

Treatment and Ethical Considerations with Transgender Children and Youth in Family Therapy

ANÍBAL TORRES BERNAL

*Mental Health Counseling Program, Indiana University-Purdue University Columbus,
Columbus, Indiana, USA*

DEBORAH COOLHART

Department of Marriage and Family Therapy, Syracuse University, Syracuse, New York, USA

In response to the dearth of family therapy literature addressing transgender issues, this article discusses treatment and ethical considerations in serving transgender children and youth and their families. Historical perspectives, basic language and concepts regarding transgender, and the developmental stages of transgender children are addressed as well as how contemporary research and treatment guidelines interact with ethics. Therapist competencies for working with transgender youth and families, components of supportive therapy, and ethical issues surrounding various gender transition treatments are discussed. Suggestions for therapists to identify and make decisions about common ethical dilemmas when working with this population are examined.

KEYWORDS ethics, family treatment, transgender children, transgender youth

INTRODUCTION

Treatment and ethical issues specific to the transgender population have been for the most part absent from the family therapy scholarly literature. This includes a dearth of articles dealing with transgender youth and

Address correspondence to Anibal Torres Bernal, Division of Science, Indiana University-Purdue University Columbus, 4601 Central Avenue, CC 139A, Columbus, IN 47203-1769, USA. E-mail: atorresb@iupuc.edu

children. Within the past decade in the field of marriage and family therapy there has been growing attention to issues of gay, lesbian, and bisexual communities, but authors often group transgender issues together with gay, lesbian, and bisexual issues, not specifically addressing or differentiating the transgender population (Connolly, 2005; Hardy & Laszloffy, 2002).

The transgender population deserves special consideration because of the distinct differences between sexual orientation (which encompasses gay, lesbian, and bisexual) and gender identity (which includes transgender). Sexual orientation refers to the gender(s) for which a person has internal attractions, feelings of falling in love, and sexual feelings, thoughts, and fantasies (Isreal, 2005; Sanders & Kroll, 2000; Savin-Williams, 2001). Gender identity refers to an internal sense, a self-concept of one's own gender, typically female/feminine or male/masculine (Lev, 2004; Stone Fish & Harvey, 2005). The developmental stages of childhood and adolescence are particularly important to examine because this is when individuals start to express and/or experiment with their gender identity. Their families also become aware of their member's gender expression, especially when they are divergent from the societal expected and sanctioned gender expressions and manifestations.

In this article we discuss treatment and ethical considerations in serving transgender children and youth within a family therapy context. However, because of the lack of attention paid thus far to transgender populations in the family therapy literature, we first briefly discuss how transgender individuals have been viewed throughout history. Then we address some of the basic language and concepts involved in discussing and understanding this community. We focus on how contemporary research and treatment guidelines (e.g., World Professional Association for Transgender Health [WPATH] Standards of Care) interact with ethics, and how therapists can identify common ethical dilemmas. Finally, a case study, which exemplifies the issues raised in the paper, is provided.

HISTORICAL PERSPECTIVES

Historically, transgendered individuals have sometimes been considered gifted, spiritual, revered, and valued. For example, many Native American cultures regarded gender variant people as possessing spiritual sanction and its associated powers (Lev, 2004). Although different native cultures had their own terms for cross-gender expression, it has become contemporarily known as "Two-Spirit." According to Tafoya and Wirth (1996), Two-Spirits have both a male and female spirit and "can see in both directions, and therefore understand the world in a more holistic manner" (p. 56). Similarly, Indian legend and culture includes many images and stories of gods and gurus crossing the lines of gender expression. According to Nanda (1994), the Hindu

religion views people as containing both male and female principles and that “hermaphroditism is the ideal” (p. 376).

Unfortunately, in modern Western history transgender individuals have been viewed as unnatural and as a byproduct of societal problems. They have commonly been ridiculed, stigmatized, and pathologized (Coolhart, Provancher, Hager, & Wang, 2008; Lev, 2004). This is mainly due to the societal adherence to gender dichotomy and a denial of the existence and prevalence of gender ambiguity (Terry, 1999).

An example of the prevalence of the societal stigma around gender ambiguity, unconventional expression of gender, and strict adherence to the gender dichotomy is the inclusion of the diagnosis of gender identity disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Because many transsexuals seek medical treatments to assist them in gender transition, it can be helpful to have a related *medical* diagnosis to seek insurance reimbursement for such treatments. However, placing the diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, the manual for psychopathology rather than the manual for medical conditions, implies that transsexuals have a psychological problem, contributing to the stigma carried by this population.

BASIC LANGUAGE AND CONCEPTS

It is extremely important to discuss with clients the basic concepts and language used by mental health and other helping professionals to describe transgender individuals. In this endeavor the marriage and family therapist is ethically required to use language the client can easily understand (AAMFT, 2001). Additionally, by having a discussion about terms and their meanings the therapist can make sure that both clients and therapist are talking about the same phenomenon, situations, or state of being.

