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Appropriate Therapeutic Care for Families with Pre-Pubescent Transgender/Gender-Dissonant Children

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Abstract In recent years, a new phenomenon has been observed in U.S. culture, that of pre-pubescent children transitioning socially from one gender role to another, with the support of their families. As this phenomenon becomes more widespread, families, schools and other institutions will turn to mental health care professionals for guidance in navigating new territory. Such children have often been assessed for gender identity disorder; the traditional treatment plan for those so diagnosed included attempts to steer their gender behavior in more "gender-appropriate" directions. Allowing such children to self-actualize, viewing their behavior as indicative of innate identity, is a relatively new approach. This paper will focus on the social worker's or therapist's role in helping pre-pubescent children and their families, should the families decide identity actualization is the path they would prefer.

Keywords Transgender children · Gender identity · Identity emergence · Gender roles · Social transition · Gender dissonance · Gender variance · Childhood gender variance

Introduction

Since I began my clinical practice in 2001, I have worked with over 350 adults seeking physical transition from one sex to another. During that time, I have also experienced an increase in the numbers of parents seeking me out because they felt one of their children might be transgender. In addition to the work I've done with

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my adult clients in helping them come to terms with their childhood issues, the experiences I've had with these families have led me to expand my philosophy of transition to include the concept of supporting a model of identity actualization for transgender children.

To avoid cumbersome descriptive language throughout this paper, I shall use the term *trans* as an umbrella term to encompass various forms of transgender identity (though when quoting others I use their terminology). Physical transition is not necessary for a pre-pubescent child, whose hormones have not yet modified their bodies in the direction of adult male or female. "Transition" for children is a strictly social process, a change of gender role and possibly gender expression. For this reason, I conceptualize a pre-pubescent transition as *social transition,* distinguishing this process from the adult process, which usually includes medical interventions such as hormones and/or surgery.

Female-affirmed and *male-affirmed* are recent additions to the lexicon, proposed by various trans people in an attempt to create self-referential language that is descriptive and non-pathologizing. Female-affirmed is a term that replaces male-to-female, while male-affirmed replaces female-to-male. Using such terminology in referring to trans children allows recognition of the fact that these children have never identified as the gender assigned them at birth and are therefore not moving from one gender to another, but into an affirmation of the gender they have always known themselves to be.

At the root of my clinical philosophy is a conceptualization of gender identity as separate from sexual orientation. Who a person is attracted to is independent of whether they consider themselves men, or women, or some other gender. In many cultures, when a baby is born, the person doing the delivery pronounces the baby's sex upon a cursory examination of genitalia. In some cases, however, the maturing child's internal experience of gender identity does not match this sex assignment. Once such children attain the ability to communicate verbally, they may make pronouncements such as, "I'm not really a girl," or "Everyone just thinks I'm a boy, but I'm not." Some may state, "I'm not a boy or a girl, I'm not sure what I am." These experiences of identity lead to a form of cognitive dissonance referred to as *gender dissonance*: An experience of some degree of difference between body and identity, in the realm of gender (Vanderburgh 2007).

An experience of *gender dissonance* may or may not translate to what is commonly referred to as *gender-variance,* or what is perceived by others to be cross-gender behavior. A female-affirmed child may identify as a girl and still enjoy athletics, for example. Or, a male-affirmed child may identify as a boy, and still enjoy cooking. Much depends on the child's milieu. Has the child observed that many women/girls enjoy sports? Are there men in the child's life who enjoy cooking? Gender roles and the gender segregation of various activities are dependent on cultural and subcultural norms, thus making it impossible to use gender-variance alone as a red flag for possible gender identity issues or problems. Gender-variance is a cultural construct; the norm from which the behavior is varying isn't a constant from culture to culture, or from one time period to another within the same culture (Bartlett et al. 2000;

Hill et al. 2005; Langer and Martin 2004; Lev 2004; Vanderburgh 2007; Wilson et al. 2006).

Though not all such individuals grow up desiring to transition physically—many end up content with their bodily sex—the experience of consistent childhood gender dissonance is sometimes a precursor to adult trans identity (Lev 2004; Vanderburgh 2007; Zucker and Bradley 1995). In reminiscing about their childhood experiences, many trans adults will make statements such as, "I knew from the time I was a small child." One female-affirmed client, 53 at the time of transition, stated during session, "I knew I was a girl before I knew my age." Thus, though not all gender dissonant children will grow up feeling a need to transition physically, childhood gender dissonance is a common experience among those who do eventually transition (Lev 2004; Vanderburgh 2007; Zucker and Bradley 1995).

Gender Identity Actualization or Gender Identity Disorder?

There has been ongoing debate about the continued presence of gender identity disorder in the DSM (Diagnostic and Statistical Manual, currently undergoing its fifth major revision process) (Karasic and Drescher 2005). Homosexuality was removed from the DSM in 1973, and a gradual mainstream cultural acceptance of gay/lesbian/bisexual identities has followed from this depathologization (Lev 2004; Rudacille 2005). The continued presence of gender identity disorder in the DSM, however, also continues the pathologization of gender dissonance, as boys who exhibit what is considered "female behavior," or girls who completely reject femininity, are somehow suspect. The cultural nature of gender roles then becomes subsumed by the tendency to pathologize behavior that is seen as deviating from what is considered "natural" or "normal" gendered behavior. Yet a cursory examination of what has been historically considered "natural" gendered behavior reveals assumptions that seem ludicrous today. For example, in the late 19th century, a man who didn't smoke was seen as deviating from "normal" male behavior (Bartlett et al. 2000; Hill et al. 2005; Rudacille 2005).

