Understanding the experience of parents of pre-pubescent children with gender identity issues

Abstract

Whilst in recent times there has been an increasing interest in the popular media in families with gender variant children, there is still a paucity of academic research into the experience of parenting a pre-pubescent child with gender identity issues. Gender dysphoria in young children engenders emotive reactions in adults meaning that social workers need to be aware of the various discourses surrounding gender identity in order to work sensitively with families affected. This research explores highly sensitive and intimate aspects of family life, requiring parents to talk and think about difficult issues and explores how it might feel for families to parent a child with gender identity issues. The psychosocial research method of Free Association Narrative Interviews was used in order to gather the data which was then coded and analysed drawing on a constructivist version of grounded theory. Five key themes relating to the process of mourning emerged from the data: loss, uncertainty, ambivalence, being unable to think and acceptance. Recommendations for both social work and clinical practice are also offered.

Introduction

Successfully raising a child is one of the most difficult challenges many individuals face, irrespective of class, religion, gender or geography. Successfully raising a child who is different, whether through disability, ability or any other reason can pose even more challenges. Many of these challenges are ones that have not even been considered as possibilities before they present themselves to the unsuspecting parent. Having a child with gender identity issues, something that is poorly understood by society as a whole, can present a parent with life-changing decisions, not only for their child, but also for themselves as an individual. The psychological state and reaction of the parents to a young child presenting with gender dysphoria is thus likely to be hugely significant in influencing how the child subsequently develops (Wren, 2002).

Family patterns of coping with stressful life circumstances, support networks, financial and emotional resources all have a key part to play in the child's experience of gender dysphoria. Yet thus far UK research has not explored the experience of parents with younger children, focusing instead on parents of adolescents (i.e. Wren, ibid; Coulter, 2010). This reflects a similar paucity of research internationally, ignoring a significant developmental period for families affected by gender dysphoria.

This research aims to provide a voice for the parent of a pre-pubescent child by adopting psychosocial research methods in order to shed some light on an under-explored and little discussed area of human experience. As such, this research explores highly sensitive and intimate aspects of family life, requiring parents to talk and think about difficult issues. Given increasing public awareness, and often negative discriminatory attitudes towards families who allow their children to transition, there may potentially be an increase in the number of families who may be referred to social workers for either assessment or child protection work. Therefore, social workers need to be aware of the discourses surrounding gender identity dysphoria in order to improve the sensitivity of their work.

Literature Review

As highlighted in the Introduction, gender dysphoria is a highly contested and emotive concept, with clinicians, academics and transgendered individuals polarised in their interpretations of aetiology, appropriate management, and

whether it is a medical condition or not (Bouman & Richards, 2013). However, prevailing professional opinion regards the causation of gender dysphoria as complex and multi-factorial (Hembree et al, 2009) and under DSM V (APA, 2013) gender identity issues are classified as a mental disorder (302.6 Gender Dysphoria in Children; 302.85 Gender Dysphoria in Adolescents or Adults).

However, some psychologists such as Ehrensaft (2011) challenge gender dysphoria as a concept and reframe it. Gender variant behaviour is not seen as pathological, but as part of an individual's creative expression of their identity. By drawing on queer theory, Ehrensaft (ibid) suggests that it is unhelpful to view gender as binary, but to conceptualise it more as being on a spectrum, where behaviour is seen as transcending normative cultural expectations of male and female.

Not all children experiencing gender identity issues will meet the full DSM-V diagnostic criteria, and research suggests that approximately 80% of children will desist in their cross-gendered behaviour by adulthood (Drummond et al, 2008; Wallien & Cohen-Kettnis, 2008). In order to be diagnosed with gender dysphoria, a child needs to exhibit "a marked incongruence between [their] experienced/expressed gender and assigned gender, of at least 6 months duration" (APA, 2013, p252). It must also be associated with significant levels of distress in social functioning. Children may reject stereotypical gendered modes of play, dislike their sexed body and strongly want to have the sexed body of their experienced gender. For younger children, they may or may not cross-dress (dependent on whether their parents facilitate this), but may repeatedly ask for

cross-gendered clothes (e.g. princess dresses) or refuse to wear overtly feminine outfits. Parents or other caregivers may also notice that the child becomes distressed when required to participate in sporting activities; swimming requires disrobing and wearing figure-revealing swimsuits and many playground sporting activities involve separating out the genders (e.g. lining up in queues of boys and girls which can cause an agonising dilemma for a child with gender dysphoria as they do not know which line to chose).

Early childhood can often pass with relatively few issues for a child with gender identity issues, particularly if the child is a natal female as society tends to be more tolerant of tomboyish behaviour (Di Ceglie et al, 2002). However, as the child, and their body, begins to mature, and they start to move outside of the often protective networks of family and primary school, difficulties can start to manifest. Steensma et al (2010) found that the years between 10 and 13 were viewed by young people as the most crucial time in their development for three reasons. Firstly, their social environment changes and the social gap between boys and girls increases. Secondly, the onset of puberty was considered to cause a change in feelings towards the developing body, and finally the experience of falling in love and forming romantic attachments triggered questioning both of cross-gender identification and sexual orientation. The researchers also found that a number of the biological girls, who had lived in role as boys in their earlier childhood, had found it extremely difficult to return to living as girls in their adolescence. This was due to feeling shame about their previous tomboyish appearance and worrying about what other people, especially their peer group, would think about their shifting gender identity.

