehrensaft, 2016). Socially transitioning may involve changing one's name, pronouns, presentation (e.g., clothing, hairstyle, mannerisms, etc.), and a request that others use the person's chosen name and preferred pronouns. Social transitions are often the first step in a gender transition and allow people to live in the social environment with their authentic gender identity (Ehrensaft et al., 2018). Although frequently misrepresented in the media and in political discourse, no medical intervention is involved in a gender transition prior to puberty (Ehrensaft, 2016; Rafferty, 2018; Reilly et al., 2019).

A *medical transition* refers to the use of hormone therapy or surgery to align one's body with their gender identity (Claahsen-van der Grinten et al., 2021). Insurance and legal requirements for medical transitions vary by state. Access to life-saving gender-affirming medical care is mediated by certain privileged positions related to age, mental status, race, and socio-economic status (Rafferty, 2018).

A *legal transition* refers to changes made to one's identity documents (e.g., U.S. passport, birth certificate, social security card) such as gender marker or legal name updates. Legally transitioning varies by state. While all states allow legal name changes, many states do not allow minors to change their gender markers, posing significant barriers for TGD children and their families (Society of Research on Adolescence, 2023; Trans Families, 2020).

We use the term *primary caregiver* as an inclusive term that includes parents, stepparents, grandparents, guardians, foster parents, and any others who are primarily and legally responsible for taking care of a child. We use the term *pediatrician* as an inclusive term that includes medical doctors, nurse practitioners, and any other medical professionals who are licensed to care for children in the medical context. Although we focus on the primary care context, we encourage all providers to adopt gender-affirming practices.

In this paper, we focus specifically on the experiences of young children in pediatric contexts. We define *young children* as children who are *prepubertal or prepubescent*, meaning that puberty and its associated bodily and hormonal changes have not occurred (Call et al., 2021). Young TGD children are often left out of conversations related to gender care, and this omission has been justified by the fact that there is no need for medical interventions (e.g., puberty suppression, hormone replacement therapy, surgery) prior to puberty, and also by the assumption that young children are incapable of making decisions about their bodies, identities, and care (Dedding et al., 2015; Gill-Peterson, 2018, 2022; Olli et al., 2012).

To position ourselves in this work, we disclose identities that are relevant to this subject matter. All three authors are parents, two authors are white, non-Hispanic, and one author identifies as a person of color. One author identifies as queer and two authors identify as non-queer. Two authors are social work researchers, and one author is a public health researcher.

CURRENT LANDSCAPE OF GENDER AND PEDIATRIC EXPERIENCES

Gender and children

For families who assume their child is the gender that corresponds with the sex they were assigned at birth, their child's announcement of a different gender identity can be unexpected and unsettling. Primary caregivers' concerns related to early childhood gender vary by culture (McGuire et al., 2016). Families in North America seek referrals to gender clinics at earlier ages than families in Europe, suggesting different intervention philosophies across various continents and societies (Aitken et al., 2015; McGuire et al., 2016). As with many unexpected emotional and behavioral quirks related to child development and milestones that arise periodically (e.g., "unusual" behaviors; picky eating; sleep irregularities), many families in the United States first turn to their pediatrician for guidance (Allen et al., 2019; Rafferty, 2018; Weiselberg et al., 2019). In the context of gender development, some families do not seek guidance, but simply wish to alert their pediatrician of their child's pronouns. Regardless, pediatricians often play an important supporting role in caring for and raising children, and many families have close relationships with their children's pediatricians.

A family's initial interaction with a pediatrician regarding their child's gender exploration has substantial implications for the child's mental and physical health and wellbeing (Durwood et al., 2021; Ehrensaft et al., 2018; Rafferty, 2018). It may influence the approach and extent to

which families affirm (or deny) their children's self-expressed gender identity for years to come. However, pediatric messaging related to gender identity is inconsistent (Ehrensaft, 2016). Medical providers tend to lean heavily on professional judgments and adhere to (outdated or ill-defined) clinical practice guidelines, resulting in care that often fails to be gender-affirming. The absence of gender-affirming care may lead to adverse outcomes for TGD children and their families, including mental health concerns (Allen et al., 2019; Ehrensaft, 2016) and higher rates of acute care encounters (Lillemoe et al., 2023). Studies with transgender adults suggest that gender-related discrimination leads to lower healthcare utilization overall (Kcomt et al., 2020). As a result of poor guidance, family wellbeing and cohesion may also be impacted as families and TGD children are likely to face increased stigma, victimization, social isolation, and low self-esteem (Bhattacharya et al., 2021; Jelinek et al., 2020; Katz-Wise et al., 2022; Rafferty, 2018). Understanding the processes influencing the wellbeing of TGD children is essential because their mental health outcomes are staggering—82% of transgender youth have had suicidal ideation, and 40% of transgender youth have attempted suicide (Austin et al., 2022).

