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Working with gender nonconforming children : why does the debate continue?

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ABSTRACT

This original empirical study explored why consensus about best practice models for working with gender nonconforming children and their families has not been reached, and identified practice frameworks available to assist clinical social workers in meeting the social and emotional needs of this vulnerable population. The experience and perspectives of 14 Canadian gender identity experts were elicited through self-developed, semi-structured interviews composed of questions that encouraged professionals to reflect on their opinion as to why the debate about how to best respond continues, as well as, their philosophical and theoretical approach to caring for gender nonconforming children and their families. Major findings confirmed the controversies surrounding different approaches to care, and the intensity of the ongoing debate in Eastern Canada where two theoretical approaches to care dominate: 1) an affirmative practice framework and 2) a developmental biopsychosocial treatment model. Key findings suggest that the lack of empirical data to support practice and treatment modalities, the complexity of caring for these children, provider anxiety, and the prevailing power of the traditional treatment approach contribute to the lack of consensus. The implications of this study suggest that future research explore further development of affirmative interventions for gender nonconforming children, the efficacy of an affirmative approach, as well as, the impact of theoretical practice frameworks on the social and emotional wellbeing of the individual child and family system.

WORKING WITH GENDER NONCONFORMING CHILDREN: WHY DOES THE DEBATE CONTINUE?

A project based on the independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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"We can only be said to be alive in those moments when our hearts are conscious of our treasures." - Thornton Wilder

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CHAPTER I

Introduction

There is evidence in literature (Brill & Pepper, 2008; Malpas, 2011; Menvielle, 2012; Vanderburgh, 2009) and in the media (Gorman, 2012; Green, 2013; Gulli, 2014; Padawer, 2012) of the emergence of new phenomena in which parents are supporting the social expression of their gender nonconforming children at very young ages. Concerned about their child's social and emotional well-being, parents are bringing their children to gender identity experts (medical and mental health professionals) for guidance as they support their child and navigate school and community systems. According to the American Psychological Association (2012), parents are concerned about their gender nonconforming children because of the level of distress they experience about their assigned gender or the gender roles they are expected to follow. For some, social transgender expression is a passing phase, but for others it is not. Gender nonconforming children and youth often feel isolated, experience difficult and stressful social relationships, and are targets of bullying (American Psychological Association, 2012; Brill & Pepper, 2008; Burge, 2007; Ehrensaft, 2011a; Hill & Menvielle, 2009; Menvielle, 2012). Parents who fear losing their transgender children to substance abuse, self-harm, depression or suicide, are supporting their transition. In his recent New York Times article, S/He, Jesse Green addresses the difficult decisions parents with transgender children have to make, and the urgency with which they need to make them (American Psychological Association, 2012; Ehrensaft, 2011b; Green, 2012; Vanderburgh, 2009).

Identified in the literature and in popular culture as lesbian, gay, bisexual, transgender and queer (LGBTQ) youth, an evolving body of research suggests that these youth face a unique set of social and emotional issues. For instance, LGBTQ youth are at higher risk for many addiction and mental health issues, and have experienced and/or fear the threat of bullying and violence. Transgender children and adolescents appear to be at the greatest risk. (Ehrensaft, 2011a; Heck, Flentje, & Cochran, 2011; Kenagy, 2005; Morrow, 2004; Ryan, Russell, Huebner, Diaz & Sanchez, 2010; Travers, Bauer, Pyne, Bradley, Gale & Papadimitriou, 2012; van Wormer & McKinney, 2003). In her study on transgender health, Kenagy (2005) found that 30% of transgender participants had attempted suicide. Of those who had attempted suicide, 67.3% reported that the attempt was because they were transgender. According to Kim Pearson, executive director for Trans Youth Family Allies (TYFA), "trans kids are the highest suicide risk on the planet, bar none" (as cited in Green, 2012).

There are no accurate statistics on the number of gender nonconforming children, and the research on the phenomenon is scarce. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) focuses on the *gender dysphoria* (distress) children experience rather than categorize a pathological disorder. Not surprisingly, "clinicians and researchers are engaged in a passionate debate about how to best help" these children (Hill, Menvielle, Sica & Johnson, 2010, p. 7). Practitioners disagree about how transgenderism in children and adolescents should be categorized and addressed. Those involved in caring for these children and their families (pediatricians, family doctors, psychiatrists, psychologists, social workers and family therapists) have not reached a consensus on the need to diagnose or suggested therapeutic practices to support transgender children and youth (Byne, Bradley, Coleman, Eyler, Green, Menvielle & Tompkins, 2012; Ehrensaft, 2011b; Hill et al., 2010; Stone Fish & Harvey, 2005;

Wallace & Russell, 2013). Two opposing practice models include the traditional *normative* intervention and the more recent *affirmative* practice framework.

Reid Vanderburgh (2008) is a trans identified therapist whose qualitative research is based on his clinical experience with over 350 adults and children seeking transition from one gender to another. Vanderburgh criticizes the normative treatment plan for children who experience gender dysphoria. *Normative*, or *reparative* therapy, emphasizes guiding children towards more "gender appropriate" behaviors, dress and friendships (p. 135). Vanderburgh identifies the current lack of transaffirmative support for children, families, schools and institutions, and suggests that the role of the family therapist is crucial to guiding families and schools as they navigate unknown territory.

As a result of their investigations, researchers have identified protective factors for minimizing risks and have suggested clinical guidelines for working with gender nonconforming and transgender children and their families (Heck et al., 2011; Hill et al., 2010; Hunter & Hickerson, 2003; Malpas, 2011; Morrow, 2004; Ryan, 2009; Travers et al., 2012; Vanderburgh, 2009). In their study, Hunter and Hickerson (2003) describe the more recent phenomenon of affirmative practice when working with LGBTQ clients. They define affirmative practice as a "frame of reference" a strength based, empowerment approach that "guides practice along the lines of helping these clients lead happy and fulfilling lives" (p. 206). The more recent terms *transaffirmative* or *transpositive* refer to approaches that aim to "affirm whatever unique identity the individual wants to develop" and "educate others about transgender persons, and advocate for their political, social, and economical rights" (p. 199).

Given that children are vulnerable research subjects and that research with minors inevitably raises considerable ethical concerns, empirical data pertaining to the treatment and developmental outcomes of gender nonconforming and transgender children is sparse and relies heavily on qualitative case studies with older teens and young adults. In light of the fact that there are a number of risk factors facing transgender youth and the more recent propensity towards trans affirmative practice, I am curious as to why the debate about diagnosis and appropriate treatment continues. As part of my field experience, I worked on a gender identity assessment team at a children and family mental health centre. Personally, I have a longstanding interest in and commitment to working equitably and compassionately with the LGBTQ community; I acknowledge my bias towards an affirmative practice framework.

Why does the debate on how to best respond to gender nonconforming and transgender children and their families continue? The purpose of this qualitative study is twofold: 1) to explore why consensus about best practice models for working with gender nonconforming and transgender children and families has not been reached among professionals working with this population, and 2) to raise awareness of the practice frameworks available to assist clinical social workers in meeting the social and emotional needs of this population.

For the purposes of this research study, the terms *children* and *youth* are used interchangeably and refer to children ranging in age from 3-18 years. The term *gender nonconforming* is used broadly to include *gender-fluid, gender-variant, gender-queer and transgender* children, and refers to children whose gender identity does not match their assigned birth gender.

The sample for this qualitative study involved 14 participants. In-depth, narrative data was gathered using a self-developed interview guide. Participants' responses to the interview may contribute to a deeper understanding of why the debate about diagnosing and treating gender nonconforming children and youth continues, and why a consensus on best practice models has not been achieved. The findings may influence how clinical social workers work with gender nonconforming and transgender children and their families as they match a practice model with the individual child and family system. Participation in the study may have given a voice to clinicians and professionals who work with gender nonconforming and transgender youth and families. Moreover, clinicians who participated in the study may now be more inclined to reach out to other clinicians and professionals and continue to build community.

CHAPTER II

Literature Review

Introduction

The following literature review is a presentation and discussion of the theoretical literature and empirical research relevant to the question: *Why does the debate on how best to respond to gender nonconforming and transgender children and their families continue?*

The first portion of this chapter reviews the more recent phenomena of parents supporting young children to socially transition and explores the concept of gender identity development. The second section describes the risk and protective factors pertinent to gender nonconforming and transgender children, as well as the diagnosis and treatment debates that contribute to the ongoing debate about best practice models for this population. The final section of the chapter reviews the existing research relevant to this study, and draws attention to the limitations of the current literature relevant to my topic and study objectives.

Recent Phenomena

Wren (2000) writes, “People with cross-gender identification have been recognized through history and across cultures and have met with varying degrees of tolerance” (p. 221). Drescher (2010) explores the interwoven history of sexual orientation and gender identity, exposing the “long standing gender beliefs that employ implicit cultural ideals about essential qualities of men and women” (p. 431). Pleak (2011) describes gender variance and transgenderism as “uncommon facets of humankind that have been present since the earliest of times," with various cultures and societies managing in many different ways, "from acceptance and accommodation" to "hostility and persecution" (p. 608). The longstanding historical documentation of gender variance notwithstanding, there is recent evidence in the literature (Brill & Pepper, 2008; Ehrensaft, 2011b; Malpas, 2011; Menvielle, 2012; Vanderburgh, 2009) and in the media (Gorman, 2012; Green, 2013; Gulli, 2014; Padawer, 2012) of the emergence of a phenomenon in which parents are supporting the social expression of their gender nonconforming children at very young ages. Concerned about their child's social and emotional well-being, parents are bringing their children to gender identity experts (medical and mental health professionals) for guidance as they support their child and navigate school and community systems. Children's gender identity clinics in Boston, Los Angeles, Toronto, London, Ottawa and Amsterdam report a four-fold increase in the number of children and families who are accessing care and guidance (Russell & Zaitzow, 2013).

Why are parents and caregivers concerned?

Parents are concerned about their gender nonconforming children because of the level of distress they experience about their assigned gender or the gender roles they are expected to follow (American Psychological Association, 2012; Brill & Pepper, 2008; Burge, 2007; Ehrensaft, 2011a; Hill & Menvielle, 2009; Menvielle, 2012). As Nancy Quay, a psychotherapist at the University of Michigan's gender services program, reported, some parents worry, "How do you move through society with a gender-variant child? What do you tell your neighbors? How do you keep your child safe?" (Gorman, 2012, p.1). Gender nonconforming children and youth often feel isolated, experience difficult and stressful social relationships, and are targets of bullying (Burdge, 2007; Ehrensaft, 2011b; Morrow, 2004; Ryan, 2009; Ryan et al., 2010;

Wallace & Russell, 2014; Zucker, Owen, Bradley, & Ameeriar, 2002). Parents who fear losing their transgender child to depression, self-harm, or suicide are now supporting their transition.

Experts recognize the difficult decisions parents with gender nonconforming and transgender children have to make, and the urgency with which many feel they need to make them (American Psychological Association, 2012; Green, 2012; Vanderburgh, 2009). According to Kimberley Manning, a political science professor and gender politics researcher at Concordia University in Montreal, “The gender binary of male and female in our society is so ingrained that, for most parents, it’s shocking and bewildering” (Gulli, 2014, p. 41). May Friedman, a professor of social work and women’s studies research at Ryerson University in Toronto, commented about parents’ struggles:

> All we want to do is get it right, and we’re terrified about whether we’re going to harm our kids more by teaching them to conform to gender norms or more by teaching them to disobey. It’s about fear and love and trying not to mess them up too badly (Gulli, 2014, p. 41).

How common are gender nonconforming children?

There are no accurate statistics on the number of children who express gender variant behaviors or are diagnosed with gender dysphoria. According to well-known pediatric endocrinologist Dr. Norman Spack, “at present, no one really knows how many transgender children there are” (Brill & Pepper, 2008, p. 2). Dr. Spack has many years of clinical experience with this population at the Children’s Hospital in Boston, MA, and offers that gathering statistics is challenging because doctors in the United States cannot conduct *population-based research* on such issues. Spack reports that gender specialists estimate that 1 in 500 children may be significantly gender variant; he wonders if those numbers may be higher. Prevalence studies, done primarily with adults, can only account for adults who seek medical attention; not all transgender people experience gender dypshoria and therefore do not present to medical clinics.

According to the World Professional Association for Transgender Health (WPATH), studies suggest that the prevalence of male-to-female transgender people ranges from 1:11,900 to 1:45,000, and the prevalence of female-to-male transgender individuals ranges from 1:30,000 to 1:200,000 (Coleman, E., et al., 2012).

In their longitudinal study on twins in the Netherlands, van Beijsterveldt, Hudziak, and Boomsma (2006) found that the prevalence of cross-gender behavior (as measured by maternal reports of behaving like or wishing to be the opposite gender) was 3.2% for 7 year old boys and 5.2% for 7 year old girls, and decreased to 2.4% and 3.3% respectfully for 10 year old boys and girls (p. 647). While there is no clear prevalence data, trans activists and researchers argue that some very young gender nonconforming children simply *know* they are trans. Kennedy and Hellen (2010) found that 80% of trans adults knew before they left primary school, and Beemyn and Rankin (2011) found that 82.6% of trans identified people knew before they were 12 years old.

Activists and advocates

Trans activists and advocates have lobbied hard for civil rights, access to care, and promoting tolerance and acceptance of gender variance (Drescher, 2010). Canadian government organizations such as the Public Health Agency of Canada and the Human Rights Commission of Ontario have transformed policies and procedures, “mandating and legislating acceptance and accommodation” (Gulli, 2014, p. 39). In 2012, a human rights tribunal ruling allowed name and gender marker changes on Ontario birth certificates without gender reassignment surgery. In Toronto, Ontario, social and children’s services such as the Toronto District School Board, Toronto Children’s Aid Society, Delisle Youth Services, City of Toronto Youth Services and Rainbow Health Ontario have all developed and are delivering trans-positive policies. Rainbow

Health Ontario has published information booklets for parents who are advocating for their gender- independent child's well-being and basic human rights (Ontario Human Rights Commission, 2011; Rainbow Health Ontario, 2013; Russell & Zaitzow, 2013).

Globally, Australia and Nepal allow adults to mark male, female or a third gender on official documents. In November 2013, Germany became the first European nation to legally recognize a third gender for babies born with ambiguous genitalia. In a law "designated to fight discrimination" parents may legally decide to wait until later in life to assign their baby's gender, never actually declare a gender, or leave their child's gender "undetermined" or "unspecified" on birth certificates (Donaldson, 2013).

Gender Identity Development

According to Brill and Pepper (2008), psychologists believe that one's core identity has the following three components; gender identity, gender expression, and sexual orientation (p.12). It is believed that these three components are distinct and separate from one another, develop in early childhood, are set by age six, and are then re-examined in adolescence. Bryan (2012) defines *gender identity* as "our inner most concept of self as male, female or queer," *gender expression* as "the way people externally communicate their gender identity to others through behavior, clothing, hairstyle, voice, etc.," and *sexual orientation* as "the direction of one's sexual attraction to the same sex (homosexual), the opposite sex (heterosexual), both men and women (bisexual) or any sexual identity (pansexual)" (p. 5). In Western society it is generally assumed that all three are aligned, when in reality many individuals vary in one or more of these aspects of self.

Gender identity is a very important part of a preschooler's definition of self. Experts describe gender identity development as a developmental process of "determining and consolidating one's gender identity" (Bryan, 2012, p. 5), which manifests first in toddlers and continues throughout adulthood. As noted by Davies (2011), "by the age of 2, toddlers have learned their gender and, through socialization, are beginning to be aware of the characteristics associated with each gender" (p. 297). Each one of us develops our identities within a wide context of ethnicity, class, culture and religion, with each of these factors influencing social gender development and a child's inner sense of being. It can be particularly challenging if a child's core identity does not align with their community's ethnic, racial and religious expectations (Brill & Pepper, 2008; Ehrensaft, 2011b; Menvielle, 2012; Ryan, Huebner, Diaz & Sanchez, 2009; Saketopoulou, 2011; Sennott, 2011).

According to Ehrensaft (2011a), *assigned gender* refers to the gender placed on a child's birth certificate, and is determined by the physician or those present at the birth based on the external appearance of genitalia (biological or natal sex). *Affirmed gender* refers to the gender individuals assert as the one they identify with, which may or may not match their assigned gender. In their book *The Transgender Child*, Brill and Pepper (2008) provide the following definitions: *cisgender* refers to an individual whose gender identity and gender expression align with their natal and assigned sex; *transgender* refers to individuals whose gender identity does not match their assigned birth gender; *gender-variance or gender nonconforming* refers to behaviors and interests that challenge what is considered normal for a person's assigned natal sex (p. 4-5).

The majority of children will find that their assigned gender aligns with their gender identity. If their gender identity does not fit with their assigned gender, or natal sex, children as young as 24-28 months may begin to voice their disagreement. Parents often remember early signs that their child was struggling with their assigned gender. Cloud (2000) wrote:

> Even before her son turned two, Sherry Lipscomb noticed that he wasn't like other boys. When she took him shopping, he would go gaga at sparkly dresses. He would toss his baby blanket around his head like a wig and prance on the balls of his feet (as cited in Ehrensaft, 2011a, p. 532).

According to Ehrensaft (2011a), g*enderists* assume there are only two genders and those who stray from their assigned male/female identities are to be challenged, pathologized and coaxed towards normativity. Ehrensaft defines *transphobia* as a fear or hatred of those who do not accept the gender assigned to them at birth. It has been well established that transphobic attitudes and behaviors place transgender and gender nonconforming children and youth at risk of physical and psychological harm (Burdge, 2007; Ehrensaft, 2011a; Heck et al., 2011; Hill et al., 2010; Kenagy, 2005; Ryan, 2009; Ryan et al., 2010; Stone Fish & Harvey, 2005; Travers et al., 2012).

Developing gender constancy

While this review of the literature is by no means complete, I found one perspective that referenced gender constancy with respect to gender identity development. According to Zucker Wood, Singh & Bradley, (2012), *gender constancy* is defined as a child's cognitive understanding that gender is an invariant part of the self, and in the early stages of gender constancy children do not fully understand its invariance (p. 377). It is suggested that until children develop the capacity for concrete operational thought (around the ages of 5 to 7 years), they often merge gender identity with expression of gender behavior, and younger children appear to have more rigid ideas about what boys and girls can do. Zucker et al., found that children with gender identity disorder (GID) appear to have a developmental lag in gender constancy acquisition.

While his beliefs are considered controversial by many who work with gender nonconforming children, (Burdge, 2007; Ehrensaft, 2011b; Hill et al., 2010; Malpas, 2011;

Wallace & Russell, 2013) Zucker (2008) believes that with respect to gender identity development, there is “greater plasticity and opportunity for change in younger children than there is in older children” (p. 360). He states:

> I would argue further that it is as legitimate to want to make youngsters comfortable with their gender identity (to make it correspond to the physical reality of their biological sex) as it is to make youngsters comfortable with their ethnic reality (to make it correspond to the physical reality of the color of their skin (p. 359).

Citing studies from the Gender Identity Services in Toronto, as well as one study from the Netherlands, Zucker et al. (2012) write, “for children who present with a diagnosis of GID, long-term follow-up suggests that their gender identity is not necessarily fixed” (p. 375). Referencing the evidence that the majority of children desist, or lose the diagnosis of GID, Dr. Zucker argues, “childhood gender identity was alterable – that there is plasticity and malleability – although the mechanisms for change are far from understood” (p. 375). Citing work by Ruble, Martin, and Bernebaum (2006), de Vries and Cohen-Kettenis (2009) state that “knowing the factors that determine gender identity, and the age at which gender identity becomes fixed, would have significant implications for the timing of hormonal treatment in adolescents. Unfortunately the literature on normative gender development is not yet of clinical relevance” (p. 101).

Risk and Protective Factors

Often grouped in the literature and research with lesbian, gay, bisexual and queer youth (LGBQ), gender nonconforming and transgender children (T) are considered particularly vulnerable (Ehrensaft, 2011a; Ryan et al., 2010; Travers et al., 2012). For LGBTQ youth, the challenge is to develop a positive identity as a sexual minority in a heterocentric social environment. Given that trans youth are a minority within a sexual and gender minority, and that rights for trans people have been slower to progress than lesbian and gay rights (Drescher, 2010; Pleak, 2011), it has been noted that trans youth may be at the highest risk for psychosocial issues

(Travers et al., 2012). Gender-based oppression and the resulting psychosocial difficulties that many transgender individuals experience (low self-esteem, depression, and suicide) are identified as risk factors for many researchers (Burdge, 2007; Ehrensaft, 2011b; Hill et al., 2010; Ryan, 2009; Ryan et al., 2010; Sennott, 2011; Travers et al., 2012).

It has been well documented that LGBTQ youth may be at risk for emotional distress, isolation, internalized homophobia and transphobia, depression, suicide, substance abuse, violence and victimization, family conflict, school performance issues, homelessness, sexually transmitted diseases, and pregnancy (American Psychological Association, 2012; Bryan, 2012; Burdge, 2007; Drescher, 2014; Ehrensaft, 2011a; Hill et al., 2010; Kenagy, 2005; Morrow, 2004; Pleak, 2011; Ryan, 2009; Ryan et al., 2010; Sennot, 2011; Travers et al., 2012; Zucker, Bradley, Owen-Anderson, Kibblewhite, Wood, Singh, & Choi, 2012). Many professionals who work with this population also highlight the protective factors that bolster and support the biopsychosocial well-being of LGBTQ youth (Bryan, 2012; Burdge, 2007; Ehrensaft, 2011a, 2011b; Heck et al., 2011; Hill et al., 2010; Malpas, 2011; Menvielle, 2012; Morrow, 2004; Ryan, 2009; Ryan et al., 2010; Travers et al., 2012; Vanderburgh, 2009; Wallace & Russell, 2014).

