The Needs of Gender-Variant Children and Their Parents

Elizabeth Anne Riley

Thesis submitted for the degree of Doctor of Philosophy

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Faculty of Health Sciences

University of Sydney

Declaration

I hereby declare that this thesis is my own work and that; this thesis describes original research undertaken in the Faculty of Health Science at the University of Sydney. No part of this work has been submitted for a higher degree to any other university or tertiary institution. To the best of my knowledge any theories or research that are not my own have been acknowledged in the text.

Elizabeth Anne Riley

Certificate of Originality

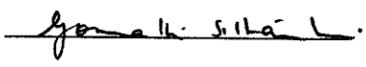
Candidate

I declare that this thesis is my own work and that this research is original in its conception, application and production in the Faculty of Health Sciences at the University of Sydney. No part of this work has been submitted for a higher degree to any other university or tertiary institution. To the best of my knowledge, any theories or research that are not my own have been acknowledge in the text.

Elizabeth Anne Riley

Supervisor's Certificate

This is to certify that the thesis entitled *The Needs of Gender Variant Children and their Parents* is ready for examination.



Dr Gomathi Sitharthan

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Abstract

Approaches to gender diversity in Western culture have had a chequered past. Gender-variant children have been institutionalised, subjected to aversion therapies and pressured into maintaining secrecy and conforming to society's gendered expectations while also dealing with bullying and harassment at school. Gender-variant adults struggle with a lack of acceptance and live in fear of violence and discrimination while at the same time dealing with the legacy of their childhood. Parents of gender-variant children are forced to contend with societal bias and assumptions that allow their children to be marginalised. Moreover, they have scarce resources to help them manage their child's welfare and deal with their concerns on a day-to-day basis.

The idea of gender variance confronts widely held assumptions that children born as male will act like 'boys' and children born as female will act like 'girls'. This imposed binary perpetuates negativity towards people who express themselves with gendered variations in attire, behaviour or preferences. Despite the existence of cross-gender presentations and behaviour in every culture and throughout time, society still appears to be unaware that diversity in gender expression and sexual formation is a naturally occurring phenomenon.

Previous research on gender-variant children has largely been focussed on the etiology and treatments of gender identity disorder, investigating demographics, heritability, co-morbid conditions, gender development, and genetic and environmental influences. However, current research within the social sciences draws attention to a range of gender variance topics such as: the challenges and inequalities affecting children presenting with gender diversity; their victimisation; their social transitions; and professionals' use of language in referring to gender variance. Research studies on the parents of gender-variant children have generally

utilised parent-reports on gender identity questionnaires relating to their child. Recent studies have explored parents' stories and mental health ratings of their child as well as their emotions and attitudes towards their child. Combined child and parent reports have focussed on therapeutic support procedures and outcomes for parents and families with gender-variant children. These studies contribute important information that aids in the diagnosis of gender identity disorder and work continues towards suitable approaches for the support of these children and their parents. However, much of the evidence provided thus far is anecdotal and interventions are based on little or no evidence. Anecdotal reports, although important contributions to understanding individual circumstances, tend to privilege certain viewpoints.

By establishing the needs of gender-variant children and their parents, this qualitative enquiry aims to contribute to research-based evidence and the development of supportive programs, training and policies. This study brings into the open forum some of the challenges that children with gender variance and their parents face, identifies ways in which the children and their parents are marginalised and explores how they cope. Evidence is provided so as to inform the practices, interventions and recommendations relied upon in supporting gender-variant children and their families.

This research was conducted through three Internet surveys which used open-ended questions to provide a rich source of thick description of personal experiences. These questions enabled a thematic and reflective analysis of data sourced from the experiences of parents raising a gender-variant child, the childhood experiences (retrospective) of transgender adults, and the views of professionals who work with the transgender community.

The results of this study indicate a severe lack of resources and access to professional help for gender-variant children and their parents. The needs of the children emerged as: the need to be heard and accepted by their parents without punishment; the need for information and peer contact; the need for personal gender expression; and the need for safety. The most common needs for parents were for information in the way of stories, research and guidelines as well as educational resources to prepare schools, professionals and local communities for providing trans-positive support for them and their child. Other identified needs of the parents addressed support from community, professionals, peers and governments.

The goals of this project include the promotion of trans-positive approaches, and awareness and education regarding bullying and ostracism of gender-variant children. Outcomes are suggested in the form of recommendations and training policies for professionals, governments, schools and parents. These suggestions aim to reduce the debilitating experiences and outcomes that gender-variant adolescents and adults have to endure.

This study of the needs of gender-variant children and their parents relies upon the voices of those in the community and fills a void in the current understanding and treatment of gender non-conforming children. The identification of these needs provides fundamental information for the development and application of resources and services that will foster positive mental health for gender-variant children during their formative years.

Publications in this Thesis

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. http://www.tandfonline.com/doi/abs/10.1080/19317611.2011.593932

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we confirm that Elizabeth Anne Riley has made the following contributions:

- designed and authored the survey from which this paper was conceived
- analysed, interpreted, coded and presented the data in this paper.
- authored this article from conception to completion.

Our involvement was to provide a critical review including advice on, logic, analysis and presentation of the findings, inclusions and layout of the paper.

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...

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...

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...

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CHAPTER 1

Introduction

1.1 Gender Variance in Western Society

The dominant discourse on gender in Western society is powerfully divided into female and male. The blurring of the boundaries between female and male attributes, particularly in the areas of attire, presentation and preferred activities, is generally regarded by society as deviant or abnormal, despite the fact that these boundaries are largely socially constructed. Although it is acceptable for male or female adults to be fashion designers, dancers, chefs, scientists or soccer players, not all children are encouraged to pursue these activities and learn their associated skills. A boy's interest in hairdressing, clothes or skipping, for instance, is quickly disapproved of and stereotypes regarding what constitutes acceptable activities for boys and girls are firmly entrenched through peer group pressure. In the late 1970s, Raymond (1979) anticipated that social change would create more flexibility and tolerance of gender variance. However, 30 years on, there is perhaps even more pressure on children to conform to gender stereotypes; for example, girls' jeans display motifs, frills or patterns that signal femininity while toys in department stores are clearly delineated into 'girls' and 'boys' sections. Dictating what boys and girls can and cannot do in relation to their preferences for hair styles, toys, activities and friends seems out-dated in this era particularly as it could be argued that a greater exposure to and practice of a wider range of skills would allow children to take advantage of the vast number of career opportunities available when they reach adulthood.

This chapter begins with some general information related to gender variance then covers in some detail the development of terms and language, the prevalence of gender variance in

children and, gender and sex role development. The chapter then continues with the historical emergence of cross-gendered behaviour in children in the literature, the etiology of gender difference, the current research on gender variance in children and the development of treatment and attitudes towards these children. The chapter concludes by presenting the impact that gender variance has had on people's lives and provides the rationale for this research project.

Gender variance refers to non-conforming gender behaviour or presentation. It challenges automatic assumptions about the types of behaviour and presentation that are considered to be congruent with a person's birth (anatomical) sex. According to Burrows (2011, p. 22), the distinction between these two concepts is that "sex is the label for someone's body as male or female. Gender identity is someone feeling they are a man or woman, masculine or feminine". These definitions suggest that the current categorisations of sex and gender (female - feminine and male - masculine) are mutually exclusive. This imposed binary serves to reinforce the invisibility of gender-variant people and subject them to a kind of "gender tyranny" (Doan, 2011, p. 636). It also discourages exploration outside of these stereotypes (Raymond, 1979). Even adults who seek supportive professional help for gender identity issues may feel confined to the binary as noted by Lev (2004, p. 132) in *Transgender Emergence*, "If the shoe doesn't fit – force it!" The assumptions behind the stereotypes are so pervasive that the vast majority of people not only remain completely blind to their own contributions to the perpetuation of gender stereotypes but also to the fact that these stereotypes are socially constructed. The apparent visibility of gender-variant people persists despite their continued existence across time, countries and cultures (Bolich, 2008; Bullough & Bullough, 1998; Ettner, 1999; Feinberg, 2001; Green, 1998; Herdt, 1994; Laqueur, 1990; Mead, 1961; Roughgarden, 2004).

In reality, the range of diversity within sex and gender is vast (Diamond, 2002; Fausto-Sterling, 1993; Feinberg, 2001; Roughgarden, 2004). Moreover, the number of people born with genitals that deviate from the typical sexual formation may be as high as one in every 50 live births (Blackless, et al., 2000). Because gender variance is not measured by a biological marker at birth, the number of people with variation in sex and gender is likely to be greater. Currently, the gender-variant population includes an increasing number of people who identify as neither strictly female nor male, but who adopt neutral, non-gender or other mixed gender identities (Bockting, 2008; Cooper, 1999; Diamond, 2003; Ekins & King, 1998; Raj, 2002; Riley, Wong, & Sitharthan, 2011; Rosario, 2004). Studies have generally not accounted for these variations in gender but rather have created categories (Lombardi, 2009) or sometimes combined them (including gay and lesbian people), creating a syndicate commonly referred to as the *queer* community despite the fact that gender-variant individuals (or others so categorised) do not constitute a homogenous group and may not identify as *queer*. Ekins and King (1998) have proposed that more flexible gender expressions would help counter rigid perceptions of gender or even allow "the idea of gender itself [to] disappear" (p. 102). Ironically, the removal of gender stereotypes might have the effect of allowing the rights of gender-variant people to become more *visible*.

The range of expectations and attitudes towards gender variance with respect to culture, ethnicity, traditions, beliefs and religion yields a controversial and volatile mix of perceptions and opinions, both lay and professional. This vast array of views influences the positioning of gender variance with respect to nature, nurture, biology, etiology and treatment (including whether treatment is or is not warranted). Gender-variant children must contend with a combination of influences and pressures on a day-to-day basis – from parents, family, friends,

neighbours, the school, local community and religious groups, and society in general. Long before they can understand what their transgressions might be, children have absorbed these expectations of gendered behaviour (Bem, 1993; Devor, 1997; Herek, 1990). Because children are compelled to restrict their presentation, activities and creativity based on the anticipation of people's judgements and reactions, their freedom can be severely limited. This lack of validation of the child's authenticity creates self-doubt about their reality, encourages the development of defence mechanisms and may impact their well-being (Benestad, 2001; Lev, 2004; Mallon, 1999b; Rieger & Savin-Williams, 2011; Sullivan, 1953). It is important to add that some childrens' sense of self appears to be so concrete and hardy that socialisation, negativity and/or punishment do not prevent the expression of their genuine identity (Boenke, 2003; Burke, 1996; Costa & Matzner, 2007; Diamond, 1982; Diamond & Sigmundson, 1997a). Parents are also subjected to external pressures and the tyranny of stereotyping, and may feel blamed or excluded by other family members or others outside the family for failing to enforce gender conformity in their children (Wren, 2002). As a consequence, some parents are unable to cope with the situation and punish their children through rejection or violence (sometimes quite severe) in order to pressure the child to conform (Alanko, et al., 2008; Costa & Matzner, 2007; Grossman & D'Augelli, 2007; Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004).

The terms used to refer to gender-variant people continue to evolve as the complexity of differing agendas – for example, social, political and legal – are accentuated in media and academic discourse (Diamond, 2003). Each term (along with its associated implications) imposes a 'label' on gender-variant people. Gender-variant individuals also have different interpretations of the terms they use to define themselves and create terms to suit their own identity and politics (Bockting, 1999; Bockting, 2008; Diamond, 2003; Gilbert, 2000; Lev,

2004). To further complicate matters, terms such as ‘sex’, ‘gender’, ‘gender-variant’, ‘transgender’ and ‘transsexual’ are often used interchangeably and sometimes erroneously. This can create artificial barriers and has been criticised as leading to ‘cisgenderism’ (the invalidation of atypical gender identities), implying differences between people when there are in fact none (Ansara & Hegarty, 2011). This sense of ‘othering’ occurs when authors separate the individuals in subject from others and is ubiquitous in the media as well as in the scientific literature where labels are only imposed when deviance from the norm is identified (Gilbert, 2000). The problem that arises is how a subset of people can be studied without labelling and thus automatic *othering* of this group. Nonetheless, the need to identify and define this group has led to the use of the terms *gender-variant* (for children) and *transgender* (for adults) (used as adjectives not nouns). The term *transgender* is an umbrella term that includes all people with gender variance within its scope (Bockting, 1999; Green, 1994; Lev, 2004). For the purposes of this study, a ‘child’ is defined as being 12 years or younger as this is the accepted age for pre-pubescence (Di Ceglie, Freedman, McPherson, & Richardson, 2002).

The rest of this chapter provides a foundation and history of gender variance in children, beginning with development of language to situate this study within the larger framework of gender behaviour and identity in language, history and treatment.

1.2 Development of Terms and Language

In the 1950s and 1960s, as different forms of gender variance started to be discussed more frequently in the literature, the terms used to describe the gender of children started to shift away from references to ‘femininity’ and ‘masculinity’ towards other terms, some of which were pejorative. Children displaying cross-gender behaviour and desires were described as

exhibiting ‘homosexual’ or ‘pre-homosexual’ behaviour (Bakwin & Bakwin, 1953; Francis, 1965), ‘incongruous’ gender roles (Green & Money, 1960), ‘transvestism’ or ‘transvestic’ behaviour (Bakwin, 1960; Stoller, 1966), ‘deviant’ gender-role behaviour (Bakwin, 1968), boyhood gender ‘aberrations’ (Stoller, 1978) and ‘deviant’ sex-role behaviours (Rekers & Lovaas, 1974). They were described as being ‘sissy’ boys (Green, 1987; Green & Money, 1960), ‘transvestites’ (Greenson, 1966) and ‘effeminate’ (Green & Money, 1966; Stoller, 1967; Zuger & Taylor, 1969). It is obvious from this list that these terms were almost always applied to children whose birth-sex was male. Expressions such as these reflected the prevailing attitudes and encouraged and supported the use of behaviour therapies to ‘cure’ the child.

The terms ‘gender identity’ and ‘gender role’ have been used to refer to aspects of psychosocial development (Emmerich, Goldman, Kirsh, & Sharabany, 1977; Kohlberg, 1966; Maccoby, 1966; Marcus & Overton, 1978; McConaghy, 1979; Slaby & Frey, 1975). John Money first used the word ‘gender’ in a 1955 article reporting on precocious puberty and defined the term *gender role* as

> signify[ing] all those things that a person says or does to disclose himself or herself as having the status of a boy or man, girl or woman, respectively. It includes, but is not restricted to sexuality in the sense of eroticism. (p. 254)

‘Gender role’ in this sense includes more than one’s gender expression and sexual orientation; it also implies that these aspects aligned with a heterosexual orientation. Benjamin (1964, p. 458) observed that sex is ambiguous as it has no “accurate scientific meaning” while Diamond (1965, pp. 148-149) described “gonadal sex, hormonal sex, chromosomal sex, anatomical sex [genitalia], assigned sex [and] gender role” as being

separate entities and later defined ‘gender role’ as encompassing “those behaviors imposed overtly or covertly by society” (Diamond, 2002, p. 323). Stoller (1964, p. 220), on the other hand, first used the term ‘gender identity’ to refer to a child’s awareness of “I am a male” or “I am a female”, an awareness which could be modified over time. Stoller (1964, p. 223) further identified a “core gender identity” as a fixed and thus unchangeable “overpowering drive” determined by anatomy, behaviour, parental expectations and biology. This core gender identity may or may not contradict other ‘gendered’ components. Money & Ehrhardt (1972, p. 146) described gender role and gender identity as “facets of the same entity” and used gender identity to embrace both. Since the 1970s, the terms gender and sex have been used interchangeably in the vernacular, irrespective of scholars’ attempts to educate people on the difference between the two (Diamond, 2002; Nye, 2010; Rosario, 2004). In 1980, the *Gender Identity Disorder* (GID) was recognised as a condition and entered the Diagnostic and Statistical Manual of Mental Disorders (APA, 1980) while in 1994 the condition of *Gender Identity Disorder in Children* (GIDC) – “a strong and persistent cross-gender identification” – was introduced into the DSM-IV (American Psychiatric Association, 1994, p. 537).

The first reference to the term *gender-variant* or *gender variance* can be found in the title “Gender Loving Care: A Guide to Counselling Gender-Variant Clients” by psychologist, Randi Ettner (1999). Ettner used this term to attempt to depathologise the treatment of people with gender issues and to bring a compassionate and client-centred approach to the support of individuals. The term *transgender* appears to have been first used by Virginia Prince when she identified herself not as someone who wore the other sexes’ clothes (transvestite) nor as someone who needed to surgically change their body to be the other sex (transsexual) but as somewhere in between (Stryker, 2006). That is, Prince identified herself as someone who

wanted to alter her gender expression. Transgender has since been adopted as an umbrella term to include all gender variance (Bockting, 1999; Diamond, 2003; Ekins & King, 1998; Green, 1994; Lev, 2004). The term now appears in the title of the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association). It is important to note that some people, particularly transsexuals, who have been included in the 'transgender' category, find the term offensive as they feel it denies their identity and experience, which they believe to be very different to that of people who simply express gender variance (Davidson, 2007; Diamond, 2003; Gilbert, 2000; Towle & Morgan, 2006).

The next section describes the challenges involved in determining the prevalence of transgender variance in children given that the terms and definitions used are subject to historical bias, personal interpretation and other influences.

1.3 Prevalence of Gender Variance in Children

The task of establishing the prevalence of gender-variant behaviour is fraught with difficulty. Firstly, even when defined as 'non-conforming gender behaviour', *gender variance* is laden with personal, familial, cultural, traditional and societal values, beliefs and expectations that generate a myriad of views on what should be considered to be different from the 'norm'. Secondly, this task is made even more complex due to transformations in the social and scientific environment in which what is considered atypical or non-conforming has also changed. Thirdly, the term *gender variance,* when used to refer to children, is often employed interchangeably with the term GIDC, even though it has been shown that cross-sex behaviour is more prevalent than gender dysphoria or GIDC (van Beijsterveldt, Hudziak, & Boomsma, 2006; Zucker, Bradley, & Sanikhani, 1997). It also appears that gender identity is so firmly

set by the time of puberty that adolescents who are diagnosed with GIDC in childhood are also diagnosed with GID in adulthood (Money & Ehrhardt, 1972; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Wallien & Cohen-Kettenis, 2008).

Unfortunately, studies of children with gender variance have not made any significant contribution to an understanding of its prevalence as the focus has typically been on clinical referrals of children diagnosed with GIDC (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, et al., 2011; Wallien & Cohen-Kettenis, 2008). The term *gender variance* itself does not assume any bodily discomfort or distress (although these may be present). Nor does it predict any particular outcome whereas a diagnosis of GIDC indicates a level of permanency. The prevalence of *cross-gender behaviour* in children is likely to be the closest we can get at this point to understanding the prevalence of gender variance.

The prevalence of cross-gender or gender atypical behaviour in children is difficult to determine as the little research that has been done in this area shows that prevalence reduces with age (van Beijsterveldt, et al., 2006; Zucker, et al., 1997). Nonetheless, the research shows that gender variance in children is not rare and ranges between 3.2% (van Beijsterveldt, et al., 2006, p. 647) to 6.6% (Fagot, 1977, p. 905) for boys and 4.9% (Fagot, 1977, p. 905) to 10.6% (Zucker, et al., 1997, p. 219) for girls. The items measured included "behaves like opposite sex" (van Beijsterveldt, et al., 2006, p. 650; Zucker, et al., 1997, p. 219) and cross-sex behaviours (Fagot, 1977). It is interesting to note that Sandberg, Meyer-Bahlburg, Ehrhardt and Yager (1993, p. 313) reported that only 0.3% of boys and 0.3% of girls aged 6-10 years showed no cross-gender behaviour at all and that 22.8% of boys and 38.6% of girls showed at least 10 expressions of cross-gender behaviour either "seldom" or "once every 3 months". Lapouse and Monk (1964, p. 441) also found that 22% of 6-12 year

olds showed deviations from what was considered normal or sex-appropriate behaviour, for example, "cooking, sewing, embroidery, knitting, playing with dolls, carpentry, electrical work, constructing models, dressing in clothes of the opposite sex, [and] playing with boys or girls" (Lapouse & Monk, 1964, p. 437). A recent study of the prevalence of gender atypical behaviour of Chinese school-aged children in a cohort of 486 boys and 417 girls showed that over 99% of these children displayed at least one cross-sex behaviour and that many (17.9% of the boys and 40.8% of the girls) displayed more than 10 different cross-sex behaviours (Yu & Winter, 2011, p. 343). The results from this non-Western sample are remarkably similar to those of Sandberg et al (1993). Interestingly, the rates show higher cross-gender behaviour in girls than boys as compared with the rates of clinical referrals for girls with GIDC, which are lower than for boys (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Cohen-Kettenis & Pfafflin, 2003; Cohen-Kettenis, et al., 2006; Di Ceglie, et al., 2002; Zucker, et al., 1997; Zucker, Owen, Bradley, & Ameeriar, 2002). This seems to indicate a greater tolerance for gender-variant behaviour in girls.

To provide a background and understanding of how research has influenced the emergence of gender variance in children in the literature, the next section traces the literature and research on sex and gender role awareness and development.

1.4 Gender and Sex-Role Development

Much research on gender and sex role development has focused on determining gender *normality*. Notwithstanding the confusion surrounding the definitions of gender, sex, gender identity, sex role and gender role (outlined in Section 1.1), researchers do agree that markers of gender roles and stereotyping emerge by the age of three (Bem, 1983; Fagot, 1986; Martin

& Ruble, 2009; Zosuls & Ruble, 2009). Gender constancy[1], on the other hand, emerges nearer the age of five (sometimes later) (Kohlberg, 1966; McConaghy, 1979; Renk, Donnelly, McKinney, & Agliata, 2006; Ruble, et al., 2007; Slaby & Frey, 1975; Zhentao & Fuxi, 2006) when children begin to understand that genitalia signals whether one is female or male (Bem, 1989, 1993).

The nature of gender and sex role development in children is generally considered to be complex and controversial (Biernat & Kobrynowicz, 1999; Constantinople, 1973; Diamond, 2009; Goldman, Smith, & Keller, 1982; Martin & Ruble, 2009; Martin, Wood, & Little, 1990; Ruble, et al., 2007; Spence, 1993). This is because it involves not only constancy and stereotyping, but also gender roles, sex roles, gender behaviour, gender beliefs, gender biases, gender identity, gender schematicity, gender attitudes, gender play styles and more. Numerous theories of learning as well as more specific theories about children's learning of gender and sex roles have been developed and applied, for example, social cognitive theory (Bandura & Bussey, 2004), gender stereotype matching (Martin, Ruble, & Szkrybalo, 2002), socialisation influences on gender schemas (Fagot & Leinbach, 1993), imprinting, nurture and socialisation (Hampson & Hampson, 1961; Money, Hampson, & Hampson, 1957; Money & Tucker, 1975a, 1975b), prenatal organisation and biased-interaction theory (Diamond, 1965, 1976, 2006, 2009, 2011) and self-socialisation theories (Kohlberg, 1966; Zosuls & Ruble, 2009). Research has also shown that parents have an impact on the development of gender roles and stereotyping in children (Fagot & Hagan, 1991; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Gelman, Taylor, & Nguyen, 2004; Lindsey, Cremeens, & Caldera, 2010; Pomerleau, Bolduc, Malcuit, & Cossette, 1990). Some authors, however, have challenged the assumptions, procedures and methods used in research on

[1] The understanding of one's permanent physical sex as female or male (Kohlberg, 1966)

gender development and have raised doubts about the legitimacy of the results. Constantinople (1973), for instance, note the value judgements (and therefore the validity) surrounding measurements of 'femininity' and 'masculinity' and question whether psychologists ought to be using these terms at all. Goldman (1982) also queried the instruments used to determine sex-role preferences in young children, pointing out that "stereotyped play" is not an indicator of "sex-role preference" but a measure of "sex-role knowledge" (p. 83).

These studies also raise the question of whether researchers are creating the very biases they are trying to measure. Firstly, children are steered toward focussing on gender (when they may not have before); secondly, they are presented with items couched in terms of the binary female (feminine) and male (masculine); thirdly, they are asked to make judgements about items or activities which suggest there is a 'right' or 'wrong' answer and may therefore respond in a way that seeks to please the examiner; fourthly, the items being measured (femininity and masculinity) are the same tools used to create the measuring instrument; and finally, the assumption that there is a 'normal' sets up children's imaginative or creative capacity as discrepant.

Diamond (1965, 1982, 1997, 2006, 2009, 2011; 1997a, 1997b; Whitam, Diamond, & Martin, 1993) provides significant evidence for the "biased-interaction theory of psychosexual development" including numerous examples where gender reassignment at birth created great distress for the individuals involved. He proposed that gender role is subject to prenatal organisation by genes and hormonal influences, which predisposes the individual to particular responses as they undergo a natural process of 'testing' themselves against others to establish whether they are similar or different.

Kohlberg (1966) argues that all children are subject to stereotyping, regardless of whether they have parent models or not. Gender role development is seen as an internal process not linked to societal expectations or awareness of genital anatomy but to characteristics that are perceived to be highly valued or prestigious, such as being powerful or clever. This suggests that children exhibit gender role characteristics through anticipation of reward, approval or opportunity whereas Diamond's research proposes that a deeper more instinctive process is at play.

Bem (1993) and Goldman (1982) have both argued that children have rigid views of gendered behaviour due to their limited knowledge and reliance upon a 'gender schema' (Bem, 1981) absorbed from the dichotomous gendered society in which they live. Following Kohlberg (1966), Bem (1993) believes that children are active in demonstrating gender behaviours that proscribe gender systems although these are *not* as 'natural' or 'inevitable' as Kohlberg claims them to be.

More recently, Egan & Perry (2001, p. 459) have proposed that children during their middle childhood have a perception of their gender identity reflected in four areas: the extent to which they emulate their gender category; their satisfaction or comfort in belonging to this category; the extent to which they are required to conform to gender stereotypes rather than free to explore other gender options; and, whether they see their category as superior. It appears that with respect to the idea of comfort in belonging to a category there has been a failure to distinguish between whether the child's satisfaction is related to the approval of others or to a deeper instinctual sense of identity.

It is evident that this multiplicity of observations and analysis reflects the complexities of behavioural, cognitive, social, environmental and biological possibilities which do not allow for a definitive approach to understanding gender and sex role development. In general it is acknowledged that 'nature' and 'nurture' have varying roles to play in this development, depending on the circumstances of the individual.

The next section provides an historical review that describes how gender non-conforming behaviour in children was first recognised, discussed and studied in the academic literature.

1.5 Historical Emergence and Research of Gender Variance in Children

This section explores the understandings presented in the literature regarding 'cross-sex' behaviour as identified in children beginning with Freud. Femininity and masculinity in children were first identified and explored through the lens of psychoanalysis. The psychoanalytical perspective confirmed stereotypes and reinforced the imposition of limitations on children's behaviour. Studies on children's 'gendered' behaviour that drew upon the psychoanalytical perspective, up until 1960, tended to attempt to explain non-conforming gendered behaviour and justify traditional gender roles. From then on, research moved towards a focus on etiology as the *cause* of cross-gender expression and behaviour.

In *The Ego and the Id* Freud discussed the Oedipus complex and referred to the "bisexuality originally present in children … [whereby a boy] … behaves like a girl and displays an affectionate feminine attitude towards his father and a corresponding hostility and jealousy towards his mother" and "a little girl after she has had to relinquish her father as a love object, will bring her masculinity into prominence and identify herself with her father" (Freud, 1990, p. 28). Drawing upon this psychoanalytic framework, Boehm (1930, p. 466)

reported a case in which "One [male] patient said to me: 'In the first years of my life, when I was learning to walk, I had a doll from which I refused to be separated until it became a mere rag, with straw sticking out'". Boehm concluded that "there is an early, feminine, phase of development, in which the boy's feelings are very much like those of a girl" and that boys all begin as "little girls" but that they grow through their "castration anxiety" to later become men (p. 466).

A number of years later, Markey and Noble (1936) commented that "It is, of course trite to say that masculinity and femininity are present in both sexes" (p. 260) and that "The little girl is at first largely undifferentiated from the little boy and is, in that sense, just as masculine as he is" (p266). They also remarked that defining the terms 'masculinity' and 'femininity' was not as simple as psychoanalysis proposed and noted Earnest Jones' "ultimate question…[that is] whether a women is born or made" (p. 266). It is interesting to note that while Markey and Noble perceived early girlhood in terms of masculinity Boehm (1930) conceptualised early boyhood in terms of femininity.

The next reference to children and cross-gendered behaviour can be found in MacDonald's (1938) article entitled 'Criminally Aggressive Behaviour in Passive, Effeminate Boys'. In this article, MacDonald (pp. 70-71) discussed eight cases of boys who had been "rejected or expelled by groups, schools, clinics and relatives". On some occasions the behaviour of these boys had been most satisfactory: "at home when permitted to assist mother or grandmother with such household activities as cleaning, dusting, washing, sewing, embroidering, and cooking, they are happy, cooperative and 'the nicest boy a mother could want'". Later in the article, MacDonald comments:

> When acting out feminine identification with females there was no anti-social behaviour but when forced into a masculine role with other boys they invariably reacted with unprovoked physical attacks in which they always felt justified because of anticipated aggression on the part of the anxiety-producing object. (p. 78)

He also noted, however, that there were no facilities in Illinois for the study or treatment of these boys.

In 1941, Ferguson presented his findings on masculinity and femininity in men and women and concluded that:

> … pleasant and desirable childhood experiences enabling the child to accept appropriate models of the culture pattern he is to adopt lead to the acquisition of the 'normal' behavior patterns, among these being femininity in women and masculinity in men. Conversely, unpleasant or undesirable childhood experiences cause the child to reject the normal models and to acquire behavior patterns which are atypical, e.g., femininity in men and masculinity in women. (p. 585)

This introduced the belief that femininity in men and masculinity in women are dysfunctional responses to adversity and consequently aberrant. Ferguson's findings may have been influenced by Bender and Paster's case studies (1941) of 23 children who exhibited sexual (mainly homosexual) behaviours and who had been severely abused and institutionalised.

In 1942, Parsons (p. 604-605) suggested that American society is "conspicuous for the extent to which children of both sexes are in many fundamental respects treated alike". He added "There are, of course, important sex differences in dress and in approved play interest and the like" and further observed:

> It seems to be a definite fact that girls are more apt to be relatively docile, to conform in general according to adult expectations, to be 'good', whereas boys are more apt to be recalcitrant to discipline and defiant of adult authority and expectations. There is really no feminine equivalent of the expression 'bad boy'. (p. 605)

Parsons (p. 605) attributed this defiance of authority to the boys' lack of a "tangible meaningful [role] model" which meant they were not initiated into the masculine role because their fathers were generally absent. He also argued (pp. 605-606) that the "equality of privileges and responsibilities … [and] … lack of sex differentiation" is extended through formal education and added, "It is only in post-graduate professional education, with its direct connection with future occupational careers, that sex discrimination becomes conspicuous". In this, Parsons identified a contradiction. On the one hand, all children should be treated alike while, on the other, girls and boys should be treated *differently* in dress, play and "the like". Parsons appears to have disregarded the encoding of gender differences in children and the pressure and limited opportunities available to girls during that era.

In 1950, Rabban wrote with a lengthy article (75 pages) exploring the "remarkable" attitudinal changes towards women following the rigid Victorian era with its "circumscriptions, proprieties, and occupational restrictions". He asked: "Are pressures to conform stronger for girls or boys?" (p. 85). His response was that children are 'trained' from birth to obey their given sex-role and that until the age of four there is little difference in play between girls and boys. Rabban also observed that after the age of four, children become increasingly aware of their peers' strict condemnation of cross-gender play, a pattern than is more pronounced for boys than girls. Rabban also noted that boys developed negative attitudes towards the work and roles of women, which was not true for girls' attitudes

towards the work and roles of men. Thompson (1903), Mead (1935) and Scheinfeld (1944) had previously condemned the restrictions placed on children and the labelling of activities as ‘masculine’ or ‘feminine’. Going against popular opinion, Thompson (1903) had spoken up: “The difference in physical training is very evident. Boys are encouraged in all forms of exercise and in out-of-door life, while girls are restricted in physical exercise at a very early age” (as cited in Rabban, p. 88). Rabban further remarked that, according to Thompson, boys are chastised for taking part in girls’ play while girls are regularly permitted to engage in boys’ games.

Rabban’s review concluded that:

- despite the significant physiological differences that exist between boys and girls, the social behaviour of members of a particular sex is to a large extent culturally determined;
- membership in a particular social class determines the specific nature of sex role behaviour;
- these patterns are learned in the very early years, particularly in the family;
- the years between two to four are especially crucial;
- these patterns are later reinforced by one’s peers and parent surrogates; and
- male status has greater prestige in American culture.

  (pp. 96-97)

Rabban’s study explored sex and age differences in children with respect to sex-role awareness as well as demands in social development of diverse social groups. He used the term *sex-role* to refer to the set of internally motivated responses that epitomise local cultural expectations.

Rabban's (1950) summary included comments from Mead (1935) and Schienfeld (1944) that emphasised how children, without prejudice, ought to have the freedom of an unencumbered imagination and their 'gifts' and talents should be recognised. Scheinfeld (1944) argued that 'feminine' and 'masculine' traits are desirable and ought to be cultivated in all persons and that "the mere labelling of traits as masculine or feminine does not give either sex exclusive rights to them, or even justify the broad division of traits between the sexes as groups" (cited p. 153). Rabban concluded his paper by questioning whether children were being harmed by these limitations:

> In the education aim of training intelligence to deal with the solution of problems, and of giving free rein to creative expression for the enjoyment of life—how much harm is implicit in over-refined definitions of appropriate behaviour and interests for either sex, in any social group? (p. 154)

It appears that these views, however, were not enough to prevent the strict application of stereotypes to children even though this placed children with cross-gender behaviour at risk.

Bakwin and Bakwin (1953)[2] promoted the discourse of cross-gender behaviours as being pre-homosexual, citing Bender and Paster's (1941) descriptions of children with "homosexual trends … [including the] behavior patterns characteristic of the other sex" (p. 108)[3]. Like Rabban, they acknowledged that "boys who show effeminate behaviour are much more likely to excite comment than are girls who dress in boys' clothes, play boys' games and so on" (p. 108). Moreover, they argued that "coercion, teasing and shaming are ineffective [in

[2] Interestingly, it was this same year that Harry Benjamin, the pioneer for advocacy of transsexuals first penned his treatise on 'Transvestism and Transsexualism'.

[3] It ought be noted, however, that Bender and Paster (1941) expressed that the children's behaviour patterns were not due to the boys' 'femininity' or the girls' 'masculinity' but rather their "psychopathic personalities" (p. 742).

preventing or stopping the behaviour] and even harmful" (p. 111). During this period, psychoanalytic case studies also appeared, reporting on the development of transvestism in boys (Friend, Schiddel, Klein, & Dunaeff, 1954). For example, in a study of three boys Friend et al. (1954) commented that:

> … in all of the children it was necessary to curtail the transvestite play at home and to introduce dressing up in the therapeutic situation… In all three cases the transvestite play was transient and did not continue. With the cessation of this symptom, the aggression became even more manifold (p. 573).

The increasing aggression, however, was regarded as a positive step towards an emergent male identification. The authors concluded that because all three boys were reared by both parents, "the earliest identifications, in a period when differentiation of object – i.e., mother from father – was possible, led to a confusion of roles and encouraged a splitting of the object to be related to" (p. 573).

