

Colt Keo-Meier and Diane Ehrensaft

Introduction to the Gender Affirmative Model

1

Recently, awareness of prepubertal gender diverse children has increased in the United States among the general population, as well as among psychologists (American Psychological Association [APA], 2014; Ehrensaft, 2011). Major media outlets have likewise increasingly featured transgender children and their families, while hotly debating their treatment needs (Mapes, 2012; Quart, 2008; Spiegel, 2008). In the same vein, diverse gender identities, behaviors that diverge from gender stereotypes, and distress at home and school related to these issues are increasingly common presentations in child clinical settings (de Vries & Cohen-Kettenis, 2012; Spack et al., 2012). Thus, the need to prepare psychologists, other mental health professionals and professionals from all disciplines who work with children and families.

Outpatient clinics that specialize in working with transgender and gender expansive (TGE) children have seen a threefold rise in the amount of child referrals they have received over the past 30 years (de Vries & Cohen-Kettenis, 2012; Zucker, Bradley, Owen-Anderson, Kibblewhite, & Cantor, 2008). Recent literature indicates that the vast majority of counseling and education programs fail to prepare practitioners to be competent clinicians to serve the needs of TGE youth (Carroll, 2010; Cole, Denny, Eyler, & Samons, 2000; DePaul, Walsh, & Dam, 2009; Gonzalez & McNulty, 2010; Goodrich & Luke, 2009). Similarly, most public health and medical school training programs fail to

<http://dx.doi.org/10.1037/0000095-001>

The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children, C. Keo-Meier and D. Ehrensaft (Editors)

Copyright © 2018 by the American Psychological Association. All rights reserved.

train their students to be gender-sensitive practitioners (Corliss, Shankle, & Moyer, 2007; Obedin-Maliver et al., 2011). Even programs that include lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) trainings commonly exclude transgender issues or only briefly mention them as an afterthought. The focus is usually on the experiences of adults who transition after puberty, and prepubertal TGE children and adolescents fall off the radar screen completely (Carroll, 2010; Case, Stewart, & Tittsworth, 2009). Because gender identity develops between ages 1.5 and 3 years and sexual orientation develops as early as age 8 (Ehrensaft, 2016), access to information about how to work with TGE children is essential for professionals who work with young children (Gonzalez & McNulty, 2010).

A sea change in gender has been occurring, in such a short time it has hit land and rocked the earth as it has—at home, in communities, in society, and across the globe. In February 2014, Facebook changed its U.S. profile options for gender, extending it from two to 50-plus categories, including transgender, cisgender, agender, gender fluid, intersex, neither, trans female, trans male, trans person, gender variant, gender questioning, bigender, androgynous, pangender, and transsexual. People creating a profile can choose as many categories as they want. In 2012, California passed legislation (Sexual Orientation Change Efforts) prohibiting mental health practitioners from engaging in practices that attempted to change a minor's gendered behaviors. New Jersey soon followed suit, along with the District of Columbia, and as of this writing, 15 other states have similar bills pending. Looking north across the border, Ontario passed a no-reparative-therapy bill in 2015, in the same year that President Obama and the White House issued a statement condemning the practice of reparative therapy. In 2013, California passed another piece of legislation (Pupil Rights: Sex-Segregated School Programs and Activities), ensuring that all students in public schools are allowed to use the facilities and engage in activities associated with their affirmed gender, rather than their natal sex. In 2013, gender identity disorder was removed from the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.; DSM-5; American Psychiatric Association, 2013), replaced by a more palatable (but still problematic) mental health diagnosis of Gender Dysphoria. In Fall 2011, the World Professional Association of Transgender Health (WPATH) released its new standards of care, which state explicitly that it is unethical and harmful to engage in any form of therapy that attempts to change one's gender. The APA (2015) followed suit and released a large volume of new guidelines for gender affirmative care; however, the majority of the focus of the guidelines and standards are on TGE adults.

New gender clinics have begun to pop up across the United States and beyond to aid children in affirming their authentic gender. The gender affirmative approach has emerged and has become an ascending international model for supporting children's gender health, an effort that we are proud to be a part of. Simultaneously, therapeutic models aimed at altering children's gender to conform to cultural norms or influencing children to accept the gender that matches the sex on their birth certificate have been challenged, declared unethical, and evaluated as harmful to children's well-being. In 2007, Barbara Walters moderated a *20/20* documentary on transgender kids (Goldberg, 2007). It was the first of its kind in TV broadcasts and a transformative

turn of events in media history—with transgender children and their families from cities and small towns all over the United States (not just well-known liberal enclaves such as Berkeley, California) portrayed in a positive and empathic light. At the time of this writing (late 2016), it seems that a week does not go by without a new media account of TGE children. The January 2017 National Geographic put out a special issue, “Gender Revolution,” that covers the dramatic changes that have occurred in gender identity and expressions. As these changes have rolled out in such a short band of time, we gender specialists, in partnership with the families who are raising the children, can hardly keep up. Every day we learn more and see how much more we have to learn about helping our children discover and fortify their true gender selves.

This book, the first of its kind representing the expertise of a wide number of gender specialists in the field, aims to serve as a substantive guide to inform clinical work with this prepubertal children according to the gender affirmative model (GAM). The authors in this book provide the essential education for psychologists, other mental health providers and professionals from other disciplines to be able to provide culturally competent care to this population of children and their families.

