

PARENTING A GENDER NONCONFORMING CHILD:
IMPLICATIONS FOR THERAPY

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ABSTRACT

Parents who are raising children who do not conform to societal gender norms are in need of support and advocacy, as they are not receiving enough in the current social climate. The focus of this single case study is on a parent's experiences raising her gender nonconforming child, and on her perception of the elements of the mental health field that are conducive to the well-being of her family. Interviews took place via online chat sessions. A queer feminist framework guided all aspects of this study. Results support current literature demonstrating that parents of gender nonconforming children are in need of support as their decisions are subject to much scrutiny because of the pervasiveness of gender norms and associated stereotypes. Despite this need, mental health clinicians are largely not prepared to work with this population. Implications for training and practice are discussed.

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CHAPTER 1. INTRODUCTION

Parents of transgender youth are in need of support and information. Currently there are few affirming resources available to these parents (Lev, 2004), yet the establishment of support may increase parental acceptance of their gender nonconforming child, and consequently the child's well-being (Brill & Pepper, 2008; Ryan, 2009). Likewise, parents demonstrate a need for supportive and comprehensive therapeutic and healthcare services (Lev, 2004). They face social judgment for their parenting decisions and secondary stigmatization for raising a transgender child (Menvielle & Tuerk, 2002). Moreover, due to the social reinforcement of strict gender roles, mental health care providers may often question their decision to affirm and encourage the transgender identities of their children. There is an overwhelming need for mental health professional training programs to educate clinicians on working affirmatively with transgender youth and their families in order to address and reduce this distress that society has placed on them (Grossman & D'Augelli, 2007).

The focus of this study is on a parent's experiences raising a transgender child as well as her perceptions of therapeutic services involving her child. Her positive and negative parenting experiences were explored in-depth, as well as the aspects of mental health services which she deemed both helpful and not helpful, and other contextual factors that contribute to her overall impression of the therapeutic environment for a family with a child who does not conform to social gender norms. Interviews took place with a parent of a gender nonconforming child as the sample comes from a larger study utilizing this sample. The study focused on parenting a pre-adolescent because adolescence is a critical developmental time for gender nonconforming individuals due to biological factors such as

entering puberty, as well as social factors such as the development of autonomy, self-identification, and the importance of peer relationships (Pleak, 2009). This study will make a unique contribution to professional literature as previous studies have typically focused on the gender nonconforming individual rather than on someone who holds a significant relationship with the individual, such as a parent (Lev, 2004).

For the purpose of this study, the following operational definitions will be used. *Transgender* will be used to encompass “the range and spectrum of genders that people experience or feel” (Pleak, 2009, p. 283). Similarly, *gender nonconformity* involves acting outside of the socially stereotypical behaviors for one’s biological sex (Pleak, 2009), or transgressing social gender norms (Toomey, Ryan, Diaz, Card, & Russell, 2010). *Gender identity* refers to a personal sense of feeling male, female, both, or neither (Menvielle, 2009). Lastly, *gender expression* is the outward expression of gender given through signals and projected by the individual through clothing, mannerisms, activities, etc. (Menvielle, 2009).

The needs of gender nonconforming individuals are unique and deserve attention within social science research. While lesbian, gay, bisexual and transgender (LGBT) populations are similar in that they are marginalized groups, sexual orientation is often the focus of social science research. Issues related to gender identity are frequently not addressed, yet these issues present relevant and important considerations for gender nonconforming people and their families. As more research emerges that focuses on the needs and experiences of gender nonconforming people, better support and advocacy can be given to them, which in turn may lead to a better understanding by their loved ones. Relationally focused research in particular will be helpful as there is very little guidance

available for the families and loved ones of transgender people; indeed, little hope is given in professional literature that these relationships can be fulfilling (Lev, 2004).

To understand gender identity, it is important to have an understanding of the term ‘gender.’ Gender is a socially constructed concept that divides people into categories, typically according to their physiological male and female bodies; gender identity, however, refers to one’s experience, identification, or the self-concept of one’s gender along a continuum (Lev, 2004). Gender recognition, and thus gender identity and gender nonconformity, usually emerge around age two (Pleak, 2009) and may be fluid throughout one’s lifespan. However, transgender feelings may peak during puberty due to the development of secondary sex characteristics and feelings of bodily betrayal (Israel & Tarver, 1997). Throughout this study, the terms *transgender* and *gender nonconforming* will be used interchangeably based on their presentation in the relevant literature, but this is not necessarily how the participant of this study described her child, or how the child described herself. Identifying inclusive language about the diversity of gender is challenging as terminology can be very politically-laden (Lev, 2004); therefore, the participant’s language was reflected as she described her child.

Social stereotypes about gender exist because one’s gender is typically a central aspect of her or his identity; for example, the first question usually asked of expecting parents is whether their baby will be a boy or a girl. Society places specific roles and expectations on a person depending on gender (e.g., what type of clothing one wears, what types of toys one plays with, what types of activities one partakes in), and if one’s gender identity does not match her or his biological sex, these roles may become complicated. “The need to assert one’s transgender or gender non-conforming status in terms of gender

identity and expression is a required process for people who live in cultures with rigidly defined gender role expectations based on birth sex” (Grossman, D’Augelli, Salter & Hubbard, 2005, p. 42). All children experience some pressure to conform to social gender norms, but transgender children experience this pressure in their core sense of self. Living in a society that imposes strict gender roles has implications for a transgender youth’s safety, sense of belonging, adult support network, health, well-being, and the opportunities that are presented to her or him (Pardo & Schantz, 2008).

Counselor training often does not include any extensive information on issues common to transgender individuals, which may serve to further the negative stereotypes or at the least leave practitioners unprepared to work with this population (Carroll, Gilroy, & Ryan, 2002). Mental health professionals must be prepared to work with transgender youth as they are at risk for suicidal ideation and life-threatening behaviors largely due to the stigmatization they experience in our culture. For instance, almost half of transgender youth report having had serious thoughts about taking their lives (Grossman & D’Augelli, 2007). Similarly, affirmative training for working with transgender individuals and their families is very relevant to family therapists. Family therapists should be sensitive to transgender issues in order to recognize the intersection of gender issues with other issues being presented in therapy by the family (Coolhart & Bernal, 2007). About half as many LGBT young adults who feel accepted within their families report suicidal thoughts as compared to LGBT young adults who do not feel this acceptance (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

In order to provide ethical treatment to a child who does not conform to traditional gender roles, a clinician must have some level of education on gender identity and family

dynamics. Professionals have typically used three different theoretical approaches with these children: adjusting the client's gender identity to match her or his biological sex, reducing distress through supportive psychotherapy, and employing a treatment strategy that views transgender identification as a reasonable outcome (Swann & Herbert, 1999). The first option of altering the child's identity has the potential to be dangerous. It communicates to the child that the therapist does not view transgenderism, and thus her or his identity, as a legitimate route to take. The second option of reducing distress through supportive psychotherapy seems to be a means of avoiding larger issues that will always remain present in the gender nonconforming client's life. The third option of viewing a transgender identity as viable is the most supportive and affirming choice. This type of therapy can help the transgender individual's family navigate the actualization of her or his identity (Vanderburgh, 2009). Additionally, treating a transgender child should not solely surround gender identity issues. "The self unfolds within the context of the child's other traits and life experiences, as well as in a sea of community, school, family, marital, parental, and sibling dynamics" (Saeger, 2006, p. 244). It should be well understood by the clinician that other facets of the child's identity (as well as the family's identity) are salient in addition to the child's transgender identity.

The findings of this study will contribute to the slowly growing literature available to therapists that is focused on parenting and clinical work with the families of transgender children. Medical and mental health establishments have demonstrated a long history of pathologizing gender atypicality and transgenderism, and the repercussions of this pathology have been detrimental to the transgender population (Carroll et al., 2002). Unsurprisingly, this has led to a high suicide rate among transgender youth (Grossman &

D'Augelli, 2007). To be ignorant toward the reasons behind higher rates of suicide and problem behaviors is to blame the victim for the way she or he is treated (Lev, 2004). More education and information available to parents and mental health practitioners will prove beneficial in providing care for the well-being of gender nonconforming children.

In addition to contributing to the professional literature available to therapists, findings of this project will contribute to the education and training of mental health professionals and social service workers, and thus provide parents of transgender youth with apt opportunities to access therapeutic resources and enhance the well-being of their families. Indeed, an experienced therapist can help a transgender child diminish internal shame and increase resiliency and self-esteem, and help validate the child's parents' choices in the face of harsh societal circumstances (Brill & Pepper, 2008). An affirmative therapist is crucial to a successful therapeutic outcome for transgender youth and their parents and families.

CHAPTER 2. LITERATURE REVIEW

Parenting and Family Dynamics

Parents of transgender children often experience secondary stigmatization which may intensify negative feelings such as isolation and shame (Saltzburg, 2007; Menvielle & Tuerk, 2002). Although the experience of learning that one's child is transgender varies from parent to parent, "[i]nitially most parents feel that their world is falling apart. There is a profound sense of devastation, loss, shock, confusion, anger, fear, shame, and grief" (Brill & Pepper, 2008, p. 39). However, with time and dedicated emotional work, many parents are able to make the shift towards acceptance (Brill & Pepper, 2008). One such example of emotional work preceding acceptance may involve a grieving process, wherein parents grieve for the child whose life is different from what they envisioned (Menvielle & Tuerk, 2002). Family acceptance can also involve positive comments, behaviors, and interactions in families, and the presence of these accepting factors is associated with lasting positive health outcomes and protection from negative health outcomes (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Lev (2004) states that the adaptive developmental process that a transgender individual's family members go through is expected, but often the process is not linear.

The quality of a transgender individual's family relationships is related to her or his life satisfaction (Erich, Tittsworth, Dykes & Cabuses, 2008); further, parental attitudes shape children's self-worth. Many parents believe that the best way to help their gender nonconforming child is to change the child's gender identity (Brill & Pepper, 2008). Even though these parents may have loving intentions, a child oftentimes experiences this as rejection. Rejection of a transgender identity may be experienced as rejection of a child's

entire identity (Ryan, 2009). Many transgender youth live in fear of parental and familial ostracism and ridicule (Grossman, D'Augelli, Howell, & Hubbard, 2006).