Cross-gender behaviour became further pathologised when Brown (1956) proposed that sex-role functioning disturbances were predisposing factors for "perversion, neurosis and psychosis … [and] sex-role behaviour constitutes a vitally important and vastly significant problem" (p. 1). Brown (p. 3) credited a colleague, Dr Sears, with making the distinction between "sex-role *identification*", whereby a child internalises the cross-gender behaviour as their own, and "sex-role *preference*", whereby a child prefers cross-sex behaviours but does not personally identify with them. According to Brown, biological sex is determined by genes and biology whereas identity as male or female is determined by upbringing, learning, experiences and environmental factors. In his study of 146 children (78 boys and 68 girls) aged 5-6 years, Brown found that 52% (34% girls and 18% boys) showed "mixed or confused

preference patterns" (p. 7). What is striking in this study is that, despite a significant number of children (30% boys and 51% of girls) either preferring the other gender role or a mix of gender roles (p. 18) (which could be seen as being so high as be considered 'normal'), it was concluded that "such role reversals or inversions of role constitute a potential source of adult, male passive and female active homosexuality … suggesting directions for re-educative procedures and preventive mental hygiene" (p. 9).

Meanwhile, Hartley (1959) observed that children are frequently faced with mixed messages regarding sex-role modelling and boys in particular are likely to develop anxiety as the pressure to conform to societal expectation is enforced with greater intensity and threat of punishment than with girls. This anxiety, Hartley noted, is induced because children are too young to understand why they are being punished. Through trial and error they learn to restrict their activities and preferences to what is regarded as acceptable.

Studies of gender-variant children from 1969 onwards were more focussed on boys expressing 'feminine' attributes. The aim of these studies was to identify causative factors and determine the etiology of the behaviour. The gender-variant children studied had been diagnosed with GIDC and clinics provided the opportunity for the gathering of data.

1.6 Etiology of Gender Variance

Several opinions regarding the etiology of gender variance, particularly GID, were presented in the scientific literature as early as 1955 when Money, Hampson & Hampson (1955) proposed that brain sex was determined entirely by nurture and environment rather than differentiated at birth. Since then, there has been vigorous debate and attempts to prove alternative viewpoints.

In 1960, Green and Money studied groups of children with cross-gendered behaviours, and their parents, for evidence of causation. Based on their studies of five boys displaying feminine behaviour and characteristics, they concluded that "no clear-cut etiological factors" of the behaviour could be found (p. 166). They suggested (1960, p. 167) that a "misprinting" of gender role may occur due to a specific stimuli during a critical learning phase and emphasised the responsibility of parents to orient children to the gender indicated at birth. The following year, Stephens (1961) found that boys from fatherless families were more likely to be effeminate. Psychoanalytic case studies also appeared, focussing on male gender-variant children and parents, in which mothers, in particular, were described as being responsible in various ways for the child's behaviour (Fischhoff, 1964; Greenson, 1966; Stoller, 1966, 1968, 1974).

Around the same time, Diamond (1965, 1976, 1995, 1996) started to assess prior studies and medical evidence regarding both the existence of sexual neutrality at birth and the predisposition theory of gender orientation. Diamond (Diamond, 1982, 1997; Diamond & Sigmundson, 1997a) was instrumental in exposing the truth about a child (a monozygotic twin) who after an accident during circumcision of his penis in infancy and consequent reassignment as a girl, had been declared to be living happily as such by John Money, the psychologist advising the parents (Money, 1975; Money & Tucker, 1975b). However, Diamond found that the child (David) had reverted, at the age of 14, to living as a male and had been deeply traumatized by his upbringing as a female (Brenda). It was only at this age that David was told about the accidental trauma to his penis during infancy.

Diamond concluded that identity results from the interaction between biological (prenatal organisation and hormones) and social forces (Diamond, 2006, 2009, 2011b). Other studies on the development of GID have also been based on biology or heritability (Bentz, et al., 2008; Garcia-Falgueras & Swaab, 2008; Hare, et al., 2009; Knafo, Iervolino, & Plomin, 2005; Kruijver, et al., 2000; Zhou, Hofman, Gooren, & Swaab, 1995) with some showing a mix of genetic and environmental factors as playing a role (Iervolino, Hines, Golombok, Rust, & Plomin, 2005; Knafo, et al., 2005; van Beijsterveldt, et al., 2006). Coolidge, Thede, & Young (2002, p. 251) showed a 2.3% finding in twin samples of clinically significant GID and concluded that not only does this counter the claims that GID is rare but that biology may have more influence than previously thought. However, not only is there a need for replication of these studies but the methodology of a number of them has been criticised (Herbert, 2008; Meyer-Bahlburg, 2010). One study that addressed beliefs about the origin of transgender identity and behaviour focussed on the Thai transgender community. The results of this study suggested that nearly 40% of participants strongly felt that biology was the cause while over 80% felt that it was a combination of biology and other influences, such as karma, friends, parents, other relatives and siblings (Winter, 2006, p. 51). Psychological factors have also been implicated as a cause of GID as a result of social, personal, familial and cultural influences (Coates, 1990; Devor, 1997; Di Ceglie, 1998; Doorn, Poortinga, & Verschoor, 1994; Stoller, 1967; Zucker & Bradley, 1995) as well as iatrogenisis (Meyer-Bahlburg, 2010).

There appear to be numerous influences on children's physical, emotional and psychological development; beginning prenatally, these include all manner of inherited, environmental and developmental processes. Due to the complexity of these influences, it may be impossible to fully understand the effects of nature and nurture on the development of GIDC. What is

necessary, however, is the need for enhanced knowledge that will ultimately provide support for gender-variant children and their parents so as to help them cope with their situation and provide more favourable outcomes than presently available.

1.7 Current Research on Gender-Variant Children and their Parents

The following literature review was generated through systematic searches using combinations of the words and phrases: 'child', 'parent', 'gender-variant', 'transgender', 'transsexual', 'gender identity', 'gender atypical', 'cross dress', 'gender confusion', 'gender non-conforming', 'gender orientation', 'gender dysphoria' and 'gender identity disorder'. The electronic databases PsycINFO via OvidSP (1806-present), Ovid MEDLINE and Scopus, were used to locate articles whereupon relevant items in their bibliographies were further identified and so on until it new information, authors or subjects were not forthcoming. This review covers research on gender-variant children and parents of gender-variant children over the last ten years. Also included were individual cases as presented in newspapers, magazines, TV and online, which depict parents supporting a social transition for a child into their preferred gender.

1.7.1 Research on Gender-Variant Children (2001-2011)

Studies during the last ten years that address gender variance in children encompass the following diverse fields: heritability[4] (Bailey, Dunne, & Martin, 2000; Coolidge, et al., 2002); comparison of demographics, social competence and behavioural problems in children with GIDC (Cohen-Kettenis, et al., 2003; Zucker, et al., 2002); children's beliefs about violating gender norms (Blakemore, 2003); the impact of gender identity on children's psychological well-being (Yunger, Carver, & Perry, 2004); genetic and environmental influences on

[4] The heritability of a phenomenon is indicated by the level of genetic inheritance of that phenomenon

atypical gender development in early childhood (Knafo, et al., 2005); play styles of children with GIDC (Fridell, Owen-Anderson, Johnson, Bradley, & Zucker, 2006); developmental processes in children with GIDC (Coates, 2006); correlates of anxiety in children with GIDC (Wallien, van Goozen, & Cohen-Kettenis, 2007); internalised body normalization in the early childhood of transgender children (Sullivan, 2009); validity testing of the Gender Identity Interview for Children (Wallien, et al., 2009); peer group status of children with gender dysphoria (Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010); association of GIDC in children with autism (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Preece & Corneil, 2011); obsessional interests of children with GIDC (Zucker, 2011a); concordance of GID in twins (Diamond, 2011a; Zucker, 2011b); gender atypical behaviours in Chinese school children (Yu & Winter, 2011); separation anxiety (Vasey, VanderLaan, Gothreau, & Bartlett, 2011); inequalities in education (Robinson & Espelage, 2011); the use of language by professionals and authors when referring to gender-variant children (Ansara & Hegarty, 2011); and the associations between peer victimisation and depressive feelings of gender-variant children aged 10-12 (Pouwelse, Bolman, & Lodewijkx, 2011). Case reports of gender-variant children have also appeared in the literature (Perrin, Smith, Davis, Spack, & Stein, 2010), with some describing the child's social transition (Luecke, 2011; Olson, Stone, & Pearson, 2011; Saeger, 2006).

1.7.2 Research on Parents of Gender-variant Children (2001-2011)

Studies over the last decade on parents of gender-variant children have covered: the psychometric properties of the Parent-report Gender Identity questionnaire (Johnson, Bradley, Birkenfeld-Adams, Radzins Kuksis, & Maing, 2004), comparisons of parent-reports on the Gender Identity Questionnaire for Children (Cohen-Kettenis, et al., 2006), parents' attitudes towards, responses to and acceptance of their children (D'Augelli, 2008; Grossman

& D'Augelli, 2006; Hegedus, 2009; Hill & Menvielle, 2009; Pearlman, 2006), parents' experiences and/or stories (Griffiths, 2002; Hill & Menvielle, 2009), expressed emotion in mothers of boys with GIDC (Owen-Anderson, Bradley, & Zucker, 2010) and parents' mental health ratings of their child (Hill, Menvielle, Sica, & Johnson, 2010).

1.7.3 Combined and Related Studies

Two studies have included both parents and their children. One explored parental acceptance and transgender children's psychological reactions (Bradley, 2010) while the other reported on group treatment of children with GID and their parents (Rosenberg, 2002).

The literature has also reported on therapeutic support processes and outcomes for parents and families of gender-variant children (Brill & Pepper, 2008; Di Ceglie & Coates Thummel, 2006; Menvielle & Tuerk, 2002; Meyer-Bahlburg, 2002; Vanderburgh, 2009) as well as protocols and recommendations for support and/or social transitioning for children (Benestad, 2009; Chen-Hayes, 2001; Mallon, 2006a, 2006b; Olson, et al., 2011; Reed, Cohen-Kettenis, Reed, & Spack, 2008).

To date, there have been no studies of the needs of either gender-variant children or their parents. Published 'needs' studies have focussed on minority homeless youths (Walls, Hancock, & Wisneski, 2007), transgender adults social service needs and/or barriers to health care (Kenagy, 2005a, 2005b; Kenagy & Bostwick, 2005; Lurie, 2005; Sperber, Landers, & Lawrence, 2005), risk factors for transgender adults (Xavier, Bobbin, Singer, & Budd, 2005), and support needs of those awaiting gender reassignment (Wylie, Hainsworth, & Ryles, 2007).

1.8 Treatment of and Attitudes towards Gender Variance

This section outlines current attitudes towards and treatment of gender-variant children in the Western media and by professionals.

1.8.1 Approaches to Gender Variance in the Western Media

Gender-variant people have often been portrayed in a negative light in the media, e.g. on chat shows as novelties to be exploited, in movies as psychopaths, or in sensational headlines created to sell newspapers or magazines. In this way, the media have helped maintain the binary status quo of male and female by punishing those who bypass their given gender. More recently there have been true stories of tragedy for those who deny their sex associated gender, for example, *Soldiers Girl* (2003) and *Boys Don't Cry* (1999). Pop stars such as Kim Petras and Dana (who represented Israel in *Eurovision* 2011), however, offer more positive portrayals of gender-variant people. Other positive representations appear in movies such as *Transamerica* (2005) and *All About My Mother* (1999) and in documentaries in support of gender-variant children such as *MiddleSexes* (2006) and *My Secret Self* (2007). Some of these movies/programs appear to have made serious attempts to treat transgender people with more respect. According to Cowan (2009), the discourses surrounding transgender people rely upon stereotypes that can create a level of comfort, satisfy curiosities, provide fascination, shock, or ease anxiety. It seems that the greater the transgression of the norm (binary) the more threatening to the individual with standard gender expectations. Ryan (2010, p. 3510) suggests three main stereotypes of transgender people: "deceivers", as "servile and palatable trans-feminine subject[s] … [to serve] gender normative people" or, as "monsters". Silverstone (1982, p. 129) is especially scathing of how individuals' struggles have been absorbed into the "ideological sludge of our contemporary culture" through various forms of narrative. He concludes: "[such] is the magic of television". He argues that presentations of

minority groups in the media are not neutral events but allow the writer to dictate the focus of the reader or viewer's attention and privilege a particular view (Silverstone, 1982). As depicted in movies and on chat shows, transsexual individuals seem to be aspiring to the dichotomy of 'male' or 'female' and in so doing they provide a safety to the audience because they at least can be seen to be attempting to conform to the expected social stereotypes (Cowan, 2009).

1.8.2 Professional Attitudes towards Gender-Variant Children

Significant controversy exists not only over the treatment of gender-variant children in general but over the inclusion of GIDC as a category in the DSM-IV (American Psychiatric Association, 1994). Various approaches to 'treating' gender-variant children have been promoted over the last 50 years. The earliest treatments involved behaviour therapy and psychoanalysis, which were designed to prevent ongoing gender-atypical expression in children. Atypical behaviour was often regulated through pharmacologies and institutionalization (Burke, 1996). Behaviourists considered children who exhibited non-conforming gendered conduct to have a disorder and implemented family therapy as well as rewards and punishments in the *hope* of reducing ostracism and preventing homosexuality or transsexuality (Rekers, 1986; Zucker, 1990; Zucker & Bradley, 1995). Though there has been conflicting evidence with respect to the outcomes (Green, 1987; Haldeman, 2000; Möller, Schreier, Li, & Romer, 2009; Saghir & Robins, 1973; Zucker & Bradley, 1995; Zuger, 1984) and as a result reparative therapy has been prohibited by the APA for over a decade (DeLeon, 1998). These approaches ignore the rights of children (Morin & Schultz, 1978) and it has become increasingly apparent that reparative practices that aim to change the child's gendered behaviour create further depression, anxiety, shame and lack of confidence rather than alleviation of their distress (Bartlett, Vasey, & Bukowski, 2000; Bockting, 1997; Burke,

1996; Meyer-Bahlburg, 2010; Richardson, 1996; Rosenberg, 2002). This further distress suggests that the difficulties experienced by gender-variant children are perhaps *caused* by the pressures and abuse they face rather than any inherent gender differences (Di Ceglie, et al., 2002; Haldeman, 2000; Landolt, et al., 2004; Lev, 2004; Meyer-Bahlburg, 2010; Möller, et al., 2009; Olsen, Forbes, & Belzer, 2011; Plöderl & Fartacek, 2009; Rosenberg, 2002; Vasey & Bartlett, 2007). Moreover, these symptoms are exacerbated through a "chronicity effect" (Bartlett, et al., 2000, p. 762); that is, it has been shown that gender-variant children with GIDC become more distressed at the onset of puberty, with its unwanted body changes (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Di Ceglie, et al., 2002).

Reparative approaches also fail to account for the complex process of development through which children identify with gender (Hill & Menvielle, 2009). Some researchers have proposed that reparative approaches hold the individual child responsible for the negativity expressed towards them rather than appreciating that these expressions of distress are consequences, rather than part of the condition (Alanko, et al., 2008; Burke, 1996; Haldeman, 2000; Landolt, et al., 2004; Lev, 2004; Plöderl & Fartacek, 2009; Spack, 2005). Proponents of reparative therapies also criticise parents who *do not* take steps to prevent their child's gender-variant behaviour (Owen-Anderson, et al., 2010; Stoller, 1974; Zucker & Bradley, 1995). More recently, approaches encouraging transgender normalization, flexibility, and validation have come to the fore (Bockting, 1997; Brill & Pepper, 2008; Di Ceglie & Coates Thummel, 2006; Ettner, 1999; Haldeman, 2000; Hill & Menvielle, 2009; Hill, et al., 2010; Hill, Rozanski, Carfagnini, & Willoughby, 2007; Lev, 2004; Menvielle, 1998; Möller, et al., 2009; Newman, 2002; Olsen, et al., 2011; Pleak, 1999; Rosenberg, 2002; Royal College of Psychiatrists, 1998; Wilson, Griffin, & Wren, 2002; Yunger, et al., 2004). Clinicians now prioritise the child's well-being and advocate for the child's immediate and long-term health.

In some cases this appears to lead to the child's identification with their *biological* gender (Rosenberg, 2002). Unfortunately, a lack of ongoing and long-term systematic data using controls has made it impossible to ascertain treatment outcomes with any confidence, particularly as it appears that for most gender-variant children the projected outcome is not transsexual with or without treatment (Green, 1987; Möller, et al., 2009; Saghir & Robins, 1973; Zuger, 1984). This appears not to be true for adolescents with GIDC where the development of secondary sexual characteristics exacerbates the condition (Drummond, et al., 2008; Steensma, et al., 2011; Wallien & Cohen-Kettenis, 2008).

Gender Identity Disorder in Children (GIDC) first appeared in DSM-III (American Psychiatric Association, 1980) under the category of psychosexual disorders and in the same edition from which 'homosexuality' was removed. In the DSM-IV, Gender Identity Disorder in Children (302.6) is included under 'Gender Identity Disorder' which is situated under the major heading of 'Sexual and Gender Identity Disorders' (American Psychiatric Association, 1994, p. 538). (See Appendix A for GID diagnostic criteria). Unfortunately, the DSM-IV (American Psychiatric Association, 1994) confines professionals to the dichotomous language and steers their thinking and treatment towards the binaries of female and male behaviour, leaving little or no room for gender variance. Moreover, the current diagnostic criteria allows children who prefer 'cross-gender' behaviours to be diagnosed with GIDC despite the fact that this was intended to be applied to children with intense *gender dysphoria* (Zucker, 2010). The fifth edition, the DSM-V, is currently under review and the GID subsection has been the focus of much controversy and fierce debate as to whether or not GID ought to be regarded as a diagnostic psychiatric disorder (Ault & Brzuzy, 2009; Bartlett, et al., 2000; Bradley & Zucker, 1998; Cohen-Kettenis, 2001; Green, 2010; Haraldsen, Ehrbar, Gorton, & Menvielle, 2010; Hill, et al., 2007; Langer & Martin, 2004; Menvielle, 1998;

Meyer-Bahlburg, 2010; Richardson, 1996; Spitzer, 2006; Wilson, et al., 2002; Zucker, 1999, 2006).

As more attention is paid to the individuals who have been subject to various approaches and treatments, it is hoped that recommendations for the DSM-V will allow for a more humane and less directive approach. A promising development is that the recent World Professional Association for Transgender Health's Standards of Care, 7th Version (WPATH, 2009) has allowed individuals affected by treatment to have a say in protocols.

1.9 The Impact of Gender Variance on Children, Youth and Adults

This section covers the impact of gender variance on children, adolescents and adults due to the lack of support in childhood. In recent years a number of lengthy (funded) reports have appeared in support of transgender people. These publications by foundations and associations include reviews, risk assessments and recommendations for transgender people and focus on health care (Bockting, Robinson, Benner, & Scheltema, 2004; Grant, et al., 2010; Institute of Medicine, 2011), experiences of inequality and the discrimination of transgender people (American Psychological Association, 2009; Whittle, Turner, & Al-Alami, 2007), suicide prevention (Haas, et al., 2011) and the treatment of lesbian, gay, bisexual and transgender children in schools (Kosciw, Diaz, & Greytak, 2008). Statistics on the incidence of discrimination, bullying and suicide are alarming and the general adult prognosis for transgender individuals is not promising given the lack of support, advocacy and resources available.

1.9.1 The Impact on Children

Gender-variant children face alarming levels of abuse and discrimination compared to their peers. Significant levels of harassment, bullying, verbal attacks, discrimination, and other difficulties with peer relationships can begin as young as six (Cohen-Kettenis, et al., 2003; D'Augelli, Grossman, & Starks, 2006; Di Ceglie, et al., 2002; Grant, et al., 2010; Institute of Medicine, 2011; Landolt, et al., 2004; McGuire, Anderson, Toomey, & Russell, 2010; Menvielle & Tuerk, 2002; Wallien, et al., 2010; Whittle, et al., 2007; Yunger, et al., 2004; Zucker, et al., 1997). Surveys of lesbian, gay, bisexual and transgender school students reveal elevated levels of verbal harassment (86%), physical harassment (60%), physical assaults (14%), school absence, as well as increased levels of depression and greater risk of suicide (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; D'Augelli, et al., 2006; Kosciw, et al., 2008; Plöderl & Fartacek, 2009; Robinson & Espelage, 2011).

These problems appear to have lasting consequences for the gender-variant child and can lead to feelings of inadequacy (Fagot, 1994; Graham, 2011; Sachs-Ericsson, et al., 2010; Toomey, Ryan, Diaz, Card, & Russell, 2010; Wyss, 2004; Yunger, et al., 2004) and greater levels of anxiety or depression (Pouwelse, et al., 2011; VanderLaan, Gothreau, Bartlett, & Vasey, 2010; Vasey, et al., 2011; Wallien, et al., 2007; Zucker, Bradley, & Lowry Sullivan, 1996), particularly as puberty approaches (Cohen-Kettenis, et al., 2008; Di Ceglie, et al., 2002). In addition, gender-variant children also face issues related to acceptance, and/or family rejection and abuse (Coates & Person, 1985; D'Augelli, et al., 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Hegedus, 2009; Wren, 2002). Such issues can result in poor performance and constrained creativity (Yunger, et al., 2004). Indeed, many parents who had previously tried to force their child to conform to gender expectations changed their

behaviour once they realised how damaging or ineffectual their efforts had been (Hill & Menvielle, 2009).

1.9.2 The Impact on Transgender Youth

Youth with gender atypical childhoods appear to be at a much greater risk for many factors that affect youth generally and at risk for consequences such as homelessness and mental health issues that wouldn't normally be considered for the general youth community.

Gender-variant youth report being 'invisible' (Grossman, et al., 2006) and have been shown to have to contend with higher rates than normal of mental health issues, employment issues, homelessness, substance abuse, risk of HIV or access to health services (Cochran, Stewart, Ginzler, & Cauce, 2002; D'Augelli, et al., 2006; Grant, et al., 2010; Grossman, et al., 2006; Namaste, 1999). They also face high rates of victimisation, violence, and/or suicide (Clements-Nolle, Marx, & Katz, 2006; D'Augelli, et al., 2006; Friedman, et al., 2006; Grossman, et al., 2006; Kosciw, et al., 2008; Kosciw & Cullen, 2001; Wyss, 2004) as well as abuse from parents (Grossman, et al., 2006). They are also at greater risk of being murdered (Toomey, et al., 2010).

These risks indicate the need for prior intervention to support children and their families, preferably *before* the added challenges of independent thinking and autonomy that naturally arise during adolescence take place.

1.9.3 The Impact on Transgender Adults

Gender-variant individuals often live difficult and traumatic lives due to victimisation, isolation and intolerance. Studies have detailed how transgender individuals are targets of

marginalisation, harassment and violence (Berrill, 1990; Herek, 1990; Lombardi, Wilchins, Priesing, & Malouf, 2002; Whittle, et al., 2007; Witten & Eyler, 1999). The existence of prejudice within health systems exacerbates these problems and creates significant barriers to health care, leading to negative health outcomes (Bockting, et al., 2004; Davis, Saltzburg, & Locke, 2009; Feinberg, 2001; Green, 1994b; Gruber & Fineran, 2008; Institute of Medicine, 2011; Kenagy, 2005b; Kenagy & Bostwick, 2005; Richardson, 1996; Wylie, et al., 2007; Xavier, et al., 2005). Gender non-conforming adults also suffer from increased levels of family rejection, poverty, employment issues, homelessness, HIV, prostitution, substance abuse and mental health issues (Bockting, Knudson, & Goldberg, 2006; Carbonne, 2008; Clements-Nolle, et al., 2006; Grant, et al., 2010; Lombardi, 2009; Lombardi, et al., 2002; Nuttbrock, et al., 2010; Plöderl & Fartacek, 2009; Rivers, 2004; Rosario, Schrimshaw, & Hunter, 2008; Sachs-Ericsson, et al., 2010; Skidmore, Linsenmeier, & Bailey, 2006; Stotzer, 2008, 2009; Whittle, et al., 2007).

The reported suicide rates in the transgender community are also alarmingly high and consistently and significantly elevated compared to the general population (Clements-Nolle, et al., 2006; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Grossman & D'Augelli, 2007; Haas, et al., 2011; Maguen & Shipherd, 2010; Whittle, et al., 2007). Not only do attempted suicide rates range from 26% to 35% of surveyed transgender participants (Clements-Nolle, et al., 2006; Grossman & D'Augelli, 2007; Maguen & Shipherd, 2010; Whittle, et al., 2007) but one report documented multiple suicide attempts. These studies point to the profoundly distressing situations and despair that transgender people face (Whittle, et al., 2007).

Transgender adults also face pressure to undergo hormone therapy and extensive surgery to conform to the male-female paradigm (Bockting, 2009). Unsafe methods of medication and

insensitive health practitioners place them further at risk (Clements-Nolle, et al., 2006; Lombardi, 2001).

1.10 Summary and Further Rationale for this Research

Identifying childhood gender variance as a problem requiring treatment labels and stigmatises these children. Such a categorisation draws attention to, and potentially punishes, behaviour that in a child of the other sex would be unremarkable. According to Schaefer and Wheeler (2004), parents' disapproval of their gender-variant child can lead to confusion and ongoing feelings of guilt and make the child more likely to accommodate their parents' expectations in order to gain acceptance (Miller, 1995). This disapproval does not allow for the normalisation of gender variance whereby a child can explore their gender expression or preferences in order to create personal congruence (Diamond, 2006).

This chapter has illustrated the vast complexity of gender variance with respect to terminology, approaches and treatment. Specifically, this chapter has highlighted the inconsistency in definitions of terms related to gender variance, the difficulty in establishing prevalence in such a culture-bound phenomenon, and the challenges of describing gender development when perceptions of gender change over time. This chapter has also discussed the pathologising of gender variance that led to the search for causes and the historical and emergent attitudes that bestowed hardship on gender-variant individuals via insensitive and damaging treatment.

This study aims to contribute to a transformation in attitudes, treatment and support of gender-variant children through professional awareness. This awareness includes but is not limited to the issues gender-variant children face on a day-to-day basis, the lack of a creative

and nurturing environment and other barriers to their overall well-being. An essential component of this support is the provision of resources and services to their parents. Identifying the needs of gender-variant children and their parents will provide a significant contribution to an evidence-based framework with which to create necessary support services and networks.

The present study also aims to inform policy, guidelines, curriculum and resources in support of these groups whilst demonstrating a formal exposure and understanding of the issues involved utilizing the voices of the individuals effected. The study explores the views and experiences of parents with gender-variant children; the experiences and opinions of transgender adults retrospectively regarding their childhood; and the input of professionals who work with the transgender community to elicit their views on the needs of gender-variant children and their parents. The study addresses two research questions: 'What are the needs of gender-variant children?' and, 'What are the needs of the parents of gender-variant children?'

CHAPTER 2

Methodology

2.1 Introduction

This chapter describes the study's research and methodology, including: the qualitative research approach and rationale; the research design and method; the sampling strategy; development of the survey; the research sample; the information needed to conduct the study; the research procedure; data analysis; ethical considerations; and validity and reliability.

2.2 Qualitative Research Approach and Rationale

Qualitative research derives its authority from description and induction with the purpose of exploring a phenomenon through the eyes of participants. By 'entering' the world of participants using the interpretative processes of a qualitative methodology, participants' perceptions and experiences with respect to a particular circumstance, interaction, social framework or event can be made visible (Bloomberg & Volpe, 2008; Denzin & Lincoln, 2000). The intention of such an approach is to obtain as broad a view as possible heuristically through participant description, meaning and perspectives and in some cases to generate theory from data (Woods, 2006). In particular, a 'grounded' approach permits the wide exploration of a phenomenon and the context within which it sits in areas where there has been little or no previous research (Grbich, 2009; Patton, 2002). In contrast, quantitative research methodologies rely on statistics, measurement and mathematics in order to test a theory or hypothesis.

For a project to establish the 'needs' of a community or population, as in this study, the qualitative approach requires researcher sensitivity to the participants' naturalistic context, detailed descriptive data and dedication to a careful process of analysis (Huberman & Miles, 2002).

2.3 Research Design and Method

In this exploratory study, an online survey system called Zoomerang (MarketTools, 2011) was used and Internet surveys were designed to investigate and understand the experiences of respondents with the experience and knowledge required to determine the needs of gender-variant children and their parents. The participants chosen as subjects for this survey were: (1) parents with gender-variant children, (2) transgender adults, and (3) professionals working with the transgender community.

The use of the Internet was particularly important in this study as it was expected that access to a sufficient number of locally available participants would be difficult, thereby limiting the study's capacity to fully explore the nature of the phenomenon. Closed questions were used to gather demographic data while open-ended questions were used to obtain a reflective expanded response. Open-ended questions allow participants to frame and articulate their experiences, behaviours, feelings, knowledge, and opinions and their use in the survey enabled the researcher to develop an appreciation of the extent and depth of participants' experiences (Huberman & Miles, 2002; Patton, 2002). Open-ended questions regarding people's experiences and behaviours provide not only more but also fuller responses, particularly in an Internet environment (Dohrenwend, 1965; Fricker & Schonlau, 2002; Sudman & Bradburn, 1973). Providing unlimited text boxes also allowed space for participants to reflect on and expand their responses.

The key researcher was also aware that some participants may have never revealed the requested information before due to the history of secrecy, shame and imposed silence in the gender-variant community. The use of computers, therefore, provided a safe and confidential naturalistic setting for participants to describe their experiences, processes, roles, interpretations, meanings and perspectives with as much or as little detail as they chose (Grbich, 2009; Woods, 2006). Because the researcher was also aware that the length of a survey can adversely impact response rates, the aim was to reduce the number of less comprehensive responses and unanswered questions (Galesic & Bosnjak, 2009). To reduce recall bias and improve the reliability of the retrospective method, the research design utilised chronological ordering of multiple open-ended questions to elicit memories of a personal nature and to aid memory retrieval (Brewin, Andrews, & Gotlib, 1993). It was hoped that the anonymity of the Internet would encourage participants to be more forthcoming with information given the sensitive nature of the topic (Daley, McDermott, Brown, & Kittleson, 2003; Lyons, Cude, Lawrence, & Gutter, 2005).

There are also elements of an action research approach in this investigation as the intention was to study particular social situations – namely, the experiences of gender-variant children and their parents – to improve their circumstances in the future (Elliott, 1991).

2.4 Sampling Strategy

To ensure the collection of relevant information-rich data that would help answer the research questions, it was necessary to locate participants who were knowledgeable and experienced on the topic of the needs of gender-variant children and their parents. When participants have experience in a subject area, the richest data can be obtained through questions this target the

area of knowledge. Solicited text is most productive when the participants judge the questions to be important and when they have a personal interest in the topic (Charmaz, 2006). Accordingly, parents with a gender-variant child, transgender adults and professionals working with the transgender community were targeted as the most appropriate populations to survey regarding the needs of gender-variant children and their parents. Parents with gender-variant children were chosen for their insight into their own experience as well as that of their gender-variant children and their ability to provide a first-hand account of day-to-day and emergent issues. Transgender adults were chosen for their direct and intimate understanding of having lived with gender variance as a child. Professionals were included in the sample to capitalise on the knowledge gained through work with the transgender community.

Purposeful and strategic sampling (Charmaz, 2006; Patton, 2002) was employed to focus on the knowledge and experience of these three groups. International contributions were also sought to provide a broad range of views and a sufficient number of participants. A snowball technique was also employed whereby participants were invited to refer others within the target populations to take part in the survey.

The participants were accessed via targeted advertising and articles in newspapers (*Sydney Star Observer*, *Sydney Morning Herald, Sun-Herald*), magazines (e.g., *Sydney's Child*, *Polare*), radio programmes (e.g., *Life Matters - Radio National, Transmission time - Joy 94.9*), websites (*e.g., University of Sydney, The Gender Centre, Joy*) and via the Listserve and conference proceedings of the World Professional Association for Transgender Health (WPATH). (See appendices B-F for details of all advertising and notifications).

General eligibility requirements included the ability to respond in English and access to a computer and the Internet. Options for entering the survey were: a parent who is raising or who has raised a gender-variant child; a transgender adult; or a professional who works with the transgender community.

Analysis was conducted on the parent and transgender adult data only where gender variance had been identified before the age of 12. This data selection for the parents and transgender adults guaranteed a focus on the needs of children. Beyond this age the needs of gender-variant children are likely to change as puberty and factors associated with adolescence significantly affect their circumstances. No limitations were placed on responses from particular types of professionals as the key researcher deemed that the needs of gender-variant children and their parents could be potentially gleaned from any focussed work with transgender people.

2.5 Development of the Survey

Development of the survey was enhanced by the inclusion of professional transgender clinicians (n=3), researchers (n=4), academics (n=5) and transgender individuals (n=2), all of whom were consulted for input and feedback. All surveys included closed- and open-ended questions (see appendices G, H & I). The closed-ended questions were designed to collect demographic data. The open-ended questions were designed to gain deep and rich meaning and were (for the parents and transgender adults) presented in chronological order beginning with the recognition of gender variance. The aim was to contextualise the responses within the relevant era while also providing time for participants to reflect on their associated history and circumstances. This alignment with history was designed to prompt participants' memory recall and awareness and thus prepare them for a more comprehensive involvement in the

later questions about gender-variant children's needs and their parents. There was also a set of debriefing open-ended questions at the end of the surveys for the parents and transgender adults to facilitate 'terminating the relationship' before the request for any comments they wish to add . To ensure that all responses were voluntary, participants were allowed to skip those questions they did not wish to answer. 'Skip' logic was used (where possible) to ensure subjects were not asked to answer questions that were not suitable to them.

2.5.1 The Parent Survey

The survey for the parents of gender-variant children comprised both closed- and open-ended questions aimed at obtaining demographic data. It canvassed the experiences, challenges, understandings, and reactions of parents raising gender-variant children (see Appendix G for the complete parent survey). The first three open-ended questions were: "What was it that you first noticed about your child that gave you the idea that your child was different?"; "What were the circumstances that led up to this realisation?"; and "What effect did this have on the child?" The survey progressively explored: the impact of the event described in the first question; the challenges that the parents faced or expect to face in the future and ways to meet those challenges; difficulties their child has experienced; the wants and needs of both their child and themselves; and any current or anticipated future concerns.

2.5.2 The Transgender Adult Survey

Transgender adults were asked ten questions related to demographics and 21 open-ended questions. The open-ended questions sought information about transgender adults' experiences of gender variance as children and the reactions of their parents and families (see Appendix H for complete transgender adult survey). The survey specifically explored the impact of being gender-variant on their friendships, their experiences at school and

throughout their life. The questions regarding their experiences during adolescence and adulthood were aimed at contextualising their current perceptions and acknowledging their experiences beyond childhood.

It was anticipated that allowing participants to write about their adulthood might assist them with personal comprehension and awareness and provide an opportunity to debrief following the lengthy reflections and recall of childhood experiences. This journaling of experiences may also have some therapeutic value (L'Abate, 2011).

The questionnaire also examined participants' perceptions of services, resources and other input that may have been helpful to them or their parents during their childhood and, importantly, those which might help gender-variant children and their parents today and in the future. Finally, the survey considered the impact (past and present) of a gender-variant childhood, with the last question inviting any further comments.

2.5.3 The Professional Survey

Six closed-ended questions were designed to gather demographic information. Eleven open-ended questions were developed to provide the space for in-depth responses where professionals could express their experience, knowledge, reflections and ideas (Huberman & Miles, 2002; Patton, 2002) (See Appendix I for the complete professional survey). The questions initially focussed on these professionals' understandings of parents' experiences and included questions such as: "What do you understand to be the issues that parents with gender-variant children face?", "What do you believe creates these issues for the parents [of gender-variant children]?" and "What do you believe parents [of gender-variant children] want and need?". The survey then addressed the children and contained the questions: "What

do you understand to be the issues that gender-variant children face?", "What do you believe creates the issues for gender-variant children?" and "What do you believe that gender-variant children want and need?" The final series of questions targeted any concerns that professionals may have about their work with gender-variant children or their parents.