In addition, this book lays the groundwork for further dialogue on and research into developing sound practice for working with TGE children and their families. All chapters examine the issue of TGE children from the perspectives of the individual, the family, and culture. In this volume, national experts review the extant literature on phenomenology, diagnosis, and treatment of children with these presenting concerns; offer case studies from clinical practice; and emphasize the importance of interdisciplinary collaborative practice to address medical, psychosocial, educational, legal, and ethical matters pertaining to their care. One thing is clear: Professionals and families alike need to relearn gender if they are to do no harm to children. This book enables this relearning in the context of clinical guidelines for work with TGE children and their families.

Defining Terms

Our genders are as unique as we are. No one’s definition is the same, and compartmentalizing a person as either a boy or a girl based entirely on the appearance of genitalia at birth undercuts our complex life experiences.

—Janet Mock, *Redefining Realness*

The complexity of gender Mock (2014) referred to, along with the ever changing and not universally agreed upon vernacular of communities and professional associations, especially when referring to children, underscores the daunting task of deciding on the terminology to use throughout this volume. We have created a working language to help the readers conceptualize TGE identities and ways of being. At the same time, we realize other terms—*gender creative*, *gender nonconforming*, *gender variant*, *gender independent*—may be seen throughout academic literature and social media, as well as heard in conversations with and about TGE people, as they describe

dynamics and attributes of the children we are talking about. The reader should be prepared for a bit of a language juggling as they read through and gain more experience working with this population, understanding that each of those terms, while nuanced, refers to the same entity. A scan of the professional literature reveals the term *gender nonconforming* to be the most often used. However, similar to the term *gender variant*, many find that *gender nonconforming* has a somewhat negative connotation of “other than normal,” not too far off from “deviant,” and can serve to reify a normative or “conforming” gender.

No sooner do we think we have all the new terminology about gender clear in our heads than we discover we were all wrong, and that today’s words are already passé. With that in mind, we present the map of our current conceptualization of gender terminology. We see *gender diverse* as the umbrella term that refers to this group of children with two subcategories—transgender and gender expansive (TGE).

Gender identity is not visible: It is one’s innermost concept of self as boy or girl or both or neither—how individuals perceive and know themselves as well as what they call themselves. It is a biological, psychological, social, and cultural concept. One’s *sex* includes several components—chromosomes, relative levels of sex hormones post-puberty, internal genitalia, and external genitalia—the latter used to assign a sex at birth. *Transgender* refers to anyone whose gender identity differs from their sex assigned at birth, that is, everyone else has told you that you are a girl and this is at odds with how you know yourself. A transgender boy was assigned the sex of female at birth and his gender identity is boy. *Cisgender* refers to the majority of the population—individuals whose gender identity aligns with the sex they were assigned at birth, that is, everyone else has told you that you are a boy and that matches how you know yourself. A cisgender boy was assigned the sex of male at birth and his gender identity is boy.

The transgender subcategory includes both binary (either girl or boy) and non-binary gender identities. Transgender children are those who declare their gender as other than reflected by the sex marker on their birth certificate. They can show up at any age, and as early as the toddler years, as individuals are aware of their gender identity between 18 months and 3 years of age (Golombok & Fivuch, 1994). Transgender children typically consistently, persistently, and insisently express a binary or nonbinary gender and realize that their gender is different from their assigned sex. They may begin talking about their gender as soon as they begin to speak and some may express dissatisfaction with their external genitalia. Transgender children are more likely to experience gender dysphoria (i.e., discomfort related to their bodies not matching their internal sense of gender as well as associated social distress) than other gender diverse children, although some transgender children are comfortable with their bodies. These children may state that they are really the other gender or that someone (e.g., doctor, religious authority) made a mistake in their gender assignment. An important part of affirming these children may include changing relational terms (e.g., *brother* to *sister* or *sibling*), pronouns (e.g., *he* to *she* or *they*), honorifics (e.g., *Mr.* to *Miss* or *Mx.*), and names (*Jerald* to *Jessica* or *Jere*).

The biological basis of gender identity in transgender people has been investigated for decades and found to be more complex than originally anticipated (Erickson-Schroth, 2013; Veale, Clarke, & Lomax, 2010). Although a full discussion of this