Therapists need to make sure clients understand the professional jargon that is being used to describe their gender identity and expression. When interacting with families, clients, and other professionals, therapists cannot take for granted that an individual’s utilization of a certain term and/or language equals the therapist’s or other professionals’ utilization of the same or similar language or term. Because of the importance of language and its meaning we discuss professionally sanctioned language and concepts associated with the transgender community.

Transgender is an umbrella term used to describe individuals who experience their own sense of gender as different from the gender they were assigned at birth. It encompasses all nontraditional gender expressions, including but not limited to transsexual, cross-dresser, gender-bender, gender outlaw, gender queer, and drag king/queen (Carroll et al., 2002; Cole,

Denny, Eyler, & Samons, 2000; Coolhart et al., 2008). There are many diverse ways of being transgender. For example, not every transgender person is interested in changing his or her gender presentation (e.g., from male to female). Instead, some in the transgender community wish to expand or dis-

05

lanie Gonzalez

traditional conceptualizations of gender, which causes self-labels to be evolving (Carroll et al., 2002).

Although the term transgender encompasses varied gender identities, some transgender people wish to transition their gender presentation from the gender they were assigned at birth to a gender presentation that more closely matches their internal sense of self. Transgender people that have either transitioned gender or desire gender transition are transsexuals. Transsexuals fall into one of two categories, those who have or desire to transition from male/masculine to female/feminine (MTF) and those who

06

lanie Gonzalez

or have transitioned from female/feminine to male/masculine (FTM).

Transsexuals often wish to make a gender transition to present themselves physically and socially as their preferred gender. Transgender identity development involves many stages, beginning with awareness of one's own gender variance and progressing to integration, which may include transition from one gender to another (Lev, 2004). Transsexuals must commonly use the mental health system because they are required to obtain recommendations for medical procedures involved in gender transition (i.e., hormone therapy, gender reassignment surgery). Because transsexual individuals and their families may seek therapy at any time during the transition process, some clients may not as yet transitioned to their preferred gender. For example, they may still be using the name assigned to them at birth even though it does not match the client's internal gender identity.

07

lanie Gonzalez

CONTEMPORARY ENVIRONMENT: RESEARCH FINDINGS

As part of their ethical obligation to the third principle of the 2001 AAMFT code of ethics, which includes professional competence, marriage and family therapists currently working with or planning to serve transgender youth and their families must be knowledgeable about the latest research findings regarding the effective treatment of transgender youth and children. Their knowledge should extend to both the benefits and detriments of taking steps toward gender transition. The therapist should also keep the family informed of what the literature states, especially as it relates to the benefits, potential harm, and limits of different therapeutic interventions.

Contemporary research shows that transgender individuals, especially transgender youth, often live in discriminatory and dangerous environments. In a qualitative study with an MTF and FTM sample Clements-Nolle, Wilkinson, Kitano, and Marx (2001) found that transgender individuals were severely discriminated in employment, housing, and health care.

08

lanie Gonzalez

A 2001 study of 900 gay, lesbian, bisexual, and transgender youth by the Human Rights Watch found that close to 50% of the youth experienced harassment. In the same study, 17.9% of the surveyed youth experienced physical harassment and 47% had experienced verbal harassment due to their gender expression. Additionally, 45.7% of the sample felt unsafe due to their gender expression. The research clearly shows that any treatment or services with the transgender population needs to take into account experiences of discrimination and unsafe environments. Thus, marriage and family therapists need to address personal safety issues and help clients with strategies to counter and cope with overt or covert discrimination.

Despite the discrimination faced by transgender children and youth, the number of children and youth pursuing gender transition is growing. This can be attributed to the fact that contemporary research and treatment protocols are starting to show the effectiveness of early intervention. Treatment at a younger age may lead to a higher likelihood of “passing” for the preferred gender identity (Cohen-Kettenis & van Goozen, 1998). It also might lead to fewer medical/surgical procedures related to gender transition later in life (Bollhart, Baker, Farmer, Melhaney, & Shipman, in press).

To effectively pursue early intervention strategies the therapist, client, and family members need to be knowledgeable about gender identity development. Ideally, all service providers (i.e., school professionals) that surround the child or youth will be knowledgeable about gender identity developmental stages. Knowledge about gender identity development increases the likelihood of appropriate informed consent. In cases of misinformation, by the client, family members, other human service professionals, the marriage and family therapist will need to engage in psychoeducational intervention strategies. When presenting the information the intervening therapist will need to be aware of the age of the client and the educational level of all family members, as this could affect how the information is presented.

GENDER IDENTITY DEVELOPMENT AND DEVELOPMENTAL STAGES OF THE TRANSGENDER CHILD AND YOUTH

Kohlberg (1966), in his classic works, developed his theory of gender consistency. According to his theory children develop their gender identity in the preschool years. During these years children start differentiating and identifying between being a boy or a girl. Additionally, they develop gender stability, which enables them to acknowledge and understand that “I will grow up to be a woman/man.” Finally, children develop gender consistency. In this developmental stage they accept the “fact” that they cannot change their sex. Kohlberg’s (1966) theory was not intended to describe the experiences of transgender children, although transgender children do typically experience gender identity development during the preschool years. During

09

lanie Gonzalez

10-11

2 notes:

12-13

2 notes:

14

lanie Gonzalez

15

lanie Gonzalez

Kohlberg's (1966) stage of gender identity, transgender children's experience of their inner self does not match the messages they are being given by people around them, likely causing confusion and stress. As transgender children continue to develop and learn that their physical body will not change (gender constancy) and that they will grow up to be their assigned gender (gender stability), this can also be quite problematic and distressing because the gender that transgender children are stuck with does not match their internal sense of gender identity (Coolhart, in press).

