

Transgender Children and Youth: A Child Welfare Practice Perspective

Gerald P. Mallon and Teresa DeCrescenzo

Using an ecological framework, the existing literature and research, and the authors' combined 60 years of clinical practice with children, youth, and families, this article examines gender variant childhood development from a holistic viewpoint where children, youth, and environments are understood as a unit in the context of their relationship to one another. The focus is limited to a discussion about the recognition of gender identity; an examination of the adaptation process through which gender variant children and youth go through to deal with the stress of an environment where there is not a "goodness of fit"; and a discussion of the overall developmental tasks of a transgender childhood and adolescence. Recommendations for social work practice with gender variant young people are presented in the conclusion of the paper.

Gerald P. Mallon, DSW, is Professor, Hunter College School of Social Work, in New York, and Founder of LGBTQ Programs, Green Chimneys Children's Services, New York. Teresa DeCrescenzo, MSW, is Executive Director and Founder, Gay and Lesbian Adolescent Social Services (GLASS), Los Angeles.

The film *Ma Vie en Rose* (*My Life in Pink*) (Berliner & Scotta, 1997) is a story about the innocence of childhood as told through the experiences of a seven year old boy, Ludovic. Ludovic desperately wants to be a girl and everything about him says that he already is one. He has it all figured out; God messed up his chromosomes, simple as that, no judgment, no morality. Ludovic is a prime example of a female brain in a male body and he is putting up a valiant struggle not to be erased as a person. It's all very honest and natural to him. He is only a small boy and is much more in tune with his needs and desires than is his family.

Ludovic is 7 years old, born to a middle class, suburban family. He is very much like other children, but he is different in one key way—Ludovic is sure that he was meant to be a little girl, not a little boy—and he waits for a miracle to “correct” this mistake. Whenever able, he dresses in typical girl outfits, grows long hair, and is certain of his gender identity despite the fact that others are less sure. His parents, while tolerant of his gender nonconforming behaviors, also are embarrassed by his insistence that he is a girl, not a boy.

His siblings, although loving their “brother” in their home, are fatigued by having to fight for him in school when he is teased and harassed. Even though everyone else is unsure, Ludovic muddles along, praying for the miracle that will change him into the girl he knows he is. Everything falls apart however, when he falls in love with a boy who happens to be the son of his father's boss, a man who is uncomfortable in his own skin.

When Ludo's father is fired from his job because his boss cannot abide by Ludovic's crush on his son, Ludovic's mother increasingly blames his gender nonconforming dress and behavior for the family's estrangement from their community. The gender variant behavior that was once tolerated is now unsupportable: Ludovic's hair is cut into a typical boy's style; he is forced to wear traditional boy's clothing; he is brought to therapy; and he is encouraged to play sports and to be more like his brothers—all “cor-

rective" actions designed to make him to be more like a boy, to make him "fit in," by force if necessary.

Ostracized by his schoolmates, misunderstood by his family, and eventually run out of town by bigoted neighbors, Ludovic accepts that he cannot be the boy his family wants him to be. In a desperate attempt to break away from his life, Ludo tries to end his life, at which point, his family realizes that in spite of what their community thinks, Ludovic should be accepted for who he really is. The final lines in the film, "Do whatever feels best. Whatever happens you'll always be my child."

"Our child" is a line that every transgender child longs to hear from his or her parent.

Ah, if life could just be as simple as it is in the movies... although, *Ma Vie en Rose* is a powerful story of a gender variant child who struggles to be accepted by his family, and finally is, contemporary real-life childhood undoubtedly is a very difficult period for gender variant children or youth and their parents. Virtually no social supports are in any of our child welfare or educational institutions for children or youth who are gender variant. Parents who attempt to negotiate a fair accommodation for the gender variant child will undoubtedly meet misunderstanding, incredulity, and resistance, even hostility, from almost everyone they encounter. "Help that child be more like a boy, get him into sports!"; "Don't let that girl be too much of a tomboy" are among the kinder things that families and gender variant young people may hear.

In such a hostile environment, blaming the child for their failure to adapt to traditional gender norms is easy. Often the gender variant child will respond to such a poor fit with symptoms of depression, anxiety, fear, anger, self-mutilation, low self-esteem, and suicidal ideation. Unfortunately, these at-risk behaviors are often taken as further evidence that something is wrong with the child, rather than the normal response to attempting to accommodate oneself to a hostile environment.

Instead of putting the focus on the systems that will not allow gender variant children to develop in their own natural way, "treatment" approaches usually focus on the child's "maladaptive" gender identity, and attempts are frequently targeted on "corrective" actions.