complexity is beyond the scope of this book, it is important to know that being transgender has no one biological “cause.” At the same time, genetic and neuroanatomic influences have been demonstrated. Twin studies of monozygotic and dizygotic twins demonstrate a genetic component where of twin pairs with at least one transgender twin, monozygotic (identical) twins are much more likely to both be transgender than dizygotic twins (Diamond, 2013). Zhou, Hofman, Gooren, and Swaab (1995) focused on a sexually dimorphic region of the brain, the central subdivision of the bed nucleus of the stria terminalis (BTSc), which is about 2 times larger in cisgender men than in cisgender women. They found that the BTSc in transgender women was found to more closely resemble that of cisgender women (gender identity match) than cisgender men (sex match) and proposed this evidence for a neurobiological basis of gender identity. The history of neuroanatomical studies examining brain differences in transgender and cisgender people has been fraught with small sample sizes and the confounding variable of adult exposure to exogenous hormones, as research methods included examining brains of transgender cadavers who had been exposed to exogenous hormones through hormone therapy (Zhou et al., 1995). However, newer neuroanatomical research studies are able to measure living participants using diffusion tensor imaging, which eliminates the confounder of exposure to hormone therapy, as participants are measured before hormone treatment. Rametti and colleagues (Rametti, Carrillo, Gómez-Gil, Junque, Segovia, et al., 2011; Rametti, Carrillo, Gómez-Gil, Junque, Zubiarrre-Elorza, et al., 2011) have posited that white matter microstructure pattern may be part of the neuroanatomical basis of gender identity. In their study of transgender men who had not initiated hormone treatment (Rametti, Carrillo, Gómez-Gil, Junque, Segovia, et al., 2011), the white matter microstructure pattern in their brains was closer to that of cisgender men, with whom they share a common gender identity, than that of cisgender women, with whom they share a common assigned sex. It is interesting that their study of transgender women who had not initiated hormone therapy yielded somewhat different results (Rametti, Carrillo, Gómez-Gil, Junque, Zubiarrre-Elorza, et al., 2011). The white matter microstructure pattern in the brains of transgender women was in between that of cisgender men and women, a beyond the binary finding. More recent research (Kranz et al., 2014) hypothesizes that white matter microstructure development may be influenced by the hormonal environment in utero during the late stages before birth as well as early during postnatal brain development. Although researchers do not know the exact mechanism or interplay of mechanisms that underlies gender identity development at present, they do know that gender identity has a biological component, supporting the notion that gender identity is not confined to boy or girl only.

Gender expansive refers to anyone whose *gender expression* differs from what is expected, typically based on their gender identity. *Gender expression* refers to readily visible sets of norms, including behaviors, clothing, hairstyle, mannerisms, roles, activities, and so on, that are ascribed to one gender or another—typically referred to as *masculine*, *feminine*, or *androgynous*. Gender expansive children (also known as *gender creative*, *gender nonconforming*, or *gender independent*) do not abide by the prescribed gender norms of their culture. Their gender expression is not consistent with socially prescribed gender roles. Their preferences for toys, clothing, sports, activities,

playmates, hair length and style, and/or accessories are not expected in the culture based on their sex assigned at birth. Gender expansive children are usually perceived to be “pink boys” and “tomboys.”

It is quite possible for an individual to be both transgender in identity and gender diverse in expressions at the same time. For example, a child who was assigned male at birth has a gender identity of girl and expressions consisting of mainly those ascribed as masculine, that is, a tomboy trans girl. Jess is one of those people. Assigned male at birth, Jess, then Jesse, balked at the terrible mistake that had been made, and by age 9 was living in her affirmed gender identity—girl. Yet she never gave up her camouflage pants and short haircut, or the army figures she liked to fight pretend battles with, as she happily lived her life as a girl named Jess.

When we use the *TGE* term in this volume, we refer to all children who challenge and explore gender identity and gender expressions. No matter what language and terminology researchers struggle to develop that will both reflect and be respectful of the multiple ways gender can present itself, children will lead the way in carving out their own self-descriptions, categorizations, and assignments of gender. So, we now build onto preexisting lists (Ehrensaft, 2016) consisting of all the ways we have heard gender described by the children who have come to see us, along with some items borrowed from social media, other people’s writing, and word on the street.

- *Gender fluid children.* Children who defy the norms of binary gender and either slide along a gender spectrum or weave their own intricate individual patterns along the gender web. The word *fluid* here refers to the potential for movement through further development of one’s understanding of their gender.
- *Gender smoothies.* Gender smoothies are a variation on the theme of gender fluid. As one teenager vividly described it, “You see, you take everything about gender, throw it in the blender, press the button, and you’ve got me—a gender smoothie.”
- *Gender hybrids.* Children who combine or alternate between genders, often in a binary way. Among gender hybrids are the following:
 - *Gender Prius.* Half girl/half boy: This gender label was invented by a school-age child who, from the front, looked like any boy in basketball shorts, tank top, and basketball sneakers, and, from the back, had a long blond braid tied at the end with a bright pink bow: “You see—I’m a Prius, a boy in the front, a girl in the back. A hybrid.”
 - *Gender minotaur.* A descriptor for the children who explain that they are one gender on the top and another on the bottom, this usually to account for genitals at odds with the gender they know themselves to be.
 - *Gender-by-season children.* Children who freely express their authentic gender (identity, expressions, or both) during summer and school vacations but never at school, or alternatively use school as the safe place to be their true gender self but keep it under wraps during home-based summers or vacations.
 - *Gender-by-location children.* A close cousin to gender-by-season, a child who knows the locations or is told the locations where free gender expression will be accepted and other locations where it is not, and chooses or is told to keep

their authentic gender muted or under wraps in the unwelcoming locations, such as conservative Aunt Mary's wedding reception.