Transgender children may rely heavily on their home environments for acceptance since they are constantly told they do not belong in many public settings such as their school environment (McGuire, Anderson, Toomey, & Russell, 2010). If there is little acceptance in their home settings, they may seek out different, seemingly affirming environments, which can lead to risky situations if the environment is dangerous (Mallon & DeCrescenzo, 2006). Also, if there is little support and acceptance in the home environment, further problems may surface. For example, in a family situation in which the transgender child is seen as the problem, the child is often scapegoated by family members making her or him feel like the reason for any problem that may arise (Grossman, D'Augelli, & Salter, 2006). Many parents may be ill-equipped to empower their transgender child, and they may even perpetuate the social oppression associated with transphobia (Burdge, 2007). For transgender youth, rejection from parents has repercussions not only on mental health, but on physical health, safety, and on their futures (Pardo & Schantz, 2008). Further complicating the issue is the severe lack of clinical information available on parenting issues for parents raising transgender children (Lev, 2004).

Conversely, transgender youth who feel supported and valued by their families experience advantageous benefits such as higher self-esteem, a more positive sense of the future, lower risks for mental and physical health issues, and greater life satisfaction and well-being as compared to youth who do not feel supported and valued (Ryan, 2009). Indeed, one of the most important factors in the lives of transgender youth is the presence

of an adult who is interested in their well-being and accepts them unconditionally (Money & Russo, 1979; Ryan, 2009). Many parents, after accepting and embracing their child's transgender identity, believe that their child has made them better people through the experience of being "different" (Menvielle, 2009). Parents may react positively to the broader range of experiences and opportunities available to a child who is not constrained by strict gender roles; for example, a parent might feel a strong sense of pride for a son who feels free to engage in domestic skills and demonstrate traits such as nurturance and empathy (Kane, 2006).

The process of disclosing gender identity has both risks and benefits. Some risks may include the loss of community networks and even altered interactions with loved ones following initial disclosure. Benefits may include personal growth through supportive networks (if present), activism, and self-exploration (Alegría, 2010). The implications of disclosure to parents may be severe if parents are unsupportive; the disclosure may result in physical or verbal abuse, which commonly leads to internalized problems and psychological and behavioral consequences (Grossman et al., 2006). Coming out can be quite overwhelming for a transgender youth as she or he is trying to come to terms with her or his identity, and if parents are discouraging, it will be even harder for their child to develop an adult identity (Pusch, 2005). Despite these unfortunate implications, after a child comes out it may be possible for a family to find balance and negotiate the larger issues surrounding the child's transgender identity, thereby reducing familial turmoil (Lev, 2004).

In general, younger transgender individuals tend to have higher rates of disclosure to significant others as compared with older transgender individuals (Maguen, Shipherd,

Harris & Welch, 2007). One explanation for this may be that younger individuals tend to be more connected to the internet, which can contribute to a feeling of community support (Maguen et al., 2007), thereby easing some of the social effects of disclosure. This generalization in particular was one of the reasons why the parent of a transgender child was interviewed for the current study.

Family Therapy

Family therapy, as opposed to solely individual therapy, may prove to be beneficial when working with gender nonconforming youth (Benestad, 2002). Families who are unfamiliar with gender nonconformity may seek therapy services for a multitude of reasons. Parents may be confused about whether their child has a mental illness, they may be unsure about what to do about their child's nonconforming actions, or they may wish for help understanding the ramifications of a transgender identity (Vanderburgh, 2009). Additional reasons that families may seek therapeutic services include a desire for more information about the transgender identity, information on the process of transitioning, education about gender in a cultural context, education on the consequences of disclosure, referrals or introductions to other families with similar experiences, advocacy for the gender nonconforming child within her or his school or community, or help with developing support systems (Vanderburgh, 2009).

Including the gender nonconforming child's family in therapy is essential, as therapists can help families with many aspects of their well-being. A family therapist may help family members gain information, exposure, support, and understanding for the gender nonconforming member's struggle, as well as negotiate the process of disclosure to others (Coolhart & Bernal, 2007). Family therapy can help parents to work through their

feelings of confusion or fear in order to send positive, affirming messages to their child (Brill & Pepper, 2008). Family therapy can also be utilized to help normalize the child's gender expression while other family members are witnesses to this education on gender diversity (Lev, 2004). "The need to treat gender-dysphoric children and their families together is essential for effective resolution" (Lev, 2004, p. 351).

Not only can family therapy be supportive for gender nonconforming children, but their parents or caregivers can be supported and empowered as well. Some benefits that parents may experience can include helpful explorations and discussions about the fear of condemnation, grief over lost dreams, and regrets or self-blame (Brill & Pepper, 2008). Family therapy may help parents focus on their love for their child, and parents who hold love paramount fare best in accepting their gender nonconforming child (Brill & Pepper, 2008). This acceptance is related to positive emotional outcomes that persist over time (Ryan et al., 2010).

Family therapists need to take into consideration the dynamics of each family they work with, and this is certainly true of families with gender nonconforming children. Saltzburg (2007) writes, "In my practice as a family therapist, youngsters and parents came looking for pathways to support and ease the coming-out process that would ensue for them...[T]he period of time between coming out to parents and parent adjustment was emotionally difficult, leaving these young people at risk" (p. 58). Parental attitudes shape the self-esteem of their children so much that lesbian, gay, bisexual and transgender young adults who are highly rejected by their parents are more than eight times as likely to have attempted suicide and nearly six times as likely to report high levels of depression when compared with LGBT young adults who did not feel rejected by their parents (Ryan, 2009).

Due to societal expectations based on gender, disclosure to family, friends, and significant others can often be a very frightening and painful process (Lev, 2004), so the rapport and trust built with a counselor or therapist is necessary in the process of therapy. This is very different from common therapeutic approaches that are “corrective” in nature, targeting an individual’s “maladaptive” identity (Mallon & DeCrescenzo, 2006). As there is little cultural support for transgender children to actualize their true identity, the therapist’s role in the child’s life may become essential (Vanderburgh, 2009). The environment that the therapist creates should be respectful and safe, and allow the child and her or his family to explore the child’s gender identity and promote a positive sense of self (Grossman et al., 2006).

One issue that complicates the therapeutic need for transgender children and their families is the pathologization of Gender Identity Disorder (GID). *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) includes Gender Identity Disorder as a clinical diagnosis. Criteria requirements include cross-gender identification and discomfort with the gender role of one’s assigned sex (APA, 2000). This diagnosis can be used to mislabel behaviors as deviant and pathological when in fact the individuals displaying these behaviors do not feel that they are problematic (Brooks, 2000). As the *DSM-IV-TR* is a highly respected standard of treatment within the psychiatric community, presenting the enforcement of strict gender roles inhibits the transgender community by further pathologizing gender nonconformity.

In spite of GID pathologization, therapy for gender nonconforming youth has undergone a relatively recent paradigmatic shift. In the past, counseling training courses have been concerning; the near invisibility of relevant LGBT (and especially transgender)

issues in training caused counselors to feel ill prepared for working with LGBT clients (Grove, 2009; Lev, 2004). Furthermore, many transgender people who seek therapy are likely to be the first transgender client their therapist has ever worked with (Korell & Lorah, 2007), so therapists may feel unprepared due to both their training and their working experience. However, in recent decades a change occurred in societal attitudes, knowledge and advocacy for marginalized populations. Accompanying this change was an increase in LGBT scholarly research (Mitchell, 2010). Although there is certainly much room for improvement, the shift has great implications on the LGBT community and on therapists working with LGBT individuals and families.

Affirmative Therapy

Approaches to therapy with gender nonconforming persons have historically been aimed at altering an individual's identity to match her or his biological sex (Mallon & DeCrescenzo, 2006; Swann & Herbert, 1999). This is problematic in a variety of ways, and there is a lack of scientific evidence showing the benefits of this type of therapy (Benestad, 2002). A therapist who practices by this approach may not change an individual's transgender identity, but may send the message that therapy is something to be avoided because of the lack of safety and comfort with one's true self (Vanderburgh, 2009). As seen with the above mentioned paradigmatic shift, a relatively recent approach to therapy with transgender youth is geared toward the outcome of identification with gender nonconformity. This approach takes societal constraints and demands into consideration and requires that therapists themselves are held accountable for their own biases (Swann & Herbert, 1999). It is an affirmative approach to therapy.

To introduce the concept of affirmative therapy, a definition of *affirmative* must be offered. In this study, ‘affirmative’ means “affirming a positive sense of self in the light of social stigma” (Hines, 2007, p. 469). Not taking the social context of the clients into consideration can have adverse effects on diverse populations (Hines, 2007). Although there are many components that may be vital to the practice of affirmative therapy with gender nonconforming persons, professional literature typically focuses on issues relevant to lesbian, gay and bisexual affirmative therapy (e.g. Grove, 2009; McGeorge & Carlson, 2011; Saltzburg, 2007). However, certain aspects that make therapy affirming for LGB clients may translate to therapy with transgender clients. Competent therapy with lesbian, gay and bisexual clients relates to the affirmative training that the therapists receive, so it would be highly beneficial to include an affirmative piece in training programs (Rock, Carlson, & McGeorge, 2010). It seems that adding an element of affirmative training for gender nonconformity would have a similar effect on therapists’ feelings of competency working with transgender clients.

An important aspect of affirmative therapy involves the therapist’s comfort level while working with diverse populations (Pixton, 2003): specifically for this study, with transgender populations. The ability to effectively communicate that the therapist does not see the client as the problem, but that harmful societal beliefs are problematic, lets the client know that the therapist is comfortable working with her or him (Pixton, 2003). Also, the therapist’s comfort level requires an intimate reflection of the therapist on her or his own sexuality or gender identity in order to recognize any heteronormative assumptions (Grove, 2009; McGeorge & Carlson, 2011). It is important for an affirmative therapist to understand that it is impossible to operate free from these personal assumptions or biases

and to continuously reflect on them in order to challenge them and remain aware of their influence on interactions with marginalized groups (McGeorge & Carlson, 2011).