Using an ecological frame to discuss the cases (Germain, 1973, 1978, 1981), the existing literature, available research, and the authors' own combined 60 years of clinical practice with children, youth, and families, this article examines gender variant childhood development from a holistic viewpoint where children and youth and their environments are understood as a unit, in the context of their relationship to one another (Germain, 1991). As such, the authors' goal is to examine the primary reciprocal exchanges and transactions transgender young people face as they confront the unique person: environmental tasks involved in being a gender variant or atypical child or youth in a society that assumes (and expects) all of its members to be gender typical. The focus of this article is limited to a discussion regarding the recognition of gender identity; an examination of the adaptation process that gender variant children and youth go through to deal with the stress of an environment where there is not a "goodness of fit," and a discussion of the overall developmental tasks of a transgender childhood or adolescence. Recommendations for competent child welfare practice with gender variant children and youth are presented in the conclusion of the article.

Gender Identity Development in Children

Although it is commonly accepted that gender identity develops in children by the age of 3, when most identify themselves as either boys or girls (Baily & Zucker, 1995; Fast, 1993; Fausto-Sterling, 1999; Green, 1971, 1974; Kohlberg, 1966; Meyer-Bahlburg, 1985; Money, 1973, Stoller, 1965, 1968), American society steadfastly refuses to believe that children have sexuality. Because people widely assume a "natural" relationship exists between sex and gender, children who

question their birth-assigned gender are pathologized and labeled "gender dysphoric." Children who deviate from the socially prescribed behavioral norms for boy or girl children are quickly pushed back in line by parental figures. Behaviors, mannerisms, and play that appear to be gender nonconforming to a parent may feel perfectly normal to the child. Although gender nonconforming behavior alone does not necessarily constitute a transgender child, Western society continues to reward parents who socialize their children to gender-bound roles. The male child who wants a Barbie, the female child who plays baseball "like a boy," the boy child who carries his books "like a girl," the girl who states she feels uncomfortable in a dress, are examples of children who express gender variant mannerisms and behaviors that are natural for them.

Like the child Ludo in *Ma Vie en Rose*, the gender variant child might wonder what is so "bad" about their behavior that upsets parental figures. Because most children desire to please parental figures, many gender variant children unsurprisingly go to great extremes to adapt to their "gender nonconforming" behaviors once they are pointed out. Other children—those who cannot change or refuse to change—are treated and judged much more harshly by a society that insists on adherence to strict gender norms. Children who are forced to comply with social stereotypes may develop behavioral problems that can lead to depression and other serious mental health issues, caused not by their gender variant nature, but by society's (and often their own parents') nonacceptance of them. In fact, as Israel and Tarver (1997) point out, as a result of preventing a child from exploring their gender identity as a child, these children frequently and ironically become examples of the very stereotype the parent had hoped to prevent—a gender-conflicted adult.

Incidence of Gender Variant Children and Youth

Transgender youths may identify their sexual orientation or to whom they are romantically and sexually attracted as gay, lesbian, bisexual, questioning, straight, or by some other label; one's

sexual orientation is different from, and not determined by, one's gender identity. Transgender youths are highly diverse in terms of sexual orientation as well as in terms of gender, race, age, religion, disability, nationality, language, and class background.

The term *gender identity disorder* (GID) first appeared in the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders (3rd Edition)* (DSM-III) in 1980. GID is described as an "incongruence between assigned sex and gender identity." *DSM-III* went on to describe a broad range of gender variant behaviors that may be observed in individuals, and resolutely indicated that "in the vast majority of cases the onset of the disorder can be traced back to childhood." Somewhat incongruously, GID is considered to be a disorder even though "some of these children, particularly girls, show no other signs of psychopathology" (APA, 1980).

The introduction of GID in children in the *DSM-III* came as the result of a U.S. government-funded experiment on gender variant boys that took place in the 1970s. These studies found that very few "feminine" boys went on to become transsexuals, but that a high percentage of them (one half to two thirds) became homosexual (Burke, 1996). GID was added to the *DSM-III* following the removal of homosexuality as an illness from that volume (Bern, 1993). Treatment, which was justified in the name of preventing transsexualism, focuses instead on modifying gender variant behavior and may be easily used covertly to "treat" future homosexuality.

Children are particularly vulnerable to medical and mental health injustices in the name of treating GID. As minors, children have no legal standing to make an informed choice to refuse "treatment." The criteria for a diagnosis of GID in children may be overly broad, taking into account all cross-gender behavior. In boys, GID is manifest by a marked preoccupation with traditionally feminine activities: playing house, drawing pictures of beautiful girls and princesses, playing with dolls such as Barbie, playing dress-up, and having girls as playmates. Girls diagnosed with GID display intense negative reactions to parental attempts to

have them wear dresses or other feminine attire. Social workers can provide parents with a broader focus and expertise to address this issue from an ecosystems perspective than might be provided by other helping professionals.

Given the extent of medical, cultural, and social misunderstanding that gender variant children endure, many unsurprisingly will become socially isolated depressed and suffer from self-esteem problems. Children who are diagnosed with GID often are treated with brutal aversion therapies intended to adjust or "correct" their gender orientation (Burke, 1996; Langer & Martuin, 2004; Scholinski, 1997).