In 21st century American mainstream culture, the gap between what is acceptable for male and female behavior is narrowing to the point that the DSM criteria for what is "male" and "female" behavior seem anachronistic and often inapplicable, particularly in progressive families that allow children free rein in choosing their modes of play and dress (Bartlett et al. 2000; Hill et al. 2005; Lev 2004). To assume that boys prefer contact sports, or that girls prefer playing with dolls—both DSM descriptions of "normal" male and female gendered behavior—could lead many a 21st century parent to wonder if their child might not be gender-variant. As Hill et al. (2005) points out,

> [S]tudies typically find an average difference on some behavior (e.g., boys on average are more aggressive than girls), but this focus on averages belies the vast overlap in the behaviors of the genders…. [T]here are individual differences in these tendencies such that any boy and any girl may fall anywhere along most dimensions (p. 11).

Further complicating the issue is the fact that children behave very differently when with their peers than in a clinical setting, or under their parents' watchful eye, where self-consciousness or the feeling of being "examined" may cause them to behave in a manner they feel will please the adults around them (Brill and Pepper 2008; Hill et al. 2005; Vanderburgh 2007). This possibility may be exacerbated if the child feels they have somehow disappointed their parents by not being "girl" or "boy" enough, or that a visit to "the doctor" is somehow a negative consequence of what feels like normal behavior to the child.

As if the issue were not complex enough, the maturation process toward "man" and "woman" evens out gender role expectations to a large degree. As Denny (2004) points out, "Almost everyone in the United States deviates from John Wayne/Marilyn Monroe gender norms in some way or another" (p. 30). Most men are not expected to participate in contact sports. Nor do most women feel pressured to spend their leisure time in feminine activities. One aspect of 21st century mainstream American culture is that few, if any, adult activities are gender-segregated. Why, then, hold children to a different standard of gender role than we hold adults (Hill et al. 2005)?

Beyond this double standard, it is also possible that children perceive gender roles as flexible because of the example of the adults around them, and possibly through receiving the overtly feminist message, "You can be anything you want to be, without limitation." Though an excellent life lesson, this message may feel hypocritical to a child if they are then criticized for their gender dissonance.

According to the DSM-IV, a person need only meet four of five diagnostic criteria to warrant a gender identity disorder diagnosis (American Psychiatric Association 2000). Thus, it is possible to be diagnosed with gender identity disorder without expressing a desire to actually change one's body, as this is only one of the diagnostic criteria (Hill et al. 2005). One prominent psychologist has suggested that such cases receive the diagnosis "gender identity disorder—not otherwise specified" (Zucker 1990, 1992). Many children may thus be labeled with a psychiatric disorder when in fact their only "pathology" is that they aren't fitting into their gender role well enough to suit the adults around them.

Established Treatment Modalities

Parents of gender-dissonant children seek help for different reasons:

- They may be unsure whether they are dealing with mental illness on the part of the child;
- They may be unsure whether there are actions they should (or should not) be undertaking to change their child's behavior/identity;
- They may be seeking resources and information to help them understand their child's identity;
- They may be seeking advocacy and advice about the social ramifications of their child actualizing a new gender role at school, or in extracurricular activities such as sports teams;

- They may be looking for professional support as they move forward with actualizing their child's identity.

The first decision for parents is, "What do we do about our child's apparent dissatisfaction with the gender we think they are?" Parents often ask questions such as: "Should we try to turn our child more into a girl or boy, or should we let them be? Is this a phase? Is our child gay, or lesbian? What is the right thing to do?" Note that the question, "Is our child transgender?" is not on the list of issues most parents initially raise. Most parents don't make the assumption their child may need to transition; the usual assumption is that they are raising a gay or lesbian child, reflecting the common misunderstanding that trans people represent some extreme form of homosexuality.

What parents most often encounter when they seek advice and clarification of the issues is a professional who has never worked with a trans client, adult or child (Vanderburgh 2007; Wren 2002). More often than not, such a professional seeks information by turning to the DSM and may end up pathologizing gender dissonance as a result. Some of the parents I've worked with, or communicated with via e-mail, have told me of attempts they'd made to find resources to help their children:

- A psychiatrist advised the parents of a happily female-affirmed teenager, "Just play more football with your boy, or enroll him in Cub Scouts, and he'll outgrow this phase." The child was 7 years old at the time, and her parents already knew that what they were observing was no phase. They had already attempted to introduce their child to a balanced array of toys and games, and knew the child had no interest in "male" activities or toys. When the mother asked the psychiatrist what would happen if they just went with the "female" behavior, the psychiatrist replied, "That could be dangerous for your boy's healthy development into a man";
- A child psychologist advised one mother to be more consistent in her gendered treatment of her 8-year-old male-affirmed child, that she should help steer the child in the direction of feminine behavior. The mother felt the psychologist was blaming her for her male-affirmed child believing himself to be a boy, because the mother had divorced the child's father and the two parents now had an acrimonious relationship;
- A pediatrician told one couple that their child (7 years old, female-bodied, with no intersex condition) would never be able to really "look like a man," or be seen as male, and therefore they should do all they could to help the child feel comfortable being female. The parents had (correctly) understood from various books and websites they'd accessed that female-to-male physical transition resulted in complete invisibility over time, that their child could attain full male gender expression as an adult. Understandably, they were confused by the information they received from the pediatrician. It was difficult for them to believe that a doctor would give them such erroneous information, yet what the pediatrician told them contradicted every other resource they had accessed.