Growing evidence suggests that a gender-affirming and supportive home and community environment has a positive influence on a TGD child's emotional and behavioral health (Bariola et al., 2015; Katz-Wise et al., 2022; Kuvalanka et al., 2014; Morgan et al., 2022; Olson et al., 2016; Puckett et al., 2019). When family members, and particularly primary caregivers, support their child and accept their gender identity, the TGD child's emotional and behavioral health is positively impacted (Durwood et al., 2021; Ehrensaft et al., 2018; Katz-Wise et al., 2022; Kidd et al., 2021). Studies show that support from primary caregivers is the strongest protective factor against adverse health outcomes for TGD children (Bariola et al., 2015; Mustanski et al., 2011; Olson et al., 2016; Puckett et al., 2019; Veale et al., 2017), and children who live in gender-affirming homes and communities experience significantly lower rates of suicidal ideation and substance use, and higher self-esteem (Ryan et al., 2010). Barriers to developing caregiver acceptance and support include a lack of understanding about gender diversity (Riley et al., 2011), traditional social norms that deny or invalidate transgender people (White Hughto et al., 2015), a sense of overwhelm and isolation (Sansfaçon et al., 2018), a concern for raising a gender diverse child in a cisnormative environment (Wagner & Armstrong, 2020), and an assumption that their child's gender diverse identity is merely a phase (Ehrensaft, 2016; Hill & Menvielle, 2009; Priest, 2019).

Although gender identity is not fixed and may shift at any point in a person's life (Bakker, 2014; Jackson et al., 2022; Klink & Den Heijer, 2014; McGuire et al., 2016), gender identification and categorization in young TGD children is on pace with non-transgender peers. Child development experts have long held that gender identification and categorization is most salient between the ages of 3 and 5 years old (Fast & Olson, 2018; Gülgöz et al., 2019; Jackson et al., 2022; Katz, 1986; Olezeski et al., 2020; Ruble et al., 2006). In the same way that non-transgender children are given autonomy to be who they believe themselves to be, without needing to constantly defend their existence and explain how and why they are who they say they are (Ahmed, 2016; Rafferty, 2018), TGD children deserve that same level of acceptance. It is important for families to provide all children with safe spaces to assert their identities from a young age. Providing support for children to assert their identities allows them to grow into healthy and happy human beings. It also allows children to build trust in their caregivers and develop self-confidence.

The liberated/infantilized child

In the United States, legal and policy frameworks, educational systems, social norms, and adults including parents, teachers, and caregivers, hold more power and decision-making authority than children (Gill-Peterson, 2018; Gill-Peterson, 2022; Luse, 2023). Children have

limited legal rights, are dependent on adults for their basic needs, care, and protection, and have limited access to resources. Children deserve and require safety and varying degrees of protection enforced by institutions. For example, teachers and social workers play a vital role in protecting children's wellbeing at school by addressing bullying or abuse, promoting mental health awareness, and ensuring access to appropriate resources when needed. Hospitals and pediatric clinics protect children's health by providing preventative care, immunizations, and access to appropriate medical treatments. Yet some institutional norms intended to keep children safe currently lag behind scientific evidence and changing social values. Schools may continue to use outdated approaches such as zero-tolerance policies or simplistic disciplinary measures to address bullying in school, despite evidence of their limited effectiveness. Similarly, depending on cultural and ideological influences, schools and health institutions may still rely on outdated abstinence-only sex education messaging despite clear evidence in support of comprehensive and inclusive sex education. By constructing children as vulnerable and dependent, we fail to recognize the agency that they *do* have, and the ways in which they actively confront and subvert power structures and social norms (e.g., cutting their own hair, requesting the use of different pronouns).