Another aspect of affirmative therapy involves the knowledge and skill of the therapist and how she or he uses these in the therapeutic relationship. This includes skill sets such as knowing when to hold and when to challenge, listening skills, and reflection skills (Pixton, 2003). These types of skills are important for therapists working with any population; however, the element of trust is extremely important when working with a transgender client because of the societal discrimination that transgender individuals continually live with (Carroll et al., 2002). In addition to these general skills, therapists working with transgender youth and families should also be somewhat knowledgeable of the political, historical and psychological contexts that their transgender clients have lived in. This helps therapists maintain affirmative dispositions toward the work that they provide (Carroll et al., 2002). Cultural awareness may serve to increase a therapist's comfort level with clients who have been societally marginalized; this awareness aids the therapist in negotiating clients' multicultural worlds (Green, Murphy, Blumer, & Palmanteer, 2009). Therapists should be prepared to offer this information, education, and support to other significant members of the gender nonconforming youth's network (Mallon, 1999). Moreover, the therapist should use the child's chosen name and pronoun in order to facilitate a comfortable space for the child (Grossman et al., 2006).

It is important to note the reasons why LGBT children are in need of support and care through affirmative therapy. Unacceptable stereotypes and beliefs of deviance are harmful to LGBT youth, making them susceptible to stress-related mental health disorders (Davis, Saltzburg, & Locke, 2009). "The fear, or the belief, that an LGBT identity is

unacceptable, unhappy, immoral, difficult, painful, repugnant, inferior, humiliating, or illegitimate renders the process of self-exploration and self-disclosure fraught with fear, anxiety, shame, and self-criticism” (Mitchell, 2010, p. 14). Additionally, acts of violence and victimization targeted at LGBT youth can begin at very young ages (Cianciotto & Cahill, 2003).

As a highly stigmatized group, youth who do not conform to traditional gender roles are subject to social isolation, mistreatment, and ostracism by their peers (Brooks, 2000). However, it is critical not to overly generalize the needs of the transgender population to the needs of other oppressed populations; the needs of the transgender community continue to remain marginalized, and social policy generally does not address their specific needs (Hines, 2007). Transgender youth may also experience other adults or peers displaying discomfort with their mannerisms or behaviors, resulting in either concealment of their identities or feelings of personal distress (Grossman et al., 2005). These reasons combined with the social stigma and bias that transgenderism carries provide strong support for the therapeutic needs that a transgender youth may have in terms of care, support, and affirmation of identity.

Research Questions

The focus of this study involved a parent’s experiences raising her gender nonconforming child, and the parent’s understandings and perceptions of mental health services regarding supporting families like hers. The primary research questions that guided this study are: “How does a parent describe her experiences raising a gender nonconforming child?” and “How does a parent describe her perception of mental health

services regarding her gender nonconforming child?” For a list of detailed questions, see the interview guide (Appendix B).

CHAPTER 3. METHODOLOGY

This study is part of a larger qualitative study focused on parenting transgender youth. The current project used a single case study approach informed by a queer feminist lens. The case study process involves a specific approach to collecting, organizing, and analyzing data (Cresswell, 2007; Patton, 2002). The purpose of a case study is to obtain comprehensive information in rich detail about a case of interest, resulting in an organized and systematic product (Patton, 2002). Case studies are *particularistic*, *descriptive*, and *heuristic*: they focus on a particular phenomenon (*particularistic*), they richly describe this phenomenon under study (*descriptive*), and they illuminate the reader's understanding of this phenomenon (*heuristic*) (Merriam, 2009). This case study explored the phenomenon of a mother parenting a gender nonconforming child, and her perceptions of how mental health services and providers promote her family's well-being. The case study approach was utilized so that the final case report could "bring about the discovery of new meaning, extend the reader's experience, or confirm what is known" about this phenomenon (Merriam, 2009, p. 44). Case studies are valued within professional literature for their ability to capture complex action, perception, and interpretation from participants (Merriam, 2009).

A case study is a useful methodology for encapsulating the meaning derived from a complex story into a finite report (Stake, 2003). The instrumental case study approach can produce unique information about a phenomenon that other methods cannot (Merriam, 2009). A case study can produce an intensive and holistic description of a single family to inspire knowledge and an expansion of ideas for future research (Merriam, 2009).

The topic of gender nonconformity as seen through a supportive lens of advocacy merits other social considerations as well, thus this study was guided by a queer feminist framework. The researcher held an awareness of the social construction of gender and family, and the marginalization that stems from the distribution of social power (van Eeden-Moorefield, Martell, Williams, & Preston, 2011). Queer theory and feminism have the commonality of addressing how language and binaries promote normativity in our culture, and how this leads certain groups to have inferior social standings (Hammers & Brown, 2004). As a researcher, I employed a queer feminist framework by continually remaining aware of the social context of reinforced gender norms and how this context affected the participant and her family. In this way, the framework influenced the way I viewed my role as a researcher, which included how I asked questions, the way I interpreted responses, and the way I formed the case report (Hesse-Biber, 2007).

The scope of feminist research emphasizes staying outside of the limitations that society may place on groups without dominant social power, as well as centering on a marginalized group's diverse situation and the institutions that create the situation (Olesen, 2003). This study focused on the marginalized nature of a gender nonconforming child and the child's parent, and the social climate that renders their situation unique. This project is intended to help researchers and mental health clinicians move toward social change and freedom from ideologies that have historically been oppressive through analyzing dominant discourse; thus, it fits within the realm of feminist research (Hesse-Biber, 2007).

The use of queer theory allows researchers to examine how socially enforced binaries, such as *male/female*, construct normality and therefore deviance, and how the classification of "normal" and "deviant" serve to regulate and punish members of society

(Oswald, Kuvalanka, Blume, & Berkowitz, 2009). To use queer methodology “means sampling whatever set of people or phenomena is of interest but then going beyond their so-called characteristics to study the mundane processes that go into these classifications” (Oswald et al., 2009, p. 51-52). Queer methodology was used in this study because it was understood that the “deviant” classification that is placed on transgender children and their parents for living beyond normative categories and social expectations has created harmful effects on the well-being of the participant and her family. The very nature of parenting a gender nonconforming child essentially queers the dominant discourse surrounding parenting and family.

Feminism and queer theory were able to be utilized together as both approaches attempt to address and deconstruct categories of gender, and both have explored the ways through which gender and sexuality are performed within contextual environments (Oswald et al., 2009). A queer feminist lens “pushes us to disconnect deviance from difference, to see it simply as a difference, not necessarily good or bad” (van Eeden-Moorefield et al., 2011, p. 565). Consequently, studying the topic of parenting a gender nonconforming child merits the use of both approaches.

Sample

Selection criteria for participation in this project included: (a) currently in a caretaking role of a child who does not conform to social gender roles, (b) over the age of 18; (c) has access to a computer with internet access; and (d) able to participate in an online chat conversation. For the purpose of this project, one parent was interviewed to fulfill the single case study process. The parent of the child was interviewed because parents are usually the ones who seek out therapy services or take on the role of gatekeeper for their

child's healthcare needs. The participant and her child's names have been changed in order to protect their identities.

Participant Recruitment

This case study is part of a larger qualitative study conducted by Dr. Kristen Benson, who is the principal investigator. Dr. Benson distributed recruitment information to national advocacy organizations that specifically support families with a transgender member, including PFLAG and Gender Spectrum. Interested persons who met study criteria were invited to contact her and complete an online demographic questionnaire. Dr. Benson then arranged for me to contact the participant via telephone to schedule an online interview.

Case Description

The participant, Sarah, is a forty year old woman who is parenting her only child, six year old transgender daughter Lee, in a small Midwestern city. Sarah works full-time and Lee is a first grader at a public school. Sarah is divorced from Lee's biological father, and while they share co-parenting responsibilities, Sarah is responsible for the majority of parenting and maintains physical custody of Lee.

Statement of Self-Reflexivity

The motivation I felt to conduct this study stems from a strong desire to be a transgender affirmative therapist and person. Though I am not yet a parent myself, I am committed to supporting parents through my work as a family therapist. I consider myself to be a cisgender woman, meaning that I am biologically female and I identify as a woman. I also have lived in the Midwest for nearly two decades, which helps me to understand Sarah's fears of social consequences if Lee's peers found out she is transgender while

living in a region where normalcy is intensely valued. For these reasons I appreciate Sarah's courage and participation in the study, and that she was willing to share her experiences through the disclosure of personal and emotional information to me. I am honored to witness the telling of her family's story, and to have the opportunity to learn from her.

Data Collection

Data was collected via online chat sessions with the participant. Online research is becoming increasingly popular; for example, online focus groups in chat rooms have often been used for marketing research, and are recently being used in social science research as well (Schneider, Kerwin, Frechtling, & Vivari, 2002). Online qualitative methodology can be beneficial to reach marginalized groups, who often connect online and maintain member listserves for the exchange of information (Mustanski, 2001). Utilizing the internet aids in external validity because of the representation of marginalized populations, and it aids in internal validity because the anonymity of interacting online reduces discomfort in responding to questions (Mustanski, 2001). In this way, online methodology can give researchers access to underrepresented populations that might not be reached otherwise (Mustanski, 2001).

This study follows an online interview model developed by van Eeden-Moorefield, Proulx, and Pasley (2008), who designed a study in which gay male participants were interviewed individually online and participated in online focus groups. It may be easier for marginalized populations, such as the parents of gender nonconforming youth, to participate in an online research process due to safety and anonymity (Mustanski, 2001; van Eeden-Moorefield et al., 2008). A semi-structured interview guide with open-ended

questions guided the online chat interview. See Appendix B for the interview guide. In addition to online transcripts, field notes and reflections were maintained throughout the interview process.

The order of contact with the participant was as follows. After receiving the participant's information from the PI, I called her to introduce myself and set up a time for the interview. She identified her preferred internet chat program to be Yahoo! Messenger. I created an account solely for the purpose of the study and sent the participant the interview username in an email. The online interview took place as scheduled, lasting for approximately three hours, when we were no longer able to send messages and the chat session seemed to time out. Since there were only two remaining questions, the participant specified that she preferred to answer these questions via email. She answered these questions within three days with a total of two more email correspondences. I then combined the transcripts with the email responses, edited the transcript for grammar and formatting purposes, read through the complete transcript to identify any areas that were in need of clarification, and asked follow-up questions through email. I emailed a final transcript to the participant to ensure accuracy, and she indicated that what she had said during the interview was accurately represented.