Some mental health care providers attempt to find a middle ground—while rejecting that adult gay/lesbian identities are malleable via reparative/conversion therapy, at the same time, they also reject the existence of trans identities as legitimate, retaining a belief in the DSM model of pathologizing gender dissonance and trans identities in general. Under this model, clinicians hold the belief that gender identity is not innately fixed, but is malleable during childhood (Zucker 1992, 2000; Zucker and Bradley 1995). The clinical focus, then, becomes helping the child actualize various aspects of themselves while retaining their original gender assignment and role. The clinical philosophy underlying this approach is that it is possible to "nip it in the bud." The therapeutic approach is one of helping children adjust to their birth gender role, such that the gender-dissonant child grows up content to remain male or female.

This approach may work well with some of those children who are on a path toward being gay men, lesbians, or non-feminine straight women, or non-masculine straight men, though the question arises why it seems necessary to tamper so drastically with a child's gender expression as to send them to a therapist on an ongoing basis for that reason alone. However, the application of this clinical philosophy would be ineffective, and possibly dangerous, to the child who is indeed trans and retains their sense of trans identity into adulthood.

One prominent child psychologist who has worked with many children around issues of gender identity approached me after a presentation I made at a professional conference, challenging me, "If a child said he wanted to be black instead of white, wouldn't you question why that was?" I said I would, but I also challenge his analogy: that the desire to be a different gender is as much a delusion as the desire to be a different race. The logical inference from his analogy is that he does not believe in trans identity at all, believing rather that such an internal sense of self is a psychological pathology stemming from childhood experiences, not an issue of innate identity.

Rosenberg (2002) has stated,

> Clinical work often involves helping patients to find a reasonably happy and comfortable adaptation to reality, while retaining their hopes and fantasies, and to find a way to accept and express formerly secret selves. *Only in this area of gender dysphoria do we attempt to help patients by pretending to change reality. It is, after all, pretense because genetic gender is not changed.* [emphasis mine] (p. 620).

A therapist with this attitude sends the message to the client: "I don't believe you're trans, because I don't believe such identities exist."

It is possible that young trans clients working with such a therapist would later transition anyway, probably telling future therapists, "I worked with this one therapist who didn't believe me at all, and tried to help me adjust to my birth gender role, but it just made me feel unsafe and like I couldn't really tell him/her who I was." I have heard such statements many times from adult trans clients who had been sent (as children or adolescents) to therapists with this sort of approach. The therapy did not change their gender identity, but did send a message that therapy is something to be avoided. As Bartlett et al. (2000) points out, lack of acceptance

takes its toll as well: "It is unreasonable to expect that an enforced repudiation of one's gender identity and accompanying behaviors would cause anything but a great deal of distress" (p. 762).

One female-affirmed client, now 46, said bluntly, "I would not have called you if I hadn't known you were transgender yourself, not after how I was treated by the psychologist I saw when I was 14. I was willing to take a chance on you" *(Client session, 2004).* The psychologist she saw during her adolescence took a Jungian approach, attempting to help her embrace her masculinity, find the positive aspects in being male, while also encouraging her to explore the meaning of the strong femininity that had always been present in her. The client internalized the message that no one would ever believe her own experience of herself, which was completely female, and shut down emotionally for many years thereafter, trying to "cure" herself via joining the military, and later getting married and fathering several children.

Had this client been a male who was resistant to the idea of having strong feminine personality traits or behaviors, the therapeutic approach of accepting all aspects "his" true self might have proved beneficial. However, as a young trans person who knew her core self to be female and not male at all, the therapy was disastrous for her sense of self-esteem and self-efficacy.

Some children actualize a clear sense of "male" instead of "female" (or vice versa) from a pre-verbal stage. Other children's identities, however, are not so clear at young ages. The approach described above may work well for some children who fall into the "unclear" category. However, such an approach is clinically inappropriate for those children who are trans, who will be more harmed than helped by such an intervention, as was the case with the client mentioned above. Given that some of those "unclear" children will indeed grow up to identify as trans, and desire to transition, this "gender adjustment" model is not a useful one, as it may not be possible at a young age to determine which "unclear" children fall into this category, and which may find this approach helpful (Bartlett et al. 2000; Money and Lehne 1993). I have seen the aftermath of this approach in many of my adult trans clients, causing me to view such modalities as potentially harmful.