Brill and Pepper (2008) discussed six developmental stages transgender individuals go through in childhood and adolescence. The first two stages occur in early childhood, between the ages of 2 and 4. First, between the ages of 2 and 3 the child's transgender identity often starts to become clear. Children classify males and females and express confusion about gender-variant adults.

Between the ages of 3 and 4 children become aware of anatomical gender differences and gender stereotypes/schemas (Brill & Pepper, 2008). Transgender children start making statements that express dissatisfaction or discomfort with their assigned gender. Children that are assigned a male gender may say, "I wish I was a girl" or "My heart is a girl, but my body is a boy." Children assigned to the female gender might say "I want to be a boy when I grow up" (Brill & Pepper, 2008).

Between the ages of 4 and 6 transgender children often believe they can grow up to be another gender (Brill & Pepper, 2008). They may start playing dress-up or rejecting clothing associated with their assigned gender. This transgender identification is often consistent and persistent for several years; however, between the ages of 5 and 7 children begin to understand their gender is not going to change (Brill & Pepper, 2008). Transgender children often express embarrassment or discomfort due to societal and familial messages that preferred gender behavior is wrong. During this developmental stage there is a potential for the development of behavioral/mental health problems.

For some children going through the fifth developmental stage, between the ages of 9 and 12, gender dysphoria becomes even stronger with pubertal changes (Brill & Pepper, 2008). Many transgender people describe puberty as extremely distressing, as changes in their bodies feel like betrayals to their sense of self (Coolhart et al., 2008). On the other hand, some preadolescents, due to the pressure to conform, express rejection of their preferred gender.

During this stage there is a risk of possible depression, self-neglect, and self-destructive behavior. During adolescence, between the ages of 12 and 19, youth feel like they are going through the wrong puberty (Brill & Pepper, 2008). Mutuality with other transgender adolescents or individuals is very important, which can often be achieved by connection to Internet/virtual communities. In the sixth and final developmental stage there is an increased risk for withdrawal, depression, and social anxiety (Brill & Pepper, 2008).

TREATMENT CONSIDERATIONS

Competencies for Ethical Treatment

There are four basic competencies that family therapists need to acquire when working with the transgender children and adolescents. First, the family therapist needs to have comprehensive knowledge of the treatment guidelines, protocols, and procedures as they relate to the effective treatment of transgender individuals. For example, WPATH provides Standards of Care for helping professionals who work with transsexuals (Meyer et al., 2001). Additionally, two particularly helpful books written for therapists working with transgender clients are Lev's (2004) *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families* and Brill and Pepper's (2008) *The Transgender Child: A Handbook for Professionals and Families*. For therapists working with transgender youth who are interested in gender transition, Coolhart et al. (in press) provide an extensive clinical tool to help assess clients' readiness for gender transition treatments.

Second, the therapist needs to be knowledgeable about the community resources available to their transgender clients. For example, it is particularly helpful for therapists to be aware of referral sources for endocrinologists, psychiatrists, and support groups (Lev, 2004). When working with youth, therapists can connect both youth and parents to resources because both of these positions can feel like very isolated experiences; hearing the stories of other transgender youth and their families can feel validating (Coolhart, in press). Through support groups, youth can gain support while they are struggling with their transgender identities (Cooper, 1999) and parents can have the opportunity to talk openly about their child (Rosenberg, 2002).

Third, the mental health professional needs to be willing to advocate for his or her client and family. Transgender youth are often functioning within systems (such as school) that do not fully support or understand their transgender identity; therapists can help advocate and educate within these systems so their clients may be treated with increased care and consideration (Coolhart, in press). Sensitivity training about the unique needs of transgender youth among school faculty and staff is rare (Burgess, 1999), and therapists can help fill this gap.

Finally, the family therapist will need to continually acquire knowledge of contemporary research, literature, and social issues around transgender issues. Because both the scholarly and empirical literature on therapy with transgender youth has been so limited, it is ever evolving. Additionally, transgender people are significantly impacted by societal discrimination and oppression. Therefore, therapists should be aware of the sociopolitical forces in the construction of gender, the issues involved in the transgender liberation movement, and the endless diversity of gender expression (Lev, 2004).

17

lanie Gonzalez

18

lanie Gonzalez

19-20

2 notes:

21

lanie Gonzalez

22

lanie Gonzalez

Role of the Therapist

It is not uncommon for families with a transgender child or youth to find themselves in the office of family therapists or other mental health professionals. Sometimes families seek the help of a professional to better cope with and understand their child's gender identity. Perhaps more commonly, families seek the help of mental health professionals for assistance in the gender transition process.

