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“Am I Doing the Right Thing?": Pathways to Parenting a Gender Variant Child

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Abstract

Gender variant (GV) children have a subjective sense of gender identity and/or preferences regarding clothing, activities, and/or playmates that are different from what is culturally normative for their biological sex. Despite increases in rates of GV children and their families presenting at clinics, there is little research on how raising a GV child affects the family as a whole or how families make decisions regarding their care. This study took an ecological-transactional framework to explore the question, “what is the experience of parents who raise a GV or transgender child?” Eight mothers and three fathers of GV male and female children (ages 5–13) referred through a GV support group participated in interviews. Transcripts were analyzed using an adaptation of grounded theory analysis. These parents attempted to pave the way to a nonstigmatized childhood for their GV child, typically through two pathways: rescuing the child from fear of stigma and hurt or accepting GV and advocating for a more tolerant world. Many participants used both pathways to different degrees or shifted paths over time, and the paths selected were related to parents’ own understanding of GV and their experiences and backgrounds as well as characteristics of the children they were parenting and the communities they inhabited. Limitations, clinical implications, and future directions are discussed.

Keywords

Parenting; Gender Variance; Gender Dysphoria; Education; Mental Health; Advocacy

Parents and gender variant (GV) children are seeking assessment and therapeutic services at increasing rates (Spack et al., 2012). This shift is occurring in the broader U.S. cultural context of increased media attention to transgender and GV youth. In this paper, *gender variance* (GV) is defined as incongruence between children’s sex assigned at birth and either their felt sense of self as male or female (gender identity) or their behaviors, interests, or dress used to communicate gender (gender role behavior). This term includes: children who qualify for a diagnosis of Gender Dysphoria (formerly Gender Identity Disorder in Children; American Psychiatric Association, 2013), which includes transgender children who have

socially transitioned and may have received medical intervention; as well as children who have no gender dysphoria or cross-gender identification but have other-gendered interests or behaviors.

Interest among families seeking services and the general public is not matched by professional or scientific knowledge. The history of psychological and psychiatric research on GV in childhood originated with the goal of preventing sexual minority identities in adulthood. A review of research on GV children (Gray, Carter, & Levitt, 2012) found that it has focused largely on (1) outcomes of sexuality and gender identity, and (2) the child in isolation or in pathological family systems; and argued that shedding the heterosexist legacy of research with GV children will require a shift toward (1) outcomes of adjustment and well-being, and (2) the child conceptualized in contexts that affect adjustment.

What *does* empirical data tell us about the trajectory of GV children? In terms of assessment, criteria to determine which children will persist in GV are lacking: Longitudinal studies indicate that childhood GV predicts a range of sexual and gender identity outcomes in adulthood, although intensity of gender dysphoria relates to GV persistence into adolescence (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). Relatedly, evidence for outcomes of the variety of treatments employed with GV children is lacking (Zucker, 2008). These treatments range from discouraging cross-gender interests and behaviors (Zucker, 2008) to supporting transition to the cross-gender role, at times with support of puberty-blocking interventions to delay development of secondary sex characteristics (Spack et al., 2012).

A debate exists around how and at what pace to intervene with GV children and families, specifically around promoting or discouraging cross-gender identification. This debate is not likely to resolve soon; as Drescher (2014) has written, “treatment. . . will continue to remain controversial since some underlying assumptions of the clinicians are a matter of opinion rather than of empirical data and empirical studies (e.g., clinical trials with random treatment assignment) are neither feasible nor ethical” (p. 14). Drescher’s warning is a reminder of how both clinician’s and parents’ responses to gender are culturally located and require a contextual approach that considers the beliefs, feelings, and experiences of children, families, and providers.

Studying Context

A transactional, ecological approach to child development situates the child within multi-level social ecologies, including both families and broader contexts, which impact development. Resilience theory emphasizes support within these environments, including family environments, as a key factor in the development of resilience among children facing stress (Sameroff, 2009). Quantitative data from LGBTQ youth suggest that acceptance in peer, family, and school social settings supports adjustment (Grossman, D’Augelli, & Frank, 2011; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010); conversely, experiences of stigma have been linked to lower levels of psychological well-being among GV youth and young adults presenting for gender-related treatment (Baams, Beek, Hille, Zevenbergen, & Bos, 2013). These quantitative data are supported by qualitative data from transgender adults

emphasizing experiences of rejection from parents, schools, and social contexts (Levitt & Ippolito, 2013, 2014). However, the social and familial contexts of GV children are rarely examined directly in research (cf. Hill & Menvielle, 2009).

Parents or Co-Parenting as Context

Parents are critical mediators of the experiences of GV children, and clinical literature has emphasized the role of parents in supporting GV children's adjustment (Ehrensaft, 2011; Malpas, 2011). Parents may be drawn to particular treatment approaches based on their own personal beliefs. A recent APA Task Force report, for example, reads, "Primary caregivers may . . . seek out providers for their children who mirror their own world views, believing that goals consistent with their views are in the best interest of their children" (Byne et al., 2012, p. 763). Lev (2004) has proposed a "family emergence model" to describe how family systems adapt to GV members in stages that include disclosure, turmoil, negotiation, and finding balance between the child's needs and the larger family's needs. Still, our understanding of parents' experience, including what beliefs or experiences draw them toward treatment approaches and influence their reactions to children's gender presentation, is under-developed.

Parents in Context

Just as GV children are influenced by their familial and cultural context, so are their parents. Notably, mental health providers are a part of this social ecology; previous critical theoretical work has emphasized how the legacies of pathologizing GV and of developing reparative approaches to treatment have located blame within the family system (Gray et al., 2012; Hill & Menvielle, 2009). As the field works to serve these children and their parents, research is needed to understand how to help parents to *support* GV children.