Many young people do not disclose their transgender identity at all to their parents, or choose only to disclose it post-puberty (Wren, 2002), or choose to disclose to their mother rather than their father. Grossman et al (2005) found that the fathers who had been informed were more likely than the mothers to react negatively to their child's gender nonconformity, and the more extreme the nonconformity, the more likely the young person was to be verbally and physically abused by their parents.

The parental perspective is poorly represented in the academic literature, and tends to focus on the contemporary experience of parents of adolescent or young adult children. However, a key theme is that of loss and the experience of transgenderism within a family is often aligned to Kübler-Ross's (1969) four stages of grieving. Lev (2004) is frequently cited for her model of transgender emergence in families. The first stage is that of 'discovery and disclosure' which is when the family first acknowledge and name the child's gender identity issues. This stage is often a period of considerable emotional lability for the family. The next stage is that of 'turmoil' when the family tries to make sense of their child's gender difficulties. Following from this is a stage that Lev calls 'negotiation' which is when families work out boundaries, what is manageable for them as a family, and how to present both privately and publicly. The final stage is that of 'finding balance' when the family feel able to move forward and the initial upset and turmoil is resolved (p281).

Parents may experience feelings of disappointment for having a child who does not match their expectations (Rosenberg, 2002) and may also find it difficult

to accept their child's expressed gender identity and insist that it is a transient phase in their development (Dearden, 2009; Moller et al, 2009). This view is often reinforced by the wider family and friends who can be experienced as very judgemental and critical if the parent is seen to be supportive, or even encouraging of, their child's gender expression (Coulter, 2010). Popular media often strengthens this judgemental stance, exposing families who chose to allow their pre-pubescent child to publicly express their felt gender identity and facilitating often derogatory comments on web discussions following on-line publication of articles (e.g. Bracchi, 2012; Manning & Adams, 2014).

Parents often have to develop what Beeler and DiProva describe as "an alternative vision of the future" (1999, p451). This can be very uncertain, as discussed previously children with gender identity issues do not always go on to have an adult transgendered identity so it is difficult for parents to imagine what the future might look like. Ehrensaft (2007), herself a mother of a gay adult child who exhibited gender atypical behaviour in childhood, draws on both personal and clinical observations to categorise parents as either 'facilitative' or 'obstructive' (p273) in their nurturance of a child's gender identity. Facilitative parents are differentiated from obstructive parents by their ability to navigate the challenges posed by both the external demands of society and the internal needs of their child. She suggests that rather than 'shaping' cross-gender behaviour, parents are 'presented' with it from as young an age as two years old (p280). Thus the part that they subsequently play is that of responding to the behaviour and aiding or abetting their child's healthy gender identity development.

(For a more detailed review of the extant literature, please see Gregor et al, 2014).

Methodology

The research follows in the tradition of psychosocial research that is mindful of the role of the unconscious in the construction of research data, and considers "the unconscious communications, dynamics and defences that exist in the research environment" (Clarke & Hoggett, 2009, p2). It rejects the positivist paradigm that sees the researcher as the expert and objective in their collection and interpretation of the data (Bryman, 2008). The epistemological stance is thus that of 'not knowing' and psychoanalytic understanding is drawn on in order to try and explore beneath the surface. Given the under-researched and invisible nature of the subject material, the research design was deliberately conceived as flexible and evolved over the course of the initial conceptualisation and data collection phase of the project. A case study design was adopted in order to both explore the parental narrative in depth, and speculate on the possibilities that the narratives presented. (The full case studies form part of a Professional Doctorate in Social Work thesis and can be found in Gregor, 2013).

The relative rarity of childhood gender dysphoria meant that identifying a potential research participant had to rely on non-probability sampling in the form of convenience sampling. Parents who were already in contact with Gender Identity Development Service (G.I.D.S) at the Tavistock Clinic, London (the U.K's only nationally designated and commissioned NHS service) and met the eligibility

criteria were approached over a year long recruitment phase. Full ethical approval was obtained from the local NHS Ethics Committee prior to the commencement of the study and all participants provided signed consent agreeing to participate in the study and allowing the findings to be published. To maintain confidentiality clinicians were responsible for recruiting to the study and opted not to approach 35 out of 64 sets of parents who met the eligibility criteria. Reasons offered for not contacting families included concerns that the research might exacerbate on-going difficulties for the family, that it might explore feelings that were too raw for the family, or that the clinician was still working on trying to engage the family in a therapeutic relationship.

Eight parents subsequently agreed to participate with children ranging in age from 6-10 years old. The interviews lasted between 25 minutes to 90 minutes and all parents were invited to comment on their transcripts to confirm accuracy. Table 1 outlines the age range and demographics of the participants at the time of the study.

Name of parent*	Name of child*	Natal gender	Age of child
Zara	Ellie	F	8yrs
Lucy Dominic	Kit	M	8yrs
Kathryn Adam	Jodie	M	10yrs
Nicola Jason	Ashley	F	9yrs
Collette	Ben	M	6yrs

Table 1: Demographics of Participants.