- *Genderqueer youth*. Not only a category of gender but also a social movement of young people who ask us, "Why do you even bother? We are so beyond gender." They are any and all, never either/or, and they challenge our thinking and carve a new path in which they invite us all to both imagine and embody a world where gender is no longer a defining category. They may also identify with the term *nonbinary*.
- *Protogay children*. Children who start out exploring and pushing the margins of gender on the way to discovering their sexual orientation identity, typically exploring their gender expressions rather than gender identity, though not always.
- *Prototransgender youth*. Children who travel in the exact opposite direction from the protogay children. In the process of exploring their sexual orientation identity, usually in adolescence or young adulthood, they discover, often through their romantic or sexual liaisons, that it is not actually their sexuality but their gender that is in question, and move to understand themselves as transgender.
- *Gender Tootsie Roll Pops*. Children who exhibit one gender on the outside but experience another gender on the inside. To follow the metaphor, the crunchy outside is often the gender that accommodates to the expectations of the surrounding world, and the soft, gooey inside is the stuff of authenticity and realness. The hard candy is in place to protect or shield the inside chewiness from an unaccepting world or an internalized unaccepting part of one's own self. It should be noted that the gender Tootsie Roll Pops, if not provided with resilience building, are often the most at-risk TGE children.
- *Gender-ambidextrous children*. Children who use both their girl self and their boy self interchangeably. It may be the child who is a sister to her brother but a male playmate to the boy across the street, or the child who is full-out "femme" one day but totally masculine-style buff the next. If children can use both their left and right hand on par with each other, so too can they use their girl and their boy part of self, not to mention all the parts in between and beyond those two genders; ergo, the gender-ambidextrous child. They may also identify with the term *bigender*.
- *Gender Teslas*. The gender Tesla is the transgender state some children reach after a stint being a gender hybrid or gender ambidextrous. Some simply go from zero to 60 to get there, meaning from the sex assigned to them at birth to their affirmed gender identity. Some go more slowly. We could say that any child in the transgender category would count as a Tesla, but we are preserving this term for children who are in motion toward an all-one-gender status.
- *Agender youth*. A close cousin of, if not the same as, genderqueer youth. We can play with the word *agender*, seeing its double entendres—"I'm a gender, but not any particular gender," or "I'm devoid of gender [similar to asexual]," which is the more common referent to the meaning of *agender*. These are youth who, similar to their genderqueer compatriots, are also pushing beyond

the limits of constricting gender confines to say, “You can’t catch me,” if it means pinning down a particular gender or any sense of gender at all as being relevant to living a life. Indeed, many agender youth also reference themselves as *genderqueer* or *nonbinary*.

It is important to note that these terms focus on gender, not sexuality. The two are certainly intertwined but are often confused for each other. Not only are the concepts of gender and sexuality intertwined but also ideas about what is normal for one’s gender encompass sexuality—cisnormativity, gender conformance, and heteronormativity. For example, when one disentangles what it means to “be a man” (gender identity—man; sex assumed to be male), one realizes that the underlying expectation is that to “be a man,” a person should also “act like a man” (gender expression—masculine). This expectation commonly comes along with a concurrent assumption that “acting like a man” also means being sexually attracted to women (sexual orientation identity—heterosexual).

Sexuality and sexual orientation identity (e.g., bisexual, heterosexual) have to do with many things, but at their center is the object of desire—do people desire those who are the same or a different gender as they are, those of any gender, those of fluidly defined gender, those who are transgender, those of no declared gender? Gender identity and expression, on the other hand, have to do with how people incorporate their own culture’s definitions about being male or female with their own internal preferences, desires, and recognition of who they are as a boy/man, a girl/woman, a third gender, a fourth gender, and so on. As people reach adulthood, they can think of it this way: Sexual orientation identity has to do with who they get into bed with; gender identity has to do with who they get into bed as. A transgender person can be gay, bisexual, straight, or any other sexual orientation identity—the most common sexual orientation identity of transgender adults is queer, indicating a desire to be understood outside of traditional definitions. A gay person can be cisgender or transgender (gender identity) and gender expansive (e.g., a butch lesbian) or gender conforming (e.g., an effeminate lesbian) in terms of gender expression. And so forth. We hope this differentiation between gender and sexual orientation serves as a helpful compass to hold in hand as this book unfolds and follow the TGE child’s journey through the mental health system.

This book focuses on children; because gender identity develops in early childhood and sexual orientation develops closer to puberty, we spend more time discussing gender identity than sexual orientation. Nearly all sexual orientation identities are based on the gender identity of the person and of the people the person is attracted to. For one’s sexual orientation to develop, one’s gender identity should have already developed. For example, if a person identifies their sexual orientation to be lesbian, then their gender identity is assumed to have already developed as girl/woman. In our work with transgender children, we have begun to see a trend with early and pubertal presentations. The early presenters will typically come in between 4 to 6 years of age with a similar story of always knowing their gender was different than what others were telling them. Their gender identities developed on a similar timeline as those of their cisgender peers. The pubertal presenters will typically come in between 10 to

16 with very confused parents who say my child has never “shown any signs” of being transgender (referring to gender expansiveness). A commonality with the majority of these pubertal presenters is that they come to understand their gender identity was different from their assigned sex as their sexual orientation was developing and as their bodies were changing. The majority of these adolescents identify as both transgender (incongruent gender identity and sex) and not heterosexual (sexual orientation). A mother once called my office in a panic saying, “My 14-year old daughter just told me that she felt that she was a homosexual boy, is that even possible? She has always been so feminine, this just does not make any sense to me.” When I met with this teenager, it was clear that he was a gender expansive (i.e., effeminate) gay boy who happened to be transgender. As many pubertal presenters approach the age of burgeoning sexuality and changing bodies that will define their adult sexual selves, they awaken first to the harsh realization that they have been living in a gender that is just plain wrong for them; once realizing that, they can then begin to sort out their sexual orientation and objects of desire after repositioning themselves in their authentic gender selves. It will be important to hold in mind this delicately choreographed developmental footwork as we as mental health professionals see these preadolescents and adolescents in our clinical offices and help their families understand their seemingly sudden turns of gender.

