

An Affirmative Intervention for Families With Gender Variant Children: Parental Ratings of Child Mental Health and Gender

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This is a report on parents who have children who exhibit gender variant behaviors and who contacted an affirmative program in the United States for assistance. All parents completed the Child Behavior Checklist, the Gender Identity Questionnaire, and the Genderism and Transphobia Scale, as well as telephone interviews. The parents reported comparatively low levels of genderism and transphobia. When compared to children at other gender identity clinics in Canada and The Netherlands, parents rated their children's gender variance as no less extreme, but their children were overall less pathological. Indeed, none of the measures in this study could predict parents' ratings of their child's pathology. These findings support the contention that this affirmative program served children who were no less gender variant than in other programs, but they were overall less distressed.

Parents and Gender Variance

Gender identity disorder (GID) in children and adolescents is marked by several related characteristics including: the child's stated desire to be, or insistence that he or she is, the other sex, a preoccupation with cross-sex activities and appearance, a strong preference for cross-sex roles, and a strong desire to live or be treated as the other sex (American Psychiatric Association, 2000). The long term implications of childhood GID are variable. Gender identity disorder in childhood does not necessarily predict GID in adolescence or adulthood, although some, but not all, adolescents and adults with GID have a history of childhood GID. Criteria to ascertain the long term stability of childhood gender variance, before the physical and psychological changes of puberty, do not exist. While there are no exact prevalence statistics on this diagnosis, and relatively very little research on the phenomenon, clinicians and researchers are engaged in a passionate debate about how to best help (Hill, Rozanski, Carfagnini, & Willoughby, 2007). Although many professionals agree that transsexual teens and adults should achieve the gender they desire through social interventions, and later medical interventions, there is controversy regarding the appropriate minimal age in which social, hormonal, and surgical interventions should be instituted. Regardless, the psychological and social implications of gender variance in childhood are significant for both the child and the family.

The Standard Treatments

The standard approach to children and adolescents diagnosed with GID is largely an individualized medical/psychiatric treatment approach. This approach assumes that the child is disordered, and the treatment should be directed at the child. Following this model, there are two basic positions regarding the best interventions for gender variance in children and adolescence. One position has been called reparative or conversion therapy since it aims to convert the child back to a stereotypically gendered child, encouraging them to conform to the gender expectations of their birth sex, thus "repairing" the gender nonconformity. While "reparative therapy" has acquired a negative connotation, mostly in the discourse on attempts

to convert gays and lesbians to heterosexuality, few proponents of this position would describe their work as reparative (mostly because it has been prohibited by the American Psychological Association; see DeLeon, 1998). Therapists who subscribe to this approach might describe their treatment as “corrective” or “normalizing” therapy, based on the assumption that a stereotypically gendered child is normal or correct.

One of the first reports of normalizing therapy was described by Rekers and Lovaas (1974). They used direct social reinforcement procedures and enlisted parents to help extinguish “maternal nurturance” in the child and promote “masculine aggression” in gender atypical boys. More recently, Meyer-Bahlburg (2002) encouraged parents to increase positive interactions between the boys, his peers, and father, as well as ignoring the boy’s cross-dressing or distracting him when engaging in cross-gender interests. Zucker and Bradley (1995) advocated similar interventions but admitted that there really was a lack of evidence that these treatments were successful. Justifications for normalization approaches include the prevention of homosexuality (Nicolosi & Nicolosi, 2002), and the elimination of “poor outcomes” like peer ostracism in childhood and transsexualism in adulthood (Zucker & Bradley, 1995). As such, Haldeman (2000) pointed out that reparative therapies for GID contravene the 1997 American Psychological Association “Resolution on Appropriate Therapeutic Responses to Sexual Orientation” (DeLeon, 1998).

On the other side of the spectrum are those interventions that accept the child’s gender wishes and help teens change their gender, commonly known as sex or gender reassignment (GRS). Gender reassignment has two components: social transition (the child or adolescent embracing a gender presentation that matches her or his declared gender) and hormonal/surgical therapies (interventions aimed at bringing the person’s physical secondary sex characteristics to better agreement with his or her declared gender). Clinicians generally consider a successful social transition as a necessary precondition for hormonal therapies. However, persons who transition socially do not always pursue surgical hormones or surgery. Although social transition is technically possible before puberty, hormones to block or delay puberty and cross-gender hormones cannot occur until secondary sexual characteristics develop. Perhaps the best known proponent of this approach is Cohen-Kettenis and Pfafflin (2003).