The main psychosocial research tool used was that of a loosely structured narrative interview drawing on the principles of a free association narrative interview (FANI). Derived from clinical psychoanalytic practice the FANI encourages the interviewee to talk about what is important to them. Open-ended questions are used and the 'why' question is avoided as it can often elicit clichéd answers rather than the interviewees own perspective. This style of interviewing allows the interviewee to be a 'storyteller' rather than a respondent, and enables them to exert more influence over the research interview process than a traditional semi-structured interview would allow. Holloway and Jefferson argue that free associations support "an emotional rather than a cognitively derived

---

* Names of both parents and children have been anonymised to protect participant identity

logic" allowing for richer insights (2000, p152) and the uncovering of the interviewees "subjective meaning-making" (Frosh & Saville Young, 2008, p114).

Due to the research project being undertaken as part of a doctorate in social work, there was only one interviewer for all of the parents (Gregor). Prior to interview, parents were invited to choose a favourite photograph to share with the researcher during the interview. After the initial warm-up question to ask about the family background and make-up, the first question asked about the photograph of their child. This was intended to stimulate free association and a telling of the story behind the photograph with minimum guidance from the researcher. The next question was about the parental understanding of gender identity issues and elicited some thoughts on its aetiology and why the parent believed that their child had developed an atypical gender identity. The next question was designed in the spirit of 'the particular incident' follow-up found in biographical interpretative narrative research (Wengraf: 2006) in order to again encourage story telling. The parent was asked to recall a particular incident that had shaped their understanding of their parenting their child with gender identity issues. A final question then was designed to stimulate a narrative about the parent's development over time from initial discovery of their child's gender identity issues to the present time. As the parents all had pre-pubescent children, it was important to try and capture their journey as previous research had only explored the parents of older children, who were therefore more distant from the early stages of their journey.

In order to ensure transparency and academic rigour in the methodology, the coding procedure suggested by Charmaz and Bryant in their constructionist version of grounded theory (2011) was used. They outline a five-step process in coding research transcripts: i) close study of the data without referral to academic literature; ii) line-by-line coding; iii) use of gerundive or "action" coding, and sensitising concepts initially; iv) thematic sampling to follow-up on initial coding in future interviews and v) selective or thematic coding. As outlined earlier, due to the small number of interviews, it was not possible to achieve saturation, nor to do thematic sampling in later interviews.

Process:

Stage 1 (*close study of the data without referral to academic literature*):

After each interview, initial responses to the material were written up and then transcription was undertaken as soon as possible. Any thoughts that occurred during the transcription process were also written down as memos for use later on.

Stage 2 (*line-by-line coding*):

Once a complete transcript had been made, it was then coded it by hand initially line-by-line using gerundive coding. This was a time-consuming process but it ensured that each line of the transcript was considered and chunks of interview were not over-looked because initially considered not relevant to the research topic.

Stage 3 *(use of gerundive or "action" coding, and sensitising concepts initially)***:**

All of the gerundive codes (e.g. *speculating about child's behaviour, challenging child's wishes, hoping it was a phase*) were then transferred to a Microsoft Excel™ spreadsheet. The spreadsheet enabled all of codes to be viewed and grouping could start. Initially the codes that featured most frequently were grouped together.

Stage 4 *(axial coding):*

Moving onto axial coding, temporal aspects were then examined and grouped codes were grouped together as *past, present* or *future*. Using Microsoft Excel™ all of the codes were then ordered into these three categories. Later on, this stage of the coding was re-visited as the code of 'the past' encompassed two distinct phases – *the emergence of gender identity issues* and *the 'crux'*. The transcripts were examined again and cross-referred looking at those codes that had appeared most frequently in the initial analysis. 'In vivo' codes were then used to ensure that the research stayed close to the parental voice.

Stage 5 (higher level coding):

The next stage of the process was to look at all the 'in vivo' codes and identify themes and links between them. This was initially done per transcript, and then later on cross-transcripts. This provided a number of higher level codes which initially were organised using the same category as Coulter (2010): Management of Issues.   However, this was then sub-divided into 'Practical' and 'Emotional' again reverting to the original transcripts to check that the strong themes that I

had identified were indeed present. Finally, the codes were organised systemically drawing on Carter & McGoldrick's notion of the Family Life Cycle (1994) in order to gather a sense of which systems were interacting most powerfully with the families at that point in time. An example of codes can be seen in Table 2 below.

Temporal	Management of issues	
	Emotional	Practical
Emergence of gender identity issues	**Not knowing**[1] Thinking it was '*just a phase*' Feeling parenting was being judged	Providing opposite gender clothes and toys Policing behaviour **(Unwillingly)** supporting gender variant behaviour
'*The Crux*'	Realising '*it goes deeper*' **'Not knowing why'** Being '*forced*' to act	Seeking advice – **'I don't know what I'm dealing with'** Gathering info on the web
The Present	Moving towards acceptance '**Having to do it for sake of child**'	Being child-led '*It's the he's and the she's*'

[1] Items in bold indicate strong themes

	'Somebody's taken my child'	
The Future	**Not being able to think about it** **'They may change'** Worrying about unknowns	Preparing child for change

Table 2: Example of Coding.