Boys and girls diagnosed with gender identity disorder, as described by Zucker and Bradley (1995), display an array of sex-typed behavior signaling a strong psychological identification with the opposite gender. These behaviors include identity statements, dress-up play, toy play, role play, peer relations, motoric and speech characteristics, statements about sexual anatomy, and involvement in rough-and-tumble play. Signs of distress and discomfort about one's status as male or female also occur. These behaviors, note Zucker and Bradley (1995), occur in concert, not in isolation. The following case examples further illustrate those behaviors:

The Case of Brian

Brian is an 8-year-old African American boy of average intelligence who was referred by his counselor at an after-school program. Brian lived with his parents, who had a middle-class socioeconomic background, and his younger brother. His parents had noted cross-gender behavior since the age of 2. He presents as a small stature, slightly built child with longish dark hair.

Brian preferred girls as playmates, and since the age of 2, enjoyed cross dressing both at home and in school. He had stereotypical girl toy preferences, including a purse, a Barbie, and jewelry. He sometimes spoke in a high-pitched

voice and talked of wanting to marry a boy when he grew up. Brian avoided rough play and sometimes verbally stated that he wished that he did not have a penis because he was a girl, not a boy, and girls did not have penises.

The Case of Betsy

Betsy is a 9-year-old girl with a 105 IQ who was referred at her mother's request. Her parents are of working class socioeconomic background. Betsy's father was concerned about his daughter's gender nonconforming behavior; her mother was less concerned, but agreed to have her evaluated to appease her husband.

Betsy wore jeans and a white tee-shirt with a hooded sweatshirt, which she hid behind for the first half of the interview. When she became more comfortable, she allowed the hood to fall and the interviewer noted that her hair was short and styled in a fashion that is more characteristic of a boy's haircut. She said people frequently mistook her for a boy, particularly if she was in the girls' rest room.

When Betsy was 3, her mother reported that she steadfastly refused to wear a dress, and in fact would throw a temper tantrum when asked to do so. Betsy reported that she hated dresses and preferred to be free to dress as she pleased.

Betsy preferred boys as play partners, engaged in baseball, hockey, and other outdoor sports, and spoke openly about wishing that she were a boy, not a girl. In fact, Betsy spoke openly about having "the operation" to become a boy when she was older. When asked to draw a picture of herself, she drew a boy with bulging muscles, which she indicated looked like her hero "The Rock" of professional wrestling fame.

Although some may view the conditions of Betsy and Brian through a lens of pathology, others who approach practice from a transaffirming perspective may ask, "Why can't Betsy construct

her identity to be male as she sees it, and how can it be so terrible if Brian envisions himself as a girl?" The larger question is: Why are gender variant children so disturbing to people, especially to parents and in some cases to child welfare professionals?

Transgender Development for Youth

The issues of gender dysphoria for transadolescents are different from those of transchildren. Over time, the pervasive societal stigmatization and pathologization of transyouth allows the low self-esteem of these young people to grow into the internalized self-hatred of many transgendered adults.

Family Issues

Coming out as transgender is challenging for everyone concerned. Consequently, some male or female teenagers who cross dress (which may have nothing to do with being transgender) may do so in secret, never telling their families and friends about it. As adults, some may continue to keep their cross dressing private, sometimes seeking support through transgender support groups and, most likely, in Internet communities. Those who disclose their transidentity to their families may experience a variety of reactions, ranging from loving acceptance to complete rejection.

If an adolescent's cross dressing is discovered by his or her parents, it is likely to precipitate an emotional crisis for the entire family. A female-to-male's "cross-dressing" may be disguised as a "tomboy" phase that a daughter stubbornly refuses to grow out of, causing friction within the family only later. If a youth is intent on gender transition, however, major changes are ahead for the entire family. Being "out" about one's sexual orientation is usually a choice for some gay sons and lesbian daughters, but rarely so for those who are entering a gender transition, because gender is so visible. Moreover, the changes arising from gender transition will be much more profound than just physical appearances (e.g., emotional and hormonal changes).

While an increasing number of parents are acknowledging their child's gender struggle, most transyouth may try to keep their gender issues secret until they cannot hold them back any longer. Thus, their revelation takes most parents by surprise. Moms and dads of these kids then must deal not only with shock, denial, anger, grief, misplaced guilt, and shame, but also many real concerns about the safety, health, surgery, employment, and future love relationships of their child. In addition, the family system must learn to call their family member by a new name, and even more difficult, use new pronouns.

Psychological Issues and Risks

When a transyouth comes out, the ability to pass in their new gender is usually limited—development of a sense of “realness” is a very important issue for most transyouth. Realness is not only about passing (being perceived as real), but also about feeling real inside. Hormonal therapy, a very controversial area, especially in child welfare systems, can take years to produce a passable appearance and may have some health risks as well.

Transyouth often feel that their true gender identity is crucial to the survival of self. If their parents refuse to permit their gender transition, or if their families and friends withhold support, these youths may incur the same risks faced by gay and lesbian youth with nonaccepting families (Burgess, 1998). Some may run away from home and live on the streets, or they may seek to escape the pain of their lives through abusing substances. Like gay and lesbian youth, transyouth also are at significantly higher risk for suicide.

