

The Experience of Gender Dysphoria for Pre-pubescent Children and their Families: A Review of the Literature

Abstract: In recent years, the experience of gender dysphoria has gained public prominence through an explosion of sensationalised interest in the popular media. However, childhood gender dysphoria remains poorly understood and both parents and children often find themselves having to educate professionals around them. This not only creates a sense of disconnect between family and professional, but also means that social workers can often be unaware of the myriad of competing perspectives that seek to explain gender variance. This review of the literature seeks to provide interested social workers with an overview of gender dysphoria, current research in the field and theoretical paradigms, with a view to promoting understanding and better practice with families in this little understood field.

Keywords: Gender dysphoria; Gender identity; Parenting; Social Work

Introduction

Gender dysphoria in young children arouses powerful reactions in adults, involving the recognition of childhood sexuality, a subject matter that often causes disquiet. The experience of gender variance engenders a range of political and polarised responses with individuals subject not only to the “confused scandal of the media” but also “the collusive, falsely liberal seduction of medical-surgical ‘re-attribution’ of sexual gender” (Argentieri, 2009: 34-5). Recent research (Riley et al., 2011, 2013) suggests that both parents and transgendered adults feel that professionals are poorly educated about gender identity issues, especially in respect of younger pre-pubescent children. Parental narratives frequently highlight their perception that many of the professionals they encountered along their journey were ill-informed about gender dysphoria and thus ill-equipped to practice effectively with their family (Gregor, 2013). This literature review thus endeavours to provide social workers with an overview of current research and theoretical paradigms with a view to promoting understanding and better practice with families in this little understood field.

Overview of Gender Dysphoria

In layman’s terms, gender dysphoria (also known as gender variance or gender identity disorder) manifests itself when a child (or adult) has a gender identity that does not match their biological identity and typically says “*I am*” not “*I want to be*” the opposite gender (Di Ceglie, 1998). For

example, a biological girl self-identifies as a boy and shows a preference for playing with boys' toys, wearing boys' clothes, and will often become acutely distressed when confronted with the reality of her biological sex. This can often occur around puberty when secondary sex characteristics start to appear such as visible changes to the body. However, children as young as two years old can present with cross-gender behaviour and retrospective studies suggest that the majority of adults who self-define as gender variant realised that they were different before the age of thirteen (Kennedy & Hellen, 2010; Riley et al., 2013).

Spack (cited in Brill & Pepper, 2008: 3) identifies a number of behavioural traits that can be indicative of gender identity difficulties. These include children having difficulties going to the toilet either attempting to urinate standing up (girl) or sitting down (boy), having an aversion to wearing a swimming costume, insisting on wearing underwear of the opposite sex and exhibiting a strong desire to play with toys that are enjoyed stereotypically by the other sex. Literature tends to focus on the needs and difficulties confronting adolescents (e.g. Grossman, 2005; Manners, 2009; Steensma, 2010) which can be very different to the issues facing younger children and their families who are in the early stages of their transgender journey. Behaviours, such as wearing opposite gender clothes and playing with cross-gender toys, can initially be viewed benignly by parents but can quickly escalate to more worrying levels with children cropping their own hair, threatening to cut off their genitals, or even attempting suicide (Sadowski & Gaffney, 1998; Grossman & D'Augelli, 2007).

Diagnostic Criteria

Although highly controversial, gender identity issues are still currently a classifiable mental disorder (302.6 Gender Dysphoria in Children; 302.85 Gender Dysphoria in Adolescents or Adults) under DSM V (Diagnostic and Statistical Manual of Mental Disorders, APA, 2013). Children or adolescents must exhibit a strong and persistent cross-gender identification for a period of at least six months, and, in addition manifest at least six additional indicators of gender dysphoria such as a strong dislike of their sexual anatomy or an expressed need for sex characteristics that correlate to their experienced gender (IFGE, 2013). This must not be linked to a disorder of sexual development, such as abnormalities of the genitalia or reproductive system, and also must cause the young person to experience either significant distress, or difficulties in social or occupational functioning.

Medical discourses dominate the field as a diagnosis is required for most forms of treatment, whether physical or psychological. Many clinics now also offer hormonal intervention to young

people under the age of eighteen, which requires a definite diagnosis and medical review by both Endocrinologist and Psychiatrist (or appropriately qualified mental health professional). Controversially, gender clinics in the Netherlands are also able to offer physical intervention in the form of cross-sex hormone treatment to children pre-puberty.