One of the least debatable problems with the above standard interventions is that clinicians have yet to be able to determine which child should receive which therapy. Children diagnosed with GID may take several developmental paths. Some children experience massive distress associated with living in their assigned gender and their commitment to their declared gender increases with the approach of puberty. For other children, childhood gender variance fades by puberty or earlier, and development proceeds towards a “homosexual path,” as they mature to become gay and lesbian teenagers. Lastly, some children and adolescents diagnosed with GID end up heterosexual and may or may not be unconventionally gendered. Currently, clinicians have no test to decide which trajectory a child will take, possibly because a child’s gender and sexual orientation are dynamic entities, developing as they mature, subject to biological and social forces and processes that have yet to be fully understood.

Critics of conversion approaches believe that such approaches may cause harm. Rosenberg (2002) suggested that therapy aimed to force children to conform to their natal gender caused additional stress to these children, a so-called gender “straightjacket.” Yunger, Carver, and Perry (2004) found that pressure to conform to gender stereotypes led to reduced acceptance by peers and increased withdrawal and social isolation. This fits with the observation of some clinicians that in some cases when parents relax gender expectations allowing for freer gender-variant expressions at home, the child’s level of anxiety decreases and with it the intensity of the child’s gender-variant expressions might wane. A persuasive argument against corrective therapies comes from child advocates, especially the families of gender-variant children. Boenke (1999) argued that therapies designed to convert the child back into a stereotypically gendered individual invalidate the child’s desires and sense of self.

Changing the Focus to the Parents

Some have suggested that parents may actually play a significant role in the genesis of their child’s gender nonconformity. Zucker (2000) asserted that some parents may actually intend to raise a cross-gender child because of a desire for a child of the other gender or because one or both parents were ambivalent about traditional gender roles. Most clinicians advocating a normalizing approach stress that parents must be

involved in the conversion effort (Newman, 2002; Zucker & Bradley, 1995).

Psychoanalytic clinicians have attributed the source of GID in children to either a distorted attachment bond between parent and child (Coates & Person, 1985; Marantz & Coates, 1991; Coates, 1997) or simply “too much mother; too little father” (Stoller, 1965, 1985). These approaches fail to recognize that parents who go along with conversion therapies are likely to experience marked discomfort with, even shame about, the child’s gender variance and therefore could be emotionally rejecting or “unavailable.”

There is no doubt that gender variant children present parents with special challenges (Hill & Menvielle, 2009). This is especially the case if the parents disapprove of their gender nonconforming children or if clinicians enlist the parents in gender conversion therapy. Parents may, however, be caught in a bind: on the one hand, they may recognize the importance of supporting their child’s wishes; on the other hand, they may be distressed by a gender nonconforming child because such a child might be exposed to social ostracism, be a target of violence, and generally have a difficult life. Most humanistic-inspired parents believe that these children need unconditional love and support to become autonomous and fulfilled adults, becoming the person that they wish to be.

Affirmative Treatment Approaches for Parents

It is becoming increasingly acknowledged that acceptance and unconditional love are central to a healthy gender-variant child and adolescent (Wren, 2002). One treatment approach for parents of gender-variant children seeks not to convert the child back to a conventional gender, but rather helps the parents understand and support their child’s declared gender. It is based on several reasons: unconventional gender expression is experienced by some of these children as an unchangeable “given” essential quality of the self, and attempts to influence could create self-doubt or confusion; what appears as cross-gender identity in early childhood does not persist into midchildhood for the majority of children, with or without clinical interventions to normalize gender expression; and there is no scientific evidence that interventions intended to normalize gender expression have long term benefits for the child’s mental health. It takes into account the child’s agency in creatively reproducing gender instead of conceptualizing the process of learning gender as passive and dominated by adults who “teach” it. An early report on such an affirmative treatment approach for parents contended that the goal of this therapy is to educate the parent and help them understand their child, even to encourage the child to have safe cross-gender exploratory experiences (Rosenberg, 2002).

Lev (2004) articulated the rationale of an affirmative approach to helping gender variant children and their families. While peer ostracism is indeed a problem for gender-variant children, therapists should focus their efforts on systemic interventions such as sensitivity training in schools or violence prevention programs. Families need assistance overcoming their antipathy toward their child’s gender choices and assistance developing skills to deal with family members, peers, and school officials who might not support a gender nonconforming child. Parents might also need assurance that their child’s gender was not caused by their parenting practices and that supporting their child’s gender will have a positive impact on self-esteem. Wyman, Sandler, Wolchick, and Nelson (2000) also identified family environment as a critical counter-weight to negative societal responses and the main catalyst in promoting psychosocial resilience in the child.