We, the authors, see the child as liberated, not yet burdened by the layers of normativity shouldered by adults. Gender normativity and stereotypes are acquired, layered on over time. Young children are perceptive and develop an early, learned awareness of gender; studies suggest that children demonstrate gender labeling between 24 and 36 months (Etaugh et al., 1989; Gelman et al., 2004; Leinbach & Fagot, 1986; Oлезeski et al., 2020; Thompson, 1975; Weinraub et al., 1984). However, children also exercise a degree of authenticity that is likely to erode over time unless given the space and support to cultivate and protect their agency and sense of self. When children are not affirmed in their gender identity, this impacts their sense of self and ability to continue to assert their identity with confidence (Ehrensaft, 2016). A TGD child embodies liberation when they claim their true identity and advocate for themselves when the adults around them (e.g., primary caregivers, providers) misjudge their gender at birth based on an inspection of their genitalia. In some cases, children correct others from the time they can talk (Kupalanka et al., 2014). When a child corrects adult figures in their lives, it represents an undermining or upheaval of the status quo and suggests that adults are wrong in assuming and exercising control over children as though they are property (Gill-Peterson, 2022).

Recognizing Zaman and Anderson-Nathe (2021) work on queering developmentalism, and Stockton (2009) concept of queer development as "growing sideways," we concur that developmentalism, a concept rooted in post-positivist psychology, is a teleological construct that delineates a start and end point. Children are seen as incomplete until they reach and align with the culturally bound and desired end markers. Children who deviate from the normative developmental trajectory (e.g., "grow sideways") are pathologized, requiring varying degrees of medical and psychological intervention to get them (back) on track. We mention development in this paper as an anchor for readers and believe that straying from the normative gender path is a testament to a child's creativity and resilience and should be celebrated rather than stifled or corrected.

Medicalization and the infantilized child

Pediatric well-child visits with young children typically involve a physical examination of the child followed by a discussion between the pediatrician and primary caregiver, during which decisions are made regarding the child's health and wellbeing. Visits also include anticipatory guidance in which primary caregivers are asked about and given information related to child development and wellbeing (Reisinger & Bires, 1980). Transgender and gender diverse children have always been excluded from conversations about their own development and medical care

(Gill-Peterson, 2018). Moreover, the American medical establishment has historically and systematically undermined and even criminalized the bodily autonomy of those seeking care (Braine, 2020). Forced sterilizations in the early 20th century, coerced medical experiments with marginalized populations, and the criminalization of abortion are just a few examples of systemically imposed limitations and criminalization of bodily autonomy. These forces fuse through a shared root in medicalization to construct the powerless pediatric patient.

Medicalization is a form of control, related to Foucault's concept of biopower, which is the idea that bodies can be subjugated and populations controlled through their interactions with and reliance on medical institutions (Shilling, 2016). Medicalization withholds bodily autonomy from the child. TGD children's vulnerability is largely manufactured by medicine, which reduces "trans children to a problem of plasticity, rather than recognizing their personhood" (Gill-Peterson, 2018, p.197). Constructing TGD children as a plasticity problem enables medicine to justify manipulation of children's bodies. For white transgender children, this means becoming a living experiment, subjected to various theories and interventions intended to alter human phenotypes related to gender and sex (Gill-Peterson, 2018). Meanwhile, Black and Brown TGD children are presumed to be "less plastic" and therefore precluded from receiving gender-affirming care, often subjected instead to carceral systems (Gill-Peterson, 2018, p.197). Black children and other racially minoritized youth experience increased health disparities compared to white children resulting from ongoing racism in medicine (Flores, 2010). Notably, when the authors advocate for improved gender-affirming care for young children, we refer to *all* children.

CONCEPTUAL FRAMEWORK: THE TRIADIC MODEL OF PEDIATRIC CARE

As a result of the infantilized child, decisions relating to a child's being and body essentially become a dyadic negotiation between the pediatrician and primary caregiver, sometimes referred to as *shared decision-making*. Shared decision-making is a core-tenet of client-centered care and has more recently become common practice in medicine (Jordan et al., 2020). When used in pediatrics, however, little space exists for the recipient of the care—the child (Jordan et al., 2020). When we apply the shared decision-making framework to pediatrics with the intention of including the child, a triadic relationship emerges.

In the child-primary caregiver-pediatrician triad, we conceptualize decision-making as a three-way conversation in which each triadic participant contributes their expertise (e.g., child's sense of their identity and body; provider's knowledge of medicine and child development; primary caregiver(s)'s broad knowledge of their child's medical, social, and environmental history and context). There may be multiple primary caregivers and providers (e.g., pediatrician, nurse, medical assistant) present at a given pediatric visit; the triad represents the three broad categories of stakeholders involved in a child's health care.