2.6 The Research Sample

Participants were only included in the study if they responded to at least one open-ended question; that is, participants who responded only to demographic questions were excluded. This ensured that the analysed data reflected the participants represented in the demographics. From a total of 244 participants who responded to the survey, 170 were included in the data analysis. The participant numbers are presented in Table 2.1.

Table 2.1 Number of Participants who Responded to the Survey

Survey Participants	Responded to the survey (n)	Responded only to demographics (n)	Included in the data analysis (n)
Professionals	46	17	29
Parents	50	19	31
Transgender adults	148	38	110
Total	244	74	170

2.7 Information Needed to Conduct the Study

This study focussed on the needs of gender-variant children and their parents and gathered survey input from parents who are either raising or have raised a gender-variant child, as well as transgender adults and professionals who work with the transgender community. In seeking to answer the research questions ("What are the needs of gender-variant children" and "What are the needs of the parents of gender-variant children?") within the conceptual

framework used in the study, it was necessary to obtain demographic, contextual, perceptual and theoretical information (Bloomberg & Volpe, 2008).

Demographic information was sought from each of these three groups of participants. For the professionals, the questions sought to identify: the number of years they had worked with the transgender community, their occupation, country of residence, qualifications and whether they had received specialised training to prepare them for their work with transgender clients. Parents were asked demographic questions about themselves as parents as well as about their gender-variant child. These questions for parents covered: what type of parent they were (mother, father, guardian), their age, marital status, whether they lived in a rural or urban area, level of education, occupation and country of residence. The questions regarding their gender-variant child included their child's birth sex, year of birth and preferred gender. For transgender adults, the demographic questions addressed: their age, birth sex, level of education, gender identity, occupation, income and country of residence.

Contextual information was sought from both the parents and transgender adults. This information identified the culture and environment within which the identification of gender variance took place as well as the circumstances and responses of those in their immediate environment.

Perceptual information from participants also provided necessary input for this study. The attitudes, concerns, approaches and reactions of the parents and transgender adults were sought so as to embed their responses within the meaning held for them of the event, circumstance or experience they were describing. This helped prevent misinterpretation in

analysing the data and possibly allowed for a more faithful assimilation of the intended meaning.

A literature review was performed to determine what research had been previously conducted regarding the needs of gender-variant children and their parents. Although several items of literature discussed some of the needs of gender-variant children and their parents (Boenke, 2003; Brill & Pepper, 2008; Costa & Matzner, 2007; Crawford, 2003; Di Ceglie, 1998; Di Ceglie & Coates Thummel, 2006; Di Ceglie, et al., 2002; Hill & Menvielle, 2009; Hill, Menvielle, Sica, & Johnson, 2010; Mallon, 1999b, 2006; Menvielle & Tuerk, 2002; Rosenberg, 2002), none of these studies had specifically set out to determine these needs for either the children or their parents.

2.8 Research Procedure

Prior to the development of the surveys, the key researcher attended the World Professional Association for Transgender Health Symposium in Chicago (2007) to confer with other professional clinicians, academics and researchers working in the field of transgender health and research. In addition, before the development of the parent survey, the key researcher attended an informal information evening for parents of gender-variant children, gaining ideas which informed the survey questions for parents.

2.8.1 Ethics Approval

Ethics approval was granted in August 2008 by the Human Research Ethics Committee (Appendix J) at the University of Sydney and included all advertising and survey notifications (Appendices B-F), the Participant Information Statements (Appendix K) and the survey questions associated with the project (Appendices G, H & I).

2.8.2 Recruitment

Participants were recruited through advertising in newspapers, magazines, radio programmes, websites and via the Listserve and conference proceedings of the World Professional Association for Transgender Health (WPATH).

2.8.3 Data Collected

Information was sourced from the three groups of participants to produce the final reports on 'the needs of gender-variant children' and 'the needs of parents with gender-variant children'. Although 244 participants responded, 74 were excluded from the data analysis as they answered only the demographic questions and not the open-ended questions. The coverage in responses to open-ended questions from the included participants was very high, as shown in Table 2.2. In the parent group, out of a possible 537 responses from 17 open-ended questions, only 9 answers were left blank and 5 of these were from the same person. In the transgender adult group, in response to 17 open-ended questions, 1821 answers were received out of a possible 1870 and 43 of the missing answers were from 6 people. In the professional cohort, from a possible 261 answers to 9 open-ended questions, 247 responses were obtained. Of the 14 missing responses, 12 were from 2 respondents.

Table 2.2 Number of Responses to Open-ended Questions

	Professionals (n)	**Parents (n)**	**Adults (n)**	**Total (n)**
No of possible responses	261	527	1870	2658
Missing answers	14 (12 from 2)	9 (5 from 1)	49 (43 from 6)	72
Total responses	247 (94.6%)	518 (98.3%)	1821 (97.4%)	2586 (97.3%)

Even though at times some participants felt they had previously answered a particular question, they nonetheless replied by elaborating on their previous answer, repeating what they had already said or pointing to a prior response.

To maintain anonymity, names and contact details were not sought although a number of participants provided these details in the final question which invited "any other comments". In this field, some participants added more information to previously answered questions as this information came to mind, some commented how grateful they were that the survey was being conducted, others said they would be emailing 'their story' (or other information they felt too lengthy to include in the survey), while others offered additional comments on their life or provided feedback on the survey.

Overall, the elicited responses were endowed with richness, depth and the voice of lived experience. They not only allowed the researcher to develop an appreciation of the participants' world view but also provided the detail required for data content analysis (Patton, 2002; van Manen, 1997). The further development of awareness through contextual sensitivity and reflexive inductive analysis encouraged an holistic perspective and deepened insight and comprehension of participants experiences and circumstances (Patton, 2002).

2.8.4 Data Collection Method

The data collection method utilised the Internet. Three surveys with open-ended questions were administered and three separate groups of participants were sampled. Research on the use and effectiveness of Internet surveys has shown significant benefits particularly with respect to access to international participants, permitting a broader range of responses in this study than would have otherwise been possible (Pequegnat, et al., 2007). The Internet also

allowed for greater flexibility in the research design and meant that the need to transcribe lengthy narratives was avoided (Kraut, et al., 2004). The Internet as a survey tool has been lauded for its speed, response rates, convenience and reduced costs (Hoonakker & Carayon, 2009; Pequegnat, et al., 2007) although some authors have raised concerns about privacy issues (Cho & LaRose, 1999), generalisability (Best, Krueger, & Smith, 2001) and coverage (Hoonakker & Carayon, 2009). While these sampling issues may be problematic for large-scale studies, they may be less of an issue when dealing with minority or stigmatised groups.

The Internet also provides a valuable resource for accessing minority populations such as the transgender community. In previous studies, the only sources available were clinically referred groups (Miner, Bockting, Romine, & Raman, 2011) and individual stories (Boenke, 2003; Costa & Matzner, 2007). The Internet also provides an important source for transgender contact due to the diversity of the group and the distances between people (Shapiro, 2004). Web-based data collection has proven to be reliable and the quality of the data high as compared with telephone-administered or paper surveys (Denscombe, 2006; Graham, et al., 2006; Rankin, Rauscher, McCarthy, Il'yasova, & Davis, 2008; Touvier, et al., 2010). The validity of Internet data has also proven to be high, as shown by the correctness of the information offered (Adair, Marcoux, Williams, & Reimer, 2006; Beasley, Davis, & Riley, 2009; Bliven, Kaufman, & Spertus, 2001; West, et al., 2006). Internet respondents have been shown to offer more information and respond more often to open-ended questions than those taking part in postal mail surveys (Gunter, Nicholas, Huntington, & Williams, 2002; Hoonakker & Carayon, 2009). The Internet has also been shown to be more suitable when participants are required to disclose information that is either confidential or likely to create a feeling of vulnerability (Pealer, Weiler, Morgan Pigg, Miller, & Dorman, 2001).

The potential inaccuracy of participants' responses was addressed by asking multiple open-ended questions regarding the same event, which allowed participants to fill in details as they came to mind. The coverage error was at least partly counteracted by the targeted sampling process and snow-balling (Hoonakker & Carayon, 2009).

A high response rate was not required for this survey due to the qualitative nature of the project although a certain level of saturation was required to establish the needs of gender-variant children and their parents. Without the need for transcription, concerns about the length of answers was significantly reduced which means there was no need to limit the number of open-ended question or the number of respondents.

Notwithstanding these limitations, the exploratory nature of this research required a targeted pool of participants and the Internet provided the range of input required.

2.8.5 Data Analysis

The qualitative data were analysed using grounded theory and content/thematic analysis (Charmaz, 2006; Grbich, 2009; Spradley, 1980) which involved an ongoing reflective-interpretive process (Moustakas, 1994; van Manen, 1997). The responses for each question, each participant and each group of participants were first considered separately and then summarised as a whole. Coding followed Buckingham and Saunders (2007, p. 142) rules of: (a) "discrete categories" where codes are unique for each category; (b) "exhaustive categories" where all responses are represented; and (c) "discriminatory categories" where variations are initially coded separately for later group identification. Although Weft Qualitative Data Analysis (Fenton, 2006) was initially used to organise and code the data, it was quickly replaced with a manual method that provided a logical trail of thinking using

colour-coding. This allowed full access to all the previous steps and saved versions of the analysis. The physical marking of the actual data, therefore, made the process more visible, accessible for review and available for examination and replication. An example of some of the initial indexed coding for the 'needs of gender-variant children' performed on the Adult Transgender data are presented in Table 2.3.

Table 2.3 Some Indexed Coding Performed on the Adult Transgender Data

Index Code	Theme	Cat no.	Item
A1	Acceptance	1	To be allowed to explore their gender through expression in order to decide for themselves later
A2	Acceptance	2	To grow up expressing their 'felt' gender
SI1	Sense of Isolation	1	To be told "that I'm not alone"
Inf 1	Information + SI?	1	To be told "I am not a freak or crazy"
Inf 2	Information	2	To be told "I am ok"
E1	Education	1	For education for parents
E2	Education	2	Education for children in school
E3	Education	3	Education for teachers
S1	Support	1	To be recognised by professionals
S2	Support	2	To be given help by counsellors, psychologists and medical practitioners
RM1	Role Model	1	To have transgender/transsexual role models - in the media
RM1	Role Model	2	To have transgender/transsexual role models – available for support
Saf1	Safety/Protection	1	To be safe
Saf2	Safety/Protection	2	free from bullying
Saf3	Safety/Protection	3	protected from threats or attacks

Each dataset (professionals, parents, transgender adults) was analysed one at a time and completed to the stage of identifying a set of needs for the children and the parents. The results were submitted for publication before the next set of data were analysed. The aim was to keep each process of analysis and the production of 'needs' as clean as possible without the previous analysis determining the index, themes, categories or final needs.

During the analysis there was a constant movement between the codes and the data, the aim of which was to achieve saturation and improve accuracy. Classifications were collapsed or expanded to yield the 'best fit' for the data, all the while ensuring the voices of the participants were included. The data were examined using three formats: a) the Zoomerang output and analysis options that provided charts, filters, cross-tabulation reports and a chronologically ordered display of responses to each question (MarketTools, 2011); b) an excel spreadsheet that showed all the data for each group of participants on one page in a matrix which allowed the researcher to see all responses from each participant and to check for participants' answers to particular questions across their total response set; and c) hardcopy printouts that were used to highlight and code each piece of data and provide an index. The process of applying an index to the data involved numerous decisions regarding the meaning and significance of the data and required many of the participants' responses to be divided and subsequently placed into several separate themes or categories. After indexing each section of the data, it was necessary for it to be re-examined for the question as a whole, identifying the range of attitudes and experiences for each theme. The coded data were then extracted from the original context and arranged according to the themes and divided into categories. This process was repeated three or four times in some cases to ensure the integrity of the process. Discrepancies were discussed by the research team until agreement was reached on the best possible category for the data.

Ultimately, two sets of needs – one for the children and one for their parents – were produced from each set of data and were displayed as a list accompanied by participants' own words exemplifying each need. Participants' specific expressions and descriptions were included in

the final sets of needs to allow their voices to be heard, to provide evidence for the stated need and to provide examples of the range of experiences and meanings.

After the demographic information was organised and presented, the data was read so as to gain an appreciation of the diversity of responses and expression and to allow for immersion in and familiarity with the data (Huberman & Miles, 2002). Each participant's full response was read as a whole to see if there were any overriding messages or an indication of a motivation for responding to the survey. Then, all responses to particular questions related to the needs of the children were read again to assess the variety of meanings and messages. Any unclear responses were tracked back to the individual participant and checked for clarity. A couple of examples are provided below:

Example 1: Where a participant used the word 'support', their other answers were checked to ascertain if they had elaborated elsewhere on what they meant by support.

Example 2: A parent responded to the question 'What difficulties/pressure have you experienced as a result of your child being gender-variant from 5-12 years?' with:

> As stated, we support [child's name] so we are fine with him/her but worry for his safety and how he will fit in the world and how to guide him to make the right decisions. If [child's name] was simply gay, it would be simple for us as we have gay friends and family.

Upon further investigation it became evident that this parent had had problems with their child being bullied and ostracised at school as well as having difficulties with other family members' lack of approval.

The first set of data analysed was from the parents. Once familiarity had been established, the coding for the content analysis began. The familiarising exercise revealed that the child's and parent's needs tended to change over time. Therefore, instead of simply categorising the identified needs, a framework was established within which needs were identified for the different stages. The identified framework included the stages: first identification, the parents' and families' response to the first identification and the need for support. 'Need for support' was later divided into 'emotional support', 'medical support' and 'advocacy support'.

The responses to the questions (Q) relating to first identification (Q11), circumstances (Q13), effect on the child (Q14), peer relationships (Q17) and the child's needs (Q18) were analysed for information regarding any 'need' the child had. This need was then situated within the framework (See Appendix G for the list of survey questions for parents). Initially the identified needs were placed into broad categories such as 'information', 'support' and 'other'. As similarities and differences were recognised within these categories and re-assessed against the raw data, the categories were re-designed to describe the needs more specifically. Data that did not fit were highlighted and studied to see whether a new category was warranted.

Finally, the needs reports identified from the three groups were compared and cross-checked to produce a final charter of needs for both gender-variant children and their parents.

2.9 Ethical Considerations

The ethical considerations for this project relate primarily to informed consent, anonymity, confidentiality and the worthiness of the research.

To make clear to participants that submitting their responses to the survey would be taken as evidence of their informed consent to take part in the research, the participant's information statement stated: "Submitting a completed questionnaire/survey is an indication of your consent to participate in the study. You can withdraw any time prior to submitting your completed questionnaire/survey. Once you have submitted your questionnaire/survey anonymously, your responses cannot be withdrawn" (See Appendix K for full statement).

Confidentiality and anonymity was maintained in two ways: by assuring that the data were only available to the research team and by removing any identifying information in all quoted sections of participants' responses in the manuscripts.

The value (worthiness) of the research is indicated by a number of factors. Firstly, no previous research that determined the needs of gender-variant children and their parents was found in the literature search. Secondly, the interest shown in the project by parents of gender-variant children, members of the professional community working for the benefit of transgender people and the media (see appendices L, M and N) point to the need and value of this research.

2.10 Validity and Reliability

Lincoln and Guba (1985), eminent scholars in the field of qualitative research, have proposed that the validity and reliability of qualitative research should be seen in terms of its

trustworthiness and evaluated according to credibility, transferability, dependability and confirmability. Other authors have also suggested "vividness" (Polkinghorne, 1983, p. 46), relevance (Hammersley, 1992) and the quality of "[listening] to the voices of ill, disabled and other silenced persons … in order to destigmatize, empower, open up dialogue … to achieve a better social world" (Bochner, 2001, p. 152). These concepts are defined below and used to provide evidence of the validity and reliability of the research project.

The credibility of a research project can be established through peer (research team) de-briefing, scrutiny, persistent immersion in the data and the field, triangulation, acknowledgement of negative or deviant cases and member checking (Lincoln & Guba, 1985). Throughout the project, debriefing with supervisors was sought on an ongoing basis, from the time of the submission of the research proposal until the final submission of the complete thesis. Peer scrutiny was sought through peer review of various sections of the thesis. Persistent immersion in the data was part of the reflective interpretive process of the data analysis. Immersion in the field of gender-variant children and their parents was obtained by the key researcher's ongoing involvement with gender-variant children and their parents as well as with transgender adults in clinical counselling practice. Triangulation involves evidence from different sources, ways or means, with each validating the other and coming to the same conclusion (Finlay, 2006; Lincoln & Guba, 1985). Triangulation of sources was achieved in this study through the use of three different groups of participants to answer the research questions. These viewpoints were then compared for similarity and differences. Deviant or negative cases are reported in the results. Member checking, though not used during data analysis, was achieved passively by sending published papers to participants who had requested to be informed of the results.

Transferability involves evidence of external validity achieved through the presentation of 'thick descriptions' which allow the reader to determine whether the conclusions of the research are in fact relevant to their own circumstances and therefore to them (Lincoln & Guba, 1985). Participants' own responses and words were used to illustrate the various real-life contexts and views across the range of answers given.

Dependability derives from the reliability of the project as accomplished by researchers and scholars not involved in the project but who evaluate whether the findings, interpretations and conclusions of the project are supported by the data (Lincoln & Guba, 1985). Three results chapters have been submitted for publication in three different peer reviewed journals. The manuscripts included, in each case, the respondents' views on the needs of gender-variant children and their parents. The reviewers' challenges and queries were responded to and ultimately all three papers were accepted for publication. The project has also been presented at numerous academic conferences and symposia where scholars and members of the transgender community not involved in the project provided feedback.

Confirmability stems from the objectivity or sense of neutrality that reveals the extent to which the findings are impacted by researcher motivation, bias or interest and is demonstrated through procedural audits, triangulation and reflexivity (Lincoln & Guba, 1985). The research procedure and data analysis are provided in detail in this chapter section 2.8. Triangulation has already been discussed with respect to 'credibility'. Reflexivity involved an ongoing practice which included checking and reassessment at each stage of the analysis and presentation of the findings.

Vividness is a feature appealing to the reader's empathy, creating a sense of connection (Polkinghorne, 1983). Connection with participants was achieved through the inclusion of their 'voices', with the transcripts revealing participants' heartfelt descriptions which allowed the reader to sincerely connect with their experiences.

Relevance is related to the *value* of the research and refers to the importance of the research topic and its ability to contribute to the field (Hammersley, 1992). The importance and contribution of this project, entitled 'The needs of gender-variant children and their parents', is evidenced by the lack of current research in this area, the enthusiasm of the participant communities towards the project and media attention and interest.

Bochner's (2001) requirement that a project contribute to "a better social world" (p. 152) is best expressed in the project's aims and outcomes and it's potential to create a safer and healthier pathway for gender-variant children to develop into emotionally healthy and functioning adults.

CHAPTER 3

Results

3.1: The Needs of Gender-Variant Children and their Parents: A Parent Survey

[Published Paper 1]

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. http://www.tandfonline.com/doi/abs/10.1080/19317611.2011.593932

3.2 Parent Survey: Additional Results

This section reports on the results of the *Parent Survey* that were not presented in the article 'The Needs of Gender Variant Children and their Parents: A Parent Survey'. It provides the results of parents' responses to questions regarding: a) their gender-variant child's peer relationships; b) their gender-variant child's difficulties that were *unrelated* to their experience of being gender-variant; c) their gender-variant child's level of anxiety; d) the quality of their relationships with their gender-variant child; e) the difficulties and/or pressures they experienced in raising a child with gender variance up to the age of 12; f) the outcomes they would like for their gender-variant child; g) how this might be achieved; h) any current concerns they may have; and i) additional comments.

3.2.1 Peer Relationships of Gender-Variant Children

Table 3.2.1 below presents parents' responses to the question "How would you describe your child's peer relationships at that time?" (referring to the time after they had became aware of their child's gender variance). Parent responses that described their child's peer relationships as "poor", "not good", "difficult', "minimal", "not very good", "non-acceptance by peers" or "[child] is having trouble connecting" were placed in the category *poor peer relationships*. Parents' responses that described their child's peer relationships as "good", "sociable & friendly", "well-integrated", "has many friends", "very good", "plays with boys and girls" or "liked and admired" were placed in the category *good peer relationships*. Minimal responses such as "fine" were accepted at face value and placed in the *good peer relationships* category. A number of parents (n=8, 26%) noted that their child had friendships but only with children of their preferred gender.

Table 3.2.1 The Quality of Gender-Variant Children's Peer Relationships by Birth Gender as Reported by Parents

Category	F (n)	(%)	M (n)	(%)	All (n)	(%)
Good peer relationships	10	(32)	13	(42)	23	(74)
Poor peer relationships	2	(6)	5	(16)	7	(23)
No answer	1	(3)	0	(0)	1	(3)
Total	13	(42)*	18	(58)	31	(100)

**Numbers do not add up due to rounding error*

Three parents also reported that although their children had "good" peer relationships, they had noticed that it was becoming increasingly difficult for their children to maintain these as they grew older.

3.2.2 The Child's Difficulties *Unrelated* to their Experience of Having Gender Variance

Parents were asked the question "Are there difficulties your child experiences (or has experienced) that are (or were) unrelated to their being gender-variant?" Although this question specifically requested information *unrelated* to their child having gender variance, a number of parents identified issues that they thought were related to their child's experience of gender variance. For example: "his fantasy of being female takes over from what he should be concentrating on" or "my child has an anxiety issue but I do not believe he would be so anxious if he wasn't TG" and "toilets are an issue for us at the moment [due to the child's gender presentation]". Because these responses are related to gender variance, they were not included in the results for this question. Therefore, of the 31 gender-variant children, 13 were identified by their parents as having difficulties unrelated to their gender variance. The parents' report of extant difficulties in their gender-variant children were: dyslexia; parent separation/divorce (n=3) (one of these was a twin in a family with a history of domestic violence); Down's Syndrome, with a history of abuse[5]; separation anxiety; slightly immature with reading difficulties; lack of concentration/easily distracted (n=2); Asperger's autistic; a

[5] The type of *abuse* was not specified.

high anxiety child with obsessive compulsive disorder and a learning disability; and adoption (n=2) (one had a sibling with behavioural problems and the other had "fears of abandonment").

Some parents stressed that it is only the gender issues that create difficulties for their child. The parent who identified their child as having obsessive compulsive disorder specifically stated: "It is unclear if the high anxiety and obsessive compulsive disorder are related to the gender issues."

3.2.3 The Anxiety Levels of Children with Gender Variance

The question put forward to parents about anxiety in their children was: "If we define anxiety as *distress or uneasiness of mind caused by fear of danger or misfortune*, where would you place your child's level of anxiety between 1 (not at all anxious) and 10 (extremely anxious)? 'Generally', 'At the worst times' and 'At the best times'". The results are presented in Table 3.2.2.

Table 3.2.2 Parent-reported Levels of Anxiety in their Gender-Variant Child on a Scale of 1-10: 'Generally', 'At The Worst Times' & 'At The Best Times'

Level of Anxiety	Generally n (%)	At The Worst Times n (%)	At The Best Times n (%)
1 Not at all	7 (23)	0 (0)	9 (29)
2-3	6 (19)	5 (16)	13 (42)
4-5	9 (29)	3 (9)	6 (20)
6-7	8 (26)	5 (16)	2 (6)
8-9	1 (3)	13 (42)	1 (3)
10 Extremely anxious	0 (0)	5 (16)	0 (0)
Total	31 (100)	31 (99)*	31 (100)

* *Rounding error*

Table 3.2.2 shows that 55% of children had an anxiety level within the middle range (between 4 and 7) while 42% had little or no anxiety. It is notable, however, that 29% of the children experienced middle or high range anxiety at 'the best of times'.

3.2.4 Parents' Relationships with their Gender-Variant Children

Parents were asked "How would you generally describe your relationship with your child?" Although no categories were provided for this question, most parents answered within the framework of good, very good or excellent. Some of the other responses were: "very close and loving", "extremely good", "close, open and honest", "loving, connected, happy", "great", "we always talk", "excellent" or "we stick together through hard times". No parent described their relationship as poor in any way. However, one parent who described their relationship with their child as "fairly good" added that "it could be and should be better", which may imply that the relationship was 'not good'.

3.2.5 The Difficulties and/or Pressures Experienced by Parents Raising Children with Gender Variance

Parents were asked two questions specifically related to the challenges they faced as parents raising a child with gender variance. The first question related to the difficulties and/or pressures they experienced when their child was younger than five. The second question requested the same information but for the age group five to twelve.

Parents' responses are presented in order of frequency for the two age groups in Tables 3.2.3 and 3.2.4 respectively. These tables show the categories derived from the parents' responses and the number and corresponding percentage of times that answers were assigned to that category.

Table 3.2.3 The Category and Frequency of Parent Responses Allocated to each Category in Answer to the Question: "What difficulties/pressures have you experienced as a result of your child being gender-variant up to age 5?"

Category	Parents n (%)
1. Trying to and/or pressure to make child conform to society's expectations	16 (26)
2. Others' lack of understanding	10 (16)
3. Being told what to do	7 (11)
4. Others critical/blaming	7 (11)
5. Marriage tension/family arguments	6 (10)
6. None or minor difficulties/pressures	4 (7)
7. Worry/concern/confusion/emotional upheaval	4 (7)
8. Lack of support/information/education	3 (5)
9. Gender variance was unidentified before age 5	3 (5)
10. Loss of friends/support network	2 (3)
Total	62 (100)

Table 3.2.4 The Category and Frequency of Parent Responses Allocated to each Category in Answer to the Question: "What difficulties/pressures have you experienced as a result of your child being gender-variant from age 5 - 12?"

Category	Parents n (%)
1. Others' criticism/lack of understanding	10 (13)
2. School issues	8 (11)
3. Fighting for child's rights	8 (11)
4. Pressure to conform	7 (9)
5. Concern about child's safety/anxiety/general well-being	6 (8)
6. Educating professionals, teachers, parents etc	6 (8)
7. Child's determination to always express their gender	5 (7)
8. Concerns for child's happiness	4 (5)
9. Relationship/family issues	4 (5)
10. None or minor difficulties/pressures	4 (5)
11. Child too young	4 (5)
12. Making the right decision	3 (4)
13. Hurt/anger at others discriminating against their child	3 (4)
14. Concerns about access to blockers	2 (3)
15. Lack of information, help or support	1 (1)
Total	75 (99)*

**Percentages do not add to 100 due to rounding error*

Although no parents specifically identified the use of pronouns as a difficulty in their responses to these questions, the subject of 'trying' to use the child's preferred pronoun or other problems with pronouns were mentioned. Seven parents (22%) consistently used the pronoun of their child's preferred gender in their reports. Most parents (n=22, 71%) referred to their child with the pronoun of the child's birth sex. A couple of parents (n=2) wrestled with referring to their child in the preferred gender, avoiding pronouns altogether and using "my child" or the child's name in place of 'he' or 'she'.

3.2.6 Parents' Desired Outcomes for their Gender-Variant Children

Parents were asked "What outcome would you like for your gender-variant child?" The responses to this question have been categorised and appear in order of frequency in Table 3.2.5. The number (n) represents the number of times this item was identified in the parents' responses and appears alongside the frequency percentages (%).

Table 3.2.5 Parents' Desired Outcomes for their Gender-Variant Child

Category	Parents n (%)
1. Happiness/confidence	25 (30)
2. To be himself/herself	11 (13)
3. To be accepted/understood society	6 (7)
4. Productive/life fulfilment	5 (6)
5. Relationships/friends	5 (6)
6. To be loved and/or be loved	5 (6)
7. Be safe	5 (6)
8. To know they are loved by parent/family	5 (6)
9. Sex change	4 (5)
10. To be comfortable with birth sex/gender	4 (5)
11. Not to be judged or discriminated against	3 (4)
12. To be healthy	3 (4)
13. To be without confusion	1 (1)
14. Reduce anxiety	1 (1)
15. Change gender in documents	1 (1)
Total	84(101)*

**Percentages do not add to 100 due to rounding*

The parents' desired outcomes were generally focussed on their child having their previously identified needs met. However, four parents specifically stated that their desired outcome was for their child to be comfortable with their born sex and associated gender. Several of these parents also stated that if this was not possible then their child's happiness would be their priority.

3.2.7 Parents' Suggestions for how these Outcomes for their Children could be Achieved

Following the question regarding parents' desired outcomes for their gender-variant child, they were asked "How do you think this could be achieved?" The parents' recommendations are presented in Table 3.2.6.

Table 3.2.6 Parents' Suggestions for Achieving the Desired Outcomes for their Children with Gender Variance (Randomly by Category)

Parenting	• Talk with child openly within the family • Help for parents to not be ashamed or give in • Taking it 'one day at a time' • Have exposure to a diversity of people • Provide love, nurturing and support at home continuously • Seek expert advice and support • Have strategies to deal with bullies • Attend support groups with venues for sharing experiences and ideas • Teach child to keep choosing what is best for them • Keep the child aware that he/she will never be alone, no matter how different he/she thinks he/she is at times, and that he/she will never have to be "stuck" in a place that doesn't accept him. • Accept the child is gender-variant and move forward • Teach child there are supportive people • Let child be open (out) to improve their confidence • Let child know they are accepted • Help child to gain a strong self esteem • Let child know they have more family out there in the world she/he hasn't even met yet. • Help child to understand that boundaries are most often about being a child and not only due to them having gender variance • Expose child to other similar children

Parents' Suggestions for Achieving the Desired Outcomes for their Children with Gender Variance (*Continued)*

School Education	• Ensure acceptance of gender-variant child through awareness, education and support programs in schools • Schools to stop segregating boys and girls • Schools to treat all children the same regardless of sex • Schools to provide a caring and protective environment at school
Medical & Professional	• Abolishing the term 'Gender Identity Disorder' • Access to medication where required • Sex change as early as possible
Education	• Teach society to accept diversity, including people with disabilities • Teach journalists positive media coverage of transgender issues • Have books/websites/pamphlets freely available • Have programs and information for gender-variant children • Provide education about diversity of genders that has always existed • Provide education for people to understand that 'Gender Identity Disorder' is not a mental illness but a biological medical condition
Government & Legislation	• Government to cover costs of therapy and surgery • Awareness by leaders in government about transgender and transsexual issues • Legislation against discrimination of transgender people in the media • Laws to protect gay, lesbian, bisexual and transgender (GLBT) people

3.2.8 Parents' Current Concerns Regarding their Child with Gender Variance

Parents were asked, in relation to their child with gender variance: "Do you have a particular concern now?" In response, some parents stated that their concerns related to current day-to-day activities like choosing clothes, bedding and school accessories. Parents' main concerns appeared to be focussed around issues to do with their child's protection, i.e. safety and dealing with bullying, particularly in school. Other concerns were related to the reactions of others as their child transitioned socially, their child's friendships and the child's acceptance of, and ability to be, themselves. Parents also expressed concerns about mental health issues,

particularly depression and anxiety, as well as the lack of support, clinics and public awareness, especially the lack of government-resourced clinics and support. There were also concerns regarding puberty and puberty blockers, for instance, determining the need for puberty blockers, the ability to obtain them and their long term effects. Future concerns related to fears, difficulties and costs associated with sexual affirmation surgery and their child's future happiness after surgery.

3.2.9 Parents' Additional Comments

Parents' additional comments in response to the question "Is there anything else you would like to add?" are presented below in no particular order. Specifically, parents' responses related to:

- receiving support for hormone blockers
- concerns regarding their feelings "that there is more to it"
- their desire to attend a gender clinic
- plans to organise/attend get-togethers with similar children/families
- details about their relationship difficulties or status
- explanations regarding their answers to previous questions to emphasise a point previously made
- their own gender preferences
- their reasons for completing the survey
- their concerns about the lack of support or correct information
- their gratefulness for their child and the experience
- their interest in the study
- appreciations for the study
- requests to be informed of the outcome of the survey

3.2.10 Discussion

This survey of parents with gender-variant children aimed to explore parents' experiences and their views of their own and their children's needs. This discussion situates previously unpresented results within the research literature, highlighting similarities and differences regarding: the ratios of born males to born females with gender variance, the child's peer relationships, any difficulties of the child unrelated to gender variance, the child's levels of anxiety, the quality of the parent-child relationship, parents' difficulties in raising a gender-variant child, parents' desired outcomes for their child, how these outcomes may be achieved, current concerns and any additional comments.

In this study, the ratio of children born male to children born female was 1.4:1. This ratio is much closer to parity than previous research that used a sample of clinically referred children. In clinical studies of gender variance, ratios of born males to born females were 6.6:1 in North America (Cohen-Kettenis, et al., 2003), 3:1 in an under 12 group (Di Ceglie, et al., 2002) and the suggested 5:1 in the DSM-IV (American Psychiatric Association, 1994). It also appears that over time the ratio of boys to girls is decreasing; for instance, in 1974 Green reported a ratio of 19:1. Apart from the fact that attitudes towards boys with cross-gender behaviour are more negative than attitudes towards girls with cross-gender behaviour (Di Ceglie, et al., 2002; Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010; Zucker, et al., 1997), the sampling techniques used in previous studies may have had an influence due to the fact that the children of the parents in the current study were not only clinical referrals. Further, cross gender behaviour represents more of a transgression for boys than for girls (Cohen-Kettenis, et al., 2003; Cohen-Kettenis & Pfafflin, 2003; Cohen-Kettenis, et al., 2006; Di Ceglie, et al., 2002; Ruble, et al., 2007; Zucker, et al., 1997; Zucker, et al., 2002). It

appears that girls' cross-gender behaviour needs to be extreme before parents consider intervention (Zucker, et al., 1997).

As noted above, some parents in this study indicated that their child had good peer relationships but only with children of their preferred gender. Wallien et al. (2010) showed that the children who were referred to the clinic for gender issues had better peer friendships with children of the opposite sex than with children of the same sex. Other literature does not find this, although all peer relationship measures of clinically referred children indicated that boys had poorer peer relationships than girls (Cohen-Kettenis, et al., 2003; Di Ceglie, et al., 2002; Wallien, et al., 2010). It has been shown that children generally prefer same-sex friendships (Fridell, Owen-Anderson, Johnson, Bradley, & Zucker, 2006) which for gender-variant children means friendships with children of their preferred gender. Parents who reported *poor peer relationships* for their children also indicated that their children were lonely and/or isolated. Boivan, Hymel and Bukowski (1995) showed that not only are poor peer relationships related to feelings of aloneness but that social exclusion, including rejection and bullying by peers, is predictive of loneliness.

The discussion of the items identified as 'difficulties their child experiences *unrelated* to their being gender-variant' must be viewed through the lens of the information gathered. Of particular importance is that participants freely offered these items as they reflected on their child's circumstances rather than in response to particular targeted questions. It is therefore likely that the items themselves and the frequency of those items do not represent the true range of experiences. The question asked of parents regarding unrelated difficulties featured some items of interest in the literature. For example, the sample included two children identified by their parents as having anxiety (one of these had obsessive compulsive disorder

and a learning disability), two children were adopted from China, three children had divorced or separated parents while two children lacked concentration or were easily distracted.