Because of severe employment discrimination, transgender youth who are homeless, runaways, or throwaways may need to find work in the sex industry to survive and pay for their hormones, electrolysis, cosmetic surgery, and genital sex reassignment surgery. These youth, therefore, are at high risk for HIV/AIDS and other sexually transmitted diseases, and they should

be referred to understanding healthcare providers for testing or treatment. Female-to-male youth may resort to con games or other marginal means to support themselves (Klein, 1998).

Ingesting or injecting street hormones or high-dose hormones without medical supervision also is commonplace and may result in lethal complications. Hormonal sex reassignment can be safely done only under the supervision of an experienced endocrinologist following the Harry Benjamin *Standards of Care* (Harry Benjamin International Gender Dysphoria Association, 2001). Some transyouth who are impatient with the slow pace of hormonal sex reassignment may seek silicone injections to immediately improve their body shape and may experiment with Androgen blockers or other substances, which may prove to have some health risks later in life (Wren, 2000).

Referral for Hormonal and Surgical Sex Reassignment

Transyouth may go to extraordinary lengths to obtain relief from their gender dysphoria (see Dreifus, 2005, for a thorough discussion of this topic). The desire to modify the body to conform to one's gender identity cannot be adequately explained by someone who is transgender nor can it be fully understood by someone who is not (see Israel and Tarver, 1997, for a complete discussion of this area). This self-perceived need becomes a determined drive, a desperate search for relief and release from one's own body. The urgency itself cannot be easily understood (see Pazos, 1998, for a discussion of female-to-male transition, and Glenn, 1998, for male-to-female transition). Transyouth face an urgent need to match one's exterior with one's interior, to achieve harmony of spirit and shape, of body and soul.

Although parents and child welfare professionals may be alarmed by a young person's desire for physical transition, they must recognize the intensity behind it. Referral to a psychotherapist or social worker experienced in transissues who can make a proper diagnosis is the key first step.

Is GID in Childhood or Adolescence Really a Disorder?

From a strictly diagnostic perspective, if the young person meets the criteria as established for GID in childhood in *Diagnostic and Statistical Manual of Mental Disorders (4th Edition) (DSM-IV)* (APA, 1994), then it is not difficult to make a diagnosis. Based on the sketchy history of this diagnostic category, however, one must also consider whether or not GID is really a disorder. One of the criteria for a disorder is whether or not the person diagnosed is distressed by their condition. Are gender variant young people distressed by their condition, and if so, what is the source of their distress? Or do they become distressed when they are told that they cannot be what they are sure they are? Or are they distressed because of the social ostracism they must endure?

In the authors' own clinical experiences with transgender children and adolescents, young people have been more harmed than helped by clinicians who insist on "correcting" the gender variant child by attempting to make them more gender-conforming. One needs only to read the superb memoir of Scholinski (1987), the powerful work of Feinberg (1993), or the compelling story by Colapinto (2001) to see that these attempts to "correct" for gender variance fail miserably. Professionals are directed to the work of Bartlett, Vasey, & Buowski (2000) as well for a very thorough discussion of this debate. With true transgender young people (and yes, for some young people, this is not a genuine gender identity issue but a phase of development) no treatment program, no residential program, no child welfare program, no group therapy, no aversion treatment plan could change who they are.

More often than not, the authors have seen parents who are greatly distressed by their gender variant child. Even mild, typical gender nonconformity sends terror into the hearts of most parents. One student who was a mother panicked when her 6-year-old son asked for an "Easy-Bake Oven." What's so scary, the professor (Gerald P. Mallon) asked? "It's a girl toy, what do you think

I should do?" "Buy the oven, if you can afford it," answered Mallon, "and then in a couple weeks your child will either enjoy it as his favorite toy, or cast it aside when the next new toy arrives."

Such advice provides no solace for other parents. They are embarrassed, guilty, ashamed, fearful that somehow their parenting was to blame for what went wrong, as the following case illustrates:

Jon was a 13-year-old American-born Trinidadian child referred by his great grandmother's Medicaid social worker. Jon was of average intelligence, his family background was working class socioeconomically, living in a housing project in Manhattan. On the day of the interview, Jon arrived for the interview dressed in boy's clothing, but with a very clear "girl" hairstyle. Jon was accompanied by his great grandmother, who was his primary caretaker and 85 years old. An obvious warm and affectionate relationship existed between the two, although some negative feelings also existed because of Jon's insistence that he was a girl. Jon's great grandmother explained that it was causing her great distress that Jon was insisting that he was a girl. She feared losing her standing in the community because neighbors began to ask her what she had done to make the child "that way." She was embarrassed by Jon's cross dressing, by his insistence on being called by his preferred name "Simone," and by other gender nonconforming mannerisms and behaviors. Jon simply said, "I can't be what I am not, and I am not a boy." Jon's great grandmother said to the interviewer, "Mister, I have one question for you. Can you change him back?" When I replied, "No," she responded, "Then, you can keep him."