WPATH recommends that individuals wishing to receive medical treatments for gender transition (i.e., hormones, surgery) obtain a letter of recommendation from a Master's level mental health professional. Thus, physicians often refer transgender patients to family therapists before prescribing hormones to transgender patients. To provide this letter of recommendation, therapists must assess the client's readiness and preparedness for gender transition. Therefore, therapists often function as gatekeepers (Cohen, 2004; Raj, 2002) or a bridge to medical gender transition. Thus, "marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality" (AAMFT, 2001, principle 1.13).

To assist in the process of making sound recommendations for gender transition medical treatments, Coolhart et al.'s (in press) clinical assessment tool can be used by therapists to determine youth's readiness for steps in gender transition. Finally, and of utmost importance when treating children and youth, the therapist supports the client and his or her family as they navigate the development of client's gender identity. Therapists can explore with families the variations of gender transition and assist them in deciding which options are best suited for their child.

Because of the potential of multiple collaborations with professionals in different realms (medical, educational, human services), family therapists need to be mindful of their adherence to the ethical principle of confidentiality. Clients need to be made aware of disclosure protocols, their right to confidentiality, and the limits of this principle. This could be challenging because the therapist is dealing with multiple relationships within and outside the therapeutic milieu.

Transition in Childhood

The transition process to the preferred gender should be explored as soon as the child expresses his or her desire to experiment with gender expressions other than his or her assigned gender. Developmental theory indicates that this often happens in early childhood. One advantage to allowing children the flexibility to explore gender transition is that early childhood transition (before puberty) does not entail any medical interventions.

The children and their families could change or modify their use of gendered names, pronouns, and clothing to the child's preferred gender. The therapist may need to directly advocate or help the family advocate on behalf of the child at schools and other social settings. Issues like bathroom use and use of preferred name/gender and pronouns by other individuals on documents need to be addressed.

The family therapist will also need to consider the ethical implications of the circumstances of disclosure of the child's transgender identity. The therapist will need to ponder with the family and child to whom, what, when and where to disclose. Along the process of disclosure, the therapist will need to prepare the family to effectively deal with and counter any possible negative reactions.

Transition: Medical Interventions for Adolescents

In prepubescent youth luteinizing hormone-releasing hormone agonists or medroxyprogesterone can be used to suppress estrogen or testosterone production (Meyer et al., 2001). This hormonal delay of puberty is fully reversible. It buys time for the youth to reflect and further develop gender identity and expression without the youth's body undergoing physical changes in the "wrong" gendered direction. Because these youth's bodies will not develop the secondary sex characteristics of their assigned gender, later treatments may be avoided, such as chest reconstruction, laser hair removal or electrolysis, tracheal shave surgery to reduce the size of the Adams apple, facial feminization surgery, and voice therapy for MTFs whose voice dropped during puberty (Coolhart et al., in press). One possible side effect of this intervention is that youth's cognitive development and adolescent growth spurt will be delayed as long as puberty is being delayed (Brill & Pepper, 2008).

The therapist along with the family and youth should carefully consider when to initiate treatments. Before making the decision and to have informed consent the family therapist is ethically obliged to be up to date on and disclose the possible negative consequences of hormonally delaying puberty or to have a sufficiently qualified third party disclose the implications of hormone therapy. The family and youth should be aware that hormonal suppression can be stopped at any time and the youth's body will naturally initiate the puberty of the assigned gender. Thus, the risks of hormonal suppression are relatively low.

Feminizing or masculinizing hormonal therapy can be used to stimulate the development of physical/emotional characteristics of the preferred gender. These types of interventions are partially reversible upon cessation of preferred hormonal treatment. Although many bodily changes caused by the hormones are reversible, such as muscle and fat distribution and changes in emotionality and skin, some changes are not reversible, such

as breast growth, voice pitch drop, and facial/chest hair. The therapist will need to disclose and discuss with the client the benefits and possible detriments of this type of intervention. Fertility considerations should be discussed with the youth and family because the reversibility of hormone-induced sterility is unclear (de Vries, Cohen-Kettenis, & Delemarre-Van de Waal, 2006). Additionally, therapists, youth, and families should consider the tension between the youth's realistic chance of successfully passing as their preferred gender and the additional stress of choosing who and when to disclose transgender identity with the overall instability of adolescence.

Further Discussion on Ethical Considerations

As stated before, informed consent is especially important when working with transgender children/youth and their families. The client and their family should be knowledgeable about the potential risks and benefits of treatment and nontreatment. It is the responsibility of the therapist to make sure the client and family understands the possible ramifications of their choices. The therapist needs to disclose the basis of her or his opinions, whether it comes from research or clinical experience. It is not good enough to state what research indicates; the therapist needs to disclose what kind of research and how reliable this information has been. If their suggestions or course of action is solely based on clinical experience, the client should be made aware of the limitations of such information.