At present, there is no literature on either gender-variant children's ability to concentrate or their propensity for distraction, although Di Ceglie et al. (2002) reported that nine (17%) of the clinically referred children under 12 in their study were reported to have "attention problems" (p.10). It may be that the *experience* of being gender-variant could be a distraction in and of itself as children continually have to negotiate their claim to be themselves. This is reinforced by Di Ceglie et al.'s (2002) finding that in the over 12 age group, this number dropped to three (4%).

Approximately 50% of children now experience parental divorce (Proto, Sgroi, & Oswald, 2012). In this study, three of the 30 parents (10%) reported being divorced or separated. A study by Cohen-Kettenis and Arrindell (1990) compared the rate of parental divorce of 45 transsexuals with 275 controls and found that the rate was significantly higher for the parents of transsexuals (n=11, 24%) than it was for the controls (n= 6, 2.2%) although 95.6% of the transsexuals and 95.3% of the controls reported that they had been brought up by *both* parents. Importantly, there were no differences in how the transsexual and control subjects responded to the divorce of their parents, indicating that gender-variant children were no more or less affected by divorce than their non-gender-variant counterparts.

Two (6%) of the children in this sample were adopted. Research has shown that the adoption rates amongst children referred for GIDC is higher (7.6%) than the average rate in the local general population (1.49%) (Zucker, 1998). One report (Menvielle & Tuerk, 2002) found

that half (n=6) of the families in their parent support group had gender-variant children who were adopted.

The experience of being gender-variant alone may be anxiety provoking due to the ongoing need for the child to be aware of those around them and how these people might respond to their behaviour. This discussion considers anxiety from the perspective of general 'anxiety' and 'separation anxiety'. Separation anxiety is considered to be the most common anxiety disorder. However, there is no consensus on the rate of anxiety in gender-variant children as the levels range between 0.5% and 20.2% in children up to 11 years of age, inclusive (Cartwright-Hatton, McNicol, & Doubleday, 2006). Various authors have reported higher levels of anxiety in children diagnosed with GIDC (Di Ceglie, et al., 2002; Wallien, van Goozen, & Cohen-Kettenis, 2007). One study has shown a positive correlation between separation anxiety and children diagnosed with GIDC (VanderLaan, Gothreau, Bartlett, & Vasey, 2010) although this is not supported by Wallien et al. (2007) for whom the rate of separation anxiety in children with GIDC was less than 6%. Interestingly, Zucker et al. (1996) found that when a conservative definition of 'separation anxiety disorder' was used, there was no significant correlation with GIDC. However, when a more inclusive definition of 'separation anxiety' was used, 64.4% of the boys with GIDC were identified as having separation anxiety.

As noted previously, all parents reported having positive relationships with their gender-variant children. Di Ceglie (2002) found that 32% of the children under 12 in their sample were reported as having relationship difficulties with their parents, as evidenced in an audit of clinical notes. These parents were clinically referred and therefore likely to include parents who were not supportive of their child's gender variance. However, the data in this study may

be biased in this respect because parents may want to give the impression that they have had a 'good' relationship with their child but also because of selection bias, that is, this survey appealed to parents who were supportive of their gender-variant child.

This study has shown that the difficulties or pressures for over 60% of parents with gender-variant children under the age of five were associated with society's pressure on them to make their child conform to gender norms, other people's lack of understanding, being told what to do, and being criticised or blamed for their child's gender non-conformity. Four parents responded that they had minor or no difficulties or pressures while their child was under 5 years of age. Two parents wrote that their child was shy and conformed, one parent explained that they "[didn't have] much pressure really when he was younger as we allowed him to dress as a girl" while another parent shared that "she didn't show any [outward] signs". One parent whose child's gender variance was unidentified during this age group explained that "he was not living with us then".

For the age group of 5-12, nearly 60% of the difficulties or pressures that parents experienced were related to the ignorance and criticism of those around them, issues to do with school, fighting for their child's rights, pressure to conform, and concerns about their child's safety or general well-being. Four parents responded that they had minor or no difficulties or pressures during this time. Two wrote that even though they were aware of their children's gender variance, their children conformed during this time. The other two parents explained that they have not yet experienced any difficulties as their children are still very young.

The parents of the older age group reported that in addition to the pressures and difficulties their children faced when they were younger they are now also facing safety and other issues

at school. Parents also found that as their children grew older they needed to advocate for them in the public sphere whereas when the children were younger, the focus was more on interpersonal issues and less on external reactions. Di Ceglie & Coates Thummel (2006) also reported that parents found that the pressure on them increased as their children became older.

Research on parent's difficulties in raising a gender-variant child is limited. Brill and Pepper (2008) reported parents' experiences of shock, confusion, grief, fears, struggling with acceptance or adversity, or a sense of self blame. Other accounts of parental difficulties have focused on the parents of transgender adults, youth or adolescents (Boenke, 2003; Cooper, 1999; Hegedus, 2009; Hill & Menvielle, 2009; Pearlman, 2006; Wren, 2002). A number of authors have reported the struggles parents face as described within support groups for parents of gender-variant children. These struggles include protecting their children and keeping them safe, the anger at being told what to do by family members or professionals, problems with schools, dealing with the reactions of others, fears of a transsexual outcome and fear of the future (Di Ceglie & Coates Thummel, 2006; Rosenberg, 2002).

The use of preferred pronouns has been acknowledged as a form of respect for gender-variant adults (Dutton, Koenig, & Fennie, 2008; Maguen, Shipherd, & Harris, 2005; Polly & Nicole, 2011). Doan (2011) recently wrote: "many people do not understand the power of these little words and how painful the persistent use of inappropriate pronouns can be". However, there has been little discussion in the literature regarding the correct pronoun usage for gender-variant children. That said, Brill and Pepper (2008) have acknowledged the value of parents using gender-neutral language as a form of respect for the sensitivities of their gender-variant

children. These authors have also described the discomfort and awkwardness that parents often feel in attempting to become accustomed to using the pronoun their children prefer.

Conclusion

This section has reported on results not previously presented in the manuscript 'The Needs of Gender Variant Children and their Parents: A Parent Survey'. These results have focussed on parent reports of their children's peer relationships, their children's difficulties unrelated to gender variance and their children's levels of anxiety. These results describe parents' views of their relationship with their gender-variant child, the difficulties or pressures they have experienced in raising a gender-variant child, their current concerns in raising their gender-variant child, the outcomes they hope for their child and how these outcomes might be achieved.

Also noted were the variations in the ratios of male to female, indications that this ratio is declining and factors that may have contributed to these variations. The discussion explored the quality of the children's peer relationships and the isolation experienced as a consequence of poor peer relationships. The rates of parental divorce in this sample proved to be lower than those indicated in a transgender population study. The varying rates of adoption across the researched transgender groups were compared whereupon these results, although lower, showed close to the expected rate for gender-variant children. The levels of anxiety in children reported in this study were compared to children diagnosed with GIDC and the inconclusive evidence regarding the incidence of 'separation anxiety' in gender-variant children was reviewed. All parents in this group reported positive relationships with their children, perhaps indicating that parents of gender-variant children with less positive relationships were less likely to respond to the survey. The parent's difficulties and pressures

in raising a child with gender variance were overwhelming and related to external factors such as criticism from others, ignorance in society generally and concerns for their child's safety. The use of pronouns emerged as a dilemma even in this group of parents who reported positive relationships. It appears that the scarce literature with respect to children's wishes as to whether they are referred to as 'he' or 'she' may contribute to this difficulty for parents.

3.3: Surviving a Gender Variant Childhood: The Views of Transgender Adults on the Needs of Gender Variant Children and their Parents

[Published Paper 2]

Riley, E.A., Clemson, L., Sitharthan, G. & Diamond, M. (2012). Surviving a gender variant childhood: The views of transgender adults on the needs of gender variant children and their parents. *Sex & Marital Therapy Journal.* [E-Print] http://www.tandfonline.com/doi/abs/10.1080/0092623X.2011.628439

[Pages 77-111]

3.4 Transgender Adult Survey: Additional Results

This section presents the results of the *Transgender Adult Survey* that were not reported in the previous published paper, 'Surviving a gender variant childhood: The views of transgender adults on the needs of gender variant children and their parents'. The aspects of the Transgender Adult Survey presented here are responses regarding: identification of gender variance as a child; parents' responses to this identification; the impact of being gender-variant at school; the impact on friendships; and the general experience of being a child with gender variance. This section also presents three other sets of results: difficulties *not related* to gender variance; the impact of a gender-variant childhood on adults; and current needs of respondents.

3.4.1 Income

Ninety-two participants responded to the question regarding their current level of income. The amounts are represented in Table 3.4.1 in Australian dollars ($AUD) and American dollars ($USD). At the time the data were collected in 2009, the average exchange rate was 1USD = .8 AUD.

Table 3.4.1 The Transgender Adult Participant's Level of Income

$AUD	**$USD**	**Participants (N=92) n (%)**
> $120,000	> $150,000	3 (3)
$80,000 - $120,000	$100,000 - $150,000	15 (16)
$40,000 - $80,000	$50,000 - $100,000	32 (35)
< $40,000	< $50,000	32 (35)
$0*	$0*	10 (11)

**Note: Of the 10 participants who have a recorded income of $0, five wrote $0 and identified as students with one also unemployed, one wrote "unemployed", one wrote "housekeeper", one typed N/A, one put $0 and one wrote "ran a loss".*

3.4.2 Transgender Adults' Identification of Gender Variance

The questions "What was it that you first noticed about yourself that told you that you were different to other children?" and "Describe the circumstances surrounding this realisation" were asked to allow participants to reflect, interpersonally and contextually, on their experience as a child with gender variance both. Table 3.4.2 displays, in order of frequency and with associated percentages, the items that 110 transgender adults identified as their first recognition(s) of being gender-variant. Participants generally identified multiple items.

Table 3.4.2 Transgender Adults' Identification of their Gender Variance

Event identified	Frequency (%)*
1. Interested in games/activities/ expression of other sex or expressed dislike in games activities/expression of birth sex	47 (43)
2. Being teased/corrected/punished/prevented from being myself	28 (25)
3. Wanted to wear opposite sex clothes/ didn't like clothes of own sex	26 (24)
4. Knew I was a girl/boy but looked like and was treated as a boy/girl	23 (21)
5. Wanted to play/be with other sex	17 (15)
6. Felt something was wrong/confused	17 (15)
7. Wanted to be identified as the other sex/gender in roles/characters	10 (9)
8. Wanted/longed for/wished to be the other sex	9 (8)
9. Felt isolated /uncomfortable/ didn't fit in	8 (7)
10. Thought there was a mistake/should have been born the other sex	6 (5)
11. Uncertain/unsure/don't know	3 (3)
12. Told I was different	3 (3)
13. Mistaken as other sex/gender	3 (3)
14. Psychological or emotional feelings/behaviour of the other gender	2 (2)
15. Thought I was more of the opposite sex than my own sex	2 (2)
16. Saw a trans person and realised they were like me	1 (1)

*Frequency (%) of 110 participants for each item identified

The question “How did you feel at the time?” was asked to allow for the further expression of memories associated with this initial recognition of their gender variance. Table 3.4.3 shows the full range of emotions, from positive to negative, remembered while recounting their first identification of gender variance as a child.

Table 3.4.3 Responses to ‘How did you feel at the time?’

Excited	Embarrassed	Fearful	Very angry
Euphoric	Confused	Scared	Ashamed
Complete	Discomfort	Frightened	Horrible
Comfortable	Thrown	Lonely	Depressed
Curious	Betrayed	Angry	Awful
Shy	Deceived	Isolated	Stressed
Surprised	Suspicious	Tearful	Like a freak
Compelled	Jealous	Sad	Dysfunctional
Strange	Perplexed	Very confused	Bullied
Supported	Hurt	Disappointed	Hopeless
Innocent	Unfair	Shameful	Perverted
Ok/fine	Inferior	Guilt	Marginalised
Observer	Secretive	Sinful	Didn’t fit in
Hopeful	Self-conscious	Afraid	Miserable
Happy & scared	In trouble	Very scared	Alienated
Mixed	Forced to be	Awkward	Unwanted
Watched	something I wasn’t	Alone	Hateful
Confident I would	As if I was acting	Frustrated	Wrong
grow a penis	As if I was not being	Abnormal	Like I was going to
	seen properly	Hiding	die

Some participants explained their feelings in differing ways. For example, “I felt like Ferdinand the Bull. I preferred to smell the flowers, rather than behave as everyone expected, like a boy.” Others explained that their feelings had changed over time as they gained a clearer appreciation of the reality of their situation: “As I became aware of the implications of the differences it became harder and harder to cope with them” and “I started to get scared of growing up, [and] included Prayers to GOD to put me in a cocoon and transform me or send in the aliens to fix me”.

3.4.3 The Reported Responses of Parents

Table 3.4.4 summarises how participants as children perceived the responses of their parents at the time, arranged according to their current age group (n= 104). The four categories are:

- *Supportive Response.* This reflected the number of parents (and care-givers) who allowed their gender-variant children to express themselves and provided protection or advocacy;
- *Conditionally Supportive Response.* This was characterised by the responses of parents who provided support, but with conditions imposed. For example, parents who allowed their daughter to dress or behave as a boy as long as they 'grow out of it' or who allowed their son to cross-dress but only so long as it did not cause distress to other family members;
- *Negative Response.* This represented the number of parents who punished or applied pressure to the child to conform; and
- *Parent(s) Unaware.* This related to the number of parents who were not informed of their child's feelings and where the respondent genuinely thought their parent(s) had no idea that they were experiencing feelings of difference or confusion about their sex or gender.

Table 3.4.4 Reported Parental Responses to Participants' Gender Variance as Children

Ages of participants	Supportive Response n	Conditionally supportive response n	Negative Response n	Parent(s) unaware n	Total n (%)
18-25	1	1	3	4	9 (9)
26-45	6	9	13	9	37 (36)
46-65	6	5	28	16	55 (53)
66+	0	0	1	2	3 (3)
Total (%)	13 (13)	15 (14)	45 (43)	31 (30)	104 (100)

Note: Parent unaware = participant reported that parents were unaware of the participants' feelings of gender variance
Note: Participants needed to respond to both the age and parental response question to be included in this table

Although this table appears to show a trend of parents becoming more aware and providing *fewer* negative responses to their child's gender variance, a chi-square test implemented on the data for those aged 45 and under and those aged 46 and over with the p-value (probability) set at 0.05, showed that the apparent differences are not significant.

3.4.4 The Impact of being Gender-Variant at School, on Friendships and on Childhood Generally

The questions "How did being gender-variant affect you at school?", "How did being gender-variant affect your friendships?" and "How would you describe your experience of being a child with gender variance up to age 12?" were analysed separately and then together as many participants responded in a narrative form about their childhood experiences. This analysis produced a number of clear categories which reflect how participants experienced their childhood (with many identifying in more than one category). According to the responses of the 110 transgender adults, 4.5% (n=5) had what they described as an "ok" or "good" childhood with none or only minor issues; 51% (n=56) were secretive, withdrawn, kept themselves hidden, complied or excelled in a particular activity to prevent exposure of their 'true' self; 55% (n=60) were isolated or extremely isolated, rejected, treated as social outcasts, or shy and "never fitted in" as a child; and 45% (n=50) were teased, bullied, verbally abused or 'picked on', including 18% (n=20) who were beaten, violently assaulted or threatened with murder.

The comments that participants wrote of the their experiences of being a child with gender variance (before the age of 12) ranged from: "pretty cruisy and sometimes frustrating" through "difficult", "unhappy", "bloody awful", "a nightmare", "internally tormented", "a living hell" to having suicidal feelings or fears of being killed. One participant stated: "I

hated it and thought I was going to be killed or kill myself before I got to be 15. I'm still shocked I got past that age. I hated life then and wanted to die." Another wrote: "I was depressed. I tried to kill myself around the age of 11 by hanging."

Even though there was one question directly related to school, only 12% (n=13) of participants described their schoolwork, perhaps reflecting the overriding need to focus on their safety and survival during these years. Nine per cent of participants (n=10) noted that they did either very well or excelled at school, while three mentioned that they had poor grades or were unable to study. Some mentioned that they "hated" school or that they were prevented from doing their preferred activities.

Regarding friendships, 25% (n=27) reported having no friends at all as a child under 12, 25% (n=27) reported having very "few" friends while 34% (n=37) reported having either good and/or many friendships (however, only 6.4% (n=7) of these were of the participants' preferred gender). Thirteen percent (n=14) provided no information regarding their childhood friendships.

3.4.5 Difficulties *Unrelated* to Gender Variance

The difficulties of the transgender adults as children that were *unrelated* to their being gender-variant are presented in Table 3.4.5. Thirty four per cent (n=37) of transgender adults identified extant conditions that they felt had an impact on their childhood in addition to their experience of being gender-variant. Mental health issues reported were suicidal feelings, obsessive-compulsive behaviour and severe depression. However, it is possible that these behaviours and thought processes may have been reactions to the difficulties the participants experienced as gender-variant children.

Table 3.4.5 The Difficulties of Transgender Adults as Children Unrelated to being Gender-Variant

Difficulty Identified	Frequency (% of total)
1. Physically and emotionally abusive family or environment (including 4 sexually abused)	19 (17.3)
2. Physical illness or other condition	7 (6.4)
3. Adopted (including 1 state ward)	4 (3.6)
4. Parents divorced/separated	4 (3.6)
5. Mental health issues	3 (2.7)
6. Parent(s) died	2 (1.8)
7. Moved numerous times during childhood	2 (1.8)
Total	37 (34)*

** Forty one items are noted (not 37) since four individuals who had been physically abused were also adopted (n=2), from divorced parents (n=1) and with mental health issues (n=1)*

3.4.6 The Impact of a Gender-Variant Childhood on Life as an Adult

Answers to the questions "What impact has your experience as a gender-variant child had on you as an adult?" and "How do you think your experience as a gender-variant child affects you now?" were generally answered as part of a narrative where participants wrote about their experience and reflected upon their life as a whole. Their responses are categorised below as 'positive impacts' and 'negative impacts'. The 'positive impacts' category includes participants' descriptions of gaining self-acceptance, developing strengths, their ability to be open-minded and tolerant of others, their compassion and sensitivity for others and their motivation to advocate for and help others. The 'negative impacts' category included mental health issues, lack of confidence and self-worth, feelings of isolation, an inability to form relationships, inability to trust and difficulties in finding or keeping a job.

Reported positive impacts of having lived with gender variance as a child

The positive consequences reported by transgender adults due to having lived with gender variance as a child include the attributes of self-acceptance, strength, open-mindedness, sensitivity and compassion for others and the ability to advocate and help others.

Self-acceptance. Participants expressed how they felt as they came to appreciate their experience of being gender-variant and developed the capacity to rejoice in their identity. One participant shared: “I love who it is that I have been able to become and I love that I have had the courage to become ME” while another wrote that “I’ve come to regard my transsexuality as something special”.

Strength. The concept of ‘being stronger’ was conveyed as being imperative to developing coping skills. Participants wrote: “It’s made me tough”; “I’m stronger in a lot of ways for having had that ‘outsider’ perspective” and “I have the strength to overcome and make anything possible”.

Open-mindedness. Their tolerance for other people’s differences was described as: “I am more open to people of all backgrounds, presentations and genders” and “I am more open to the diversity in people and to many new ideas”.

Sensitivity and compassion for others. Some participants felt that they have an enhanced ability to understand and be empathetic toward the experiences of others. They wrote: “I am very sensitive to others that don’t fit into the category of mainstream ‘normal people’” and “I have learned compassion and respect for people, animals, and the environment. Through abuse I have learned how NOT to be.”

Advocacy and helping others. Participants described how their experience has given them the drive and motivation to make a difference, in particular to young people experiencing gender diversity. One participant explained: “I now see it as my mission to educate [others]

about being transgender so no child has to grow up as alone as I was" while another wrote "I have a strong desire to help trans-children and teens."

Negative impacts of having lived with gender variance as a child

The negative outcomes reported by transgender adults are described below. The most often cited outcomes were mental health issues and having low confidence and self-worth. There were also feelings of isolation, the inability to form relationships, a lack of trust and difficulty in getting or keeping a job. The category 'other negative impacts' includes responses not falling within the above categories.

Mental health issues. Depression, post-traumatic stress disorder, being suicidal and recovering from addictions were themes for some participants. They wrote: "I'm absolutely miserable. Until I transition I remain a risk to myself"; "I suffer from major depression and fight suicidal feelings on a daily basis. My husband pleads with me to 'change my mind'"; "[this] abusive treatment by others has left me emotionally and psychologically damaged. I now have PTSD disorder and I'm suicidal" and "[I was] ashamed of my chest. This eventually led to such a depression that I made serious suicide attempt and shot myself at age 25". Another participant described their issues with food: "I am obese. Eating was the only thing I could control as a teen. Now it controls me."

Low confidence and self-worth. Participants lamented the ongoing effects of having suffered due to gender variance. Responding to how they felt their gender-variant childhood had affected them, they wrote: "I'm damaged goods with impaired self-esteem, struggling in this world – still an outsider"; "[the effect] is drastic in every single minute of my life – due to stereotypes imposed against our will" and "[I] regret the lost opportunities – still lack self-

confidence and [trying to] figure out who I am". Others wrote about their feelings of shyness and lack of day-to-day confidence.

Isolation and inability to form relationships. Being lonely and socially isolated was a major difficulty for many participants who described feelings of alienation that they have never been able to resolve. For example: "[I have] a well-established predisposition to reclusiveness and melancholy and keeping things to myself" and "I am more lonely and socially isolated than I would like. I still find it very hard to make friends. I left it too late [in life] to address my gender variance although, as far as I can tell, nobody guesses my history".

Participants relayed their feelings of awkwardness in social situations which directly inhibited their ability to form ongoing friendships and relationships. They wrote: "It looms huge in my life. It's the reason I'm still single and do not have children. Nobody knows me"; "At 34, I still feel 19, inexperienced & socially awkward, with bouts of depression" and "[I've] never had a serious relationship, I don't believe I can be in a relationship with another adult". One participant wrote:

> I find it hard to get beyond superficial connection with people. I have had a drug problem and the reason is that I fell in love with someone who did accept me. He had a drug problem. I was so determined not to lose him that I decided to become addicted to rescue him so that we could get off drugs together. I have now been clean for 12 months. We have separated and he is still not clean.

Lack of trust. A number of participants described their inability to trust. For example: "I have a lack of trust. I have never dated, even though I dream of marriage. I feel 'judged' by others, even when they may not be [judging me]" and "I guess I still have shame and live in

fear of telling anyone about me. I believe that people will lose respect/love/interest in me and my opinions/advice etc. if they know the whole truth of my past". Another explained:

> The habits I learned of hiding who I am, and keeping personal information secret is well engrained. I 'came out' to save my life, but I fear the kind of openness with another person. I want it – but I fear it. I also fear in some way harming them due to who I am – so I remain alone except when my kids are here.

Difficulty getting or keeping a job. Participants explained how the "fear of rejection" prevents them from looking for work and one participant wrote that they have "paid a heavy professional price for transitioning". Others described their difficulties with keeping jobs and making enough money to cover surgeries.

Other negative impacts. Participants mentioned sadness, physical problems and how the delay in identifying the issue prevented them from being able to address their needs. For example, one participant wrote: "Physically, I have back problems which are related to having learnt bad posture as a teenager trying to hide my breasts and I'm still trying to relearn [good posture]". Some of the responses reflect relentlessly difficult circumstances. One participant described their ongoing struggle even after transitioning many years ago:

> I've been living in my proper gender for 21 years, and yet I still hesitate to tell people about my past. The fear is disappearing, slowly, but I'm sure it will never completely go away. I am confused. I had 43 years of play-acting being male. I was never socialized as a woman. Consequently, now, I'm both – and I'm neither.

Another participant wrote:

> [I have] profound loneliness, depression, very low self-esteem and isolation. I didn't transition until 49. I feel as if I came close to taking my own life just before I finally

> transitioned, really I only transitioned when I felt I had no other choice. I have deep sadness and a sense of helplessness about myself as a child. I continue to have intense self-esteem issues. I take SSRI medication for my depression and have gone to a therapist for the past 5 years.

It is important to add that although this participant would most likely be clinically diagnosed with a psychiatric *disorder*, this response may be more credible than 'disordered' given the lack of support available to them as a child along with the reported pressures, discrimination and abuse they experienced at that time.

These reports from transgender adults suggest that positive outcomes are possible for individuals who are supported as children since the negative outcomes seemingly emerge from gender suppression, isolation, discrimination and abuse.

3.4.7 The Needs of Transgender Adults at the Time of Completing this Survey

The final question related to the experiences of transgender adults was "Do you have any special needs now?" This question was asked to acknowledge participants' current experience and bring them into the present after reflecting on their past. These responses covered many areas relating to the need for health insurance, work and legal job protection, acceptance, non-discriminating doctors, counselling, money, supportive legislation, transitioning, family support, strategies to overcome isolation, surgery, self-help groups, respect, love and sex. Participants explained: "I feel as if my entire life has been building up to transition, my entire life has been one long struggle over my gender identity" and "It has been the defining theme of my life – the isolation and misery of my teenage years are still powerful enough memories to bring me to tears over 25 years later". Others discussed their

situation with respect to transitioning: “I'm still seen as female within my family and with family friends who knew me as a child which still makes me feel sad …” and “I am sad that I was never honest with my parents, who unknown to me would have loved me unconditionally, whoever I wanted to be”. A few shared that they were still unable to tell their parents or that their parents have since passed away without being told. Many expressed a regret of the loss of time as well as grief about the personal damage that the imposed silence caused them. Another participant explained that their current difficulties are in repairing family relationships: “I mourn the years spent struggling with depression and in conflict with my family, and the years spent trying to fit in. As an adult, I’m trying to forgive both my family and myself for those lost years.”

3.4.8 Discussion

The survey of transgender adults was designed to seek input from people who have experienced a gender-variant childhood so as to contribute to the literature on the needs of gender-variant children and their parents. This section has presented results of the transgender adult survey not previously published.

The average income of the transgender adult participants appears to reflect a higher rate of education than that seen in the lower income levels of transgender individuals described in previous research (Dean, et al., 2000; Gehi & Arkles, 2007; Lombardi, 2009; Rosser, Oakes, Bockting, & Miner, 2007). The average income of these participants in USD was $63,417 compared with the average income in the USA in 2009, which was $51,726 (US Census Bureau, 2011). The average income of this same cohort in AUD was $50,784 as compared with the average income during the 2009-2010 financial year in Australia, which was $44,096 (Australian Bureau of Statistics, 2011). Unfortunately, the discrepancy between the

incomes of females and males in the US is so great (between $2,500 to nearly $3000) that it is impossible to make comparisons (US Census Bureau, 2011). In general, the figures for the transgender adults appear to be higher than average despite some of the participants' concerns about their ability to find and keep employment. These higher figures may be explained in part by the high level of education in this cohort (46% reported a post-graduate qualification) and the need to access a computer.

The indications of gender variance identified by transgender adults for when they were children (Table 3.4.2), perhaps not surprisingly, correspond strongly to the DSM-IV *Diagnostic criteria for Gender Identity Disorder* (American Psychiatric Association, 1994) Criteria A and B, as shown in Table 3.4.6.

Table 3.4.6 The DSM-IV Diagnostic Criteria for GIDC

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference for playmates of the other sex

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing. (p537)

Many of the items in Table 3.4.2 and in the DSM-IV (American Psychiatric Association, 1994) appear to be aspects of behaviour that others have highlighted to the individual as not

meeting expected gender norms. Given that none of these behaviours or expressions are inherently harmful to the child or anyone else, attention should be drawn to the current debate regarding the suitability of GIDC as a mental disorder (Ault & Brzuzy, 2009; Hill, Rozanski, Carfagnini, & Willoughby, 2007; Meyer-Bahlburg, 2010; Zucker, 2010) and the socially constructed nature of normative gender behaviour as the lens through which normative expectations are created (Haldeman, 2000).

Participants' reported feelings at the time when they recognised their gender variance reflect a vast array of presentations, reactions and meaning made of their situations as children. These could perhaps be used as indicators for children who have difficulty speaking about their feelings. Identification and validation of feelings may allow for the exploration of personal constructs and meanings regarding the child's situation and the larger context.

Forty-three per cent of participants (Table 3.4.4) wrote of their parents' negative responses to their gender variance. On the other hand, 13% reported supportive responses while 30% reported their parents were seemingly unaware of their gender variance. 'Negative responses' included reported responses that could be interpreted as 'negative', such as deliberately ignoring the child's behaviour or requests for discussion about feelings associated with gender. These results are similar to those of Grossman, D'Augelli, Howell and Hubbard (2006, p. 11) whereby 42% of transgender youth's mothers "first reacted *negatively* or *very negatively*", 20% reported that their mothers responded *positively* or *very positively* and 22% of mothers were unaware of their child's transgender identity. The greater positive response in their study may be due to different categorisations. For instance, in the present study 14% of participants are categorised as having had *conditional support* from their parents. It is feasible that Grossman et al.'s group of participants who reported that their mothers

responded either *positively* or *very positively* may have included responses categorised here as *conditional support.* Although Grossman et al.'s participant sample was different in that it included transgender youth from a different generation and a sample size of 55, the percentages of response types are remarkably similar, providing validation for the findings in this study of transgender adults.

Thirty per cent of transgender adults reported that their parents were unaware of their feelings of gender variance. Whether this was due to the parents' unwillingness to acknowledge their child's situation or whether they were completely unaware of the situation is not known. Grossman et al. (2006) reported that a significant proportion of transgender youth in their study (21.8%) believed their parents remained unaware of their transgender identity. Other authors have reported similar findings (Buhrich & McConaghy, 1978; Reed, Cohen-Kettenis, Reed, & Spack, 2008). That many parents have no idea at all about their child's gender preference or status is reflected in the 'shock' reported by parents when they are told their child is transgender (Brill & Pepper, 2008; Ellis & Eriksen, 2002; Lev, 2004; Pearlman, 2006). Parents may have never heard of gender variance and therefore have no way of conceptualising what their child is expressing (Hegedus, 2009; Pearlman, 2006).

The lack of a supportive environment that could encourage discussion and open dialogue was also common (30%). It appears that while the child (now the transgender adult) was being pressured to conform to gender stereotypes, the parents were using denial as a coping mechanism, which created an atmosphere of silence regarding the child's gender variance. This imposed silence has also been noted by Boenke (2003) who recounts how secrecy infiltrated many of the childhood histories told by transgender individuals and those close to them. In 'Male Bodies, Women's Souls', Costa and Matzner (2007) recount stories from

Thailand's transgendered youth who suffer from imposed silences, fear of ridicule or abuse and a sense of regret regarding the inevitability of these.

Supportive responses were reported for 13% of participants. This may either reflect actual numbers or the disinclination of transgender adults with supportive and positive childhood experiences to take part in the survey. Even though participants were overwhelmingly in favour of more support for gender-variant children in their preferred gender, longitudinal studies are required to confirm the longer-term benefits of affirmative-supportive approaches.

The vast majority of participants (over 95%) expressed ongoing hardship in childhood due to the responses of people around them. Their responses are unsurprising given the well-known problems facing gender-variant children, including unacceptable levels of violence towards them (Burke, 1996; Coates & Person, 1985; Costa & Matzner, 2007; D'Augelli, Grossman, & Starks, 2006; Lombardi, Wilchins, Priesing, & Malouf, 2002; Witten & Eyler, 1999; Wyss, 2004; Yunger, Carver, & Perry, 2004; Zucker & Bradley, 1995). In 1998, Dominico Di Ceglie began to raise awareness of the need for non-judgemental acceptance and tolerance of uncertainty in children with gender identity disorders. Only recently have practices that embrace gender variance in children been adopted (Brill & Pepper, 2008; Di Ceglie, 2008; Di Ceglie & Coates Thummel, 2006; Hill & Menvielle, 2009; Hill, et al., 2010; Vanderburgh, 2009).

There appears to be no research documenting the school performance of children with gender variance, though there have been reports of bullying and harassment impacting on children's learning outcomes (Henning-Stout, James, & Macintosh, 2000; Savin-Williams, 1994). On the contrary, peer relationships of gender-variant children have received significant attention

due to the documented preference of these children for friendships with children of the opposite sex (Wallien, et al., 2010) and reports of ostracism, stigma and isolation (Fagot, 1977; Fridell, et al., 2006; Meyer-Bahlburg, 2002; Wallien, et al., 2010; Zucker, et al., 1997; Zucker, Wilson-Smith, Kurita, & Stern, 1995). It also appears that as gender differences become more noticeable to peers and pressure to conform becomes greater (D'Augelli, et al., 2006; Fagot, 1977; Yunger, et al., 2004) gender-variant children have greater difficulty forming friendships (Cohen-Kettenis & Pfafflin, 2003).

As this is an exploratory study there was no direct questions about specific childhood difficulties unrelated to gender variance. The responses to the question "Are there any particular difficulties you had as a child that were not related to your being gender-variant or your non-gender conforming behaviour?" are therefore unlikely to be representative of the actual circumstances. Further research using named items to inform question organisation will assist in obtaining more accurate data.

Studies of violence and abuse in families with transgender children highlight several disturbing trends. The latest research on parents' abuse of gender-variant children describes higher rates of neglect, emotional abuse and criticism compared to control groups (Simon, Zsolt, Fogd, & Czobor, 2011). An earlier study reported that lesbian, gay and bisexual (LGB) youth (n=528) who had been discouraged by their parents from expressing gender-variant behaviour were at greater risk of verbal and physical violence – the rate of sexual abuse against these youth was nine per cent (D'Augelli, et al., 2006). This is significant due to the similarity between violence against transgender individuals and lesbian, gay and bisexual individuals (Witten & Eyler, 1999). The negativity of parents towards children who exhibit differences in sexual orientation and gender presentations appears to arise from long-held

beliefs and ignorance about the implications of such differences. It is likely that these parents would not know (or be interested in) gender and sex diverse individuals.

The rate of adoption of non-clinic-referred transgender adults in this sample was 3.6%. Although this is not as high as the rate of 7.6% reported by Zucker (1998) in a clinic-referred group, it is still more than double the rate of 1.49% for the local general population in Zucker's study. Though being non-clinic referred, in a wider geographic population and across a different era, it is dubious whether these comparisons have any meaning at all. The adoption rates in the USA are reported in terms of the number of adults per 100,000 who *became adoptive parents* in a specific year (Child Welfare Information Gateway, 2011), which makes it impossible to determine similarities with this cohort.

Issues surrounding the mental health of transgender individuals are complicated. Firstly, there is the ongoing debate about whether GID belongs in the DSM as a psychiatric disorder (Hill, et al., 2007; Meyer-Bahlburg, 2010; Zucker, 2010) and secondly, co-morbidities in transgender individuals are often the result of discrimination, abuse, marginalisation and stigma and/or emotional abuse and neglect (Clements-Nolle, Marx, & Katz, 2006; Cole, Denny, Eyler, & Samons, 2000; D'Augelli, et al., 2006; Garnets, Herek, & Levy, 1990; Kidd, Veltman, Gately, Chan, & Cohen, 2011; Nuttbrock, et al., 2010; Simon, et al., 2011). Furthermore, for adolescents diagnosed with GID, puberty appears to create an increased risk of psychiatric co-morbidity although the rates vary between clinics and countries (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011). The mental health of transgender individuals also suffers due to barriers preventing access to support (Sennott & Smith, 2011; Shipherd, Green, & Abramovitz, 2010), which may be a contributing factor to the high rates of suicide (Clements-Nolle, et al., 2006; Grant, et al., 2010; Mustanski, Garofalo, & Emerson,

2010; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Xavier, Bobbin, Singer, & Budd, 2005).