One of the limitations of being a solo researcher is that the codes were devised by the lead researcher and therefore are subject to researcher bias as the transcripts were not be co-coded or compared by another researcher in their entirety. As Ruane (2005: p72) reminds us, "humans 'see' what we want to see". Therefore, extracts from the transcripts were shared regularly with a research discussion group in order to keep thinking open and to help ensure that the analysis kept close to the data.

Findings and Discussion

Five key themes relating to the process of mourning emerged during the analysis of the data: *loss*, *not thinking*, *uncertainty*, *ambivalence* and *acceptance*. These

will now be considered in turn, and illustrated with quotes from the parent participants.

Loss – "*Somebody's taken my child*"

Whilst aspects of mourning and grief are considered in other research accounts of parents with children with gender identity issues it is usually with the hopeful outcome that a sense of acceptance of the child's gender identity will be achieved (Lev, 2002). In this way, the process of grieving has become sanitised and somehow made less painful by proposing that there is an 'end goal' or desirable, and, indeed, achievable outcome. Whilst this may indeed be the case for some parents, the uncertainty faced by the parent participants in this research did not suggest that this was a reality for them at this time. Many parental narratives were very painful; one mother spoke poignantly of both being "*robbed of the joy of being told that I had a baby girl when I gave birth*" and also feeling "*robbed of my little boy because he's gone*" (Kathryn). Another mother, when discussing her biological daughter dressing as a boy, said

> "*I just hate when she's dressed like that because ummm, it just, it's*
> *not the same child. It's like somebody's taken my child and put*
> *back one that's not mine*" (Zara).

Suggestions of a process through a number of stages during grieving for the loss of their child suggests society's need to compartmentalise mourning and denies the ongoing vacillation between different and often painful states of mind for the parent.

One mother's comment captures this sense of uncertainty talking about when her biological male child asked her to call him by his chosen female name,

> *"I've said to him would you prefer me to call you [girl's name] and he said yes but he doesn't mind when I don't...umm so I don't...I suppose there is deep down there is a part of me that finds it difficult to do that because of what it means and also because of habit and there is definitely this sense of no matter how ok I am with it, there is a sense of loss and I know people talk about that but I can understand that"* (Lucy)

However, what a staged approach of mourning, as outlined by previous researchers, fails to consider is the joy and vitality that parents also experience loving a child with gender identity issues. Emotionally painful experiences were reframed as positive personal growth, and all bar one of the families spoke proudly of their child.

Not Thinking – "*I can't think*"

As part of the mourning process, a stage of disbelief and denial is commonly experienced (Dickenson & Johnson, 1993). In keeping with this, parental narratives were peppered with comments such as "*I can't think*" (Nicola) or "*I didn't think anything of it at all*" (Collette). With the benefit of retrospection offered by the opportunity to discuss their experiences, some parents appeared to be able to use the research interview as an opportunity to think. One family had only

recently realised that their biological daughter had been expressing unhappiness with her gender identity from a very young age. She was repeatedly in trouble with her school, and as a result her parents were frequently contacted,

> *"Nothing was ever mentioned about gender, we never thought anything about it then. And we moved two years ago to another school. They said there was more acceptance then but we did say, you know, he's very much a tomboy, thinks of herself as a boy, still, never thought anything then, did we really?"* (Nicola).

It was only when a CAMHS worker identified that their daughter behaved worst when at the swimming pool and asked to wear a swimming costume that the parents were finally able to "*put two and two together*". Their previous inability to think suggests a process of denial or repression, which can be seen as a fundamental defence against the anxiety that their child's gender variant behaviour was causing them.

Parents in this study were initially unable to think or even name their child's gender identity issues reflecting the complexities and social pressures of contemporary parenting practice. For example, it was only when a Family Centre worker passed on the website details of Mermaids (a UK-based Family Self-help Charity) to Kathryn, that she realised how her child felt,

> *"I was reading about children with gender dysphoria. Because obviously I had never heard of it and I didn't know what was, was*

going on and you know, it ticked all the boxes...I couldn't believe what

I was reading you know."

It may be that they worried about their own internalised homophobia, or the possible homophobic reactions of others if they put into words their concerns. Parents may also have worried that it was their fault that their child was exhibiting gender variant behaviour and therefore found it easier to deny this thought, than allow it space. Certainly the tone of moral outrage epitomised by responses in the blogosphere to online media articles about transgender issues makes it extremely difficult for thoughtful thinking to take place.

Uncertainty – "*I haven't got a clue*"

As one might expect, parents expressed a great deal of uncertainty, both about their child's diagnosis and the prognosis, and their narratives were situated largely in the past and present domains. Describing the early days of his child's journey, one father reflected

"I think just in the early days you, you wanna do the right thing but

don't really know what the right thing is" (Dominic)

Where the future was discussed, it was briefly referred to as something that posed a great threat to their child's wellbeing, and filled the parent with fear and trepidation. Unlike the past and present which were described in detail, the future, as for many bereaved individuals, was described with vague brushstrokes. The same father commented, "*you don't know what to do, what's best*".

Like Coulter's (2010) research, parents were specifically asked how they understood gender identity in terms of their child which enabled a discussion about possible aetiology. Speculations about aetiology were peppered through the narratives, "*I wondered if it was something to do with some faulty gene somewhere*" (Nicola); "*it's a medical condition*" (Kathryn), although no one cause was conclusively subscribed to. All of the parents were aware of possible psychological interpretations for their child's behaviour, but presented as reluctant to accept them, either dismissing them outright, or questioning their validity.