In her study of 182 transgender individuals, Kenagy (2005) found alarmingly high levels of violence experienced by transgender adults (mean age of the respondents was 32.2, and ranged from 17 to 68 years). Kenagy found that 56.3 % of participants had experienced violence in their home, 51.3% reported being physically abused and 53.8% had been forced to have sex. Kenagy's findings on suicide support previous studies that suicide is a major health concern. Of the participants, 30.1% had attempted suicide, and of those, 67.3% stated they did so because they are transgender. Fostering self-acceptance, positive family and peer supports, and a safe and supportive school environment can facilitate positive identity development and help keep these youth safe.

Peer relationships

Gender nonconforming and transgender children face a high level of social rejection from peers and may be the targets of bullying and violence. Zucker et al. (2002) compared 358 children and 72 adolescents (who were referred for problems in their gender identity development) with regard to demographic characteristics, behavioral problems as measured by the Child Behavior Checklist (CBCL), and peer relations. The authors found that “the strongest predictor of CBCL psychopathology was that of the Peer Relations Scale” (p. 398). The adolescent sample had significantly poorer peer relations than the child sample. Results of a multiple regression analysis showed that this variable was the strongest predictor of child behavior checklist psychopathology. The researchers write:

> One interpretation of the age effect is that it represents a proxy for social ostracism, i.e., with age, youngsters with gender identity difficulties encounter more problems in their social relationships (e.g., with peers) and this had the consequence of causing more general behavioral and emotional difficulties to emerge (p. 406).

The school environment

The school environment can be among the most dangerous places for LGBTQ youth. Two social workers, van Wormer and McKinney (2003), conducted a qualitative research study to examine the school environment in terms of disempowerment and empowerment aspects. They argue that “failure to take a proactive stance to help youth with gender identity issues is a major cause of psychological problems, leading in some cases to suicide, alcohol and other drug abuse, and homelessness” (p. 409). Van Wormer and McKinney suggest that taking a harm reduction approach to working with LGBTQ students in schools can lower the risk of homelessness, substance abuse and suicide in the LGBTQ population. The social workers outline a detailed plan for working within the school system to support LGBTQ youth that parallels clinical strategies suggested in Burdge (2007), Morrow (2004), and Vanderburgh (2009).

Family acceptance and support

LGBTQ identified youth cannot always count on family for love, safety and support; family members may even perpetuate the oppression and discrimination (Burdge, 2007; Ehrensaft, 2011a; Morrow, 2004; Ryan, 2009; Ryan et al., 2010; Stone Fish & Harvey, 2005; Travers et al., 2012; Vanderburgh, 2009). Family rejection is associated with significantly higher rates of substance abuse, depression, suicide and sex-related health risks. Many youth are disowned, thrown out of their homes, or forced to leave because of abuse and/or violence. There are a disproportionate number of transgender youth in foster care, juvenile detention, or living on the streets (Ehrensaft, 2011a; Ryan et al., 2010), and according to Ryan, "conflict related to the adolescent's sexual orientation and gender identity is a primary cause of rejection or removal from the home" (p. 350). Concerned about the overrepresentation, Ehrensaft (2011a) adds "this singular risk factor for youth is even more pronounced for gender nonconforming and transgender than gay youth" (p. 530).

Ryan, Russell, Huebner, Diaz and Sanchez (2010) conducted a quantitative study with items from their prior qualitative work, specifically, in-depth interviews with young adults, (Ryan, et al., 2009) and retrospectively assessed family accepting behaviors in response to LGBTQ youth's gender expression, sexual orientation and their relationship to mental health, substance abuse and sexual risk. Referred to as the *Family Acceptance Project*, the findings showed that family acceptance of an adolescent's lesbian, gay, bisexual or transgender identity is associated with young adult positive health outcomes (self-esteem, social support, and general health) and has been shown to be protective for negative health outcomes (depression, substance abuse, and suicidal ideation and attempts). Ryan et al. found that with LGBTQ identified adolescents who had highly accepting families, 18.5% reported thoughts of suicide and 30.9% had attempted suicide. Alarmingly, with LGBTQ adolescents who describe low family acceptance, 38.3% reported suicidal ideation and 56.8% had made attempts.

Ryan et al. (2009) state:

> Because families play such a critical role in child and adolescent development, it is not surprising that adverse, punitive and traumatic reactions from parents and caregivers in response to their children's LGB identity would have such a negative influence on their risk behavior and health status as young adults (p. 350).

The Family Acceptance Project offers focused prevention and interventions with diverse families who have LGBTQ children (Ryan, 2009). Practice approaches that specifically support families of LGBTQ children and adolescents have the potential to prevent well-documented LGBTQ health disparities.

In an earlier study, Ryan, Huebner, Diaz & Sanchez (2009) assessed family rejection and family support in 224 gay, lesbian and bisexual youth: 48% identified as non-Latino whites and 52% as Latino, while 51% identified as male and 49% as female. To determine if health outcomes differed according to gender and ethnicity, a series of regression analyses were employed, and significant gender-by-ethnicity interactions were noted. Higher levels of family rejection, higher rates of negative mental health (depression and suicidal ideation), and higher levels of HIV risk behavior were found among gay and bisexual Latino men, suggesting that this group is particularly vulnerable. Exploring further and including trans youth in their sample, Ryan et al. (2010) found that "Latino, immigrant, religious, and low-socio-economic status families appear to be less accepting, on average, of LGBT adolescents" (p. 210). Ryan, et al.

state that future research should “include greater ethnic diversity and assess potential cultural differences in family reactions to their children’s LGBT identity” (p. 210).

In their study, Travers et al. (2012) aimed to provide data on the health impacts of parental support for trans youth aged 16-24 living in Ontario. Travers, et al. recognize that “trans youth have trans-specific needs and vulnerabilities that may not necessarily be captured in studies of LGBT youth” (p. 1). Their analysis is based on data from 84 youth who had socially transitioned (or begun to), had come out to their parents, and were willing to provide information on how supportive their parents were of their gender identity or expression. Travers, et al. assessed the degree to which parental support of trans youth’s gender identity and expression had an impact on life satisfaction, physical and mental health, self-esteem, depression and suicidality. Of the sample, 34% describe their parents as “very supportive”, 25% feel their parents were “somewhat supportive”, and 42% feel their parents were “not very” or “not at all” supportive. For their purposes, the researchers divided the two groups accordingly: 34% report very supportive parents and 67% of the youth report parents who were not strongly supportive. Trans youth who describe their parents as very supportive were more likely to report being satisfied with their lives (72%), positive mental health (70%), and high self-esteem (64%). Comparatively, for trans youth whose parents were not supportive, 33% report being satisfied with their life, 15% report positive mental health, and only 13% report high self-esteem. With respect to depression and suicide, 23% of trans youth with very supportive parents report depressive symptoms, 35% report suicidal thoughts, and of the latter group, only 4% had attempted suicide. Alarmingly, 75% of trans youth whose parents were not very supportive report depressive symptoms, 60% acknowledged suicide ideation, and of that group, 57% had made attempts. Having adequate housing was reported by 100% of the youth with strongly supportive parents, and by only 45% of youth whose parents were not supportive of their gender identity or expression. Travers, et al. (2012) believe that their findings indicate that "anything less than strong support may have deleterious effects on a child's well-being" (p. 3), and they make the recommendation that parents of trans youth need adequate support for themselves in order to provide the strong support that children and youth need.

Diagnosis and Treatment Debates

Practitioners disagree about how gender variance and transgenderism in children and adolescents should be categorized and addressed. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) provided gender identity disorder (GID) as a diagnosis (American Psychiatric Association, 2000); however, the DSM-5 offers a diagnosis of gender dysphoria. Gender dysphoria refers to the *distress* that may accompany the incongruence between a one's experienced or expressed gender and one's assigned gender, and focuses on dysphoria as the clinical problem (American Psychiatric Association, 2014). Given that the DSM-5 was recently published in the spring of 2013, the diagnostic term *gender dysphoria* is not used in the literature I read; for the purposes of this paper, the term *GID* is used most frequently.

There are no accurate statistics on the number of children diagnosed with gender dysphoria or gender identity disorder, and the research on the phenomenon is scarce. Not surprisingly, "clinicians and researchers are engaged in a passionate debate about how to best help" these children (Hill et al., 2010, p. 7). Those involved in caring for these children and their families (pediatricians, family doctors, psychologists, psychiatrists, social workers and family therapists) have not reached a consensus on the need to diagnose or suggested therapeutic practices to support transgender children and youth (Byne et al., 2012; de Vries & Cohen-

Kettenis, 2009; Drescher, 2014; Ehrensaft, 2011a; Ehrensaft, 2011b; Hill et al., 2010; Stone Fish & Harvey, 2005; Wallace & Russell, 2013).

Two polarities

Wallace and Russell (2013) write that in theorizing and treating gender nonconforming children there are “two polarities” (p. 113), and suggest that although the two approaches are united in the goal of optimizing the child’s function and well-being, they diverge in opinion about specific goals for treatment. Citing Byne et al. (2012), Wallace and Russell describe one approach that aims to reduce gender dysphoria and decrease cross-gender behaviors and identification. Wallace and Russell associate Stoller, Rekers, Nicolosi, and Zucker with this intervention approach, and suggest that these practitioners view gender variance as pathological and emerging from a disruption in normal psychosexual development or attachment failure. This first approach is discussed later in this section as a *normative intervention*.

On the other hand, Wallace and Russell suggest that practitioners such as Lev, Ehrensaft, Hill, Menvielle and Spack “remain neutral with respect to gender identity and …have no therapeutic target with respect to gender identity outcomes” (as cited in Byne et al., 2012, p. 763). Their goal is to allow the developmental trajectory of gender identity to unfold naturally without pursuing or encouraging a specific outcome. This second group of practitioners view gender variance as healthy diversity and their goal is to support the child and family as they navigate social systems that might put the child’s self-esteem and well-being at risk. Wallace and Russell (2013) state, “Hence, their work shifts away from a focus on fixing the child to fixing the system that pathologizes them and on developing strategies to mitigate the injuries of the system” (p. 114). This second approach is discussed further as *affirmative practice*.

Byne et al. (2012) identify a third approach that focuses on gender affirmation of the child's cross-gender expression and identity. Family, friends, teachers and practitioners support the child to transition socially, with the option of endocrine treatment to suspend puberty and suppress the development of unwanted secondary sex characteristics if the cross-gender identity persists into adolescence. The primary counterargument to this approach is based on the evidence that GID in children does not usually persist into adolescence and adulthood. Pleak (2010) questions whether supporting social transitioning in childhood might increase the likelihood of persistence; trans advocates and activists disagree.

Normative interventions

Developed in the 1970s, this approach to caring for gender nonconforming children was intended to help them become more comfortable with the gender they were assigned at birth. This intervention model is referred to in the literature as traditional, normative, corrective or reparative (Ehrensaft, 2011b; Hill et al., 2011; Malpas, 2010; Stone Fish & Harvey, 2005). For the purposes of this paper, the term *normative* will be used.

According to Ehrensaft (2011a), psychoanalytic theorists believe that gender nonconforming children are responding to trauma, or disruptions in attachment. Those who advocate for normative therapies encourage children diagnosed with GID to conform to assigned gender expectations in terms of dress, play, and behaviors. Stone Fish and Harvey (2005) found that normative interventions are behaviorally focused and designed to:

> "Fix" children so that they begin to act, dress and live as the appropriate sex…It is important to note that this continues to be the standard approach for youth diagnosed with GID despite the fact that there is little evidence to suggest that it actually succeeds in obtaining the intended outcome (p. 82).

Canadian psychologist Dr. Kenneth Zucker is a leading expert in the field of normative therapy and has published numerous studies on children with GID. Dr. Zucker led the team that reviewed GID for the DSM-5. His research findings suggest that transgender and gender nonconforming children are either "expressing interfamilial conflicts" or "serving as objects of their parents' own unresolved gender and psychiatric issues" (as cited in Ehrensaft, 2011a, p. 532), or on the developmental path to identifying as gay or lesbian. Dr. Zucker's theories and clinical practice model are viewed by the affirmative community as pathologizing and potentially dangerous to the self-esteem and well-being of the trans identified child (Ehrensaft, 2011a; Hill et al., 2011; Malpas, 2011; Stone Fish & Harvey, 2005; Wallace & Russell, 2013).

In a special edition of the *Journal of Homosexuality*, Zucker et al. (2012) describe the therapeutic approach that has evolved at the gender identity service at the Centre for Addiction and Mental Health (CAMH) in Toronto. Since the clinic was established in the mid-1970s, Zucker, et al. have evaluated 590 children ages 2-12 years. Naming it a *developmental biopsychosocial model* for the treatment of children with GID, Zucker et al. write:

> We would like to characterize it as a developmental, biopsychosocial model that we use in case formulations and in generating treatment decisions and recommendations. It is a model informed by a variety of theoretical and empirical advances that have emerged in the clinical and scientific literature over the past several decades (p. 374).

It is beyond the scope of this literature review to describe the developmental, biopsychosocial model. For a detailed outline of assessment protocol, multifactorial developmental case formulation and clinical examples of how the treatment model is used, refer to Zucker (2008) and Zucker et al. (2012).

Affirmative practice

Malpas (2011) writes that "there is little evidence that treatment for GID in children significantly impacts later sexual or gender identity," and suggests that attempts to alter or manipulate a child's future gender identity raises serious ethical questions. Given these concerns as well as the failure of treatment to change gender identity or sexual orientation, "contemporary approaches to gender nonconformity in childhood are moving toward an affirmative standpoint" (p. 456).

In their study, Hunter and Hickerson (2003) describe the more recent phenomenon of *affirmative* practice when working with LGBTQ clients. According to the authors, affirmative practice is a "frame of reference;" a strength-based, empowerment approach that "guides practice along the lines of helping these clients lead happy and fulfilling lives" (p. 206). The more recent terms *transaffirmative* and *transpositive* refer to approaches that aim to "affirm whatever unique identity the individual wants to develop," and "educate others about transgender persons, and advocate for their political, social, and economical rights" (p. 199).

Affirmative treatment approaches help parents affirm and support their children while actively promoting healthy development and social adjustment. Affirmative models have been described in the literature as "leading edge interventions to help gender nonconforming youth" (Hill et al., 2010, p. 11), with proponents openly criticizing and contradicting the findings of physicians and agencies treating children with normative therapies. Studies are beginning to emphasize the importance of trans affirming clinical social work skills when working with this population. Wren (2002) found that "it is becoming increasingly acknowledged that acceptance and unconditional love are central to a healthy gender-variant and transgender adolescent" (as cited in Hill et al., p. 9). According to Hill et al., transgender children are exposed to social exclusion and isolation, threats of violence, depression, and "generally a very difficult life" (p. 9). Transgender children need unconditional love and support in order to live healthy, autonomous and productive lives; they need their deeply felt sense of gender self-affirmed.

Malpas (2011) writes that families with gender nonconforming children need to navigate two gender systems: 1) a rigid social, cultural and familial gender binary and 2) a fluid gender spectrum articulated by their child. Parents often feel the need to choose between accepting their child's atypical gender identity and protecting them by acculturating them more deliberately. Malpas believes this stress and tension can erode the parent-child bond and create marital conflicts. With an emphasis on attachment, both parents and children are provided with separate but interconnected space to process. As Malpas has experienced, "gradually parents realize that acceptance is protection." (p. 468). From Malpas' point of view:

> These perspectives consider gender as a fluid spectrum and claim that 1) gender nonconformity is not a pathology but a normal human variation, 2) gender nonconforming children do not systematically need mental health treatment, and 3) caregivers of gender nonconforming children can benefit from a mixture of psychoeducational and community-oriented interventions. These aim at de-stigmatizing and normalizing their experiences while offering tools to negotiate their children's safety, wellbeing, and optimal development in their familial and natural environment (Malpas, 2011, p. 456).

Because a detailed description of both the theoretical framework and suggested structure of an affirming practice goes beyond the scope of this paper, please refer to Brill and Pepper (2008), Ehrensaft (2011a, 2011b), Hill et al. (2010), Hunter and Hickerson (2003), Malpas (2011), and Menvielle (2012).

Wise Practice

As the reader will discover in the study findings, a few participants reference the Aboriginal concept of *wise practice* as a theoretical lens through which to consider working alongside gender nonconforming children and their families. Therefore, I thought it important to discuss the concept, if only briefly. According to Aboriginal traditions, wise practices reflect the richness of relationships, respect for uniqueness, and the contextual nature of community. Encompassing Aboriginal values of inclusiveness, appreciation of knowledge and respect for all, a wise practice approach closely resembles the North American native cultures that are both reflective (giving people time to internalize choices and reach consensus) and integrative (giving voice to everybody, with nobody left behind). Leaders must be “wise” about their community; wise practice is founded on “wisdom.” Goodfellow (2001) lists the following characteristics of wisdom: sound reasoning ability, an expression of concern for others, an ability to learn from ideas and environment, an ability to make sound judgments (moral issues), the expeditious use of experience, and the use of intuition (as cited in Wesley-Esquimaux & Calliou, 2010, p. 21). A wise practice approach combines practical knowledge, sound judgment and thoughtful action; it integrates communal experience to qualify the community’s sense of well-being and cultural efficacy.

Research

Empirical research with transgender and gender nonconforming children is sparse (Brill & Pepper, 2008; Bryan, 2012; Byne et al., 2012; de Vries & Cohen-Kettenis, 2009; Drescher, 2014; Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Ehrensaft, 2011b; Hill & Menvielle, 2009; Hunter & Hickerson, 2003; Ryan et al., 2010; Wallien & Cohen-Kettenis, 2008). de Vries and Cohen-Kettenis (2009) state:

> There is a woeful absence of research supporting the ideas about management of GID in young people…With respect to the phenomenon itself, there is an almost complete lack of knowledge on gender variance in the general population,” adding “yet despite this lack of knowledge, clinicians have to make decisions that are crucial for the youth involved. Relevant clinical information is also missing with regard to the role of co-morbidity and of the social problems of children with GID. Past and current intervention methods have not been properly evaluated (p. 106).

The studies that have been conducted are primarily qualitative (Gutierrez, 2004; Heck et al., 2011; Hill et al., 2010; Hunter & Hickerson, 2003; Malpas, 2011) and rely heavily on case study examples. The quantitative studies appear to be conducted primarily by physicians and psychologists who adhere to a medical model of care and diagnose GID (de Vries & Cohen-Kettenis, 2009; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker et al., 2002;

Zucker, 2008; Zucker et al., 2012). Referring to their own studies in the Dutch clinic, de Vries and Cohen-Kettenis write, “Because these results come from one clinic, the results are in need of replication.” (p. 103). There are more recent quantitative studies out of California and Ontario that address the specific needs of trans youth (Ryan et al., 2009; Travers et al., 2012).

Three of the studies I have found by researchers Gutierrez (2004) and Ryan et al. (2009, 2010) address the intersectionality of race, culture, and socioeconomic diversity in transgender children and youth. Gutierrez presents four case studies in which female transgender students of color relate their experiences in school. Gutierrez “exposes the need to advocate for education that acknowledges and addresses the ways that race, sexuality, class, ethnicity, and gender together inform life experience and identity” (p. 70) and suggests that activist-oriented curriculum in schools. Ryan et al. focus on LGB non-Latino white and Latino young adults as they explore the impact of culture, ethnicity and socioeconomic class on family acceptance of their LGBTQ child. In 2009, they found that Latino men reported the highest number of negative family reactions to their sexual orientation in adolescence. In their 2010 study, Ryan et al., found that Latino, immigrant, religious, and low-socioeconomic status families appear to be less accepting, on average, of LGBT adolescents. Ryan et al., offer that their data might not be representative of all subpopulations of LGB young adults, and suggest that future research should include greater ethnic diversity to assess cultural potential differences in family reactions to their child’s LGBT identity (Ryan et al., 2009, p. 351).

Acknowledging that both the diagnosis and treatment of GID are controversial, the American Psychiatric Association’s (APA) Board of Trustees formed a task force:

> Charged to perform a critical review of the literature on the treatment of GID at different stages, to assess the quality of evidence pertaining to treatment, and to prepare a report that includes an opinion as to whether or not sufficient credible literature exists for development of treatment recommendations by the APA (Byne et al., 2012, p. 759).

The task force found no evidence of randomized double-blind control trials and recognize that "due to the lack of feasibility and ethical concerns" (p. 760) of studying children and adolescents diagnosed with GID, these studies will not be forthcoming. Comparing the alternative approaches to caring for gender nonconforming children, the task force found no randomized or adequately controlled nonrandomized longitudinal studies, and very few follow-up studies without a control group. The majority of the evidence is derived from qualitative reviews and experimental systemic single-case studies. The task force writes, "Consensus could not be reached regarding the legitimacy of particular goals of therapy with children diagnosed with GID (e.g., prevention of transgenderism or homosexuality) even when consistent with the religious beliefs or sociocultural values of the parents or primary caregivers" (p. 761). The task force recommends that the APA create a separate mechanism for assessing the mental health needs of individuals with disorders of sex development (DSD), including gender dysphoria, and work toward better integration of mental health providers and parents into the interdisciplinary team providing care (p. 791).