Until 2013, the official diagnostic title for gender dysphoria in both children and adults was 'Gender Identity Disorder' (APA, 1994). An international Working Party convened from interested and experienced clinicians reviewed both the diagnostic criteria and title as part of broader revisions to the DSM IV. Although it could be viewed as purely a semantic shift, this change in title is significant in no longer describing the intense emotional experience as being that of a mental *disorder*, and thus it signifies a move in the professional community to more of a recognition of the intense emotional discomfort experienced as apposed to dysfunction.

There is no age range specified for childhood gender dysphoria, and from the time that they are able to communicate verbally children have been reported to express discomfort with their assigned gender identity (Vitale, 2001: Brill & Pepper, 2008: Ehrensaft, 2011a). A qualitative review of twenty-five adolescents aged fourteen to eighteen by Steensma et al (2010) suggests that only 15.8% of children persist with feelings of gender dysphoria into adolescence. Research by Drummond et al (2008) of twenty-five girls and Wallien and Cohen-Kettenis (2008) of seventy-seven children further suggest that, for approximately 80% of children who have experienced gender dysphoria, symptoms will not persist into adulthood. As can be seen from the number of research participants in these three studies alone, studies tend to be small scale due to the relative rarity of gender dysphoria. However, children who are not brought to the attention of specialised clinics do not feature in these studies and thus there may be a far greater prevalence of children with gender identity issues (who may or may not experience distress as a result) than these studies suggest.

The Aetiology of Gender Identity Issues

Prevailing professional opinion regards causation as complex and multi-factorial (Hembree et al: 2009). However, due to the emotive nature of gender identity issues, particularly in pre-pubescent children, any explanation as to its aetiology is liable to be problematic and it is easy for individuals to adopt an intractable position in relation to their understanding (Di Ceglie, 2008). This poses a particular risk for non-specialist social workers who may find themselves mirroring the confusion and uncertainties faced by the families.

Given the limited clinical population of children with gender identity issues, there are equally limited research findings. In addition, it is important to bear in mind that there are considerable differences in cultural and environmental factors for families seen in either North America or Europe. For example, writing from a North American context, Zucker and Bradley (1995) found that most of the children seen in their Toronto clinic came from higher social classes and were from 'intact' families which counters Di Ceglie et al's (2002) later UK findings. Furthermore, all of the children who were considered in the research detailed in this review were part of clinical populations and thus more likely to have additional difficulties. As Schwartz (2012) points out, each clinic or research group tends to have its own formulation about the possible aetiology of gender identity issues and this informs treatment offered. Parents are thus unlikely to approach a particular clinic for help unless they are persuaded about their treatment modalities and thus there may be some bias in the presentation of children to specific clinics. At the time of writing, the majority of the clinically significant studies originate from researchers working in clinics specifically for childhood gender dysphoria in Canada (e.g. Zucker & Bradley), the Netherlands (e.g. Cohen-Kettenis & Pfäfflin), the UK (e.g. Di Ceglie) and the USA (e.g. Spack, Menvielle).

As can be inferred from the requirement to be medically assessed in order to acquire a diagnosis of gender dysphoria, there are a number of possible biological explanations for the development of gender identity issues. The relationship between sex hormones and behaviour is often cited in studies that draw on so-called "experiments by nature" (Cohen-Kettenis & Pfäfflin, 2003: 12). Such studies examine individuals who have been inadvertently exposed to atypical hormone levels whilst in the womb and found that if a developing female baby is exposed to high levels of androgen-based testosterone in the womb, they are more likely to prefer stereotypical male activities, seek out male playmates and have higher levels of aggressive behaviour (Auyeung et al., 2009; Pasterski et al., 2011). Research in this area examines the role of genetics and sex hormones on gender identity development and studies by Zhou (1995) and Kruijver (2000) suggest that transsexualism can be clearly linked to the neurodevelopment of the brain. MRI scanning has revealed differences in the brains of males and females, as well as in the brains of homosexual men, and neurotransmitters have been discovered to be distributed differently (Goldstein et al., 2001).

However, whilst biological theories are non-judgemental and do not place any blame on parents, they do enable a clinical diagnosis to be made that in itself can pathologise or stigmatise an individual. A diagnosis thus implicitly reinforces gender role conformity and gender stereotypes in a way that can be perceived as unhelpful by individuals (Brooks: 2000). In addition, leading experts consider that there is currently insufficient neurological and endocrine research to conclusively

support an understanding of gender dysphoria purely from a bio-medical perspective (Hembree et al., 2009).