 A commonly held view was that the child was "*born that way*", suggesting a tendency towards a biological understanding of gender identity. Whilst parental views on aetiology have not previously been reported in empirical research, this biological perspective does tie in with the prevalent discourses of both GIRES (Gender Identity Research and Education Society) and Mermaids, organisations strongly linked to families in the UK.

Many of the parents cited the research by Drummond et al (2008), and Wallien and Cohen-Kettenis (2008) that 80% of children will desist in their gender dysphoric behaviour by adulthood. Whilst they were aware of this research, and appeared to understand the possibility of change for their child, the parents still seemed to need to take up a position regarding their child's future gender identity. One father was particularly clear about his views,

"There's nothing wrong, there is absolutely nothing wrong. Kids develop the way they need to. They develop...it's not nurture, it's definitely nature. Umm if it's in them then it's always going to be in them so just support them, that's all you need to do" (Adam).

Some parents held on to the hope that their child would revert back to their biological gender identity, whilst others felt that their child would most probably persist. Holding a position of uncertainty appeared too difficult for these parents, and binary positions appeared to offer more comfort. As Wiseman and Davidson (2011) suggest "a binary discourse of sex and gender provides concrete predictability where there may be a great deal of uncertainty and fluidity, both temporal and contextual" (p3).

Ambivalence – "*Having to do it for the sake of my child*"

Whilst all of the parents expressed their willingness to do whatever they needed to do to support their child in their transgender journey, this was often countered with comments about not really wanting to, or even feeling forced. Hill et al (2010) found that parents were often "caught in a bind" (2010, p9), trying to balance the child's wishes with their fears of resultant social exclusion and bullying. Lucy's comments capture this,

"You try to remain open minded and umm just be led by the child but then there is the dilemma of protecting them from society and letting them be happy with who they are."

From a psychoanalytic perspective, such "contradictory impulses and emotions towards the same object" (Rycroft, 1995, p6) can be understood as ambivalence, and far from being a pathological emotion, can be viewed positively as being part of being a 'good enough' parent (Winnicott 1958; 1965). Parents repeated spoke of the challenges that they faced everyday in parenting their child,

> *"it's daunting and it's still very, it's like a minefield, it's like oh because it's the not knowing. If he was, I don't know, let's just say diabetic, then it's quite simple in the sense that you manage the diet, you have insulin [laughs] And you know you get on, but with this it is just so ambiguous, it's like how, how do you...umm... sometimes I think how do I justify me not encouraging it, but allowing it, when he is a physical boy?"* (Collette).

Whilst other research suggests that parents may be subject to conflicting emotions (Hill & Menvielle, 2009), there is little indication that this is a normal healthy process, leading parents to feel pathologised and often misunderstood by professionals, a failure in their parenting project.

Acceptance – "*You hear these horror stories in the paper*"

Acceptance is seen as the final stage in Emerson & Rosenfeld's (1996) model, although their interpretation of acceptance is that it does not have to signify agreement with their child's gender identity. Although the circumstances leading up to point of seeking professional help were usually very traumatic,

parental narratives tended to gloss over this part of the history telling. This may be because it was too painful to recall in detail, or, possibly because they feared it was contrary to their carefully constructed discourse of accepting their child. Like the parents in Harden's (2005) study of parents with children with mental health problems, parents spoke consistently about accepting their child's gender identity issues and this appeared to be viewed as a positive step forward, and an important part of 'good parenting' (Harden, ibid, p219).

Certainly, acceptance, in the form of "acknowledging the unvarnished facts of a situation rather than passivity or resignation" (Williams & Lin, 2010, p23) seemed to be inherent in parental narratives of personal growth and change. Acceptance in this study seemed to be couched more in terms of how others might view and 'accept' their child, rather than how the parents themselves accepted their child which has been the reported findings of other research (Grossman et al, 2005; Hegedus, 2009). Some of the parents spoke of having mixed feelings about facilitating other people calling their child the correct biological gender,

> *"Sometimes I do and other times I think ok I can't be bothered [laughs] umm because sometimes I just think, do you know what it's going to be too complicated because he's there with Barbie in one hand, Mopsie in the other and you know looking very feminine and I am not going to see you again probably so I can't, I'm not even going to end up going there...mmm, how, I don't know, no, I don't*

think I have really...I think there is part of me that feels happy for

[him] when they say it" (Collette).

Whilst a couple of parents explicitly said that they accepted their child, the parental narratives made implicit that all parents both supported and accepted their child, no matter what the eventual psychosexual orientation or outcome for them. Kathryn's comment "*I can't accept she's not going to change*" is not untypical. Given the often conflicting and ambiguous narrative presented in the interviews, there is a possibility that the concern about others accepting their child is in fact a projection of their own unwanted feelings. Whilst the potential, and indeed, social reality of stigma and even violence for these families is undeniable (Grant el, 2010), the projection of non-acceptance onto others may be an additional coping strategy that parents adopt in order to manage the anxiety of having a child who is different.