Persistence and desistance

The findings regarding adult gender dysphoria outcomes ("persistence" outcomes) for gender nonconforming children are inconsistent and range from 12-27% (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). The relationship between sexual orientation outcomes for children diagnosed with GID vary widely, with the Toronto clinic suggesting that 24-32% identify as gay, lesbian or bisexual in adulthood (Drummond et al., 2008) and the Dutch providing a higher estimate of 68% (Wallien & Cohen-Kettenis, 2008). Wallien and Cohen-Kettenis address the small sample size of their data and the risk of memory distortion in retrospective studies. They suggest that long-term follow-up studies, in which gender nonconformance is measured in large normative samples of young children and psychosexual outcome is measured in adolescence and adulthood, are needed to understand the relationship between childhood gender nonconformity and sexual orientation. More systemic follow-up every few years, particularly around critical development times (starting school, onset of puberty) are needed to better understand when and how GID persistence or desistence takes place.

Research on specific models of care

The history of the different approaches to working with gender nonconforming children and their families is well documented (Byne et al., 2012; Drescher, 2010; Drescher, 2014; Ehrensaft, 2011a; Hill et al., 2010; Hunter & Hickerson, 2003; Pleak, 2011; Wallace & Russell, 2013). Concerned about the potential harm done to individuals by traditional approaches to care, the psychosocial impact of discrimination and oppression on sexual minorities, and the more recent emphasis on the human rights of LGBTQ people, the majority of professionals are moving towards an "affirming" approach to care (Ehrensaft, 2011a; Ehrensaft, 2011b; Hill et al., 2010; Hunter & Hickerson, 2003; Menvielle, 2012; Pleak, 2011; Wallace & Russell, 2013).

Referencing Menvielle's affirming practice, and considering it through an attachment theoretical lens, Wallace and Russell (2013) write, "although not stated in terms of attachment theory, the goal of intervention is to build positive relations between parent and child by directly attending to the impact of stigma and shame on the parent-child relationship" (p. 123). Wallace and Russell suggest that supportive interventions are more likely to avoid harm by "buttressing the attachment relationships and so reduce the risk of engendering shame as a core element of identity (p. 123), which they argue is less likely to put the child at risk of depression. The two psychotherapists "note the areas in which supportive interventions lack evidence to support them" (p. 123), and suggest the need to test the efficacy of affirmative interventions. Wallace and Russell recommend that further research explore the impact of affirmative strategies on the attachment security between the parent and child and on the vulnerability to shame and depression, as well as whether affirmative interventions reduce the impact of social ostracism and increase resiliency in the face of stigma.

In reviewing the literature, it was noted that providers who are informed by one theoretical framework often critique another approach to working with gender nonconforming children and their families. Dr. Ken Zucker's approach, often referred to as "reparative," and his work at the gender identity services at the Centre for Addiction and Mental Health (CAMH) in Toronto are mentioned frequently (Ehrensaft, 2011b; Hegarty, 2009; Hill et al., 2010; Hunter & Hickerson, 2003; Malpas, 2011; Pleak, 2011; Wallace & Russell, 2013). In comparing one approach to another, some researchers write papers in response to one another's work (Hegarty, 2009; Singh, Bradley, & Zucker, 2011). As the work with gender nonconforming and transgender children becomes progressively more affirming, one gets a sense for why the debates continue. In his paper, Drescher (2010) suggests that a more detailed, scholarly study of the potential harm from gender identity conversion efforts (GICE), and how that might compare with the sexual orientation change effort (SOCE) therapies, would be beneficial. He suggests that the approaches differ and does not equate reparative with gender identity conversion therapies. Drescher encourages interested colleagues to immerse themselves in both the literature on reparative therapy as well as the literature on clinical interventions to change gender variant children.

Other limits to the empirical evidence include: studying LGBTQ youth as a group and not controlling for transgender specific issues; small sample sizes with very small age range samples, which make it difficult to generalize; program comparisons that are being made between transgender children from different countries with different cultures and socioeconomic statuses; and LGBTQ youth often completing surveys retrospectively and in environments with varying levels of systemic and intuitional homophobia and transphobia. Researchers recommend that future studies should use controlled experimental evaluations of treatment practices for this population, using longitudinal designs and incorporating pre-test and control groups. Given the small scale and time constraints of my thesis project, larger-scale longitudinal quantitative research was not feasible.

Summary

Burdge (2007) and Vanderburgh (2008) stress that, given the vulnerabilities that place transgender and gender nonconforming children at great social and emotional risk, there is an immediate need for more research in order to explore how to best support them. According to Burdge, future research should be directed towards an "urgent need to jumpstart a gender-transgender dialogue amongst social workers" (p. 248). Given the growing numbers of gender nonconforming children and their families who are accessing support from mental health and medical professionals; the shift to an affirming theoretical approach to individual and family work; and the recent findings that family acceptance and strong support of gender identity and expression predict greater self-esteem, social support, and general health status, as well as protect against depression, substance abuse and suicidal ideation and behaviors, I wondered, *why does the debate on how to best respond to gender nonconforming children and their families continue*? This qualitative study was designed to fill a need for further research into best practice models with gender nonconforming and transgender children and their families.

CHAPTER III

Methodology

This qualitative study is an exploration of the following question: *Why does the debate on how to best respond to gender nonconforming children and their families continue?* The purposes of the study are 1) to explore why consensus about best practice models for working with gender nonconforming children and families has not been reached among professionals and 2) to raise awareness of the practice frameworks available to assist clinical social workers in meeting the social and emotional needs of this population. Qualitative methods, using semi-structured interviews, were selected as the basis for the study's design for several reasons. Qualitative research seeks to arrive at an understanding of a particular phenomenon from the perspective of those experiencing it (Padgett, 2008; Rubin & Babbie, 2013; Vaismoradi, Turunen & Bondas, 2013). Furthermore, according to Rubin & Babbie (2013), qualitative research methods are flexible, allow research procedures to evolve as more observations are gathered, and "permit the use of subjectivity to understand the deeper meaning of human experience" (p. 40).

Given that children are vulnerable research subjects and that research with minors inevitably raises considerable ethical concerns, empirical data pertaining to the treatment and developmental outcomes of gender nonconforming children is sparse and relies heavily on qualitative case studies with older transgender teens and adults. The literature and popular media suggest that the increasing number of parents supporting the social expression of their young gender nonconforming child is a more recent phenomenon. A search of the literature revealed no previous studies that specifically address why a consensus about best practice models has not been reached among professionals working with the population. For these reasons, the researcher chose qualitative methods to support "a study with a purpose of generating insights about a new phenomenon" (Rubin & Babbie, 2013, p. 50).

A general inductive approach was used in this study. Rubin and Babbie (2013) state that "an inductive qualitative method begins with observations and looks for patterns, themes or common categories" (p. 255) and can be used in conjunction with other forms of qualitative research. The openness of this approach allows for the discovery of unexpected findings and for the researcher to continually reconsider his/her working assumptions. The research process is based on inductive logic in which the researcher begins with observations, seeks patterns in those observations and generates tentative conclusions from those patterns. As patterns are perceived across interviews, concepts and working hypotheses are developed based on the patterns. Patterns and concepts are then compared to and across earlier interviews, which modifies the findings in light of further observations (Rubin & Babbie, 2013, p. 255).

Sample

Participants in the study were medical or mental health professionals who met the following criteria: had worked with gender nonconforming or transgender children and families in Canada or the United States for at least one year, were currently practicing [at the time of the study], and held a medical degree or a bachelor's, master's or a doctorate in social work, psychology or marriage and family therapy. Originally, I had considered including educators, however, I limited the sample to medical and mental health professionals upon the suggestion of the Smith College School for Social Work (SCSSW) Human Subjects Review Committee. It was suggested that teachers are not clinicians and may have different perspectives based on different training. Given the small scope of my project and the small sample size, educators were eliminated from the sample. Participants practiced in one of the following settings: social agency, children and family agency, hospital, school, or private practice, and were asked to indicate their primary practice setting. Individuals were excluded from participation in the study if, at the time of the data collection, they 1) were not or did not have at least one year of experience working with gender nonconforming or transgender children and families in one of the aforementioned settings, 2) did not hold the required educational degrees or 3) were practicing outside of the United States or Canada.

People interested in participating in the study were asked to complete a short, Yes/No screening questionnaire that was either self-administered and returned to the researcher via email or completed over the phone (Appendix A). Participants who answered yes to all of the following questions were informed that they qualified to participate in the study:

1. Do you hold a bachelor's degree, master's degree, doctorate or medical degree in one of the following disciplines: social work, psychology, psychiatry, medicine, or marriage and family therapy? (Yes/No)
2. Do you have at least one year's experience working with gender nonconforming or transgender children in Canada or the United States? (Yes/No)
3. Are you currently practicing in Canada or the United States? (Yes/No)

In the present investigation, 14 participants were interviewed. No attempts to verify the participant's responses to the screening questions were made, and unless participants contacted me with specific questions related to the participation criteria, I allowed people to interpret the meaning of the questions themselves.

Recruitment

Prior to recruitment of participants for this research, approval for the study and all safeguards to ensure ethical standards were obtained from the Smith College School for Social Work Human Subjects Review (HSR) Committee (Appendix B). Recruitment for this study involved the use of nonprobability sampling procedures to find research participants and included a mixture of purposive and snowball sampling. According to Rubin and Babbie (2013), “snowball sampling is appropriate when the members of a special population are difficult to locate” (p. 173) and is used primarily for exploratory research purposes. Rubin and Babbie describe the option of initially selecting a purposive sample of “professionals known for their work with and expertise on the problem” (p. 173) and then seeking their assistance in locating other potential participants. Snowball sampling is commonly used in qualitative research and in research on minority and oppressed populations. I first asked prominent professionals and acquaintances in the field to participate and to pass along my information and recruitment email to contacts they had in the field (Appendix C). Each potential participant and organization received the recruitment email that included information relating to the research topic, inclusion criteria and the nature of participation. In an attempt to recruit a balanced sample, emails were sent out to potential participants two or three times. Due to the study time constraints and the volunteer nature of participation, if I did not hear back from participants it was assumed that they were not interested in participating and no further attempts were made to recruit them.

Once participants passed through the screening questions, we either made arrangements to meet in person for the interview or arranged a telephone interview. I sent the consent form (Appendix D) and a preview list of the interview questions (Appendix E) to those who qualified for participation in the preferred format (email or mail). Due to the potential controversial nature of the topic, as well as the 30-45 minute time constraints of the interview, I wanted to give participants time to reflect on their responses. The interview guide was sent out a few days prior to the scheduled interview as a precaution against external influences. For those who were scheduled for a telephone interview (n=5), I explained that I needed a signed consent form before I conducted the interview and provided a self-addressed stamped envelope to ensure the forms were returned prior to the interview date. Participants with whom I met face-to-face (n=9) signed the [informed] consent form before we commenced the interview process. The first few minutes of the interview included a review of the informed consent in order to ensure that the participants understood the requirements and limitation of their participation. Two consent forms were provided, one for the participant to keep and one for my research purposes. The interview did not proceed until this procedure was completed. The participants were informed that they could refuse to answer any questions and that they had the right to withdraw from the research study any time before November 1, 2013.

Ethics and Safeguards

Protection of confidentiality

Participation in this study was not anonymous because of the nature of conducting personal interviews. Every attempt was made to keep information about each participant and their responses to my research questions confidential. The following steps were taken to maintain confidentiality to the best of my ability. Interviews were conducted in a setting that allowed for privacy. I designed a system for assigning code numbers to each participant. Once interviews had taken place, each demographic questionnaire and tape recording was assigned the corresponding code, as were the transcribed interviews. Interview transcribers were required to sign a confidentiality agreement (Appendix F). The participant log, audio recorder and research journal were kept in a locked filing cabinet that only the researcher had access to, where they will continue to be held for three years as required by Federal regulations, after which they will be destroyed or kept secure as long as they are needed. Computer files have been encrypted and password protected, and will be held for three years and then deleted or kept secure for as long as they are needed. All identifying information was stripped before data was shared with the research advisor of this study.

Clinicians were cautioned not to provide any identifying client information in their responses. Information was redacted in the case that participants did use their clients' names or other identifying information about clients or themselves. Illustrative quotes have been carefully disguised and any possible identifying information has been removed, in order that material from the study may be used for future presentation and publication. Due to the relatively small community of care providers who work with this population, concerns about specific comments and quotes that may identify participants was particularly important. Following data analysis, two participants were contacted via email, provided with their chosen comment or quote, and asked if they were comfortable with it being included as read. The content of these participant's responses made it difficult to conceal their identities. Several study participants referenced Dr. Ken Zucker either personally or by naming the clinic that he leads. Dr. Ken Zucker was contacted and I met with him in person to ask if he would grant permission to use both his name and position in this study (Appendix G); he generously agreed to both.

Risks and benefits of participation

The consent form outlined the purpose of the interviews to potential participants, who were also provided with a preview of the interview questions so that they would have a sense of the content. Because the list was provided beforehand and the questions were designed only to explore the participant's professional experience, and not to inquire about personal information or experience, risks of participation were considered minimal. The study also posed a low risk to participants because they were professionals (physicians, psychiatrists, psychologists, and social workers). However, because they were asked to reflect on their work with this population, it was possible that participation in the study may have caused uncomfortable feelings such as guilt, sadness or embarrassment to surface. Participants were made aware prior to beginning the interview that participation was completely voluntary, that their responses would be kept confidential, and that they had the right to refuse to answer any question without repercussion. Participants were also asked to refrain from sharing any identifying client information and to speak from their own experience.

It is possible that participation in the study gave a voice to clinicians and professionals who work with gender nonconforming and transgender children and their families. Participants' responses to the interview contributed to a deeper understanding of why the debate about diagnosing and treating these children continues, and why a consensus on best practice models has not been reached. The findings might influence how clinical social workers work with gender nonconforming and transgender youth and families as they match a practice model to the individual child and family system. Moreover, clinicians who participated in the study may be more inclined to reach out to other clinicians and professionals and continue to build community.

Data Collection

According to Rubin and Babbie (2013), “Qualitative measures rely primarily on interviews that are usually unstructured and that mainly contain open-ended questions with in-depth probes ” (p.123). When gathering qualitative data, semi-structured interviews allow the interviewer to be flexible, informal and conversational, and to adapt the style of the interview and the sequencing and wording of questions to each particular interview. For the purposes of this study, I used a semi-structured interview guide as my qualitative measurement instrument (Appendix E). I followed the guide with specific questions I wanted to cover with each participant, as well as probes to solicit “in a nondirective and unbiased manner a more complete answer to a question” (Rubin & Babbie, 2013, p. 124).

The interviews took approximately 45 minutes and were conducted as follows. First, I attempted to build rapport with participants by engaging in a few minutes of small talk, explained what would happen in the interview process, and asked for a signature on the informed consent forms (one for my records and one for the clinician I was interviewing). Participants were then asked to respond to seven demographic questions (Appendix H) that required them to identify their gender, race/ethnicity, degree/diploma certifications, number of years practicing with transgender youth, the approximate portion of their caseload that this population comprised, primary practice setting, and the type of community they practiced in (urban, suburban or rural). Participants completed the demographic questionnaire before the tape recorder was turned on. Questionnaires were collected by the researcher, and stored in a locked filing cabinet. Demographic questions [during the interview process] addressed issues of diversity within the group of participants being interviewed. Given the small sample size in this specialized study, diversity of sample was not anticipated. No eligible participant was excluded due to race, ethnicity or gender.

I generally allocated 10-15 minutes for this part of the interview, and 30 minutes for addressing specific questions. I then explained to participants that I would be asking a set of open-ended questions and would actively listen while they responded. I also explained that at times I might need to be more directive in the interview to ensure we covered all the questions and kept to our 45-minute time limit. I allocated approximately 5 minutes at the end of the interview to thank participants and to wrap up the interview process.

In order to make sure my interview questions were clear and minimize the risk of misinterpretation, the interview guide was subjected to expert review and I incorporated the feedback. I pre-tested my interview questions with two volunteers who hold a Master's in Education, as well as with a psychology PhD candidate who had some experience working with gender nonconforming children but did not fully meet the inclusion criteria for the study. Following the pretests, I reworded one of the open-ended questions and resubmitted the interview guide to the Human Subjects Review committee for final approval. The pretests also gave me a sense of whether I could conduct the full interview in the time allotted, and allowed me to test my recording equipment.

According to Rubin and Babbie (2013), "The aims and philosophical roots of qualitative inquiry mandate that the respondent's answers should be recorded as fully as possible. Recording them verbatim is ideal." (p. 259). I used a Sony digital voice recorder to record the interviews I conducted in person, as well as those conducted over the phone. Informal notes were taken during the interview or as soon afterwards as possible. I also used a research log as a tool to jot down summary points or key phrases to facilitate later analysis of the tape (Padgett, 2008; Rubin & Babbie, 2013). Following each interview, I included the following information in my log: a face sheet (date, time, setting, location of the interview, length of the interview); an interviewer reaction sheet (observations about the participant's tone of voice, facial expressions, eye-contact, body language as well as interviewer's personal reflections and feelings).

Audio recordings were encrypted and saved on this researcher's computer; each interview was saved as a separate file. Thorough and complete transcription of the entire recorded interview (with names and locations omitted) was chosen over selective transcription to provide full access to the data. Given the volume of data to be transcribed, I hired three transcribers to transcribe all the interviews; each was required to sign the confidentiality agreement approved by Smith College's HSR Committee (Appendix F). I read through each transcribed interview methodically to check for accuracy.

Data Analysis

Content analysis and thematic analysis are commonly used approaches in qualitative data analysis (Padgett, 2008; Rubin & Babbie, 2013; Vaisomoradi, Turunen & Bondas, 2013); both allow researchers to make valid inferences by objectively and systematically analyzing text. Content analysis is widely used in social work and is often cited as the method used in published studies (Drisko, 1997). As a novice investigator, I searched for a straightforward and non-technical approach for analyzing my qualitative data. I followed Thomas' (2006) general inductive approach to content analysis because it "provides an easily used and systemic set of procedures for analyzing qualitative data that can produce reliable and valid findings" (p. 237) and is frequently reported in health and social science research. Thomas describes inductive analysis as an approach that primarily uses detailed readings of raw data to enable researchers to arrive at concepts, themes or a model through interpretation of texts. Inferences are made based on literal interpretation of the content. The intention of an inductive approach is to allow research findings to emerge from the common, recurring or meaningful themes inherent in raw data, without the restraints of imposed structured methodologies (p. 238). Thomas lists the purposes for using an inductive approach as a) to condense raw textual data into a brief, summary format; b) establish clear links between the evaluation or research objectives and the summary findings derived from the raw data; and c) develop a framework for the underlying structure of experiences or processes that are evident in the raw data (p. 237).

The process I used is described in detail as follows.

1. Interviews were transcribed verbatim and individual files were consistently formatted using a common font size, uniform margins, and highlighting and ordering interviewer's questions. Each interview was printed, and individual files were encrypted and backed up on the researcher's computer.
2. Each transcript was read in detail, multiple times, until an understanding of the categories began to emerge in the text. Categories were created from "in vivo" (Thomas, 2006, p. 241) coding, or labeling of the actual phrasing and meanings in specific text segments.
3. Categories were linked and combined when the meanings were similar, and overlapping codes were condensed into upper level or more general codes. Contradictory and outlier statements were included in the appropriate category. Meticulous and systematic reading and coding of the transcripts allowed major themes to emerge. Citing Ryan and Bernard (2003), Bradley, Curry and Devers (2007) define themes as "fundamental concepts that characterize specific experiences of individual participants by the more general insights that are apparent from the whole of the data" (p. 1760).

4. The category system was revised and refined, using specific participant quotations to help define and reduce. Participant identity was kept confidential and quotes were anonymous.
5. A model was created that incorporated the most common and significant categories or themes. The intended outcome of the inductive process is to create between three and eight categories that in the researcher's view capture the key themes identified in the raw data given the evaluation objectives.

In qualitative research, stakeholder or member checks can be used to improve trustworthiness (Padgett, 2008; Rubin & Babbie, 2013; Thomas, 2006). Stakeholder checks enhance the credibility of findings by allowing participants and other people who have specific interests to comment on or assess the findings, interpretations and conclusions. Prior to submitting my thesis, I provided a summary of my findings to participants and invited written or oral commentary. Specifically, I asked for feedback on the categories and themes identified, as well as participants' comfort level with the degree of anonymity maintained in the paper.

CHAPTER IV

Findings

Introduction

This chapter presents the findings from analysis of interviews conducted with fourteen practicing professionals (medical doctors, social workers, psychologists, and a psychotherapist) in Canada who have at least one year of experience working with gender nonconforming and transgender children and their families. In order to clarify the population, all participants were given the following descriptor: for the purposes of this study, the terms *children* and *youth* are used interchangeably and refer to children ranging in age from 3-18 years. The term *gender nonconforming* is used broadly to include *gender-fluid, gender-variant, gender-queer and transgender* children, and refers to children whose gender identity does not match their assigned birth gender. The interview guide was sent to participants in advance in an attempt to provide them with some time to think about and formulate their responses. Due to the potential controversial nature of the topic, as well as the 30-45 minute time constraints of the interview, I wanted to give participants time to reflect on their responses. The interview guide was sent out a few days prior to the scheduled interview as a precaution against external influences. Without exception, participants had previewed the four questions and were prepared and thoughtful with their responses.