These results show that although living a life with gender variance is often traumatic and difficult for participants (sometimes extremely so), 42 of 110 participants (38%) reported positive views of themselves or their abilities that they directly attribute to their experience of gender variance in childhood. Although there are a significant number of studies on transgender individuals' satisfaction with health and surgery outcomes, there has been little attention paid to the perceived benefits or positive outcomes of the experience of living with gender variance.

Regarding the negative impacts, an inability to create social networks was reported as having a significant impact on some individuals' sense of belonging. The isolation and lack of friendships and relationships also contributed to a negative self-image which in turn was associated with lower levels of social functioning (Bodlund & Armelius, 1994).

Although employment is an ongoing issue for transgender adults (Clements-Nolle, et al., 2006; DiStefano, 2008; Sangganjanavanich & Cavazos, 2010), virtually no research has been conducted on the needs of transgender people in the workplace (Whittle, Turner, & Al-Alami, 2007). Transitioning in the workplace often takes place in an environment where there are no guidelines or policies to follow, no education for staff, and considerable oppression, discrimination, harassment and assault of transgender people (Lombardi, et al., 2002; Sangganjanavanich & Cavazos, 2010; Whittle, et al., 2007). Whittle et al. (2007) point out that transgender individuals who do not meet the definition of 'transsexual' are often excluded from legal protection and therefore prevented from expressing gender variance in

the workplace. A consequence of violence towards transgender people in public can constitute an 'outing' of the person which may add to further harassment thereby perpetuating homophobic or transphobic attitudes.

Family support has been identified as a crucial element in fostering emotional and psychological resilience and as having a counter effect on negative social reactions (Rutter, 1985, 2012; Wyman, Sandler, Wolchik, & Nelson, 2000). In a seminal paper entitled 'Resilience in the face of adversity', Rutter (1985, 2012) outlines specific elements that provide protection against mental health issues that develop in response to negative and stressful events, particularly in childhood. Rutter (1985, p. 608) highlights the need for a strong and secure attachment figure, a degree of control for the child, a healthy self-esteem, confidence and faith in self-efficacy, the development of skills and the ability to problem-solve. He further adds that a child's distress in response to a negative or stressful situation can be mitigated by two factors in particular: the availability of an attachment figure and a greater number of positive experiences over negative ones. When these factors are applied to the experiences of the transgender adults in this survey, it becomes clear that the withdrawal of support by parents (attachment figures) appears to significantly impact the development of self-esteem social skills and resilience (the ability to handle adversity).

To complete this discussion, a series of links are proposed between a gender-variant child's experience of negativity and outcomes in adulthood. Based on the literature and the later outcomes and ongoing consequences as reported by the participants in this survey, these links indicate that a child who has become or been made aware of their variation in gender may be especially vulnerable when exposed to negativity.

The links between gender-variant childhood experience and adult outcomes are:

- Parents do not accept gender variance in their child and are likely to enforce stereotypes and maintain secrecy (Wren, 2002).
- Children who experience negative reactions tend to become secretive about their feelings (Cohen-Kettenis & Pfafflin, 2003).
- This silence in the child allows parents to assume that the issue has been resolved (Menvielle & Tuerk, 2002), thereby further entrenching the parents' denial.
- This inability of parents to recognise the child's situation and/or force the child to conform to gender expectations is interpreted by the child as rejection, contributing to distress, shame and low self-esteem (Cole, et al., 2000; Hegedus, 2009; Hill & Menvielle, 2009; Yunger, et al., 2004).
- This in turn negatively affects the child's feelings of self-worth and impacts their ability to trust and express feelings (Grossman, et al., 2006).
- Feelings of inadequacy lead to social withdrawal and isolation (Yunger, et al., 2004).
- Social withdrawal and isolation affects the child's abilities and limits their opportunities to form social relationships (Bodlund & Armelius, 1994).
- These coping mechanisms all lead to reduced mental and emotional health (Grossman, D'Augelli, & Frank, 2011).

Conclusion

This section has reported on results not previously presented from the survey of transgender adults on the needs of gender-variant children and their parents. These results were derived from the survey items: transgender adults' identification of gender variance and their feelings at the time; reported responses of parents; the impact of being gender-variant at school, on friendships and on childhood generally; difficulties experienced as a child unrelated to gender

variance; the impact of a gender-variant childhood on life as an adult; and the needs of the participants at the time of completing the survey.

This discussion has highlighted similarities between the participants' responses regarding their identification of gender variance as children and the diagnostic criteria in the current DSM-IV (American Psychiatric Association, 1994). The list of associated feelings (Table 3.4.4) may be a useful tool to support gender-variant children who attend counselling and to help them explore the feelings and meaning associated with their gender identity. Different types of responses from parents were outlined along with the hardships created when children are forced to conform to gender stereotypes or punished for their gender expression. The ongoing controversy regarding the categorisation of gender identity disorder as a psychiatric disorder as well as the mental health issues and difficulties transgender individuals experience as a result of negativity, hostility and abuse were also described. The discussion concluded with a cognitive model covering a chain of events starting with parents not accepting their gender-variant children through to the consequences for the transgender person as an adult and the negative impact on their well-being.

These results offer a substantial window through which to view the experiences and perceptions of transgender adults as children and could be used to provide input into programs and information in support of the transgender community.

3.5: The Needs of Gender Variant Children and their Parents According to Health Professionals.

[Published paper 3]

Riley, E., Sitharthan, G., Clemson, L. & Diamond, M. (2011). The needs of gender variant children and their parents according to health professionals. *International Journal of Transgenderism, 13*(2), 54-63. http://www.tandfonline.com/doi/abs/10.1080/15532739.2011.622121

3.6 The Needs of Gender-Variant Children

This section aggregates the 'needs of gender-variant children' from the results of the three surveys: 3.2.1 'The needs of gender-variant children and their parents: A parent survey' (Riley, Sitharthan, Clemson, & Diamond, 2011a); 3.3.1 'Surviving a gender-variant childhood: The views of transgender adults on the needs of gender-variant children and their parents' (Riley, Clemson, Sitharthan, & Diamond, 2012); and 3.1.1 'The needs of gender-variant children and their parents according to health professionals' (Riley, Sitharthan, Clemson, & Diamond, 2011b). The needs of gender-variant children identified from responses to the questions in these surveys show similarities and differences between the three groups of participants: parents of gender-variant children, transgender adults, and professionals who work with the transgender community.

3.6.1 The Views of Parents, Professionals and Transgender Adults Regarding the Needs of Gender-Variant Children

Parents described their frustration in watching their children suffer while at the same time feeling unable to create a safe environment for them as they faced ongoing difficulties. They expressed their challenges in dealing with children who were at times sad, depressed or suicidal. They also spoke of their struggles in responding to bullying, hostility and judgements towards their child and family. They observed and were sensitive to the fear and anxiety in their gender-variant child and sought strategies to alleviate their child's discomfort.

The transgender adults in this study were finely attuned to the challenges and hardships facing gender-variant children and had a distinctly marked understanding about the causes of their own pain and suffering as children. They wrote about their experiences and needs in a heartfelt, evocative and often brutal fashion. The adults were clear that they ought to have

had more resources and support available to alleviate their concerns about 'being crazy' or 'feeling like a freak'. Transgender adults felt that appropriate support would have prevented their isolation, confusion and suffering. They also felt that children ought to be taught about gender variance from as young an age as possible so that they can develop language to talk about their feelings. This would allow the subject of gender variance to be open and discussed rather than hidden, creating secrecy and shame.

The professionals' responses, on the other hand, tended to reflect a broader perspective with needs framed as 'rights' or as pragmatic solutions: for example, children should be allowed to be themselves, school authorities should be educated, bullying polices should be put in place, and so forth. The professionals' views emphasised that gender-variant children ought to be heard and believed, given choices, and loved unconditionally.

3.6.2 A Comparison of the Views of Parents, Professionals and Transgender Adults on the Needs of Gender-Variant Children

Although some of the needs identified by the three groups of participants seemed similar, on further investigation the reasons for specifying a particular need was at times different. Both parents and transgender adults felt that gender-variant children needed to be provided with information about gender issues and gender variance, in particular through education in schools. From the parent's perspective, this would have relieved the pressure by firstly reducing the burden they felt in needing to respond to their child's situation without adequate knowledge of their child's condition and, secondly, by knowing that appropriate and correct information regarding sex and gender was available to their children. From the transgender adults' perspective, they, as children needed information that could be relied on, that

validated their feelings, that could provide comfort because they knew they were neither alone nor crazy.

There was a consensus amongst the parents, professionals and transgender adults that safety and protection was an important area of need for gender-variant children. The transgender adults described the fear and anxiety they had felt as children that resulted from a lack of protection. Parents also highlighted their concerns about the safety of their gender-variant children in their absence, notably, the lack of support from schools and their community. All groups emphasised the need for strategies and policies to prevent and respond to bullying of gender-variant children.

Parents in general agreed with the professionals and transgender adults that children ought to be free to choose their clothes, friends and personal expression. However, parents also expressed the need to place some boundaries on their children's presentation in order to prevent negative reactions and hostility from others.

All three groups listed peer contact and socialising with similar others as necessary to validate the gender-variant child's experiences and assist with the development of appropriate strategies. Transgender adults also stressed the importance of having access to transgender role models and described how they, as children, needed to know that gender variance is a naturally occurring phenomenon. They noted that this would have helped them situate their experience in the wider world and see a future for themselves.

Parents, professionals and transgender adults all felt that schools need to be supportive of gender-variant children while providing safety and protection for them. Transgender adults

wrote of the need to eliminate gender stereotyping in schools. They explained that since most schools do not usually have a way to position the gender-variant child's behaviour within established frameworks, the child is often punished and their choices of activities limited, affecting their future prospects.

All groups stressed that gender-variant children should not have to conform to societal gender expectations. Parents described the misery that this created for them and their gender-variant children. Adults explained the anguish they felt as children due to the pressure of having to 'perform' in their assigned gender and the ongoing ramifications of dealing with anxiety and the fear of being teased, humiliated and beaten even when they felt they were conforming. Professionals observed that the pressure and disapproval from society was the *cause* of many difficulties and consequences for both the child and family. At the World Professional Association for Transgender Health symposium in Atlanta, 2011, Diamond succinctly summed up these reactions in the statement "… nature loves variety, unfortunately society hates it" (Diamond, 2005, 2011).

Puberty-delaying hormones were also targeted as a need by parents, professionals and transgender adults. Parents whose children were older felt that the lack of access to puberty blockers significantly increased their child's suffering. Transgender adults described the misery they felt during puberty and the ongoing issues that not having had access to puberty-delaying hormones has created for them as adults. Professionals, as witnesses to the distress of adolescents with extreme gender dysphoria, stated the need for adherence to best-practice guidelines for adolescents who need puberty-delaying hormones.

3.6.3 The Identified Needs of Gender-Variant Children

The needs of gender-variant children identified by parents, transgender adults and professionals are: to be **H**eard, to be **A**ccepted, to have **P**rofessional access and support, to have **P**eer contact, to have access to current **I**nformation, **N**ot to be bullied, blamed, punished or otherwise discriminated against, to have freedom of **E**xpression, to feel **S**afe, and to have **S**upport. These results can be presented for recall as the acronym H-A-P-P-I-N-E-S-S. Recommendations based on these needs are described below.

Recommendations based on these needs for gender-variant children

To be heard. Gender-variant children need permission to discuss their feelings with parents and to talk about gender issues, to have parents listen and, importantly, provide a safe and comfortable environment for this disclosure.

To be accepted. Acceptance is indicated by feeling valued, respected and loved unconditionally by parents while being referred to in their preferred gender. Family acceptance, tolerance of diversity at schools and in the wider community is also necessary for gender-variant children's overall well-being.

To have access to professional support. Counselling and medical practitioners specifically need the knowledge and expertise to recognise gender variance and to provide help for children who are anxious about their bodies. Specialist support is also required for those children whose symptoms are exacerbated by puberty.

To have peer contact. Access to support groups, either face-to-face or online, allows gender-variant children to make friends with similar others and provides peer support to help reduce feelings of isolation and marginalisation.

To have access to information. Gender-variant children require age-appropriate knowledge, resources and education programmes to be available in libraries, schools, doctors' surgeries and other public places. These resources should include suitable websites, strategies for dealing with bullying and referrals for face-to-face assistance.

Not to be bullied, blamed, punished or otherwise discriminated against. This need advocates for gender-variant children's rights: to be treated equally without having to conform to gender stereotypes, to have their differences embraced, to be offered the same opportunities as other children, to live without fear and anxiety and to have the potential for a satisfying and successful future.

To have freedom of expression. Freedom of expression means allowing gender-variant children to make choices regarding their presentation, selection of clothes, friends and activities and the flexibility to have a blended or fluid gender expression.

To feel safe. All children need safety and protection from abuse and violence. The vulnerability inherent in being gender-variant means these children require specific support for their well-being to be prioritised.

To have support. Gender-variant children require pro-active advocacy and emotional and physical support by parents, professionals, schools, other community and religious groups, and society generally.

3.6.4 Discussion

These needs provide new insights into the experiences and requirements of gender-variant children in their day-to-day lives and generally. To date, there has been limited reference in the literature to the needs of gender-variant children. Those that have been identified tend to be by-products of support programs organised in support of gender-variant children. For example, Mallon (1999b) in 'Practice with transgendered children' proposed a framework for clinicians who work with transgender children and their families. This framework includes recommendations for practitioners regarding the recognition of transgender children's needs with respect to information; acceptance and unconditional love; support; and advocacy. Brill and Pepper (2008) in their proposal for trans-positive support of gender-variant children reported that children need to be able to discuss their situation, to be actively loved and supported by their parents and be allowed to make choices regarding their clothes, activities and toys. Although Wyss (2004) identified several safety needs of transgender school children, this information was related to teenagers only.

Conclusion

This section has integrated the needs of gender-variant children identified in the three published papers, 'The needs of gender-variant children and their parents: A parent survey' (Riley, et al., 2011a), 'Surviving a gender-variant childhood: The views of transgender adults on the needs of gender-variant children and their parents' (Riley, et al., 2012) and 'The needs of gender-variant children and their parents according to health professionals' (Riley, et al., 2011b). The needs identified by parents, professionals and transgender adults were compared and formalised into an evidence-based record of the needs of gender-variant children represented by the acronym HAPPINESS. The needs are: to be heard, to be accepted, to have access to professionals, to have peer contact, to have information, to not to be blamed,

punished or otherwise discriminated against, to have freedom of expression, to have safety and finally, to have support.

Any relevant attitudes and biases of the three groups of participants were outlined with reference to the specific needs identified. In particular, parents were seen to have a dilemma in making decisions for their children based on their own and their children's realities in managing gender variance on a day-by-day basis. The views of transgender adults were based on their memories from childhood depicting their struggles, hopes and fears. Professionals' positions reflected a solution-focussed approach, outlining strategies and programmatic approaches to the difficulties experienced by gender-variant children.

3.7 The Needs of Parents of Gender-Variant Children

This section combines the needs of parents of gender-variant children based on the results of the three surveys. These views – parents with gender-variant children and their day-to-day experiences of raising a gender-variant child, transgender adults with an insider's view to the issues their parents faced, and professionals who work with the transgender community – allow a broader perspective of the needs of the parents of gender-variant children.

3.7.1 The Views of Parents, Professionals and Transgender Adults Regarding the Needs of Parents of Gender-Variant Children

Parents in this study disclosed their uncertainties, challenges and needs in raising a gender-variant child. Parents expressed concerns and fears about making the right decisions and wrote extensively about their need for resources and various types of support. Transgender adults shared experiences of their parents' ways of managing with a gender-variant child. These adults also offered what they saw as their parents' needs, viewed retrospectively. The

professionals' views of parents' needs were both compassionate and pragmatic as they proposed support mechanisms to help parents cope and to make informed decisions in the best interests of their children.

3.7.2 A Comparison of the Views of Parents, Professionals and Transgender Adults on the Needs of Parents of Gender-Variant Children

Parents gave lengthy and detailed views on their needs relating to: information and education including books, stories, research and guidelines for themselves and their families and strategies for parenting. Suggested strategies included setting limits on their child's behaviour, accepting uncertainty and managing negativity and bullying. Parents also noted the need for access to peers, other transgender people, knowledgeable counsellors and medical support. Additionally, they cited the need for training and guidelines for professionals, school staff, 'special needs' and disability staff, and community education. They also appealed for financial and legal aid, political advocacy and lobbying for themselves and their gender-variant children.

Transgender adults described the constraints they felt had inhibited their parents' acceptance and explained that, had their parents' needs been met, they as children could have felt supported as opposed to ignored or punished. They reported that parents needed to have access to information and schools, other parents and people, therapists and medical professionals needed to have more and knowledge about gender variance. They explained that this information and knowledge is necessary for gender-variant children to live in an accepting open-minded society where public portrayals of successful transgender people are welcomed. They also specified parents' needs for family counselling, financial support, legal protection and for clinicians to provide public advocacy and presentations.

Professionals outlined a support-based pathway for meeting the needs of parents of gender-variant children. They first advocated information and education for parents and families. Professionals recommended that emotional and practical support be provided by family, friends, peers and schools. Furthermore, they recommended that clinicians be both caring and informed. In this context, professionals also acknowledged the needs of parents for guidelines, diagnosis and treatment protocols, and general support. They also identified the need for education of community groups and society generally to allow for a wider acceptance of parents' situations as well as the need for parents to have access to the latest research, legal support so as to help their child be happy.

3.7.3 The Identified Needs of Parents of Gender-Variant Children

The needs of parents with gender-variant children identified by parents, transgender adults and professionals are for: information, education, support from family and friends, support from schools, counselling, professional support, peer support, community support, contact with transgender people, financial support, legal support and government support. Recommendations based on these needs are described below.

Recommendations based on the needs of parents with gender-variant children

Information. Material in the form of books, stories about gender-variant children and their families, up-to date research published in available media and guidelines and strategies for parenting are necessary for parents to comfortably support their children. Guidelines and strategies may be needed to help set limits on their child's behaviour, handle negativity towards their child and provide advice on how to choose a gender-variant friendly school.

Education. Education for counsellors and medical professionals, for schools, for all parents and for community programmes will increase knowledge and general awareness about gender variance.

Support from family and friends. Support from immediate family and friends will help to provide an accepting and caring environment in which parents can manage their child's needs with respect and compassion.

Counselling. Parents and family of gender-variant children may benefit from the individual, compassionate and confidential support offered through counselling.

Support from professionals. Parents need professionals to be informed, aware, trained, caring and to provide a diagnosis and treatment pathway for children entering puberty. In particular, professionals must have the willingness to make the child's well-being a priority. Parents also need to hear therapists and professionals speak publically about gender-variant children's needs.

Peer support. Peer support includes contact with other parents of gender-variant children and access to support groups both face-to-face and online.

Community support. Support across local and wider community frameworks requires assistance from accepting religious groups, local clubs and schools, and tolerance of gender diversity in society generally.

Access to transgender people. Parents need to meet and get to know transgender people and have access to visible and positive portrayals of transgender individuals and communities.

Financial support. Parents need financial support to be able to afford the costs of counselling and other professional resources as well as medical fees they are likely to encounter if their child needs to transition.

Legal & government support. Parents deserve appropriate recognition through legal lobbying and protection, from politicians and leaders with awareness of the issues faced by parents with gender-variant children. Parents are also entitled to the recognition of their own rights and those of their children.

3.7.4 Discussion

There are scarce references to the needs of parents of gender-variant children in the literature. A study by Hill and Menvielle (2009) focussed on the experiences of parents with gender-variant children and teens and identified parents' needs for education and boundaries to set limits on their child's dressing. Mallon (1999b) recommended that social workers be more aware of the needs for parents of gender-variant children, e.g. resources, family support and strategies for negotiating with their child and others.

Parents' need for peer contact was first recognised by Pleak (1999) who organised a group for parents of boys diagnosed with GIDC. Pleak reported benefits for the parents in being able to speak openly about their situation which resulted in greater acceptance and support of their own children. Menvielle and Turk (2002) ran two groups for parents of gender non-conforming boys, one focusing on the children, the other on the parents. Their aim was to

optimise outcomes for the children and increase parents' acceptance. The parent-focused group reported finding support for disclosure, grieving, solutions to embarrassing situations, and humour. Rosenberg (2002) also organised a group for parents of children diagnosed with GIDC, which provided education and support. The outcomes reported for parents were relief in speaking about their situation and strategies for coping with family members, teachers and neighbours.

Conclusion

These 'needs of parents with gender-variant children' have been compiled from the three surveys eliciting the views of parents, transgender adults and professionals on these needs. The identified needs of parents of gender-variant children are in some ways similar to the needs of the children themselves. The needs of the parents were: information, education, support from family and friends, support from schools, counselling, professional support, peer support, community support, contact with transgender people, financial support, legal support and government support.

This report on the needs of parents of gender-variant children mainly relies on the voices of parents, incorporating their knowledge and experience. This was enhanced by reports of the experiences of transgender adults' and their understanding and awareness of their own parents' needs when they themselves were gender-variant children. Insights from professionals who work with the transgender community were also added. The combined wisdom of these three groups of people has delivered the first comprehensive understanding of the needs of parents with gender-variant children. This compendium can be used to inform programmes in support of gender-variant children and their parents.

CHAPTER 4

Final Discussion & Recommendations

4.1 Introduction

The purpose of this research has been to determine the needs of gender-variant children and their parents. Specifically, the aims were to: identify the support needs for children with gender variance; identify the support needs of parents raising a gender-variant child; raise awareness of some of the major issues faced by gender-variant children and their parents; identify ways in which gender-variant children and their parents are marginalised; and discover how gender-variant children and their parents cope with the challenges they face. The objectives of the research were to: contribute to information, resources and curriculum in educating professionals, schools, parents and the community generally about gender variance in children; influence the development of evidence-based health and policy in support of gender-variant children and their parents; invite professionals to advocate for and reduce the stigma attached to gender variance; and pave the way for future research. The longer term aims are for the establishment of clinics and support services to advocate for and meet the needs of gender-variant children and their parents and, ultimately, to reduce the stigma, marginalisation and hostility faced by gender-variant children and their parents.

This chapter restates the findings from Chapter 3 and provides the groundwork for the application of these findings. The goal of the research is to *meet* the needs of gender-variant children and their parents through education, resources, guidelines, government policies, and legislation. The findings are therefore contextualised and integrated with the current literature

on gender variance to establish program frameworks for the training of the general public, medical and clinical professionals, schools and parents. The role of government is also considered with respect to legislation and the funding of services, training and research. The chapter concludes with the limitations of this project and proposals for future research.

4.2 The Findings

Through data analysis, the needs of gender-variant children were identified using the acronym **h-a-p-p-i-n-e-s-s** which represents the following needs:

- to be **h**eard
- to be **a**ccepted
- to have **p**rofessional access and support
- to have **p**eer contact
- to have access to current **i**nformation
- **n**ot to be bullied, blamed, punished or otherwise discriminated against
- to have freedom of **e**xpression
- to feel **s**afe
- to have **s**upport

The needs of parents of gender-variant children identified from the data are needs for:

- information
- education
- support from family and friends
- support from schools
- counselling
- professional support
- peer support
- community support
- contact with transgender people
- financial support
- legal support
- government support

4.3 Recommendations and Discussions

Taking into consideration the 'needs of gender-variant children' and the 'needs of the parents of gender-variant children' and acknowledging the complex issues they face, this section presents proposals as to how these needs could be met within training frameworks. These ideas and recommendations draw on the literature to take full advantage of current research and suggested protocols. Although some of this information was originally intended for the support of gender-variant adults, it is also relevant for the support of gender-variant children and their parents.

4.3.1 General Education and Information

The need for community and social awareness of the issues faced by gender-variant children and their parents has been explicitly stated and sometimes implied in a variety of articles, books, biographies and research studies (American Psychological Association, 2009; Benestad, 2001; Berrill, 1990; Bockting, Robinson, Benner, & Scheltema, 2004; Doan, 2011; Feinberg, 2001; Green, 2004; Haas, et al., 2011; Kosciw, Diaz, & Greytak, 2008; Lev, 2004; Winters, 2008; and many others).

To achieve a level of tolerance, acceptance and open-mindedness towards gender diversity in society generally, the participants in this study made the following thoughtful suggestions. They proposed that:

- *correct* information be easily accessible by all members of the community;
- information be made available not just online, but in GPs' offices, schools, libraries as well as through responsible coverage on TV and radio. National trans-positive campaigns can also be developed to promote awareness of gender variance and provide at least a minimum level of knowledge for the general public;

- religions not be exempted from discrimination policies but instead their representatives be educated with the view to open-mindedness and acceptance of gender-variant people; and
- research on gender variance be made available not just to scholars but to the general public.

The implementation of such measures would go some way towards addressing some of the issues voiced in the literature. These issues include the pressure experienced by gender-variant children to conform to normative gender expectations, which has been shown to be harmful (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Grossman, et al., 2011), the stigma, shame, discrimination, victimisation and violence experienced by gender-variant children (D'Augelli, et al., 2006; Grossman & D'Augelli, 2006, 2007; Kosciw, et al., 2008; Ma'ayan, 2003; Robinson & Espelage, 2011) and the awareness and enhanced understanding of terms and categories related to sex and gender (Devor, 2004).

Books, resources and prenatal classes could be used to inform parents about variations in sex and gender formation as naturally occurring phenomena. Parents could also be alerted to the fact that their children will not always meet expectations and that children need unconditional love irrespective of their appearance, gendered preferences and behaviour. Classes could include an appreciation for a child's uniqueness and point out that punishing imaginative and creative explorations may create anxiety, fear and distress for the child, particularly if the child feels shamed or silenced (Baker, 2002; Bartlett, Vasey, & Bukowski, 2000; Bradley, 2010; D'Augelli, et al., 2006; Egan & Perry, 2001; Grossman, et al., 2011; Hill, et al., 2010; Matos & Pinto-Gouveia, 2010; McDermott, Roen, & Scourfield, 2008; Price-Robertson,

Smart, & Bromfield, 2010; Sachs-Ericsson, et al., 2010; Weisz, Suwanlert, Chaiyasit, & Walter, 1987; Yunger, et al., 2004).

Dissemination of information such as this would provide the opportunity for a supportive approach towards gender-variant children, encourage open conversations about gender diversity, help to reduce widespread ignorance about gender variance, and ease the isolation and fear of judgement felt by gender-variant children and their parents.

4.3.2 Professional Training

Although professionals bear a significant responsibility and have a vital role to play in helping parents make decisions in the best interests of their child, participants in this study indicated that professionals did not have the requisite knowledge, expertise, information or referral networks to support gender-variant children and their parents. It has been commonly recognised that training for professionals in gender variance is lacking (American Psychological Association, 2009; Bockting, et al., 2004; Carroll & Gilroy, 2002; Feinberg, 2001; Goldberg, 2006; Lev, 2004; Lurie, 2005; Mallon, 1999b, 2006; Raj, 2002; Robinson, 2010; Scher, 2009). A wide variety of professional roles and duties were suggested by the parent and transgender adult participants in this study, for instance, the reduction of stigma, the development of best-practice guidelines for gender-variant children, commitment to creating optimal health and well-being for gender-variant children, and referrals to other competent practitioners. These two sets of participants want professionals to understand that gender variance is typically not a choice and to take seriously parents' concerns and fears. They appealed for resources to help parents raise their gender-variant children and for professionals to become familiar with the latest World Professional Association for Transgender Health's Standards of Care (WPATH, 2009). Although little has been written

about training professionals how to work successfully with gender-variant children, the literature that does exist recommends this training be informed by a framework of suggested competencies, roles and programs, as well as ways to develop such expertise. The next section outlines initiatives that have been identified to help prepare professionals for gender-affirming attitudes and competent service delivery.

The professional approach

The attitude of professionals working with gender-variant children and their families is crucial to the development and maintenance of a successful working relationship. The participants in this study requested that professionals be knowledgeable and caring and have the wisdom to guide them in making their child's needs a priority. The parents and transgender adults also appealed for advocacy and a commitment to promoting awareness of the issues that gender-variant children and adults face. According to Burrows (2011), professionals have a duty to offer assistance both competently and without prejudice so as to provide the greatest opportunity for the child's empowerment and overall well-being.

Principles of and approaches towards clinical work with gender-variant children have been voiced with special regard to transgender-affirmative therapies. The susceptibility of children to external influences and stigma, in particular, necessitates non-coercive treatment (Haldeman, 2000). Dworkin and Yi (2003) have called for international initiatives and collaboration to continually develop affirmative resources (such as safe zone policies) and take a stronger stance against reparative therapies. Although many writers support affirmative approaches to the treatment of gender-variant children, there have been calls for longer-term studies to identify the advantages and disadvantages of both reparative and gender-variant support therapies (Diamond, 2011). The transgender adults in this study who experienced

reparative assistance explicitly stated, and in some cases implied, that they had suffered unnecessarily as children due to these therapies and in some cases felt that it had caused them long-term distress. While parents do have the right to choose an approach aimed at helping their gender-variant child maintain or regain their birth assigned gender if that is their wish, they also have the responsibility to choose therapies that realise their child's potential for long-term happiness, fulfilment and success.

The client-centred approach (Rogers, 1951) has been the approach of choice for many contemporary clinicians working with gender-variant clients (Bockting, 1997; Carroll & Gilroy, 2002; Ettner, 1999; Lev, 2004; Mallon, 1999a; Raj, 2002; Riley, et al., 2011). This approach encourages clinicians to be "respectful, sensitive, accepting, validating, affirming, empathic, caring, compassionate, encouraging, supportive, and mutually trusting and trustworthy … [and] clinically-competent" (Raj, 2002, p. 11). In keeping with this approach, clinicians must commit to providing a friendly, safe, and private setting with a suitable restroom and the use of preferred pronouns (Ettner, 1999; Robinson, 2010; Sennott & Smith, 2011; WPATH, 2009). Some professionals emphasise the need for collaborative 'sensitive' care while respecting their clients' autonomy and tailoring their approach to their clients' unique presentation (Devor, 2004; Di Ceglie, 1998; Ettner, 1999; Lev, 2004; Mallon, 1999a, 2000; Meyer, Bockting, Cohen-Kettenis, Coleman, & DiCeglie, 2001; Raj, 2002; Riley, et al., 2011; Sennott & Smith, 2011). It seems obvious that all people would benefit from a wider range of options concerning self-expression (Monro, 2000).

A practice model for professionals working with transgender patients either separate from or within medical establishments should be based on the principles of equality, diversity and

autonomy. Such a model would provide significant improvements to the support currently available to gender-variant children and their parents (Monro, 2000).

Assessment

All groups of participants in this study identified the need for professionals to firstly be able to recognise gender variance and secondly to be able to assess the situation to determine if any support, direction or intervention is necessary. A number of recommendations have been made regarding the assessment of gender-variant children. One of these is for practitioners to be particularly mindful of their clients' developmental, psychological, familial, cultural, historical and political contexts when conducting an assessment (Carroll, Gilroy, & Ryan, 2002; Newman, 2002; Robinson, 2010) while providing recognition and psychosocial support (Bockting, Knudson, & Goldberg, 2006; Di Ceglie, 1998; Goldberg, 2006; Mallon, 1999b). Vanderburgh (2009) has called upon clinicians to assess clients for indicators of family dysfunction in order to determine whether any systemic patterns may have created in the child the cross-gender behaviour or the belief they belong to the other gender, to provide referrals and help clients develop supportive networks. A truly trans-positive approach in the assessment of gender-variant children must focus on the whole of the individual's context. It must also conceive of gender as a continuum and aim at alleviating the child's discomfort (Di Ceglie, 1998; Lev, 2004). Accordingly, a comprehensive support protocol would involve a thorough intake process that includes behavioural, emotional, relational and systemic factors (Di Ceglie, 1998) as well as an assessment of the child's distress, vulnerabilities and developmental issues (Cohen-Kettenis & Pfafflin, 2003). Ideally, this would take place in a team environment. Therapists who take responsibility for the support of gender-variant children also need to pay careful attention to the complex ethical and social issues involved (Zucker, 2004).

Competencies

The American Counseling Association (American Counseling Association, 2010) has developed competencies for counsellors who work with transgender clients. These competencies cover: a gender-affirming approach; an appreciation of the multitude of influences on transgender individuals' lives (e.g., social, historical, developmental, familial, religious etc.); an understanding of the barriers, oppression, hostility and violence that is present in most, if not all, transgender people's lives; and an acknowledgement of the complexity of these and many other factors at work in the lives of transgender individuals. The guidelines also include instruction on specific counselling practices, ethics, intentions and approaches for working with transgender individuals.

Bockting, Goldberg & Knudson (2006) have provided detailed guidance for counselling transgender individuals that includes a list of principles for practice and competencies that cover gender assessment, psychotherapy, medical and treatment evaluation, and general counselling approaches. Goldberg (2006) has recommended core competencies relevant for all professional clinicians working with transgender clients, and has specified further details for professionals working in endocrine therapy, mental health, speech and voice therapy and primary medical care.

Cultural awareness acknowledges that cultures differ in their understanding of gender as well as in approaches and sensitivity to gendered behaviour (Newman, 2002). Armed with such an awareness, professionals can appreciate the various influences on people's beliefs and attitudes and can be attuned to the existence of different sub-cultures within which assumptions about gender can vary (Devor, 2004; Newman, 2002; Robinson, 2010). The development of cultural competence can be achieved through an ongoing and supportive

cooperation with the individuals concerned that goes beyond mere politeness or tolerance (Devor, 2004; Robinson, 2010). In training to work with the transgender community generally, and with gender-variant children specifically, professionals need to be exposed to competent professional role models and sensitive case management skills related to gender-variant children and families.

Working with parents of gender-variant children

Professionals have a role to play in educating parents about gender variance and helping them to understand their child's vulnerability and need for protection and validation (Grossman & D'Augelli, 2006). They can help parents understand the use of aversion or reparative therapies and provide relevant information about these while at the same time helping them to understand the impact of their decisions and to develop effective strategies for working with their children (Grossman, et al., 2006; Mallon, 2006). When working with parents of gender-variant children, the chances of success are enhanced by providing accurate information that normalises the parents' experience while preparing them for the emotional dependence that children will require (Rachlin, 2002). Wren (2002) has advised that clinicians recognise parents' beliefs and styles of coping so as to facilitate acceptance of their child and, importantly, not apply pressure on parents to change their attitudes until they have come to accept their child.

Clinicians must also help parents to develop self-awareness (Carroll & Gilroy, 2002; Mallon, 1999a), to counter secrecy and to create networks. They must also help them tolerate uncertainty, develop flexibility and encourage optimism about their child's future (Di Ceglie, 1998; Sennott & Smith, 2011). Not all parents will seek specialist help and some may not even consider gender variance in their child to be an issue (Crothers & Levinson, 2004).

Therefore, professionals need to respect parents' choices where it is clear that the child is at no risk of harm. Conversely, where a child is at risk, it is advised that parents seek professional guidance.

Advocacy

Advocacy by professionals has been described as the provision of necessary support for transgender individuals (Carroll, et al., 2002; Chen-Hayes, 2001; Ettner, 1999; Godfrey, Haddock, Fisher, & Lund, 2006; Holman & Goldberg, 2006; Lurie, 2005; Mallon, 1999a, 2006; Riley, et al., 2011; Sangganjanavanich & Cavazos, 2010). Representation by professionals supports client autonomy, offers a role model of trans-positive support for gender-variant individuals and provides service delivery in the client's best interests (Riley, et al., 2011). Advocacy can also involve consultation with service agencies, community and religious groups (Mallon, 2006). Clinicians also have an obligation to actively de-stigmatise gender non-conformity by advancing research and using their influence to promote change to intake forms by expanding gender and name options (Lurie, 2005; Mallon, 1999a; Robinson, 2010).