Perhaps one of the largest interventions of this kind is the Outreach Program for Children With Gender-Variant Behaviors and Their Families recently renamed the Children’s Gender and Sexuality Advocacy and Education Program (www.childrensnational.org/gendervariance) developed by Edgardo Menvielle and Catherine Tuerk at the Children’s National Medical Center in Washington, DC. Menvielle and Tuerk (Menvielle, 1998; Menvielle & Tuerk, 2002) described their group therapy program for parents of gender nonconforming children and adolescents. The therapy is aimed at helping the parents affirm and support their children, while actively promoting healthy adjustment in their offspring. Parents learn how to model strategies for dealing with teasing and harassment, cope with the loss of an idealized future for the child, and use humor to deal with and resolve difficult situations (Hill & Menvielle, 2009). They noted that trying to enforce gender conformity in the children will only lead to feelings of shame and lower self-esteem. They encouraged parents to advocate for their children, ultimately educating those around the child, with the goal of creating a safe space for their gender nonconforming child. They observed that as parents resolve their

own shame or discomfort, others in their social networks tend to become more supportive. They urged parents to unconditionally value their child, validate their gender wishes, and avoid criticism of the child's choices. This program has been hailed as the leading edge of interventions to help gender nonconforming youth (e.g., Crawford, 2003). This program openly opposes clinical approaches that pathologize gender variance and “. . .contradicts the claims of doctors working to treat what [the Children's Program calls] 'gender variance' as a disorder” (Feder, 2007, p. 112).

Affirmative programs for parents make strong claims about the effect they have on both the parents and child, but there is very little research to substantiate these promises. Moreover, critics of these programs argue that such interventions reach parents who have children with less “severe” GID compared to more traditional treatment programs (e.g., Zucker, Bradley, Ben-Dat, Ho, Johnson, & Owen, 2003). Calls for more research on all interventions for GID-diagnosed children and adolescents, including those treated by Zucker and his colleagues, are laudable even though clinical interventions are rarely withheld until evidence of efficacy becomes available.

A Study of Parents in an Affirmative Program for Gender-Variant Children and Adolescents

This study had several objectives. The first goal was to describe the parents who solicited assistance from the Children's Program. The hypothesis was that these parents, because they sought help from an affirmative program rather than a normalization program would be tolerant and accepting of gender variance. The second goal was to compare the children of these parents to children referred to other gender clinics in Toronto, Canada (Zucker & Bradley, 1995; Johnson et al., 2004) and Utrecht, The Netherlands (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003), both in terms of their overall level of gender nonconformity and pathology. The second hypothesis was that the clients would not be any less gender-variant than those served by other programs, but that their ratings of pathology would be less than those served by conversion or gender reassignment treatments. Specifically, the children of parents referred to this parent program would be rated as having less internalizing and externalizing tendencies as well as better peer relations. This study also sought to see if any pathological tendencies of gender-variant children and adolescents could be predicted by either the parents' attitude toward gender variance or the degree of gender nonconformity exhibited. It was believed that children of parents who were less tolerant of gender variance would exhibit more pathology; likewise, previous research suggests those children who displayed more significant gender nonconformity would be rated as more pathological.

METHOD

Participants

The participants were all affiliated with the Children's Program. All had contacted the therapists associated with the program over concerns about their gender-variant child. Parents had a range of experiences with the program, from being actively involved with an in-person support group, to those who had just been referred to the program and begun to participate in the online list serve, to those who had at the time of the study very little contact with the program. A clinician-led interview to ascertain that the child met GID criteria, either live or by telephone, was a requirement for any involvement with the program and referral to the study. This sample represented those parents who consented to participate in the research, including parents who ultimately had little involvement with the program as well as those who were highly involved both on the Internet and the “in-person” activities.

In all, 42 parents participated in this study. Twenty-six were mother/father or lesbian couples. Among the remaining 16 parents, only one parent of the pair participated (15 mothers and one father). Mothers ranged in age from 22–58 years ($M = 43.5$); fathers were slightly older, ranging in age from 35–61 ($M = 46.6$).