The open-ended interview questions were designed to elicit information and professional opinions regarding why consensus about best practice models for working with gender nonconforming and transgender children and families has not been reached. Study participants were asked why a lack of consensus is not okay, why the debate about practice models continues, and what they believe this population needs from those who serve them. In closing the interview, professionals were asked if they would like to share further information that could benefit those who currently or hope to work with gender nonconforming children and their families.

During the interviews, it was noted by some participants and myself that the discussion about the perceived debate about how to best respond to gender nonconforming children and families often brings up intense emotions. Of note, the majority of professionals (n=11) identified as practicing from an affirmative theoretical framework, two participants did not declare an approach, and one suggested his approach follows a developmental biopsychosocial model. Without exception, participants were eager to share their beliefs and strategies for working with this population. A few participants (n=5) identified as trans activists and advocates who have been working alongside the trans community for a number of years. I made a concerted effort to recruit more participants who practice from a more traditional or normative perspective. In an attempt to recruit a balanced sample, emails were sent out to potential participants two or three times. Due to the study time constraints and the volunteer nature of participation, if I did not hear back from participants it was assumed that they were not interested in participating and no further attempts were made.

The majority of people who volunteered for the study felt strongly that it was both important and timely to bring the debate into the discourse. As one social worker said about the study, “I am really excited that you are doing it and I hope it can get out there. I hope it can either be a published paper, or read,” and one physician shared, “I applaud you for your work. I look forward to reading through the transcripts and then actually seeing your results." Three unexpected findings include: the perceived divide between Ontario and other Canadian provinces given that the debate "rages" more prominently in Ontario; a language divide and inter-University competition that may exacerbate "silo health care" and contribute to the lack of collaboration amongst professionals and major centers, and the concept of incorporating First Nations' ideals of *Wise Practice* to frame the work with gender nonconforming children and youth.

While most interviews (n=9) were conducted in person, five were carried out through a telephone interview. Non-verbal communication is an essential part of qualitative research and there are numerous ways in which meaning is conveyed during face-to-face contact. It can be argued that data were lost during the telephone interviews given that the loss of non-verbal cues made it more difficult at times to access meaning. One cannot rely on facial expressions and other visual cues, so the questions needed to be asked in a clear manner. One participant paused for several seconds on the telephone prompting the interviewer to ask "are you still there?" In response, the participant stated that they simply needed more time to formulate a response. The data from the interviews are presented in the following sequence: demographic data of participants, why consensus about best practice models has not been reached, why the lack of consensus is not okay, why the debate about best practice models continues, and what the respondents believe gender nonconforming children and their families need from the professionals who serve them.

Participant Demographic Data

Participants were asked to complete a demographic questionnaire and return it to the interviewer. For in-person interviews, participants completed the questionnaire prior to the semi-structured interview. For interviews that were conducted on the telephone, demographic questionnaires were completed in advance and mailed to the researcher along with the signed informed consent form. The following summarizes responses to the demographic questions.

The study participants comprised 14 professionals who were practicing at the time of the study and had at least one-year experience in Canada working with gender nonconforming children and their families. When asked to state the gender with which they most identified, five participants self-identified as female, six as male, two as trans men, and one as a cisfemme male. One respondent hesitated before writing their response stating, "I enjoy the privilege of being seen as male, however I don't feel strongly gendered." When listing their racial and ethnic identities, one person self-identified as South Asian, one as Filipino, and ten as White or Caucasian. Four participants acknowledged European heritage, four identified as Canadian, and five self-identified as Jewish.

The following section offers information pertaining to the participants' professional identities, years of experience working with this population, and their current practice setting. Five interviewees were medical doctors (areas of practice include psychiatry, pediatrics, adolescent medicine, and pediatric endocrinology), five social workers (four MSWs and one doctoral candidate) and three psychologists (one doctorate, one doctoral candidate and one master's degree), and one psychotherapist (master's degree). The range of experience working with gender nonconforming and trans youth was anywhere from 1 to 38 years, with seven subjects reporting more than five years of experience. The percentage of their caseload that includes working with and supporting these children and families ranged from 10% to 100 %, with most (n=7) reporting that > 75% of their work centered on this population. All participants acknowledged an increase in the number of children and youth who are coming forward for services, with one community-based participant suggesting “especially with advocacy and community development.” Participants worked in a variety of settings including hospitals or mental health centers (n=7), community based organizations (n=5), schools (n=2), the child welfare system (n=1) and private practice (n=1). One participant who practices in a hospital setting stated that his “goal is to not run the clinic out of the hospital within the year” adding that he is looking at “a satellite clinic outside of the hospital” in order to demedicalize and depathologize the experience for trans youth who are seeking care. All 14 participants described the community in which they practice as urban, with three respondents stating they offer support and training provincially as well as nationally.

The literature suggests that language used to describe children with gender nonconforming interests and behaviors can be interpreted as inclusive and affirming or oppressive and harmful. In an attempt to be inclusive and not offend participants, I asked which term they preferred to use when describing the children and families with which they work. Half the respondents (n=7) chose one term with which they were most comfortable, and several (n=6) listed two or three terms with one subject stating he “uses several interchangeably.” One respondent chose not to list a specific term and described the population as “children/people whose interests and behaviors, and/or emerging identities trigger other people’s learned shame and fear.” The terms the participant professionals preferred included gender independent (n=5), trans (n=5), gender variant (n=3), gender nonconforming (n=2), gender creative (n=1), gender diverse (n=1), gender atypical (n=1), children with gender dysphoria (n=2), and children with gender identity disorder (n=1). One participant wrote that they use the latter two terms “for formal reports.” (See Table 1)

Table 1

Demographic Characteristics of Participants

		N=14
Gender	Female	5
	Male	6
	Trans man	2
	Cisfemme male	1
Race and Ethnicity *	White/Caucasian	10
	Filipino	1
	South Asian	1
	European	4
	Canadian	4
	Jewish	5
Discipline	Medical doctor	5
	Social work	5
	Psychology	3
	Psychotherapy	1
Years' Experience with Population **	1-3 years	6
	5-10 years	4
	11-38 years	3
Percentage of Caseload **	10-20 %	6
	50-80 %	4
	> 90 %	3
Practice Setting *	Hospital or mental health centre	7
	Community based agency	5
	Schools	2
	Private practice	1
	Child welfare	1
Practice Community	Urban	14

* Some participants identified with more than one category.
** One participant chose not to respond to years of experience and percentage of caseload.

Lack of Consensus about Best Practice Models

This section details the subjects' responses to the question: *In your opinion, why do you think consensus about best practice models for working with gender nonconforming children and families has not been reached?* The data are presented in the following sub-sections: recent phenomenon, issues of discrimination and oppression, the legacy of a pathologizing model and scarcity of empirical data, the debate about terminology, and the lack of collaboration.

Recent phenomenon

A significant number of participants (n=10) answered that "it is too soon for consensus" (n=2), that working with gender nonconforming and transgender children is a "rare phenomenon" (n=4) and "very young work" (n=4). However, most respondents (n= 9) felt there is movement towards consensus, and as one participant framed it "we are well on our way; it's unstoppable, but we're not done yet." A few respondents shared that it is only of late that people are even talking about gender diversity and professionals are beginning to talk about how to work with the "explosion" of kids they are seeing in their practices. One participant put it this way; "It is only relatively recent that people are putting together conferences about working with children with gender variance."

While some participants (n=4) believe that on the whole, society has moved towards acceptance of people who identify with the LGBQ community, they describe a slower change and acceptance in the trans community. In one participant's view, "It just seems in terms of one community finding acceptance and affirmation, that the gender independent and trans community are not there yet." Historically, it has been very challenging because gender diversity is not widely known or accepted and it is difficult to confront entrenched gender roles and stereotypes (Burdge, 2007; Ehrensaft, 2011). Explaining that as a society we have not evolved enough for acceptance and affirmation, one respondent stated, “the pathologizing piece” is not necessarily from an “ill-intentioned” place, more from “I don’t understand it therefore it is wrong.” With respect to gender independence, one participant qualified that there needs to be a shift away from “I care about this kid and I don’t want their life to be hard” to “I care about this kid and I need to support them to be authentic and [simultaneously] work on the rest of the world.”

A number of the participants (n=6) expressed optimism and a perception that there appears to be a change in society’s willingness to consider new issues. A few participants acknowledged that cultural shifts take many years and possibly generations, and that although there is a shift because of media attention and considerable more discussion, gender diversity remains a new phenomenon for a lot of people. One participant shared the following:

> Only now, happily, people who are directly involved are finding a voice. And for reasons that I am not sure, there seems to be more inclusivity, more openness within the larger community who really look at this and take on a new perspective. And so that’s given us somewhat of a conflict between what was and what is. And it’s very hard to change old habits.

One participant responded by saying, “I haven’t experienced it as debate, I’ve experienced it more as a legacy of mispractice that is more recently being challenged” with an emergent discourse around diversity and affirming. Four participants credited the World Professional Association for Transgender Health’s (WPATH) New Standards of Care (September 2011) for the shift from pathology to diversity with respect to work with trans people. One participant referenced the following “victorious” quote, “transgender identity is not a question of pathology but of diversity, and anyone who attempts to change this is unethical.”

Discrimination and oppression

Many participants (n= 8) stated that prejudice, discrimination and oppression play significant roles in the lack of best practice model consensus. As one respondent strongly stated, “we aren’t talking about anything that has to do with science, what we are talking about is discrimination.” Several participants described a “biased” and “privileged” fundamental belief that gender identity should be aligned with physical sex, that physical sex should determine our gender identity, which is the preferred way of being in society. Some participants drew parallels between historical views about homosexuality, whereby heterosexual orientation is preferred with the view that it should be promoted as much as possible and that children should be guided in that direction.

A number of respondents (n=6) stressed that steeped in bias is privilege, and those of us whose gender identities happen to agree with their physical sex have privilege. Many stated that there needs to be a greater understanding that gender identity is in fact a spectrum, and as one person said, “when practitioners believe that gender identity should agree with physical sex, they’re failing to understand the spectrum of gender identity and they’re operating from their own belief system which inherently is responding to social pressures to fit in.” There is an assumption that a transgender child has a psychiatric problem, instead of understanding the spectrum of diversity that exists within the human condition across many measures (race, ethnicity, faith, sexual orientation, height, weight, etc.). A few respondents (n=3) described an element of prejudice amongst some professionals who, in their opinion, have bias against the existence of transgender and whether it is a phase or a reality for youth. One participant put it this way, “it makes sense that a community of service providers is going to represent the spectrum of society in not being able to understand and affirm.”

Several participants (n= 6) described elements of *power* at play in the lack of best practice consensus. One suggestion is that there is power in maintaining the status quo:

> If practitioners believe that their job is to help the child fit in, to live a normal life and that this child's rebelliousness against the family's attempts to do that are problematic, then the practitioner may then continue to pressure the child to fit into gender stereotypes.

Some participants (n=4) voiced their belief that there is tremendous power inherent through which clinics and agencies receive funding, why and by whom. As one social worker said:

> It means that those gender identity clinics are established with a lot of power and have been granted a lot of authority. And then those clinics then continue to turn out research and continue to provide treatments that operate from a lens that gender identity should agree with physical sex at birth, then really the research is biased, I believe. And they hold a lot of power in determining how other practitioners will deal with children who come before them who are gender independent.

A few participants (n=4) voiced that care providers have significant power given that they may represent a place of authority within systems. The medical paradigm within which Western medicine operates is one that grants considerable power to medical practitioners, other care providers and social services, which has been difficult for the general public to challenge. With more focus on human rights and the onus on professionals to provide culturally sensitive services, changes are slowly taking place. Three participants identified that these changes create opportunities for families to not necessarily follow the advice of practitioners and in fact "listen to their children in ways that would have been more difficult a few decades ago." Several participants (n=4) note that it is children, and the families who are listening to their children, that are now leading the way in transforming best practice models. It was suggested by some that clinics that are not listening to the children and families' voices, and therefore are not changing their approaches in response to the voices of children and families, are holding onto their power.

Finally, it is argued that a great deal of power lies in how systems operate to reflect and reinforce homophobic and transphobic attitudes and beliefs. One participant stated that there is "homophobic fear that a gender independent child is going to grow up to be trans, gay or lesbian" and many systems work together to reinforce these dynamics. It is argued that all our systems: the education system, medical system, child welfare, social services, faith and cultural systems work to reinforce gender conforming behaviors. In one social worker's words:

> When these systems operate from a model that views gender nonconformity as dangerous and will punish those who step out of the gender lines, that's incredibly powerful and oppressive to those whose gender feels different from what other people think it should.

The legacy of the pathologizing model and scarcity of empirical data

More than half of the respondents (n=8) stated that the legacy of a pathologizing model, the inherent power in the medical model, and insufficient data to support an affirming model of practice all contribute to the lack of consensus of best practice models. As one respondent put it, in "this developing field, there is not a strong evidence base for one type of assessment and treatment protocol." Another subject firmly stated, "There has been research done, and that research is invariably flawed, but unfortunately has allowed people to fall back on that information in terms of being the best empirical data we have." Explaining further, this participant believed there has been a number of subjects lost to follow-up and therefore "a significant cohort in much of the research that we never hear what the outcome has been" which in the respondent's opinion should not be ignored. In another subject's view "there is a lack of scientific rigor applied to professional practice analysis."

A few practitioners (n=3) identified the lack of long-term outcomes in terms of the safety and effectiveness of hormone interventions as either harmful or beneficial as contributing to difficult decision-making and lack of providers' confidence in suggesting a particular treatment option for some youth. One physician commented on the *fear* inherent in a lack of consensus for some practitioners, adding, "It actually builds or creates more of a problem because people are afraid of stepping up and making recommendations because of potential repercussions or judgments from their colleagues or others if proven wrong." Other participants noted the lack of long-term follow up studies to explore individual health and wellbeing ten years after intervention. Two respondents commented that most children who are seen in gender identity clinics do not identify long-term as trans; they "desist." Questioning further "what does it mean to desist," one participant wondered if it suggests a change in brain anatomy or structure such that the person no longer identifies as trans, or does it mean they have been socialized in such a way as to "disavow themselves from their own identity?" This participant believes that some of the "presumptions upon which reparative therapy, in particular, was developed are just flawed."

In describing the lack of empirical data to support affirming practices, one participant stated:

> I think it is the tension between old and new. There's this discourse that is emerging in a different way around affirming practices, however, a lot of the theoretical framework is based "on our gut" – it's what we feel and it just makes sense to support parents and we're seeing the benefits in terms of our practice but there's no research. It's just emerging so it doesn't have a legacy. If it had the same legacy as the pathologizing model there'd be no question because it just makes sense intuitively, on every level. The results are staggering between kids who have supportive parents and kids who don't – it's literally life versus death. It's just a matter of time, providers want data and there's lots of data to support pathology.

Most participants described the two camps (pathologizing and affirming) as polar opposites with one participant stating:

> I think there are two main camps and within that there are variation: people who think that children with gender variance are better to have their expression of gender variance be subdued, and others who think that it should be allowed, and even encouraged and supported in different ways…Probably the first group tends to see gender variance as something that went wrong, a pathology, and the second group tends to see it as a normal variant.

Many participants shared that even though the pathologizing model has been around longer, there still isn’t very much written about how to treat these children. There is information about how to view them, assess and diagnosis, but little on what to do. One participant shared, “I think people often feel torn about how to help these kids” adding that in their opinion, “the lack of consensus reflects how people feel on the inside.” A few subjects (n=5) suggested that parents’ own philosophical predisposition likely leads them to look for one type of clinician over another. Four participants shared that although many providers are practicing from an affirming framework, families and other professionals and families are not even aware of this option. As one subject put it, “it’s only if you are an insider” that you can help families find links to other like-minded professionals.

One participant responded, “I’m not looking for consensus, in the sense that if consensus implies compromise, then it’s not something I am interested in.” It was suggested that those who work within this area see the camps as not overlapping enough to seek consensus. Describing it as a “battlefield” at times, one subject said that “it’s not about trying to get consensus, it’s about trying to win”, adding that it is currently “us and them” which galvanizes people into a camp.

Finally, a few participants (n=4) acknowledged that within the affirming framework there is considerable variation. Most believe that as the affirming framework becomes more identified as best practice, more people will align with the framework but perhaps not all of the goals (n=3). Of note, eleven participants self-identified as practicing from an affirming theoretical framework. As one social worker stated, “Once you work with people, I don’t understand how you aren’t in the affirming camp. Once you hear a five year old express to you who they really are, how could you think any differently?”

The debate about terminology

Four participants identified the debate about terminology, specifically language and terms used to describe the population, as another reason for the lack of consensus. In one participant's view, "vocal folks nowadays are adopting alternative terminology," and although other people may not wholeheartedly agree with the terminology they are decidedly less vocal and visible "and just stay out of trouble because it is so controversial."

Two participants challenged the language I chose to describe the population in my study. As one subject put it:

> I think there is a lot of confusion in terms of what these terms mean. As much as I like the umbrella term [gender nonconforming], I think it leads to much confusion. I think when we are talking about best practices we have to be very specific when we make a best practice guideline, or model, in terms of what we are actually dealing with - and when you have these large umbrella terms it's just not possible.

This participant added that the lack of consistent terminology makes it "difficult for providers to communicate with each other and also for families and youth themselves." The respondent expressed being somewhat disappointed to have *gender identity disorder* (GID) removed from the DSM 5 because they found it to be a very clear diagnosis. In their opinion, the term *gender dysphoria* may or may not include wanting to transition which can make things more complicated for providers as they figure out how to help youth. Two participants suggested that this study should have focused more specifically on either children aged 3-12 who may be experiencing concerns with gender expression, or youth aged 12-18 with gender dysphoria who may be exploring transitioning.

Another participant remarked that by not including the DSM-IV-TR diagnostic terms gender identify disorder (GID) and DSM-5 gender dysphoria in my description, I (the researcher) was exposing my bias towards an affirming and supportive framework. In their opinion, "Gender nonconforming makes certain assumptions that suggest a particular philosophical position that perhaps you are taking, which is fine, but should be unpacked." A few respondents (n=3) believe that one of the issues to consider is what is meant by all these terms, with one person suggesting that the terminology one uses is "layered with underlying meaning." These respondents argued that newer terms such as gender creative, gender fluid or gender queer are seen as very political and meant to depathologize, but suggest their meaning is unclear. In one participant's experience, the children they see "are anything but fluid" in their gender expression, "they are as rigid as typically developing children." It was suggested that research should be done to operationalize what one actually means by gender fluid, gender creative, or gender-queer.

Lack of collaboration

In three participants' opinion, there is a lack of consensus because "there has not been enough of a professional conversation" about working with kids with gender variance. In Canada, consensus is still far from a reality because people are working on their own without necessarily communicating with partners in other places. As one provider stated:

> We don't have a long standing history of collaboration across professionals, across disciplines, across centers, let alone across different communities…even in the same city you don't necessarily have two different university centers speaking to each other about how they care for gender variant kids.

This participant stated that there has not been a community-based conversation about best practice models, which has "prevented consensus" because everyone has been in a "silo developing what they feel most confident, doing", adding "there have been numerous pseudo good practice models that have been developed individually without collaborators." One reason this participant cites for silo, or fragmented care, is the language divide between Anglophone and Francophone medical systems that reach out to and learn from international sources, however are "not necessarily talking to each other." As other participants have experienced, this respondent feels that the community itself (gender variant children and families) is helping to break down the silos because "as long as they are being served properly by knowledgeable health care providers" they do not care what language they are served in.

One participant suggested that both the artificial language divide between Ontario and Quebec, as well as the underlying competition between two leading health care institutions (namely the University of Toronto and McGill University), contribute to the lack of consensus and collaboration. This participant wonders if the misconception that one must speak French well in order to collaborate with partners in Quebec contributes to an artificial academic silo. Stating "we would be much better served working in partnership", this respondent would like to see more national collaboration and providers who publicly build community as they work with trans and gender variant communities.

One physician argues that like the United States, professionals in Canada have formed many silos that are cut off from a national discussion. "So, I think we aren't quite there yet in Canada, to break down the ideologies that have contributed to silo-health care around the gender variant community – I think we are getting there, but it is still going to take some time." A few participants credit *Gender Creative Kids Canada* for working to build community and set up a national registry of professionals who work with gender nonconforming children, and *Rainbow Health Ontario* (RHO) for working to build community to collaborate and support one another as we bridge the divide between Canadian provinces. Several participants (n=6) also credit RHO for working to educate professionals, supporting and offering guidance to families, and for their efforts to build community.

Why is a Lack of Consensus Unacceptable?

This section details the subjects' responses to the question: *why do you think the mental health community isn't okay with the lack of consensus?* Of note, most participants (n=9) found this question confusing; with one commenting on the double negative, three asking for clarification about what was being asked, and five wanting the interviewer to define "mental health community." As the interviews progressed, the interviewer simplified to inquire more generally about "community", which again required further explanation before participants responded. The data are presented in the following sub-sections: provider anxiety, professional training and attitudes, and do no harm.