This in itself is problematic, as there is a significant amount of power vested in the professionals working with individuals with gender dysphoria. Practice guidelines (RCPsych, 1998; Hembree et al, 2009; BSPEDA, 2009) state that an individual must initially be diagnosed as having gender dysphoria by a mental health professional before physical interventions will be considered. Thus, not only do professionals have the power to diagnose, or not, but they also have the power to treat, or not. For children, there is the additional power differential that parents can also dictate whether or not they will receive any support, and what form that will take.

Psychological explanations traditionally have fallen into three distinct groupings: identity formation, attachment difficulties, and parental, particularly maternal, influence. Freud's conceptualisation of the acquisition of sexual or gender identity being linked to the primary relationship with the mother is often drawn on by psychoanalytic writers seeking to explain the development of gender identity dysphoria (e.g. Bleiberg et al., 1986). The process of identification-disidentification with the primary identification with the mother and the extent to which it has become arrested or confused forms the backdrop to most psychoanalytic discussions of gender dysphoria (Argentieri: 2009). For example, in a clinical paper Tyson (1982) describes gender dysphoria in boys as a failure to dis-identify with their mother; in other words a failure to resolve the oedipal complex. For girls, Di Ceglie (1998) observed that where a girl perceives her mother as weak and vulnerable "a masculine identification with physical masculine characteristics becomes the solution to enable psychic survival" (p19). Drawing on Bowlby's (1973) attachment theory, Coates and Person (1985) found that 60% of boys identified with gender dysphoria could also be diagnosed with separation anxiety disorder, although this was not supported by empirical evidence. Zucker and Bradley (1995) also found that most children with gender dysphoria have insecure attachments and develop gender dysphoria in order to reduce their anxiety. Research has additionally suggested that mothers of children with gender dysphoria are more likely to suffer with depression and/or borderline personality disorder themselves and to behave in ways that might trigger separation anxiety in their child (Coates et al: 1991; Marantz and Coates: 1991). As a result of the separation anxiety, a male child may over-identify with his mother and thus develop a female gender identity in order to guard against future losses of any maternal figures in his life. Indeed, in a clinical audit of cases seen by GIDS, 42% of children had experienced the loss of one or both parents and over 26% had spent some time in local Authority care (Di Ceglie et al: 2002).

Writing in the early years of research into gender identity issues, and drawing on clinical experience rather than empirical evidence, Stoller (1975) did not see gender dysphoria in boys as being 'caused' by trauma, rather he saw it as the result of a combination of factors, namely i) a bisexual mother, ii) an absent or distant father who allows an overly enmeshed relationship between mother and son, iii) a long period of sustained over-closeness between mother and son, and iv) an especial physical attractiveness in the son (p55). Similarly, Zucker and Bradley (1995) noted that marital problems and, in particular, maternal difficulties in regulating affect had a strong correlation with gender dysphoria.

However, this traditional diagnostic discourse incorporating histories of trauma and constructions of non-conformity, disordered and atypical gendered behaviour in so-called 'girlyboys' has been challenged by theorists such as Corbett (2009), as well as transgender activists. Corbett suggests that discourses built on trauma also incorporate "unquestioned beliefs about masculinity" (p353) and as such are out of kilter with modern times. He further argues that displays of femininity should not be decried as a symptom and that the very notion of masculinity should be explored further and not used as a binary diagnostic tool with which clinicians can seek to regulate 'masculine expressivity' (ibid: 366).

Recent qualitative research using free association narrative interviews by Gregor (2013) also found that some parents of pre-pubescent children struggle with psychoanalytic explanations and reject its credibility, preferring alternative conceptualisations propounded by psychologists such as Ehrensaft (2007, 2011a, 2011b) that challenge gender identity disorder as a concept and reframe it. Gender variant behaviour is not seen as pathological, but as part of an individual's creative expression of their identity. Typically such conceptualisations are viewed more favourably by families as there is no blame attributed, and they enable both families and professionals to move towards a more accepting and sensitive understanding of gender dysphoria.

Psychological discourses explaining gender identity issues sit squarely within a Western Eurocentric paradigm that sees gender as a binary concept (Wiseman and Davidson, 2011). However, other world views dating back centuries are far more inclusive and accepting of individuals with atypical gender identities which suggests that gender identity disorder can be seen as a social construct of Western society. As Vanderburgh (2009) points out, gender variance can be seen as a cultural construct whereby behaviour is often understood differently by local and distant communities through lenses tinted by geographical, practical and temporal constraints. Yet, whilst it is helpful to understand such cultural anomalies, understanding alone is not enough to help individuals and their

families to manage their lived realities of stigma and oppression due to their different expression of gender.