As she got up to leave, the interviewer stopped her and explained that she could not leave her great grandson with him. Then they explored the possibility of family supports

for her and her great grandson and discussed the possibility of out-of-home placement options. Both of these prospects were quite dismal; transgender children and youth are not accepted easily in child welfare agencies, nor are there many competent practitioners in the field. After some discussion, the great grandmother agreed that he could stay at home with her, but they settled on a treatment plan that included some compromises for both she and her grandson. It was not an ideal plan, but it was a better scheme than an out-of-home placement.

Transgender Children and Their Families

Although some transgender children and youth are healthy and resilient, many gender variant children are at great risk within their family system and within institutional structures (Cooper, 1998). Gender variant children and youth, because they are told that they do not fit in, are in a constant search for an affirming environment where they can be themselves. In the search for this situation, many transgendered youth are at risk for the associated symptomatology of depression, anxiety, self-abuse, substance abuse, suicide, and family violence. In their desperate search for affirmation, they often place themselves in risky environments, such as public venues where adults congregate seeking sexual contacts.

Parents seeking to find answers may seek to have their transgender child "cured" through punishment, physical violence, or endless mental health assessments. Transgender young people may be locked in their rooms, forced to wear their hair in gender typical styles or dress in gender typical clothing, and denied opportunities to socialize. Transgender young people, as in the filmic story of Ludovic, are viewed as the "problem" in the family. Such classification leads the family to scapegoat them, in which they become the reason for everything that goes wrong. Families may begin to project their anxieties about other family conflicts on the transgender child as a way of avoiding confronting the real issues.

Some transgender children and youth are shipped away to behavioral camps, psychiatric hospitals, or residential treatment facilities, where rigidly enforced gender conformity further represses their needs and does more harm than good. In the authors' 60 years of experience in child welfare, they rarely have come across a mental health professional or social worker who is knowledgeable and proficient about working with a transgender child in an affirming manner. Most do not understand the condition, and few have ever had training to prepare them for competent practice with transgender children and youth. At present, very few gender-specialized services exist in mental health and child welfare systems across the country, with Green Chimneys in New York and Gay and Lesbian Adolescent Social Services (GLASS) in Los Angeles as two exceptions.

Regrettably, most schools of social work are not preparing practitioners to respond to the needs of this population. In his recent research, Brooks (2005) makes some important suggestions for integrating content on transgender youth into existing social work curriculum, such as using transgender persons in case examples in human behavior and clinical casework classes, and using social work literature that address transgender issues.

Israel & Tarver (1997) observe, "As there are no treatment models for curing transgender feelings, needs and behaviors, one is left to wonder what types of treatment transgender children and youth endure at the hands of parents and professionals. Such treatment approaches are little more than abuse, professional victimization, and profiteering under the guise of support for a parent's goals" (pp. 134-135). Minter (1999) and Haldeman (2000), however, offer transaffirming perspectives of diagnosis and treatment, as well as provide a thorough examination of the clinical and social issues affecting transyouth. Such guidance is welcome where affirming literature on this topic is scarce.

Many parents are surprised initially when they hear a transaffirming professional state that compromise is the best approach

to supporting young people who have strong transgender feelings and need. After all, don't parents always know what is best for their children? Based on the high incidence of familial abuse (both verbal and physical), which the authors have witnessed toward transgender children, they would have to answer "no," parents do not have training or preparation for dealing with a transgender child. Recommendation for parents are presented in the conclusion of this article.

Transgender Young People in Educational Settings

Educational settings, unfortunately, are amongst the least affirming environments for gender variant young people. School officials who perceive children and adolescents as gender variant target them as individuals to be closely monitored.

Gender variant boys may be mercilessly teased for not being rough-and-tumble, they may be frequently assumed to be gay by those adults who are ill-informed, and some are moved toward what the authors term, "the sports corrective." They are pushed into organized sports teams as if participation in such activities will correct their gender nonconformity.

Gender variant girls are also verbally harassed for being too much like a boy and not enough like a girl. Although other girls seldom wear dresses nowadays, gender variant girls always are confronted by both peers and adults who try to enroll them in what the authors term, "the etiquette corrective." Turn them from tomboys into ladies and everything will be all right. It seldom, if ever, works for them, and only adds to the pain and the self-blame, as this vignette from Scholinski (1997) illustrates:

Pinning me to the ground, the girls at school forced red lipstick onto my mouth...the social worker with the pointy high heels said I was wrecking the family and that if I kept things up the way they were going, with my bad behavior getting all of the attention, my parents were going to lose my sister too. I knew I was bad, I wasn't crazy though. (p. 6)