Provider anxiety

More than half of the participants (n=8) described the "anxiety", "uncertainty" and "fear" that can be provoked both among professionals who have either little or no prior experience working with gender nonconforming children, and professionals who disagree with what the current empirical data suggests best practice should entail. Providers who may be working with gender nonconforming children for the first time, or are new to the developing field, are often uncertain about how to best support the child, their family and in some instances other systems (school, church and extracurricular activities). A number of participants (n= 5) stated that it can be very confusing for people who are unfamiliar with this population, and as one respondent stated, "they're well-intentioned, they want to do it right, and they go and look up and there is this complete lack of consensus." As another participant has found, "the conflict is so diametrically opposed in terms of the two camps, so to speak, that it leaves the inexperienced provider out in left field a bit." Another participant put it this way, "I think that people see this as rare, or not in their area, and it makes them nervous" adding:

> Someone who is not involved might see this as a problem but not want to offend the family, or they might not see it as a problem but they are scared they would be encouraging families to let their kids do something that is not good for them if they really let them express their gender experience. So I think that often people feel torn, so really, the lack of consensus reflects how people feel on the inside.

Several respondents spoke of the anxiety inherent in the lack of consensus (n= 6). Five participants said that deciding whether one path is better for a child is complicated and they attribute the disagreement amongst providers to very fundamental philosophical and theoretical disagreements that inform treatment. A few participants addressed the challenges inherent in supporting very young and prepubescent children given the more recent increase in the numbers who are transitioning socially, the recent literature that cautions social transition as only 20-25% persist, and the lack of long-term follow-up studies with respect to the safety and effectiveness of puberty suppressing hormones. One physician shared their concerns about the potential risks involved in prescribing alternative forms of treatment, specifically hormones, saying, "what if we are wrong and 10 years from now these kids come back to us and say, you know what, I was 14, I didn't know, I didn't really appreciate what my life was going to be like in the future. Why did you let me make this decision?" One participant voiced anxiety about new treatment options for transgender youth saying, "if we are right, that's wonderful, and if we are wrong, how much harm have we done? How many people have we persuaded to do wrong by sharing our new school of thought or our new approach?" One participant described his own initial "fears" and his progressive shift to a much more "hands off" approach that he has developed over time. He has come to believe that kids need to find their way, and adults, professionals, parents and teachers need to follow their lead.

Uncertainty and confusion can be anxiety provoking for some providers and paralyzing for others (n=8). The anxiety stems from providers not trusting their own judgment and what feels right for them based on how they hear and experience the child and their family (n=5). Many participants shared that often providers refer out to the "experts", to those in positions of authority, rather than trusting that they would be able to compassionately and ethically work with the child and their family. It was reported that some medical and mental health professionals choose not to work with gender independent children and families (n=4). Expanding further, one respondent shared that some pediatric endocrinologist colleagues do not consult with or treat gender nonconforming children and their families. These professionals reportedly state they do not have time to develop expertise in this area, adding that they are not getting any referrals. In short, some health care providers argue there is no identifiable need for care, while in reality it is more likely that gender nonconforming children and families self-select out of working with certain providers. A few participants (n=4) stated strongly that choosing not to work with this population, more specifically trans people, is in fact harmful and puts children who are entering puberty at high risk.

One participant stated that five years ago the consensus would have been closer to the pathologizing model. They report being encouraged that the current lack of consensus reflects discomfort with the older model and progression towards affirmation and acceptance saying, "the lack of consensus is a sign of progress, we are moving towards a new consensus" by having the discussions and the debates. Finally, another participant shared their own view and at the same time paraphrased what many respondents have found:

> I don't actually feel like I need consensus and I just need to know who other people are and what they're doing so it will help improve my practice…as long as I know I am serving my population properly and what I am doing is out there for professional consumption, so that I can get feedback and critique if I am doing something wrong. But I don't need to fall in line with an algorithm of 1-2-3-4, because not every person is the same, not every trans person is the same. I actually am okay without consensus but I think the medical community, and particular the mental health piece of the medical community cannot really function without consensus because they are accustomed to –

> and almost programmed to – follow algorithm-based health care. If there's no label, no diagnoses, no steps, no standard that is backed up by another bunch of professionals somewhere, hopefully everywhere, they don't necessarily feel confident in making decisions because I think they've been trained to think in life and death terms: *If I make the wrong decision, this patient might go kill themselves. Then I'm liable for the suicide.* It's that kind of thinking that undercuts being independent and making intuitive choices when you're dealing with a family or a patient and being able to understand their needs best.

A few participants referenced the intensity of the debate that rages, and the intensity of the feelings that can be ignited when discussing approaches to care with gender conforming and transgender children and youth. One participant suggested that there is a lot of "intense emotions" in the lack of consensus because of the experience of some individuals who advocate working from an affirmative stance, adding that there are "many people who are both consumers of the system and advocates within it." Dr Ken Zucker, Clinical Lead Gender Identity Services and Psychologist in Chief at the Centre for Addiction and Mental Health (CAMH), put it this way:

> It's a political area so you have to enjoy politics or it would be unbearable. I kind of like politics. Most of my trainees are just – I shouldn't say just – most of my trainees are smart, caring people who vary in how aware they are of the politics…they just want to help people. But the politics sometimes can be quite nasty and I think some people are over involved with the issues because either their own personal experience, or their kids, and I think the gender transition subculture is fascinating because it's developed an identity, a life force of its own. One of the interesting issues that goes back to question one and it's a theoretical question that ultimately it has clinical implications which is, "To what extent does the adoption of this terminology or the encouragement or support of kids gender transitioning affect long term developmental trajectories?" I think it does and I think it is what I call sometimes, in the media, an experiment of nurture. Again, it's separating values from empirical data because deciding whether or not one pathway is better for a kid in the long run is complicated.

Professional training and attitudes

More than half of the participants (n=8) stated that providers have been trained in systems in which "experts" are seen as the authority and research dictates practice and preferred outcomes. Providers want to engage in "evidence based practice" to ensure that the care they are providing is following best practice guidelines. Evidence based practice requires a review of the scientific literature which one combines with their clinical expertise. Over half of the participants (n=8) spoke about the complexities of working with gender nonconforming children because of the lack of literature, conflicting findings, and contradictory opinions.

A number of participants (n=6) believe that the need for evidence-based practice undercuts being independent and making "intuitive choices" that take into account what is best for the individual and their family. One participant asked rhetorically, "What does evidence mean? It means you have money and prestige." A few participants (n=5) explained that there is friction because there is evidence for a pathologizing practice and a push for an affirming practice that feels more intuitive but is only beginning to have supporting evidence.

It was suggested that doctors, psychologists, family therapists and social workers require more learning because training programs are set up such that no one really thinks independently (n=6). Professionals have been trained to seek an opinion " because they don't trust their own judgment and their own sense of what feels right"; they are looking for the "right answer" from someone in a place of "authority" (n= 4). As a society, we have been raised to think and believe in authority, to believe that someone else knows the answer rather than have a sense of empowerment that we can trust what feels right professionally and how to handle it. Four participants, all physicians, believe that one has to train oneself to see things a little bit differently and learn to trust oneself and the conversation they are having with the patient. Three participants emphasized that "making intuitive choices" is a professional attitude and a professional choice.

Referencing an internal struggle with the pathologizing approach, Dr. Stephen Feder, Head of The Division of Adolescent Medicine, Children's Hospital of Easter Ontario, shared "it was counter-intuitive, but it is what the research said. It puts you in a very, very delicate position of promoting something you don't feel is okay, and asking parents to do something they don't think is okay." Dr Feder explained that as he became more involved with the communities of trans people and people working in this area, he heard and learned about the pain and suffering as a result of some of the pathologizing, or in their words "reparative," interventions. Being "present" with individuals and communities has been "eye opening" for this physician and lead to his affirming practice.

Several participants (n=5), primarily physicians, shared that they were trained in an era at which time the "reparative" (n=3) model was the accepted theory, and which influenced the thinking and training of most mental health professionals in Ontario, in Canada and in the US. They relayed that during their training, Dr. Zucker was the public face of this approach; he was widely published, often the invited expert speaker at conferences, and as one participant stated, the professional training offered suggested that "if you get these kids young enough you can make them normal."

One pediatric physician shared the following history. In the 1990's the thinking with intersex children was that before the age of three doctors could choose the sex of gender rearing based on what they felt would be the best surgical and physical outcome from an external genitalia perspective. Parents were then instructed on which gender to raise their child. It wasn't until the 2000's when John Money's research was found to be fraudulent, that physicians began to listen to their clients and question whether one could change gender rearing and gender identity. Explaining how the new information influenced their practice and concerns today, this participant said:

> It was a real wakeup call to all of us, in how much harm had been done to those kids and those parents over the previous several decades… We lived through that, we did harm to

> families because we were told that you could do this, that you could change gender rearing and gender identity and it would be successful as long as the child was young enough. And then we find out we were given bad information, bad advice and fraudulent data, and in fact that they had unsuccessful outcomes and damage was done to these families.

Sharing this history, the participant stated their current concern that in medicine one holds onto facts until proven wrong, stating "if you're right, that's wonderful, and if you are wrong, how much harm have you done?"

Do no harm

Fifty percent of the participants (n=7) spoke at length about the harm they believe has been done to individuals, as well as to the trans community, as a result of transphobic and pathologizing approaches. In one respondent's words:

> I'm not okay with the lack of consensus because I find a clinical pathologizing model very harmful. And if there is a particular approach that is potentially harmful or may potentially cause other issues or mental health problems than that's problematic. I think the medical pathologizing model of labeling has serious potential to be harmful to young people, so I am not comfortable with it being a primary option, and a well-respected option, in the community.

Another participant explained that they get very concerned about the long-term impact on a gender independent or transgender child who constantly gets pressured to conform to gender boxes. Many (n=6) emphasized that they have heard from and worked with individuals and families who have been hurt by, in their words "traumatized" (n=3) by the pathologizing model.

Four participants referenced more current evidence in support of affirming practices, specifically Ontario data that Trans Pulse is using (n=4) and the Family Acceptance Project (FAP) in the United States (n= 3). Three participants referenced the findings from FAP which found that parents' responses to their children had an enormous impact, and that one of the most important things that parents can do to promote positive outcomes for their children is to *support* their gender expression. As practice models are often instructions to parents about how to respond to their children's gender expression, some participants feel that parents are basically being told to reject their child's gender expression and not support their children. With publications by Trans Pulse and the FAP, there is now data on the outcomes when parents reject their children and "dramatic data" to show what happens when parents support their children's gender choice. Recent studies have found that family acceptance of an adolescent's lesbian, gay, bisexual or transgender identity is associated with young adult positive health outcomes (self-esteem, social support, and general health) and has been shown to be protective for negative health outcomes (depression, substance abuse, and suicidal ideation and attempts) (Ryan, 2010, p. 210). Ryan found that with LGBT identified adolescents who had highly accepting families, 18.5 % reported thoughts of suicide and 30.9% had attempted suicide. Alarmingly, with LGBT adolescents who describe low family acceptance, 38.3% reports suicide ideation and 56.8% had made attempts. As one participant stated, "we need to start to understand the damage that's caused when working with children, youth or families and are encouraging gender role stereotypes, because that can kill our young people."

Citing his "international" power and "legitimacy", six respondents criticized Dr. Ken Zucker's pathologizing, or "reparative" approach to working with gender nonconforming children. Three other participants referenced the gender identity services at the Centre for Addiction and Mental Health (CAMH) and another two participants spoke more generally about "the other clinic," referring also to the clinic at CAMH. As one participant said, "people always say Zucker is controversial, but the problem with him is not that he's controversial – that's not why we're upset – we're upset because of what he's doing and not what he's saying." Respondents state that his approach has been harmful to gender nonconforming and transgender people on two levels, micro and macro. On the micro level, there has been direct harm to the individual (n=5), and on a macro level, there is *symbolic harm* in setting up a treatment program to prevent someone from becoming trans. One participant suggested that because the stigma of being a trans person is still strong perhaps preventing someone from becoming trans is considered a reasonable goal for some. However, participants are concerned that the symbolic harm contributes to feelings of hopelessness and trans identified people believing "there's no future for me." Research shows that the community experience does have an impact on suicide rates.

One participant said that while following the medical maxim "do no harm" is honorable, refusing to work with gender nonconforming and transgender children because it is "out of their scope of practice or a potential liability", is actually very harmful. Not doing anything is not being neutral. On the contrary, there is evidence to support that refusing to work with transgender youth who are entering puberty comes at a very high risk to their mental and physical wellbeing, and perhaps to their life.

In closing, one medical doctor summarized what many (n=7) participants had shared:

> People have been hurt by a certain approach, and that's not acceptable. We are supposed to "do no harm" and I think we have to just not allow that to continue. As providers the onus is on us to do the best we can with the information we have, always with an open mind to evaluation, "is this really working?" and to looking to other paradigms to deal with it. We need to be very sensitive about where some of the information is coming from and whether it has the potential to harm an individual or a family.

Dr. Zucker believes there is "disagreement among the people who work in this area because there are theoretical and philosophical disagreements." Referencing work done by the Dutch, Dr. Zucker estimates that in five years professionals will be saying "If you gender transition your kid at the age of 5, he or she is going to be more likely to go down a sex reassignment pathway than if you don't do that." Dr. Zucker stated that some parents and professionals take a very essentialistic view, "this is who my child is and I am just letting her take the lead." Zucker believes that there is no willingness on the part of these parents and professionals to suggest that there is an interactive process going on. As Dr. Zucker notes, "So if you say this is who a child is, then it would say nothing can be done externally to move a kid away", adding, "I would certainly argue that one has to think about if one does want to modify or shift a child's behavior, you have to have a sophisticated model to work from."

Why Does the Debate Continue?

This section details the participants' responses to the question: *Why does the debate continue?* The data are presented in the following sub-sections: lack of empirical data, complexity of care, prevailing power hierarchy, and remedying a system deficit.

Lack of empirical data

More than half of the respondents (n=8) identified the lack of empirical data, particularly randomized controlled studies (n=2) and long-term follow-ups (n=6) for contributing to the ongoing debate about which paths to take when working with gender nonconforming and transgender children and families. As one participant stated:

> I think it is very hard to prove anything in this area unless anyone did a randomized control trial where some families were told to treat their child this way and some a different way. It's impossible to prove that the outcome is the best one or the worst one that could have happened.

Several participants expressed that it is impossible to prove best outcomes without long-term follow-up. Another participant stated "papers have an impact on how care providers work and think," and in their opinion it is "exciting" to have the beginnings of research to support the shift to an affirming and supportive approach. Referencing the delicate and challenging decision of whether or not to prescribe hormones to trans youth, one participant emphasized, "Until we know that those kids are healthy and happier in the long-term, I think the debate will continue because many people need data and are not convinced by short-term results." The difficulty lies in the fact that the medical community needs research to support decision making for providers, for the individual patient, and for families. In one participant's words:

> Parents need data. Parents are helping make decisions for their youth; they want to know what happens. How many kids changed their minds? How many kids, at the end of the day, 10 years out, say I made the right decision, I'm happy.

With the number of children and youth seen in clinics increasing "dramatically" in only a short period of time, participants caution about sensitively balancing the need for long-term outcomes and follow-up studies with the trans community being skeptical of research (n=3). While participants acknowledge that people have been hurt by prior research, at the same time they believe it will ultimately be important to be able to argue coherently using solid information. As Dr. Feder emphasized, "the onus is on us to make sure that anything that is researched is not for our own resume, but rather in order to move this field forward in a way that's positive and constructive and helpful to those who are most directly involved."

Three participants stressed the need for a shift in research paradigm and encouraged researchers to consider the following: How do we plan our research and for whom? To whom are we most accountable? How many of us are promoting community action based research or participant action based research and evolving language of accountability. As one participant put it:

> This is about the hard work of coming out of old paradigms of research with a sole researcher owning, controlling, and competing with longer-term community development models of empowerment and accountability. And more skill sets that include education training, communication, conflict-resolution, accountability, and maybe even looking at different ways of expression that aren't normally academic writing that are significant knowledge transfer outcomes. Who says what that needs to look like? People who are most vulnerable should dictate that as well. It's not just about getting published in a prestigious academic journal at a rate where one can maintain tenure. Education, research and community engagement are all affected by neoliberalism in action in academia. It's really influenced by financial bottom lines more than ever before. Social action and community based research are models that take more time, a broad skill set,

group development work, and shifting of power, as well as methodological knowledge and experience.

The complexity of care

A number of participants (n=7) on both sides of the debate have found that working with gender nonconforming children can fuel anxiety and uncertainty among providers as well as among their parents. The lack of best practice consensus is said to exacerbate the discomfort. One participant stated that exploring services and support for their gender nonconforming child, "causes a lot of anxiety for parents and becomes even more confusing when there's different opinions and guidelines out there through the media or through different professionals that they speak to." Some parents reportedly emphasize how liberal and accepting they are but at the same time communicate ambivalence at not being sure if they are "doing it right." Parents worry long term because issues of gender identity, particularly for transgender children, are portrayed in the media as a very difficult path for kids to navigate; the risk of suicide is often top of mind. Parents want to support them the best way they can. Participants unanimously acknowledged the higher rates of internalized and externalizing problems facing this very vulnerable population. However, one participant said, "I think the data on completed suicides is probably over-stated", they believe that trans youth in Canada are more at risk for violence and murder.

Working with gender nonconforming and transgender children is a rather rare phenomenon, with only a few specialists who practice from different philosophical and theoretical frameworks in major Canadian cities. A number of participants (n=7) from both camps acknowledge that they see "biased samples" with families who have researched the different clinical options. In one participant's words, "I see a biased sample because people who think these kids aren't meant to express themselves go to another clinic – if they know about both and have done their homework." Children, parents, teachers and guidance counselors, seek "expert opinion" from specialists and the information and service they receive depends on the philosophical and theoretical framework of the individual or clinic they sourced.

Acknowledging an affirming framework that has been nurtured over the course of their practice, one participant shared that "Instinctively, I think they want to support these kids because it feels so honest and true the way these kids experience gender." A number of participants believe it is really difficult for professionals and parents to take a stance in isolation. These adults reportedly seek out confirmation, and in one physician's words, "once they hear me say it they say yes, that's what I was thinking, that feels right, that makes sense to me." Citing an example of a social worker from a Catholic School Board who was seeking guidance about how to support a trans youth one participant shared, "when she came to us the best I could do was congratulate her for being brave enough to be an advocate for this child. She did the best she could, but in the end the parents blocked her from seeing their child and the school supported it." In this participant's view, the experience "was very sad."

Most respondents (n=9) have found that working with gender independent children and transgender children can be very complex and at times overwhelming. One participant suggested that some professionals have "preconceived" notions about how difficult and challenging the population is before they even see a single patient. By having these preconceived ideas, one "cuts off certain possibilities and realities" which they argue limits care and adds to the debate. Finally, one participant shared "it is one of the most satisfying patient populations that I work with, but it's also draining and very intense from a time perspective and resources, because this is not simple."

The research out of the gender identity clinic at CAMH suggests that 20-25% of the youth they see do not follow a path to transitioning. Only one participant wondered about the more “permissive and supportive” clinicians who in their opinion “are much too quick to want to put kids on hormones” and cited an example of a 15 year old girl who came out as trans and reportedly “within an hour” her pediatrician was going to start her on testosterone. This teen’s mother found another professional to consult with and her daughter reportedly “has desisted and come out as gay.” According to the respondent, the teen shared that she just wasn’t ready to admit that she is lesbian. This participant believes that “in an era of being very permissive, it’s going to get more complicated because I think we are going to see more kids coming in where they are really using gender dysphoria as a solution to something else.”

Prevailing power hierarchy

In answering *why the debate continues*, one participant emphasized what the majority of participants (n=9) had expressed:

> History, hierarchy, authority, control, power, projecting one’s own experience as the right experience onto others, and not recognizing that some people have created and been given moral authority to impose their belief system and life experience onto others. And that’s all part of the tension. So that’s part of why the debate continues. It is some people resisting letting go and not honoring people’s self-expression and self-knowledge.

A number of participants stressed the power difference inherent in the larger urban clinics, specifically the gender identity services at CAMH, and community-based models of care. A number of participants acknowledged that community-based models do not have the same kind of funding, recognition or clout to influence large audiences across the world, or professional status that is conferred on them. Certain gender identity clinics that use the more traditional model have considerable power, and a few participants believe that as a society we are only beginning to grapple with these traditional views. One participant concluded, “It is where the power is, the OHIP [Ontario Health Insurance Plan] funding is going to CAMH’s gender identity clinic…so right now, when you have the money you kind of have the power," adding that "unless the funding gets realigned I don't see how the status is going to change."

One participant named "advanced capitalism" and "neoliberalism" as impacting who gathers in systems, what their morals are, how they patrol where money should go, and who is "*deserving.*" This participant believes that there is gate keeping through money and belief systems, and despite the more recent emphasis on human rights for trans people, oppression has cost the lives of people unnecessarily.

A good number of participants (n=8) believe that children can know who they are, and that as adults it is our job to help nurture that and help that child find their own path and their own voice. However, there is also power inherent in a system in which adults make decisions for children. As one participant stated:

> There is an assumption that children cannot know what is in their best interest, and we have to make decisions on their behalf, which certainly to an extent it's true we do, adults do make decisions on behalf of children, but there's a lack of recognition that children can understand and know how they feel and who they are. We assume that they're too young to know that this is just foolishness and we have to steer them in the right direction. There's a lack of ability to trust children's ability to know themselves and we don't know how to nurture that ability within children, in fact we shut it down more often.