Additional terminology used throughout this volume is listed below.

- *Transphobia/transnegativity*. A range of attitudes, feelings, and behaviors ranging from the idea that being transgender is less optimal than being cisgender to hatred and disgust toward anyone perceived to diverge from gender expectations.
- *Cisnormativity*. The assumption that everyone is cisgender or should be.
- *Heteronormativity*. The assumption that everyone is heterosexual or should be.
- *Passing*. Being perceived by others as the gender one knows oneself to be, regardless of sex assigned at birth. This term has a different meaning in the LGBTQ community where passing means being perceived as heterosexual. “Passing” for many today, particularly youth, is a controversial issue, as it is dependent on cis- and heteronormative directives of what counts as a “real” man or woman, directives we are trying to dismantle in a gender affirmative construct of gender in all its imaginative hues and shades.
- *Gender Dysphoria versus gender dysphoria*. *Gender Dysphoria*, capitalized, is a diagnosis in the *DSM-5*, and *gender dysphoria*, lowercase, is the experience that “something is not right” regarding one’s gender. This can include body dysphoria—commonly chest dysphoria and genital dysphoria—as well as distress related to being TGE in a cisgender world.
- *Clueing in versus coming out*. *Clueing in* is the experience of coming to an understanding of one’s gender and/or sexual orientation as being different than expected (an internal process). *Coming out* is the experience of sharing one’s gender and/or sexual orientation with others (an interpersonal process).
- *Gender transition*. An individual process that may consist of social, legal, medical, and/or surgical changes in gender. A social gender transition can include a new name, pronouns, and honorifics (e.g., *Ms.*) and presenting as one’s

true gender self in selected or all environments. Legally, one may get one's new name and/or gender updated on one's identification documents. Medical interventions include puberty-blocking medication and masculinizing and feminizing hormone therapy (see Chapter 12, this volume). More than 10 surgical interventions may be accessed as a part of gender transition—these include facial, chest, and genital surgeries.

- *Binding*. When a person, typically postpubertal and assigned female at birth, attempts to flatten their chest to present the appearance of a masculine chest. Many youth attempt to use ace bandage wrap or duct tape, both of which can cause pain and potential damage to one's health. Several online companies sell chest binders in many different skin tones that are safer for use. *Padding* is the term for adding breast forms to present the appearance of breasts.
- *Tucking*. When a person, typically assigned male at birth, attempts to minimize their genital bulge. Children can be creative, using Band-Aids to tape their penises back. Several online companies sell gaff panties to assist in tucking that are safer for use. *Packing* is the term for adding the appearance of a genital bulge.

Stopping the Harm

My third-grade teacher called my mother and said, “Ms. Cox, your son is going to end up in New Orleans in a dress if we don't get him into therapy.” And, wouldn't you know, just last week I spoke at Tulane University and I wore a LOVELY green and black dress.

—Laverne Cox

Controversy exists as to whether the *DSM-5* Gender Dysphoria diagnosis for children pathologizes normal variations in gender role behaviors and adaptations or represents a psychiatric medical disorder (Lev, 2005; see also Chapter 11, this volume). WPATH and the Endocrine Society have both published guidelines that include treatment of adolescents (Hembree et al., 2009; WPATH, 2011), yet no expert consensus on the treatment of prepubertal children exists. This is a particularly glaring problem because research has indicated that the social support of children in their gender development is directly correlated with mental health outcomes for children. Yet the field of psychology is divided on the form that social support should take and what constitutes “gender health” in children. At the same time, legislative actions have already been taken or are being proposed in three states in the United States (California, New York, New Jersey) that prohibit the use of therapeutic interventions that attempt to change a minor's gender behaviors.

Differing perspectives dictate divergent treatment models for prepubertal and early adolescent children and youth (de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2011; Hidalgo et al., 2013; Hill, Menvielle, Sica, & Johnson, 2010; Spack et al., 2012; Zucker & Cohen-Kettenis, 2008). Prior treatment models have included a “wait and see if these behaviors desist” approach; prohibition of starting adolescents on cross-sex

hormones until age 16 (Netherlands model); and attempts to behaviorally modify gender-nonconforming behavior in young children and help them “live in their own skin,” that is, the sex assigned to them at birth (the Centre for Addiction and Mental Health model in Toronto; this clinic was recently closed).

In contrast, the GAM, upon which this book is based, is emerging as the treatment of choice of many gender specialists in the United States and in other countries. We posit the GAM to be the best practice for children and adolescents in their gender development. Central to the GAM is the evidence-based idea that attempting to change or contort a person’s gender does harm. Instead, the GAM defines *gender health* as follows: the opportunity for a child to live in the gender that feels most real and/or comfortable for the child and the ability for children to express gender without experiencing restriction, criticism, or ostracism. In the model, the role of the mental health professional is a facilitator in helping a child discover and live in their authentic gender with adequate social supports. We as mental health professionals are their translators—striving to understand what they are telling us about their gender in words, actions, feelings, thoughts, and relationships.