Data Analysis

After the data was collected, I organized the information into a case record, which establishes an orderly resource for the reader by including all of the edited and reordered information that is important to the final case analysis (Patton, 2002). I created the case record by reading through the data several times, making notes in the margins to form

initial codes, developing primary themes and patterns, and finally, presenting an in-depth and organized picture of the case (Creswell, 2007).

Similar to the concepts of reliability and validity in quantitative research, a qualitative researcher aims to establish a level of trustworthiness. Trustworthiness of qualitative research involves the fairness and balance in relation to the research that is presented through the verification and validation of information in order to utilize competent analyses (Patton, 2002). This process of verification may include member checks by the participants (Creswell, 2007; Dahl & Boss, 2005). The participant involved in this case study received a copy of the case record of her interview and was allowed to make any corrections or address any misunderstandings that may have been present. The reliability of qualitative research often rests on the stability of responses between the multiple coders of information (Creswell, 2007). This study employed multiple coders so as to gain a more balanced perspective on the themes presented in the data. To protect confidentiality, the names of the participant and her child have been changed, and any potentially identifying information was omitted.

One common misunderstanding about the case study method is that a lack of rigor in the collection, construction, and analysis of data is linked to researcher bias due to a lack of objectivity (Merriam, 2009). Rigorous data collection generally involves multiple forms of data or extensive data collection, yet rigor also involves a validation of the accuracy of the information collected using a method such as member checking or peer audit (Creswell, 2007). As such, a case study is not intended to provide generalizable information to readers, but rather to accurately depict one case that may inspire further ideas and research possibilities. “Anchored in real-life situations, the case study results in a rich and holistic

account of a phenomenon. It offers insights and illuminates meanings that expand its readers' experiences. These insights can be construed as tentative hypotheses that help structure future research" (Merriam, 2009, p. 50). For this project, the case study method was chosen because the researcher was interested in discovery and insight rather than hypothesis testing.

CHAPTER 4. RESULTS

In my interview conversations with Sarah, I asked a variety of questions about her experiences and her perspectives. I expected that some of the questions I asked would be difficult for her to answer, which made me greatly appreciate her willingness to be open and direct throughout the interview despite the potential social consequences for her and her daughter, such as discrimination at work and school. She remained engaged in the conversation in spite of the sensitive nature of some of the questions. In an effort to provide a clear and accurate portrayal of Sarah's experience parenting her transgender child, I will describe the themes that emerged during our online conversations.

I am a Girl

Around the age of three, [Lee] noticed a distinct difference between girls and boys, how they wore their hair and their clothing. [She] started expressing a very strong preference for all things typically girl... Around that time I was reading a bedtime story that had a line: 'Some of us are boys and some of us are girls.' That is the first time she broke down into tears and ... started expressing fears of growing up into a man with a man face and a beard... It was a little scary.

Though she did not start researching gender identity until Lee was 4 or 5, Sarah had always known that something was unique about her child. When Lee was very young she presented as gentle, preferring to spend time with girls rather than boys. She always expressed a preference for feminine clothing, hairstyles, and toys. Sarah had tried getting Lee interested in more typical masculine things, but that had negative effects on her, such as frustration, anger, and depression. Since then Sarah has followed Lee's lead in her gender presentation, and the transformation that resulted was Sarah's proof that it was the

right thing to do. Lee turned into an amazingly happy, spunky, and outgoing young girl who wears her hair long, has an all-girl wardrobe, and a bubblegum pink bedroom. Her name was legally changed from a masculine name to the name of her choosing, and she is enrolled at school as female. When asked to describe her daughter in three words, Sarah responded, “creative, dramatic, [and] loving.”

Sarah explained that she believes gender identity is all in the brain. It is a feeling that usually matches the body, but not always. It is a complicated and multidimensional thing that was challenging for her to articulate. She first really learned about gender identity around two years ago when she “had to,” and at that time she began by researching the topic online. Since then Sarah has sought mental health services for further direction, talked to other parents in an online support group, and kept up-to-date on research regarding transgender children.

Challenges of Parenting a Transgender Child

[Parenting Lee is] the toughest job I will ever love... It’s challenging, but I love it. I love her so much and feel incredibly blessed to have such an absolutely amazing little being in my life.

As the parent of a transgender child, there are responsibilities placed on Sarah that are above and beyond the stress of traditional parenting duties. She stays updated on research about transgender issues, especially regarding children. She keeps in contact with their therapist so that they can continue to check in as needed, and she spends a substantial amount of time online on trans/gender parenting message boards. She also keeps accurate and thorough records of Lee’s life for herself and the professionals involved in her life.

Sarah has not been able to separate from her ex-husband as many divorced couples do. When asked in-depth questions about her relationship with Lee's father, Sarah thought for some time before submitting her responses. She understands the importance of nurturing and maintaining his support, so she has worked very hard to help encourage his relationship with Lee. Sarah perceived herself as going overboard to help them get together for Lee's sake, and she has accompanied Lee during visits with her father to act as a buffer.

Sarah has had numerous difficult and deep conversations with Lee about gender. One night when Lee was only three years old, she tearfully expressed to Sarah her fears of growing up into a man. Sarah was not sure what to say, so she just hugged her and told her that it would be a long time before she had to worry about that. These fears turned into nightly conversations in which Sarah gave Lee reassurance that things would be okay, and informed her that there is medicine available to keep that from happening.

There has been much stress on Sarah and Lee's family due to unfamiliarity with how to support a transgender child. Some family members have been supportive, but Sarah admitted that the family is currently still fractured. Initially she had to cut almost everyone off because of the harm they were causing Lee by acting disrespectful and unsupportive of her identity.

In the very beginning, when I allowed Lee to socially transition, some family members were trying to band together to get an attorney to "save this boy" from me.

Sarah's willingness to allow Lee to live as a girl, which is her identified gender, elicited accusations from her family suggesting child abuse or neglect. She has faced judgment and stigma in other social areas as well, stating that she continually receives the

message that she is doing something wrong. This message has caused Sarah anguish and self-doubt in her parenting choices, leading her to seek support. Throughout the interview, she addressed her own emotional process.

Emotions and Parenting

Anxiety and Fear

I worry about her future. I worry about her safety. I worry sometimes about doing the right thing in order to keep her healthy, happy, and emotionally secure. I worry about people who don't understand or bigots who may want to have her taken away from me.

Understandably Sarah has experienced strong emotional reactions resulting from the overwhelming pressures of raising a transgender child in the current social climate. She has countless worries, as stated clearly in the preceding quote. Sarah is sad and frustrated that Lee will probably never have a close relationship with her father. She is anxious about other family members' negative responses to her parenting decisions. Sarah is nervous about Lee's peers accidentally learning that she is biologically male, and the social ramifications that may have for Lee. At this point I realized the real risks that could potentially be associated with participation in this interview, and I really appreciated Sarah's involvement. I am aware of the social stigma that transgender people endure, and Sarah helped me to understand how a mother might have fears for her child, as well as her own need to protect herself.

They Call Me “Crazy Mother”

My family liked to tell me that I must be doing something wrong to make my son loathe his maleness. [They told me] I was too permissive and supportive with all his girly interests. ... It's always the mother's fault, don't you know?

Sarah has continually endured the social message that she is doing something wrong as a mother. She has been told that she should not be so permissive and that she should “affirm Lee's maleness and not allow all the girl stuff.” Sarah sometimes feels as if everyone around her believes that Lee is transgender because she is a “feminist hippie,” and thus she caused Lee to be transgender. When she decided to allow Lee to socially transition, Sarah's own mother became hostile, did not speak to her, and joined with the other family members who met with an attorney to discuss the possibility of removing Lee from Sarah's home. Her family questioned her parenting decisions at a critical time when she was trying to do what was best for Lee. At one point, Sarah sought out support from an LGBT resource center, and she was referred her to transgender-friendly therapist. Later, the therapist told Sarah that the woman from the center who referred her told the therapist that Sarah is “a crazy mother who was doing the wrong thing.” This experience highlights the lack of knowledge and understanding of gender identity even within the LGBT community.

We are Modern Day Pioneers

While Sarah endured hardships, she also expressed many positive emotions associated with parenting Lee. Sarah described her process of learning and becoming an advocate for her daughter by saying:

I spent so much time in the beginning with extreme anxiety. I spent many nights crying myself to sleep. There have been some very scary times. I worry still

sometimes. It was just awful. Now though, I feel strong. I feel educated. I feel that I can be an advocate and supporter of my child 100%.

Sarah feels extraordinarily blessed to have Lee in her life. Though parenting has been challenging, it has also been very rewarding for her. She is proud of the way she has chosen to navigate gender issues, and she called Lee her greatest teacher. Like other parents of young children, she is proud to have a happy and healthy child. Moreover, Sarah has defied social norms by expressing pride in the open minded parenting she has provided to Lee throughout Lee's life, which is highlighted in the following statement:

I just see myself as a normal parent trying to get through and do the very best I can for my child and her future. ... I do, however, also see myself and Lee as modern day pioneers regarding how we are choosing to deal with gender issues.

The Importance of Support

Sarah stated that she is fortunate to have supportive people and groups in her life. She named her friends, an online transgender family support group, her grandmothers, and her mother as important supports for her and Lee. Sarah's friends have been supportive from the time when they believed Lee to be a boy who liked girl things, and still when they learned that Lee is transgender. She described the impact of her support system by stating:

Oh my. I seriously don't know what would have happened without [a support network]! I had no idea [we] could be helped in such a way! ... It's amazing! Wonderful!

Sarah described a friend who sent Lee a "girl" lunchbox in the mail with a supportive card tucked inside. Another friend accompanied her to out-of-town meetings to find therapists, and to see an attorney for the purpose of learning her legal rights when

Lee's father's family was threatening to involve Child Protection Services because of Sarah's decision to let Lee live as a girl. Sarah openly described her feelings of heartfelt appreciation for the support and help that her friends have shown to her family.