When asked why the debate continues, one participant stated, "because of who is still in power" and another said, "it is startling that we could talk about this for an hour and only use his name for that camp." Another participant shared that the debate is not "raging" in his city quite the same way it does in Toronto, or in the province of Ontario. This participant offered the following:

> There is a bit of a vicious circle going on and I did sort of allude to this when I said that there is a lot of good stuff happening in Toronto, or Ontario, but it doesn't necessarily speak at all to what is happening in Montreal. By that I mean that the debate isn't raging quite the same way here, or the topics of debate are different here.

This participant noted that the “culturally debate-related conversations” are not going on between the trans community, specifically the family and the trans population itself, and care providers. The debate, as this participant sees it, continues because of providers “lack of confidence to make decisions on their own.” Providers seek support and consensus because the “pathology” is complex and overwhelming and there is a preconceived notion that working with this population can be very difficult and challenging.

More than half of the participants (n=8) referenced either the gender identity clinic at CAMH, or more specifically, Dr. Ken Zucker as having an extraordinary amount of power. As the head of psychology at a major health centre, and as the public face for the traditional approach, Dr. Zucker is considered to have a lot of power in the Province of Ontario, in Canada, as well as internationally. One subject stated, “Every family doctor, every guidance counselor at one point will refer to Zucker.” Dr. Zucker headed the DSM-5 international committee on gender dysphoria and is respected by some in the WPATH community. Many participants shared that Dr. Zucker’s views and practices are considered extremely controversial by many, citing the organization of international protests in response to Dr. Zucker being an invited speaker and named as the head of the DSM-5 committee.

One participant commented, “no one else is writing [papers] saying this is what we should do”, adding that while Dr. Zucker does train a lot of students, and did have contemporaries at one time, they wonder if someone else will “take up the mantel when he retires.” Over half of the participants believed that Dr. Zucker realizes his approach is considered controversial (n=8), with some wondering if he feels passionate about his beliefs or simply refuses to back down (n=4). One participant stated, “He’s not changing, he’s not apologizing” and another, “it’s astounding to be in his backyard.”

Remedying a deficit system

Dr. Zucker is aware of the controversies. He acknowledged that professionals will at times "dis CAMH," and shared, "I'm often accused of doing reparative therapy. I don't think most people know what it is, but it sounds bad." Dr. Zucker stated "Ninety percent of families that come to meet us are very happy once they meet us." He suggested that the following would be a fascinating research question: "What do the families look like that we see compared to the families who wind up going to see someone else?'

Despite their deeply held concerns, a few participants (n=2) acknowledged that children and families have been helped by the clinic at CAMH. Another participant cautiously stated:

> To be fair, there are families and young people who use his services and are quite happy with the approach and it works for them. But there is a large, large component of people, particularly in trans communities, who have experienced his approach as very damaging and very hurtful and harmful to them as individuals, and to the community as a whole. And I will never be able to accept that that's a primary option.

A few participants stated that while families may have found a service useful, it remains "really hard for me to refer families there" because of the harm that has been done to some individuals. When parents are exploring where to go with concerns about their child's gender expression, the first thing they find in their Internet search or through their family physician is the clinic at CAMH (n=4). There are seemingly no alternatives unless parents "happen to be in the know or know somebody and have talked to folks."

Several participants (n=4) acknowledge a "huge deficit" within our system. They believe the recently opened clinic for transgender youth at the Hospital for Sick Children (HSC) in Toronto, Ontario in October 2013 will be a "ground breaking piece in the community and the field." Putting HSC's reputation on par with CAMH's, these participants are encouraged that families will now have "access to folks who have a different perspective." These participants expressed excitement to be able to provide a range of options and then let families do their work and figure it out for themselves, with one social worker adding, “And I would never just endorse one over another, but generally one is left off the list.”

With the controversy not abating, and the risk of harm to children and families a concern, one activist stated, “it was time to stop fighting that clinic because we weren’t going to win. It was time to stop and start building alternatives. So we really shifted our focus and have worked quite hard to build alternatives.” A number of respondents (n=8) feel the approach to offer alternative practice and services has been successful. Throughout the interview, most participants (n= 10) recognize Rainbow Health Ontario (RHO) as working very hard to help Ontario be known as an “extremely progressive place for trans people and gender independent kids.” RHO is credited by one participant with “beginning to develop and armamentarium of empirical data, of testimonies” and of educational information that “will have the credibility that it takes to counter some of the high-powered research that has hitherto been unchallenged.” One participant acknowledged that it is very difficult for grassroots organizations to counter “the big guns” stating that being published in a medical journal comes with a great deal of respect and prestige, compared to an anecdote in a non peer-reviewed journal. In this instance, it has been very challenging to fight research with research. Others credit RHO for working to become a known resource to professionals, and for working towards building community so that professionals no longer feel they are practicing in isolation. Many participants were aware of or had participated in the gender independent advisory project that RHO had put together as one means to build professional community to increase networking.

Working with Gender Nonconforming Children and Families

This section details participants' responses to the final question: *From your perspective, what do you believe this population needs from the professionals who serve them?* The data are presented in the following sub-sections: an affirmative approach, family support, advocacy, and wise practice.

An affirmative approach to care

In answering the final question, most participants were eager to share their beliefs and practice approach with one participant stating, "I really like this question" and another enthusiastically replying, "Great question." An overwhelming number of respondents (n=11) described an affirmative theoretical framework with respect to working with gender nonconforming children and families, with seven participants naming the model outright. One participant stated, "I think, right now, all the things I would say are clustered under the title affirmation," another participant believes children and families need "a lot of validation and affirmation," and still another smiled widely and simply stated "shut up and listen."

Many participants believe children and families need validation and an opportunity to collaborate with a "team" of adults (parents, grandparents, aunts, uncles, friends and professionals (teachers, guidance counselors, medical and mental health providers when indicated) "who bring certain skills to the table in a very non-hierarchal way." They need to be validated, affirmed and supported. Families need access to information about treatment options; the pros and cons, the risks and benefits, and ideally, safety and effectiveness data with respect to hormone intervention. Children and youth need to know that they have options and "that there are multiple ways of being and they are OK and there are many people in the world who exist in different ways along the gender spectrum and that they can live full and happy lives and be OK exactly as they are." Children, teens and parents need to be aware of all the possibilities as legitimate life paths, healthy life paths, whether that's transitioning or not. One respondent emphasized:

> They absolutely need professionals who understand and value the full gender spectrum, who understand that gender identity and gender expression can be very different from what other people expect based on their physical sex at birth, or as operated on, if they're an intersex child. They need professionals who can help families understand and support their children, and children need clear messages from professionals that they are wonderful and fabulous just as they are.

While two participants shared that recent literature cautions the concept of social transition for younger children, the majority of study participants stated that they encourage and support social transitioning. One participant, who has been working with this population for a number of years, shared their belief that children should be encouraged to come out in their own community rather than moving schools or towns. In their opinion, "The kids I have seen in the last three years who have come out in a really open way, where everyone in the community knew, have done exceptionally well. They have not been bullied," adding, "I think what they all had in place was they felt sure of themselves, they really wanted to live that way and they had *key* family support." This participant stated, "The whole process has been quite astounding and beautiful. I see these children get generally more confident and proud, and families more confident." Another participant shared their experience that younger transgender children "are far more hopeful, far more positive, and far more 'out' and they don't really have much problem saying, *I'm going to have a gender transition at school…I'm glad and I want everyone to know*." This participant feels that younger trans youth have opportunities that the older generation did not have and "they're running with it and appreciating the efforts and the progress that has been made," expanding further to say, "They're just asking for more acceptance of trans individuals. Period."

Another participant, who did not declare a specific theoretical framework, described their approach to care as an "individualized approach applying a developmental framework and being knowledgeable about the literature that is out there when you're trying to help parents understand what's going on, especially when there's parents who've come in and have never heard the term transgender." This participant feels it is imperative that professionals are aware of the discrimination and stigmatization that these youth may face at school, with peers or in public, and help them "find strategies to manage that, especially given that we know this population is so vulnerable."

As an exception, Dr. Zucker responded, "You don't need to go to graduate school or medical school to be a babysitter, which sometimes [the word] supportive connotes to me." This participant acknowledges that other professionals in his clinic "are much more empathic than me, they don't have any trouble with the word." He argues that one can be empathic that a child is experiencing distress with respect to their gender identity, without making simplistic interpretations of the behavior. Dr. Zucker rejects the references to his approach as "reparative." He suggests that the there is a religious component to a reparative model and argues "the critique is developmentally naïve." Dr. Zucker stated:

> I'd agree that it would be as difficult for a person to change their gender identity as their sexual orientation, once you match for age, but to say that shifting a child's gender identity at age 3 is the same as someone trying to shift their sexual orientation at age 30 is ridiculous! If you look at some of the discourse on sexual orientation in females, where everybody says "oh sexual orientation in women is fluid, then it gets even more muddier" but I don't get into that stuff. To me, the confound is developmental levels, so I would be as reluctant to say to someone, "oh yeah your gender identity can change at age 25, as I would say about their sexual orientation." Philosophically, I could care less if someone wants to try something; it's up to them. We have some young adults in therapy who are trying to figure out their gender identity; it isn't fixed yet because they have unstable identities in general. So you let them sort it out but not with any kind of ideological axe to grind or biblical analysis.

Dr. Zucker stated that his work with gender nonconforming and transgender children follows a "developmental biopsychosocial approach."

Family support

The majority (n=11) of participants believe that gender identity and gender expression are not pathological. They stated that although a very vulnerable group whereby some children and youth may at some point experience mental health concerns that warrant care, the majority of the "work" in an affirmative theoretical practice model is done with families, more specifically with parents and guardians. With an emphasis on depathologizing children, one participant said, "The kids are fine and what isn't fine is the world around them." Another participant stated that children and families need "patience, understanding, openness, flexibility, creativity, care, and connection", adding "mostly I think families need opportunities to connect with each other." A significant number of participants (n=8) feel strongly that families need community, with one participant emphasizing, "what families need is not cure but community" adding that "the primary need is for parents to find each other, so parents are with other parents and kids are with other kids."

A number of care providers shared that an important piece of the work is to provide education and support to parents, so that in turn, they can be strong advocates for gender variance and develop a strong support system for their children. One physician shared that a goal should be to educate and support families early on before "they have a slew of negative experiences." A few providers often see parents independent of the children or teen, as one physician stated:

> I have the parents come in alone so they can dispel, they can express their own biases and prejudices and ask their question without either suppressing certain issues because their kid is there and they don't want to hurt them, or the opposite, expressing them and

> hurting their child. So I work very hard with parents to get them up to speed so that they can become the solid support that the kid requires.

Professionals are encouraged to help children and families find connection to trans and gender queer communities. Almost half of the respondents (n=6) identified that kids and teens need role models and mentors, "folks who live in all different spots on the spectrum." As one participant suggested:

> How often do these kids feel like they're the only one? And it's almost like people are afraid to allow them to meet other people like them. And they need to meet other people like them! They need to meet other kids who are like them, or who are somewhere on this broad and beautiful spectrum around what gender can be, so they see that there's all kinds of variation. And they need to meet adults who are like them, or who are at various places along the spectrum.

A few participants added that children and families need education and resources such as books and movies that show the spectrum of possibility around gender. As one social worker stated:

> Isolation is huge and the requirement that we place on children to be so strong—we test them to see how strong they can be in the face of having no one around them to turn to who is like them and we want to see - *Well is it really going to persist past puberty*? But we don't give them any opportunity to experience other people and the range of possibility. So I get concerned when I see kids who have been gender independent and then who become more gender conforming. I think for some of them that's their preferences, their tastes, their feelings, they just sort of shift over time, which is great, there has to be lots of space for that to happen. But there's a bias that sees that as the preference.

Dr. Stephen Feder shared the urgency with which he tries to see children and families, "I think they need to be seen in a timely fashion, so I consider this an emergency." In his practice, a child is usually seen within a few weeks of the referral:

> I think it's not fair to make them wait months. Oftentimes by the time this issue comes out, they've been struggling with it for months, if not years, and finally they can't handle it any longer and they just need to tell somebody, and I feel it's not fair to make them wait in order to do that. They need understanding, they need recognition that there are most likely going to be some difficult times in store, and that there's a commitment to following through regardless of whether things are going well or not well.

Many participants (n=7) spoke about meeting the child and family where they currently are, following their lead, and when appropriate gently and compassionately offering "guidance." Respondents recognize that there are certain obstacles and challenges that may appear over the course of the young person's process, around names, pronouns, socialization at school, and official name change for example. One physician stated, "We know this is going to happen so we need to just anticipate, and prepare, and introduce these topics at the appropriate times… Again, because we have more experience having been through it with a few people than they have, because this is their first time and they need a bit of a guide through it."

Care providers are encouraged to create an environment in which the child, teen and family feel respected, listened to and are allowed to tell their story (n=8), along with space to express all the challenges that might come up without pushing or shaping transition or gender fluidity. Speaking specifically about supporting parents, one respondent stated, "We need care providers who can sit down with parents who are really scared, or really worried, or really confused and just create that safe space to say, *It's not your fault, your child can have a good life.*" It has been found by many care providers that parents need strong supports and adults with whom to process their discomfort, grief, homophobia and transphobia. As one respondent has said to parents or guardians, "You're struggling. You need support. Your kids need you, so let's work through this." With respect to supporting children who do not identify with either gender binary, one care provider observed:

> I think the hardest experience with families is the kids who aren't either or. Again it's accepting that your kid may not be who you thought they were in terms of their gender assigned at birth, but having trouble getting outside of that gender binary. My kid isn't quite this and isn't quite that, can I live with that in between?

At the same time, many participants expressed concern that not every child or every family needs to be "served" or "space to process." As stated earlier, while some children and youth may benefit from mental health support, and children and youth entering puberty may require medical intervention, providers are cautioned to be very present and listen to what individuals and families need. Speaking primarily about younger children, one participant commented:

> They may need other things, but they don't need therapies because of their gender. They may need a space to talk about it and think about it, because they may not be allowed that space in many other places, but they may not. They may just be who they are and be totally cool with that and let's move on with it. And that's what I think is hard for some schools, let's get this kid to the social worker and let's get this kid this and that, and maybe the kid needs it and maybe the kid doesn't.

Advocacy

The majority of participants (n=9) believe care providers need to offer children and families hope, and to work as allies and advocates. Children and families need us to be able to see the strength, the courage, the beauty, and the richness that these children and youth have, and the incredible lessons that they have to teach us; working alongside the family, the school, the healthcare provider, the recreation program, or the summer camp. "We need to be in there educating and advocating for that child so that changing the world starts to happen in that child's world. So we have to be at the tip." Another participant shared that WPATH "outlines that advocacy is now part of the work you do as a mental health provider," adding, "to fight for our clients, to follow their lead, and support them in ways where we can use the power we have as providers to open doors and fight battles alongside them."

A number of participants (n=4) believe there should be "a fundamental shift at a cross-social level" that starts to understand gender differently and that starts to see, respect and value the gender spectrum. A few participants (n=4) explained that there must be a social transformation that starts to unpack how confining and limiting the gender boxes are for everyone, "including those of us whose general gender identity and expression more or less agrees with what people expect from our sex, physical sex." One participant summarized it this way:

> This isn't just about gender independent and transgender kids, this is about helping our whole society rethink how we understand gender and sexual orientation and be able to be more comfortable in our own skin and finding our own place in the spectrum where we don't have to feel afraid of being thought of as something that we've been taught to see as negative and therefore we alter our behavior in all kinds of ways in order to fit into the gender stereotypes because of the fear that we might be called a fag or a dyke.

Participants on both sides of the debate (n=3) note that a crucial aspect of education is helping the child understand that if they're facing harassment or problems with other people, the problem is not with them, the problem is with other people who don't understand and who learn to develop hatred against them and harass them. Emphasizing that the problem is not with the child, the problem is with other people, one participant stressed, "This concept, I think, is pivotal." These participants believe that more and more people are starting to understand that there is nothing wrong with the child and that they will be able to find people in their midst who can accept them for who they are.

A few participants (n=4) answered that gender nonconforming and transgender children require care providers to examine their own biases and privileges. They require providers to unpack the whole question regarding both gender and sexual orientation and what we really think and where our fears lie. One participant emphasized, "Being cis-gendered, I think it's important to acknowledge that identity, and that privilege, and to be up front about. I'm not going to have the answers but maybe I can be a conduit to connect you to folks who do."

Wise practice

In closing the interview and summarizing their philosophical approach to working with gender nonconforming and transgender children and families, four participants referenced "wise practice", "wise instructions" or a "wellness approach." One participant shared their belief that a wellness model focuses on “something we do to be well”, expanding that there are professionals on hand if needed but they are not at the centre of the model; the child and family lead the way. Another respondent described “wise practice” as a derivative from Aboriginal studies that includes local realities, cultural sensitivities and intersectionality. In their words, “all those rich complexities about really what it is to be human.” Finally, in describing their strongly held philosophical approach, one participant humbly emphasized the following:

> We need humility, because we have to see that these children are a gift to us, they have so much to teach us about unlearning the stuck gender stereotyping we’ve all grown up with in various forms. And the incredible gift that they bring to our society, and, to honor them. I often look to, or think about the traditions within First Nations communities where two-spirit people were not just accepted, they were honored, they were seen as gifts to the community, they were highly-valued because of the greater understanding that they could bring to the whole community. That’s where we need to get to. And First Nations communities taught us as well that *there’s always room for everyone at the circle…* and what that really means is, there’s room for everyone to be who they are, as they are. So we don’t need to change who we are to be part of the circle. That’s a very powerful concept, when we start thinking about all the –isms that we face in our society. Looking to those wise teachings and wise practices from Aboriginal communities and the traditional teachings around two-spirit people gives us real opportunity to learn.

Summary

This chapter is a presentation of the responses to four questions asked to 14 participants (medical doctors, social workers, psychologists and a psychotherapist) with at least one year experience working in Canada with gender nonconforming children and families. In most questions, there were a variety of answers that predominantly supported each other, with some overlap noted between questions. In some questions, however, responses varied which may be due to individual comfort level, experience and training. Again, there was considerable overlap. However, at times the participants’ discipline reflected the area of care that was most salient in their individual responses. For example, medical doctors were more likely to discuss medical intervention and complex decisions surrounding administering hormones. Social workers and participants who identified as activists unequivocally addressed the impact of oppression and discrimination on individuals and the trans community, and the need for family support. Finally, participants with a degree in psychology were more likely to discuss the psychological impact and possible mental health issues as seen with this very vulnerable population.

There were many areas of agreement amongst participants. Irrespective of their philosophical or theoretical approach to care, participants all agreed that working with younger gender nonconforming children and families is a rare and more recently increasing phenomenon. The majority of participants list the lack of empirical data, the complexity of care, provider and parental anxiety, the legacy of a pathologizing model, and the prevailing power hierarchy as contributing factors to why the debate continues about how to best serve gender nonconforming children and families. A few participants feel that lack of consistent terminology, as well as the lack of professional collaboration further contribute to a fragmented system of care. Many subjects identified issues of oppression and discrimination that affect this very vulnerable population. Many participants applaud organizations such as Rainbow Health Ontario, the recently opened transgender youth clinic at the Hospital for Sick Children, and parent initiatives such as Gender Creative Kids Canada for building community and support systems and providing alternatives to care.

The majority of study participants identified the lack of consensus on best practice models as contributing to both the complexity of working with younger children, as well as parent and professional anxiety. Some attribute professional training and attitudes to slowing down the progression to a more affirmative and accepting framework to care, and argue that considerable harm has been done to individuals and the trans community at the hands of the older pathologizing model.

Finally, the vast majority of study participants agreed that gender nonconforming children and families need the following from the professionals who work with them: an affirming approach to care, family support, advocacy, and societal transformation. A few participants referred to First Nations' ideals of *Wise Practice* as a compassionate, inclusive and equitable approach to working alongside gender nonconforming children and their families.

Without exception, participants all identified a desire to provide compassionate care and a commitment to do well by the children and families they work with. Despite the selective sample, with eleven participants identifying an affirmative approach to their work with children and families, it can be argued that there may be more areas of agreement than disagreement amongst the opposing camps. The specific areas of agreement and disagreement identified in this study will be discussed in further detail in the discussion chapter.

CHAPTER V

Discussion

The Purpose of this Study

The purpose of this study was to explore why consensus about best practice models for working with gender nonconforming children and their families has not been reached amongst the professionals they seek care from, and to raise awareness of the practice frameworks available to assist clinical social workers in meeting the social and emotional needs of this population. The experience and perspectives of professionals (medical doctors, social workers, psychologists and psychotherapists) who have at least one year of experience working with this population were gathered through in-person and telephone interviews. The focus on gender identity experts' experience is key to the study because, beyond the purpose of understanding why consensus about best practice models may not have been reached, participants may influence how future care providers work with these children and youth as they match a practice framework model with the individual child and family system.