Family therapists will also need to make sure to obtain all the necessary patient and parental consents. This could get complicated when working with single parents, children under the care of the state, or blended families. Therapists need to be aware of the differences between physical and legal custody. The parent that has physical custody might have shared legal custody, in which case consent will need to be obtained from all whom hold legal custody. The same could happen with minors under the care of the state; the state might have physical custody but the parent still might retain legal rights over the child. Thus, whenever a family therapist is working with families they need to clarify who needs to give consent. Therapists should never take for granted that all who have participated in therapy are the only individuals that need to be asked for consent.

Confidentiality and the implication of disclosure will need to be thoroughly discussed with the client and their family. The family and client need to determine who should know and when they should know. Questions such as "Should the school be informed? When? Who at the school should be informed? Should neighbors be informed?" need to be addressed. Finally, the therapist needs to obtain all the necessary paperwork and consent forms and to talk with any outside entities.

30-31

2 notes:

Treatment Options: Therapy Beyond Medical Transition

Supportive psychotherapy (Lev, 2004) has been used with transgender children, youth, and their families. This model follows four basic steps or guidelines. First, information and education about transgender issues need to be provided to parents, child, and siblings. Second, the therapist needs to effectively use community resources and referrals to reduce individual and familial isolation. Third, the therapist needs to act as an advocate, especially as it relates to the family's interaction with school and legal authorities. Finally, appropriate familial boundaries should be developed and encouraged throughout the therapeutic services.

The Family Acceptance Project in San Francisco is conducting research to decrease major health and related risks for lesbian, gay, bisexual, and transgender (LGBT) youth, such as suicide, substance abuse, HIV, and homelessness, in the context of their families. Publications of this ongoing research to date suggest that family acceptance of LGBT youth is related to better physical and mental health outcomes. One such study found that higher rates of family rejection of gay, lesbian, and bisexual adolescents were associated with youth reporting increased rates of suicide attempts, higher levels of depression, increased use of illegal drugs, and increased engagement in unprotected sex (Ryan, Huebner, Diaz, & Sanchez, 2009). Although this study did not include transsexual youth, another study of the Family Acceptance Project found similar results for a sample that included transgender participants. Ryan, Russell, Huebner, Diaz, and Sanchez (2010) sampled young LGBT adults to explore the role of family acceptance of LGBT youth as a predictive factor for LGBT young adults. Their study found that family acceptance of LGBT adolescents predicts greater self-esteem, social support, and general health status in young adulthood. Also, family acceptance was found to protect against depression, substance abuse, and suicidal ideation behaviors.

Because research indicates that transgender youth with more accepting and supportive parents may have better mental and physical health outcomes, interventions that increase parental understanding and acceptance are supported. The parents who ascribe to the vow of parental acceptance (Brill & Pepper, 2008) promise to follow eight principles:

1. Speak positively about my child to them and to others about them.
2. Take an active stance against discrimination.
3. Make positive comments about gender diversity.
4. Work with schools and other institutions to make these places safer for gender variant, transgender, and all children.
5. Find gender variant friends and create our own community.
6. Express admiration for my child's identity and expression, whatever direction that may take.

32

lanie Gonzalez

33

9/24/2017

lanie Gonzalez

34

lanie Gonzalez

35-36

2 notes:

37-38

2 notes:

7. Volunteer for gender organizations to learn more and to further the understanding of others.
8. Believe my child can have a happy future.

Counter Indications

Conversion therapy and related interventions are counter indicated for transgender youth, children, and their families. The harms of conversion therapies are well documented (Blackwell, 2008). Because of the enormous research-based evidence of the harmful effects of conversion therapies, the American Psychiatric Association and American Psychological Association have determined conversion therapy to be unethical. Because marriage and family therapists are ethically bound to “advance the welfare of families and individuals” (AAMFT, 2001, principle I), it is imperative that if families want to pursue such treatment modalities they are informed of the harms associated with such interventions and the therapist refrains from engaging in these discredited intervention programs.

CASE STUDY¹

Teresa, mother of 13-year-old “Sean,” sought therapy for assistance with her “son” who recently disclosed to her a transgender identity. When the mother and teen began sessions with the therapist, there was an immediate discussion regarding language to be used in therapy, specifically how the teen self-labeled gender and what name and pronouns were preferred by the youth. The youth expressed a preference for feminine pronouns and the name “Tammy.”

Tammy described to the therapist feeling like she was a girl from the time she was 4. Her earliest gender-related memory was when she put on her older sister’s dress, and when she went to show her parents how pretty she looked, her father angrily told her to go take it off. Tammy recalled feeling confused and ashamed about her father’s reaction, not knowing what she had done wrong but sensing it was a serious offense. Over the next year Tammy realized she was different, that even though she felt like a girl inside she had a penis, which made everyone else believe that she was a boy.

Throughout her childhood Tammy tried to hide her internal sense of female gender and adjust to the male identity, which was prescribed to her. However, Tammy felt a sense of body dysphoria, particularly with her penis, reporting that she often tucked it between her legs and believed like it was not supposed to be part of her body. And even though Tammy tried to blend in with the boys, she was often teased for being effeminate. Tammy’s

¹ This case example is a composite of the author’s (DC) transgender youth clients. All identifying information of the family, including names, has been changed.

mother, Teresa, agreed that her “son” was always feminine and that, over the years, she and her husband discussed the possibility that “Sean” might be gay. Tammy felt distress due to her difference, often experiencing anxiety when she was in situations when she felt unable to be male enough, such as when being made to play sports with boys in gym class.