Training programs

Professionals working in the area of gender variance currently have access to a variety of training programs for working with gender-variant adults and youth (Benestad, 2001; Carroll & Gilroy, 2002; Devor, 2004; Godfrey, et al., 2006; Goldberg, 2006; Israel & Selvidge, 2003; Lev, 2004; Lurie, 2005; Mallon, 1999b; Scher, 2009). Although little has been proposed specifically to advance the interests of children, some of the recommendations proposed for professionals working with both transgender adults and youth will aid in the provision of competent service delivery to gender-variant children. Lurie (2005) has argued that, due to limitations on training opportunities, gender-variant awareness training needs to become an

integral part of other highly prioritised training programs, such as diabetes and obesity training.

The requirement that professionals examine their own personal beliefs and values is recommended as a key component for training in transgender awareness (Godfrey, et al., 2006; Guth, Lopez, Rojas, Clements, & Tyler, 2004; Mallon, 1999a, 1999b, 2000; Scher, 2009; Sennott & Smith, 2011). This approach has been found to enable a greater trans-positive attitude (Guth, et al., 2004). Sennott & Smith (2011), for example, have designed a tool that helps training participants understand differences between designated sex, gender identity, gender expression and sexuality by incorporating a consideration of their own gender expression and identity into the program. They suggest that professionals need this intimate and thorough knowledge of their own gender identity, an awareness of their own biases, and their assumptions about transphobia, misogyny and homophobia.

Current programs that include clinical experience, gender-variant speakers, discussions and practical exercises reflect some of the requests of participants in this study and apply a systems perspective to training which enables trainees to contextualise their learning (Godfrey, et al., 2006; Lurie, 2005; Scher, 2009). In fact, it has been noted that programs such as the 'safe zone project' that include these components can actually *increase* some trainees' negativity towards LGBT people as they become more aware of their own biases (Israel & Hackett, 2004; Scher, 2009). On a more positive note, however, this may ultimately lead to a greater awareness that they may need to refer particular clients elsewhere (Scher, 2009).

Awareness of the current discourse and debates in the literature as well as immersion in transgender information, experiences, language, procedures and resources are also recommended to help professionals develop their proficiency in working with gender-variant individuals (Carroll, et al., 2002; Goldberg, 2006; Mallon, 1999b; Pearlman, 2006). The types of programs described above may serve to nurture the commitment of professionals and help them become more caring, to remain current and take a serious interest in the needs and concerns of gender-variant children while simultaneously becoming more visible advocates for the gender-variant community.

Goldberg (2006) has outlined a procedure for developing competencies for working with gender-variant individuals within the context of a three-tiered training system. Tier 1 (basic level) develops core competencies of awareness, knowledge and skills with respect to transgender concerns and is implemented through online classrooms, videos, WebCT, discussion groups, seminars, publications and presentations. Tier 2 assumes Tier 1 competencies and is described as involving a "quantum leap in awareness, knowledge and skills" (p. 226). Tier 2 training is experiential, incorporating role plays, observations, videotaped examinations, critical reflection and client interaction. Tier 3 training is reserved for clinicians who already have substantial experience working with the transgender community. Goldberg notes that training also needs to be developed for professionals working in dedicated areas such as acute and palliative care facilities, prisons, and other contexts.

Supervision of clinical practice

Supervision provides counsellors with significant opportunities for professional development (Tribe & Morrissey, 2005) and encourages awareness of the privileged position they hold. A

peer group or therapist knowledgeable in the areas of gender and sexuality acting as a supervisor can encourage practitioners' exploration of their own assumptions, stereotypes, and countertransference in working with transgender clients (Ettner, 1999; Mallon, 1999a; Sennott & Smith, 2011). Supervision also facilitates personal growth due to challenges to practitioners' personal beliefs available through connections with differently gendered clients (Carroll, et al., 2002).

In summary, the recommendations made in this section on professional training reflect the participants' own views of the need for knowledgeable, aware, compassionate and committed professionals. Because the only guidance found for professionals working with gender-variant children specifically was in the area of assessment, the recommendations outlined in this section have drawn upon literature which focuses on working with transgender adults or youth. However, such a focus fails to address the need for advocacy and pathways for the treatment of gender-variant children. Perhaps because transgender or transsexual adults are more likely to seek support than parents of gender-variant children or the children themselves, a focus on programs in schools is critical for fostering an environment where meeting children's needs becomes an integral objective rather than a mere supplement to professionals working with transgender adults.

4.3.3 School Inclusion of Gender-Variant Children

Reports of bullying, harassment and discrimination of gender-variant children in school are all too common and this kind of behaviour is more likely to occur if the child does not identify as female *or* male (Baker, 2002; Grossman, et al., 2009; Kosciw, et al., 2008; McGuire, Anderson, Toomey, & Russell, 2010; Rivers, 2004; Robinson & Espelage, 2011; Russell, et al., 2011). These behaviours have a significant impact on children's attitudes

towards school and can lead to unexplained absences (Graham, 2011; Rivers, 2004; Robinson & Espelage, 2011). Research has shown that the impact of bullying on gender-variant children can be devastating and has lasting and long-term effects, such as post-traumatic stress (Friedman, et al., 2006; Graham, 2011; Grossman, et al., 2009; Gruber & Fineran, 2008; Kosciw, et al., 2008; Rivers, 2004; Russell, et al., 2011; Wyss, 2004).

Studies of bullying have provided some understanding of the factors, structure and systems that contribute to its maintenance. Salmivalli, Lagerspetz, Bjorkqvist, Osterman, et al. (1996) have identified six possible participating roles in bullying events. These roles are: victim, bully, reinforcer of the bully, assistant of the bully, defender of the victim, and outsider. These roles appear to be linked to their social status as well as gender roles. Merton (1997) found that a school culture where adults ignored their responsibility for dealing with bullying and left students to 'stand up for themselves' actually *promoted* bullying. Katz and Porath (2011) observed that children who engaged in an honest dialogue with their peers produced a general increase in respect for others and an improvement in the class environment. In a review of qualitative research on bullying, Thornberg (2011) found that several other factors contributed to bullying: having a low social position, a 'do not tell' culture and the justification of being a bully to *avoid* being bullied.

In a report on the murder and suicide of gender-variant children, Higdon (2011) compared the bullying of gender-variant children to lynching:

> Just as the violence used during the civil rights era was designed to produce compliance through fear, such bullying likewise operates to create fear in those who are bullied, send them the powerful message to either conform to their expected gender role or face continued bullying … it is only after we begin to see this kind of

> bullying for what it is – a form of lynching – that our society and legal community can even begin to hope to craft a solution to the problem (p. 832)

Higdon (p. 861) explained that both bullying and the figurative lynching of gender-variant children "are driven by unwritten social codes", that is, both have the support of onlookers or the greater society and are usually not prevented, reported or acted upon. Moreover, both "result in extreme harm" for the bullied and achieve their goal by generating fear – obey or else. Higdon suggested that any solution to the problem of bullying of gender-variant children will depend upon litigation by victims, enabling the generation of legislation prohibiting bullying and promoting education regarding the harm caused.

Bullying interventions are likely to improve the health and well-being of potential victims and have been shown to reduce aggression and improve classroom conditions, particularly when there was *no* focus on the aggressors (Fonagy, et al., 2009; Russell, et al., 2011). Changing a school climate to one of safety and support for gender-variant children will enable them to have a more positive attitude towards school and help them achieve both academically and socially (Brock, Nishida, Chiong, Grimm, & Rimm-Kaufman, 2008). Additionally, schools that employ anti-bullying and harassment programs are more likely to find that their students enjoy a sense of belonging and connection (McGuire, et al., 2010). Accordingly, a training program for schools combining both gender variance and anti-bullying training would be the most effective way to establish acceptance and safety for gender-variant children at school. Unfortunately, trans-positive programs are often only implemented when a gender-variant child's parents approach the school authorities for support and the school is cooperative (Mallon, 2006).

Professionals have devised procedures and training programs to make gender-variant expression at school a smooth and achievable process (Benestad, 2009; Blackburn, 2004; Brill & Pepper, 2008; Dykstra, 2005; Finkel, Storaasli, Bandele, & Schaefer, 2003; Franse, 2007; Goldman, 2008; Grossman, et al., 2009; Haldeman, 2000; Henning-Stout, et al., 2000; Higdon, 2011; Ma'ayan, 2003; Sadowski, Chow, & Scanlon, 2009; Saeger, 2006; Stufft & Graff, 2011). Programs directly related to gender-variant children are described below.

Training programs for schools

Stufft and Graff (2011) provide the most comprehensive training program, specifying roles for teachers, principals, superintendents and school boards in facilitating a trans-positive, gender diverse and safe environment. First and foremost, Stufft and Graff emphasise that all parties must examine their own biases, assumptions and expectations so as to be able discuss the subjects of sex and gender identity with some degree of comfort. They also stipulate that teachers must be sensitive to their own use of language as well as to the biases presented in textbooks. An awareness, sensitivity and comfort with sex and gender empowers staff to display appropriate responses during discussions. Teachers are described as role models who can: demonstrate and instruct students about tolerance; execute a zero-tolerance approach to the use of stereotypes; incorporate lesbian, gay, bisexual, transgender and queer (LGBTQ) topics into discussions including those related to multiculturalism; and provide emotional support for any LGBTQ members of the school. The role of the principal is aimed at ensuring gender as well as multicultural sensitivity and inclusivity, reinforcing teachers' attention to and support of LGBTQ students; ensuring equal access to activities for LGBTQ students; providing LGBTQ professional development; advocating for full inclusivity for LGBTQ students and teachers; and dealing with controversial issues that may be raised in response to the mentioned initiatives. The superintendent's role in supporting a gender-variant friendly

environment involves providing leadership in supporting a multicultural climate; keeping up-to-date on contemporary discussions regarding LGBTQ students and teachers; addressing any emergent issues relating to LGBTQ concerns; ensuring LGBTQ training for the school board; and supporting zero-tolerance policies regarding all forms of harassment and bullying. The role of the board is to institute: policies to protect the rights of all LGBTQ students and teachers; promote multicultural education, curriculum and material; support diversity in staff appointments; and actively encourage LGBTQ parents' participation in district meetings.

Brill & Pepper (2008, pp. 163-178) also specify a training program for schools with gender-variant children. Their aim is to create a supportive and organised school culture with zero-tolerance for any kind of discrimination, including policies of which all staff, students and parents are made aware. These policies include the use of gender-inclusive language out of respect for students' preferred names and pronouns. Guidelines also help staff deal with issues that gender-variant children might face. Staff training includes: language and definitions distinguishing between gender identity and sexual orientation; ways to identify issues that gender-variant students face and strategies to support them; ways to facilitate the positive development of gender-variant students; preparations that help students be more flexible with gender and gender transitions; commitment to resources for gender-variant students (including books, posters and opportunities for dialogue); and the recognition of students at risk. They recommend that education for parents includes information about: anatomy, the gender continuum and definitions, gender variance and intersex, and the rights of gender-variant children to receive protection. This curriculum educates students about the meaning of gender variance, why it is necessary to support gender diversity and how to recognise and deal with harassment. The program also ensures safe bathroom access for all

students, record-keeping of all reported harassment, the provision of gender-variant resources, support for families and the regular administration of a gender sensitive inventory.

Katz & Porath (2011) have also designed a program, 'Teach to Diversity', that incorporates social and emotional interventions aimed at increasing awareness of and respect for the self and others. There is evidence that the program, while not specifically targeting gender variance, has led to improvements in students' self-respect and their levels of respect and sensitivity towards others, resulting in a friendlier classroom atmosphere. The interventions include strategies related to managing emotions, increasing awareness and respect for self and others and promoting respect for diversity through the utilisation of multiple intelligences.

Higdon (2011) has proposed that, to counter bullying, a school's culture needs to change. Recommendations include policies, attitudes, knowledge, understanding and dialogue related to bullying and stereotyping behaviour. Specifically, Higdon suggests training for all school staff to ensure that: all adults know how to implement the necessary processes; teachers understand what led to the bullying incident; there is a discussion of gender stereotypes; there is recognition of how society maintains these stereotypes; there is active intervention to reduce stereotyping; there are definitions and understanding of gender identity, gender expression, homophobia and discrimination based on gender presentation and the relationships between these factors; there is knowledge about the harms of bullying; teachers know how to recognise bullying; and teachers know how to help the children involved.

Specific recommendations have also been made to create a trans-positive friendly environment in schools. Benestad (2009, p. 211) has recommended that training programs

include the ‘deconstruction’ of gender into the seven areas of somatic sex, reproductive sex, gender identity, body consciousness, body image, gender role and “attraction talents” (preferred activities). In this study, Benestad provided parents with an opportunity for in-depth reflection and discussion, disagreement and sharing followed by an invitation to make their own decisions about how they each approach their gender-variant child. Dykstra (2005) has offered a number of activities suitable for a pre-school context involving colours, dress-ups, trying out names and activities the children would not normally choose and engaging children in recognising stereotyping. Sadowski et al. (2009) recommended that schools (as an institution rather than just some of the individuals in the school) must promote sincere, unconditional and affirmative relationships and support in order to provide the greatest opportunity for academic success and development for gender-variant children. Sadowski et al. (2009) have stressed that in the school environment a gender-variant child needs at least one person they can trust and go to for support. Ma’ayan (2003) has advised that schools need to create a safe environment for cross-dressing, including ‘safe zones’ and ‘gay-straight alliances’.

Rigby (2001) has proposed a series of steps to create the necessary and dramatic changes required in school cultures with respect to the way gender diversity is handled. These steps include: a robust statement by every school member, staff and parents against all bullying and harassment; “a clear definition [of bullying] *with illustrations*” [italics added]; a statement of the rights of all to freedom from bullying of all kinds; a statement of commitment that any person who witnesses bullying has a responsibility to stop it; a request for parents to have ongoing communication with the school regarding concerns about bullying; a plan for how bullying will be dealt with; and a re-evaluation of the policy on a regular basis.

Porter and Smith-Adcock (2011), however, have provided a number of cautions regarding the implementation of bullying programs. They warn that any reliance on children's help to implement these programs requires the ongoing inclusion of adults. They note that changes do not happen quickly and require maintenance, and that children need to be taught anti-bullying strategies in a manner similar to how they are taught and learn any other subject. They also point out that while programs based on children's strengths may be of benefit, they have yet to be tried. Crothers & Levinson (2004) suggest that instruments be developed and used to measure bullying in schools. Goldman (2008) warns that adults must not take sides and *all* complaints of harassment and discrimination must be taken seriously irrespective of the cause or the people involved. Goldman (2008) also suggests that schools need to make clear that they are mandated to support opposing views; that is, fairness must be extended to all parties, and adults must determine the facts and not make accusations.

A number of authors have identified specific responsibilities and commitments for which they believe teachers ought to be accountable. Teachers should get to know students outside of their gender roles and identities, and encourage students to see each other as individuals away from gender labels (Ma'ayan, 2003). Teachers could also include stories of gender-variant individuals in history (Ma'ayan, 2003) and should 'tap' into children's strengths and abilities to allow them to express their genuine selves (Blackburn, 2004).

In addition to the ideas proposed above, Goldman (2008) has offered several solutions to the difficulties currently apparent in school systems. Goldman believes that teachers should view risky behaviours in gender-variant children not as rebellion but as a way of seeking recognition for difficulties and as a call for help. Moreover, the message 'you can be gender-variant and be OK' ought to be communicated to children.

The parents, transgender adults and professional participants in this study also made suggestions regarding gender variance school training and policies that are not covered in the training schedules and recommendations outlined above. These participants recommended that schools promote ways for gender-variant students' to locate each other, for example, through the development of websites for children specifically supported and moderated. Other suggestions were to empower children by including them in brainstorming exercises about their safety as well as encouraging them to be advocates for themselves and others. The participants felt that gender-variant children's gifts and talents are often overlooked despite the fact that their contribution to problem-solving and creativity could provide unique and valuable perspectives across the curriculum. They also expressed a desire for children to be able to explore and critique gender in a similar way to discussions and exploration of other curriculum content and activities.

Haldeman (2000, p. 199) has acknowledged that schools are under enormous pressure to "uphold culturally sanctioned norms" and cautions against assumptions about a child's sexuality or gender identity, particularly as children's preferences may change over time. School personnel also may force the child to choose an *acceptable* identity (Vanderburgh, 2009). This pressure to 'pass' denies gender-variant children respect as transgender individuals and the opportunity to be supported in their flexible presentation (Brill & Pepper, 2008; McGuire, et al., 2010; Vanderburgh, 2009).

The meanings attached to a stressor and how these are integrated into belief systems, play an important role in future responses (Rutter, 1987). Schools have substantial influence in developing such meanings for children. It is vital that schools accept the mantle of

responsibility for the support and protection of gender-variant children as they have an important role to play in reducing stigma, validating children's reality, reducing their distress and helping them develop healthy patterns of functioning as gender-variant people.

4.3.4 Education and Information for Parents

As the managers of their children's lives, parents have a duty of care to provide a safe and successful childhood for them. For parents to make the most beneficial decisions for themselves and their gender-variant child, they need correct and useful information, support and guidance. Parents need information, advice, assurance and advocacy regarding their child's behaviour, what to do and how to better understand their child (Vanderburgh, 2009). It is of great importance that parents receive this help and assurance to prevent them from rejecting their child as it has been shown that rejection by parents is a likely predictor of future adult attachment anxiety and avoidance (Landolt, et al., 2004). This view has been reinforced by the adult transgender participants in this study. The quality of the parent-child relationship is also likely to affect the child's willingness to disclose their concerns to their parents (Savin-Williams & Dube, 1998). The following section reviews suggestions and recommendations aimed at providing knowledge and valuable resources for parents to help meet their needs in raising a gender-variant child. This review incorporates the requests of participants in this study.

Brill & Pepper (2008) have provided key information for parents about: how to recognise gender variance in children; gender expression, gender identity and intersex conditions; how to handle gender fluidity and understand sexual orientations; and how to develop acceptance. They acknowledge parents' possible grief and fears and provide detailed guidance in how to develop effective parenting strategies and supportive parent-child relationships. They

emphasise the need for unconditional love and acceptance of the child, their gender identity and gender expression. Brill & Pepper (2008) also provide a checklist for parents to assist them in finding a gender-variant friendly school. Brill and Pepper's guidance, although incredibly valuable as a resource for parents, provides little in the way of acknowledging the complex relationships and decision-making inherent in managing negativity within families and close relations.

It is also important to keep in mind that parents' understanding and feelings are likely to change over time as they learn about and develop increased awareness of the meaning that gender has for their child (Wren, 2002). Parents need validation that their concerns are real and that it is okay to be unsure of what to do or to know how to react (Vanderburgh, 2009). Parents also need to be aware of the range of possible outcomes for their gender-variant child, including the potential for an abundant and successful future (Benestad, 2001). However, they also need to be aware of the negative consequences of psychological, verbal and physical abuse that result in life-threatening behaviours in transgender youth (Grossman & D'Augelli, 2007; Rosenberg, 2002).

A close parent-child relationship is recognised as providing a solid basis for the child's self-esteem (Devor, 2004; Hegedus, 2009; Rachlin, 2002). Rutter (1987), in a study of psychosocial resilience in children, found that high self-esteem and self-efficacy derive from a secure and agreeable parent-child relationship, successful life transitions, task accomplishment and access to opportunities based on achievement. These factors were seen to protect the child against negative outcomes resulting from a risk encounters. It has been shown that parents who were the most successful in raising a gender-variant child were those who recognised that "their children were separate people in their own right". These parents

were open-minded as to their child's eventual outcome and were able to put their child's needs above their own concerns about others' reactions (Vanderburgh, 2009, p. 144).

Professionals tend to agree that biology and environment play a role in the development of gender awareness and identity. TheBiased-interaction theory (Diamond, 2006, 2011) provides the latest research on the role of biology in the development of gender variance in children. Biological explanations for gender variance may provide some relief for parents who might feel blamed or shamed for their child's behaviour and can give them the necessary leverage to demonstrate unconditional love for their child and to talk openly with family members about their strategies for working with the child (Wren, 2002).

Parents in the current study requested information about how other parents with gender-variant children managed. Wren (2002, p. 390) provides a summary of the coping behaviours parents adopted in support of their gender-variant child. These coping behaviours are:

- active and persistent attempts to communicate with their child
- actively listening to child
- confiding in at least one other person
- getting information from books and the Internet
- contacting a support group
- actively challenging ignorance and prejudice in oneself and others
- thinking positively about the child and his/her competences
- respecting and making room for child's autonomy
- seeking help from professionals and attending appointments
- showing willingness to support other families in a similar position
- confronting issues of self-blame and perceived responsibility

Parents' knowledge may also be enhanced by the information presented in the previous section about bullying. The fear of bullying may interfere with a gender-variant child's expression (Crothers & Levinson, 2004) and parents and families have an important role to play in preventing the adverse effects of bullying (Bowes, Maughan, Caspi, Moffitt, & Arseneault, 2010). Therefore, parent's awareness of the likelihood of bullying and their ability to recognise the signs of bullying can only further contribute to their support of their child.

4.3.5 Role of Government

Political leadership and the advocacy of gender variance has had little airing in the literature. Participants expressed their disappointment in the lack of government leadership and observed levels of ignorance. They highlighted the need for political progress and the legislation of rights for gender-variant children, suggesting that sound government legislation would give parents confidence in the validity of their concerns.

The responsibilities of government in meeting the needs of gender-variant children and their parents, as identified and recommended by this study, are:

1. The provision of funding for:
    - general training and resources on gender variance to be available in all areas of public service including libraries, hospitals and non-government organisations;
    - specific training programs in all schools;
    - specific bullying programs in all schools to establish and maintain trans-positive approaches;

- specific training programs on gender variance to be mandated in professional training programs where professional services will be delivered to gender-variant clients or patients, particularly in the fields of medicine, psychology, counselling and social work;
- specific training programs on gender variance to be made available to all practicing clinicians in the above fields;
- the establishment of specialist clinics in support of gender-variant children and their parents;
- specialist services for gender-variant individuals;
- websites established for the education and support of gender-variant children and their parents;
- the establishment of outreach services particularly in support of gender-variant children at risk;
- public advertising campaigns against transphobia;
- public campaigns to reduce the stigma of gender variance;
- support for policies advocating zero-tolerance of harassment and bullying targeted at gender-variant people;
- research on gender variance and gender-variant individuals; and
- legal support for gender-variant individuals where their rights have been violated.

2. The passing of legislation to:
    - support the rights and safety of all gender-variant individuals in schools;
    - support the rights and safety of all gender-variant individuals in the workplace;
    - enforce penalties when these laws are breached;
    - prevent religious groups from discriminating against LGBTQ people;

- mandate trans-positive policies in all government, non-government, private and public organisations, clubs and community groups; and
- mandate respectful gender-variant reporting in the media.

3. Government leaders speaking positively about gender variance and the benefits of diversity to society.

Governments and leaders must take the needs of gender-variant children and their parents seriously. They have a duty to be aware of the rates of abuse and neglect in gender-variant children and the impact this has in adulthood and to use this awareness to inform policy development and implementation. Clements-Nolle, Marx & Katz (2006) emphasise that the association between gender-based prejudice experienced by gender-variant people and attempted suicide signals a critical need for legislation and policies that protect all LGBTQ individuals from discrimination and hate crimes. Jesdale and Zierler's (2002) study showed that the introduction of gay rights protection laws reduced the suicide rate at every age from 12 to 18 in white non-Hispanic males. These results attest to the importance of government legislation and places the onus on governments to enact laws that protect minority groups as a matter of urgency.

4.4 Limitations

Qualitative research is usually concerned with meanings participants make of themselves, their experiences, relationships or events. In aiming to understand the participants in this study, their context and perceptions, the initial questions invited them to reflect on their first memory of awareness with gender variance, their experience at the time, how they reacted and what helped them cope. Therefore, the quality and depth of peoples' understanding and

expression of their meanings and feelings was the principal focus. Their responses were then used to answer the research questions: “What are the needs of gender-variant children?” and “What are the needs of parents with gender-variant children? The aim was to accurately describe and interpret the data to identify these needs.

Although this exploratory study breaks new ground in understanding the needs of gender-variant children and their parents, there are several limitations which may restrict its impact and significance. Some of these are inherent in qualitative research and some are specific to this study.

Qualitative research is generally limited by the researcher’s subjectivity. Reflexivity is required to make the researcher aware of their bias, assumptions, interests, perceptions and tendency to impose meaning (Willig, 2001). While the researcher tends to pay attention to what attracts them, it is important for them to also be attuned to the impact of their own culture and their inclination to ignore particular data (Huberman & Miles, 2002). Aiming to take account of these aspects of qualitative research, the key researcher sought peer debriefing and professional supervision on a regular basis particularly with regard to coding, logic and presentation of the results. Moving both closer to the project and further away from it to gain a clear view was crucial to honouring the intention of the project and the participants who took part. Copious notes were kept on the procedure, allowing for a review for any bias that may have influenced the process or findings.

Although Denzin & Lincoln (2005) have voiced their concerns about brief answers to open-ended questions, in this study participants offered rich and detailed responses delivering a large mass of data that was handled in a number of ways. Firstly, not all of the collected data

were used for content analysis; only those data specifically related to 'needs' were included. Other responses were used to clarify, provide context or track an answer indicated in another response. In addition, the analysis was systematic, one set of data at a time, one question at a time and, where necessary, one answer or participant at a time. Following this separate analysis, whole responses were traced to reflect on meaning in a more integrative manner. This rigorous method therefore allowed the data to be managed in an orderly manner.

Another potential limitation of the project was the fact that all the data were collected via online surveys. However, the amount of descriptive data from the parents and the transgender adults collected through the surveys provided a range and depth of information. Moreover, had parents been interviewed as well as surveyed through the Internet, it is likely that only those who had already contributed to the survey would have been available, given the limited source of locally available parents of gender-variant children. Concerns have been raised about the quality of data collected in this way due to misrepresentation. Denzin and Lincoln (2005, p. 809) warn that "Anonymity in text-based environments gives one more choices and control in the presentation of self, whether or not the presentation is perceived as intended". Invisible to the researcher, people may have had other distractions impacting them at the time they were responding. On reflection, given the topic and the willingness of the participants to contribute to providing a better future for gender-variant children (including their own), it is unlikely that there would have been any deliberate manipulation of the data. It is acknowledged that participants may have minimised or overstated their difficulties and the impact gender variance has had on them to match their current beliefs or values. One other limitation of the text-only environment was that some participants may have found using text-only a restriction on their ability to express themselves. In addition, not only was there a requirement to express oneself in a text-only environment but the survey had to be completed

in English. Therefore, the on-line surveys not only excluded those without access to a computer or the Internet but also those who could not express themselves effectively in written English. This medium also prevented the researcher from probing peoples' answers or using other cues such as physical presence, body language or voice, although it has been questioned whether these elements of presence are necessary, distracting or even relevant (Denzin & Lincoln, 2005).

It was assumed that the professionals who entered the survey would come from a clinical context. This turned out not to be the case. Only 76% identified as using a clinical setting for their clients. The other 24% (directors/coordinators, educators, one lawyer and one researcher) did appear to have significant and ongoing association with transgender people as they provided thoughtful and significant responses to the survey's open-ended questions.

Unlike the other sets of participants, the professionals were not guided through a chronological process of questioning. Rather, they were directly asked what they considered to be the issues and needs of the children and their parents. In hindsight, more descriptive responses might have been obtained from the professionals had they been given the opportunity to reflect on their practice with the transgender community over time.

This study did not account for variations in the needs of children born female or born male, or those identifying with a female gender, male gender or 'other' gender. In fact, the 'needs' identified for these groups were remarkably similar, which could be attributed to the fact that the focus was on children prior to puberty (during which time the differences between the sexes become more apparent). Nor were parents who did not accept gender variance in their children surveyed. The circumstances of non-accepting parents were only expressed in this

study through the experiences of transgender adults who reported this attitude in their parents and therefore extremely inadequate in representing their concerns. Future research is required to determine how these groups' needs are different from those groups studied.

Finally, there has been little evidence against which to measure these findings; further research, perhaps using these results as a base or tool, could provide greater validation of the conclusions.

4.5 Future Research

This chapter has consolidated the findings from this study and the extant literature to recommend programs for training and education, and roles for government so as to implement the results. This section looks at the implications of the study and provides directions for future research in meeting the needs of gender-variant children and their parents.

The findings of this study contribute to the current literature by making clearer the needs of gender-variant children and their parents. These results, combined with the current literature on gender-variant children, suggest responsibilities with certain implications, notably for schools, medical and clinical professionals and governments. This process of identifying the needs of gender-variant children and their parents as well as generating the input for training programs and roles for government has raised a number of issues.

First, most research on the experiences of gender-variant individuals focuses on the negative aspects of their experience. It would be of great benefit for future studies of gender-variant

people to examine those who have had successful lives and productive outcomes to ascertain those elements that may have contributed to their success.

Second, this study has a significant 'Western' bias. Research on the needs of gender-variant children and their parents in non-Western countries would allow a multicultural perspective to be incorporated into training programs on gender variance and contribute to policies and legislation in support of gender-variant individuals.

Third, because teachers have such an influence on and input into children's lives, it would be pertinent to gain their views on the integration of gender variance into various aspects of the school curriculum.

Fourth, understanding the psychological dynamics of shame and stigma would help in developing therapeutic approaches to working with clients who have been victims of stigma. Such approaches would aim to recalibrate faulty beliefs and cognitions in order to counteract feelings of worthlessness and anxiety, and to prevent associated risk behaviours.

Fifth, the use of language and pronouns had a significant impact on the gender-variant individuals in this study. Understanding the power of pronominal use for a variety of people would assist in teaching the impact of pronouns in gender variance training.

Sixth, aversion and coercive therapies, although prohibited by the American Psychological Association, are still practiced. Research on individuals who have experienced coercive or aversion therapies would provide an evidence base from which to educate professionals, parents and the public about the dangers and/or benefits of these approaches.

Seventh, the hostility directed towards gender-variant children and their parents indicates that people somehow feel threatened by gender non-conformity. Research into the motivations for transphobia and homophobia would be advantageous in the development of general training programs.

Eighth, the media could potentially be used in education programs and campaigns in support of gender-variant people. Understanding the impact of the media on people's belief systems, values and behaviour would be useful in determining the power of the media and how best to use it to promote tolerance and acceptance of diversity.

Ninth, gender-variant children appear to be an untapped source of input into the development of anti-bullying programs. Their views and recommendations could provide key information for the development and implementation of these programs.

Tenth, long-term studies evaluating the outcomes for gender-variant children who do have their needs met will allow professionals, parents and training programs to target those aspects that provide the greatest benefit.

4.6 Conclusion

This study has attempted to understand the experiences and needs of gender-variant children and their parents. Scant information and studies currently exist according to which these findings could be validated. Recommendations have been provided in support of gender variance education programs aimed at the general community, clinical and medical professionals, schools and parents. These recommendations have included ideas for meeting

some of these needs within current frameworks. Proposed tasks for governments include roles for government leaders.

Across the three groups of participants surveyed, the findings indicate a significant shortfall in: the education and training available to professionals; the support available to parents of gender-variant children; the awareness of schools regarding the needs of gender-variant students; the management of bullying of gender-variant children in schools; and compassion towards gender-variant children.

It became increasingly clear from the data that even when gender-variant children actively endeavoured to conform, their efforts were often thwarted by insensitive individuals who chose to marginalise and victimise them for their differences. Children therefore suffered both invisibility and a lack of recognition of their needs and the violation of their personal boundaries which, for some, forced the development of a general anxiety as they recognised the need to be constantly vigilant. Gender-variant children must also deal with the conflict between needing to belong to or be part of a group and the need to honour their integrity by being themselves. These children have the right to safe and meaningful lives and need our help to survive in a world that is not yet prepared for them.

For parents of gender-variant children who suffer on a daily basis from the pressure to conform, negativity, bullying, harassment and violence, these results provide validation of their concerns and introduce ways to address at least some of them. More parents than ever before are seeking support in raising a gender-variant child but are constantly frustrated by the lack of resources available.

The aim of the proposals offered here for training programs in gender variance and government intervention is to begin the process of providing for the unmet needs of gender-variant children and their parents. These proposals promote ideas and strategies that professional associations, schools and governments can use to begin to address the distress experienced by gender-variant children and their parents. New knowledge, awareness and recognition of these needs have the potential to transform the pathologisation and lack of knowledge prevalent in medicine, other clinical professions, schools and the general community, into sensitivity and compassion for gender-variant children.

That gender identity appears to be firmly formed during childhood places even more responsibility on adults to bestow upon children conscientious affirmation without coercion. Children deserve the opportunity to either come to terms with or confidently find their own identity in a caring environment.

Finally, although children have no choice but to live in the world that is made available to them, society *does* have a choice about how to treat them. Several questions arise: Can society, professionals and schools facilitate a child's self-identification rather than policing conformity to gender norms? Can the stigma of gender variance be eliminated so that children can live in peace while embracing their differences? And, finally, can people allow children to be themselves when their behaviour harms no-one?

Slesaransky-Poe and Garcia (2009) sum up the responsibilities of parents and schools in supporting gender-variant children: "When we, as parents and educators, limit children from developing their strengths because of rigid constructions of masculinity and femininity, then both the family and educational systems have failed, and we all lose" (p.209).

References

Adair, C., Marcoux, G., Williams, A., & Reimer, M. (2006). The internet as a source of data to support the development of a quality-of-life measure for eating disorders. *Qualitative Health Research, 16*(4), 538-546.

Alanko, K., Santtila, P., Harlaar, N., Witting, K., Varjonen, M., Jern, P., et al. (2008). The association between childhood gender atypical behavior and adult psychiatric symptoms is moderated by parenting style. *Sex Roles, 58,* 837-847.

American Counseling Association. (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling, 4*(3), 135-159.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders: DSM-III*. Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (4 ed.). Washington, DC: American Psychiatric Association.

American Psychological Association. (2009). Report of the Task Force on Gender Identity and Gender Variance. Washington, DC: American Psychological Association, Task Force on Gender Identity and Gender Variance.

Ansara, Y. G., & Hegarty, P. (2011). Cisgenderism in psychology: Pathologizing and misgendering children from 1999 to 2008. *Psychology & Sexuality, iFirst*, 1-24. doi: 10.1080/19419899.2011.576696.

Ault, A., & Brzuzy, S. (2009). Removing gender identity disorder from the Diagnostic and Statistical Manual of Mental Disorders: A call for action. *Social Work, 54*(2), 187-189.

Australian Bureau of Statistics. (2011). *Household income and income distribution, Australia, 2009-10*. Canberra: Australian Bureau of Statistics Retrieved from www.abs.gov.au.

Baker, J. M. (2002). *How homophobia hurts children: Nurturing diversity at home, at school, and in the community*. New York, NY: Haworth Press; US.

Bakwin, H. (1960). Transvestism in children. *The Journal of Pediatrics, 56*(2), 294-298.

Bakwin, H. (1968). Deviant gender-role behavior in children: Relation to homosexuality. *Pediatrics, 41*, 620-629.

Bakwin, H., & Bakwin, R. M. (1953). Homosexual behavior in children. *Psychologic Aspects of Pediatrics, 43*, 108-111.

Bandura, A., & Bussey, K. (2004). On broadening the cognitive, motivational, and sociostructural scope of theorizing about gender development and functioning: Comment on Martin, Ruble, and Szkrybalo (2002). *Psychological Bulletin, 130*(5), 691-701.

Bartlett, N., Vasey, P., & Bukowski, W. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles, 43*(11/12), 753-785.