The literature strongly supports that LGBTQ children and youth are considered vulnerable and may be at risk for emotional distress, isolation, bullying, school performance issues, family conflict, depression, suicide, substance abuse, violence and victimization, and homelessness; trans youth are considered to be at the highest risk, bar none (American Psychological Association, 2012; Bryan, 2012; Burdge, 2007; Drescher, 2014; Ehrensaft, 2011a; Hill et al., 2010; Kenagy, 2005; Morrow, 2004; Pleak, 2011; Ryan, 2009; Ryan et al., 2010;

Sennott, 2011; Travers et al., 2012; Zucker et al., 2012). Much has been written about the ongoing controversies surrounding the different theoretical approaches to working with gender nonconforming children and transgender youth (Byne et al., 2012; Drescher, 2014; Ehrensaft, 2011a; Singh, et al., 2011), as well as the lack of empirical data to support the effectiveness of different treatment modalities (Byne et al., 2012; de Vries & Cohen-Kettenis, 2009; Drescher, 2014). There is recent evidence that supportive and affirming approaches to care with LGBTQ children and youth are associated with positive health outcomes (self-esteem, social support, and general health) and protective against negative health outcomes (depression, substance abuse, and suicidal ideation and attempts) (Ryan et al., 2009; Ryan et al., 2010; Travers et al., 2012). Given the increasing numbers of gender nonconforming children and families who are accessing support and guidance from gender identity experts, as well as the societal and clinical shift towards an affirming theoretical model of care, why does the debate about how to best respond continue? This study was designed in part to address a gap in the literature that explores why consensus about best practice models for working with this population has not been reached. Why isn't the professional community okay with the lack of consensus? Finally, what do gender identity experts believe that gender nonconforming children and their families need from the professionals from whom they seek care?

The study findings confirm the controversies surrounding the different theoretical approaches to care, and the "intensity" of the "politics" that contributes to the lack of consensus. The findings provide insight into the debate that appears to "rage" in Eastern Canada, where two "polar opposite" theoretical approaches to care dominate, namely, an affirmative practice framework (Brill & Pepper, 2008; Ehrensaft, 2011b; Hill et al., 2012; Menvielle, 2012) and a traditional treatment approach that has more recently been described as a developmental biopsychosocial model (Zucker, 2008; Zucker et al., 2012). Although the study sample can be described as selective, the findings also highlight what Canadian gender identity experts with different philosophical and theoretical approaches to care believe this population needs from those they seek care and guidance from.

The discussion section begins with a summary of the key findings: 1) Rare and recent phenomena 2) the lack of empirical data, 3) provider and primary caregiver anxiety, 4) the complexity of care, 5) terminology: inclusive and affirming or oppressive and harmful, 6) the legacy of the pathologizing model and the prevailing power hierarchy, and 7) what gender nonconforming children and their families need. This section connects the study's findings with the theoretical information presented in the literature review, and will conclude with a brief discussion of the study's limitations, as well as recommendations for future research.

Key Findings

Despite differences in individual philosophical or theoretical approaches to care, there were many areas of agreement amongst study participants. Without exception, respondents identified their goals for working with this population as supporting the health and well-being of the individual child and family system; how these goals are reached is a matter of philosophical and theoretical perspective (Byne et al., 2012; Drescher, 2014).

Rare and recent phenomenon

Gender identity experts agree that people with cross-gender identities and behaviors have been recognized throughout history, with varying degrees of tolerance and acceptance, and across cultures since the earliest of times (Drescher, 2009; Pleak, 2011;Wren, 2000). Study participants supported the findings in the literature that suggest that parents supporting the social expression of their young gender conforming child is viewed as a rare and relatively recent phenomenon (Brill & Pepper, 2008; Ehrensaft, 2011b; Malpas, 2001; Menvielle, 2012; Vanderburgh, 2009). This study confirms that approaches to care are moving towards acceptance and affirmation; however, the lack of empirical data to support an affirmative practice framework's effectiveness fuels the lack of consensus (Byne et al., 2012; Drescher, 2014; Hill & Menvielle, 2009; Wallace & Russell, 2013). A significant number of participants confirmed that it is "too soon for consensus," yet that they were encouraged that the discourse is taking place.

The study findings support the literature that suggests that prejudice, discrimination and oppression play significant roles in the lack of consensus for how to respond to gender nonconforming children (APA, 2012; Burdge, 2007; Drescher, 2010; Ehrensaft, 2011a). Agreeing with Coleman et al. (2012), the majority of participants felt that there is growing social acceptance of people who identify as lesbian, gay, bisexual or queer, with an emergent discourse around diversity and equity. The study also supports Drescher's (2010) findings that acceptance of an individuals' transgender identity, and of the trans community in general, has been slower to evolve, suggesting that it is difficult to challenge entrenched gender roles and stereotypes (Burdge, 2007; Drescher, 2010; Ehrensaft, 2011a; Hunter & Hickerson, 2003). Participants described a "biased" and "privileged" fundamental belief that gender identity should align with physical sex, which in turn determines our gender identity. Confirming findings in the literature, participants stated that there needs to be a greater understanding that gender identity is in fact a spectrum, with a larger societal goal of understanding the spectrum of diversity that exists within the human condition across many measures (Burdge, 2007; Ehrensaft, 2011b; Vanderburgh, 2009).

Lack of empirical data

Irrespective of theoretical or philosophical approaches to care, study participants supported the major findings in the literature that the shortage of empirical evidence to support theoretical practice models and treatment modalities contributes significantly to the lack of consensus about best practice models (Byne et al., 2012; de Vries & Cohen-Kettenis, 2009; Drescher, 2014; Singh et al., 2011). An APA task force was charged with the task of performing a critical review of the literature on the treatment of GID at different ages, and providing a report that included an opinion on whether or not there is sufficient credible literature to develop treatment recommendations (Byne et al., 2012). The task force found no evidence of randomized double-blind control studies, concluding that "given the very nature of GID, such trials, or even unblended trials with random assignment to treatment groups, are not likely to be forthcoming due to the lack of feasibility and/or ethical concerns" (p. 760). Study participants supported the APA findings that, when comparing alternative approaches, there are no randomized or adequately controlled nonrandomized longitudinal studies, and very few follow-up studies. The majority of available evidence is derived from qualitative reviews and single case studies. Participants support Byne et al.'s (2012) conclusion that "A consensus could not be reached regarding the legitimacy of particular goals of therapy with children diagnosed with GID (e.g., prevention of transgenderism or homosexuality) even when consistent with the religious beliefs or sociocultural values of the parents or primary caregivers" (p. 761).

Both the current literature and the findings from this study indicate that it is impossible to prove best outcomes without randomized controlled studies and reliable long-term follow-ups. As one physician stated, "Until we know that these kids are happier and healthier in the long-term, I think the debate will continue because children, youth, parents, agencies and institutions need data and are not convinced by short-term results."

One participant stated, "This is a developing field; there is not a strong evidence base for one type of assessment and treatment protocol." Acknowledging the number of studies that CAMH's gender identity services have published, study participants indicated that "there is more data to support pathology" and a need for research that explores the efficacy of affirming practice models of care. Study participants who identified with an affirming practice framework suggested that their work is often based on *practice wisdom*, which they describe as an integration of research and "gut". For many, their "gut" tells them that it makes sense to encourage, validate and affirm gender nonconforming children (Ehrensaft, 2011b; Hill et al., 2010; Menvielle, 2012), yet the most widely cited empirical data caution parents to discourage gender atypical behavior (Zucker, 2008; Zucker et al., 2012). Participants stress that they are seeing the benefits to their affirming practice, but lack research to support it. Providers, parents and children want data, and currently "there is a lack of scientific rigor applied to professional practice analysis."

Of note, and not included in the literature review, a few participants cautioned that a level of sensitivity is required to balance the need for more research with the reality that some people in the trans community are skeptical of research because they have been hurt by it. As was phrased by one participant, "the onus is on us to make sure that anything that is researched is not for our own resume, but rather in order to move this field forward in a way that's positive, constructive and helpful to those who are most directly involved." In the same regard, study participants described the need for a paradigm shift as we look to different ways of transferring knowledge, and suggested a model of research that takes more time, a broad skill set, group development and methodological knowledge and experience.

While Singh et al.'s (2011) commentary on Hill et al.'s (2010) work can be read as a critique, the authors state:

> We agree with Hill et al. (2010) that more research is needed to understand the complex relation that exists between GID and other behavior problems, how this relation might interface with the kinds of clinical programs currently available, and the factors that influence parental choices in accessing therapeutic programs that differ in their conceptual and philosophical underpinnings (p. 156).

Provider and primary caregiver anxiety

The lack of scientific rigor and evidence is said to increase provider and parental anxiety. There is "fear" and "anxiety" inherent in the lack of long-term studies that either confirm or refute the safety and effectiveness of a particular course of medical intervention. Study participants recognized that agencies and institutions need data to support their programs; parents also need data. Parents need to make informed decisions with, and at times on behalf of, their children. They need data and long-term results that suggest that the health and well-being of gender nonconforming children and youth has improved. One participant argued that there is power inherent in the a system in which adults make decisions for children, and that it can be challenging to find the balance between listening to children, protecting them and making decisions in their best interest: "We assume they are too young to know that this is just foolishness and we have to steer them in the right direction." This suggests further that we should nurture the child's ability to know him or herself, rather than shut it down.

The complexity of care

The majority of study participants supported the literature findings that working alongside children who experience discomfort with their gender identity is complicated and sensitive work (American Psychological Association, 2012; Brill & Pepper, 2008; Byne et al., 2012; Drescher, 2014; Ehrensaft, 2011a; Hunter & Hickerson, 2003; Pleak, 2011; Wallace & Russell, 2013; Zucker, 2008; Zucker et al., 2012). The study participants supported Drescher's (2014) statement, "I have come to appreciate that any understanding of this subject requires a capacity to 'hold complexity' and tolerate the anxiety of uncertainty" (p. 11). It is impossible to predict which children will continue to experience gender dysphoria (persist) into adolescent and adulthood, and there are no long-term follow-up data that demonstrate that any approach to treatment has a statistically significant effect on later gender identity (Byne et al., p. 763). Studies suggest that 20-25% of gender nonconforming children will identify as transgender in adulthood, while the majority will desist and become comfortable with their assigned gender over time. GID that persists into adolescence is more likely to persist into adulthood (Zucker, 2008).

Despite differences in care approach, participants were unanimous that the overall goal in working with this population is to optimize the well-being of the child and the family system. However, what each participant considered essential for promoting the child's well-being, as well as the selection and prioritization "treatment goals," differed according to their philosophical and theoretical underpinnings (i.e., affirmative or developmental biopsychosocial model of care). Study participants in the "affirming camp" disagreed strongly with the therapy goal of minimizing gender atypical behavior in order to prevent adult transexualism. The majority of participants referenced individual youth and adult-lived experiences to address the issue of "harm" that has been done to individuals, families, as well as the trans community. Many clinicians expressed sadness and outrage as they described the lived experiences of individuals and the trans community as a result of a pathologizing model of care that aims to minimize atypical gender behavior and prevent children from life as a trans person. Participants who follow a developmental biopsychosocial treatment model believe that a child's gender identity is "malleable" and that therefore, with treatment children can learn to be more comfortable with the gender they were assigned at birth (Zucker, 2008).

Terminology: inclusive and affirming or oppressive and harmful?

Study participants felt that the lack of consistent terminology contributes to the ongoing debate and lack of consensus for best practice models. Researchers and clinicians disagree about whether prepubescent children should be diagnosed with a "stigmatizing mental disorder" such as GID, and as Drescher (2014) states, many "disagree whether this category should exist at all, whether it should be applied to children and what diagnostic criteria should be applied" (p. 12). Study participants indicated that diagnosing children with GID or gender dysphoria contributes to the pathologizing aspect of what is otherwise considered a normal part of a child's sense of self: their fluid and evolving gender identity. Those in the affirming camp seek to remove medical labels and frame gender variance as a narrative of normal gender variation. However, access to care often requires a diagnosis, a "narrative of pathology" (Drescher, 2013, p. 12). One participant stated that she apologizes in advance to her young clients for the need to diagnose and assign a (pathologizing) label to their distress in order for the child to receive treatment. This endocrinologist confirmed Drescher's (2014) finding that "it is difficult to find reconciling language that removes the stigma of having a mental disorder diagnosis while maintaining access to medical care" (p. 12). The findings in this study confirm that it is challenging to reconcile a narrative that does not attach stigma to the phenomena with one of pathology, given that access to care necessitates a medical, and therefore pathologizing, label. Most participants confirmed what Hill and colleagues (2007) found:

> Overall, there is deepening discomfort with pathologizing children and youth with extreme gender variance. Since this is a highly contentious diagnosis – with little established reliability and validity and problematic assessment and treatment approaches – researchers and clinicians need to establish that GID is validly diagnosed with no biased assessments and treated effectively in accordance with current standards (as cited in Drescher, 2014, p. 12).

While the shift in the community in which this study takes place is clearly towards an affirming model of practice, issues of language appear to muddy the waters: Clinicians are sensitive to the language being used as either inclusive and affirming or oppressive and harmful. Most participants, many of whom identified as trans activists and advocates, preferred affirming terminology such as *gender independent, gender variant* and *trans* (Brill & Pepper, 2008; Bryan, 2012; Ehrensaft, 2011b). Practitioners who diagnosed children in order to serve them were more likely to use terms from DSM diagnostic categories such as *GID* and *gender dysphoria* (APA, 2000; APA, 2013). Both camps agreed that language is laced with implicit and explicit meanings.

The legacy of a pathologizing model of care and the prevailing power hierarchy

Without exception, participants were eager to share their beliefs and approaches to working with this population. It was significant to this researcher that discussion about the perceived debate about best practice models often brought up intense emotions, and was described as "raging" in the province of Ontario. Without exception, participants either addressed the "intensity" of the debate or the political nature of the field, with one participant stating that "sometimes the politics can be quite nasty." Of note, participants who lived and worked outside of Ontario did not experience the debate in the same way or to the same degree. It seems reasonable to assume that the controversies are heightened in Ontario given the legacy of the gender identity services program at CAMH, as well as the "power" many participants believe is inherent in the legacy and the funding they receive. While Dr. Zucker is openly criticized in the affirming literature (Ehrensaft, 2011b; Hegarty, 2009; Hill et al., 2010), it was quite astounding to interview participants who practiced from an affirmative theoretical framework right "in his own backyard." Dr. Zucker is very aware of the controversies that his work and his program has received over the years and was generous in allowing both his name and position to be used in this study.

When participants were given the opportunity to be identified in the study, only two chose to do so. Four participants responded very thoroughly, and were eager to check their quotes and careful to ensure that their identities remained confidential. Given the small community of care providers who work with gender nonconforming children and their families, I wondered how significant it is to be identified with a certain philosophical approach to care. By far, the majority of participants chose to remain anonymous. Given their eagerness to have the discussion and excitement that the "debate" was being brought into discourse, it was curious to this researcher why some participants, who had very strong and thoughtful opinions, were very careful to remain anonymous. One participant took several days to decide whether or not he would like to be identified in the study, and in the end he chose to "stand in solidarity with his peers" and remain anonymous.

In their APA task force report, Byne at al. (2012) noted:

> Opinions vary widely among experts and are influenced by theoretical orientation as well as assumptions and beliefs (including religious) regarding the origins, meanings, and perceived fixity or malleability of gender identity. Primary caregivers may, therefore, seek out providers for their children who mirror their own worldviews, believing that goals consistent with their views are in the best interest of their children (p. 762-763).

Three primary approaches have been identified in the literature (Byne et al., 2012; Drescher, 2014) with the acknowledgment that assessment and treatment of gender variant children remains controversial, "since the underlying assumptions of treating clinicians are a matter of opinion rather than of empirical data" (Drescher, 2014, p. 10). Most participants in this study (*n* = 11) identified as practicing from an affirmative theoretical framework

Agreeing with the literature, most participants argued that the controversies continue because of the legacy and power inherent in the prevailing approach that considers transitioning to another gender to be an undesirable outcome, and the idea that "if we get these kids young enough we can make them normal." Most participants struggled with this approach, citing numerous trans youth and adults who have been "harmed" by it.

What do gender nonconforming children and their families need?

In summarizing their opinions and experiences, the majority of participants described affirmative practice models and philosophical approaches as illustrated in the literature (Brill & Pepper, 2008; Ehrensaft, 2011a, b; Hill et al., 2010; Hill & Menvielle, 2009; Hunter and Hickerson, 2003; Malpas, 2011; Menvielle, 2012). It can be argued that the study sample is selective, with 11 of the 14 participants identifying as practicing from an affirming theoretical framework, two participants who did not declare a specific approach, and one participant who stated that he follows a developmental biopsychosocial treatment model. Therefore, it is not surprising that the majority of gender identity experts interviewed indicated that acceptance, affirmation, and validation of the child's gender identity and gender expression are essential components to their philosophical approach to care. They believe that children need support from a "team" of adults, and that strong family support is key to children's social and emotional well-being. Families need opportunities to collaborate with professionals in a non-hierarchical way; they need data and respectful guidance in order to make informed decisions with and at times on behalf of their children. Children, teens and parents need to be aware of all possibilities as legitimate and healthy life paths, whether they are transitioning or not.

The majority of participants (*n* = 11) expressed beliefs that gender identity and gender expression are not pathological. Although gender nonconforming children may at some point experience mental health issues that warrant care, the "work" in an affirmative approach is done primarily with parents and primary caregivers. As one participant stated, "The kids are fine and what isn't fine is the world around them." Study participants supported the literature in stating that families with gender nonconforming children need opportunities to connect with, learn from and support one another (Hill & Menvielle, 2009; Menvielle, 2012; Ryan, 2009). Children need to connect with other children, and they need role models and access to education, books and movies that show the spectrum of possibility with regards to gender. Parents and caregivers may need safe space to process their fears, grief, homophobia and transphobia. They need to be supported as they support and advocate for their child.

Although specific assessment and treatment goals were not provided in detail, two participants described formulating a treatment approach along a developmental continuum that is supported by empirical evidence (Zucker, 2008; Zucker et al., 2012). One participant argued that providers should be empathic that a child is experiencing distress with respect to their gender identity, and offer sound treatment options based on empirical data. Participants in this camp may be more likely to offer individual therapy to the child as one of the treatment options.

Participants on both sides of the debate believe in helping children understand that if they are being bullied or harassed, the problem is not with them, it is with those who learn to develop hatred. Study findings support the standards of care outlined by WPATH (Coleman et al., 2012). Advocacy is part of the work one does as a mental health provider; as one social worker phrased it, "we fight for our clients, follow their lead, and support them in ways where we can use the power we have as providers to open doors and fight battles alongside them." Children and families need hope, optimism and a vision of possibilities; they need professionals who will work alongside them as allies and advocates. Paraphrasing what one social worker said, I offer these final thoughts:

> Children and families need us to be able to see the strength, the courage, the beauty and the richness that these children and youth have, and the incredible lessons that they have to teach us about unlearning the stuck gender stereotypes. We need humility. I often look to the traditions within First Nations communities where two-spirit people were not just accepted, they were honored, they were seen as gifts to the community, they were highly valued because of the greater understanding they could bring to the community.

Unexpected findings: not otherwise discussed in the literature

The following were unexpected findings that were not otherwise addressed in my limited literature review. Study participants attributed the following as contributors to both the lack of best practice consensus as well as the fragmented system of care in children's mental health: 1) The perceived divide between Ontario and other Canadian provinces given that the debate "rages" more prominently in Ontario, 2) the need for a national organization to reflect the cultural needs of children in all provinces, 3) academic and institutional competition that may contribute to "silo health care," 4) lack of collaboration amongst professionals and major centers, and 5) the perceived language divide between French- and English-speaking professionals.

Summary

This study confirms that working with gender nonconforming children is a rare yet more recent phenomenon. The community of service providers is small, with very few gender identity experts working in major Canadian cities. Compassionately, ethically and scientifically meeting the individual needs of the child and family system is complicated. The lack of strong empirical data to support particular treatment approaches contributes to provider and parental anxiety, which in turn further complicates individual paths to health and well-being. Participants who adhere to an affirming practice framework believe that the legacy of a pathologizing model of care, and the power inherent in the long-standing approach, contribute significantly to the lack of consensus concerning best practice models. A few participants expressed beliefs that disagreements about the need to diagnose young children with a pathological disorder (Byne et al. 2014; Drescher, 2010; Ehrensaft, 2011a), the lack of consistent terminology to describe the population, and the lack of professional and institutional collaboration perpetuate a fragmented system of care and contribute to the debates about best practice models.

Limitations and Strengths

The findings of this study must be considered within the scope of its limitations. While the flexible nature of the qualitative interview design allows for deep exploration of a particular phenomenon, all qualitative research is threatened by researcher bias and respondent bias (Drisko, 1997; Padgett, 2008; Rubin & Babbie, 2013). Biases include influences that impair complete and accurate sampling, data collection, data interpretation and reporting. My inexperience as a researcher increases the likelihood that personal bias influenced the recruitment and interview processes, as well as the data analysis. My privileged identities as a white, straight, cis-gendered female and my lack of personal experience with gender variance can be considered limiting; I do not share the lived experience of trans individuals and families. A potential area of strength may be that I was open to the areas of agreement and disagreement amongst the respondents with the intentions of being balanced and accurate.