When Tammy was 11 years old she saw a documentary on television about a transgender individual, which was her first exposure to a person that was like herself. She immediately felt a sense of excitement, used the Internet to further learn about what it meant to be transgender, and was sure this description fit her. Because of Tammy’s clear identification with the label “transgender,” feminine pronouns, and the name “Tammy,” the therapist adopted this language in therapy. The therapist also invited Tammy’s father, Anthony, to be a part of therapy and advocated for Tammy with her parents for the use of this language, educating them about why this language was so important in respecting Tammy’s internal sense of gender.

Before coming to therapy Teresa had begun to learn about what it meant to be transgender, and although uncomfortable with this path for her child, she expressed wanting her child to be happy. Anthony, on the other hand, had thus far rejected the idea that his child was transgender, not really knowing what it meant, and had not made efforts to learn more about it. Therefore, there was a lot of therapeutic work to do with the parents in exploring the meaning of transgender, processing thoughts and emotions about what it meant that their child was transgender, and negotiating a new understanding of their child as a daughter. This work was going to take time, though the therapist was immediately concerned about Tammy’s progression through a male puberty. Tammy’s voice had not yet become lower, a development that is irreversible and may cause future distress for Tammy. Therefore, ethically the therapist needed to discuss with the family the risks and benefits of taking steps toward gender transition versus allowing Tammy to continue to develop through male puberty.

Tammy expressed a clear desire to transition to female as soon as possible, feeling that this transition would allow her to feel on the outside how she has always felt on the inside. However, the family was not ready for this step and needed time to adjust to this new development in the family and all its implications. The therapist educated the family about the different steps in gender transition, including nonmedical transition, pubertal delay, and feminizing hormones. The therapist also talked with the family about the possibility of Tammy becoming infertile if she pursued feminizing hormones and continued taking them for a prolonged time. The therapist discussed the long-term advantages to early intervention and how it may prevent Tammy from needing later medical procedures. The family was clearly not ready to support a full gender transition, so the step of pubertal delay was discussed in detail. If Tammy’s puberty was delayed, then it would give the family more time to adjust, give Tammy more time to confirm that transition was

the right path for her, and prevent Tammy's body from developing in ways that were incongruent with her internal sense of self.

The family was agreeable to the step of pubertal delay, so the therapist used the clinical tool for assessing a youth's readiness for gender transition (Coolhart et al., in press). The therapist informed the family that there was an additional limit to the confidentiality of information shared in the clinical assessment; it would be necessary to share much of the information with the endocrinologist when the recommendation was made for pubertal delay. Also discussed was the likelihood that Tammy would be diagnosed at some point with gender identity disorder to receive her medical treatments. The therapist talked with the family about concerns and feelings they had with this process.

After Tammy began treatment with an endocrinologist to begin pubertal delay, the therapist continued to work with the family for an additional year. In meeting with the parents, the therapist created space for them to express their concerns about Tammy's gender and her potential gender transition. Anthony, in particular, struggled to understand his child's identity and thought it was a choice. In addition to processing Anthony's emotional experience, the therapist informed Anthony that the literature suggests being transgender is not a choice and that transgender identities typically are present early in childhood. The therapist validated the parents' process, and as part of normalizing the transgender identity, the therapist suggested the parents contact a local center that holds meetings for parents of LGBT children. Additionally, the therapist shared with the parents the results of research on importance of family support, which indicates that family support leads to better mental and physical health outcomes for LGBT youth.

After a few months of therapy the family seemed more ready to begin allowing Tammy to transition to a female gender presentation. Anthony, after having time to process his feelings and talking with other parents of transgender children, felt more accepting of Tammy's gender identity and even began referring to her as his daughter. One of Anthony and Teresa's major concerns was the experiences of discrimination that Tammy would face. The family processed these fears in therapy, and the therapist discussed with the family strategies for maintaining safety, ways to counter the discrimination, and how to cope with such experiences. In this discussion the therapist gave examples of situations that might be challenging, such as if a peer at school said something unkind to Tammy about her gender. The family brainstormed possible responses in the moment, who Tammy might want to inform at school to ensure her safety, and ways the family could support Tammy after school in her emotional experience of the discriminatory remark.

During the summer before Tammy was starting her eighth grade year, the family decided to start Tammy on feminizing hormones and for her to start the upcoming school year as a female. They legally changed their child's name to Tammy and began to talk with the principal at school. Upon

the therapist's recommendation, the principal agreed to a meeting with the therapist, also including other key school personnel, such as Tammy's teachers and the school social worker. Before going to this meeting the therapist talked with the family about what information they would prefer to have shared at the meeting and what information would be kept confidential. The appropriate consent forms were then signed.