The level of understanding shown by her grandmothers was shocking to Sarah, especially as one grandmother was described to be "extremely religious" and married to a minister. Sarah had expected her to react to Lee's gender expression negatively, but in fact, she told Sarah not to listen to any criticism because no one can speak for God. Early on her grandmother said that although she did not understand everything, she still wanted to remain in Lee and Sarah's lives. Since then she and Sarah have had many conversations about transgenderism, and she has said that the more she learns about it, the better she feels.

Trans Youth Family Allies, or TYFA, have been imperative in both Lee and Sarah's lives. Sarah said, "I would have never made it through or been able to support Lee if I hadn't found TYFA." She found them by chance after researching transgender children on an online search engine, and they have provided her with valuable information and support. Sarah considered social transitioning as an option for Lee after learning about it through TYFA, and that has understandably been very helpful to them both. TYFA has helped Sarah contact other parents of transgender children, and allowed Lee to see pictures and videos of other kids like her. Sarah only had positive things to say about TYFA, for instance, the simple yet profound statement: "They saved us."

Parent as Educator

I have copied every research paper or article that I could get my hands on, given [Lee's father] books, drug him along to therapy appointments... Our doctor told me she would take any and all information I had, and would be sure to study it all.

Although the support Sarah has received has a tremendous impact on her family, not everyone has shown understanding to them from the beginning. Sarah has had the difficult task of educating many of the important people in Lee's life about transgender issues. She gave Lee's father an immense amount of research to look through, and she even tried taking him to therapy appointments to increase his level of understanding. She said that she wants to keep Lee's father educated, involved, and on her side so that she and Lee will always have him as an ally. Sarah's extended family's initial reactions when they realized how Lee expressed her gender showed that they, too, were in need of education on how to be supportive to someone like Lee. Sarah has especially helped her mother understand Lee's gender identity, and her mother has come a long way in the past few years. Similarly, she has had to help bring transgender awareness to a director of Lee's old preschool (along with other staff), and various professionals within the medical and mental health community. It is interesting that Sarah has been in the position of bringing awareness to mental health providers, when normally it is the mental health providers who strive to bring awareness to their clients.

Experience with Mental Health Services

I needed some information, direction ... [and] professional confirmation that I was doing the right thing by allowing Lee to live as a girl. ... The therapists I have gone

to ... seem to have known next to nothing regarding gender nonconforming kids or how to support them.

Sarah has seen several mental health professionals. She went to a local therapist who was referred by a LGBT resource center, but this therapist was unsupportive and Sarah believed her to be largely uneducated about transgender issues. She then traveled out of town a few times to see a psychiatrist, but the distance was a deterring factor for continuing to receive services from that source. She traveled to a large city nearby to see a therapist with a gender-variant son and a specialization in youth, but this therapist did not contact Sarah after their initial session. Then she started seeing a nearby therapist who also sees a few other transgender teenagers. Sarah and Lee have been seeing this therapist for approximately eight months.

When asked her overall impression of the field of mental health in regard to helping gender nonconforming individuals and families like hers, Sarah's response was that it is "crappy." She has seen therapists that have been somewhat supportive, but most do not seem very educated on gender nonconforming children and how their families should be supported. She reported multiple times that she is worried about the future, and specifically about finding a doctor or psychiatrist who will be able to provide a letter of reference for Lee's next medical step of taking puberty blockers. The relationship Sarah has with her current therapist is important to her so that if any issue were to come up for both of them, or if anything would come up for Lee that Sarah could not help her with, they would at least have a supportive professional available to discuss the matter at hand.

Sarah has noticed some indications that mental health providers are not supportive. For example, one therapist suggested that perhaps the community that Sarah and Lee lived

in was too conservative to accept a transgender child, so as a result Lee could live how she wanted at home, but present as a boy to the rest of the world. This suggestion seemed largely unsupportive of Lee's true identity. Yet another therapist had unappealing ideas, no education on transgender issues, made Sarah "jump through hoops" before writing a support letter for Lee's safe folder, and even reinforced the harmful social message that Sarah is a "crazy mother." Experiences like this immediately indicated to Sarah that mental health providers were unsupportive of her family, which is certainly opposite of what she and Lee need from mental health services.

Expectations for Therapy

LEARN FACTS! [Remain aware of the] updated research regarding what it means to be transgender/gender nonconforming. Know which course of medical treatment might be necessary as a child/teen grows. Knowing about transgender/transsexual adults and their issues is not even close to being enough information for helping trans/gender variant youth and their families.

In Sarah's experiences, the most helpful aspect of therapy has been the inherent knowledge that a therapist just "gets it." It seems that the importance of education and prior experience with gender nonconforming youth holds a high value to her. She explained the importance of an apology she received from her family doctor for telling her that Lee was just going through a phase. The doctor told her that she was willing to learn what she could from Lee and Sarah so that she and her staff would be aware to use pronouns and proper names, with hopes of being better able to show respect. The presence of an open mind and a willingness to learn more about transgender children and their relationships helps any professional demonstrate support for families such as Sarah's.

Sarah stated that she had no clear goals for therapy with Lee. She was not sure if the services she sought should have included both her and Lee or if they should be seen individually. She simply wanted information and direction. She had fears of Child Protection Services showing up and demanding proof that Sarah was not a “crazy mother who wished she had a girl instead of a boy.” She wanted professional confirmation that she was providing the best course for Lee by allowing her to live the life of her choosing. One thing Sarah was absolutely certain of was that she did not want any type of help to “fix” her daughter. This certainly was not always met in her family’s involvements in therapy.

CHAPTER 5. DISCUSSION

Sarah's story reinforced much of the existing literature and research regarding gender nonconforming youth and their families. Some of the parallel themes throughout her interview and relevant professional literature include: social judgment and secondary stigmatization for parents, family disruption, pride regarding open-minded parenting, and frustration with inexperienced healthcare providers. Her experiences reflect the multiple layers of discrimination a single mother of a transgender child faces. Sarah took the initiative to educate herself about gender identity, to seek out a support network, to stand for what she believed was best for her child, to advocate for Lee within the family and healthcare community, and she continues to plan for the future. While literature that focuses on gender nonconforming children has been increasing, this case study further demonstrates a need to explore the experiences and support for parents.

In our interview Sarah discussed secondary stigmatization, saying that she was perceived by others to be too permissive or "crazy," which is a theme shared by other parents of gender nonconforming children (Menvielle & Tuerk, 2002). As transgender individuals are often highly stigmatized and subject to social isolation (Lev, 2004; Brooks, 2000), their loved ones are certainly prone to feeling affected by this judgment. Being a single mother, Sarah faces societal stereotyping for other reasons as well, as negative attributes are placed on single mothers more so than single fathers (Haire & McGeorge, 2012). This intersection of stigma only further complicates the social message of deviation; Sarah has repeatedly received the message that she has done something wrong in parenting Lee, and this message has, at times, caused her much anguish and doubt.

Nevertheless, Sarah has defied the dominant definition of motherhood, and she has responded to societal discrimination with activism through bringing transgender awareness to other community members. Activism is an affirmative step many members of LGBT families have taken (Broad, Alden, Berkowitz, & Ryan, 2007; Riley et al., 2011). Activist parenting typically involves protecting LGBT children by challenging the traditional definition of parenting and responding to bigotry with activism that is both political in nature and relational within a community (Broad et al., 2007).

Many transgender youth feel ridiculed and rejected by family members (Grossman et al., 2006). Sarah felt that she and Lee were isolated from much of their extended family due to disrespect shown to Lee and general unsupportiveness. However, she has received the support of some of her family, including her grandmother whom she described as a religious woman. Supportive individuals such as Sarah's grandmother are able to use their religious beliefs and values to encourage and affirm a transgender child's diversity (Brill & Pepper, 2008). Nevertheless, many Judeo-Christians have an understanding of gender diversity that is less compromising: "The rhetoric concerning such a view focuses on ... the idea that humans were created as male and female only. Any confusion about gender is thought to go against the natural God-given order of things" (Conroy, 2010, p. 309).

Oftentimes parents believe that their gender nonconforming children make them better people through living the experience of being "different" (Menvielle, 2009), and Sarah is no exception. She feels blessed to parent her transgender child, proud of her ability to encourage Lee to live the life she wants, and she has mentioned that Lee is her best teacher. It was very apparent to me that Sarah cares deeply for Lee's well-being, and she is

doing everything in her power to ensure that Lee leads a full and healthy life through the nurturance of her identity.

Consistent with much of the literature, Sarah has had various frustrations with mental health services. There is no good system available to support transgender youth and their families, and mental health literature is still relatively silent regarding working with a transgender individual's loved ones, and more specifically, parenting a gender nonconforming child (Lev, 2004). Sarah's experiences highlight the major flaws underlining these issues: lack of education and awareness in many clinical settings. Her needs are similar to other documented needs of parents of gender nonconforming children: peer support, professional support, medical support as the gender nonconforming child nears puberty, and ongoing advocacy (Riley et al., 2011). Though she has many frustrations, Sarah understands the importance of maintaining a relationship with a mental health professional; she needs a therapist so that she can have access to comprehensive treatment options and opportunities for Lee.

Therapists are trained to adhere to a code of ethics to guide them in providing the most upstanding level of care to their clients. The American Association for Marriage and Family Therapy Code of Ethics states that therapists should respect the rights of clients to make decisions, and they should not abandon or neglect clients (AAMFT, 2006). Sarah described violations in both of these areas. Sarah's right to decide to help Lee transition socially was not respected by the therapist who suggested that Lee only transition at home. The therapist who did not contact Sarah after her initial meeting seemingly abandoned her. As a therapist, I am aware of professional ethics, thus learning about these negative

experiences increased my awareness of discrimination in clinical practice, which I found to be disappointing. The need for transgender affirmative therapists is overwhelming.

Implications for Clinical Practice: Transgender Affirmative Therapy

Sarah and Lee's story has many implications for clinical practice as it supports what has been documented in professional literature. Simply put, Sarah's overall impression of the mental health field for families like hers ("crappy") demonstrates a clear need for transgender affirmative training and clinical practice. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) outlines competencies for providing counseling to transgender clients. These include the use of transgender-affirmative language, a belief that all persons are able to live healthy lives while embracing the full spectrum of gender diversity, an acknowledgment of the fact that the oppression of transgender people pervades this culture, and an understanding that one must seek consultation or supervision to address personal biases (2009). I will discuss the need to incorporate a transgender affirmative training piece in graduate programs, how therapists or clinicians should remain up-to-date on research and professional literature on transgender issues, addressing supportive parenting in family therapy with transgender children, and intentionally holding on to an awareness of one's values and the effects of these values on clients' well-being.