Even though transgender people encounter multiple obstacles, including coming out, as well as possibly losing family, friends, partners, and employment opportunities, rates of regret of gender transition in adults are extremely low (0%–2%; Pfäfflin & Junge, 1998), with the majority of transgender adults stating that their only regret is not transitioning earlier. In Beemyn and Rankin’s (2011) *The Lives of Transgender People*, a recurring theme was seen across the nearly 3,500 adults they interviewed. The story went something like this:

If only I had the supports and green light that some of the young children have today, I would have had such a better life. I always knew since I was little that my gender was not what people thought, but there was no place to go with it. So, I had to wait, and wait, with many years of pain and suffering until I could get to the place that was “me.”

The GAM is informed by the stories of transgender adults who have been telling us this for years. As more and more providers become proficient in working with TGE children, they won’t have to wait near as long to be who they are.

As psychologists and mental health providers, we are bound by the oath that dictates the actions of all medical and mental health professionals: Do No Harm. Yet all around us, physicians, psychiatrists, and child therapists are doing just that—in clinics and private practice consultation rooms where parents are advised to take away their little boys’ dolls and pink tights or make their little girls grow out their buzz cuts; mothers and fathers are directed to ignore or punish their children’s “inappropriate” gender expressions and pay attention to or reward only the “gender-appropriate” ones; and families are sent home to make sure the TGE children are redirected to same-sex friendships and to their same-sex parent as the main or only parent to identify with. Replacing that viewpoint with the perspective of the GAM provides a new lens through which people can clearly see the vibrant plethora of TGE children. Looking through this lens, one can see children who declare, sometimes at a very early age, that the gender they are is not the one they were assigned at birth.

Ehrensaft (2011, 2016) created the concept of the *gender web* to guide viewing of the children. The gender web is a four-dimensional structure, the three material dimensions being nature, nurture, and culture, and the fourth dimension being time. Imagine a spider web stretched out in a tree to get the visual image, a web that may change its dimensions over time as the spider enhances its home. The gender web is each child's personal creation, spinning together the three major threads of nature, nurture, and culture that interface to allow the child to construct a gender self. Like fingerprints, no two individuals' gender webs will be exactly the same; unlike fingerprints, the gender web is not immutable—it will inevitably change over time. While people are little, to promote individual *gender health*, defined as freedom to explore and live in the gender that feels most authentic, the only person who should be doing that spinning is the child. If parents grab the thread of the web as children are spinning it, and tell them what their gender has to be, rather than listening as children spell out their gender or rather than watching them do their own creative work, the web risks ending up as a tangled knot of threads rather than a beautifully spun web that shimmers and glows. Alternatively, if parents and the surrounding environment facilitate, protect, and respect children's creative spinning, they stand to grow up gender healthy and proud. It is the role of the gender affirmative clinician to assure that the latter occurs.

The Gender Affirmative Model: Theoretical Basis

The major theoretical bases informing the GAM of clinical practice are: (a) no gender identity or expression is pathological; (b) gender presentations are diverse and vary across cultures, requiring our cultural sensitivity; (c) according to current knowledge, gender involves an integration of biology, development and socialization, and culture and context, with all of these bearing on any individual's gender self; (d) gender may be fluid, and is not binary, both at a particular time point and if and when it changes within an individual over time; and (e) any pathology that is present is more often caused by cultural reactions to gender diversity (e.g., transphobia, homophobia, sexism) than by internal psychological disturbances within the child (Hidalgo et al., 2013). Implicit in this model is a focus on resilience, coping, and wellness. The GAM serves to assist in facilitating gender health, not labeling any part of gender as an illness. We do not see gender diversity as an illness, but rather a variation of health. We define *gender health* as a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection (Hidalgo et al., 2013). Recent emerging research indicates that those children who are not allowed these freedoms are at later risk for negative psychosocial outcomes (Ryan, Huebner, Diaz, & Sanchez, 2009). The GAM is supported by this research, as it also finds that family acceptance acts as a protective factor against these negative outcomes and that building gender resilience helps a child be confident in a world that may be far from accepting TGE people.

The GAM holds several tenets. Primary to these tenets is that we, as care providers, need to be able to reevaluate our social constructs of gender and sexuality within our cultural context and the positions we impose on children. We see gender identity and expression as a basic human right. GAM practitioners should remain open to fluidity and changes overtime and listen closely to our children's best attempt to explain themselves and respond in affirming way. As there is no way to know with complete certainty what the gender and sexuality of a child will be once they reach adulthood, much of the work of GAM clinicians involves helping parents cope with the "not knowing" and moving forward to deal with what is known. As therapists, we should increase our ability to make use of the countertransference and manage our own biases and minimize the risk in collapsing our clinical judgment. One priority is to tease out what is gender dysphoric stress and something else and treat in a triage and harm reduction fashion, as well as go deep into the psychological and social experiences of the children we treat in the context of the family, community, and culture in which they live. As GAM practitioners, we aim to increase our capacity to not know, be curious, and celebrate human diversity.