An ecological view of GV development is supported by quantitative evidence that perceived stigma and support impact adjustment outcomes for GV youth (Baams et al., 2013; Grossman et al., 2011). Such a view requires an understanding of parents' experience of children, as well as how that experience is impacted by the broader social ecology. Despite the theorized importance of parents in the developing GV children's experience, the voices of parents themselves largely have been absent from the literature. Qualitative analysis lends itself to "thick description" that situates individuals within contexts and considers the meanings and intentions of individual actions (Ponterotto, 2006).

Two previous qualitative studies that focused on the experiences of parents of GV children (Hill & Menvielle, 2009) and adolescents (Wren, 2002) have been conducted. These studies described parents' journeys to acceptance or nonacceptance; however, they did not explicitly theorize or investigate the broader social ecology, including larger family systems, schools, and health care delivery systems. While transphobia and feelings of blame have been identified in parents' own narratives, parents' interactions with larger systems that likely contribute to those experiences have not been articulated in the literature.

The Present Study

In order to further elaborate the context around the developing GV child, the present study is a qualitative grounded theory analysis of interviews with eleven parents connected to a GV support network. Study objectives were to describe the experience of parenting a GV child in this sample, as well as the mutual influence between the child, the family, and the environment.

METHOD

Participants

Parents were selected to be the source of data, because they know their children's experiences as well as their family, community, education, and social contexts and how systems have intersected. Children were not interviewed because study objectives were to describe parenting experiences. Participants were recruited from a support group for parents of GV children at a medical center in the Boston region. The group coordinator, a health care provider, made an announcement at the group meeting with contact information of the first author, and an email inviting parents to the study was sent to the group. All parents who made contact participated.

Participants included eight mothers and three fathers, including three married co-parenting couples. The inclusion of these couples supported understanding how parents' differential experiences of parenting a GV child might influence a family system; parents were interviewed alone in order to facilitate discussion of co-parenting stressors and experiences that may be divergent across co-parents.

Parents' average age was 45 (range 37–48) and all identified as heterosexual, cisgender, and White; two adopted children were non-White (see Table 1 for additional demographics). All parents reported household incomes over \$65,000 and had at least a college education. Participants were whiter, wealthier, and had higher educational attainment than the Boston population (Boston demographics: 54% white; median income \$53,136; 43% bachelor's degree; U. S. Census Bureau, 2013). Thus, this sample included diversity in parent gender, approach to gender variance, and adoptive or biological or adoptive parents, and child age and gender presentation. However, it was not diverse in terms of parent education, race, income, or access to GV supports.

Procedure

Parents received \$50 for the interview; there was no obligation from the recruitment source that they participate in the project. The study was approved by a university Institutional Review Board.

Interviews—Eleven in-person individual interviews were conducted in parents' homes or in public locations of the participant's preference, such as a library or parent's work, at parent's choice. A semistructured interview protocol focused upon the central question: "What is the experience of parenting a GV child?" To facilitate analyses about the larger social context of parenting a GV child, parents were asked about their experiences with

systems (e.g., schools, health and mental health, extended families) beyond the child and family. Specific sub-questions included (a) how parents understand their child's GV behavior, (b) when and where they are most aware of their child's gender variance, (c) what kinds of choices they have had to make in parenting their child, (d) what kinds of experiences around their child's gender they have had with others, including schools, health professionals, and extended family, and (e) how experiences with GV have impacted their view of themselves as parents. Questions were asked in an open-ended and nonleading manner and adjusted as the study progressed to address gaps in understanding, typical within grounded theory methods; throughout, the interviewer attempted to maintain an open and neutral stance to parents' responses. Interviews ranged in length from approximately 1–3 hours.

Adapted Grounded Theory Analysis

Grounded theory methods (e.g., Glaser & Strauss, 1967) are qualitative approaches designed to develop (rather than verify) theories or understandings, typically based upon analysis of interviews. In the present paper, researchers adapted a version developed by Rennie (2000) for use in a team model, incorporating a process of consensus (cf., Hill, 2011). In this approach, researchers divided interviews into meaning units (borrowed from phenomenology; Giorgi, 1985), or sections of text with one main idea relevant to the study's focus. Units were compared to one another using the method of constant comparison to identify categories based on commonalities. Next, categories were reviewed and higher order categories, continuing until a hierarchy of categories was formed, topped by a core category reflecting the central meaning in the analysis. This process continued with each interview until incoming data no longer led to new understandings, indicating saturation, which occurred at interview 8 in this sample.

Investigators—Researchers memo-ed their thoughts to keep a record of evolving interpretations of the data and cultivate awareness of bias. Researchers all were White women who identified as cisgender or genderqueer; heterosexual, queer, or lesbian; and LGBTQ-affirming therapists and researchers (e.g., Levitt & Ippolito, 2013). They appreciated social privileges associated with being cisgender, yet their affirmative stance means that they support the development of positive transgender identities. As a result, they used team meetings to support caution in representing different perspectives of parents. In the research process, the first author developed the study idea, conducted the interviews, and acted as the internal auditor of analysis. The second and third authors conducted the initial unitization and categorization of the data while supervised by the final author.