After Tammy had started the new school year as a female and experienced the initial challenges of this transition, the family terminated therapy. At the time they seemed well equipped to handle what was ahead of them. Although people at Tammy's current school knew about her gender transition, the therapist suggested to the family that new people the family met would not be aware of her previous male identity. There was some discussion about who would be told about Tammy's transgender identity and what information would be shared. The therapist encouraged the family to return to therapy if additional support was needed in the future.

CONCLUSION

Marriage and family therapists, even those who do not specialize in treating transgender populations, should be knowledgeable about the treatment and ethical protocols to be followed with transgender children and youth. It is increasingly likely that in their careers marriage and family therapists encounter families seeking therapy for issues dealing with the gender identification of their children or youths. This is supported by research showing that this population is increasingly seeking the services of mental health professionals, especially family therapists, and the number of helping professionals equipped to effectively serve them is low. By becoming knowledgeable about and effectively serving transgender youths and children, marriage and family therapists will fill an increasingly significant therapeutic service need for a population that has been historically misunderstood and underserved.

ACKNOWLEDGMENTS

Aníbal Torres Bernal and Deborah Coolhart contributed equally to the development of this article. Aníbal Torres Bernal acknowledges Isabelle Wilczewski for her invaluable help and support in the development of this article.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental health disorders* (4th ed.). Washington, DC: Author.

- American Association for Marriage and Family Therapy. (2001, July 1). *AAMFT code of ethics*. Retrieved from http://www.aamft.org/resources/lrm_plan/ethics/ethicscode2001.asp
- Blackwell, C. W. (2008). Nursing Implications in the Application of Conversion Therapies on Gay, Lesbian, Bisexual, and Transgender Clients. *Issues in Mental Health Nursing, 29*(6), 651–665.
- Bochenek, M., Brown, A. W., & Human Rights Watch (Organization). (2001). *Hatred in the hallways: Violence and discrimination against lesbian, gay, bisexual, and transgender students in U.S. schools*. New York, NY: Human Rights Watch.
- Brill, S. & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco, CA: Cleis Press Inc.
- Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgendered youth. In G.P. Mallon (Ed.), *Social services with transgender youth* (pp. 35–47). Binghamton, NY: Harrington Park Press.
- Carroll, L. C., Gilroy, P.J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling and Development, 80*, 131–139.
- Clements-Nolle, K., Wilkinson, W., Kitano, K., & Marx, R. (2001). HIV prevention and health service needs of the transgender community in San Francisco. In W. Bockting and S. Kirk, (Eds.), *Transgender and HIV: Risks, prevention, and care* (pp. 69–89). Binghamton, NY: Haworth.
- Cole, S. S., Denny, D., Eyler, A. E., & Samons, S. L. (2000). Issues of transgender. In L. T. Szuchman & F. Muscarella (Eds.), *Psychological perspectives on human sexuality* (pp. 149-195). New York, NY: Wiley.
- Cohen-Kettenis, P., & van Goozen, S. (1998, December). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. *European Child & Adolescent Psychiatry, 7*(4), 246–254.
- Connolly, C. M. (2005). A process of change: The intersection of the GLBT individual and their family of origin. *Journal of GLBT Family Studies, 1*(1), 5–20.
- Coolhart, D. (2012). Supporting transgender youth and their families in therapy: Facing challenges and harnessing strengths. In J. Bigner & J. Wetchler's (Eds.), *Handbook of LGBT-affirmative couple and family therapy*. New York, NY: Routledge Press.
- Coolhart, D., Baker, A., Farmer, S., Melhaney, M., & Shipman, D. (in press). Therapy with transsexual youth and their families: A clinical tool for assessing youth's readiness for gender transition. *Journal of Marital and Family Therapy*.
- Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301–324.
- Cooper, K. (1999). Practice with transgendered youth and their families. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 10*(3), 111–129.
- de Vries, A.L.C., Cohen-Kettenis, P.T., & Delemarre-Van de Waal, H. (2006). *Clinical management of gender dysphoria in adolescents*. Vancouver, BC, Vancouver Coastal Health - Transgender Health Program. Retrieved from <http://transhealth.vch.ca/resources/careguidelines.html>
- de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-Van de Waal, H. (2006). Clinical management of gender dysphoria in adolescents. In *Caring for transgender*