A more useful conceptualization (both to the family in general and to the child) is to hold the view that the child's gender identity is what it is, and to encourage self-exploration and self-acceptance rather than trying to steer their gender identity in any particular direction (Brill and Pepper 2008; Lev 2004; Vanderburgh 2007). There is nothing wrong with encouraging children to accept all facets of themselves, an inherent point in the "gender adjustment" therapeutic philosophy; the difficulty lies in the assumption on the part of the clinician that being trans is a matter of behavior and not core identity, and therefore children cannot be innately trans.

The importance of supporting a child's presenting identity is underscored by Coates and Person's (1985) finding of greater mental health issues in "gender-referred" boys age 12–14 than in those age 6–11. In addition to having lived with their gender dissonance for a longer period of time, the 12–14 year olds were also dealing with puberty affecting their bodies, as well as the social milieu of adolescence. Helping a child actualize their gender identity prior to the onset of

puberty may well mitigate many of the mental health issues found in various studies of child/adolescent gender dissonant individuals (Vanderburgh 2007).

Given that some gender dissonant children grow up to be gay or lesbian, no longer identifying as trans, what kind of message does it send the child if their behavior is a red flag to others, and lands them in a therapist's office? Many an adult gay man or lesbian spends some time dismantling feelings of shame and/or guilt, imbued by just such a response to their childhood attempts at actualizing their true identities (Hill et al. 2005; Kaufman and Raphael 1996). One former client of a prominent gender identity specialist describes how his early therapy experience affected him as an adult:

> I experienced this [rejection of my femininity] as a strong negative judgment about something I felt very deeply about myself, at my core. As a result, I think that the main thing that I took away from my years at [Green's gender clinic] UCLA was a kind of self-hatred and a loss of a sense of who I really was. I learned to hide myself, to make myself invisible, even to myself. I learned that who I was, was wrong (Hill et al. 2005).

Family Assessment

If a therapist wishes to move away from the pathologization of the DSM model, what model can they then follow in working with families with gender dissonant children? A model that follows the path of identity actualization rather than pathologization of behavior necessitates a paradigm shift on the part of the therapist. From assessment of behavior, one moves toward assessment of identity and family patterns that can affect identity actualization (Vanderburgh 2007).

The first step in working with families seeking services on behalf of a trans child is to assess the family structure for dysfunctionality. There may be various dysfunctional patterns on the part of the parents that could cause a child to behave in a manner that appears to be trans (Hill et al. 2005; Vanderburgh 2007; Zucker 2000). For example, narcissistic desires on the part of the parents for a boy and not a girl, or vice versa, could cause the child to behave in a manner consistent with the parents' desired gender, in a desperate attempt to win the parents' approval. Or, a child who has been sexually abused over a period of time may actualize a different gender identity, in a vain attempt to become someone else, in order to 'escape' the abuse. Assessment of parents and the family structure is thus an essential initial focus for the therapist. Unlike adult clients, it is not the trans child who is calling the therapist for the appointment to discuss their identity; it is the parents seeking help. One of the therapist's first tasks is to determine if a family dynamic is driving the identity issue.

Some therapists take this view to an extreme, blaming the parents for not presenting their children with a dichotomous view of gender, and feeling the parents are too permissive in teaching their children how to be a "boy" or "girl" (Hill et al. 2005). One therapist recommends working with the parents of gender-dissonant children to help them learn to raise their children in a less "gender-confused"

manner (Meyer-Bahlbarg 2002). This is a quite different view from believing that while trans identity is a real possibility, some children may be actualizing a gender identity at odds with their sense of self, driven by the need for a dysfunctional parent's approval.

In cases of extreme family dysfunctionality, the family may have come to the attention of Child Protective Services (CPS) through a mandated reporter such as a teacher. It may be a CPS caseworker seeking help on the child's behalf, having noted what appears to be a gender identity issue and desiring an "expert" opinion. In such cases, the therapist must be careful not to conclude too quickly that family dysfunctionality has caused gender-related behavior in the child, and dismiss the possibility of trans identity. It is possible the child is trans, and the parents or other family members have reacted negatively and abusively toward the child as a result (Vanderburgh 2007).

Such cases are made more difficult by the fact that within a dysfunctional family system, the parents' assessment of the child cannot be trusted to reflect the child's reality, and it would be in the child's best interest that the therapist talk to others who are prominent in the child's life (teachers, perhaps other relatives). This allows the therapist to gain a more holistic view of the child's sense of self in real-world settings removed from the somewhat-rarified atmosphere of the therapist's office. If the therapist concludes that the family has some form of dysfunctionality that may be affecting interpretation of the child's identity, it would be in the best interest of the child to involve a child therapy specialist to help the child find their own sense of self, and work with the parents separately, to help deconstruct and dismantle the dysfunctionality, to the degree possible.

In addition to assessing the family structure, clinicians must also assess the child for various mental conditions that may appear similar to a gender identity issue, such as Asperger's syndrome. As Atwood (2007) points out,

> Some children with Asperger's syndrome dislike who they are and would like to be someone other than themselves, someone who would be socially able and have friends. A boy with Asperger's syndrome may…recognize that girls and women…are naturally socially intuitive; so to acquire social abilities he starts to imitate girls (p. 28).