Rubin & Babbie (2013) argue that one of the major shortcomings of exploratory qualitative studies is that they "seldom provide conclusive answers to research questions and can only hint at an answer" (p. 51). The authors suggest that the issue of representativeness contributes to lack of definite answers, and in this study the use of nonprobability sampling decreased the generalizability of the population. Citing Leininger's work in 1994, Drisko (1997) defines transferability, or generalizability, as “the application of findings and conclusions derived from one context to another” (p. 189). Given the small scale and time constraints of my project, only 14 participants were interviewed for this study. The small sample size makes it difficult to generalize to the larger population. Furthermore, my sample can be described as selective, given that eleven of the 14 participants identified as professionals who practice from an affirming theoretical framework. Although attempts were made to recruit more participants with opposing views, I was unable to secure their volunteer participation. Given that clinics and services for gender nonconforming children and families are located in major Canadian cities, all 14 participants work in urban settings in Eastern Canada.

I developed the interview guide in response to a review of the literature, engagement with experts in the field, consultation with my thesis advisor, and suggestions from the HSR committee. In order to make sure the interview questions were clear and to minimize the risk of misinterpretation, I pre-tested the interview questions with three volunteers: two who hold a Master’s in Education and one PhD psychology candidate. I made every effort to phrase my interview questions in a way that reduced the risk of participants feeling judged or contributing to social desirability bias. However, the reality in the transgender community is that there are opposing practice models that may contribute to individual professionals feeling defensive; the dichotomous nature of the debate may contribute to participants’ biases. Social desirability bias, or the tendency for participants to say or do things that will make them look good, should be considered as a measurement error.

The personal nature of my observations may be influenced by my bias toward a strong belief that gender nonconforming and transgender children should be supported and their gender identity affirmed. Agreeing with the more recent literature and suggested practice models (Brill

& Pepper, 2008; Burdge, 2007; Ehrensaft, 2011b; Hill et al., 2012; Hunter & Hickerson, 2003), I do not view gender variance as psychopathology, but rather as an essential aspect of the child's sense of self. As other researchers have found, the psychological issues that arise are generally caused by external factors, namely gender-based oppression, social rejection, lack of family support, threat of violence and bullying (Burdge, 2007; Ehrensaft, 2011b; Hill et al., 2010; Ryan, 2009; Ryan et al., 2010; Sennott, 2011; Travers et al., 2012). Aware of my biases, I describe them up front and have made every attempt not to let them influence how I interpret the findings. My thesis advisor was instrumental in providing feedback and guidance when it appeared that my bias may have been operating. A third reader, who is a respected researcher and holds a PhD in social work, generously volunteered her time to read my study findings and provide feedback. In this sense, peer examination increases credibility because the research process and findings were discussed with an impartial colleague who has experience with qualitative methods (Krefting, 1991, p. 291).

A research log was used to record observations of the participants as well as personal thoughts and feelings following the interview. Accurately describing the participant's behavior and interviewer's reactions lends to the study's credibility. The transcribed interviews served as text and the log allowed a check of how the texts correspond. These reflections helped to shape and reshape the analysis and interpretation of the texts by allowing me to gauge the trustworthiness of the texts as portrayals of participants' actions and experiences. Reflecting on my reaction was helpful in identifying personal biases and devising ways to manage them. Non-verbal communication is an essential part of qualitative research; there are numerous ways that individuals convey meaning during face-to-face contact (Padgett, 2008, p. 112). It can be argued that data was lost from the telephone interviews (n = 5) given that the loss of non-verbal cues made it more difficult to assess meaning in some cases.

There are advantages to using an inductive approach to content analysis in terms of the economy of time and money. I conducted the qualitative data analysis on my own and in my own time. The major fiscal costs for undertaking this research included the cost of the tape recorder, fees for transcribing, and the cost of some note cards. Following the interviews, I sent each participant a personalized thank-you note as a symbol of my gratitude. Another strength is that content analysis is relatively unobtrusive because it does not affect the subjects being studied. Once the interviews had been conducted, it was largely my responsibility to complete the rest of the study.

A weakness of content analysis is that it is limited to the examination of recorded communications, and subject to the individual researcher's inductive interpretation. Words are rendered meaningful by the perspective and understanding of the researcher for specific purposes. Inferences are made based on literal interpretation of the content and must be authentic and accurate. Findings are shaped by the assumptions and experiences of the researcher who is conducting the study and analyzing the data. Validity, also referred to as credibility or trustworthiness, is described as the demonstration of evidence in support of the appropriateness of the inferences made in the study; results that appear to be real or truthful (Drisko, 1997). Most approaches to content analysis are considered to be *face valid* in that the data appears to fit well with the interpretations made.

In qualitative research, stakeholder or member checks can be used to improve trustworthiness (Padgett, 2008; Rubin & Babbie, 2013; Thomas, 2006). Member checks enhance the credibility of findings by allowing participants and other people who have specific interests to comment on or assess the researcher's data, analytical categories, interpretations and conclusions. The strategy of revealing research material to the participants ensures that the researcher has accurately translated the participants' viewpoints into data. Making sure the data makes sense decreases the chances of misrepresentation (Krefting, 1991).

Prior to finalizing the findings chapter, I provided each study participant with a copy of their transcribed interview. I invited oral or written feedback on individual participants' level of comfort with respect to the data accurately reflecting their point of view, the use of specific quotes in the findings chapter as currently stated, and the level of anonymity maintained in the paper. Participants were also asked if they would prefer to remain anonymous or would like to give permission to have their name and position used in the study. Seven participants responded; of those, two gave permission to have their name and positions used in the study and the other five chose to remain anonymous. To ensure their intended message was conveyed accurately, five participants clarified specific comments and two respondents made slight adjustments to the wording of chosen quotes. As was written in my email correspondence to all participants, given that I did not hear back from the other seven participants by the chosen date, it was assumed that they gave permission to use the quotes from their transcripts as written and that they wished to remain anonymous. Prior to submitting my thesis, one peer examiner and one participant were provided with a summary of my findings and invited to provide feedback on the categories and themes identified, as well as the degree of anonymity maintained in the paper. Neither reader identified any concerns.

Implications for Clinical Social Work Practice

The implications of this study for clinical social work practice may be considered at the macro, mezzo and micro practice levels. At the macro level, social workers may be inclined to be strong advocates for increased funding to trans-positive programs and services for gender nonconforming children and families. Access to supportive and affirming services may contribute to remedying the deficit system of care options identified in this study.

At the mezzo level, social workers may be inclined to be strong advocates for continued societal change, namely a shift away from pathology towards accepting and affirming healthy gender diversity. The findings from this study suggest a need to advocate for trans-positive education and training in agencies, at public schools, as well as in curriculua offered to clinicians and care providers. Training and education may increase the awareness of the physical, social and emotional needs of gender nonconforming children and their families.

At the micro level, social workers may be inclined to explore their own identities and privileges, be better allies, and make advocacy part of their work. Social workers, especially those of us with unearned privilege, are encouraged to consider the following: what do I need to know to be a better ally and advocate? What do I need to know to be a better ally for children and adolescents are different developmental stages? What do I need to know about the different theoretical approaches to working alongside gender nonconforming children and their families in order to match a model of care with an individual child and family system?

Recommendations for Future Research

Both the findings in this study and the current literature indicate that further research exploring the efficacy of different practice frameworks and treatment modalities may be of great benefit to gender nonconforming children, transgender youth and their families. The majority of study participants supported the views of Ehrensaft (2011b), Hill et al., (2010), and Hill & Menvielle (2009), who suggest that future research should encourage further development of affirmative interventions for youth with gender-variant behaviors, as well as more rigorous scientific studies on the impact of these interventions on children and their families. As Hill and Menvielle (2009) state, “Better research can only help parents who are raising children and pioneering new ways to live gender” (p. 269). Wallace & Russell (2013) recommend that future research explore the impact of affirmative strategies on the attachment security between parent and child and on the child’s vulnerability to shame and depression, as well as whether interventions reduce the impact of social ostracism and increase resilience in the face of stigma.

Study participants acknowledged that they typically see a biased client base. In other words, parents who are aware of the different philosophical and theoretical underpinnings may access care from gender identity clinics that align with their personal and cultural values. Dr. Zucker described his approach as a developmental biopsychosocial model of treatment and suggested that the following would be a fascinating research question: “What do the families look like that we see compared to the families who wind up going to see someone else?”

The age range explored in this study was likely too broad (children 3-18 years of age). Study findings suggest that researchers should clearly define the age group of the children and youth being discussed, namely: prepubescent (3-11 years), adolescents (12-16 years), youth (16-18 years), and young adults. More systemic follow-up every few years, particularly around critical times in development (starting school, onset of puberty), is needed to understand when and how GID persistence or desistence takes place. If such long-term follow-up studies were conducted, professionals might be able to offer guidance to parents concerning what to expect at specific developmental periods. Gender identity experts, parents, and children need more empirical data in order to make informed decisions regarding social transition and possible medical intervention should the child’s gender dysphoria persist into adolescence and young adulthood.

The findings in this study align with the evidence that strong family support increases protective factors and decreases the risk factors faced by many trans youth (Ryan et al., 2009; Ryan et al., 2010; Travers et al., 2012). Travers et al. (2012) contend that parents of trans youth need adequate support themselves in order to provide the strong support that children and youth need. Ryan et al. (2009) encourage future researchers to “include greater ethnic diversity and assess potential cultural differences in family reactions to their children’s LGBT identity” (p. 210). Future research may explore what families feel they need in order to be supported so that they, in turn, can advocate for and support their child and family system. Future research initiatives may offer children and youth opportunities to voice what they need in order to feel supported by their family, their communities, as well as the professionals from whom they seek care and guidance. Finally, long-term follow-up studies would enable researchers to explore the choices that gender nonconforming children and transgender youth make with respect to social transition and medical interventions (hormone suppressants, hormone replacements, and/or surgery). Ten years out, are they happy? Are they doing well? Were there bumps along the way?

The findings of this study indicate that future research should be sensitive to the discrimination and oppression that this vulnerable population faces, and be designed in collaboration with the community it serves. It bears repeating what one participant powerfully and empathically stated, “the onus is on us to make sure that anything that is researched is not for our own resume, but rather in order to move this field forward in a way that is positive, constructive and helpful to those who are most directly involved,” adding, “we have to be very sensitive about where some of the [research] information is coming from and whether it has the potential to harm an individual or a family.”

As an ally, a researcher, and a clinical social worker with a long-standing interest in working with children and families, I am interested in researching attachment security with prepubescent gender nonconforming children. Applying attachment theory, does a child's atypical gender behavior impact their attachment security? Given that gender nonconforming children can be socially ostracized, how does attachment security impact their ability to engage with peers and explore their world? Is reflective family play therapy effective in repairing attachment disruptions or encouraging earned security? With respect to family work impacting and enhancing secure attachments, Diane Ehrensaft (2011a) states:

> The goal is to facilitate the parent's affirmation of their child's authentic gender self and help them overcome deeply embedded negative attitudes that stand to tatter the bonds with their child if not actually tatter their child (p. 547).

It stands to reason that models of care that enhance attachment security are more likely to foster a child's self-esteem, independence, and hope for a full and rich life.

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Appendix A

Screening Questions

1. Do you hold a Bachelor's degree, Master's degree, Doctorate or Medical degree (MD) in one of the following disciplines: clinical social work, psychology, psychiatry, medicine or marriage and family therapy?

Yes

No

2. Do you have at least one year's experience working with gender nonconforming children in Canada or the United States?

Yes

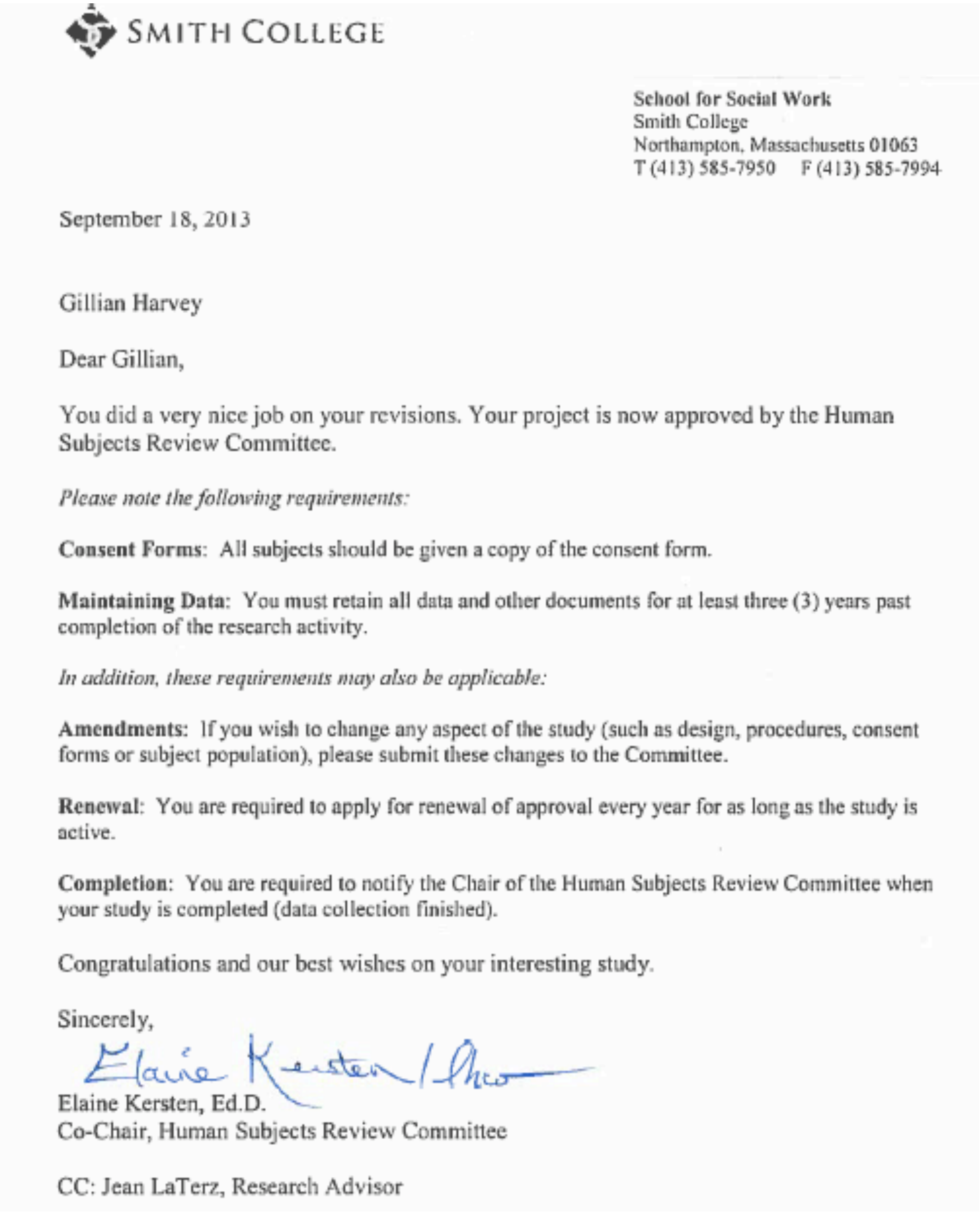
No

3. Are you currently practicing in Canada or the United States?

Yes

No

Appendix B



SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

September 18, 2013

Gillian Harvey

Dear Gillian,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished).

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix C

Recruitment Email

Dear____________,

My name is Gillian Harvey, and I am in my final year at Smith College School for Social Work. For my Masters thesis, I am doing a qualitative research study that explores the lack of consensus among professionals on how to best respond to gender nonconforming and transgender children and their families. Why does the debate on how to best respond to gender nonconforming children and their families continue? Participation in this study may provide insight into the challenges of choosing best practice models, why the debate about treatment and intervention continues, and what those who work with this population believe is needed to assist children and families with such decisions.

I would like to invite you to participate in my study, which is an interview that I will be conducting with potential participants in person or over the phone. I am sending you this email because you are a professional who may currently be, or has previous experience, working with gender nonconforming and transgender children and their families.

Professionals are eligible to participate in my study if they are currently practicing in Canada or the United States with a Bachelors, Masters, Doctorate or MD in one of the following disciplines: social work, psychology, medicine, psychiatry, or marriage and family therapy, and have at least one year of experience working with gender nonconforming children and families. For the purposes of my study the terms *children* and *youth* are used interchangeably and refer to children ranging in age from 3-18 years. The term *gender nonconforming* is used broadly to include *gender-fluid, gender-variant, gender-queer and transgender* children, and refers to children whose gender identity does not match their assigned birth gender.

Participation in the study will involve meeting the inclusion criteria, signing an informed consent form, and participating in the interview. During the 45 minute interview participants will be asked seven demographic questions (such as gender, race/ethnicity and professional affiliation) and four open-ended questions specific to their experience and knowledge about working with gender nonconforming children and their families. Although participation will not be anonymous, every attempt will be made to keep your participation confidential. If you meet the eligibility criteria I invite you to participate in the study and encourage you to reply to this email (gharvey@smith.edu) or to call me at 416-616-4838 to discuss participation further. If you do not meet the eligibility criteria, I invite you to please forward this email to any acquaintances or colleagues you know of who may be eligible to participate, and I thank you in advance for your consideration.

If you have any questions about my research or the nature of participation, please feel free to reply to the email (gharvey@smith.edu) or contact me at xxx-xxx-xxxx.

Thank you for your time, assistance and interest in my research project.

Sincerely,

Gillian Harvey
MSW Candidate, Smith College School for Social Work

Appendix D

Informed Consent

Dear Participant,

My name is Gillian Harvey, and I am a graduate student at Smith College School for Social Work in Northampton, MA, USA. I am conducting research for my Masters thesis, which explores clinical social work practice with gender nonconforming and transgender children. The study focuses on the lack of consensus among professionals on how to best respond to gender nonconforming and transgender children and their families. The results of my study may be used for presentation and publication.

I am currently recruiting professionals practicing as a physician, psychiatrist, psychologist, marriage and family therapist, or social worker who hold a medical degree, BSW, MSW or PhD in social work, or Masters or PhD in psychology. You must have worked with gender nonconforming children and families in Canada or the United States for at least one year.

This study will be conducted through personal interviews with the researcher, either in person or over the phone. During the 45-minute interview, you will be asked seven demographic questions (such as gender, race/ethnicity, and professional affiliation). You will then be asked four open-ended questions specific to your work with gender nonconforming children and their families. The interview will be audio recorded. I will use a transcriber to record the interview verbatim, and he/she will sign a confidentiality pledge.

Because the questionnaire will include reflections on your own experiences there is a small risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include having the opportunity to reflect on your practice, and knowing that your responses could contribute to the development of knowledge regarding clinical practice skills for working with gender nonconforming and transgender children. Unfortunately, no monetary or material compensation for your participation can be provided.

In the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses. Any identifying data you include about yourself or your client will be destroyed and will not used in the study. All data from the interview will be kept in a secure location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed. Initial data will only be viewed by me and by my research advisor. When material from the study is used for future presentation and possible publication, illustrative quotes will be carefully disguised and any possible identifying information will be removed.

Your participation in this study is voluntary. You have the right to refuse to answer any question during the interview process. You may also withdraw from the study at any time prior to November 1, 2013. If you chose to withdraw prior to November 1, 2013, any prior information you provided will be deleted. If you withdraw after November 1, 2013, your information and responses will be considered in the data collection.

Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me at xxx-xxx-xxxx, or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS,

AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. Please keep a copy of this document for your records.

Participant: ___________________________ Date:_____________________

Researcher: ___________________________Date: ____________________

Thank you very much for your time and interest in this study.

Sincerely,

xxx-xxx-xxxx
gharvey@smith.edu

Appendix E

Interview Guide

This preview is provided for you so that you have a chance to familiarize yourself with the types of questions that I will ask you if you are willing to participate in an interview. Please remember that you are welcome to participate in the interview process even if there are certain questions that you would prefer not to answer.

For the purposes of my research study, the terms *children* and *youth* are used interchangeably and refer to children ranging in age from 3-18 years. The term *gender nonconforming* is used broadly to include *gender-fluid, gender-variant, gender-queer and transgender* children, and refers to children whose gender identity does not match their assigned birth gender.

The purpose of the study is to explore why best practice models or working with gender nonconforming and transgender children has not been reached among professionals working with them. Why does the debate on how to best respond to gender nonconforming children and their families continue?

1. In your opinion, why do you think consensus about best practice models for working with gender nonconforming and transgender children has not been reached?

2. Why isn't the mental health community OK with the lack of consensus?

3. In your opinion, why does the debate continue?

4. From your perspective, what do you believe this population needs from the professionals who serve them?

Appendix F

Volunteer or Professional Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

- The researcher for this project, Gillian Harvey, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Gillian Harvey for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

____ Signature

____ Date

____ Gillian Harvey

____ Date

Appendix G

Permission To Use Participant's Name And Position

I give permission for Gillian Harvey to use my name and my position in her master's thesis for Smith College School for Social Work.

Name ____

Position____

Signature____

Date____

Appendix H

Demographic Questions

Please respond to the following demographic questions.

1. Please indicate the gender you most identify with.

____

2. How do you identify racially/ethnically?

____

3. Please list your discipline, (social work, medicine, psychiatry, psychology, education), and your degrees, certificates and license(s).

____

4. Please indicate which term you prefer to use when referring to this population, and how many years of clinical practice you have working with them?

____

5. Approximately what percentage of your current caseload, if any, involves working with these children and their families?

____

6. Please describe the type of setting you currently practice in. (For example: hospital, mental health center, social service agency, school, private practice).

____

7. Please describe the type of community you practice in. (For example, urban, suburban, rural).

____