Confusing Gender Variant Young People with Gay or Lesbian Young People

Gender variant young people frequently have been confused with youth who are gay or lesbian. In fact, many of the same diagnostic criteria used to justify a diagnosis of GID are also supposed "cues" to a gay or lesbian identity. Some gay boys play with girls, enjoy girl toys, have effeminate mannerisms, and avoid rough-and-tumble play. Some young lesbians enjoy playing with the boys, play sports and games associated with boys, possess mannerisms and speech associated with boys, and dress in typical boy clothing. The biggest difference, and a critical one, is that gay boys and lesbian girls generally do not express dissatisfaction with their gender, that is, their sense of maleness or femaleness. In some cases, children with limited information about their emerging gay or lesbian identity may speak about *wishing* that they were a boy or a girl, but seldom do they state that they *are* a boy or a girl. The following case illustration represents an example of this misperception:

Damond is a 10-year-old Latino child who was referred because his therapist felt inadequate in treating what he described as a transgender child. Damond lives with his mother, her second husband, a younger sister, and an older brother in a two-bedroom, middle income housing project in Brooklyn, New York. An MSW therapist at a community mental health clinic sees both David and his mother. Damond is bright, very verbal and precocious.

The interview, which consisted of Damond, his therapist, his mother, and me [the interviewer], began with a series of questions initiated by David. Who was I? Was I a doctor? Why was I interested in seeing him? I answered directly and honestly and then proceeded with my own questions. First, given that he was a bright child, what were his career ambitions? He asked if he could draw his

answer and on his own pad of paper that he had with him. He drew a naked boy.

When I asked what his drawing represented, he informed me that he wanted to be the first nude male dancer. He suggested that if he was a naked dancer, then boys would like him. He then went on to explain that first he would need "the operation" because the only way he could get boys to like him was if he was a girl.

He then asked if he could share a secret with me and, when I agreed, he wrote on another piece of paper, "I AM GAY." He also inquired as to whether or not I was gay, and then whether or not his therapist was gay. We all answered. He also was clear, when probed, that he did not see himself as a girl, but felt that to get boys to like him, he needed to become a girl and for that he would have to have "the operation."

Based on this interview, this child did not seem to be transgender, but a child who may be gay and in need of some accurate information about sexual identity development. I also sensed that there might be some issues of sexual abuse occurring in the household, such as when I inquired about his older brother and his stepfather. He responded with responses that required further exploration, but that was not the purpose of the interview, so I passed that insight along to the child's therapist. I do not mean to assume in any way that gender identity development or sexual identity development is influenced by sexual abuse; these are separate treatment issues and should be treated as such.

In this case, Damond most likely was not transgender, because he seemed comfortable in his gender identity and self-identified as gay in his sexual identity. Other cases may not be always so clear. Just as important transgender children and youth are

not mislabeled as gay or lesbian, although they frequently self-label as such prior to coming to a full understanding their transgendered nature, gay and lesbian young people must not be mislabeled as transgender. Coming to understand the childhood experiences of transgender persons is a complex phenomenon that requires training and supervision from a trained and skilled transaffirming social worker. Practitioners who listen carefully to the narratives of their young clients and who do not permit their own negative judgments about transgendered persons to misguide them are the most effective. The following section provides further recommendations for child welfare practice with transgender children, youth, and their parents.

Implications for Practice

Child welfare professional workers who are unfamiliar with transgender young people's issues need guidance about how to proceed. The following recommendations provide a foundation for practitioners interested in enhancing their practice with transgender children, youth, and their parents.

1. Child welfare professionals should begin by educating themselves about transgender children and youth. Practitioners should not wait until they have a transgender young person in their office to seek out information. Books, especially those written by transgender persons (several of which have been identified in this article), are extremely useful ways of gathering information about transgender persons. Films that portray transgendered persons through a nonpathological lens, most specifically *Ma Vie en Rose*, the brutal but true story of Brandon Teena in *Boys Don't Cry*, and the 2005 release of *TransAmerica*—all of which are available in video stores—can be extremely informative and enlightening. Professional articles in print journals also can be educative. The plethora of Internet resources

provides a rich array of resources and information. One should be cautious in exploring Internet resources, as some may be misinformed, misguided, or even exploitive in nature. As bibliotherapy has been proven to be useful with clients, many of these materials, print, video, and virtual, also can be shared with clients to increase their information and knowledge.

2. Child welfare professionals must assist parents in resisting electroshock, reparative, or aversion-type treatments outright. These are unethical and dangerous practices and inappropriate interventions to use. Residential programs that offer to turn transchildren into "normal" children should be avoided, because they do more harm than good.
3. Treatments for depression and associated conditions should not attempt to enforce gender stereotypical behavior and should focus on practice from a transaffirming perspective. Rather, they should focus on helping the clients to get at, and eliminate, the depression or other condition.
4. Child welfare professionals should assist parents in developing mutually acceptable compromise strategies, which can include asking the gender variant child to dress in original gender clothing for formal events such as weddings, but permitting the child to dress androgynously for school and peer activities. Young people who insist on using opposite gendered names can be encouraged to adopt an androgynous name until they are old enough to be certain what name to which they want to permanently change.
5. Parents and young people must work with practitioners to keep communication open (Crawford, 2004). All young people, despite gender issues, need love, acceptance, and compassion from their families. It is one of the things they fear losing the most. Children and youth need to be reminded that their parent's love for them is unconditional.
6. Practitioners need to be able to identify resources for transchildren, youth, and families in the community, or be willing to take the risks necessary to create them (Minter, 2002).