Parenting a child with gender dysphoria

Research into parental experiences of having a child with gender dysphoria is in its infancy and the studies that do exist again tend to be either based on case vignettes, small-scale or retrospective. Kennedy, a transgendered academic, and Hellen (2010) questioned 121 adults retrospectively about their childhood utilising an on-line survey. Their findings suggest that up to two-thirds of young people with gender dysphoria do not disclose their feelings to anyone until after the age of eighteen years. Even then, they do not necessarily tell their parent as research by Grossman et al (2005) corroborates. Thus, the parents of pre-pubescent children who do actually come in to contact with professionals are likely to be even more of a minority population.

Assuming that the child actually discloses their gender dysphoric feelings to their family, the impact of gender dysphoria can have wider ramifications not just for the child, but also for their siblings and family (Israel, 2004). The family may be shunned by the extended family or their friends, and the sibling may also get bullied due to their gender non-conforming sibling. Based on her clinical experience, Ehrensaft (2011a, 2011b) also points to the fact that some siblings may also be responsible for the bullying of their gender variant sibling, either through unkind behaviour or inappropriate 'outing' of their sibling. Many parents also speak of feeling socially isolated and disappointed that they cannot draw on family and friends more for emotional support (Coulter: 2010).

Coulter (ibid) undertook a qualitative study of twelve parents who were involved with the Gender Identity Development Service in London. She also found that parents struggled with the complexities of navigating both people and systems throughout their transgender 'journey' in order to try and maintain stability for their family. Over the course of their journey, parents learned how to manage and cope with the stress that having a transgendered child could cause to the family. In the earlier stages of the child's gender dysphoria, parents reported feeling stressed about most situations. However, they later learned to 'pace' themselves and evaluate each situation as it arose for its potential seriousness. Like many parents of children with disabilities or mental health problems, this often led to parents becoming experts themselves and taking on an educative role for professionals (Harden, 1995).

The need to work through feelings of disappointment on the part of the parents, both for having an overly femininised son/masculinised daughter contrary to their expectations, and also for having a child who is the object of bullying and misunderstanding is also highlighted in research by Rosenberg (2002). She suggests that part of the professional task in working with such families is to help parents create an accepting and nurturing environment for their child. Parents may also struggle themselves to come to terms with their child's gender identity and may ignore the child's distress and persist in thinking that it is 'just a phase' that the child will grow out of (Dearden, 2009; Möller et al., 2009).

Whilst initially conceived in relation to coping with the emergence of a transgendered spouse, Lev (2004) draws on Kübler-Ross' concept of the grieving process to explain how families process the disclosure of a transgendered child's identity. Based on clinical experience and using a life-cycle framework for the whole family system, Lev identifies four stages that parents and family members go through:

1. Discovery and Disclosure – even when this is anticipated, the realisation of a child's gender dysphoria can be extremely traumatic for the family;
2. Turmoil – a time of chaos and upheaval in the family as they struggle to come to terms with the reality of their child's difficulties;
3. Negotiation – a period of adjustment and compromise, working out what is and is not acceptable within the private and public spheres;
4. Finding Balance – the ending of the internal family secret and the resolution of the initial turmoil (p281).

Zamboni (2006) further suggests an additional initial stage of 'latency' which reflects the fact that many families are partially aware of their child's gender dysphoria without openly acknowledging it.

Focusing specifically on parents of pre-pubescent children who were known to the Gender Identity Development Service in London, Gregor (2013) expands on the theme of mourning for parents suggesting a number of emotional processes that parents go through that are often hidden from professionals. Her psychosocial research into the experiences of eight parents found that they were experiencing what Doka refers to as 'disenfranchised grief' (1989: 1). Parents are unable to publicly own their feelings of grief and loss of for their idealised child and can struggle to tolerate the

uncertainty of both the diagnosis and the possible outcome of their child's gender. Where aspects of mourning and grief are considered in accounts of parents with children with gender identity issues it is usually with the hopeful outcome that a sense of acceptance of the child's gender identity will be achieved (Emerson & Rosenfeld, 1996; Hegedus, 2009). The process of grieving becomes sanitised and somehow made less painful by proposing that there is an 'end goal' or desirable, and indeed achievable outcome. Whilst this may indeed be the case for some parents, the uncertainty faced by many parents may not suggest that this is a reality for them at this time. Additionally a staged approach of mourning also fails to consider the joy and vitality that parents also experience loving a child with gender identity issues (Brill & Pepper, 2008).