However, outside of the immediate family system all of the parents in this study were acutely aware of social stigma and the challenges that came from their child being perceived as 'different'. A number of parents specifically referenced negative newspaper coverage where children and families had been 'outed' and this lack of societal tolerance weighed heavily on their minds. As Adam commented,

"What worries, what worries me is you hear these horror stories in

the papers where it's all going out and everybody at the school gets

to know and...it's not the kids, I'll tell you now it's not the kids, the

kids are no problem. At the school the kids are no problem but if

the parents get to hear about things...they can kick off".

Due to the younger age of the children in this study, many of the children were 'under the radar' and their gender identity issues were therefore not as publicly evident.

The 'social' aspects of the parental experience were very powerful, yet in terms of hearing the parental narratives on a surface level and coding the data, it remained quite hidden. It may be because there is so much anxiety about social stigma, and indeed violent feelings about atypical sexualities, that the parents were forced to defend against their own anxieties in order to protect their children. Whilst some concern was voiced about the onset of puberty, parents' main worry seemed to be about how their child would be accepted in the future, and how their future happiness, whatever their gender identity, could be ensured.

Practice Recommendations

One of the challenges for parents of pre-pubescent child with gender dysphoria as discussed earlier is their inability to 'know' what is happening to their child in the early stages of their journey. This makes it difficult to access any support as parents are not initially able to 'name' what the difficulty is, and social workers and other professionals working in proscriptive services driven by eligibility criteria may be unable to offer appropriate help. Additionally, as one mother commented

"it's difficult having a child with gender identity and parents do get

forgotten. There's no real support for the parent. The child gets

the support which obviously they need but there's nothing there

for the parent" (Zara)

All of the parents who did participate in the research had reached a point in their journey whereby they felt able to 'name' their child's difficulties as being related to extreme distress over their gender identity. For these parents, non-pathologising support should be offered via existing non-specialist networks such as Family Centres. Some of the families involved in this research had positive experiences of Family Centres and thus more consideration should be made to including them within support networks, especially where there are siblings. As discussed earlier, families may normalise gender identity issues, but outside of the family system, the sibling, and indeed parents, may encounter prejudice and fear. Professionals are thus ideally placed to act as 'containers' for the parent's anxieties (Ruch, 2007) and can enable them to tolerate uncertainty and live with ambivalence. As discussed earlier, these two aspects are central to the parental experience and very much in keeping with current good practice guidelines promoted by GIDS (Di Ceglie, 1998).

However, staff working in Family Centres may not be familiar with the issues affecting families with gender identity issues, and more training may need to be put in place to support this. Information is readily available on the Internet relating to gender dysphoria, but this is frequently biased towards one perspective and does not always present the spectrum of views in this contentious area. As a

professional it is important to try and resist being forced into binary certainties in order to enable the parent to tolerate the uncertainty of their child's gender identity.

Given the ongoing debates within the academic and transgender community as to whether gender dysphoria is a psychiatric condition, it is understandable that local service providers may differ in their assessment as to whether Child and Adolescent Mental Health Services (CAMHS) or regular Social Care services are most appropriate to meet the family's needs. A seemingly happy pre-pubescent child with gender dysphoric feelings may not meet the eligibility criteria for many CAMHS teams, which could result in their parents not being offered the support that they require. Parents then become 'expert' parents, enabling the professionals to acquire knowledge from them, rather than receiving the emotional support that they need.

Given the uncertainty and ambivalence that families experience in relation to supporting their child with gender dysphoria, increased levels of support should be offered to them. This should acknowledge the emotional strain that having a pre-pubescent child with gender identity issues can pose, and allow the opportunity for parents to grieve the loss of their internalised ideal parent. Support could be via participation in a parents' group, or 1,1 support and offer the opportunity to discuss feelings of ambivalence in order to empathise that it is a 'normal healthy' response to a child's gender identity issues.

Limitations of the Study

As mentioned earlier, theoretical sampling was not possible due to the small number of research participants recruited. Whilst the aim of the research had been to recruit more participants, this was not achievable, even with a year long recruitment phase. Undoubtedly the emotionally sensitive nature of the research and the hidden nature of the gender identity issues made it difficult to recruit. The research protocol presented to the NHS Ethics Committee also only allowed for one contact interview with participants, thus removing the possibility of returning to explore emergent themes or hunches in more detail. Sampling was restricted to known families seen by GIDS, which may have led to a particular bias in their parental experience e.g. they were already asking for professional help with their child. With such a small sample, negative case analysis was equally difficult to undertake, although one narrative was noticeably different to the other parents in the study, and indeed, many of the parents seen at GIDS. However, despite the differences in this narrative, there were many similarities, which thus add to the credibility of the emergent themes discovered.

The parental perspective has been explored from a subjective standpoint as it is impossible to have either a control group of parents with non-gender disordered children, or have parents comment objectively on their parenting of non-gender disordered siblings as well. Charmaz's (2001; 2006) constructivist approach allows for research to be a product of its time, place and interactions between participant and researcher, nonetheless the resultant findings can be transferable to other similar parent populations.

Conclusion

Despite the increasing awareness of gender dysphoria amongst lay people, there still remains very little written in academic papers, and even less in social work journals. Given that social workers are often in the front-line of supporting families with gender dysphoria, it is hoped that this research helps to both inform and stimulate debate about the ongoing and future care for both young children with gender dysphoria and their parents. All the parents commented that they had felt poorly understood and had had to take on the role themselves of educating professionals, it is thus hoped that the study presented makes a contribution to increasing the understanding of social workers who do come into contact with families who experience gender dysphoria.