Current estimates of the prevalence of Asperger's syndrome conclude that 1 in 250 children fall somewhere on the Asperger's spectrum (Atwood 2007). Accurate statistics are difficult to come by, but estimates of numbers of trans people fall far short of 1 in 250, no matter which statistics one examines. Estimates of the prevalence of trans identity range from 1 in 9,000 to 1 in 100,000, several orders of magnitude removed from 1 in 250 (Lev 2004). Thus it is all the more important to eliminate the possibility of a more-prevalent condition.

Working with Functional Families

If the family assessment does not lead to any conclusion of dysfunctionality or abuse, and an assessment of the child doesn't lead to diagnoses such as

Asperger's syndrome, the next step is to focus on both the child's self-assessment as well as the parents' anecdotal history of their experience with their child. The therapist can only view the child in session, a snapshot in time, outside the child's everyday milieu. The parents are in a much better position to observe the child's behavior, and self-descriptive language, over time. One of the hallmarks of any form of gender identity is its stability over time and across situation, thus the parents' input is crucial. It is for this reason that families must be assessed first for any form of dysfunctionality that might affect the parents' interpretation of reality.

The families I have worked with don't exhibit serious dysfunctionality of their own, nor are the parents trying to change their child's identity. I believe that as I am transgender myself, parents seeking to "cure" their children are not going to seek me out for help. The families I have worked with have few demographic characteristics in common—they don't share race, religion, ethnicity, socioeconomic status, marital status, urban or small-town living situation, or educational level. However, they do share the following patterns:

- The parents have observed their child's behavior, and listened to their child's self-descriptive language, gradually coming to understand that what they were observing was trans identity. For some, this has been an easier process than for others, largely related to their child's age. The older the child, the less information was available to the parents when their child's gender identity was first emerging;
- The parents did not try to mold their children into little carbon copies of themselves. They recognized their children were separate people in their own right, and did not take issue with what they initially thought was a budding gay or lesbian identity. Though not what they would have chosen for their children, based on societal discrimination against gay/lesbian individuals, they also believed their children had the right to be themselves;
- The parents put their child's well-being before all other considerations, including what the neighbors might think, or how various relatives might react to having a trans child in the family;
- The parents were willing to work with their child's teachers and with school administrators to facilitate a smooth social transition process, but were adamant that the school ultimately take a stand on the side of their child.

The above patterns are indicative of a family structure in which the parents are themselves individuated people, with a good sense of self and healthy ego strength. Their own self-esteem and identity is not predicated on their children's identity following any norm or expectation on the part of the parents. Genograms of these families show a structure with little enmeshment or serious conflict, and with healthy boundaries. These are also families that value communication and relationship as much as any sense of individualism and self-reliance, resembling a feminist model of identity actualization more than a traditional model of reinforcing fairly rigid gender roles (McGoldrick 2005).

The Identity Emergence Process

Though the parents of some trans children come to recognize their child's identity over time, they rarely questioned the original sex assignment pronounced when their child was born. In all good faith, never thinking to question the original sex assignment of their child, most parents socialize their children along the path toward "girl" or "boy," and the parents of trans children are no exception (Lev 2004; Vanderburgh 2007). Some parents attempt to raise their children (trans or not) in a gender-neutral fashion, not "gendering" the various toys their children may choose to play with. Nonetheless, the very language used in talking about children, and in many cases the name the child is given, necessarily "genders" the child, as most languages have no gender-neutral pronoun in talking about people. Thus, parents may accept their son playing house with dolls, yet still call him their son and use male pronouns for him, without thinking twice about the "gendering" effect this has on the child.

What is the gender-dissonant child's experience of this early gender socialization? Until the child reaches the age of verbal communication, their only recourse is through behavior. One mother of a female-affirmed teenager described the experience, using female pronouns for her former-son:

> From the time she could crawl, we just couldn't keep her out of my closet and make-up. From the age of about 18 months [1992], we assumed we were raising a gay male child *(Confidential personal correspondence, 2005).*

The father of one male-affirmed adolescent stated:

> From the time he was toilet-trained, he refused to wear girls' panties and wanted to wear his brother's fly-front underwear. He threw a tantrum every time we tried to dress him up in the least like a girl, no matter what the situation was. We originally thought this was hero worship, that he just wanted to be like his older brother, but as he got older we realized it was more than that, because their interests diverged and he wasn't following in his brother's footsteps. It wasn't ever about behavior, it was about who he was *(Confidential personal correspondence, 2005).*

Often, parents are confused about what they are observing in their child, assuming they are seeing the early signs of gay or lesbian identity (Lev 2004; Vanderburgh 2007; Wren 2002). It is not only parents who misunderstand identity and may assume a trans person is gay or lesbian; therapists unfamiliar with trans issues may make the same error (Vanderburgh 2007). The reverse can also be true, that a mental health professional may assume a trans identity if they have no familiarity with gay/lesbian/bisexual identities. One Florida therapist, a lesbian, was consulted by a heterosexual male colleague, who was mystified by a client's story. He told his lesbian colleague that he thought the client (an adult female) was a female-to-male transsexual, but he wanted a second opinion as he felt confused. Upon talking with the client, the lesbian therapist quickly realized the client had no desire to be male, but was herself a lesbian, new to her self-knowledge and grappling with the idea of not being heterosexual. She was uncomfortable with the