These parents represented 31 children; one mother reported on both her children, while the others reported on one child per family. The children ranged in age from 4 to 17.5 years ($M = 8.0$). Ten (32%) were 5 or younger; 16 (52%) were 6–11 years of age; and the remaining 5 (16%) were 12 and older. Of the 31 children, 23 were born male and 8 were born female.

The majority of all parents were White. Eighty percent of mothers were White, while 10% were Hispanic, one was Black, and one identified as multi-racial. Eighty-five percent of the fathers were White, with only one identifying as Hispanic and one as Jewish.

The children were more varied in race/ethnicity than their parents. Fiftytwo percent were White, 16% were Hispanic, 13% were Black, 10% were Asian, 10% were multi-racial, and one child's race/ethnicity was undeclared. The higher racial diversity in the children was due to the high proportion of adoptees in the study: just over half the children (52%) were adopted.

Participants lived throughout the United States and Canada (Table 1).

The Hollingshead (1975) socio-economic status (SES) of the mothers (there is only comparative data on SES for mothers) in this sample was higher, in absolute terms, than the Toronto sample. Socio-economic status differences can be attributed to Canadian/U.S. economic realities, but all levels are within one standard deviation of each other (Table 2). Thus, the SES of this sample of parents was comparable to those in Toronto clinics.

TABLE 1. State and Province for Participants

| <u>State or Province</u> | <u>n</u> |
|--------------------------|----------|
| California | 3 |
| Washington, DC | 2 |
| Illinois | 2 |
| Maryland | 5 |
| Maine | 1 |
| Minnesota | 1 |
| Nebraska | 1 |
| New Jersey | 2 |
| New Mexico | 1 |
| New York | 2 |
| Ontario | 1 |
| Pennsylvania | 3 |
| Virginia | 1 |
| Washington | 1 |
| Wisconsin | 5 |

Materials

THE CHILD BEHAVIOR CHECKLIST (CBCL)

Parents completed the CBCL (Achenbach & Edelbrock, 1981), a standardized behavioral rating scale widely used in the assessment of GID-diagnosed children and adolescents (Zucker & Bradley, 1995). In this study, parents completed the 1983 version of the scale to match the data collection and scoring in the Toronto and Utrecht clinics. This scale asked parents to record their observations of a wide range of child behaviors. It assesses clinically significant tendencies like internalizing (withdrawal, somatic, and anxious) and externalizing (aggressive and delinquent), and peer relations (responses to items 25, 38, and 48). Two items, "Behaves like opposite sex" (item 5) and "Wishes to be the opposite sex" (item 110) specifically tap into gender-variant behaviors. The main part of the scale asks parents to identify tendencies or behaviors of the child on a 3-point scale (0 = not true, 1 = somewhat true, 2 = very true). In this study, the scoring technique used in Toronto was adopted, and raw scores were transformed to z-scores ($M = 50$, $SD = 10$) using established norms. It is scored such that the higher the score, the greater the pathology in the child.

TABLE 2. Comparison of SES Across Samples and Gender

| Sample | SES M (SD) | n |
|-------------------------|-------------|-----|
| Current | | |
| Boys | 53.0 (11.5) | 21 |
| Girls | 60.9 (5.8) | 7 |
| Johnson et al. (2004) | 43.0 (14.9) | 325 |
| Zucker & Bradley (1995) | | |
| Boys | 42.4 (17.4) | 161 |
| Girls | 38.1 (15.2) | 24 |

THE GENDER IDENTITY QUESTIONNAIRE (GIQ)

Parents were also given the GIQ (Johnson et al., 2004) which measures the extent of cross-gendering in a child. There were two parallel forms, one for boys and one for girls. The GIQ asks parents to judge the frequency of a range of behaviors commonly understood to be gendered (e.g., “She plays with boy-type dolls such as GI Joe. . .”). For this study, we adopted the scoring rubric used by Johnson and colleagues. A lower score indicates higher gender variance.

THE GENDERISM AND TRANSPHOBIA SCALE (GTS)

The parents also completed the GTS (Hill & Willoughby, 2005). The GTS measures cognitive, affective, and behavioral reactions to extreme gender nonconformity. It asks respondents to rate their attitudes on a series of questions on their attitudes to gender variant people along a 7-point Likert scale (1 = strongly agree to 7 = strongly disagree). There are three subscales: 10 items assess transphobic attitudes, 12 items measure genderism (the tendency to subscribe to beliefs that there are only two stereotypically different genders), and 10 items assess gender-bashing (the respondent’s tendency to use violence against those who exhibit gender nonconformity). The higher the score, the more likely a person is to be intolerant of gender variance.