Beasley, J. M., Davis, A., & Riley, W. T. (2009). Evaluation of a web-based, pictorial diet history questionnaire. *Public Health Nutrition, 12*(5), 651-659.

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review, 88*(4), 354-364.

Bem, S. L. (1983). Gender schema theory and its implications for child development: Raising gender-aschematic children in a gender-schematic society. *Signs, 8*(4), 598-616.

Bem, S. L. (1989). Genital knowledge and gender constancy in preschool children. *Child Development, 60*(3), 649-662.

Bem, S. L. (1993). *The lenses of gender: Transforming the debate on sexual inequality*. New Haven, CT: Yale University Press.

Bender, L., & Paster, S. (1941). Homosexual trends in children. *American Journal of Orthopsychiatry, 11*, 730-744.

Benestad, E. E. P. (2001). Gender belonging: Children, adolescents, adults and the role of the therapist. *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice, 1*(8), 58-80.

Benestad, E. E. P. (2009). Addressing the disturbed, like ripples in water: Intervention with the social networks of children who transe. *Sexual and Relationship Therapy, 24*(2), 207-216.

Benjamin, H. (1964). Clinical aspects of transsexualism in male and female. *American Journal of Psychotherapy, 18*, 458-469.

Berrill, K. T. (1990). Anti-gay violence and victimization in the United States : An overview. *Journal of Interpersonal Violence, 5*, 274-294.

Best, S., Krueger, B., & Smith, C. (2001). An assessment of the generalizability of internet surveys. *Social Science Computer Review, 19*(2), 131-145.

Biernat, M., & Kobrynowicz, D. (1999). A shifting standards perspective on the complexity of gender stereotypes and gender stereotyping. In J. William B. Swann, J. H. Langlois & L. A. Gilbert (Eds.), *Sexism and stereotypes in modern society: the gender science of Janet Taylor Spence*. Washington, DC: American Psychological Association.

Blackburn, M. V. (2004). Understanding agency beyond school-sanctioned activities. *Theory Into Practice, 43*(2), 102-110.

Blackless, M., Charuvastra, A., Derryck, A., Fausto-Sterling, A., Lauzanne, K., & Lee, E. (2000). How sexually dimorphic are we? Review and synthesis. *American Journal of Human Biology, 12,* 151-166.

Bliven, B. D., Kaufman, S. E., & Spertus, J. A. (2001). Electronic collection of health-related quality of life data: validity, time benefits, and patient preference. *Quality of Life Research, 10*(1), 15-21.

Bloomberg, L., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. Thousand Oaks, CA: Sage Publications.

Bochner, A. P. (2001). Narrative's virtues. *Qualitative Inquiry, 7*(2), 131-156.

Bockting, W. O. (1997). Transgender coming out: Implications for the management of gender dysphoria. In B. Bullough, V. Bullough & J. Elias (Eds.), *Gender blending*. Amherst, NY: Prometheus Books.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *SIECUS Report, 28*(1), 3-7.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*, 211-224.

Bockting, W. O., Knudson, G., & Goldberg, J. (2006). *Counselling and mental health care of transgender adults and loved ones*. Retrieved from transhealth.vch.ca

Bockting, W. O., Robinson, B. E., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex & Marital Therapy, 30*, 277-294.

Bodlund, O., & Armelius, K. (1994). Self-image and personality traits in gender identity disorders: An empirical study. *Journal of Sex & Marital Therapy, 20*(4), 303-317.

Boehm, F. (1930). The femininity-complex in men. *International Journal of Psychoanalysis, 11*, 444-469.

Boenke, M. (2003). *Trans forming families: Real stories about transgendered loved ones*. Hardy, VA: Oak Knoll Press.

Boivin, M., Hymel, S., & Bukowski, W. M. (1995). The roles of social withdrawal, peer rejection, and victimization by peers in predicting loneliness and depressed mood in childhood. *Development and Psychopathology, 7*, 765-785.

Bolich, G. G. (2008). *Transgender realities*. Raleigh, NC: Psyche's Press.

Bowes, L., Maughan, B., Caspi, A., Moffitt, T. E., & Arseneault, L. (2010). Families promote emotional and behavioural resilience to bullying: Evidence of an environmental effect. *Journal of Child Psychology and Psychiatry, 51*(7), 809-817.

Bradley, H. (2010). Transgender children and their families: Acceptance and its impact on well-being. *Dissertation Abstracts International: Section B: The Sciences and Engineering* (Vol. 71, pp. 650).

Brewin, C., Andrews, B., & Gotlib, I. (1993). Psychopathology and early experience: A reappraisal of retrospective reports. *Psychopathology Bulletin, 113*(1), 82-98.

Brill, S., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Fransisco, CA: Cleis Press Inc.

Brock, L. L., Nishida, T. K., Chiong, C., Grimm, K. J., & Rimm-Kaufman, S. E. (2008). Children's perceptions of the classroom environment and social and academic performance: A longitudinal analysis of the contribution of the Responsive Classroom approach. *Journal of School Psychology, 46*(2), 129-149.

Brown, D. G. (1956). Sex-role preference in young children. *Psychological Monographs: General and Applied, 70*(14), 1-19.

Buckingham, A., & Saunders, P. (2007). *The survey methods workbook: From design to analysis*. Cambridge, UK: Polity Press.

Buhrich, N., & McConaghy, N. (1978). Parental relationships during childhood in homosexuality, transvestism and transsexualism. *Australian and New Zealand Journal of Psychiatry, 12*(2), 103-108.

Bullough, B., & Bullough, V. L. (1998). Transsexualism: Historical perspectives, 1952 to present. In D. Denny (Ed.), *Current concepts in transgender identity*. New York: Garland.

Burke, P. (1996). *Gender shock: Exploding the myths of male and female*. New York: Anchor Books/Doubleday.

Burrows, G. (2011). Lesbian, gay, bisexual and transgender health. *Practice Nurse, 41*(4), 22-25.

Carroll, L., & Gilroy, P. J. (2002). Transgender issues in counselor preparation. *Counselor Education and Supervision, 41*, 233-242.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender variant clients. *Journal of Counselling and Development, 80*(Spring), 131-139.

Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26*, 817-833.

Carver, P., Yunger, J., & Perry, D. (2003). Gender identity and adjustment in middle childhood. *Sex Roles, 49*, 95.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.

Chen-Hayes, S. F. (2001). Counseling and advocacy with transgendered and gender-variant persons in schools and families. *Journal of Humanistic Counseling, Education and Development 40*(1), 34-48.

Child Welfare Information Gateway. (2011). How many children were adopted in 2007 and 2008? Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Cho, H., & LaRose, R. (1999). Privacy issues in internet surveys. *Social Science Computer Review, 17*(4), 421-434.

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons. *Journal of Homosexuality, 51*(3), 53-69.

Coates, S., & Person, E. S. (1985). Extreme boyhood femininity: isolated behavior or pervasive disorder. *Journal of the American Academy of Child Psychiatry, 24*(6), 702-709.

Cohen-Kettenis, P., & Arrindell, W. A. (1990). Perceived parental rearing style, parental divorce and transsexualism: a controlled study. *Psychological Medicine, 20*(3), 613-620.

Cohen-Kettenis, P., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31*(1), 41-53.

Cohen-Kettenis, P., & Pfafflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices.* Thousand Oaks, CA: Sage.

Cohen-Kettenis, P., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national,cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry, 11*(3), 397-405.

Cole, S., Denny, D., Eyler, A., & Samons, S. (2000). Issues in transgender. In L. Szuchman & F. Muscarella (Eds.), *Psychological perspectives on human sexuality* (pp. 149-168). New York: John Wiley.

Constantinople, A. (1973). Masculinity-Femininity: An exception to a famous dictum? *Psychological Bulletin, 80*(5), 389-407.

Cooper, K. (1999). Practice with transgendered youth and their families. *Journal of Gay & Lesbian Social Services, 10*(3), 111 - 129.

Costa, L., & Matzner, A. (2007). *Male bodies, women's souls: personal narratives of Thailand's transgendered youth*. Binghamton, NY: The Haworth Press, Inc.

Crawford, N. (2003). Understanding children's atypical gender behavior: A model support group helps parents learn to accept and affirm their gender variant children. *Monitor on Psychology, 34*(8), 40. Retrieved from www.apa.org/monitor/sep03/children.html

Crothers, L. M., & Levinson, E. M. (2004). Assessment of bullying: A review of methods and instruments. *Journal of Counseling & Development, 82*(4), 496-503.

D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence, 21*, 1462-1482.

Daley, E. M., McDermott, R. J., Brown, K. R. M., & Kittleson, M. J. (2003). Conducting web-based survey research: A lesson in internet designs. *American Journal of Health Behavior, 27*(2), 116-124.

Davidson, M. (2007). Seeking refuge under the umbrella: Inclusion, exclusion, and organizing within the category transgender. *Sexuality Research & Social Policy: A Journal of the NSRC, 4*(4), 60-80.

de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *The Journal of Child Psychology and Psychiatry, 52*(11), 1195-1202.

Dean, L., Meyer, I., Robinson, K., Sell, R., Sember, R., & Silenzio, V. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4*(3), 105-151.

Denscombe, M. (2006). Contents of near-identical questionnaires delivered in different modes web-based questionnaires and the mode effect: An evaluation based on completion rates and data. *Social Science Computer Review, 24*, 246-254.

Denzin, N. K., & Lincoln, S. L. (2000). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage publications.

Denzin, N. K., & Lincoln, S. L. (2005). The methods, politics and ethics of representation in online ethnography. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage Handbook of Qualitative Research* (2nd ed.). Thousand Oaks: Sage publications.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay & Lesbian Psychotherapy, 8*(1-2), 41-67.

Devor, H. (1997). *Female-to-male transsexuals in society*. Bloomington, IN: Indiana University Press.

Di Ceglie, D. (1998). Management and therapeutic aims in working with children and adolescents with gender identity disorders, and their families. In D. Di Ceglie & D. Freedman (Eds.), *A stranger in my own body: Atypical gender identity development and mental health*. London: Karnac Books.

Di Ceglie, D. (2008). Working at the edge: Engaging in therapeutic work with young people with atypical gender identity development. *Neuropsychiatrie de l'Enfance et de l'Adolescence, 56*(6), 403-406.

Di Ceglie, D., & Coates Thummel, E. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387-396.

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). Retrieved from www.wpath.org/publications

Diamond, M. (1965). A critical evaluation of the ontogeny of human sexual behavior. *The Quarterly Review of Biology, 40*(2), 147-175.

Diamond, M. (1976). Human sexual development: biological foundations for social development. In F. A. Beach (Ed.), *Human sexuality in four perspectives*. Baltimore, MD: The John Hopkins University Press.

Diamond, M. (1982). Sexual identity, monozygotic twins reared in discordant sex roles and a BBC follow-up. *Archives of Sexual Behavior, 11*(2), 181-185.

Diamond, M. (1997). Sexual identity and sexual orientation in children with traumatized or ambiguous genitalia. *Journal of Sex Research, 34*(2), 199-211.

Diamond, M. (2002). Sex and gender are different: Sexual identity and gender identity are different. *Clinical Child Psychology and Psychiatry, 7*(3), 320-334.

Diamond, M. (2003). Title: What's in a name? Some terms used in the discussion of sex and gender. *Transgender Tapestry Journal 102*, 18-21.

Diamond, M. (2005). Transsexuality, intersexuality and ethics. In L. May (Ed.), *Transgenders and intersexuals* (pp. 72-94). Adelaide, SA: East Street Publications.

Diamond, M. (2006). Biased-interaction theory of psychosexual development: "How does one know if one is male or female?" *Sex Roles, 55*, 589-600.

Diamond, M. (2009). Clinical implications of the organizational and activational effects of hormones. *Hormones and Behavior, 55*, 621-632.

Diamond, M. (2011). *Gender identity concordance among monozygotic and dizygotic twin pairs.* Paper presented at the WPATH Biennial International Symposium, 24-28 Sept, 2011: Transgender Beyond Disorder: Identity, Community, and Health, Emory Conference Center, Atlanta, Georgia.

Diamond, M., & Sigmundson, H. K. (1997a). Sex reassignment at birth: Long-term review and clinical implications. *Archives of Pediatrics and Adolescent Medicine, 151*(March), 298-304.

Diamond, M., & Sigmundson, H. K. (1997b). Sex reassignment at birth: Long term review and clinical implications *Archives of Pediatrics and Adolescent Medicine, 151*(March), 298-304.

DiStefano, A. S. (2008). Suicidality and Self-Harm Among Sexual Minorities in Japan. *Qualitative Health Research, 18*(10), 1429-1441. doi: 10.1177/1049732308322605

Doan, P. L. (2011). The tyranny of gendered spaces – reflections from beyond the gender dichotomy. *Gender, Place & Culture, 17*(5), 635-654.

Dohrenwend, B. (1965). Some effects of open and closed questions on respondents answers. *Human Organization, 24*, 175-184.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34-45.

Dutton, L., Koenig, K., & Fennie, K. (2008). Gynecologic care of the female-to-male transgender man. *Journal of Midwifery and Women's Health, 53*(4), 331-337.

Dworkin, S. H., & Yi, H. (2003). LGBT identity, violence, and social justice: The psychological is political. *International Journal for the Advancement of Counselling, 25*(4), 269-279.

Dykstra, L. A. (2005). Trans-friendly preschool. *Journal of Gay & Lesbian Issues in Education, 3*(1), 7-13.

Egan, S. K., & Perry, D. G. (2001). Gender identity: A multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology, 37,* 451-463.

Ekins, R., & King, D. (1998). Blending genders: Contributions to the emerging field of transgender studies. In D. Denny (Ed.), *Current concepts in transgender identity*. New York: Garland.

Elliott, J. (1991). *Action research for educational change*. Buckingham: Open University Press.

Ellis, K., & Eriksen, K. (2002). Transsexual and transgenderist experiences and treatment options. *The Family Journal, 10*(3), 289-299.

Emmerich, W., Goldman, K. S., Kirsh, B., & Sharabany, R. (1977). Evidence for a transitional phase in the development of gender constancy. *Child Development, 48*(3), 930-936.

Ettner, R. (1999). *Gender loving care: A guide to counseling gender-variant clients*. New York, NY: W.W. Norton & Company, Inc.

Fagot, B. I. (1977). Consequences of moderate cross-gender behavior in preschool children. *Child Development, 48*(3), 902-907.

Fagot, B. I. (1986). Beyond the reinforcement principle: Another step toward understanding sex role development. *Developmental Psychology, 21,* 1097-1104.

Fagot, B. I., & Hagan, R. (1991). Observations of parent reactions to sex-stereotyped behaviors: Age and sex effects. *Child Development, 62*(3), 617-628.

Fagot, B. I., & Leinbach, M. D. (1993). Gender-role development in young children: From discrimination to labeling. *Developmental Review, 13,* 205-224.

Fausto-Sterling, A. (1993). The five sexes: Why male and female are not enough. *The Sciences, March/April*, 20-24.

Feinberg, L. (2001). Trans health crisis: For us it's life or death. *American Journal of Public Health, 91*(6), 897-900.

Fenton, A. (2006). Weft Quallitative Data Analysis (QDA) (Version 1.0.1.). http://www.pressure.to/qda/: Alex Fenton.

Finkel, M. J., Storaasli, R. D., Bandele, A., & Schaefer, V. (2003). Diversity training in graduate school: An exploratory evaluation of the Safe Zone project. *Professional Psychology: Research and Practice, 34*(5), 555-561.

Finlay, L. (2006). 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy 69*(7), 319-326.

Fonagy, P., Twemlow, S., Vernberg, E., Nelson, J., Dill, E., Little, T., et al. (2009). A cluster randomized controlled trial of child-focused psychiatric consultation and a school systems-focused intervention to reduce aggression. *Journal of Child Psychology and Psychiatry, 50*(5), 607-616.

Francis, J. J. (1965). Passivity and homosexual predisposition in latency boys. *Bulletin of the Philadelphia Association for Psychoanalysis, XV*, 160-174.

Franse, B. C. (2007). *Benefits of an active and constructive attitude from schools towards children and adolescents with gender-variant behavior.* Paper presented at the The World Professional Association for Transgender Health (WPATH) 2007 XX Biennial Symposium, Chicago, USA.

Freud, S. (1990). The ego and the id. In J. Strachey & P. Gay (Eds.), *Standard edition of the complete psychological works of Sigmund Freud* (pp. 128). New York: W. W. Norton & Company.

Fricker, R., & Schonlau, M. (2002). Advantages and disadvantages of internet research surveys: Evidence from the literature. *Field Methods, 14*(4), 347-367.

Fridell, S. R., Owen-Anderson, A. F., Johnson, L. L., Bradley, S. J., & Zucker, K. J. (2006). The playmate and play style preferences structured interview: A comparison of children with gender identity disorder and controls. *Archives of Sexual Behavior, 35*, 729-737.

Friedman, M. S., Koeske, G. F., Silvestre, A. J., Korr, W. S., & Sites, E. W. (2006). The impact of gender-role nonconforming behavior, bullying, and social support on suicidality among gay male youth. *Journal of Adolescent Health, 38*, 621-623.

Friend, M. R., Schiddel, L., Klein, B., & Dunaeff, D. (1954). Observations on the development of transvestism in boys. *American Journal of Orthopsychiatry, 24*, 563-575.

Galesic, M., & Bosnjak, M. (2009). Effects of questionnaire length on participation and indicators of response quality in a web survey. *Public Opinion Quarterly, 73*(2), 349-360.

Garnets, L., Herek, G. M., & Levy, B. (1990). Violence and victimization of lesbians and gay men : Mental health consequences. *Journal of Interpersonal Violence, 5*, 366-383.

Gehi, P. S., & Arkles, G. (2007). Unraveling injustice: Race and class impact of Medicaid exclusions of transition-related health care for transgender people. *Sexuality Research & Social Policy: A Journal of the NSRC, 4*(4), 7-35.

Gelman, S. A., Taylor, M. G., & Nguyen, S. P. (2004). Mother-child conversations about gender: Understanding the acquisition of essentialist beliefs. *Monographs of the Society for Research in Child Development, 69*(1), 116-127.

Gilbert, M. (2000). Special issue: What is transgender? The transgendered philosopher. *International Journal of Transgenderism, 4*(3). Retrieved from www.wpath.org

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*(4), 491-504.

Goldberg, J. (2006). Training community based clinicians in transgender care. *International Journal of Transgenderism, 9*(3/4), 219-231.

Goldman, J. A., Smith, J., & Keller, E. D. (1982). Sex-role preference in young children: What are we measuring? *The Journal of Genetic Psychology, 141*(1), 83-92.

Goldman, L. (2008). *Coming out, coming in: Nurturing the well-being and inclusion of gay youth in mainstream society*. New York, NY: Routledge/Taylor & Francis Group; US.

Graham, A. L., Papandonatos, G. D., Bock, B., C , Cobb, N. K., Baskin-Sommers, A., Niaura, R., et al. (2006). Internet- vs telephone-administered questionnaires in a randomized trial of smoking cessation. *Nicotine & Tobacco Research, 8 (Suppl 1)*, S49-S57.

Graham, J. E. (2011). *Bullying and childhood abuse: Implications for mental and physical health across the lifespan*. Paper presented at the WPATH 2011 Biennial International Symposium: Transgender Beyond Disorder: Identity, Community, and Health, Emory Conference Center, Atlanta, Georgia.

Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). *National transgender discrimination survey report on health and health care*. Washington, DC: National Center for Transgender Equality and the National Gay and

Lesbian Task Force Retrieved from http://transequality.org/PDFs/NTDSReportonHealth_final.pdf.

Grbich, C. (2009). *Qualitative data analysis: An introduction*. London, UK: Sage Publications.

Green, J. (1994). Investigation into discrimination against transgendered people. *A report by the Human Rights Commission City and County of San Fransisco*. Retrieved from http://www.sf-hrc.org/index.aspx?page=6

Green, J. (2004). *Becoming a visible man*. Nashville: Vanderbuilt University Press.

Green, R. (1974). *Sexual identity conflict in children and adults*. New York: Basic Books.

Green, R. (1987). *The "Sissy Boy Syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.

Green, R. (1998). Mythological, historical and cross-cultural aspects of transsexualism. In D. Denny (Ed.), *Current concepts in transgender identity*. New York: Garland.

Green, R., & Money, J. (1960). Incongruous gender role: nongenital manifestations in prepubertal boys. *Journal of Nervous and Mental Disease, 131*, 160-168.

Green, R., & Money, J. (1966). Stage-acting, role-taking, and effeminate impersonation during boyhood. *Archives of General Psychiatry, 15*(Nov), 535-538.

Greenson, R. R. (1966). A transvestite boy and a hypothesis. *International Journal of Psychoanalysis, 47*(2-3), 396-403.

Grossman, A. H., & D'Augelli, A. R. (2006). 'Transgender Youth'. *Journal of Homosexuality, 51*(1), 111-128.

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37*(5), 527-537.

Grossman, A. H., D'Augelli, A. R., & Frank, J. A. (2011). Aspects of psychological resilience among transgender youth. *Journal of LGBT Youth, 8*(2), 103-115.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent' reactions to transgender youth' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services 18*(1), 3-16.

Grossman, A. H., Haney, A. P., Edwards, P., Alessi, E. J., Ardon, M., & Howell, T. J. (2009). Lesbian, gay, bisexual and transgender youth talk about experiencing and coping with school violence: A qualitative study. *Journal of LGBT Youth, 6*(1), 24-46.

Gruber, J. E., & Fineran, S. (2008). Comparing the impact of bullying and sexual harassment victimization on the mental and physical health of adolescents. *Sex Roles, 59*, 1-13.

Gunter, B., Nicholas, D., Huntington, P., & Williams, P. (2002). Online versus offline research: Implications for evaluating digital media. *Aslib Proceedings, 54*(4), 229-239.

Guth, L. J., Lopez, D. F., Rojas, J., Clements, K. D., & Tyler, J. (2004). Experiential versus rational training: A comparison of student attitudes toward homosexuality. *Journal of Homosexuality, 48*(2), 83-102.

Haas, A. P., Eliasonb, M., Maysc, V. M., Mathyd, R. M., Cochrane, S. D., D'Augellif, A. R., et al. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality, 58*(1), 10-51.

Haldeman, D. (2000). Gender atypical youth: clinical and social issues. *School Psychology Review, 29*(2), 192-200.

Hammersley, M. (1992). *What's wrong with ethnography? Methodological explorations*. London, UK: Routledge.

Hampson, J. L., & Hampson, J. G. (1961). The ontogenesis of sexual behavior in man. In W. C. Young (Ed.), *Sex and internal secretions* (3 ed., pp. 1401-1432). Baltimore, MD: Williams and Wilkins.

Hartley, R. E. (1959). Sex-role pressures and the socialization of the male child. *Psychological Reports, 5*(3), 457-468.

Hegedus, J. (2009). *When a daughter becomes a son: Parents' acceptance of their transgender children.* In partial fulfillment of the requirements of the degree doctor of psychology, Alliant International University, San Francisco Campus.

Henning-Stout, M., James, S., & Macintosh, S. (2000). Reducing harrassment of lesbian, gay, bisexual, transgender, and questioning youth in schools. *School Psychology Review, 29*(2), 180-191.

Herdt, G. (1994). *Third sex, third gender: Beyond sexual dimorphism in culture and history*. New York: Zone Books.

Herek, G. M. (1990). The context of anti-gay violence : Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*, 316-333.

Higdon, M. J. (2011). To lynch a child: bullying and gender nonconformity in our nation's schools. *Indiana Law Journal, 86*(3), 827-878.

Hill, D. B., & Menvielle, E. J. (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. B., Menvielle, E. J., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy, 36*(1), 6-23.

Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2007). Gender identity disorders in childhood and adolescence: A critical enquiry. *International Journal of Sexual Health, 19*(1), 57-75.

Holman, C. W., & Goldberg, J. M. (2006). Social and medical transgender case advocacy. *International Journal of Transgenderism, 9*(3/4), 197-217.

Hoonakker, P., & Carayon, P. (2009). Questionnaire survey nonresponse: A comparison of postal mail and internet surveys. *International Journal of Human-Computer Interaction, 25*(5), 348-373.

Huberman, A. M., & Miles, M. B. (2002). *Qualitative researcher's companion*. Thousand Oaks, CA: Sage.

Israel, T., & Hackett, G. (2004). Counselor education on lesbian, gay, and bisexual issues: Comparing information and attitude exploration. *Counselor Education and Supervision, 43*(3), 179-191.

Israel, T., & Selvidge, M. M. (2003). Contributions of multicultural counseling to counselor competence with lesbian, gay and bisexual clients. *Journal of Multicultural Counseling and Development, 31*(2), 84-98.

Jesdale, B. M., & Zierler, S. (2002). Enactment of gay rights laws in U.S. states and trends in adolescent suicide: An investigation of non-Hispanic white boys. *Journal of the Gay & Lesbian Medical Association, 6*(2), 61-69.

Katz, J., & Porath, M. (2011). Teaching to diversity: creating compassionate learning communities for diverse elementary school students. *International Journal of Special Education, 26*(2), 1-13.

Kidd, S. A., Veltman, A., Gately, C., Chan, K. J., & Cohen, J. N. (2011). Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *American Journal of Psychiatric Rehabilitation, 14*(1), 13-39.

Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82-173). Stanford, CA: Stanford University Press.

Kosciw, J., Diaz, E., & Greytak, E. (2008). The 2007 national school climate survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. Retrieved from www.glsen.org

Kraut, R., Olson, J., Banaji, M., Bruckman, A., Cohen, J., & Couper, M. (2004). Psychological research online: Report of Board of Scientific Affairs' Advisory Group on the conduct of research on the Internet. *American Psychologist, 59,* 105-117.

L'Abate, L. (2011). *Sourcebook of interactive practice exercises in mental health*. New York, NY: Springer Science + Business Media.

Landolt, M., Bartholomew, K., Saffrey, C., Oram, D., & Perlman, D. (2004). Gender nonconformity, childhood rejection, and adult attachment: A study of gay men. *Archives of Sexual Behavior, 33*(2), 117-128.

Lapouse, R., & Monk, M. A. (1964). Behavior deviations in a representative sample of children: variation between sex, age, race, social class, and family size. *American Journal of Orthopsychiatry, 34,* 436-446.

Laqueur, T. (1990). *Making sex: Body and gender from the Greeks to Freud*. Cambridge, Mass: Harvard University Press.

Lev, A. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth

Lincoln, Y. S., & Guba, E. (1985). *Naturalistic Enquiry*. Beverley Hills, CA: Sage.

Lindsey, E. W., Cremeens, P. R., & Caldera, Y. M. (2010). Gender differences in mother-toddler and father-toddler verbal initiations and responses during a caregiving and play context. *Sex Roles, 63,* 399-411.

Lombardi, E. L. (2009). Varieties of transgender/transsexual lives and their relationship with transphobia. *Journal of Homosexuality, 56*(8), 977-992.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2002). Gender violence. *Journal of Homosexuality, 42*(1), 89-101.

Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism, 3*(2/3), 93-112.

Lyons, A. C., Cude, B., Lawrence, F., & Gutter, M. (2005). Conducting research online: Challenges facing researchers in family and consumer sciences. *Family and Consumer Sciences Research Journal, 33*(4), 341-356.

Ma'ayan, H. D. (2003). Masculine female adolescents at school. *Equity & Excellence in Education, 36*(2), 125-135.

Maccoby, E. E. (1966). *The development of sex differences*. Stanford, CA: Stanford University Press.

MacDonald, M. W. (1938). Criminally aggressive behavior in passive, effeminate boys. *American Journal of Orthopsychiatry, 8*, 70-78.

Maguen, S., Shipherd, J. C., & Harris, H. N. (2005). Providing culturally sensitive care for transgender patients. *Cognitive and Behavioral Practice, 12*(4), 479-490.

Mallon, G. P. (1999a). Knowledge for practice with transgendered persons. In G.P.Mallon (Ed.), *Social services with transgendered youth*. Binghamton, NY: Harrington Park Press.

Mallon, G. P. (1999b). Practice with transgendered children. *Journal of Gay & Lesbian Social Services, 10*(3), 49-64.

Mallon, G. P. (2000). Appendix B: A guide to staff self-awareness. *Journal of Gay & Lesbian Social Services, 10*(3/4), 147-148.

Mallon, G. P. (2006). Transgender children and youth: A child welfare practice perspective. *Child Welfare, 85*(2), 215-241.

Marcus, D. E., & Overton, W. F. (1978). Gender permanence and the genital basis of gender: Stages in the development of constancy of gender identity. *Child Development, 49*(2), 434-444.

MarketTools. (2011). Zoomerang survey tool. Retrieved from www.zoomerang.com

Markey, O. B., & Noble, H. (1936). An evaluation of the masculinity factor in boarding home situations. *American Journal of Orthopsychiatry, 1*(2), 258-267.

Martin, C. L., & Ruble, D. N. (2009). Patterns of gender development. *Annual Review of Psychology, 61*, 353-381.

Martin, C. L., Ruble, D. N., & Szkrybalo, J. (2002). Cognitive theories of early gender development. *Psychological Bulletin, 128*, 903-933.

Martin, C. L., Wood, C. H., & Little, J. K. (1990). The development of gender stereotype components. *Child Development, 61*(6), 1891-1904.

Matos, M., & Pinto-Gouveia, J. (2010). Shame as a traumatic memory. *Clinical Psychology and Psychotherapy, 17*, 299-312.

McConaghy, M. J. (1979). Gender permanence and the genital basis of gender: Stages in the development of constancy of gender identity. *Child Development, 50*(4), 1223-1226.

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviours. *Culture, Health and Sexuality, 10*(8), 815-829.

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 and Adolescence, 39*, 1175-1188.

Mead, M. (1961). Cultural determinants of sexual behavior. In W. C. Young (Ed.), *Sex and internal secretions* (3 ed., pp. 1433-1479). Baltimore, MD: Williams and Wilkins.

Menvielle, E., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(8), 1010-1013.

Merten, D. E. (1997). The meaning of meanness: Popularity, competition and conflict among junior high school girls. *Sociology of Education, 70*(3), 175-191.

Meyer-Bahlburg, H. (2002). Gender identity disorder in young boys: a parent- and peer-based treatment protocol. *Clinical Child Psychology and Psychiatry, 7*(3), 360-376.

Meyer-Bahlburg, H. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 35*(2), 461-476.

Meyer, W., Bockting, W., Cohen-Kettenis, P., Coleman, E., & DiCeglie, D. (2001). The Harry Benjamin Internation Gender Dysphoria Association's standards of care for gender identity disorders- Sixth Version. Retrieved from www.wpath.org

Miner, H. M., Bockting, W., Romine, R. S., & Raman, S. (2011). Conducting internet research with the transgender population: Reaching broad samples and collecting valid data. *Social Science Computer Review*. Retrieved from www.sagepublications.com

Money, J. (1955). Hermaphroditism, gender and precocity in hyperadrenocorticism: Psychologic findings. *Bulletin of the Johns Hopkins Hospital, 96*(6), 253-264.

Money, J., & Ehrhardt, A. (1972). *Man & woman, boy & girl: the differentiation and dimorphism of gender identity from conception to maturity*. Baltimore, MD: John Hopkins University Press.

Money, J., Hampson, J. G., & Hampson, J. L. (1957). Imprinting and the establishment of gender role. *Archives of Neurology & Psychiatry, 77*(3), 333-336.

Money, J., & Tucker, P. (1975a). Childhood. In J. Money & P. Tucker (Eds.), *Sexual signatures: On being a man or a woman*. London: George G. Harrap & Co Ltd.

Money, J., & Tucker, P. (1975b). Gender identity. In J. Money & P. Tucker (Eds.), *Sexual signatures: On being a man or a woman* (pp. 86-118). London: George G. Harrap & Co Ltd.

Monro, S. (2000). Theorizing transgender diversity: towards a social model of health. *Sexual and Relationship Therapy, 15*(1), 33 - 45.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications Inc.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Research and Practice, 100*(12), 2426-2432.

Newman, L. (2002). Sex, gender and culture: issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology and Psychiatry, 7*(3), 352-359.

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, H., Macri, M., et al. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons [Report]. *The Journal of Sex Research, 47*(1), 12-23.

Nye, R. A. (2010). How sex became gender. *Psychoanalysis and History, 12*(2), 195-209.

Parsons, T. (1942). Age and Sex in the Social Structure of the United States. *American Sociological Review, 7*(5), 604-616.

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

Pealer, L. N., Weiler, R. M., Morgan Pigg, R., Miller, D., & Dorman, S., M. (2001). The feasibility of a web-based surveillance system to collect health risk behavior data from college students. *Health Education & Behavior, 28*(5), 547-559.

Pearlman, S. F. (2006). Terms of connection: Mother-talk about female-to-male transgender children. In J. Bigner & A. Gottlieb (Eds.), *Interventions with families of gay, lesbian, bisexual and transgender people: From the inside out*. New York: Harrington Park Press.

Pequegnat, W., Rosser, B. R. S., Bowen, A. M., Bull, S. S., Diclemente, R. J., Bockting, W. O., et al. (2007). Conducting Internet-based HIV/STD prevention survey research: Considerations in design and evaluation. *AIDS and Behavior, 11*, 505-521.

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender non-conformity and homosexual childhoods* (pp. 34-51). New York: University Press.

Polkinghorne, D. (1983). *Methodology for the human sciences*. Albany, NY: Suny Press.

Polly, R., & Nicole, J. (2011). Understanding the transsexual patient: Culturally sensitive care in emergency nursing practice. *Advanced Emergency Nursing Journal, 33*(1), 55-64.

Pomerleau, A., Bolduc, D., Malcuit, G., & Cossette, L. (1990). Pink or blue: Environmental gender stereotypes in the first two years of life. *Sex Roles, 22*(5/6), 359-367.

Porter, J. R., & Smith-Adcock, S. (2011). Children who help victims of bullying: Implications for practice. *International Journal for the Advancement of Counselling, 33*(3), 196-205.

Price-Robertson, R., Smart, D., & Bromfield, L. (2010). Family is for life: Connections between childhood family expereinces and wellbeing in early adulthood. *Family Matters, 85*, 7-17.

Proto, E., Sgroi, D., & Oswald, A. J. (2012). Are happiness and productivity lower among young people with newly-divorced parents? An experimental and econometric approach. *Experimental Economics, 15*, 1-23.

Rabban, M. (1950). Sex-role identification in young children in two diverse social groups. *Genetic Psychology Monographs, 42*, 81-158.

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from www.WPATH.org

Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *International Journal of Transgenderism, 6*(2). Retrieved from www.WPATH.org

Rankin, K., Rauscher, G., McCarthy, B., Il'yasova, I., & Davis, F. (2008). Comparing the reliability of responses to telephone-administered versus self-administered web-based surveys in a case-control study of adult malignant brain cancer. *Cancer Epidemiological Biomarkers & Prevention, 17*, 2639-2646.

Raymond, J. (1979). *The transsexual empire: the making of the she-male*. Boston: Beacon Press.

Reed, B., Cohen-Kettenis, P., Reed, T., & Spack, N. (2008). Medical care for gender variant young people: Dealing with the practical problems. *Sexologies, 17*, 258-264.

Rekers, G. A., & Lovaas, O. I. (1974). Behavioral treatment of deviant sex-role behaviors in a male child. *Journal of Applied Behavior Analysis, 7*(2), 173-190.

Renk, K., Donnelly, R., McKinney, C., & Agliata, A. K. (2006). The development of gender identity: Timetables and influences. In K.-S. Yip (Ed.), *Psychology of gender identity: An international perspective*. Hauppauge, NY: Nova Science Publishers.