Psychosocial research methods have enabled a snapshot to be presented of a point in time for a five families who have a pre-pubescent child experiencing gender identity issues. Whilst painful and often raw emotions were shared with the researchers, the over-riding sense that parents conveyed was that their children offered a huge amount of joy, and their parents were immensely proud of them, no matter how uncertain their future might have been. Through this research, It is hoped that professionals can also be enabled to tolerate the uncertainties of gender dysphoria and work effectively in the future with such families.

References

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* 5th ed. (DSM V) Washington DC, APA

Beeler, J., DiProva, V. (1999) *Family Adjustment Following Disclosure of Homosexuality by a Member, Themes Discerned in Narrative Accounts,* Journal of Marital and Family Therapy, 25, 4, 443 – 459

Bouman, W, P., Richards, C. (2013) *Diagnostic and Treatment Issues for People with Gender Dysphoria in the United Kingdom*, Sexual and Relationship Therapy, 28, 3, 165-171

Bracchi, P. (2012) *Mixed up Five Year Olds and the Alarming Growth in the Gender Identity Industry* http,//www.dailymail.co.uk/news/article-2106215/Mixed-year-olds-alarming-growth-gender-identity-industry.html [accessed 11/11/13]

Bryman, A. (2008) *Social Research Methods* 3rd ed. Oxford, Oxford University Press

Carter, B., McGoldrick, M. (1999) *The Expanded Family Life Cycle: Individual, Family and Social Perspectives* 3rd ed. London: Allyn & Bacon

Charmaz, K., Bryant, A. (2011) *Grounded Theory and Credibility* in ed. Silverman, D. *Qualitative Research: Issues of Theory, Method and Practice* 3rd edition Thousand Oaks, CA: Sage

Clarke, S., Hoggett, P. (2009) *Researching Beneath the Surface* London, Karnac

Coulter, S. (2010) *Parenting a Child with Gender Identity Issues,* unpublished clinical psychology Doctoral thesis, University of East London

Dearden, G. (2009) *Transwomen's Memories of Parental Relationships, An Interpretative Phenomenological Analysis Study,* https,//uhra.herts.ac.uk/dspace/bitstream/2299/4518/1/Georgina%20Dearden%20-%20DClinPsy%20research%20thesis.pdf [accessed 3/6/11]

Di Ceglie, D. ed. (1998) *A Stranger in my own Body, Atypical Gender Identity Development and Mental Health* London, Karnac

Di Ceglie, D., Freedman, D., McPherson, S., Richardson, P. (2002) *Children and Adolescents Referred to a Specialist Gender Identity Development Service, Clinical Features and Demographic Characteristics* International Journal of Transgenderism , 6 (1)   http,//www.symposion.com/ijt/ijtvo06no01_01.htm [accessed 1/6/09]

Dickenson, D., Johnson, M. eds. (1993) *Death, Dying and Bereavement* London, Sage

Drummond, K., Bradley, S., Peterson-Badali, M., Zucker, K. (2008) *A follow-up study of girls with gender identity disorder,* Developmental Psychology ,44, 34–45

Ehrensaft, D. (2007) *Raising Girlyboys, A Parent's Perspective* <u>Studies in Gender and Sexuality</u> , 8 (3), 269 - 302

Ehrensaft, D. (2011a) *Gender Born, Gender Made, Raising Healthy Gender non-conforming Children* New York, The Experiment

Emerson, S., Rosenfeld, C. (1996) *Stages of Adjustment in Family Members of Transgendered Individuals,* <u>Journal of Family Psychotherapy</u>, 7, 3, 1 - 12

Frosh, S., Saville Young, L. (2008) *Psychoanalytic Approaches to Qualitative Psychology* in eds. Willig, C., Stainton-Rogers, W. *The SAGE Handbook of Qualitative Research in Psychology* London, SAGE

Grant, J., Mottet, L., Tanis, J., Herman, J., Harrison, J., Keisling, M. (2010) *National Transgender Discrimination Survey , Report on health and health care* National Centre for Transgender Equality Washington DC http://2fwww.thetaskforce.org/downloads/resources_and_tools/ntds_report_on_health.pdf [accessed 18/10/12]

Gregor, C. (2013) *How might parents of pre-pubescent children with gender identity issues understand their experience?* Unpublished Thesis Professional Doctorate in Social Work, University of East London in collaboration with the Tavistock Clinic http://repository.tavistockandportman.ac.uk/803/1/Claire_Gregor_Gender_Identity.pdf

Gregor, C., Davidson, S., Hingley-Jones, H. (2014) *The Experience of Gender Dysphoria for Pre-pubescent Children and their Families, A Review of the Literature* Child and Family Social Work early on-line version

Grossman, A., D'Augelli, A., Jarrett Howell, T., Hubbard, S. (2005) *Parents' Reactions to Transgender Youths' Gender Nonconforming Expression and Identity,* Journal of Gay and Lesbian Social Services, 18, 1, 3-16

Harden, J. (2005) *"Uncharted Waters", The Experience of Parents of Young People with Mental Health Problems* Qualitative Health Research , 15 (2), 207 – 223