Procedure

Participants contacted the therapists for the Children’s Program or were already members of either the in-person parent group or the e-mail list serve. After gaining consent, participants were sent the questionnaires, and then once returned to the first author (DH), were contacted for a telephone interview. The interviews ranged from 20 to 80 minutes, averaging 48 minutes overall. Each participant was paid \$37.50 for his or her participation in this study.

RESULTS

Interrater Reliability on Parent Ratings

Since there were matched ratings on the GIQ, GTS, and CBCL ratings for 12 parents, a test of interrater reliability was conducted. For this test, ratings on the GIQ for the female children were excluded because there were only two such cases. For the remainder of the sample, the ratings of the parents correlated strongly and significantly, except for the GTS ratings, which approached significance (see Table 3).

TABLE 3. Inter-Rater Reliability on Parent Ratings

| Mother | Father | | | |
|------------|----------|------------|-----------|-----------|
| | GTS | GIQ (Boys) | CBCL INT | CBCL EXT |
| GTS | .51 | | | |
| (n, p) | (12,.09) | | | |
| GIQ (Boys) | | .81 | | |
| (n, p) | | (10,.005) | | |
| CBCL INT | | | .83 | |
| (n, p) | | | (12,.001) | |
| CBCL EXT | | | | .67 |
| (n, p) | | | | (12,.019) |

CBCL = Child Behavior Checklist; GIQ = Gender Identity Questionnaire; GTS = Genderism and Transphobia Scale; EXT = external; INT = internal.

Parental Attitudes to Gender Variance

This sample of parents scored relatively low on the GTS scale. To get a sense of how tolerant these parents were of gender nonconformity, their attitudes were compared to a sample of parents drawn from the community and a sample of university students (see Hill & Willoughby, 2005). Since this data was available, statistical analyses confirmed that this sample of parents were significantly lower than the other samples on genderism ($M = 20.3$, $SD = 6.2$), transphobia ($M = 23.5$, $SD = 7.9$), gender-bashing ($M = 17.4$, $SD = 4.5$), and the GTS total score ($M = 61.1$, $SD = 16.7$) (Figure 1). A MANOVA analysis comparing the three samples on the total and subscale scores proved significant, $F(6, 526) = 7.13$, $p = .0001$. Simple main effects for this test on each of the GTS scores were also significant ($p = .0001$), $\eta^2 = .12$ to $.15$, a small effect. Tukey pairwise comparisons across each of the groups established that, in fact, the current sample of parents scored the lowest on all three dimensions and the total score, the parents from the community scored the next highest, and the university students scored the highest ($p < .05$). Thus, the parents of gender-variant children were the most tolerant of gender nonconforming behaviors of the three samples compared.

Gender Variance

Other researchers, at both the Toronto and Utrecht clinics, only reported data from the mother ratings of the child, mostly because of the infrequent

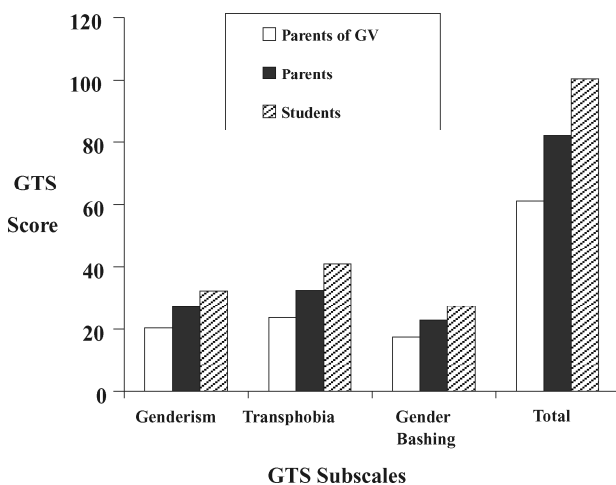


FIGURE 1. GTS responses by sample.

participation of fathers in research. In fact, in this sample, there were only two father ratings for girls, making inclusion of the father ratings dubious. Considering only the mother ratings on the GIQ, both the females ($M = 2.3$, $SD = 0.32$) and males ($M = 2.6$, $SD = 0.42$) were statistically indistinguishable from those children studied in Toronto (Johnson et al., 2004) (Figure 2).