Trustworthiness Checks—To assess the credibility of the interview and analysis, three checks were used (e.g., Morrow, 2005). First, at the end of each interview, participants were asked about the comprehensiveness of the interview; whether anything relevant was not asked about; their comfort in interviewing; and whether anything restricted disclosure. Second, a process of consensus was used between investigators; discussions between researchers were meant to increase the complexity of understanding and unfolded in weekly research meetings between the second, third, and fourth authors over a period of approximately 1 year and with the auditor at approximately bi-monthly intervals. Finally, the

first author conducted member checks by phone in which participants were invited to provide feedback on a summary of results. Eight participants responded and described how well the overall findings represented the experience of parenting a GV child both qualitatively (described in results) and on Likert scales from 1 = *Not at all* to 7 = *Very much*. Parents who provided member checks represented both accepting and rescuing approaches, as described below. Parents' responses were positive, with eight parents providing an average rating of 6.75 ($SD = 0.70$) on how much findings supported their experience and a complimentary rating of 1.12 ($SD = 0.35$) on how much the findings contradicted this experience.

RESULTS

The hierarchy resulting from analysis included 2,270 meaning units from 11 interviews. The method of constant comparison described above yielded a hierarchy that consisted of five levels; levels described here include: (a) the *core category*, or the uppermost level that was the central idea uncovered in analyses; (b) six *clusters*, which represented the level below the core category; and (c) 20 *categories*, which comprised the third level of the hierarchy (see Table 2).

To describe how many participants' interviews contributed units to a category, the following terminology will be used. *All* indicates 11 participants, *most* indicates 9–10; *many* indicates 6–8; *some* indicates 3–5; and *few* indicates 1–2. Interviews were semi-structured; therefore, participants were not asked to provide opinions on all ideas that emerged from other participants, but rather to describe experiences salient to their own parenting. These numbers, then, should be understood as indicators of how salient an experience was for parents when asked to describe their experience parenting a GV child, rather than indications of agreement.

Cluster 1: Parents Journey to Rescue or Accept

In this cluster, all parents ($n = 11$) described that their understanding of their child's GV was a dynamic "journey" in which there was vacillation in their responses to GV. Two processes were identified: (1) *accepting*, characterized by a drive to accept and support their child's GV, and (2) *rescuing*, characterized by a drive to rescue their child from being GV.

Category 1.1: parenting journey—All parents ($n = 11$) described the evolving process through which they became aware of their child's GV: "It's just a process—I can't tell you a specific point where I realized he was trans. I think he led the way—I always say he led the journey and we just followed him" [P04]. Many ($n = 6$) described initially framing GV as a "phase" [P03] but assertions by the GV child, as well as professional and family input, helped parents incorporate that GV would be long-lasting.

Category 1.2: causes and consistency—All parents ($n = 11$) described their beliefs about causes of GV, connecting those causes to reactions to children's gender presentation. Parents who viewed GV as innate were more likely to be accepting and looked to the steadfastness in their child's preferred gender presentation: "There's never been any sort of back sliding or lessening, it's been, very steady" [P06]. In contrast, parents who believed

that GV could be changed looked to environmental causes: “I’m a single mother. . . [My child] doesn’t have a strong, male influence on a, on a daily basis. I blamed [GV on] that” [P09]. Those who saw GV as changeable were more likely to be rescuing and believe that they could influence the child’s gender expression: “it’s not something I wanna bring out in him” [P08].

Category 1.3: parents’ beliefs and values—All parents ($n = 11$) linked personal beliefs and values to their accepting or rescuing processes. Most parents ($n = 9$) prioritized children’s current feelings and linked this to their acceptance of GV: “he knows he is loved, and supported, and accepted, exactly the way he is” [P09]. For many ($n = 7$), acceptance was also linked to valuing gender diversity and pride in advocacy for a more accepting society: “I know [my child] has changed hundreds of people, just with how she is” [P06]. In contrast, other parents connected a rescuing process to trying to protect their child from future stigma: “I hope he, uh, follows the common trail, and, uh, you know, decides to stay wearing, uh, typical male gender roles, okay? Life is hard enough without, uh, the other things going on” [P10]. Whereas accepting was associated with a focus on children’s present happiness via GV expression, rescuing was associated with limiting GV expression to avoid heterosexism.

Category 1.4: contact with LGBTQ communities—All parents ($n = 11$) described the influence of LGBTQ communities on their reaction to their child’s GV. Parents who had little contact with LGBTQ communities feared their children may grow up to be LGBTQ: “[my son] might find himself in a lifestyle that I just have no understanding, and is very alien to me” [P10]. Parents who accepted described value in contact with transgender and GV communities: “The more I meet other people who have gone through this, or are going through this, the more I understand, like, [GV people are] just the way they’re supposed to be” [P04]. Most parents ($n = 9$) felt that support provided by GV communities increased their confidence to navigate parenting decisions: “The one thing that really helps is the knowledge that there are other people that are dealing with the same thing. . . I know that I’m not entirely alone in this” [P01].

Category 1.5: professional guidance—Many parents ($n = 7$) described negative experiences with professionals such as pediatricians and therapists, ranging from professionals who saw GV as a pathology to “fix” [P06] to others who knew little about GV. Many ($n = 8$) expressed a wish that there was more education in the healthcare system about GV. While searching for a supportive professional could be like looking for a “needle in a haystack” [P01], many parents ($n = 7$) found that professional guidance helped them come to acceptance of GV.

Eight participants evaluated whether this cluster represented the experience of parenting a GV child, yielding a mean rating of 6.63 ($SD = 0.52$) on a Likert scale ranging from 1 (not at all) to 7 (very much). Two married parents noted that the term “acceptance” was not sufficiently positive to capture their approach to GV. They suggested their perspective was “embracing.”

Cluster 2: Child's GV Impacts Parenting Self-Efficacy and Parental Worry

In this cluster, all parents ($n = 11$) described how children's GV impacted their view of themselves as parents and the worries they have about their child.