Table 1 Knowledge of identity

	Childhood knowledge of trans identity (%)	Childhood knowledge of being "different" (%)	No conscious knowledge of being "different" (%)
Male-affirmed	60.4	39.6	<1
Female-affirmed	52.7	47.3	<1

idea of being a lesbian, though she admitted her primary attractions were to women. Her original therapist had interpreted this discomfort with lesbian identity as meaning she wanted to be a man *(Confidential personal correspondence, 2002).*

It is only in recent years that social transition at young ages has become a possibility for trans children. However, this does not mean the phenomenon itself is new. An examination of my own clinical records from 2001 to 2008 results in the following breakdown of self-reported client histories among my adult clients who have expressed a clear desire to transition physically. Of 186 male-affirmed clients (age range 18–59), 60.4% knew from a young age (usually about 4–6 years old) that they were boys; 39.6% knew at a young age that they were somehow "different" from girls, though they did not understand the difference at that age to be able to describe it to themselves or others. Among my 169 female-affirmed clients (age range 18–71), 52.7% knew themselves to be girls at a young age, while 47.3% knew they were "different" from boys. Those who expressed no conscious knowledge of their gender identity as children had very few memories of childhood to draw on, in any context (Table 1).

The Therapist's Role

Absent serious family dysfunctionality, what is the therapist's role in helping families with trans children if their desire is for identity actualization? If there is no family issue requiring a therapist's help, and if the issue is indeed one of emerging identity, *is* there a role for the therapist? Families in this situation need the following:

Information About Trans Identities of Various Kinds, and How Gender Identity Differs from Sexual Orientation

If the therapist is not knowledgeable already about how trans identities play out in their culture, the learning curve is steep. However, it is in the best interest of the clients that the therapist undertake their own educational process and learn what they can about trans identities and how those identities differ from various forms of sexual orientation (Vanderburgh 2007; Zamboni 2006). This is not an issue that is private to the therapist/client relationship, as might be the case with issues such as adults dealing with residual effects of abuse at the hands of a now-deceased perpetrator, for example. Trans identity is a real-world, whole-life issue that the

therapist can only glimpse during a session. Thus, it is incumbent on the therapist to seek out trans community, read what literature exists (both professional literature and the personal accounts of trans individuals), and learn on their own time. The internet is an invaluable resource, for both therapist and client, as there are many list-serves and good websites available (My own website, www.transtherapist.com, contains many links that can serve as a springboard for such self-education).

In addition to accurate information about terminology the parents may have heard, such as transsexual, the therapist should also introduce the parents to terms and definitions unfamiliar to them, such as the concept of *genderqueer*—middle-ground gender identities that are not clearly male or female. Some children may express a gender that is not clearly male or female. While there is space for such identities in some cultures, mainstream American culture is not one of them, and the parents may be completely at sea when confronted with such a declaration from their child (Herdt 1994; Nanda 1990, 2000; Vanderburgh 2007; Williams 1992).

Information About the Physical Realities of Transition

In conjunction with learning about living a trans identity, the therapist will face questions from the family such as, "Should we start hormones at the beginning of puberty?"or "Does our child have to have surgery?" It is a good idea for the therapist to consult with a knowledgeable physician (this can be done via the internet), in order to understand what is and isn't possible, or realistic, in terms of physical transition. Though it is outside the scope of the therapist's expertise to offer medical advice, it is helpful to the client that the therapist have a good working knowledge of the effects of cross-gender hormones as well as those medications available to block the birth sex hormones at the onset of puberty.

Psychoeducation About the Cultural Nature of Gender

Looking at other cultures' perspectives can help parents understand that their own attitudes about gender roles, norms, etc. are cultural in origin, and are not fixed reality. There are other situations therapists may be more familiar with that provide useful analogies when conceptualizing how to work with trans families. For example, a child born into a multi-racial, multi-ethnic, or multi-religious family, will mature in a manner that incorporates elements of the various backgrounds of other family members (Newman 2002). Children meld these various backgrounds into a cohesive world view that makes sense to them, but that is unlike the individual backgrounds of their parents. For instance, if the mother is Euro-American and the father Japanese, their children will experience a cultural identity that is neither Euro-American or Japanese, but is Japanese-American. Just so, a trans child will develop a gender lens that does not match either "male" or "female" as other family members experience those gender identities. A trans child will experience a cultural identity similar to their siblings, but their experience of gender will not match that of their siblings (Vanderburgh 2007).

Psychoeducation About the Ramifications of Disclosure

Those families who do not have experience being in a minority position culturally may need help navigating the emotions that arise when they experience discrimination, or other negative reactions to trans identity. Discussions should focus on safety, privacy, and how to maintain the child's self-esteem in the face of hostility or teasing from peers. Discussions can also focus on the nature of gender identity, gender roles, and gender expression. If a parent is challenged by others about their child's identity, it is helpful if they have already thought deeply about the various issues involved, developing their own language and cognitive understanding of trans identity, with which to defend their position. Discussions should also focus on how much gender expression is appropriate or safe for a trans child in various common life situations. Does the family live in an area where the child would be at risk if they dress as their true selves outside the home? Does the family belong to a church or other social institution such that the entire family will be ostracized completely if the child actualizes their identity outside the home? Are certain common situations safe, while others are not? Individual family circumstances vary widely, such that there is no right or wrong answer to any such question, but in all cases, such circumstances should be addressed.