Parental Ratings of Child Pathology

Similarly, only the maternal ratings on the CBCL were used for the following analyses so that comparisons could be made with the ratings from the other gender clinics. Zucker and Bradley (1995) calculated what they have called the “peer relations” subscale as an indication of how well the child gets along with peers. They found that this rating predicts psychopathology. In this sample, the males ($M = 1.41$, $SD = 1.2$) scored lower than the Toronto

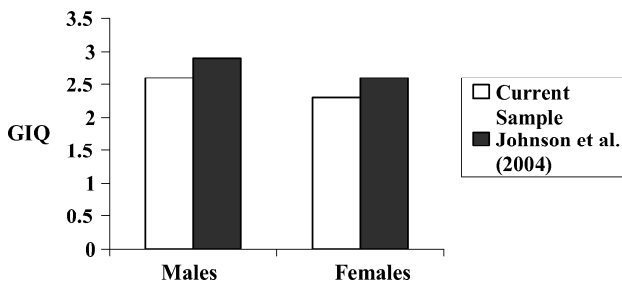


FIGURE 2. Comparison of boys and girls across samples on the GIQ scale.

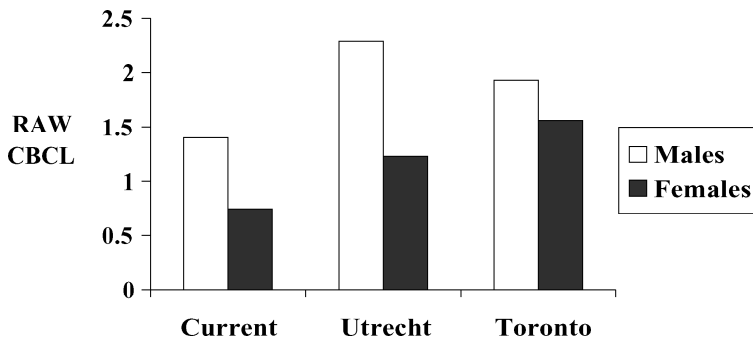


FIGURE 3. Peer relations subscale comparisons.

males diagnosed with GID ($M = 1.93$, $SD = 1.75$) and the Utrecht males diagnosed with GID ($M = 2.29$, $SD = 1.88$) as reported by Cohen-Kettenis and colleagues (2003) (Figure 3). Similarly, the females in this sample ($M = 0.75$, $SD = 1.4$) were rated lower than the Toronto females ($M = 1.56$, $SD = 1.51$) and the Utrecht females ($M = 1.23$, $SD = 1.38$). Thus, there were fewer problems with peer relations in this sample compared to the Toronto and Utrecht samples.

Another estimate of the degree of cross-gender interest is the total score of the two items of the CBCL (Items 5 and 10), which specifically assess crossgender interests. In this sample, the females were rated as more extreme in their gender variance ($M = 3.50$, $SD = .53$) than the males ($M = 2.68$, $SD = 1.17$), but this was not a significant difference, $t(28) = -1.89$, $p = .07$, a test perhaps biased by having only seven females in the sample with complete mother ratings. Cohen-Kettenis and colleagues (2003) reported that in a combined sample from Toronto and Utrecht, girls had higher ratings than boys, and the Utrecht ratings were overall higher than in Toronto. Figure 4 graphs the means from the two clinics with the current sample, suggesting that this sample of parents reported the least gender distress in their child

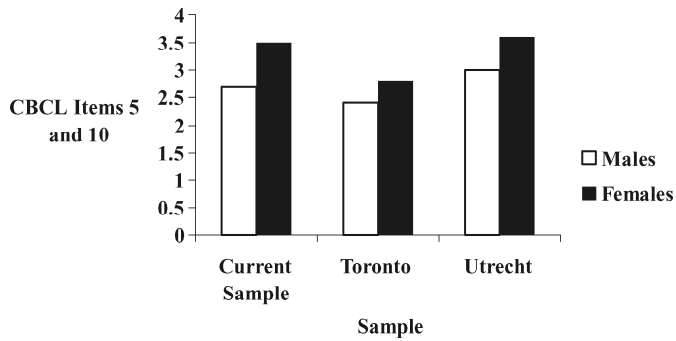


FIGURE 4. Ratings on CBCL items 5 and 10 by gender and clinic.