Category 2.1: intersections with mental health—In this category, many ($n = 7$) parents described how mental health or learning-related issues outside of GV intersected with their child's GV. For instance, a parent of a child with a learning disability stated, “if we just had the transgender [issue] to deal with, it would be one thing, but it's such a series of things... I feel like we're addressing all of these issues simultaneously” [P07]. Some parents ($n = 5$) also described how existing vulnerabilities were exacerbated by GV-related stress, such as bullying.

Category 2.2: rescuing and power struggle—In this category, most ($n = 9$) parents described limiting GV expression to rescue the child from perceived negative outcomes. Some ($n = 5$) linked rescuing to feelings of sadness and guilt: “I worry for me, and for him, about society. . . but he's so good at editing himself now, I think he'll get even better at it. I think it's kinda sad that he has to do it, but I think it just is a reality. And that I'm gonna encourage him to continue to do it” [P09]. Many parents ($n = 7$) described how rescuing was at times successful in limiting children's GV behavior, but many ($n = 6$) said this process sometimes provoked power struggles or escalated behavioral difficulties in their child.

Category 2.3: accepting leads to relief and connection but also stress—In this category, many ($n = 8$) parents described how as they came to accept GV behavior, closer parent-child communication resulted; a few ($n = 2$) described an alleviation of their children's mental health challenges. For instance, one parent said that professionals helped her believe, “that if he lived fully as a boy, he would be able to deal better with the anxiety, with going to school, and everything else. And they were right, it was like magic” [P11]. For some ($n = 4$), accepting GV was rewarding: “It makes me proud of the mother I am” [P09]; “It's been good for my parental self-esteem” [P05]. Additionally, some parents ($n = 8$) discussed stressors associated with accepting GV, indicating stress in wondering about whether accepting is the best approach: “It's the constant, ‘Am I doing the right thing?’” [P04].

Eight participants evaluated this cluster, yielding a mean rating of 6 ($SD = 1.07$) on the 1–7 Likert scale. Two parents noted that their child's other mental health issues were more at the forefront of their parenting experience than GV.

Cluster 3: Having a GV Child Changes Relationships in the Whole Family

In this cluster, all parents ($n = 11$) described how having a GV child impacted the entire family system.

Category 3.1: spousal agreement and tension—Most parents ($n = 10$) described a range of experiences in co-parenting their GV child. Many ($n = 6$) reported that their partner agreed with them on shared parenting goals, including both rescuing and accepting approaches toward GV expression, although negotiation was required:

I think my wife and I have always been more or less on the same page, but sometimes one or the other of us would get further ahead, because it's a big leap from wearing boxers before toilet training to contemplating going on [hormone] blockers, a lot of mental hurdles to pass between those two things. [P05]

Many ($n = 6$) parents noted that differences in perspectives about how to respond to the child's GV led to tension and conflict between co-parents.

Category 3.2: siblings as amplifiers—Eight parents discussed how siblings responded to children's GV, with a theme emerging that siblings' responses tended to echo and sometimes amplify parents' own rescuing or accepting processes. Rescuing parents ($n = 2$) described siblings who mocked or excluded the GV child. Accepting parents ($n = 3$) noted that they have had to address siblings' anti-GV statements and behaviors; however, in large part, parents who accepted GV described accepting siblings. In some cases ($n = 4$), siblings with accepting parents acted as defenders of their GV sibling: "He almost sort of acts like [GV child]'s protector in situations . . . if [GV child] is upset because someone said something mean to him, [brother] will, without saying anything, put on [GV child]'s favorite song" [P01]. A few siblings ($n = 2$) participate in gender activism.

Category 3.3: journey for extended family—Many parents ($n = 8$) described that family members' responses to children's GV have been dynamic over time and included a range, from outwardly and vocally rejecting to embracing children's GV with open arms. Many parents ($n = 8$) described attempts to shape the behavior of extended family members to fit their parental accepting or rescuing processes, and a few ($n = 2$) found that family members who seemed to passively accept GV suggested disapproval in "unspoken" [P07] ways.

Eight parents evaluated this cluster, yielding a mean rating of 6 ($SD = 0.76$) on the 1–7 Likert scale. Two parents noted that experiences with extended family felt less central to their experience.

Cluster 4: Parents of GV Children Struggle to Create a 'Normal' Childhood

In this cluster, all parents ($n = 11$) discussed how in the face of stigma, they work to create a "normal" [P04] childhood for their child.

Category 4.1: rescuing as normalcy—A few parents ($n = 2$) linked their rescuing approaches to a desire for a "normal," nonstigmatized childhood. One parent described a sense of relief when her child's GV behavior went "underground": "That made me feel better, like a lot better. That he was playing with boys, to be honest. . . . I just want him to have a normal childhood" [P08]. In contrast to more accepting parents' attempts to protect their child by changing the environment through advocacy, parents in rescuing processes described a desire to change their child's behavior to protect the child.

Category 4.2: stealth as "the dream"—Some parents ($n = 5$) discussed how times where the child is perceived as the non-birth gender (so their birth gender can be kept secretive or "stealth") can be moments of "the dream" [P11] of a nonstigmatized experience.

One parent described how a child's desire to "out" himself as transgender challenged the parent's sense of their role as protector:

I considered the issue that all parents consider about him being stealth . . . and it's about safety. And I was really scared about that, like all parents are, and then, I realized that he didn't want to be stealth, and I realized that I could probably respect that, but it would be a harder way to go. [P11]

Because the decision to go "stealth" requires a decision to change gender identities and enter a new environment, these children tended to be older. A few parents ($n = 2$) also discussed challenges to a "stealth" position, including fears about the child being outed in the course of childhood activities or due to parental advocacy.