Introductions to Other Families

These families may feel they are alone in their experience. While they may find other families on the internet, in other parts of the country, it is in the best interest of the parents that they meet other families in their region who are experiencing similar issues (Zamboni 2006). If the therapist is working with more than one such family, it is a good idea to introduce them to each other, unless there is an underlying clinical reason why such introductions would be counterproductive. With mutual permission, I have facilitated introductions between the families I'm working with. In some cases, this has resulted in close friendships between some of the parents. In other cases, while friendships have not resulted, the families have nonetheless been comforted with the knowledge they are not alone. In no case has a family refused the opportunity for introduction to other families. Quite the contrary, they are eager for the opportunity. Among my clients, the parents have benefited greatly from such introductions, though the trans children have not. In these particular cases, the children were not the same age, had little in common beyond their gender dissonance, and thus did not form close friendships with each other.

Possible Advocacy and Education within the Child's School Setting

Pre-pubescent children don't need hormone therapy, but can benefit greatly from being allowed to actualize their gender identity, whatever it may be (Dykstra 2005). For those trans children whose gender is clearly male or female, at odds with how their bodies appear, this advocacy can result in allowing the child to attend school as their true gender. To date, the schools I've worked with (or heard about via e-mail accounts) have allowed such social transitions successfully, with little or no

"pushback" from other students, though initially some administrators or parents were resistant to the idea.

Some children, however, are gender-independent in some way, not feeling their gender is reflected by the binary choices of "male" or "female." Such children can best be aided by allowing them as full gender expression as possible, though this can be difficult for school administrators to accept if a child's chosen gender expression is not clearly male or female, as the administrators define those roles. It may be that the family, with full input from the child, will be forced to choose one gender or another. In this situation, part of the therapist's job will be to help the family sustain the child's self-esteem in the face of not being able to actualize their true gender at school. Acknowledging the unfairness of the situation, reinforcing for the child that the most important people in their lives do understand who they really are, will help the child retain a positive sense of self that will stand them in good stead as they mature.

In addition, providing school administrators with accurate information about trans identities can go a long way toward helping the child by making allies of those in positions of power within the school. Acceptance is a top-down attitude, and if the school administration sets a tone of not tolerating intolerance, the child's experience at school can retain the focus it should—on learning and social development. Too often, the trans child is blamed for others' hostility, and the child is then perceived as having difficulty with peer relationships (Vanderburgh 2007; Lev 2004). School administrators that approach the issue as one of safety for all concerned, with a zero-tolerance policy toward bullying or discrimination for any reason, will find social transition all the smoother at their schools (Dykstra 2005).

It is important to note that children who are perceived to be gender-dissonant (particularly those who are considered to be boys) are at higher risk for verbal and/or physical abuse by peers, thus necessitating support from administrators to send a zero-tolerance message regarding abusive behavior (Bartlett et al. 2000; Pilkington and D'Augelli 1995; Remafedi 1987). The extant literature in this realm has primarily studied the experiences of gay or lesbian adolescents. However, it can be inferred logically that the adolescent who is most at risk for abuse has an appearance which causes others to perceive them as lesbian or gay, when in fact the adolescent may be trans and expressing their gender accordingly.

Unfortunately, the current lack of support within educational or social welfare institutions for trans identities does not allow parents much leverage with which to pressure administrators to accept their children for who they are (Chen-Hayes 2001; Mallon and DeCrescenzo 2006). Thus accessing organizations such as Trans Youth Family Allies (TYFA) is all the more crucial for such parents, as such groups have a great deal of information about successful social transitions that have taken place in various parts of the country. Founded in 2006, TYFA is a national organization that advocates for families with trans children (TYFA 2006).

Bringing in local resources, if available, can also have a powerful impact on school administrators in conservative school districts, who may feel social transitions are possible in progressive areas but not in a conservative region. Of the families I've worked with, roughly half live in urban areas; the rest live in smaller towns or suburbs. Thus far, the non-urban families I've worked with have

been able to negotiate a successful social transition and have not felt they had to move to a large city in order to facilitate a transition for one of their children.

Helping Families Develop Appropriate Support Structures

The GSA model (Gay/Straight Alliance) is useful for high school or college students, whose developmental needs include social groups that allow them to form alliances and friendships beyond the bounds of their families of origin (Bilodeau and Renn 2005). Younger children transitioning socially in elementary school, however, are still very much tied to their families of origin, and thus consideration of support structures must take into account this developmental difference. One informal support structure involved one mother taking it upon herself to organize a periodic Skate Night at a local roller skating rink her husband manages. The families were invited to a private event on a night when the rink was ordinarily closed. This kind of all-family event is more appropriate for the developmental level of a pre-pubescent trans child than for the gay or lesbian adolescent.