The inclusion of affirmative gender identity training in graduate studies for students in the mental health field is unquestionably needed. With an awareness of transgender issues and how to address them in a therapeutic context, mental health workers are able to better recognize the intersection of gender issues with other issues presented in therapy by the individual, couple, or family (Coolhart & Bernal, 2007). Sensitivity to the issues

common to gender nonconforming individuals and their families allows mental health care providers to be better resources for these clients, who are at risk for suicidal ideation and other life-threatening behaviors due to social stigma (Grossman & D'Augelli, 2007). Further, lack of awareness and training leaves professionals unprepared to work with this population (Carroll et al., 2002). These topics can be incorporated into graduate coursework through assigning affirmative supplemental readings about transgender issues, which may provide a means to diffuse negative stereotypes and decrease prejudice against gender nonconforming people (Case, Stewart, & Tittsworth, 2009). Additionally, coursework should include information to support students' specific knowledge of transgender issues rather than including it with content related to LGB topics (Case et al., 2009). Students should also receive appropriate supervision for any practicum or internship matters related to gender identity that may arise. Sarah stated that the most helpful thing a therapist can do is to learn facts, remain aware of current research, and know the best course of treatment to help a child and family like hers.

Therapists should address the importance of supportive parenting in family therapy with a transgender child, and they should be considered advocates for supportive parents, empowering their decisions in spite of negative social messages (Brill & Pepper, 2008). A child's family has a tremendous impact on her or his well-being, so discussing a gender nonconforming child's family life is crucial to providing comprehensive mental health services (Ryan, 2009). An important aspect of this therapy includes addressing which family patterns serve to promote the healthy development of a child's transgender identity, and which serve to pathologize the child's identity (Vanderburgh, 2009). A therapist can help parents to move beyond social messages that are experienced as non-affirming and

defeating, thereby creating space for more positive emotional possibilities and relationships within and outside of the family (Saltzburg, 2007). Therapy for the parents and families of transgender children should address physical and emotional safety concerns, particularly for children in school; educate family members; support each family member emotionally; and serve as a safe place where the family can receive referrals to other professionals, e.g., medical doctors, school administrators, and even legislative support (Riley et al., 2011).

It is also important for therapists to be aware of their own biases, assumptions, and beliefs, and how they influence therapy. A mental health provider should understand that it is not possible to live without these biases, but conscious reflection may help to challenge them and allow the provider to work in a more affirmative way (McGeorge & Carlson, 2011). Affirmative therapy can be of great benefit to gender nonconforming individuals and their families by helping them feel safe to share information, letting their voices be heard, and by giving them support in a world that is largely unsupportive. As it is with Sarah and Lee, support is a vital aspect of receiving care for anyone experiencing marginalization. Transgender youth and their families often experience other people in their lives showing discomfort with their gender presentation, resulting in personal and familial grief (Grossman et al., 2005), so the presence of a supportive and affirmative care provider can make a large impact.

There are certain steps that an affirmative therapist can take towards public advocacy in order to be supportive of transgender clients and their families. Community activism is a significant way to let clients know that one is a transgender ally. One may demonstrate her or his ally status publicly through participating in relevant rallies, petitioning politicians or lawmakers for their support, helping to educate other

professionals, and taking a stance within one's professional organization (McGeorge & Carlson, 2011). It is also important for mental health professionals to have knowledge of local, regional, and national support networks for the community of transgender people and their loved ones (Carroll et al., 2002). Moreover, some families may seek therapy specifically for the purpose of obtaining help with navigating outside networks such as teachers, extended family, and community members who are not necessarily familiar with the gender nonconforming child's struggles (Korell & Lorah, 2007). Lev (2004) proposed that treatment for gender nonconforming youth "should, first and foremost, normalize the children's gender expression, and educate social service and school systems to celebrate the diversity of human gender expression" (p. 335). Affirmative therapy and public advocacy are important ways to support and care for gender nonconforming youth and their families, and to celebrate the diversity of gender.

Narrative Therapy

Narrative theory was developed from social justice roots; narrative therapists maintain an awareness of how individuals and families are dominated by oppressive cultural assumptions from which they need liberation (Nichols & Schwartz, 2008; White, 1993). Thus, narrative therapy in particular would be helpful to utilize when working with gender nonconforming youth and their families. Indeed, an oppressive message that society may place on Sarah is that she is a deviant mother. These types of messages are easy to internalize and can undeniably have harmful effects on a person (e.g., guilt, shame, and decreased self-worth). To counter this, narrative therapists attempt to deconstruct these dominant cultural knowledges by employing techniques to help clients identify these problems to be external to themselves, by aiding clients in ascribing their own meaning to

their lives, and by articulating certain values and beliefs that make up an alternative and preferred way of living (White, 1993).

A narrative therapist working with a parent like Sarah would help her to externalize the influences in her life that she finds problematic; for instance, ideas that she's a crazy mother, ideas that she is parenting wrong, transphobia and secondary stigmatization, etc., and identify ways in which she can stand against these problems. Perhaps one way for Sarah to stand against these harmful ideas is by identifying times she felt confident as a mother. "Turning away from the practice of pathologizing people and relationships, a narrative approach creates an empathic and supportive therapeutic context for people to call forth other ways of knowing themselves and their lives in order to bring about change" (Saltzburg, 2007, p. 59). For this reason, narrative therapy is an especially helpful approach for working with oppressed individuals and families.

A therapist being guided by Narrative principles would create space for a gender nonconforming child and her or his family to identify alternative ways of being, perhaps relating to hope, possibilities, affirmation, and connection within relationships (Saltzburg, 2007). This way of working is particularly essential for families such as Sarah and Lee's, as they typically do not experience acceptance within a society filled with homophobia, transphobia, and the pathologization of any type of deviance from the norm. A narrative therapist may help Sarah identify her ethics and values as a mother, and some therapeutic goals may surround increasing the times she lives out these ethics and values, and decreasing the influence of the externalized problem. As Sarah is able to articulate the real effects on her life of working on these goals, she will be better able to separate herself from

harmful cultural assumptions, and able to more actively shape her own life in her preferred way of living (White, 1993).

If I were to see Sarah in therapy, I may start by helping her to identify and externalize the problem in her life that has led her to seek therapy; we might call the problem Transphobia. This would require some background knowledge on my part of the history and effects of transphobia on the gender nonconforming community. I would ask Sarah how this Transphobia influences various aspects of her life, including her perception of herself as a mother, the social judgment she feels, her relationships with other family members, and even her relationship with Lee. I would inquire about how the Transphobia teams up with other forces in Sarah's life to gain strength, for instance, Worry, Depression, and Fear. I would ask about times that Sarah has felt stronger than the Transphobia, and what she was doing at those times. Further, I would have Sarah choose a strong belief or ethic that she lives for, and help her identify ways that this belief or ethic helps her to stand against Transphobia. Eventually I would ask Sarah to describe to me an alternative way of living, a way in which she maintains power over Transphobia and is able to live out her personal ethics, and I would have her describe times that she has made progress toward living this chosen life. Throughout the process I would remain up-to-date on transgender research to be available for any questions or discussions Sarah may want to have, and I would constantly keep my personal assumptions and biases, as well as cultural assumptions and stigma, in mind to provide the best value of care to Sarah and her family. This would help facilitate a safe therapeutic environment and allow Sarah to fully explore the prospects of hope and possibility in her preferred way of living.

Strengths

This study had certain strengths: specifically, the online data collection was advantageous. By recruiting participants online and conducting an online interview, I was able to engage with a mother who I would not have otherwise had access to due to her location in the rural Midwest, and safety concerns which cause her and her transgender daughter to remain stealth in their community. This format provided her the opportunity to share her story. Further, “case studies are of value for refining theory and suggesting complexities for further investigation, as well as helping to establish the limits of generalizability” (Stake, 2003, p. 156). I was fortunate to interview a mother of a transgender child who had extensive experiences with mental health services, including various disciplines within the field of mental health (e.g., psychiatry, individual and family therapy, family medicine, etc.). The data she provided supports existing literature and provides a foundation for future research implications, particularly regarding supporting family well-being instead of pathology and diagnosis for gender nonconforming children and their parents.

Limitations

There are certain limitations associated with this study. One limitation of the online chat format is the absence of face-to-face contact, which limited my ability to make observations such as facial expressions and other types of nonverbal communication. These cues may have been important in the telling of Sarah’s story. It is traditional when conducting a case study to include these observations in the form of field notes, thereby allowing readers to assimilate certain descriptions into their memories (Stake, 2003); however, the notes I was able to take were somewhat different. I tracked subtleties such as

which questions elicited a longer pause before the participant typed her response. There are undoubtedly differences between field notes from an online interview and a face-to-face interview.

Another limitation presented itself when the chat session timed out before all of the questions were answered. The last few questions of the interview took place via email correspondence, which restricted my ability to follow up with probing questions or ask for clarification on the spot. Email format tends to produce broken conversation rather than a more natural flow, as with instant messaging. Further, conducting a study that requires a participant to have access to the internet may limit the available participants since there are certain class issues associated with owning a computer and having internet access. As this aspect of the selection criteria for participation was necessary for the methodology at hand, it was deemed worth the limitation to conduct the study online.

Implications for Future Research

There is a wide opening for future research possibilities associated with this case study, as “the characteristics of the [case study] method are usually more suited to expansionist than reductionist pursuits” (Stake, 1978, p. 7). In the present study, Sarah’s responses to interview questions almost completely supported current research and professional literature regarding transgender parents and their children and families. As such, more research is needed regarding other, more diverse, families as well. For instance, what would the experiences be of a parent raising a gender nonconforming child in a two-parent household? What are the experiences of a parent considered to be a cultural or racial minority raising a child who does not conform to traditional gender norms? How would the needs of a family living in a more urban area and raising a transgender child differ from a

rural family with a transgender child? What are the experiences of parents of older children or adolescents who are gender nonconforming? These questions are just the beginnings of larger, more complex inquiries regarding families and loved ones of transgender individuals.