Hegedus, J. (2009) *When a Daughter Becomes a Son, Parents' acceptance of their transgender children* unpublished dissertation Alliant International University, San Franciso Bay

Hembree, W., Cohen-Kettenis, P., Delemarre-van de Waal, H., Gooren, L., Meyer, W., Spack, N., Tangpricha, V., Montori, V., (2009) *Endocrine Treatment of Transsexual Persons, An Endocrine Society Clinical Practice Guideline,* Journal of Clinical Endocrinology & Metabolism , 94, 9, 3132–3154

Hill, D., Menvielle, E. (2009) *"You have to Give Them a Place Where They Feel Protected and Safe and Loved", The Views of Parents Who Have Gender-variant Children and Adolescents* Journal of LGBT Youth 6, 243 - 271

Hill, D., Menvielle, E., Sica, K., Johnson, A. (2010) *An Affirmative Intervention for Families with Gender Variant Children, Parental Ratings of Child Mental Health and Gender* Journal of Sex and Marital Therapy , 36, 6-23

Hollway, W., Jefferson, T. (2000) *Doing Qualitative Research Differently, Free association, narrative and the interview method* London, Sage

Kubler-Ross, E. (1969) *On Death and Dying*, New York, Simon & Shuster

Kunst, J. (2012) In Search of the Good Enough Mother Psychology Today http,//www.psychologytoday.com/blog/headshrinkers-guide-the-galaxy/201205/in-search-the-good-enough-mother [accessed 29/9/12]

Lesser, J. (1999) *When Your Son Becomes Your Daughter, A Mother's Adjustment to a Transgender Child,* Families in Society, 80, 2,182-189

Lev, A. (2004) *Transgender Emergence, Therapeutic Guidelines for Working with Gender-variant People and Their Families,* Binghamton, The Haworth Press

Manning, S., Adams, S., (2014*) NHS to give sex change drugs to nine-year-olds: Clinic accused of 'playing God' with treatment that stops puberty*, http://www.dailymail.co.uk/news/article-2631472/NHS-sex-change-drugs-nine-year-olds-Clinic-accused-playing-God-treatment-stops-puberty.html [accessed 7/6/14]

Möller, B., Schreier, L,i A., Romer, G. (2009) *Gender Identity Disorder in children and Adolescents,* <u>Current Problems in Paediatric Adolescent Health Care</u> , May/June, 117-143

Palmer B (1973) *Thinking About Thought* <u>Human Relations</u> , 26 (1), 127-141

Rosenberg, M. (2002*) Children with Gender Identity Issues and Their Parents in Individual and Group Treatment,* <u>American Academy of Child and Adolescent Psychiatry</u> , 41, 5, 619 – 621

Ruane, J. (2005) *Essentials of Research Methods* Oxford: Blackwell

Ruch, G. (2007) *Reflective Practice in Contemporary Child-care Social Work, The role of containment* <u>British Journal of Social Work</u> , 37, 659 - 680

Rycroft, C. (1995) *Critical Dictionary of Psychoanalysis* London, Penguin

Segal, J. (1992) *Melanie Klein* London, Sage

Steensma, T., Biemond, R., de Boer, F., Cohen-Kettnis, P. (2010) *Desisting and Persisting Gender Dysphoria After Childhood, A Qualitative Follow-up Study,* <u>Clinical Child Psychology and Psychiatry</u> ,16, 4, 499-516

Wallien, M, S., Cohen-Kettenis, P. (2008) *Psychosexual outcome of gender-dysphoric children,* Journal of the American Academy of Adolescent Psychiatry , 47, 1413–23

Wengraf, T. (2006) *Interviewing for life-histories, lived situations and personal experience: The Biographic-Narrative Interpretive Method (BNIM) on its own and as part of a multi-method full spectrum psycho-societal methodology* http://webcache.googleusercontent.com/search?q=cache:fp51U3u_IAIJ:www.uel.ac.uk/cnr/Wengraf06.rtf+&cd=1&hl=en&ct=clnk&gl=uk&client=firefox-a [accessed 23/10/12]

Williams, J., Lin, S. (2010) *Acceptance, An historical and conceptual review* Imagination, Cognition and Personality , 30 (1), 5-56

Winnicott, D. (1958) *Collected Papers, Through Paediatrics to Psycho-analysis* London, Tavistock

Winnicott, D. (1965) *The Maturational Process and the Facilitating Environment* London, Hogarth

Wiseman, M., Davidson, S. (2011) *Problems with binary gender discourse, Using context to promote flexibility and connection in gender identity,* Clinical Child Psychology and Psychiatry,
http,//ccp.sagepub.com/content/early/2011/11/09/1359104511424991 [accessed 23/2/2012]

Wren, B. (2002) *I Can Accept My Child Is Transsexual But If I Ever See Him In a Dress I'll Hit Him, Dilemmas in Parenting a Transgendered Adolescent* ,<u>Clinical Child Psychology and Psychiatry</u> , 7, 3, 377-397

Zamboni, B. (2006) *Therapeutic Considerations in Working with the Family, Friends, and Partners of Transgendered Individuals,* <u>The Family Journal, Counselling and Therapy for couples and Families</u> , 14, 2,174-179