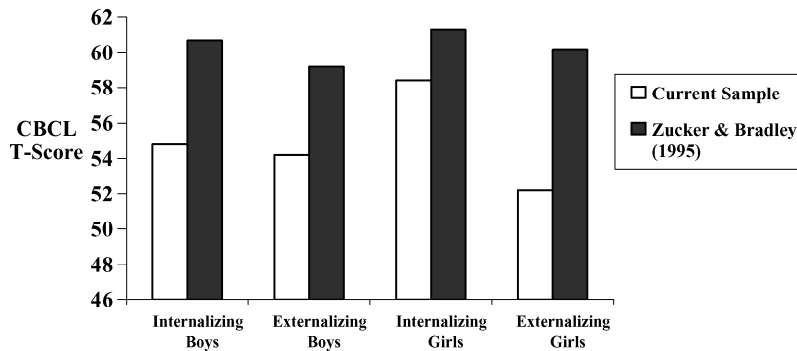


FIGURE 5. Internalizing and externalizing subscale comparisons.

compared to the other samples, with girls reporting more gender variance than boys.

On the summary scales of the CBCL, the males in this sample scored slightly lower on both the internalizing scale ($M = 54.8$, $SD = 13.1$), and externalizing scales ($M = 54.2$, $SD = 12.7$) of the CBCL (Figure 5) when compared to children studied by the Toronto clinic. Zucker and Bradley (1995) reported slightly higher scores on the internalizing ($M = 60.7$, $SD = 10.1$) and externalizing ($M = 59.2$, $SD = 10.7$) dimensions. The females also scored lower on the internalizing scale ($M = 58.4$, $SD = 22.3$) and the externalizing scale ($M = 52.2$, $SD = 10.5$), compared to Zucker and Bradley's (1995) internalizing ($M = 61.3$, $SD = 11.2$) and externalizing ($M = 60.2$, $SD = 13.7$) ratings. It is significant to note that while Zucker and Bradley's sample reached one standard deviation above the mean for all but the externalizing score for males, usually considered a clinically significant elevation, the average scores in this sample were all within normal ranges. Indeed, the number of children with a CBCL total score in the clinical range in the current sample, Toronto, and Utrecht samples (Table 4) suggests less pathology among this sample's participants, especially for those 6–11 years of age. Cohen-Kettenis and colleagues (2003) reported that 6–11 year olds in Toronto were more likely to have clinical elevations, but not in Utrecht. According to the parents in this sample, the 6–11 year-olds were the least likely of all three samples to have CBCL profiles in the clinical range. Framed another way, parents of 6–11-year-olds contacting Toronto and Utrecht were more likely to report clinical levels of distress in their children than the parents in this sample.

TABLE 4. Percentage of CBCL Total Scores in Clinical Range by Age and Location

| Sample | 4–5 Year Olds | 6–11 Year Olds |
|---------|---------------|----------------|
| Current | 22.2% | 13.6% |
| Utrecht | 43.8% | 61.7% |
| Toronto | 26.1% | 62.1% |

In order to see if gender-variant clients were any different from other clients attending the same clinic in Washington, DC, scores on the CBCL for the present sample were compared to a matched (on age and sex) clinical control group. Overall, ANOVA tests of group differences found no difference on internalizing scores, $F(1, 61) = 2.99, p = .09$. The control group, however, showed stronger externalizing tendencies, $F(1, 61) = 11.9, p = .001, \eta^2 = .17$, a small effect. Indeed, although the CBCL scores from those exhibiting characteristics of GID were all within the normal range, the control group's internalizing scores ($M = 63.2, SD = 18.3$) and externalizing scores ($M = 68.7, SD = 22.0$) were both in the clinical range.

Predicting Child Pathology

To test whether the gender variance of the child and the attitude of the parent toward gender variance predicted pathology on the CBCL ratings, a simultaneous forward regression analysis was performed. For this analysis, if there was only one parent, the sole parent's ratings were used. If there was a pair of parents, averages of the mother and father (or the other mother in the lesbian couple) ratings were calculated. Before this was done, however, pairwise t-test comparisons tested whether or not the parental ratings on the same child were significantly different. None of the ratings from mothers and fathers differed significantly ($p > .05$).