7. Transgender children and youth should be assisted with developing strategies for dealing with societal stigmatization, name calling, and discrimination.
8. In completing an assessment of a transgender child, the child welfare professional should be familiar with the criteria in *DSM-IV* for *GID*; be comfortable with discerning the differences between a gay, lesbian, bisexual, or questioning child and a transgendered child; and use a modified version of Israel and Tarvers' (1997) Gender Identity Profile. Although Pleak (1999) and Raj (2002) provide more current models, professionals also may find relevance in reading the works of Rekers' (1977, 1988), and Rekers, Bentler, & Lovaas' (1977) on this topic.
9. The decisionmaking process for any gender procedure must include consideration on the critical factors of age, maturity, and physical development. Hormone administration and genital reassignment surgery—which always should be conducted under the supervision of a medical doctor—are not advised during childhood or adolescence.
10. Practitioners should be aware that transgender young people are part of every culture, race, religion, and experience. Transgender young people of color and their families face compounded stressors resulting from transgenderphobia and racism, and may need additional emotional and social support, as well as legal redress of discrimination.
11. Practitioners should make sure that all individual, self-help, family, and group treatment approaches are appropriate for intervening with a transgendered child and his or her family (Benestad, 2001; Swann & Herbert, 1998).
12. Practitioners must be aware of the possibility that violence both within and outside of the child's family may be directed toward the transgender child. Sexual violence, including rape, also is prevalent, and the practitioner should closely monitor the safety of the youth.
13. Practitioners must be ready to respond and reach out to siblings, grandparents, and other relatives of the transgender child to provide education, information, and support.

14. Practitioners should help parents understand that the gender variant child's behaviors and mannerisms are natural to them.
15. Practitioners should help parents to develop a strategy and sometimes a script for addressing the questions neighbors and members of the community may have about their transgender child.
16. Schools, social service, child welfare systems, mental health systems, religious institutions all are likely to encounter gender variant youth. These organizations and the individuals who work within them need to identify consultants to act as transaffirming professional guides and provide in-service training to assist them with the process of becoming transaffirming systems. These systems must set about *transforming* their organizational cultures to include sensitive and welcoming services for all children, youth, and families (Mallon, 1998a). Child welfare systems, which are residential in nature and may have unique issues, will need specialized training to care for transgender children, youth, and their families.
17. Child welfare organizations and state level policymakers must develop clear, written policies about hormone use for transyouth in their care. In most states, if a person is over 18, he or she may consent to his or her own medical or mental health treatment. In the absence of clearly stated policies, however, transyouth may use a variety of approaches, including injectable hormones, usually obtained illegally on the street and used without medical supervision; androgen blockers to stop the development of secondary sexual characteristics; and, in some cases, irreversible surgical procedures to alter their appearance. Child welfare policymakers, with consultation from professionals in their field, must struggle to develop these guidelines in-house (DeCrescenzo & Mallon, 2002). Failure to do so will result in youth developing their own very individualistic policies and, most likely, will cause litigation from the state.

18. Gay, lesbian, bisexual, and questioning youth providers must also work to respond to the unique needs of transgender young people (Lev, 2004; Mallon, 1998b). Most LGBTQ organizations solely meet the needs of teens and young adults; services for younger youth should also be explored.
19. Practitioners must accept the reality that not everyone can provide validation for a transgender child or teen. Some will simply not be able to understand the turmoil and pain transgender children and youth experience.

Conclusions

The authors cannot imagine a better way to conclude this article than to pay homage to the powerful words of Leslie Feinberg (1993), transgendered activist, who knew firsthand the pain that accompanies the life of a transgender child:

I didn't want to be different. I longed to be everything grownups wanted, so they would love me. I followed their rules, tried my best to please. But there was something about me that made them knit their eyebrows and frown. No one ever offered me a name for what was wrong with me. That's what made me afraid it was really bad. I only came to recognize its melody through its constant refrain: "Is it a boy or a girl?"

"I'm sick of people asking me if she's a boy or a girl," I overheard my mother complain to my father. "Everywhere I take her, people ask me."