Rethinking Confidentiality

When working with families with trans children, therapists must reconsider the ramifications of confidentiality. Maintaining the strict confidentiality normally inherent within the therapy profession helps reinforce a model of secrecy that may be detrimental to the family. Secrecy about identity is often a precursor of shame, and the legacy of the "family secret" (Kaufman and Raphael 1996). If the child does indeed transition to a different gender role publicly, this can't be done in secrecy (Vanderburgh 2007). Introducing families to each other may seem a violation of confidentiality, but it can also be an appropriate and powerful clinical intervention, allowing families to get used to discussing the issues openly with others who already understand what they are going through. This practice will give family members an opportunity to develop more fully their own cognitive understanding of trans identity, which will be helpful when they later encounter less-supportive reactions. One of the most powerful methods of facilitating introductions is to invite new client families to attend a support group meeting of an organization such as P/FLAG (Parents/Friends of Lesbians and Gays). If a family doesn't live near a town with a P/FLAG chapter, I offer introductions via e-mail.

Information About Support Groups and Organizations

In all cases, the families I work with have benefited from being introduced to the local P/FLAG chapter, and various other peer support groups as available (Griffiths 2002). On a national level, Trans Youth Family Allies provides resources to help families transition within their community, providing advocacy within schools (TYFA 2006). If there are other local/regional resources available, it is a good idea for therapists to keep abreast of such resources in order to make them available to families. Having a resource table in the office, or a list of available resources on a website, can be an invaluable tool for helping families.

Names of Other Service Providers

Parents need other providers as well, and it is helpful that the therapist have business cards available, as needed: Sympathetic pediatricians and/or pediatric endocrinologists, attorneys knowledgeable about trans issues, child therapists/psychologists, other therapists for individual family members to consult.

A Forum in which to Process the Various Emotional Reactions Family Members will have to Shifting Their Gendered Perceptions of the Child

This is the most traditionally-therapeutic role the therapist will find themselves undertaking in supporting a basically-healthy family with a trans child. For example, while a mother may be able to recognize that her daughter really feels like a boy, and may support her male-affirmed child, she will also grieve the loss of her daughter. She will probably not feel it appropriate to show such feelings to her child, not wanting to cause any feelings of guilt or shame, but she does need a place to process her own quite-valid emotional responses. While fathers and mothers may process such emotions differently, it is important that the therapist make space for both to express whatever feelings are arising in them around the issue of having a trans child (Zamboni 2006).

As is true with adults who transition, letting go of the old gendered conception is the key to being able to embrace the new. I normalize for all clients dealing with transition issues that loss-and-grief processes come with the territory (Vanderburgh 2007). For some parents, this involves a slow process of self-examination and questioning social norms and beliefs. One parent expressed feeling guilty after discovering prejudicial feelings she had not known were present in herself; she had thought of herself as an open and affirming person, easily able to accept her children just as they were, and found that having a trans child challenged her self-concept as a non-judgmental parent (Boenke 1999).

Other issues parents may grapple with arise in cases where the child is not identifying as male or female, but as some form of genderqueer identity the child may not have language to describe. Such identities will challenge the parents on a deeply personal level, challenging their view of reality. One parent remarked in session, "If you'd told me a year ago that there were gender identities beyond "male" and "female," I would have said, 'That's like saying the sun rises in the west'"*(Client session, 2006).*

What I have observed is that when they are accepted and allowed to behave in accordance with their internal gender identity, it is not the children themselves who are in need of therapy, but various family members. The children themselves are quite content and usually mystified as to why everyone else is having trouble with their identity (Bartlett et al. 2000; Lev 2004; Vanderburgh 2007). One of the reasons these children are content is because they are receiving support for their identity from their parents. A consistent theme among many of my adult clients is that those who tried to tell a parent or teacher who they really were, learned very young that this was not acceptable "behavior." This message, usually delivered

quite consistently, led many of my clients to internalize a great deal of shame and guilt over their core identities, feelings that are very difficult to dismantle as adults.

In all cases, such families are far more the expert on their child's experience of identity than the therapist can hope to be. A therapeutic approach consistent with this clinical philosophy will be most helpful to the parents, and least harmful to the child in question (Anderson and Goolishan 1992).

Conclusion

There is so little cultural support for trans children to actualize their true identity, the family therapist's role is all the more crucial. The cultural imperative to assign gender at birth is a powerful norm to challenge. Nowhere is this urgency to assign gender more apparent than in the treatment of intersexed infants (those born with ambiguous genitalia) (Beh and Diamond 2000; Lev 2004). As Lev (2004) points out,

> Despite the fact that…no medical emergency exists in the majority of intersexed births, the presence of a human being who cannot be easily assigned a sex classification is considered a crisis needing immediate intervention. Decisions are made quickly, within days or hours of the child's birth, to assign the child an official sex (p. 356).

The cultural urgency to assign (and maintain) gender can result in a backlash against families with trans children, such that the support of a knowledgeable therapist can feel like a lifeline to parents who view identity actualization as the key to their child's happiness and well-being.

While Trans Youth Family Allies is doing what it can to advocate for such children, the need may eventually outstrip the organization's current capabilities. Just as P/FLAG has local chapters, it may be that TYFA will eventually follow the same model. As noted earlier, many of my adult transgender clients knew from very early ages that they were not really girls, or boys. It is my observation that some parents are beginning to recognize, and act on, such identities in a way that has not been the case in previous decades. All these families are seeking social transition for their children. I have heard similar stories from colleagues in other areas of the country, leading me to believe we are on the cusp of a new stage in trans identity actualization, that of childhood social transition on the part of those who would otherwise have been forced to wait until adulthood.

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