Writing from a sociological stand-point, Malpas (2011) describes a series of tasks that a parent of a gender non-conforming child has to undertake. A key parental task identified is enabling the child to negotiate the "rigid gender binary imported from familial, social, and cultural experiences" (p468). Additionally parents needed to work out how to position themselves at the 'intersection' of two conflicting parental tasks, namely how to nurture their child's confidence and developing personal identity, whilst also enabling them to adapt to the reality of their heavily engendered social environment. The parent crucially also needs to negotiate the balance of being flexible about the possible outcome of the child's gender in the future whilst also being supportive of their "current embodiment" (p454). Gendered behaviours can also become stereotyped with families responding in gendered ways to gender variant behaviour. Drawing on her own clinical experience, rather than an empirical study, Malpas (ibid) found that fathers in a therapeutic group for parents of gender variant children tended to express more concerns about protecting and ensuring the safety of their children. Mothers were more likely to express concerns around nurturing and acceptance. However, when their views were held up to scrutiny by the group, mothers and fathers were also able to acknowledge their gender stereotypes.

The gender beliefs of parents are key to understanding parental responses to their child's behaviour. In a US study of thirty-one parents conducted by telephone, many admitted to "policing gender choices" (Hill & Menvielle, 2009: 255). This includes encouraging stereotypical gender behaviour and discouraging cross-gender behaviour. However, all parents who admitted to the latter concluded that it was unhelpful and had a negative effect on their child, often resulting in extremely distressing behaviour. Indeed, there is a body of evidence to suggest that this type of parenting behaviour increases self-harm and suicidal ideation (Hill et al: 2010). Wren (2002) similarly found that parents known to the Gender Identity Development Service in the UK who were likely to be more accepting tended to be more actively engaged in generating support strategies such as

attending parental support groups, challenging stigma and actively listening to their child's concerns. Parents who were less accepting tended to be more passive in their approach and adopted strategies that were focused on trying to both ignore the gender dysphoria, and restore "the lost status quo" (p390).

Ehrensaft (2011b) suggests that families can schematically be categorised into three different types: 'transformers', 'transphobic', and 'transporting'. She points out that the child shapes the parents as well as the parents shaping the child in a transformative process. 'Transforming' parents are those who are comfortable in their own gender identity, and are strongly enough bonded to their child in order to cope and manage the challenges of the transformative journey that their child needs to go on. Whilst they may have had transphobic feelings initially, they are able to overcome them in order to offer support and advocacy for their child (p12). 'Transphobic' parents are those who are less secure in their own gender identity and may experience the child as an extension of themselves, and thus may be prone to scapegoating. They may never have transitioned successfully from adolescence themselves and thus be unable to step up to some of the demands of parenthood, especially parenting a child with gender dysphoria (p15). Finally 'transporting' parents are those who to all extents and purposes have embraced their transgendered child, yet still struggle internally to fully accept it. Such parents go at breakneck speed on the journey towards full transition with their child without exploring some of the more difficult issues that need to be addressed (p17).

Conclusions

As the above discussion has highlighted, working with families where a child is experiencing gender dysphoria is complex and still poorly understood. There are still comparatively few empirical studies into this area, and they tend to be conducted by researcher-clinicians with their own biases and perspectives. However, as with most fields of practice, becoming conversant with the core issues and being aware of the pull of competing perspectives can assist the social worker who does encounter such a family to work with them in a non-judgemental and supportive manner. Social workers who are able to keep an open mind and reflect on their own preconceptions are invaluable for families going through significant distress and uncertain times. Although challenging, it is imperative to try and maintain a neutral and non-prejudicial stance that enables both child and family to explore the emergent gender identity, both within and without the nuclear family.

There is currently no clear guidance on how to ensure that families with a gender dysphoric child do not need to reach the crisis point of being deemed to be in need of child protection services before

supportive input can be offered. Arguably, whilst local funding constraints may restrict service provision, families with a child who has gender identity issues should always be considered to meet the threshold for preventative or therapeutic services. This should include exploratory, relationship-based social work that draws on the theoretical paradigms and research findings outlined in this paper.

Contemporary social work practice is often driven by policy imperatives and social workers can find themselves forced to 'do' rather than simply to 'be' (Ruch et al., 2010). Mirroring the experience of parents, professionals can find themselves drawn to finding solutions for the child's gender identity issues (Di Ceglie, 2009). Yet, what appears to be important for these families is to be enabled to tolerate the uncertainty of their situation, allowed the opportunity to explore how they feel, and provided with a supportive framework to enable them to explore, at their own pace, their child's emerging gender identity. The future for these families is uncertain, but with an appropriately informed social worker alongside them, the journey can hopefully be made more tolerable.

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