For the conversation to be truly triadic, we must de-pathologize a child "growing sideways" (Stockton, 2009). This includes queer and TGD children, and it also includes neurodivergent, disabled, and young children whose voices are routinely and systematically undermined to a greater extent than those of children whose development follows a more linear and normative path (Dedding et al., 2015; Olli et al., 2012; Williams et al., 2022). Novel gender-inclusive developmental models offer potential approaches to de-pathologizing sideways children. For example, Riggs (2019) proposes a critical developmental approach to gender development in which no distinctions are made between transgender and non-transgender development. Jackson et al. (2022) propose a development model in which individuals self-categorize their gender throughout childhood and into adulthood. By queering development and practicing a Triadic Model of Pediatric Care, we encourage providers to explicitly invite the expertise of the child into the

medical interaction, and we reframe medicine as an approach intended to “fix” or “cure” patients to a preventive, supportive practice. There is nothing inherently pathological about gender diversity and expansiveness (Coleman et al., 2022).

The Triadic Model of Pediatric Care aligns with and expands upon two existing models: the Gender-Affirmative Care Model (GACM; Rafferty, 2018) and a triadic model by McCollum and Yates (1994) developed in the context of early childhood intervention. The GACM, developed by the American Academy of Pediatrics in collaboration with other transgender health experts, provides guidelines for healthcare professionals working with TGD children that focus on centering the child’s gender experience and assisting caregivers to do the same (Rafferty, 2018). The GACM prioritizes the individual’s self-identified gender and respects their gender identity as valid. Rafferty (2018) promotes a holistic approach to healthcare, suggesting that providers consider the needs of TGD children beyond medical interventions to include social, mental health, and other community supports, thereby counteracting the alienating and infantilizing experiences familiar to TGD children in the medical setting. McCollum and Yates’ (1994) triadic model intends to build competence and efficacy in parenting young children by helping parents to recognize the agency their young children possess.

We propose the Triadic Model of Pediatric Care (Figure 1) as a means for conceptualizing interactions between a child, their primary caregiver(s), and their pediatrician, with consideration of the structural factors that facilitate and limit these interactions. This model, specific to the pediatric healthcare context, outlines a practical implementation approach for providers and caregivers alike to create an affirming environment for TGD children (and therefore all children). The model can also be applied to other contexts and settings such as the school context (in which case the triad would be the child, primary caregiver(s), and teacher(s) or other school representative(s)). The arrows represent bi-directional communication between each stakeholder in the triad, meaning that the child, their caregiver, or the pediatrician can each initiate communication with any other member of the triad. Communication may also occur with the primary caregiver as an interlocutor between the child and the pediatrician (e.g., child talks to primary caregiver, primary caregiver relays conversation to the pediatrician; pediatrician

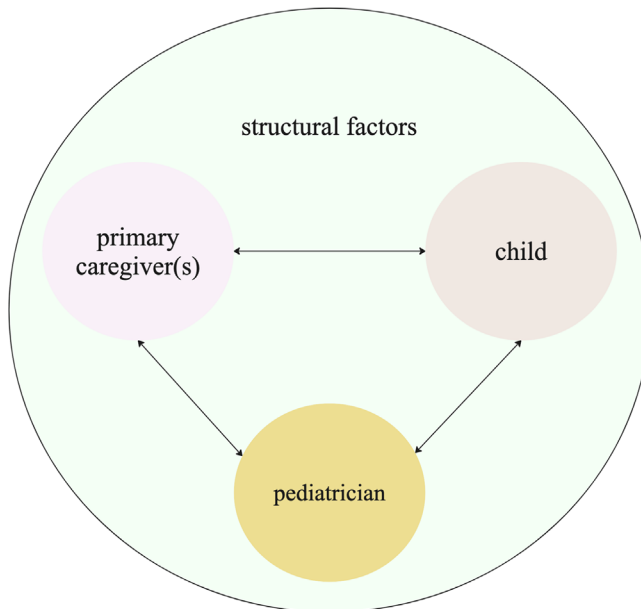


FIGURE 1 Triadic model of pediatric care.

talks to primary caregiver, primary caregiver relays conversation to the child). In the figure, the primary caregiver and the child are on the same plane, representing the family unit, whereas the pediatrician is outside the family unit, weighing in on aspects of the child's care. The triad is surrounded by a larger circle representing structural factors, such as state laws and policies, insurance coverage, media representation, healthcare systems, and education and training, all of which make it difficult for a child to assert their identity in the pediatric context and which influence whether and how pediatricians provide gender-affirming care.