Guide to This Volume

To that end, we have organized this volume to guide all of us in accomplishing this goal. We have had the privilege of working with a group of experts from coast to coast in the United States to bring this work together. Some of us are transgender ourselves, some have raised TGE children, some have TGE romantic partners, and all of us have been touched by the lives of TGE people around us. We lecture, train, write, advocate, build a professional community, and conduct research on the lives of these TGE people who have been our greatest teachers.

Each of the following chapters is designed to be its own independent learning module about psychological, social, and community issues as we get in clearer focus the infinite variety and rapidly growing population of TGE children across the globe. Chapters 2 through 6 focus on the individual child in development and psychotherapy. This section brings the reader through developmental theories of gender development, provides tools to sharpen skills at differentiating gender identity and expressions, increase consciousness about issues impacting TGE children of color, considers the accompanying psychological factors that often show up alongside gender creativity, and delves into trauma-informed practice through the GAM lens. Chapter 7 is a comprehensive child and family assessment guide that includes guidance for using both gender-specific and general instruments with TGE children. Chapters 8 through 10 center on family dynamics and family therapy. This section highlights the importance of therapeutic intervention focused on the parents' emotional response to discovering they have a TGE child, building family resilience through using multiple therapeutic modalities, and navigating clinical work with families in conflict. Chapters 11 and 12 cover the interdisciplinary, collaborative, and intersectional nature of GAM providers, as it truly takes a village to create the

conditions necessary for gender health. These chapters discuss creating a network of professionals across disciplines, advocating on the front lines for TGE children and their families and best practices for coordinating care with medical providers. Chapter 13, our conclusion, brings up the current limitations of the GAM as well as ideas on where to go from here.

A Final Note Before We Start

A problem facing untrained providers in the mental health community is that more and more TGE children and their families are seeking the services of psychologists and other mental health providers to help gender explorations or conundrums. Although many resources have been developed to address the needs of transgender adults, mental health providers typically have not received adequate training to guide them in supporting and treating the younger cohort of TGE children and their families.

The source of the lack of professional training is multifaceted: (a) graduate mental health and health care education rarely addresses issues pertinent to working with these children and their families; (b) little to no attention to this topic is paid by primary psychological and medical journals; (c) very few educational resources exist on this topic; (d) formal training on this issue is exceedingly rare; and (e) training that does exist is often outmoded, incorrect, and/or endorses practices that are likely to cause harm rather than promote health. Much of the available research has focused on the etiology of being transgender and research on transgender adults. Although affirming practice interventions and protocols for working with transgender adults are widely available, very little guidance exists for therapists who are working with children and families. Consequently, mental health providers increasingly face daunting challenges in the diagnosis and treatment of these children, who are showing up in larger numbers each year (de Vries & Cohen-Kettenis, 2012; Spack et al., 2012; Zucker et al., 2008), and providers are at risk for providing substandard care because of lack of access to proper training.

Recognizing a need for clearer guidance for mental health professionals providing services for children with gender-related concerns, this edited book is a compilation of the work of a mental health and medical group of experts who have experience working with TGE children, with the aim of increasing the clinical and cultural competence of psychologists and allied mental health professionals who will be treating these children.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- American Psychological Association. (2014). *Fact sheet: Gender diversity and transgender identity in children*. Washington, DC: Author. Retrieved from <http://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf>

- American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*, 832–864. <http://dx.doi.org/10.1037/a0039906>
- Beemyn, G., & Rankin, S. (2011). *The lives of transgender people*. New York, NY: Columbia University Press.
- Carroll, L. (2010). *Counseling sexual and gender minorities*. Upper Saddle River, NJ: Pearson.
- Case, K. A., Stewart, B., & Tittsworth, J. (2009). Transgender across the curriculum: A psychology for inclusion. *Teaching of Psychology, 36*, 117–121. <http://dx.doi.org/10.1080/00986280902739446>
- Cole, S. S., Denny, D., Eyler, A. E., & Samons, S. L. (2000). Issues of transgender. In L. T. Szuchman & F. Muscarella (Eds.), *Psychological perspectives on human sexuality* (pp. 149–1954). New York, NY: Wiley.
- Corliss, H. L., Shankle, M. D., & Moyer, M. B. (2007). Research, curricula, and resources related to lesbian, gay, bisexual, and transgender health in U.S. schools of public health. *American Journal of Public Health, 97*, 1023–1027. <http://dx.doi.org/10.2105/AJPH.2006.086157>
- DePaul, J., Walsh, M. E., & Dam, U. C. (2009). The role of school counselors in addressing sexual orientation in schools. *Professional School Counseling, 12*, 300–308. <http://dx.doi.org/10.5330/PSC.n.2010-12.300>
- de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality, 59*, 301–320. <http://dx.doi.org/10.1080/00918369.2012.653300>
- Diamond, M. (2013). Transsexuality among twins: Identity concordance, transition, rearing, and orientation. *International Journal of Transgenderism, 14*, 24–38. <http://dx.doi.org/10.1080/15532739.2013.750222>
- Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children*. New York, NY: The Experiment.
- Ehrensaft, D. (2016). *The gender creative child: Pathways for nurturing and supporting children who live outside gender boxes*. New York, NY: The Experiment.
- Erickson-Schroth, L. (2013). Update on the biology of transgender identity. *Journal of Gay & Lesbian Mental Health, 17*, 150–174. <http://dx.doi.org/10.1080/19359705.2013.753393>
- Goldberg, A. B. (Producer). (2007, April 27). *My secret self: A story of transgender children* [Television program]. Houston, TX: ABC News.
- Golombok, S., & Fivuch, R. (1994). *Gender development*. Cambridge, England: Cambridge University Press.
- Gonzalez, M., & McNulty, J. (2010). Achieving competency with transgender youth: School counselors as collaborative advocates. *Journal of LGBT Issues in Counseling, 4*, 176–186. <http://dx.doi.org/10.1080/15538605.2010.524841>
- Goodrich, K. M., & Luke, M. (2009). LGBTQ responsive school counseling. *Journal of LGBT Issues in Counseling, 3*, 113–127. <http://dx.doi.org/10.1080/15538600903005284>
- Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer, W. J., III, Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of