One major area for further research involves gaining multiple perspectives by interviewing other family members. Siblings of gender nonconforming children would offer interesting and essential perceptions regarding family therapy, family well-being, and ways to best support families such as their own. It is clear after researching gender nonconforming youth that sibling relationships have received very limited attention in professional literature (Lev, 2004; Toomey & Richardson, 2009). Being able to gain insight from different family perspectives would benefit the mental health field by making resources available for practitioners and students working with families of gender nonconforming children, and it would benefit parents who are searching for relevant information as well.

Conclusion

In sum, the results of this study demonstrate a need to raise awareness of ways to support children who do not conform to societal gender norms and the families of these children. Further empirical research should be conducted, thereby creating more professional literature and resources available to students and mental health clinicians working with these families. Parents and their gender nonconforming children are in need of support and advocacy due to pervasive gender norms and stereotypes about the parents who permit their children to defy these norms, and in today's social climate they are not

receiving enough. It is up to mental health professionals to take action through education, affirmation of gender identity, activism, and the overall embracing of gender diversity.

REFERENCES

- Alegría, C. A. (2010). Relationship challenges and relationship maintenance activities following disclosure of transsexualism. *Journal of Psychiatric and Mental Health Nursing, 17*, 909-916. doi: 10.1111/j.1365-2850.2010.01624.x
- American Psychiatric Association (APA) (2000). *Diagnostic and statistical manual of mental disorders* (Fourth edition, Text revision). Washington, DC: American Psychiatric Association.
- Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *Competencies for counseling with transgender clients*. Alexandria, VA: Author.
- Benestad, E. E. P. (2002). Gender belonging: Children, adolescents, adults and the role of the therapist. In D. Denborough (Ed.), *Queer counselling and narrative practice* (pp. 204-225). Adelaide, S Australia: Dulwich Centre Publications.
- Brill, S. & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco, CA: Cleis Press Inc.
- Broad, K. L., Alden, H., Berkowitz, D., & Ryan, M. (2007). Activist parenting and GLBTQ families. *Journal of GLBT Family Studies, 4*, 499-520. doi: 10/1080/15504280802191749
- Brooks, F. L. (2000). Beneath contempt: The mistreatment of non-traditional/gender atypical boys. *Journal of Gay & Lesbian Social Services, 12*, 107-115. doi: 10.1300/J041v12n01_06
- Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work, 52*, 243-250. doi: 10.1093/sw/52.3.243

- Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131-139. doi: 10.1002/j.1556-6678.2002.tb00175.x
- Case, K. A., Stewart, B., & Tittsworth, J. (2009). Transgender across the curriculum: A psychology for inclusion. *Teaching of Psychology, 36*, 117-121. doi: 10.1080/00986280902739446
- Cianciotto, J. & Cahill, S. (2003). *Education policy: Issues affecting lesbian, gay, bisexual, and transgender youth*. New York, NY: The National Gay and Lesbian Task Force Policy Institute.
- Conroy, M. (2010). Treating transgendered children: Clinical methods and religious mythology. *Zygon: Journal of Religion and Science, 45*, 301-316. doi: 10.1111/j.1467-9744.2010.01082.x
- Coolhart, D. & Bernal, A. T. (2007, May-June). Transgender in family therapy. *Family Therapy Magazine, 36-37*.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Dahl, C. M., & Boss, P. (2005). The use of phenomenology for family therapy research: The search for meaning. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (pp. 63-84). New York, NY: The Guilford Press.
- Davis, T. S., Saltzburg, S., & Locke, C. R. (2009). Supporting the emotional and psychological well being of sexual minority youth: Youth ideas for action. *Children & Youth Services Review, 31*, 1030-1041. doi: 10.1016/j.childyouth.2009.05.003
- Erich, S., Tittsworth, J., Dykes, J., & Cabuses, C. (2008). Family relationships and their

- correlations with transsexual well-being. *Journal of GLBT Family Studies*, 4, 419-432. doi: 10.1080/15504280802126141
- Green, M. S., Murphy, M. J., Blumer, M., & Palmanteer, D. (2009). Marriage and family therapists' comfort level working with gay and lesbian individuals, couples, and families. *The American Journal of Family Therapy*, 37, 159-168. doi: 10.1080/01926180701441429
- Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior*, 35, 527-537. doi: 10.1521/suli.2007.37.5.527
- Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parents' reactions to transgender youths' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services* 18, 3-16. doi: 10.1300/J041v18n01_02
- Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth. *Journal of GLBT Family Studies*, 2, 71-92. doi: 10.1300/J461v02n01_04
- Grossman, A. H., D'Augelli, A. R., Salter, N. P., & Hubbard, S. M. (2005). Comparing gender expression, gender nonconformity, and parents' responses of female-to-male and male-to-female transgender youth: Implications for counseling. *Journal of LGBT Issues in Counseling*, 1, 41-59. doi: 10.1300/J462v01n01_04
- Grove, J. (2009). How competent are trainee and newly qualified counsellors who work with lesbian, gay, and bisexual clients and what do they perceive as their most effective learning experiences? *Counselling and Psychotherapy Research*, 9, 78-85. doi: 10.1080/14733140802490622
- Haire, A. R., & McGeorge, C. R. (2012). Negative perceptions of never-married custodial

- single mothers and fathers: Applications of a gender analysis for family therapists. *Journal of Feminist Family Therapy*, 24, 24-51. doi: 10.1080/08952833.2012.629130
- Hammers, C., & Brown, A. D. (2004). Towards a feminist-queer alliance: Paradigmatic shift in the research process. *Social Epistemology*, 18, 85-101. doi: 10.1080/0269172042000249408
- Hesse-Biber, S. N. (2007). The practice of feminist in-depth interviewing. In S. N. Hesse-Biber & P. L. Leavy (Eds.), *Feminist research practice: A primer* (pp. 111-148). Thousand Oaks, CA: Sage Publications, Inc.
- Hines, S. (2007). Transgendering care: Practices of care within transgender communities. *Critical Social Policy*, 27, 462-486. doi: 10.1177/0261018307081808
- Israel, G. E., & Tarver, D. E., II (Eds.). (1997). *Transgender care: Recommended guidelines, practical information, and personal accounts*. Philadelphia, PA: Temple University Press.
- Kane, E. W. (2006). "No way my boys are going to be like that!": Parents' responses to children's gender nonconformity. *Gender & Society*, 20, 149-176. doi: 10.1177/0891243205284276
- Korell, S. C. & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender children. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 271-288). Washington, DC: American Psychological Association.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender*

variant people and their families. New York: Haworth Press.

- Maguen, S., Shipherd, J. C., Harris, H. N., & Welch, L. P. (2007). Prevalence and predictors of disclosure of transgender identity. *International Journal of Sexual Health, 19*, 3-13. doi: 10.1300/J514v19n01_02
- Mallon, G. P. (1999). Practice with transgendered children. *Journal of Gay & Lesbian Social Services, 10*, 49-64. doi: 10.1300/J041v10n03_04
- Mallon, G. P. & DeCrescenzo, T. (2006). Transgender children and youth: A child welfare practice perspective. *Child Welfare, 85*, 215-241. Retrieved from <http://www.cwla.org/articles/cwjabstracts.htm>
- McGeorge, C., & Carlson, T. S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*, 14-26. doi: 10.1111/j.1752-0606.2009.00149.x
- McGuire, J. K., Anderson, C. R., Toomey, R. B., & Russell, S. T. (2010). School climate for transgender youth: A mixed method investigation of student experiences and school responses. *Journal of Youth & Adolescence, 39*, 1175-1188. doi: 10.1007/s10964-010-9540-7
- Menvielle, E. (2009). Transgender children: Clinical and ethical issues in prepubertal presentations. *Journal of Gay & Lesbian Mental Health, 13*, 292-297. doi: 10.1080/19359700903165357
- Menvielle, E. & Tuerk, C. (2002). A support group for parents of gender non-conforming boys. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 1010-1013. doi: 10.1097/00004583-200208000-00021
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San

Francisco, CA: John Wiley & Sons, Inc.

Mitchell, V. (2010). Developing the therapeutic self: Supervising therapists with lesbian, gay, bisexual, and transgender clients in the 21st century. *Women & Therapy*, 33, 7-21. doi: 10.1080/02703140903404671

Money, J. & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4, 29-41. doi: 10.1093/jpepsy/4.1.29

Mustanski, B. S. (2001). Getting wired: Exploring the internet for the collection of valid sexuality data. *The Journal of Sex Research*, 38, 292-301. doi: 10.1080/00224490109552100

Nichols, M. P., & Schwartz, R. C. (2008). *Family therapy: Concepts and methods* (8th ed.). Boston, MA: Pearson Education, Inc.

Olesen, V. L. (2003). Feminisms and qualitative research at and into the millennium. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 332-397). Thousand Oaks, CA: Sage Publications, Inc.

Oswald, R. F., Kuvalanka, K. A., Blume, L. B., & Berkowitz, D. (2009). Queering “the family”. In S. A. Lloyd, A. L. Few, & K. R. Allen (Eds.), *Handbook of feminist family studies* (pp. 43-55). Thousand Oaks, CA: Sage Publications, Inc.