Triadic roles: Primary caregiver as interlocutor/gatekeeper/ally

Children spend the most time in relationship with their primary caregiver(s) and in the family context. This specific child-adult context offers key opportunities for children to express agency (Gurdal & Sorbring, 2018) and make decisions with input and guidance from their caregiver(s). Thus, primary caregivers carry a responsibility for the long-term wellbeing of their children, and for young children, they wield significant power as gatekeepers (Dedding et al., 2015; Ehrensaft et al., 2018; Frasier et al., 2020; Olli et al., 2012). They may choose to help their child understand an emerging and felt identity by naming it, connecting the child to others who share that identity, reading related picture books to the child, seeking professional support, and leaving the door open for questions and conversation (Ehrensaft et al., 2018). Caregivers may also choose not to address the identity, perhaps taking a “wait and see” or “watchful waiting” approach, or they may choose to actively oppose the identity (Claahsen-van der Grinten et al., 2021; Ehrensaft et al., 2018; Rafferty, 2018). Such approaches are harmful to children because they fail to honor children's agency, withhold critical support, and emphasize a culturally-bound end goal that must be met rather than valuing children as they grow (Rafferty, 2018; Zaman & Anderson-Nathe, 2021).

Until a child is able to provide legal informed consent, primary caregivers act as gatekeepers for many aspects of a child's participation in society, managing access to medical care, affinity groups, and other resources and support (Dedding et al., 2015; Olli et al., 2012). The primary caregiver also facilitates medical interactions to varying degrees, seeking out care, setting up appointments, and facilitating or limiting access to specialty providers. Primary caregivers direct almost every aspect of a young child's life and often act as liaisons with others (Dedding et al., 2015; Olli et al., 2012).

Due to structural factors and power differentials, children enter the triad with significantly less power than their primary caregivers. As a result, the degree of affirmation or rejection a child receives is highly influenced by their caregiver. For example, children likely do not have a choice in who they see and may be forced to contend with a provider who does not practice gender-affirming care. Relatedly, in states that ban gender-affirming care for minors, a child's ability to access gender-affirming care is dependent on whether their caregiver is willing and able to travel out of state to access care. For primary caregivers who wish to affirm their TGD children, such bans impose a significant loss of power for both caregiver and child, whereas caregivers who do not want to affirm their children's gender identities may experience a gain in power, at the child's expense.

Triadic roles: Pediatrician as medical expert/gatekeeper/ally

Pediatricians are typically involved in anything medically related to the child—in the context of school (e.g., diagnoses are required for IEP and 504 education plans, doctor's notes are required for missing attendance and physical education accommodations), legal status (e.g., some states require a physician letter to change gender markers and names on birth certificates), access to

specialty care (e.g., referrals to mental health services, gender clinics, etc.), and more. The pediatrician is an essential factor in the endorsement or prevention of a child's gender transition (Coleman et al., 2022; Ehrensaft et al., 2018), yet in many cases pediatricians may miss opportunities to facilitate acceptance and understanding among caregivers and family.

Many families conceptualize their pediatrician as an ally—someone who advocates for the family and child and provides guidance and support. Families often intentionally seek out pediatricians who share similar values related to medication usage, immunization practices, religiosity, gender, and more. The pediatrician is guided by their training, values, and beliefs. They also adhere to licensing requirements and follow clinical practice guidelines. Their professional identity and expertise in medicine carries a degree of power that they must examine and carefully navigate as part of the triadic relationship.

Recognizing the impact of structural factors, we also acknowledge the powerlessness that pediatricians may experience because of gender-affirming care bans enacted in 19 states (Reed, 2023). The legal constraints pediatricians face in states with anti-trans laws undermine their expertise and prevent them from providing comprehensive and evidence-based care. As a result, they are likely to witness first-hand the detrimental impact such policies have on the mental and physical health of TGD children and youth with little agency to affect change.