- transsexual persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology and Metabolism*, *94*, 3132–3154. <http://dx.doi.org/10.1210/jc.2009-0345>
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development*, *56*, 285–290. <http://dx.doi.org/10.1159/000355235>
- Hill, D. B., Menvielle, E., 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*, 6–23. <http://dx.doi.org/10.1080/00926230903375560>
- Kranz, G. S., Hahn, A., Kaufmann, U., Küblböck, M., Hummer, A., Ganger, S., . . . Lanzenberger, R. (2014). White matter microstructure in transsexuals and controls investigated by diffusion tensor imaging. *The Journal of Neuroscience*, *34*, 15466–15475. <http://dx.doi.org/10.1523/JNEUROSCI.2488-14.2014>
- Lev, A. I. (2005). Disordering gender identity: Gender identity disorder in the *DSM-IV-TR*. *Journal of Psychology & Human Sexuality*, *17*(3/4), 35–69. http://dx.doi.org/10.1300/J056v17n03_03
- Mapes, D. (2012, February). More transgender kids seeking help, getting treatment. *MSNBC*. Retrieved from https://vitals.nbcnews.com/_news/2012/02/20/10450683-more-transgender-kids-seeking-help-getting-treatment?d=1
- Mock, J. (2014). *Redefining realness: My path to womanhood, identity, love, and so much more*. New York, NY: Atria.
- National Geographic. (2017). *Gender revolution* [Special issue]. Available from <https://www.nationalgeographic.com/magazine/2017/01/>
- Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., . . . Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*, *306*, 971–977. <http://dx.doi.org/10.1001/jama.2011.1255>
- Pfäfflin, F., & Junge, A. (1998). *Sex reassignment: Thirty years of international follow-up studies after SRS: A comprehensive review, 1961–1991*. Düsseldorf, Germany: Symposium Publishing.
- Pupil rights: Sex-segregated school programs and activities, S., 1266, § 221.5 (2013).
- Quart, A. (2008, March 16). When girls will be boys. *The New York Times*. Retrieved from <http://www.nytimes.com/2008/03/16/magazine/16students-t.html>
- Rametti, G., Carrillo, B., Gómez-Gil, E., Junque, C., Segovia, S., Gomez, Á., & Guillamon, A. (2011). White matter microstructure in female to male transsexuals before cross-sex hormonal treatment: A diffusion tensor imaging study. *Journal of Psychiatric Research*, *45*, 199–204. <http://dx.doi.org/10.1016/j.jpsychires.2010.05.006>
- Rametti, G., Carrillo, B., Gómez-Gil, E., Junque, C., Zubiarré-Elorza, L., Segovia, S., . . . Guillamon, A. (2011). The microstructure of white matter in male to female transsexuals before cross-sex hormonal treatment: A DTI study. *Journal of Psychiatric Research*, *45*, 949–954. <http://dx.doi.org/10.1016/j.jpsychires.2010.11.007>

- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, *123*, 346–352. <http://dx.doi.org/10.1542/peds.2007-3524>
- Sexual orientation change efforts, S., 1172, § 865 (2012).
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*, *129*, 418–425. <http://dx.doi.org/10.1542/peds.2011-0907>
- Speigel, A. (2008, May 7). Two families grapple with sons' gender identity: Psychologists take radically different approaches in therapy. *National Public Radio: All Things Considered*. Retrieved from <https://www.npr.org/2008/05/07/90247842/two-families-grapple-with-sons-gender-preferences>
- Veale, J. F., Clarke, D. E., & Lomax, T. C. (2010). Biological and psychosocial correlates of adult gender-variant identities: A review. *Personality and Individual Differences*, *48*, 357–366. <http://dx.doi.org/10.1016/j.paid.2009.09.018>
- World Professional Association for Transgender Health. (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people* (7th version). Retrieved from <https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf>
- Zhou, J. N., Hofman, M. A., Gooren, L. J., & Swaab, D. F. (1995, November 2). A sex difference in the human brain and its relation to transsexuality. *Nature*, *378*, 68–70. <http://dx.doi.org/10.1038/378068a0>
- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? [Letter to the editor]. *Journal of Sex & Marital Therapy*, *34*, 287–290. <http://dx.doi.org/10.1080/00926230802096192>
- Zucker, K. J., & Cohen-Kettenis, P. T. (2008). Gender identity disorder in children and adolescents. In D. L. Rowland & L. Incrocci (Eds.), *Handbook of sexual and gender identity disorders* (pp. 376–422). Hoboken, NJ: Wiley. <http://dx.doi.org/10.1002/9781118269978.ch13>