Rieger, G., & Savin-Williams, R. C. (2011). Gender nonconformity, sexual orientation, and psychological well-being. *Archives of Sexual Behavior*. Retrieved from www.springerlink.com doi:10.1007/s10508-011-9738-0

Rigby, K. (2001). Health consequences of bullying and its prevention in schools. In J. Juvonen & S. Graham (Eds.), *Peer harassment in school*. New York: Garland.

Riley, E. A., Clemson, L., Sitharthan, G., & Diamond, M. (2012). Surviving a gender variant childhood: The views of transgender adults on the needs of gender variant children and their parents. *Journal of Sex & Marital Therapy*. Retrieved from www.tandfonline.com doi:10.1080/0092623X.2011.628439

Riley, E. A., Sitharthan, G., Clemson, L., & Diamond, M. (2011a). The needs of gender-variant children and their parents: A parent survey. *International Journal of Sexual Health, 23*, 181-195.

Riley, E. A., Sitharthan, G., Clemson, L., & Diamond, M. (2011b). The needs of gender-variant children and their parents according to health professionals. *International Journal of Transgenderism, 13*(2), 54-63.

Riley, E. A., Wong, W. K. T., & Sitharthan, G. (2011). Counseling support for the forgotten transgender community. *Journal of Gay & Lesbian Social Services, 23*(3), 395-410.

Rivers, I. (2004). Recollections of bullying at school and their longterm implications for lesbians, gay men, and bisexuals. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 25*, 169-175.

Robinson, A. (2010). The transgender patient and your practice: what physicians and staff need to know. *The Journal of Medical Practice Management, 25*(6), 364-367.

Robinson, J. P., & Espelage, D. L. (2011). Inequalities in education between straight and LGBTQ in middle and high school. *Educational Researcher, 40*, 315-330.

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.

Rosario, V. (2004). The biology of gender and the construction of sex? *GLQ: A Journal of Gay and Lesbian Studies, 10*(2), 280-287.

Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(5), 619-621.

Rosser, B., Oakes, J., Bockting, W. O., & Miner, M. (2007). Capturing the social demographics of hidden sexual minorities: An internet study of the transgender population in the United States. *Sexuality Research & Social Policy: A Journal of the NSRC, 4*(2), 50-64.

Roughgarden, J. (2004). *Evolutions Rainbow: Diversity, gender, and sexuality in nature and people*. Berkeley, CA: University of California Press.

Ruble, D. N., Taylor, L., Cyphers, L., Greulich, F. K., Lurye, L. E., & Shrout, P. E. (2007). The role of gender constancy in early gender development. *Child Development, 78*, 1121-1136.

Russell, S. T., Ryan, C., Toomey, R. B., Diaz, R. M., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health, 81*, 223-230.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147*, 598-611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*(3), 316-331.

Rutter, M. (2012). Resilience as a dynamic concept. *Development and Psychopathology, 24*(2), 335-344.

Sachs-Ericsson, N., Gayman, M. D., Kendall-Tackett, K., Lloyd, D. A., Medley, A., Collins, N., et al. (2010). The long-term impact of childhood abuse on internalizing disorders among older adults: The moderating role of self-esteem. *Aging & Mental Health, 14*(4), 489-501.

Sadowski, M., Chow, S., & Scanlon, C. P. (2009). Meeting the needs of LGBTQ youth: A "Relational Assets" approach. *Journal of LGBT Youth, 6*(2-3), 174-198.

Saeger, K. (2006). Finding our way: Guiding a young transgender child. *Journal of GLBT Family Studies, 2*(3/4), 207-245.

Salmivalli, C., Lagerspetz, K., Bjorkqvist, K., Osterman, K., & Kaukiainen, A. (1996). Bullying as a group process: Participant roles and their relations to social status within the group. *Aggressive Behavior, 22*(1), 1-15.

Sandberg, D. E., Meyer-Bahlburg, H. F. L., Ehrhardt, A. A., & Yager, T. J. (1993). The prevalence of gender-atypical behavior in elementary school children. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*, 306-314.

Sangganjanavanich, V., & Cavazos, J. (2010). Workplace aggression: Toward social justice and advocacy in counselling for transgender individuals. *Journal of LGBT Issues in Counseling, 4*, 187-201.

Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives on lesbian, gay male and bisexual youths: Associations with school problems, running away, substance abuse, prostitution and suicide. *Journal of Consulting and Clinical Psychology, 62*(2), 261-269.

Savin-Williams, R. C., & Dube, E. M. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *Family Relations, 47*(1), 7-13.

Scher, L. J. (2009). Beyond acceptance: An evaluation of the safe zone project in a clinical psychology doctoral program. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 69*(10-B), 6435.

Sennott, S., & Smith, T. (2011). Translating the sex and gender continuums in mental health: A transfeminist approach to client and clinician fears. *Journal of Gay & Lesbian Mental Health, 15*(2), 218-234.

Shapiro, E. (2004). Trans'cending barrier: Transgender organizing on the Internet. *Journal of Gay & Lesbian Social Services, 16*, 165-179.

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*, 94-108.

Simon, L., Zsolt, U., Fogd, D., & Czobor, P. (2011). Dysfunctional core beliefs, perceived parenting behavior and psychopathology in gender identity disorder: A comparison of male-to-female, female-to-male transsexual and nontranssexual control subjects. *Journal of Behavior Therapy and Experimental Psychiatry 42*(1), 38-45.

Slaby, R. G., & Frey, K. S. (1975). Development of gender constancy and selective attention to same-sex models. *Child Development, 46*(4), 849-856.

Slesaransky-Poe, G., & Garcia, A. M. (2009). Boys with gender variant behaviors and interests: From theory to practice. *Sex Education, 9*(2), 201-210.

Spence, J. T. (1993). Gender-related traits and gender ideology: Evidence for a multifactorial theory. *Journal of Personality and Social Psychology, 64*(4), 624-635.

Spradley, J. (1980). *Participant observation*. Orlando, FL: Harcourt Brace & Company.

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16*(4), 499-516.

Stoller, R. J. (1964). The hermaphroditic identity of hermaphrodites. *Journal of Nervous and Mental Disease, 139*(5), 453-457.

Stoller, R. J. (1966). The mother's contribution to infantile transvestic behavior. *International Journal of Psychoanalysis, 47*, 384-395.

Stoller, R. J. (1967). Effects of parents' attitudes on core gender identity. *International Journal of Psychiatry, 4*(1), 57-60.

Stoller, R. J. (1978). Boyhood gender aberrations: Treatment issues. *Journal of the American Psychoanalytic Association, 26*, 541-558.

Stryker, S. (2006). (De)subjugated knowledged: An introduction to transgender studies. In S. W. a. S. Stryker (Ed.), *The transgender studies reader*. New York, NY: Routledge.

Stufft, D. L., & Graff, C. M. (2011). Increasing visibility for LGBTQ students: What schools can do to create inclusive classroom communities. *Current Issues in Education, 14*(1), 1-24.

Sudman, S., & Bradburn, N. M. (1973). Effects of time and memory factors on response in surveys. *Journal of the American Statistical Association, 68*(344), 805-815.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton & Company, Inc.

Thornberg, R. (2011). 'She's weird!' - The social construction of bullying in school: A review of quallitative research. *Children & Society, 25*, 258-267.

Touvier, M., Me´jean, C., Kesse-Guyot, E., Pollet, C., Malon, A., Castetbon, K., et al. (2010). Comparison between web-based and paper versions of a self-administered anthropometric questionnaire. *European Journal of Epidemiology, 25*, 287-296.

Towle, E. B., & Morgan, L. M. (2006). Romancing the transgender native: Rethinking the use of the "third gender" concept. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader*. New York, NY: Routledge.

Tribe, R., & Morrissey, J. (2005). Training supervision: Professional and ethical considerations. In R. Tribe & J. Morrissey (Eds.), *Handbook of ethical practice for psychologists, counsellors and psychotherapists*. New York, NY: Brunner-Routledge.

US Census Bureau. (2011). *American community survey (ACS)*. U.S. Census Bureau. Retrieved from www.census.gov.

van Beijsterveldt, C. E. M., Hudziak, J. J., & Boomsma, D. I. (2006). Genetic and environmental influences on cross-gender behavior and relation to behavior problems: A study of dutch twins at ages 7 and 10 years. *Archives of Sexual Behavior, 35*(6), 647-658.

van Manen, M. (1997). *Researching Lived Experience: Human science for an action sensitive pedagogy*. London, Ont: Althouse Press.

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal, 26*, 135-154.

VanderLaan, D. P., Gothreau, L. M., Bartlett, N. H., & Vasey, P. L. (2010). Recalled separation anxiety and gender atypicality in childhood: A study of canadian heterosexual and homosexual men and women. *Archives of Sexual Behavior, 40*(6), 1233-1240.

Wallien, M., & Cohen-Kettenis, P. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1413-1423.

Wallien, M., van Goozen, S. H. M., & Cohen-Kettenis, P. (2007). Physiological correlates of anxiety in children with gender identity disorder. *European Child & Adolescent Psychiatry, 16*(5), 309-315.

Wallien, M., Veenstra, R., Kreukels, B., & Cohen-Kettenis, P. (2010). Peer group status of gender dysphoric children: A sociometric study. *Archives of Sexual Behavior, 39*(2), 553-560.

Weisz, J. R., Suwanlert, S., Chaiyasit, W., & Walter, B. R. (1987). Over- and undercontrolled referral problems among children and adolescents from Thailand and the United States: The wat and wai of cultural differences. *Journal of Consulting and Clinical Psychology, 55*(5), 719-726.

West, R., Gilsenan, A., Coste, F., Zhou, X., Brouard, R., Nonnemaker, J., et al. (2006). The ATTEMPT cohort: a multi-national longitudinal study of predictors, patterns and consequences of smoking cessation; introduction and evaluation of internet recruitment and data collection methods. *Addiction, 101*(9), 1352-1361.

Whitam, F. L., Diamond, M., & Martin, J. (1993). Homosexual orientation in twins: A report on 61 pairs and three triplet Sets. *Archives of Sexual Behavior, 22*(3), 187-206.

Whittle, S., Turner, L., & Al-Alami, M. (2007). *Engendered penalties: Transgender and transsexual people's experiences of inequality and discrimination*. A Research Project and Report Commissioned by the Equalities Review Retrieved from http://www.pfc.org.uk/files/EngenderedPenalties.pdf.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, UK: Open University Press.

Winters, K. (2008). *Gender madness in american psychiatry: Essays from the struggle for dignity*. Dillon, CO: GID Reform Advocates.

Witten, T. M., & Eyler, A. E. (1999). Hate crimes and violence against the transgendered. *Peace Review: A Journal of Social Justice, 11*(3), 461-468.

Woods, P. (2006). *Successful writing for qualitative researchers*. Oxon, UK: Routledge.

WPATH. (2009). World Professional Association for Transgender Health's, standards of care for the health of transsexual, transgender, and gender nonconforming people. *7th Version*. Retrieved from www.wpath.org

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. *Clinical Child Psychology and Psychiatry, 7*(3), 377-397.

Wyman, P. A., Sandler, I., Wolchik, S., & Nelson, K. (2000). Resilience as cumulative promotion and stress protection: Theory and intervention. In D. Cicchetti (Ed.), *Promotion of wellness in children and adolescents*. Washington, DC: Child Welfare League of America Press.

Wyss, S. E. (2004). 'This was my hell': the violence experienced by gender non-conforming youth in US high schools. *International Journal of Qualitative Studies in Education, 17*(5), 709 - 730.

Xavier, J., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism, 3*(2/3), 31-48.

Yunger, J., Carver, P., & Perry, D. (2004). Does gender identity influence children's psychological well-being. *Developmental Psychology, 40*, 572.

Zhentao, F., & Fuxi, F. (2006). Development of the concept of gender constancy in preschoolers. *Acta Psychologica Sinica, 38*(1), 63-69.

Zosuls, K. M., & Ruble, D. N. (2009). The acquisition of gender labels in infancy: Implications for gender-typed play. *Developmental Psychology, 45*(3), 688-701.

Zucker, K. J. (1998). Adoptee overrepresentation among clinic-referred boys with gender identity disorder. *Canadian Journal of Psychiatry, 43*(10), 1040-1043.

Zucker, K. J. (2004). Gender Identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*, 551-568.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*, 477-498.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K. J., Bradley, S. J., & Sanikhani, M. (1997). Sex differences in referral rates of children with gender identity disorder: Some hypotheses. *Journal of Abnormal Child Psychology, 25*(3), 217.

Zucker, K. J., Owen, A., Bradley, S., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*, 398.

Zucker, K. J., Wilson-Smith, D. N., Kurita, J. A., & Stern, A. (1995). Children's appraisals of sex-typed behavior in their peers. *Sex Roles, 33*, 703.

Zuger, B., & Taylor, P. (1969). Effeminate behavior present in boys from early childhood. II. Comparison with similar symptoms in non-effeminate boys. *Pediatrics, 44*(3), 375-380.

Appendices

Appendix A. Gender Identity Disorder Diagnostic Criteria

Psychiatric News July 18, 2003
Volume 38 Number 14

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DSM-IV-TR Diagnostic Criteria For Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference for playmates of the other sex

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix B. **Advertisement 1: General**

Graduate Program in Sexual Health
The University of Sydney
Faculty of Health Sciences

Are you or have you ever considered yourself transgender?

Are you a parent of a transgender child or adult?

Are you a professional that works with transgender clients?

If so, would you like to take part in an important research study on the needs of gender variant children and their parents?

Elizabeth Anne Riley in conjunction with the University of Sydney is doing her PhD and conducting the research titled,

Gender Variant Children: Views of Professionals, Parents and Transgender Adults
[Ref. no. 11203]

If you would like to take part, or get more information about this survey, visit [URL]

This is an international survey, please pass it on to anyone who may be interested.

Appendix C. Advertisement 2: Sydney's Child

ARTWORK PROOF

Sydney's child
the best guide for parents

Publication: ●SC ○MC ○AC ○BC ○CC ○PC ○SD | ●General ○Party ○Holiday | ○Colour ●Mono

Client: Uni of Sydney - Gender Variant Size: 1/20 Issue: Feb09 Sales Rep: Pamela

Are you the parent of a gender non-conforming child or adult?

Take part in an important research study on the needs of gender variant children and their parents.

Elizabeth Anne Riley in conjunction with the University of Sydney is conducting PhD research titled: **Gender Variant Children: Views of Professionals, Parents and Transgender Adults [Ref.no.11203]**

For more information about this survey visit **www.fhs.usyd.edu.au/sexualhealth** then choose 'Current Research'

This is an international survey, and includes surveys for transgender individuals as well as professionals working in the field. Please pass it on to anyone who may be interested.

Contact Elizabeth at eril6366@usyd.edu.au

Graduate Program in Sexual Health
The University of Sydney
Faculty of Health Sciences

Appendix D. Advertisement 3: Polare

Issue Eighty-Two

Graduate Diploma in Sexual Health
The University of Sydney
Faculty of Health Sciences

Are you or have you ever considered yourself transgender?

Are you a parent of a transgender child or adult?

Are you a professional who works with transgender clients?

If so, would you like to take part in an important research study on the needs of variant children and their parents?

Elizabeth Anne Riley, in conjunction with the Universityof Sydney, is doing her PhD and conducting the research titled:

Gender Variant Children: Views of Professionals, Parents and Transgender Adults [Ref.no. 11203]

If you would liketo take part, or would like more information about this survey, visit

www.fhs.usyd.au/sexual health

This is an international survey, please pass it on to anyone who may be interested.

Appendix E. **Invitation to Professionals**

Graduate Program in Sexual Health
The University of Sydney
Faculty of Health Sciences

Gender Variant Children: Views of Professionals, Parents & Transgender Adults
[Ref. no. 11203]

Dear Professional,

I would like to invite you to participate in this research identifying the needs of children with gender variance and the needs of their parents. The ultimate aim is to develop an evidence-based supportive approach and environment for gender variant children.

This will be a study exploring, the childhood experiences of transgender adults and the experiences of parents who currently have a child with gender variance or who have raised a child with gender variance. Professionals working with the transgender community are being invited to include the voice of experience in contributing to understanding the support needs of parents and their children with gender variance.

Your participation in this research is entirely voluntary and no individual will be identified in any report of the results.

Submitting a completed questionnaire/survey is an indication of your consent to participate in the study. You can withdraw any time prior to submitting your completed questionnaire/survey. Once you have submitted your questionnaire/survey anonymously, your responses cannot be withdrawn.

The study is being conducted by Elizabeth Anne Riley and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the supervision of Dr Gomathi Sitharthan, Research Coordinator, Faculty of Health Sciences.

Please pass this survey on to any professional, parent or transgender individual; who may be interested in participating.

Preliminary results will be presented at the World Professional Association for Transgender Health (WPATH) conference in Oslo, Norway, 2009 and at the XIXth World Congress of Sexual Health in Goteburg, Sweden, 2009.

To take part in this survey, click or cut & paste the link below:

http://www.zoomerang.com/Survey/?p=WEB228CP3PGE8H

I look forward to your participation in this research.

If you would like to know more at any stage, please feel free to contact *Elizabeth Anne Riley, PhD student (health Sciences) at* eril6366@usyd.edu.au*, or Dr Gomathi Sitharthan,*

Research Coordinator at Cumberland Campus C42, East Street (PO Box 170), Lidcombe NSW 1825, Australia. Telephone:+61 2 9351 9584 or at g.sitharthan@usyd.edu.au

Sincerely,

Elizabeth Anne Riley

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@usyd.edu.au (Email).

Appendix F. Survey Notification

Graduate Program in Sexual Health
The University of Sydney
Faculty of Health Sciences

SURVEY NOTIFICATION

Gender Variant Children: Views of Professionals, Parents and Transgender Adults

Adult clients seeking help for Gender Dysphoria have generally lived traumatic existences for years and the process of transitioning is often 'tortuous and conflict-laden' (Diamond, 2002).

This is a study exploring, the childhood experiences of transgender adults and the experiences of parents who currently have a child with gender variance or who have raised a child with gender variance. In this context 'gender variant' means *non-conforming gender behaviour*. The study involves participants completing an on-line questionnaire taking 20-30 minutes.

This research aims to: identify the support needs of children with gender variance; bring to the open forum some of the issues that children with gender variance and their parents are dealing with; identify the ways in which children with gender variance are marginalized; and recognise the coping skills that the children and their parents have.

To further enhance the survey, professionals working with the transgender community are also being invited to include the voice of experience in contributing to understanding the support needs of parents and their children with gender variance.

This study will provide research-based evidence with which to support the parents and their children, provide advocacy and enhance current trans-positive guidelines for parents with gender variant children and also contribute to trans-positive education models, training and guidelines for working with gender variant children.

The longer term benefit of these programs have the potential to, reduce bullying and ostracism of gender variant children, contribute to positive mental health during development and ultimately help to mitigate the difficult circumstances that transgender adults experience.

The study is being conducted by Elizabeth Anne Riley and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the supervision of Dr Gomathi Sitharthan, Research Coordinator, Faculty of Health Sciences.

If you would like to know more about this research, please feel free to contact *Elizabeth Anne Riley, PhD student (health Sciences) +61 412 880 376 or* eril6366@usyd.edu.au *; or Dr Gomathi Sitharthan, Research Coodinator on +61 2 9351 9584* or g.sitharthan@usyd.edu.au .

Appendix G. Survey Questions: Parents of gender variant children

Survey for Parents
1. Are you a a. Mother: b. Father: c. Other guardian:
2. What is your age? a. 26-45 b. 46-65 c. 66+
3. What is your marital status? a. Single b. De facto c. Married d. Separated e. Divorced
4. Place of residence? a. Rural b. Urban
5. Educational level? a. High school b. Certificate c. Diploma d. Undergraduate e. Postgraduate
6. Occupation?
7. Country?
8. What is the birth sex of your child with gender variance? a. Female b. Male c. Other
9. What is the year your gender variant child was born?
10. What is the preferred gender of your child with gender variance? a. Female b. Male c. Other
11. What was it that you first noticed about your child that gave you the idea that your child was different?
12. How old were they at the time? a. 6 – 12 b. 13 – 18 c. 18+
13. What were the circumstances that led up to this realisation?
14. What effect did it have on the child?
15. What was your response?
16. What was the family's response?

17. How would you describe your child's peer relationships at that time?
18. What do you think your child wanted or needed, or if current, wants or needs now?
19. Are there any other difficulties your child experienced that were unrelated to their being gender variant?
20. What difficulties/pressures have you experienced as a result of your child being gender variant up to age 5?
21. What difficulties/pressures have you experienced as a result of your child being gender variant from 5 to 12 years?
22. What difficulties/pressures have you experienced (or do you expect) as a result of your child being gender variant as an adult?
23. What would help or would have helped you deal with these aspects?
24. Do you have a particular concern now?
25. What do you think your child wants/needs?
26. What outcome would you like for your gender variant child?
27. How do you think this could be achieved?
28. How would you generally describe your relationship with your child?
29. If we define anxiety as *distress or uneasiness of mind caused by fear of danger or misfortune*, where would you place your child's level of anxiety between 1 and 10. a. Generally: b. At the worst times: c. At the best times Note: Participants were asked to rate the level of anxiety on a scale of radio buttons from *Not at all anxious*: 1 2 3… 10: *Extremely anxious*
30. What do you feel you have learned from the experience of having a gender variant child?
31. Is there anything else you would like to add?

Appendix H. Survey Questions: Transgender Adults

Adult Survey
1. How do you describe yourself? a. Transgender b. Transsexual ftm c. Transsexual mtf d. Female e. Male f. Other
2. What is your age? a. 18-25 b. 26-45 c. 46-65 d. 66+
3. What was your birth sex? a. Female b. Male c. Other
4. Educational level? a. High school b. Certificate c. Diploma d. Undergraduate e. Postgraduate
5. What is your gender identity? a. Female b. Male c. Androgynous d. Both female and male e. Neither female nor male
6. Please enter the following information: a. Occupation b. Annual Income c. Country of residence
7. How would you rate your sexual orientation? a. Attraction to FtM b. Attraction to androgynous males c. [*No label*] d. Attraction to both males & females e. [*No label*] f. Attraction to females g. Attraction to androgynous females h. Attraction to MtF

8. Do you live full-time or part-time in your preferred gender? a. Never b. Occasionally c. Part time d. Full time
9. Are you taking hormones? a. Yes b. No
10. If not, are you planning to take hormones at some time in the future? a. Yes b. No
11. Have you had gender assignment surgery? a. Yes b. No If yes, what types of gender assignment surgery have you had?
12. What was it that you first noticed about yourself that told you that you were different to other children?
13. Describe the circumstances surrounding this realisation.
14. How did you feel at the time?
15. What did you do?
16. How old were you at that time? a. 0-5 b. 6-12 c. 13-18 d. 18+
17. How did your family respond? (parents, siblings, significant others)
18. Did you dress in your preferred gender as a child? a. Yes b. No If no, why not?
19. How did being gender variant affect you at school?
20. How did being gender variant affect your friendships?
21. Are there any particular difficulties you had as a child that were not related to your being gender variant or your non-gender conforming behaviour?
22. How would you describe your experience of being a child with gender variance up to 12 years?
23. How would you describe your experience of being a child with gender variance from 13 to 18 years?
24. How would you describe your experience of being gender variant as an adult?
25. What do you think would have helped you as a child then?
26. What do you think would help gender variant children today?
27. What do you think would have helped your parents/family?
28. What do you think would have help parents today?
29. What impact has your experience as a gender variant child had on you as an adult?
30. How do you think your experience as a gender variant child affects you now?
31. Do you have any special needs now?
32. Is there anything else you would like to add?

Appendix I. Survey Questions: **Professionals**

Professional Survey
1. Number of years working with the transgender community? a. 1-5 b. 6-10 c. 11-20 d. >20
2. What is your occupation?
3. What are your qualifications?
4. Did you receive any specialized training to prepare you for working with transgender clients?? a. Yes b. No
5. What is your country of residence?
6. What do you understand to be the issues that parents with gender variant children face?
7. What do you believe creates these issues for the parents?
8. What do you believe that parents want and need?
9. How do you think this could be achieved?
10. What do you understand to be the issues that gender variant children face?
11. What do you believe creates the issues for the gender variant children?
12. What do you believe that gender variant children want and need?
13. How do you think this could be achieved?
14. Do you have any particular concerns about your work with gender variant children or their parents?
15. Do you follow any guidelines in working with gender variant children and their parents?
16. Is there anything else you would like to add?

Appendix J. **Ethics Approval**

The University of Sydney

NSW 2006 Australia

Human Research Ethics Committee

www.usyd.edu.au/ethics/human
Manager: Gail Briody
Telephone: (02) 351 4811
Fax: (02) 9351 6706
Email: gbriody@usyd.edu.au
Deputy Manager: Marietta Coutinho
Telephone: (02) 9306 7566

Human Secretariat
Telephone: (02) 9036 9309
(02) 9036 9308
(02) 9036 7274
Facsimile: (02) 9036 9310
Mailing Address:
Room 313, Level 3, Old Teachers College – A22

12 August 2008

Dr. G. Sitharthan
School of Behavioural & Community Sciences
Faculty of Health Sciences-Building T
Cumberland Campus
The University of Sydney

Dear Dr. Sitharthan,

Title: **Gender Variant Children: Views of Professionals, Parents and Transgender Adults [Ref. no. 11203]**

Thank you for your ethics application that was considered at the meeting of The University of Sydney Human Research Ethics Committee held on 5th August 2008.

Approval of this project has been deferred for the following reasons. The Executive will give the application further consideration when this information is provided. **Please provide one (1) original of your response.**

1. Application section 1.1.d and 9.1 imply parents and transgendered people will complete the survey online while professionals will complete a paper survey. Yet, the Participant Information Sheet (PIS) for professionals indicates the survey is online. Please clarify whether it is an on-line survey or a paper survey and amend accordingly.
2. Application section 3.3.b implies that participants will be recruited by an Advertisement, yet there is a direct approach to professionals via a letter included with the documentation. Please clarify if there is, in fact, an Advertisement and if so, provide a copy.
3. Application section 3.3.b also does not provide enough detail on the recruitment process. The PIS does not provide the URL for the online survey and it is unclear when and how the participants will be provided with the PIS. Please clarify and amend accordingly.
4. Participant Information Sheet amendments:
    - The Participant Information Statements need to be on a complete letterhead (ie name and contact details). They should also indicate “Page 1 of 1” at the bottom. Please consult the HREC website for a template (http://www.usyd.edu.au/ethics/human/sample/sampled.html
    - Item 3 of the Transgender Adults PIS should match the other two Participant Information statements. Please amend accordingly.

- Item 6 of the Professional PIS should state “The study may benefit…”

5. Some of the questions in the Survey appear to be asking information unnecessary to the study. Please clarify/amend accordingly:
   - age of the professional?
   - age and marital status of the parent
   - Annual income of transgendered person
6. Amendments to the ‘Letter to Professionals’:
   - Please delete the words, “in this ground-breaking research” from the last paragraph.
   - Please include the Name and complete contact details of the Associate Researcher for enquiries/further information and the Name and complete contact details of the Manager-Human Ethics. Please consult the HREC website for details (http://www.usyd.edu.au/ethics/human/sample/sampled.html

The above information should be addressed numerically, referring to the corresponding numbers above. If the Committee has requested amendments to particular questions in the application form, submit the relevant pages and underline the changes. DO NOT re-submit the entire application.

If the Committee has requested that you amend any additional documents, such as the Participant Information Statement or Consent Form, you are asked to underline these changes to assist the Committee’s checking of the amended documents.

Your reply should be sent to the Ethics Office, Human Research Ethics Committee, Room 313, Level 3, Old Teachers College A22.

Please note that if the Ethics Office does not receive a response from you within three months, the application will lapse and a new application will be required.

Yours sincerely

Professor D I Cook
Chairman
Human Research Ethics Committee

CC: Ms. Elizabeth A. Riley, 14 Llewellyn Street, Rhodes NSW 2138

Appendix K. **Participant Information Statement**

Graduate Program in Sexual Health
The University of Sydney
Faculty of Health Sciences

Dr Gomathi Sitharthan
Deputy Coordinator (Research)
Graduate Program in Sexual Health
Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 1825, Australia
Telephone: : +61 2 93519584
Facsimile: +61 2 9351 9540 or 9112
G.Sitharthan@.usyd.edu.au

PARTICIPANT INFORMATION STATEMENT
Research Project

Title: Gender Variant Children: Views of Professionals, Parents and Transgender Adults

(1) What is the study about?

This study is about identifying the needs of, children with gender variance and their parents. In this context 'gender variance' means *non-conforming gender behaviour*.

(2) Who is carrying out the study?

The study is being conducted by Elizabeth Anne Riley and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the supervision of Dr Gomathi Sitharthan, Dr Patricia Weerakoon and Professor Milton Diamond.

(3) What does the study involve?

The study involves parents and transgender adults completing an on-line questionnaire taking about 30 minutes and professionals completing an online survey taking approximately 10-15 minutes.

(4) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to participate. If you choose to participate you can choose to leave questions unanswered or withdraw at any time.

Submitting a completed questionnaire/survey is an indication of your consent to participate in the study. You can withdraw any time prior to submitting your completed questionnaire/survey. Once you have submitted your questionnaire/survey anonymously, your responses cannot be withdrawn.

(5) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information. A report of the study will be submitted for publication, and presented at conferences. Individual participants will not be identifiable in such a report. No identifiable data is collected from participants.

(6) Will the study benefit me?

Your participation in this study may raise your awareness of the needs of children with gender variance and their parents.

(7) Can I tell other people about the study?

You are welcome to discuss this study with others. Anyone interested in this project is welcome to access the survey.

(8) What if I require further information?

When you have read this information, Elizabeth Anne Riley is available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact *Elizabeth Anne Riley, PhD student (health Sciences) +61 412 880 376 or* eril6366@usyd.edu.au *; or Dr Gomathi Sitharthan, Research Coordinator on +61 2 9351 9584* or g.sitharthan@usyd.edu.au

(9) What if I have a complaint or concerns?

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@usyd.edu.au (Email).

Appendix L. Media Article 1: Sydney Star Observer

http://www.starobserver.com.au/news/2009/03/18/researcher-looks-to-help-trans-children/5004

Researcher looks to help trans children

Category: News
Author: Ani Lamont
Posted: Wednesday, 18 March 2009

Researchers from the University of Sydney are keen to hear from members of the trans community about their childhood experiences, in an effort to develop services that could help parents and their gender variant children.

Researcher Elizabeth Riley is looking for more people to take part in an online survey, as part of her study Gender Variant (GV) Children: Views of Professionals, Parents and Transgender Adults.

The study aims to "identify the support needs of children with GV; convey the issues that children with GV and their parents are dealing with and ascertain the ways in which children are marginalised."

It is an essential first step towards creating stable adults, explained Riley, a former counsellor at the Gender Centre.

"I worked as a counsellor and it was seeing the trauma that the adults deal with that made me think there must be a way to prevent this."

The survey, which asks questions about people's childhood experiences as well as the attitudes adopted by parents, has already been completed by 150 people.

"What is coming through right now is that there is a need for more public awareness, more trans role models and letting people know there are other people out there dealing with the same issues," Riley told Sydney Star Observer.

"I hope this [study] will really be used to set up services to help parents, because really, right now, there is nothing in Australia. As soon as word started getting out, I was inundated with calls from parents asking, 'Is there a support group? Can I join it? Am I really not the only person dealing with this?'"

Riley decided to start a support group, which held its first meeting on Monday night at the Burwood Woodstock community centre.

Riley's study will run over the next six months and she hopes the support group will offer ongoing assistance to parents beyond that time period.

Appendix M. **Media Article 2: Sun Herald**

http://www.smh.com.au/news/national/window-into-why-girls-will-be-boys-and-vice-versa/2009/02/07/1233423559180.html

Window into why girls will be boys and vice versa

Swinging feelings … research has started into gender identity disorder.
Photo: *Darren Pateman*

Danielle Teutsch
February 8, 2009

A SYDNEY researcher has begun the first study of its kind on what are known as gender-variant children - boys who act like girls and girls who act like boys.

Sydney University doctoral student Elizabeth Riley is conducting an online survey, which will take in the views of families, health professionals and transgender people, and is setting up a support group. She has already had about 25 inquiries.

Ms Riley said in the past, professionals working in the field of gender identity disorder would not see patients until they were older teens or adults. But now, a new generation of more enlightened parents were seeking advice on the best way to deal with a young son who has a clear preference for long hair and dresses; or a girl who says she wants a boy's body.

"There's a real unmet need for help," Ms Riley said. "Parents want to do the right thing by their children. There's a fear their child could be teased or bullied and anxiety about what other parents will think."

She said little was known about gender-variant children, except about 80per cent turned out to be gay, with a small number becoming transsexual.

The chairwoman of perinatal and infant psychiatry at the University of Newcastle, Professor Louise Newman, welcomed research on such a poorly understood topic. "There are some children from very early on who have an absolutely clear sense of being trapped in the wrong body," she said. "The youngest I've seen is 2½years old."

There is still debate about whether biological factors - possibly caused by a hormonal imbalance during pregnancy - or psychological factors are responsible, although Professor Newman believed it was a combination. "There's likely to be more than one reason," she said.

When Alex was five he decided he wanted to be called Courtney. He would grab the venetian blind cords and put them behind his ears to make "earrings". Now aged nine, he is still as uninterested as ever in sport, cars and all things masculine. He's obsessed with Disney princesses and often sashays around the house in a feather boa and tiara. With his $20 of Christmas money, Alex bought a sparkly purple butterfly necklace and bracelet.

"The stuff that thrills him is uber-feminine. The glitzier, the frillier the better," his mother, Melissa, told *The Sun-Herald*.

Sarah is the mother of a five-year-old daughter who has gone through phases of wanting to be called "Nathan", loves cricket, utes and football and says she feels like a boy on the inside. She loves clothes featuring Spider-Man - "the more boy-like, the better" - and wears her hair in a closely-cropped style. Lately, she has told her mother she no longer wants to wear a top at the pool so she can be like the boys. "Ever since she could speak, she has wanted to be a boy. She's really clear and sure about it," Sarah said.

Both Sarah and Melissa have spoken of their confusion at how best to parent their children - whether to accept and indulge their desire to behave like the opposite sex, or gently steer them within social norms. They did not want themselves or their children identified because of a desire to protect them. Alex is already ostracised at school.

"It's hard to get clear-cut guidance," Melissa said. "For the first few years I tried buying gender-neutral toys, but it didn't really work. This Christmas, I just abandoned all that and bought what I knew would make him happy - a Barbie bride doll. If you could have seen his eyes, it was just magical."

Appendix N. **Media Article 3: Radio National**

http://www.abc.net.au/rn/lifematters/stories/2009/2517205.htm

http://www.abc.net.au/radionational/programs/lifematters/gender-variant-kids/3138514

Life Matters

on ABC Radio National

17 March 2009

Gender variant kids

| download audio

What do you do when your little boy tells you he's really a little girl?

Some children feel very strongly that they are actually of the opposite sex. It's called gender variance, and it's more common than you may think.

We hear the stories of two mothers—one whose son identifies as a girl, and one whose daughter identifies as a boy.

Researcher Elizabeth Anne Riley is trying to find out what parents and professionals can do to help gender variant kids thrive.

Guests

Elizabeth Anne Riley
Counsellor and PhD Candidate

Further Information

Graduate Program in Sexual Health, University of Sydney

Participate in Elizabeth Anne Riley's research

Presenter

Richard Aedy