Triadic role: The empowered child

The child completes the triad and is their own expert. By including the child in the triad, we trouble the notion that children possess agency only when adults determine that children have developed the capacity to have forethought and be intentional, self-reflective, and self-reactive (United Nations, 1989). Such interpretations of agency typically deny disabled and/or young children power, by assuming that their autonomy and cognitive competence are inadequate (Olli et al., 2012). In the proposed Triadic Model of Pediatric Care, the pediatrician and caregiver recognize a child's power to decide when and how they would like to participate in decision-making related to their health.

APPLICATION OF THE TRIADIC MODEL OF PEDIATRIC CARE

To further conceptualize the Triadic Model in the context of pediatric healthcare encounters related to gender identity assertion and affirmation, we modify a framework developed by McCollum and Yates (1994) in the context of early childhood interventions to fit the pediatric context (see Table 1). McCollum and Yates lay the groundwork for child-centered and involved care, focusing primarily on the caregiver's concerns and roles because their framework primarily deals with parent-child relationships from birth through age three. Our modified framework focuses on creating an affirming environment for TGD children (and therefore all children), and it aims to equip primary caregivers with the tools they need to provide optimal support for their children. This framework is most effective when implemented not only by the pediatrician, but also by other clinic staff (e.g., front desk staff, medical assistants, nurses, social workers).

To ensure that the approach is child-centered, we suggest that pediatricians encourage primary caregivers to consider how the child is feeling and what they are experiencing by providing prompts such as, "What do you think it was like for your child to tell you their gender identity?" and "What do you think your child needs right now?" The goal is to empower the parent to feel competent and equipped to provide an environment for a child to safely explore their identity and create space for the child to gain self-efficacy and autonomy in their identity development. Importantly, the pediatrician should also allow children to express their feelings and experiences. Children should not be expected to consider how their caregiver is feeling, nor

TABLE 1 Modified framework for creating a gender affirming environment for TGD children.

McCullum & Yates (1994)	Proposed adaptations
1. <i>Establish a supportive context.</i> Elements of the environment are arranged or rearranged by the interventionist to increase the probability of playful interaction.	1. <i>Establish a supportive context.</i> Elements in the environment reflect inclusivity and open-mindedness (e.g., a “library” shelf with children’s books representing a wide range of identities and experiences; a reference bookshelf with inclusive parenting books; inclusive images on walls; gender-neutral bathrooms).
2. <i>Acknowledge parent competence.</i> Developmentally facilitative behaviors of the parent are warmly recognized and expanded, as are characteristics of child competence.	2. <i>Acknowledge parent competence and child’s agency and resilience.</i> Relay to primary caregiver(s) what is going well in their parenting approach with their child (e.g., observation, reflections regarding positive aspects of the dyadic relationship). Relay to the child that they are resilient, brave, and worthy.
3. <i>Focus attention.</i> Aspects of the interaction are commented on, questioned, or expanded in order to draw the parent’s attention to particular competencies or actions.	3. <i>Focus attention.</i> Recognize and validate the child’s perspective and self-knowledge. Identify caregiver(s) competencies and suggestions for change.
4. <i>Provide information.</i> Information about the child’s developmental agenda is given within the context of play.	4. <i>Provide information.</i> Information about gender development in children and gender-affirming strategies are shared with the primary caregiver(s) and the child.
5. <i>Model.</i> Dyadic interaction roles are momentarily taken on by the interventionist.	5. <i>Model.</i> Model gender inclusivity by sharing pronouns, asking the child and their primary caregiver(s) to share pronouns if they feel comfortable, using “they” language in instances when gender identity is unknown. Model affirming and open-minded ways of speaking with the child.
6. <i>Suggest.</i> The parent is given a specific suggestion as to what to do with the child.	6. <i>Suggest.</i> The primary caregiver is given suggestions for how to create a gender affirming home specific to the family’s current circumstances, as well as a list of resources tailored to the family’s needs.

Abbreviation: TGD, transgender and gender diverse.

should they be asked to explain or justify their felt gender identity, but they may be encouraged to ask questions and share their thoughts if they feel comfortable.

The primary caregiver(s) may have myriad valid concerns related to their child’s expression of their gender identity (Ehrensaft, 2016). It is important that concerns are addressed in such a way that shields children from shouldering caregivers’ sense of ambiguous loss (Coolhart et al., 2018), feelings of being blindsided (Ehrensaft, 2016), and resistance to moving through a transition too quickly (Ehrensaft, 2016). Ehrensaft (2016) refers to this as “de-centering,” which she describes as removing oneself from one’s own desires and needs to focus instead on the desires, wishes, and needs of one’s child. The pediatrician should proactively provide caregivers with a space and format to candidly explore feelings and acknowledge their concerns so as not to emotionally harm the child. This can be done by scheduling a separate visit or follow-up call, and by providing a list of parent–family support groups, parent–peer navigators, gender clinics, and therapists.