Pardo, S. T., & Schantz, K. (2008). *Growing up transgender: Safety and resilience*. Retrieved from <http://www.actforyouth.net>

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Pixton, S. (2003). Experiencing gay affirmative therapy: An exploration of clients’ views

- of what is helpful. *Counselling and Psychotherapy Research*, 3, 211-215.
doi: 10.1080/14733140312331384372
- Pleak, R. R. (2009). Formation of transgender identities in adolescence. *Journal of Gay & Lesbian Mental Health*, 13, 282-291. doi: 10.1080/19359700903165290
- Pusch, R. S. (2005). Objects of curiosity: Transgender college students' perceptions of the reactions of others. *Journal of Gay & Lesbian Issues in Education*, 3, 45-61.
doi: 10.1300/J367v03n01_06
- Riley, E. A., Sitharthan, G., Clemson, L., & Diamond, M. (2011). The needs of gender-variant children and their parents: A parent survey. *International Journal of Sexual Health*, 23, 181-195. doi: 10.1080/19317611.2011.593932
- Rock, M., Carlson, T. S., & McGeorge, C. R. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of Marital and Family Therapy*, 36, 171-184. doi: 10.1111/j.1752-0606.2009.00172.x
- Ryan, C. (2009). *Supportive families healthy children: Helping families with lesbian, gay, bisexual, & transgender children*. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23, 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Saeger, K. (2006). Finding our way: Guiding a young transgender child. *Journal of GLBT Family Studies*, 2, 207-245. doi: 10.1300/J461v02n03_11
- Saltzburg, S. (2007). Narrative therapy pathways for re-authoring with parents of

- adolescents coming-out as lesbian, gay, and bisexual. *Contemporary Family Theory*, 29, 57-69. doi: 10.1007/s10591-007-9035-1
- Schneider, S. J., Kerwin, J., Frechtling, J., & Vivari, B. A. (2002). Characteristics of the discussion in online and face-to-face focus groups. *Social Science Computer Review*, 20, 31-42. doi: 10.1177/089443930202000104
- Stake, R. E. (2003). Case studies. In N. Denzin & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 134-164). Thousand Oaks, CA: Sage Publications, Inc.
- Stake, R. E. (1978). The case study method in social inquiry. *Educational Researcher*, 7, 5-8. Retrieved from <http://www.jstor.org/stable/1174340>
- Swann, S. & Herbert, S. E. (1999). Ethical issues in the mental health treatment of gender dysphoric adolescents. *Journal of Gay & Lesbian Social Services*, 10, 19-34. doi: 10.1300/J041v10n03_02
- The American Association for Marriage and Family Therapy (AAMFT) (2006). *User's guide to the AAMFT Code of Ethics*. Alexandria, VA: AAMFT.
- Toomey, R. B., & Richardson, R. A. (2009). Perceived sibling relationships of sexual minority youth. *Journal of Homosexuality*, 56, 849-860. doi: 10.1080/00918360903187812
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46, 1580-1589. doi: 10.1037/a0020705
- van Eeden-Moorefield, B., Martell, C. R., Williams, M., & Preston, M. (2011). Same-sex relationships and dissolution: The connection between heteronormativity and

homonormativity. *Family Relations*, 60, 562-571. doi:
10.1111/j.1741-3729.2011.00669.x

van Eeden-Moorefield, B., Proulx, C. M., & Pasley, K. (2008). A comparison of internet and face-to-face (FTF) qualitative methods in studying the relationships of gay men. *Journal of GLBT Family Studies*, 4, 181-204. doi:
10.1080/15504280802096856

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender dissonant children. *Child & Adolescent Social Work Journal*, 26, 135-154. doi: 10.1007/s10560-008-0158-5

White, M. (1993). Deconstruction and therapy. In S. G. Gilligan & R. E. Prince (Eds.), *Therapeutic conversations* (pp. 22-61). New York, NY: W. W. Norton & Co., Inc.

APPENDIX A

Demographic Questionnaire

1. Would you prefer to be contacted by the researcher via phone or email to arrange a date and time for the interview?
- I prefer to be contacted by phone
 - I prefer to be contacted by email
 - You may contact me by phone or email

Phone number _____

Email address _____

Name you would like to use _____

2. What is your gender? _____ Woman _____ Man _____ Transgender
(If these categories do not accurately represent you, please fill in your response)

3. What is your relationship status?
- Single/not living with a partner
 - Cohabiting/living with a partner
 - Married
 - Dating
 - Other (*please specify*): _____

4. Who do you live with? Check all that apply.
- Children
 - Romantic partner/spouse
 - Roommate
 - Parent(s)
 - Siblings or other family members (*please specify*): _____
 - Living alone
 - Other (*please specify*): _____

5. What is your current age? _____

6. What is your race/ethnicity?
- Asian/Pacific Islander
 - Black/African American
 - Latino(a)/Hispanic/Chicano(a)
 - White/Caucasian/European American
 - Native American/American Native
 - Middle Eastern
 - Biracial/Multiracial

Other (*please specify*): _____

7. What is your current work status?

- Full-time
- Part-time
- Seasonal/ Temporary
- Student
- Homemaker
- Retired
- Unemployed/ not working
- On Disability

8. What is your annual household income from all sources?

- \$0 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 - \$200,000
- \$200,000 or higher
- I prefer not to answer

9. What is the highest level of education you have completed?

- Grade School
- High School/ GED
- Some College
- Associates Degree or Technical Training
- Bachelor's Degree
- Graduate or Professional Degree (Master's, Ph.D.)
- Other (*please specify*): _____

10. Where do you live?

- Metropolitan area/ Large City
- Small City
- Rural/ Country
- Other (*please specify*): _____

11. What region of the U.S. do you live?

- Northeast
- Southeast
- Midwest
- Southwest
- Northwest

12. How would you describe your political views?

- Very conservative
- Conservative

- Moderate
- Liberal
- Very liberal

13. Children and Parental Status

Please provide information about your child(ren)	a. Child's Birthday	b. Child's grade in school	c. Relationship to you? Biological child Adopted child Stepchild Foster child Other	d. How often does this child sleep at your home?		e. Your age when this child entered your life
				100%	90%	
				75%	50%	
a. First Child					25%	
b. Second Child						
c. Third Child						
e. Fourth Child						
f. Fifth Child						
g. Sixth Child						
h. Seventh Child						

14. Which child(ren) does not conform to cultural gender expectations?

- First Child
- Second child
- Third child
- Forth Child
- Fifth Child
- Sixth Child
- Seventh Child
- Other (*please specify*): _____

15. Do you share co-parenting responsibilities of this child with someone else? Yes or No

If Yes to question 15:

16. What is your relationship to this co-parent?

- Married spouse
- Committed relationship
- We are divorced
- We are separated
- Other (*please specify*): _____

17. What is your child's relationship to the co-parent you refer to above?

- Biological child
- Adopted child
- Stepchild
- Foster child
- Other (*please specify*): _____

18. How do you share the co-parenting responsibilities?
- a. I am responsible for the majority of the parenting
 - b. We share the parenting responsibilities equally
 - c. The other adult is responsible for the majority of the parenting
 - d. Other (*please specify*): _____

If there is another co-parent, such as a step parent, relist questions 13- 15.

19. What is your relationship to this co-parent?
- Married spouse
 - Committed relationship
 - We are divorced
 - We are separated
 - Other (*please specify*): _____

20. What is your child's relationship to the co-parent you refer to above?
- Biological child
 - Adopted child
 - Stepchild
 - Foster child
 - Other (*please specify*): _____

21. How do you share the co-parenting responsibilities?
- I am responsible for the majority of the parenting
 - We share the parenting responsibilities equally
 - The other adult is responsible for the majority of the parenting
 - Other (*please specify*): _____

22. What, if any, is your religious preference?
- Protestant
 - Catholic
 - LDS / Mormon
 - Jewish
 - Muslim
 - Buddhist
 - Hindu
 - Other _____
 - No Preference / No religious affiliation
 - Prefer not to say

Please use the scale for the following questions.

1	2	3	4	5
Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree

- | | | | | | |
|--|---|---|---|---|---|
| 23. I consider myself to be a religious person. | 1 | 2 | 3 | 4 | 5 |
| 24. I find it impossible to conceive of myself as not being religious. | 1 | 2 | 3 | 4 | 5 |
| 25. I pray regularly. | 1 | 2 | 3 | 4 | 5 |
| 26. Participation in an organized religion is the primary source of my spirituality. | 1 | 2 | 3 | 4 | 5 |

APPENDIX B

Interview Guide

Introduction

Thank you for agreeing to talk with me. I am hoping to learn about your experiences raising a child who does not express gender in traditional or expected ways. The information you share with me will help therapists in their work with families similar to yours. I am curious about your thoughts and suggestions.

To start our conversation, please tell me about a typical day with your family.

Gender Identity

What does gender identity mean to you?

When did you first learn about gender identity?

Describing the Child

How would you describe your child's gender identity?

At what age did you notice that your child did not express her gender as you might expect?

How did you know?

What did [child name] say or do to indicate this to you?

How does [child name] currently express her gender identity?

What three words best describe your child?

Family Interaction

What kinds of discussion have you had with your children about gender identity?

How do you talk about [child name]'s gender expression in your immediate family?

(If there are siblings) Can you tell me how [child name] gets along with [siblings]?

What has been your experience with your extended family?

Describe family members' initial reactions when they first realized how [child name] expressed her gender.

Parenting

What is it like for you to parent [child name]?

Are there any specific events that stand out in your mind?

What messages have you received about your parenting?

From whom?

Social Relationships

How have your friends responded to [child name]'s gender expression?

What has it been like with [child name]'s friends?

Who in your life has been most understanding and how did they show you support?

What experiences have you had with friends or family that surprised you?

School

What has it been like at [child name]'s school?

Can you tell me about a problem you have experienced?

How have teachers and administrators treated [child name]?

What kinds of school policies exist to support [child name]?

Mental Health Services

Has anyone in your family been to see a mental health professional like a therapist, counselor, psychologist or psychiatrist?

What was the reason for going?

Was [child name]'s gender expression talked about?

If you haven't gone, what has kept you from going?

Have you sought out mental health services for [name of child]?

(If yes): How did you know the therapist/counselor could help [child name]?

How knowledgeable was the therapist/counselor about gender identity?

How did you know?

What was this experience like?

What did the therapist(s) do that was helpful?

What did the therapist(s) do that was not helpful?

Overall, what was your experience?

Overall, what was your child's experience?

Are you aware if your child has received a diagnosis?

(If yes): What is the diagnosis?

What do you think about that?

Family Therapy

What advice do you have for family therapists who want to help and support families like yours?

What do you think family therapists need to know to help families like yours?

Support

What kinds of resources are you connected to (i.e., support groups)?

How did you locate them?

What is it like for you to have [name resource they describe]?

What is it like for [child name]?

Parent Experience

Is there a metaphor that captures your experience parenting a child like [child name]?

Do you have a picture in your mind that shows what it is like to be you?

What stressors have you experienced related to [child name]'s gender expression?

Can you describe the strategies you have found most effective in dealing with these stressors?

Have any strategies been ineffective?

Concluding Interview

Is there anything that you have not shared with me or that I have not asked that you would like to say now?