Category 4.3: advocacy and challenging the binary—All parents described advocating for their children and many ($n = 8$) described a desire for their child to be comfortably in the open with their GV expression. One parent stated, "It's like a job. . . I mean, maybe it's too much. But I want her to, I wanna pave the way for her to have normalcy. And so, normalcy is when she doesn't have to think about [being GV]" [P06]. Advocacy included educating teachers and school administrators about GV, modeling acceptance of the child in public, empowering the child to self-advocate, and creating a safe space in the home for GV expression. Parents described needing language to describe GV, then learning how and when to advocate, making "judgment calls" [P01]. Some parents ($n = 4$) described how initial feelings of isolation motivated them to advocate: "I felt this strong feeling, like I didn't want other parents to go through that journey so much alone . . . so I kind of made it my work" [P11]. Many parents ($n = 7$) described how parenting a GV child has made them more generous, tolerant, or empathic. Still, some ($n = 3$) parents described that their children attempted self-censor their GV in response to stigma.

Seven parents evaluated this cluster, yielding a mean rating of 6.28 ($SD = 0.76$). Two parents noted that other goals, including "happy, secure, supported," are more important than "normalcy."

Cluster 5: Social Intolerance and Child Factors Amplify Stressors of Raising a GV Child

In this cluster, all parents ($n = 11$) described how the stressors of raising a GV child are impacted by social intolerance and child-level factors.

Category 5.1: social intolerance hurts—All parents ($n = 11$) described experiences of social intolerance. Parents felt angry and sad when their child experienced social rejection and some ($n = 3$) feared for children's safety. Parents also worried that others negatively judged their parenting. Parents' responses varied: A few ($n = 2$) described using avoidance in social spaces deemed unsafe: "You sort of self-select also places you might go" [P09]. Concerns that others may outwardly express acceptance but harbor internal stigma led to vigilance: "[There is] constantly that awareness and wondering—do people accept it or not? Are they just being nice to me? Is this just face value?" [P04]. Parents in accepting processes defended GV: "My view is that gender variance as we talk about it now as a 'problem' is not

really the kid's problem, it's society's problem in that we have a few narrow categories" [P02]. In contrast, parents in rescuing processes sought to further limit GV expression.

Category 5.2: attributions of others' stigma—Some ($n = 5$) parents speculated about causes of others' GV stigma. A few parents ($n = 2$) noted that adults tend to link GV behavior with sexuality; one parent described that adults are "drawing dirty pictures with GV kids. It's like, 'He's wearing a dress, he must be gay, he's a transvestite!'" [P01]. Others attributed stigma to a fear of difference or the unknown, including other parents' fear that it might influence their children. Some parents ($n = 4$) wondered if increased media attention to GV, while sensationalizing, may bring more awareness and reduce stigma.

Category 5.3: child factors affect response—Many ($n = 8$) parents described child-level characteristics that either buffer or exacerbate experiences of stigma. Some parents ($n = 4$) attributed children's confident social skills to protection from stigma. Parents also noted how intersecting identities impact social responses; GV girls who can be described as "tomboys" seem to be more accepted than GV boys, and non-White children may experience amplified stigma. Other parents noted that children who socially transition to another gender and fit the gender binary tend to be more accepted than those who are "in the middle" of the gender binary.

Eight parents rated this cluster, yielding a mean rating of 6 ($SD = 1.19$) on the 1–7 Likert scale. Two parents suggested further emphasis on parents' experience of others judging their parenting.

Cluster 6: Future Uncertainty

In this cluster, all parents ($n = 11$) described their child's future, including hopes for increased acceptance but fear of increased stigma or medical interventions.

Category 6.1: developmental uncertainty—Some parents ($n = 5$) described uncertainty of what the future holds for their child's gender or sexual identities in adulthood. One parent noted, "When you have [a GV child], you can't have any dreams. Not because they're not possible, but because you can't visualize anything. You can't visualize a man, do you visualize a woman?" [P04]. Parents cited uncertainty as a source of stress.

Category 6.2: medical & social fears—Many ($n = 7$) parents described fears about the medical interventions that might lie ahead for their child, including hormone blockers and surgeries. Many ($n = 6$) parents also described fears about social harassment or intolerance. Some parents ($n = 3$) noted that they feel they can protect younger children, but that they expect it will become harder with age: "He's dealing with these problems that come out of, you know, there not being a proper slot for him in society, and you know, that's going to be with him for the rest of his life, and I'm sort of sad that it has to be that way" [P02]. One parent described how social transitions are less permanent and therefore less threatening than medical ones: "The decisions that will come that will actually physically impact [the child's] body will be the hardest, just because you always wonder if you're doing the right thing. It's easy to let [a child] put on a coat and tie, or play soccer with boys, because there's nothing you can't undo about that." [P05]. All parents ($n = 11$) sought out professional

advice to guide their decisions and linked advocacy to their desire to create a more tolerant world for their children.

Category 6.3: hopes for happiness through relationships—Most ($n = 9$) parents hoped that the future would be better for their children: “When you’re older, the fact that someone’s in the middle [of the gender binary] can make someone sort of intriguing and mysterious and it’s a cool thing” [P01]. These hopes were linked to the idea that young adults have more flexibility to find accepting peer groups: “I want him to have friends that see him as the young man that he is . . . but I want them to know that he is trans, because there’s nothing to be ashamed of or embarrassed about. I want him to have enough good friends that they know that and they respect that” [P04]. Some parents described hopes that their children would find meaningful intimate relationships ($n = 3$) and career paths ($n = 4$). Nonetheless, these hopes were intermingled with fears that stigma or discrimination will interfere with these developmental attainments. Eight parents rated this cluster, yielding a mean rating of 6.88 ($SD = 0.35$) on the 1–7 Likert scale.