Separate regression equations were calculated for CBCL internalizing and externalizing scores. Neither the parent's ratings of gender variance on the GIQ nor the parent's attitudes toward gender variance on the GTS significantly predicted CBCL pathology ratings. Internalizing scores could not be predicted ($R^2 = .08$) using either the GIQ ($\beta = -.29, t = -1.56, p = .13$) or the GTS ($\beta = .02, t = .13, p = .90$). Similarly, externalizing scores could not be predicted ($R^2 = .04$) using either the GIQ ($\beta = -.11, t = -.59, p = .56$) or the GTS ($\beta = .19, t = 1.01, p = .32$). At least for these parents, pathology of their child was unrelated to either the child's level of gender variance or the parent's attitude toward gender variance.

DISCUSSION

Consistent with the hypotheses, this sample was comparable with previous studies. The parents in this sample were slightly higher than other samples on SES in absolute terms, but this was not a large difference and may be due to American/Canadian economic differences. Moreover, it does not appear that the parents seeking help for their gender-variant children were motivated by a fear or disgust of gender variance. Supporting the first hypothesis, these parents were, compared to a sample of parents drawn from a community sample and university students, very tolerant and accepting of gender nonconformity. Based on parental ratings of the gender-variant children and adolescents, the current sample appears to have the same degree of gender variance as those referred to the clinics in Toronto supporting the second hypothesis. While this sample was not rated any less extreme in their gender variance, the parents rated their behavior as less pathological overall on the peer relations, the internalizing and externalizing subscales of the CBCL, and the CBCL gender items, as compared to the other samples of children diagnosed with gender identity disorder, supporting the third hypothesis. On average, the children and adolescents in this sample were below clinical elevations on the CBCL and were less pathological than a matched clinical control group. Attempts to predict pathology using parental attitudes to gender variance and level of gender nonconformity failed. Neither seems to be related to distress in this sample, perhaps because there was not overwhelming evidence of pathological tendencies in these children.

One finding that sets the families in this study apart from other reports is the high proportion of adopted children. While other researchers have noted the role of adoption in gender variance (Gilmore, 1995), no other study has found such a large role as in this study. Zucker and Bradley (1998), for instance, reported that in 18 years of cases, 12% were adopted. Moreover, the parents in this study felt that adoption was a bigger threat to their child's adjustment than their gender choices. This sample of parents was biased in terms of having such a large proportion of adopters.

The argument that the Children's Program is getting referrals and assisting families with less severe cases of gender variance was unsupported. Even though the children exhibited similar levels of gender variance as

other studies, they were rated as showing less pathological tendencies. These results suggest that an affirmative model, such as that used by the Children's Program may lessen manifestations of pathology in the child. However, this interpretation should be cautiously applied. It could be that the children referred to this program were initially less pathological; or that parents with less pathological children, children who are not suffering a great deal, find affirmative therapy most attractive. It could also be that parents who seek an affirmative therapy approach are overall less judgmental and therefore rate their child's overall behaviors as less deviant. Certainly, the parents in this sample evinced very tolerant attitudes to gender variance. How a given clinical program characterizes itself could also convey a message to the parents that influences their rating of the child's behavior. This study didn't associate the level of intervention with pathology, and the parents in this study reported a wide range of involvement with the program, it is difficult to be certain of any treatment effects. At any rate, the children do not appear to be fairing worse because of the affirmative intervention with their parents. It is certainly the case that for at least some parents and gender-variant children, an affirmative approach is a route to a healthier child. Thus, good adjustment in a child can be achieved without the anti-humanistic rejection of a child's gender choices and enlisting parents in gender policing and behavior modification.

More research, of course, is warranted. The realities of conducting a national survey with limited resources on a community-based program weakened this study. As such, it was an exploratory "post-test only" study with limited comparisons among a convenience sample of parents. Moreover, this study did not control for exposure or involvement with the program so it is difficult to definitively attribute any effects of the program. The comparisons made to the other samples from Toronto and Utrecht need to be cautiously interpreted. There are obvious cultural differences between Canada, the United States, and The Netherlands unaccounted for in this research. The higher SES in this sample, for instance, may have an ameliorating effect for distress in children. Moreover, the data from Toronto and Utrecht were for those 12 and under; this study used data on older teens. It's unknown how age may influence the results in a study such as this. Zucker and Bradley (1995) found older age was associated with more pathology on the CBCL, but those results are contrary to the findings here that a relatively small proportion of the older children had clinical elevations on the CBCL.

This study does show, however, that future research deploying more controlled experimental evaluation of treatment efforts with gender-variant children and their parents is both feasible and promising. Ideally, a longitudinal design, which studies the children over time especially before and after intervention, compared to a nontreated control group, will be crucial in understanding how best to help gender-variant children and adolescents.

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