- adolescents in BC: Suggested guidelines*. Vancouver, BC: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.
- Hardy, K. V., & Laszloffy, T. A. (2002). Enraged to death: A multicontextual approach to LGBT teen suicide. *In the Family*, 7(4), 8–13.
- Harry Benjamin International Gender Dysphoria Association., & Meyer, W. J. (2005). *The standards of care for gender identity disorders, sixth version*. Minneapolis, MN: Harry Benjamin International Gender Dysphoria Association.
- Israel, G. E. (2005). Translove: Transgender persons and their families. *Journal of GLBT Family Studies*, 1(1), 53–67.
- Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex role concepts and attitudes. In E. E. Maccoby's (Ed.), *The development of sex differences* (pp. 82–173). Stanford, CA: Stanford University Press.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. Binghamton, NY: The Haworth Clinical Practice Press.
- Meyer, W., III, Bockting, W., Cohen-Kettenis P., Coleman, E., DiCeglie, D., Devor, H., et al. (2001). *The standards of care for gender identity disorders* (6th version). Retrieved from <http://www.symposion.com/ijt/soc2001/index.htm>
- Nanda, S. (1994). Hijra: An alternative sex and gender role in India. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 373–417). New York, NY: Zone Books.
- Raj, R. (2002). Towards a transpositive therapeutic model: Developing sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *The International Journal of Transgenderism*, 6(2). Retrieved from <http://www.symposion.com/ijt/ijtvo06no0204.htm>
- Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Children and Adolescent Psychiatry*, 41, 619–621.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346–352.
- Ryan, R., Russell, S. T., Huebner, D., Diaz, R. & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205–213.
- Sanders, G. L., & Kroll, I. T. (2000). Generating stories of resilience: Helping gay and lesbian youth and their families. *Journal of Marital and Family Therapy*, 26, 433–442.
- Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed*. New York, NY: W. W. Norton & Company, Inc.
- Tafoya, T., & Wirth, D. A. (1996). Native American two-spirit men. In J. F. Longres (Ed.), *Men of color: A context for service to homosexually active men* (pp. 51–67). New York, NY: Harrington Park Press.
- Terry, J. (1999). *An American obsession: Science, medicine, and homosexuality in modern society*. Chicago, IL: University of Chicago Press.

Copyright of Journal of Family Psychotherapy is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Treatment and Ethical Considerations with Transgender Children and Youth in Family Therapy

Bernal, Aníbal Torres; Coolhart, Deborah

-
- 01 Melanie Gonzalez Page 2
20/9/2017 21:33
-
- 02 Melanie Gonzalez Page 2
20/9/2017 21:33
-
- 03 Melanie Gonzalez Page 3
20/9/2017 21:33
-
- 04 Melanie Gonzalez Page 3
20/9/2017 21:33
-
- 05 Melanie Gonzalez Page 4
20/9/2017 21:33
-
- 06 Melanie Gonzalez Page 4
20/9/2017 21:33
-
- 07 Melanie Gonzalez Page 4
20/9/2017 21:33
-
- 08 Melanie Gonzalez Page 4
24/9/2017 20:00
-
- 09 Melanie Gonzalez Page 5
24/9/2017 20:00

- 10 Melanie Gonzalez Page 5
24/9/2017 19:59
Read Coolhart's other article about this finding
-
- 11 Melanie Gonzalez Page 5
24/9/2017 20:00
-
- 12 Melanie Gonzalez Page 5
24/9/2017 19:59
-
- 13 Melanie Gonzalez Page 5
24/9/2017 19:59
-
- 14 Melanie Gonzalez Page 5
24/9/2017 19:59
-
- 15 Melanie Gonzalez Page 5
24/9/2017 19:59
-
- 16 Melanie Gonzalez Page 6
24/9/2017 19:59
-
- 17 Melanie Gonzalez Page 7
24/9/2017 19:59
-
- 18 Melanie Gonzalez Page 7
24/9/2017 19:59
-
- 19 Melanie Gonzalez Page 7
24/9/2017 19:59
-
- 20 Melanie Gonzalez Page 7
24/9/2017 20:00

21	Melanie Gonzalez	Page 7
	24/9/2017 19:59	
22	Melanie Gonzalez	Page 7
	24/9/2017 19:59	
23	Melanie Gonzalez	Page 8
	24/9/2017 20:00	
24	Melanie Gonzalez	Page 8
	24/9/2017 19:59	
25	Melanie Gonzalez	Page 8
	24/9/2017 20:47	
26	Melanie Gonzalez	Page 8
	24/9/2017 20:47	
27	Melanie Gonzalez	Page 9
	24/9/2017 20:47	
28	Melanie Gonzalez	Page 9
	24/9/2017 20:47	
29	Melanie Gonzalez	Page 9
	24/9/2017 20:47	
30	Melanie Gonzalez	Page 10
	24/9/2017 20:47	
31	Melanie Gonzalez	Page 10
	24/9/2017 20:47	
32	Melanie Gonzalez	Page 11
	24/9/2017 20:47	

- 33 Melanie Gonzalez Page 11
24/9/2017 20:47
Can compare w/ Coolhart's 4 competencies
-
- 34 Melanie Gonzalez Page 11
24/9/2017 20:47
-
- 35 Melanie Gonzalez Page 11
24/9/2017 20:47
-
- 36 Melanie Gonzalez Page 11
24/9/2017 20:47
Important to add in my pilot study!!!
-
- 37 Melanie Gonzalez Page 11
24/9/2017 20:47
-
- 38 Melanie Gonzalez Page 11
24/9/2017 20:47
-
- 39 Melanie Gonzalez Page 12
24/9/2017 20:47
Add note about conversion therapy in my pilot study under Trans and Therapy
-
- 40 Melanie Gonzalez Page 12
24/9/2017 20:47
-
- 41 Melanie Gonzalez Page 12
24/9/2017 20:47
-
- 42 Melanie Gonzalez Page 15
24/9/2017 20:47
-
- 43 Melanie Gonzalez Page 15
24/9/2017 20:47