Core Category

The core category reflecting the central theme within the analysis was, “Seeking a nonstigmatized childhood for a GV child: Pathways include either rescuing a child from fear of stigma and hurt or accepting and advocating for a more tolerant world.” Participants’ reactions to the core category were positive, rating it a mean of 6.75 from 1 (not at all) to 7 (very well) ($SD = 0.46$).

All parents in this sample were clear that seeking the best present and future for their GV child was central to parenting. The main theory put forward is that these parents took two different pathways toward the same goal of long-term safety and happiness for their child: (1) trying to rescue the child from a stigma by discouraging GV expression, and (2) accepting their child’s GV and advocating for a more tolerant world.

The shape of these parents’ pathways was impacted by their own beliefs about GV, background, and values, as well as characteristics of their child. Broadly speaking, parents’ rescuing approaches were associated with a belief that environmental influences affected the child’s GV, fear of future stigmatization for their child, and limited contact with LGBTQ communities, or supportive professionals. In contrast, accepting approaches were related to a belief that GV is innate, a value of following the child’s lead, and more solidified connections to LGBTQ and GV communities and supportive professionals.

While the rescuing and accepting pathways are distinct, parents’ use of these pathways was fluid. In this study, most parents ($n = 10$) described having moved from a rescuing process toward an accepting process over time. Many parents ($n = 8$) described themselves as actively negotiating between rescuing and accepting paths simultaneously as they sought to balance an emphasis on the child’s authentic expression with an emphasis on the child’s safety. Many ($n = 8$) also described difficulty finding medical and education professionals who understood GV and the concerns that parents of GV children face.

DISCUSSION

This analysis was conducted among a white, economically and educationally privileged sample of parents who had access to a support network for parents of GV children. The current analysis emphasizes how, among these parents, parenting a GV child includes a focus on promoting children's maximal adaptation to their environment. That drive resulted in different pathways for these parents: a pathway of rescuing the child from stigma (changing the child), and a pathway of accepting the child's gender variance (changing the environment). These pathways were associated with different values driving parenting, with rescuing associated with concerns for protection and safety, and accepting associated with emphasis on children's choice and following children's leads. These pathways affirm pathways to acceptance identified in a prior qualitative study of parents from an affirmative treatment clinic: "unconditional acceptance," "just a phase or a stage," and "policing gender choices" (Hill & Menvielle, 2009).

Also consistent with Hill and Menvielle's (2009) data, parents in this study emphasized a developmental and dynamic understanding of children's GV that changed over time and, for some parents, remained fluid. Many parents described benefits of acceptance, including stronger relationships and pride through advocacy. Still, even accepting parents in this sample described stress associated with acceptance, including a nagging sense of "am I doing the right thing?" reflective of the transphobic and genderist cultures in which they are raising GV children.

Parents in this sample described both child- and community-level factors related to their responses to children's presentation, consistent with a transactional ecological perspective (Ehrensaft, 2011; Ryan et al., 2010). In these data, children were described as agents of change upon their parents' beliefs (Hill & Menvielle, 2009); in turn, parents influenced larger family systems, including siblings and extended family members. This pathway of influence was bi-directional, as family systems influenced the parents by providing or withdrawing support. Beyond the family, many participants' parenting values were informed by encounters with other adults, which in this sample, recruited from a supportive parenting group, included members of LGBTQ communities and education and health professionals who helped develop parents' understanding of GV and who could help secure a safer context for GV children. As there were many interacting influences, it follows that parenting decisions shifted across time as education, resources, and supports were developed and advocacy skills improved in both parent and child.

These data draw attention to how among these white, economically and educationally privileged parents, a social ecology of genderism may encourage parents to engage in one of two processes to protect their GV children—either advocating to adapt the context to the child, or helping the child adapt to the context. The parents' shifting estimations of the likelihood of an environment to be supportive and of their abilities to effect change appeared to influence the processes they selected at any time. Although many parents described shifting over time from rescuing processes toward accepting processes, no parents in this small sample connected to GV-affirming supports described moving in the other direction. It appeared that, particularly when parents felt efficacious in advocacy, the accepting parenting

processes led to a closer relationship with the child and a sense of parenting self-efficacy, which were compelling rewards for parents.

Consistent with literature on adult transgender identity development (Levitt & Ippolito, 2013), the gulf between parents' own experience of their children's GV and the gendered culture that they inhabit made their own processes of self-education challenging. This gulf also made communicating and advocating with others a challenge, as parents encountered a lack of transgender education and awareness in health and educational professionals. Failed attempts at communicating had consequences for parents' own sense of parenting esteem, as parents reported feeling judged and scrutinized by others, including miseducated teachers or health and mental health professionals. However, some parents transformed these feelings of isolation and frustration into experiences of advocacy, from which they derived meaning and pride.

Clinical Implications

The APA task force report on the treatment of gender identity disorder suggested that parents seek out treatments that parallel their own worldview (Byne et al., 2012). While these findings partially support this suggestion, they also underscore the dynamic ways in which families might be impacted by others, including treatment providers. Additionally, these parents, all connected to a support group, described providers as crucial sources of support for understanding their child and for advocacy related to children's needs.