Relatedly, pediatricians should equip primary caregivers and children with resources and language related to gender identity. When offering anticipatory guidance, pediatricians have an opportunity to provide caregivers the support and resources needed to assist them and their children in recognizing their agency and self-knowledge. They can connect caregivers with community resources and relevant reading materials so that caregivers can continue to process

and learn, without placing the onus of that process on their child. Pediatricians should also provide developmentally appropriate resources for children (e.g., books, digital media, gender expansive playgroups) to promote inner-resilience and self-advocacy. Pediatricians are trained to support families with countless complexities related to childrearing and development. By including gender-affirming care as part of the anticipatory guidance they routinely provide, pediatricians are uniquely positioned to validate children, dispel harmful myths, and foster community-building and resilience.

There may be instances in which not all triadic members are aligned—for example, the pediatrician and the child may be aligned, whereas the primary caregiver(s) expresses resistance (Frasier et al., 2020). In cases like this, the pediatrician can direct the triad to return to the collaborative premise of the model, which centers each triadic member's expertise and insights, in order to weigh the most appropriate and reasonable path forward. To resolve profound misalignments, pediatricians may consider involving a social worker or other mental health professional trained in supporting family systems to assist in creating a gender-affirming plan to support a TGD child.

CONCLUSIONS AND LIMITATIONS

The Triadic Model of Pediatric Care represents an innovative approach to pediatric care that has the potential to benefit all children by centering their voices and experiences in their medical care. The model recognizes the agency of children and the insights and value they bring to pediatric encounters. Each member of the triad shares their knowledge and expertise—the pediatrician's medical knowledge, the primary caregiver(s)'s knowledge of their child's medical, social, and environmental history and context, and the child's knowledge of their body and identity. True shared decision-making is not possible without each member's input.

The current legislative agenda seeks to deny gender-affirming care and bodily autonomy to gender minorities with a disregard for the implications this has on the lives of countless TGD children and their families. TGD children are systematically denied autonomy, agency, and power by the medical system, resulting in elevated risks for mental illness and suicidality (Allen et al., 2019; Austin et al., 2022; Jelinek et al., 2020; Katz-Wise et al., 2022; Rafferty, 2018). Gender affirmation is critical in ensuring physical and emotional wellbeing (Coleman et al., 2022; Rafferty, 2018). Children suffer when they cannot access gender-affirming health care and are excluded from decision-making about their bodies and healthcare. Subsequently, families and communities experience secondary stigmatization and trauma (Johnson & Benson, 2014).

We propose using the Triadic Model of Pediatric Care to empower prepubescent TGD children, calling on pediatricians and other professionals who provide care to children to incorporate the perspectives and expertise of the clinical provider, the primary caregiver(s) *and* the child in health care decision-making. By including children in conversations about their care, we affirm that TGD children are liberated and powerfully self-aware human beings who know themselves and courageously assert their identities, growing sideways (Stockton, 2009) and contradicting their caregivers' adherence to heteronormative conventions (Gill-Peterson, 2022). It is our duty as adults to help children feel competent and confident in who they are, so that they may avoid processes of conforming to normative culture and expectations and become self-actualized individuals.

In addition to being adopted by pediatric offices and teams, the Triadic Model of Pediatric Care also has the potential to be modified for application in other settings and contexts such as family therapy, child welfare, special education services, and specialty care clinics. Implementation of the Triadic Model of Pediatric Care is likely to benefit not only TGD children, but also disabled children and other children who are systematically silenced in medical care contexts.

The Triadic Model of Pediatric Care is a theoretical model, and empirical studies of its implementation and efficacy are needed, with the eventual goal of widespread adoption. In particular, research should identify effective strategies for mitigating misalignments between the triadic members. Other next steps include exploring how gender-affirming pediatric experiences affect healthcare utilization and overall health and wellbeing in adulthood, how provider training for LGBTQ+ populations can be improved, and how current guidelines for providing gender-affirming care to prepubescent children can be clarified so that pediatricians are better equipped to address gender diversity in young children.

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