Although from a small sample connected to supports, these data resonate with clinical and theoretical descriptions of parents striving to strike a balance between promoting children's protection from stigma and supporting their authentic gendered expression (Ehrensaft, 2011; Lev, 2004). The diversity of processes described by these parents is perhaps most resonant with Malpas's (2011) description of the multi-dimensional family approach, which focuses on flexibly working to affirm both children and parents. It emphasizes moving from an "either/or" to a "both/and" position for both children and parents, whereby "children can *both* affirm their identity *and* understand the demands of a world mostly organized around the mutually exclusive binary of gender. Parents can *both* nurture their child's singularity *and* operate as a mediator between the child's wish and the social reality" (Malpas, 2011, p. 457). The theme of "both/and" was present in these data, specifically the movement between many parents' desire to rescue children from stigma and their desire to model acceptance. These data also lend qualitative support for treatment approaches that focus on working with systems outside of the child in order to promote children's optimal development (e.g., Hill, Menvielle, Sica, & Johnson, 2010).

Limitations

These data are not generalizable, given their qualitative nature, the small sample size, and the nature of this sample. All parents were white, cisgender, heterosexual, middle- to upper income, and connected to GV resources, representing only a specific and likely minority segment of parents raising a GV child. Given the cultured nature of gender and the intersecting nature of social identities, these processes undoubtedly vary across groups. All participants were recruited from the same referral source, which was a GV-affirmative

pediatrician, representing a potential source of bias, and participants' self-selection to engage in the study may have influenced the findings. Additionally, the small sample size limits the exploration of whether child factors, such as age and natal sex, may impact parents' experiences. Finally, this study was designed to investigate the experience of parenting a GV child; thus, while the experiences of GV children are present in the results, a truly transactional approach will require the voices of GV children as well.

CONCLUSION

Overall, our qualitative findings offer preliminary suggestions for how a group of parents connected to GV supports came to understand children's GV via the influence of the child and the environment (Hill & Menvielle, 2010; Wren, 2002). Also, findings acknowledge the interwoven nature of social systems in supporting GV children; the repercussions of children's GV through the larger family system as well as social structures including schools; the role of advocacy from parents in changing systems; and parents' coping with social intolerance.

The sharp increases in rates of referrals to gender services over the past decades are not likely to taper, nor are we likely to have strong empirical data supporting specific interventions in the near future (Drescher, 2014). These qualitative data provide suggestion that interventions might benefit from focus on the child, the family, and the social context to different degrees across situations. In addition to intervention research, larger scale, quantitative analyses that examine factors such as perceived stigma, social support, and transphobia may be warranted. It is also critical that future research examine these pathways and patterns across different cultural and social contexts, including among families who may not be connected to GV-related supports, as well as in larger samples where individual child factors, such as age and natal sex, can be considered. We as clinicians and researchers can continue to share in the wondering alongside [P04] in this study who asked, "Am I doing the right thing?" In working with families, "doing the right thing" requires using our research and clinical skills and our empathy to understand the contextually located experiences of GV children and their families, to listen to the questions they are asking, and to address the needs they identify—including the need for increased understanding and education in our workforce.

References

- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5. Arlington, VA: American Psychiatric Publishing; 2013.
- Baams L, Beek T, Hille H, Zevenbergen FC, Bos HMW. Gender nonconformity, perceived stigmatization, and psychological well-being in Dutch sexual minority youth and young adults: A mediation analysis. *Archives of Sexual Behavior*. 2013; 42:765–773. DOI: 10.1007/s10508-012-0055-z [PubMed: 23358856]
- Byne W, Bradley SJ, Coleman E, Eyler AE, Greene R, Menvielle EJ, et al. Report of the American Psychiatric Association task force on treatment of Gender Identity Disorder. *Archives of Sexual Behavior*. 2012; 41:759–796. DOI: 10.1007/s10508-012-9975-x [PubMed: 22736225]
- Drescher, J. Gender identity diagnoses: History and controversies. In: Kreukels, BPC, Steensma, TD., de Vries, ALC., editors. *Gender dysphoria and disorders of sex development: Progress in care and knowledge*. New York: Springer; 2014. p. 137-150.

- Ehrensaft D. Boys will be girls, girls will be boys: Children affect parents as parents affect children in gender nonconformity. *Psychoanalytic Psychology*. 2011; 28:528–548. DOI: 10.1037/a0023828
- Giorgi, A. *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press; 1985.
- Glaser, BJ., Strauss, A. *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine; 1967.
- Gray SAO, Carter AS, Levitt HM. A critical review of assumptions about gender variant children in psychological research. *Journal of Gay & Lesbian Mental Health*. 2012; 16:4–30. DOI: 10.1080/19359705.2012.634719
- Grossman AH, D’Augelli AR, Frank JA. Aspects of psychological resilience among transgender youth. *Journal of LGBT Youth*. 2011; 8:103–115. DOI: 10.1080/19361653.2011.541347
- Hill, CE. *Consensual qualitative research: A practical resource for investigating social science phenomena*. Washington, DC: APA; 2011.
- Hill DB, Menvielle EJ. “You have to give them a place where they feel protected and safe and loved”: The views of parents who have gender-variant children and adolescents. *Journal of LGBT Youth*. 2009; 6:243–271. DOI: 10.1080/19361650903013527
- Hill DB, Menvielle EJ. An affirmative intervention for families with gender-variant children: A process evaluation. *Journal of Gay & Lesbian Mental Health*. 2010; 15:94–123.
- Hill DB, Menvielle EJ, Sica KM, Johnson A. An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy*. 2010; 36(1):6–23. doi:10.1080/00926230903375560. [PubMed: 20063232]
- Lev, A. *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. Binghamton, NY: Haworth Press Inc; 2004.
- Levitt H, Ippolito MR. Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Women Quarterly*. 2013; 38:46–64. DOI: 10.1177/0361684313501644
- Levitt HM, Ippolito MR. Being transgender: The experience of transgender identity development. *Journal of Homosexuality*. 2014; 61:1727–1758. DOI: 10.1080/00918369.2014.951262 [PubMed: 25089681]
- Malpas J. Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*. 2011; 50(4):453–470. DOI: 10.1111/j.1545-5300.2011.01371.x [PubMed: 22145719]
- Morrow S. Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*. 2005; 52:250–260. DOI: 10.1037/0022-0167.52.2.250
- Ponterotto JG. Brief note on the origins, evolution, and meaning of the qualitative research concept ‘thick description’. *The Qualitative Report*. 2006; 113:538–549.
- Rennie DL. Grounded theory methodology as methodical hermeneutics: Reconciling realism and relativism. *Theory & Psychology*. 2000; 10:481–502. DOI: 10.1177/0959354300104003
- Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*. 2010; 23:205–213. DOI: 10.1080/0092623X.2011.628439 [PubMed: 21073595]
- Sameroff, A., editor. *The transactional model of development: How children and contexts shape each other*. Washington, DC: American Psychological Association; 2009.
- Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, et al. Children and adolescents with Gender Identity Disorder referred to a pediatric medical center. *Pediatrics*. 2012; 129:418–425. DOI: 10.1542/peds.2011-0907 [PubMed: 22351896]
- Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2013; 52:582–590. DOI: 10.1016/j.jaac.2013.03.016 [PubMed: 23702447]
- U.S. Census Bureau. Boston, Massachusetts State & County QuickFacts. 2013. Retrieved June 15, 2014, from <http://quickfacts.census.gov/qfd/states/25/2507000.html>
- Wren B. “I can accept my child is transsexual but if I ever see him in a dress I’ll hit him”: Dilemmas in parenting a transgendered adolescent. *Clinical Child Psychology and Psychiatry*. 2002; 7:377–397. DOI: 10.1177/1359104502007003006

Zucker KJ. Children with gender identity disorder: Is there a best practice? *Neuropsychiatrie de l'Enfance et de l'Adolescence*. 2008; 56:350–357. doi:0.1016/j.neurenf.2008.06.003.

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Table 1

Participant Demographics

Participant number	Child natal sex	Child gender identity	Child age	Child race	Relationship
1	Male	Male, gender variant	8	Black	Adoptive mother
2	Male	Male, gender variant	8	Black	Adoptive father (spouse of 1)
3	Male	Transitioning to female	5	White	Biological mother
4	Female	Male	13	White	Biological mother
5	Female	Female, gender variant	8	White	Biological father
6	Female	Female, gender variant	8	White	Biological mother (spouse of 5)
7	Female	Male	12	Asian	Adoptive mother
8	Male	Male, gender variant	5	White	Biological mother
9	Male	Male, gender variant	8	White	Biological mother
10	Male	Male, gender variant	5	White	Biological father (spouse of 8)
11	Female	Male	13	White	Biological mother

Table 2**Clusters and Categories, With Number of Participants Who Contributed Units**

Cluster and Category Titles^a
Cluster 1: Parents journey to rescue or accept: A dynamic process between accepting child's GV and trying to rescue their child from being GV (11)
Parenting Journey: Awareness that GV is not a "phase" evolved over time and was impacted by child and others (11)
Causes and Consistency: Innate causes linked to acceptance, parenting causes linked to rescuing (11)
Parents' Beliefs and Values: Emphasizing current happiness and choice linked to acceptance, belief of control over GV linked to rescuing (11)
Contact with LGBT Communities: Limited experience or fear linked to rescuing, contact linked to acceptance (11)
Professional Guidance: Finding a needle in a haystack (11)
Cluster 2: My parenting self-efficacy and my worry about my child are impacted by my child's GV (11)
Intersections with Mental Health: Exacerbating vulnerabilities (7)
Rescuing and Power Struggle: Encouraging editing linked to power struggles, sadness (9)
Accepting Leads to Relief and Connection but also Worry: Acceptance alleviates child's difficulties and worry about present and future (10)
Cluster 3: Having a GV child changes relationships in the whole family (11)
Spousal Agreement and Tension: Negotiating co-parenting a GV child (10)
Siblings as Amplifiers: Siblings' responses tend to amplify parents' acceptance or rescuing (8)
Journey for Extended Family: Family responses are dynamic and wide-ranging (8)
Cluster 4: Parents of GV children struggle with how to create a 'normal' childhood for their child in the face of stigma (11)
Rescuing as Normalcy: Protecting children from stigma (2)
Stealth as "the Dream": Moments of peace and worry (5)
Advocacy and Challenging the Binary: Exhausting but can be a gift (11)
Cluster 5: Social intolerance and child factors can amplify the stressors of raising a GV child (11)
Social Intolerance Hurts: All parents described pain of stigma to child and self that varied across social spaces(11)
Attributions of Others' Stigma: Fear of difference, childhood sexuality, and contamination (5)
Child Factors Affect Response: Child traits and social identities buffer or exacerbate stigma (8)
Cluster 6: Future uncertainty: Parents hope for increased acceptance but fear increased stigma and medical interventions (11)
Developmental Uncertainty: Unsure if child will be GV, transgender, cisgender, gay, or straight (5)
Medical & Social Fears: Fears of the permanency of medical intervention and lack of a "proper slot" (7)
Hopes for Happiness through Relationships: Envisioning futures of out and accepted (9)

Note. LGBT = lesbian, gay, bisexual, transgender; GV = gender variant.

^aThe number in parentheses is the number of participants who contributed units to the preceding cluster or category.