I was ten years old. I was no longer a little kid and I didn't have a sliver of cuteness to hide behind. The world's patience with me was fraying, and it panicked me. When I was really small I thought I would do anything to change whatever was wrong with me. Now I didn't want to change, I just wanted people to stop being mad at me all the time. (p.116)

References

- American Psychological Association. (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.)*. (DSM-III). Washington, DC: Author.
- American Psychological Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. (DSM-IV). Washington, DC: Author.
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31(1), 43–55.
- Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles*, 43(11/12), 753–785.
- Benestad, E. E. P. (2001). Gender belonging: Children, adolescents, adults, and the role of the therapist. *Gecko* 2(1), 58–80.
- Berliner, A. (director, cowriter), & Scotta, C. (producer) (1997). *Ma Vie en Rose* [Film]. Available from SONY Classics, Los Angeles.
- Bern, S. L. (1993). *The lenses of gender*. New Haven, CT: Yale University Press.
- Brooks, F. (2005). Transgender behavior in boys: The social work response. Unpublished doctoral dissertation. Boston: Simmons School of Social Work.
- Burke, P. (1996). *Gender shock: Exploding the myths of male and female*. New York: Bantam Books.
- Burgess, C. (1998). Internal and external stress factors associated with the identity development of transgender youth. In G. P. Mallon (Ed.). *Social services for transgendered youth* (pp. 35–48). New York: Haworth Press.
- Colapinto, J. (2001). *As nature made him: The boy who was raised as a girl*. New York: HarperCollins Books.
- Cooper, K. (1998). Social work practice with transgendered youth and their families. In G. P. Mallon (Ed.). *Social services for transgendered youth* (pp. 111–131). New York: Haworth Press.
- Crawford, N. (2004, September). Understanding children's atypical gender behavior: A model support group helps parents learn to accept and affirm their gender variant children. *Monitor on Psychology*, 34(8). Accessed December 6, 2005, at www.apa.org/monitor/sep03/children.html.

- DeCrescenzo, T., & Mallon, G. P. (2002). *Serving transgendered youth: The role of child welfare systems* [Monograph]. Washington, DC: Child Welfare League of America.
- Dreifus, C. (2005, May 31). Declaring with clarity, when gender is ambiguous. *New York Times*, p. D2.
- Fast, I. (1993). Aspects of early gender development: A psychodynamic perspective. In A. E. Beall & R. J. Sternberg (Eds.), *The psychology of gender* (pp. 173–193). New York: Guilford Press.
- Fausto-Sterling, A. (1999). Is gender essential? In M. Rottnek, (Ed.). *Sissies and tomboys: Gender nonconformity and homosexual childhood* (pp. 52–57). New York: New York University Press.
- Feinberg, L. (1993). *Stone butch blues*. Ithaca, NY: Firebrand Books.
- Germain, C. B. (1973). The ecological perspective in casework practice. *Social Casework: The Journal of Contemporary Social Work*, 54, 323–330.
- Germain, C. B. (1978). General-systems theory and ego psychology: An ecological perspective. *Social Service Review* 35, 535–550.
- Germain, C. B. (1981). The ecological approach to people–environment transactions. *Social Casework: The Journal of Contemporary Social Work*, 62, 323–331.
- Germain, C. B. (1991). *Human behavior and the social environment*. New York: Columbia University Press.
- Glenn, W. (1998). Reflections of an emerging male to female transgendered consciousness. In G. P. Mallon (Ed.), *Social services for transgendered youth* (pp. 83–94). New York: Haworth Press.
- Green, R. (1971). Diagnosis and treatment of gender identity disorders during childhood. *Archives of Sexual Behavior*, 1, 167–174.
- Green, R. (1974). *Sexual identity conflict in children and adults*. New York: Basic Books.
- Haldeman, D. C. (2000). Gender atypical youth: Clinical and social issues. *School Psychology Review* 29(2), 192–200.
- The Harry Benjamin International Gender Dysphoria Association. (2001). *The HBGDA standards of care for gender identity disorders (6th version)*. Minneapolis, MN: The Harry Benjamin International Gender Dysphoria Association. Accessed April 5, 2006, from www.hbgda.org.

- Israel, G., & Tarver, D. (1997). *Transgender care: Recommended guidelines, practical information, and personal Accounts*. Philadelphia, PA: Temple University Press.
- Klein, B. (1998). Group work practice with transgendered male to female sex workers. In G. P. Mallon (Ed.) *Social services for transgendered youth* (pp. 95-110). New York: Haworth Press.
- Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82-173). Sanford, CA: Sanford University Press.
- Langer, S. J., & Martin, J. I. (2004). How dresses can make you mentally ill: Examining gender identity disorder in children. *Child and Adolescent Social Work Journal* 21(1), 5-23.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Press.
- Mallon, G.P. (1998a). A call for organizational trans-formation. In G. P. Mallon (Ed.), *Social services for transgendered youth* (pp. 131-142). New York: Haworth Press.
- Mallon, G. P. (Ed.). (1998b). *Social services for transgendered youth*. New York: Haworth Press.
- Meyer-Bahlburg, H. F. L. (1985). Gender identity disorder of childhood: Introduction. *Journal of the American Academy of Child Psychiatry*, 24, 681-683.
- Minter, S. (1999). Diagnosis and treatment of gender identity disorder in children. In M. Rottnek, (Ed.), *Sissies and tomboys: Gender nonconformity and homosexual childhood*. (pp. 9-33). New York: New York University Press.
- Minter, S. (2002). Listening to gender variant children: A humanistic strategy for advocates. San Francisco: NCLR. Accessed December 6, 2005, at www.nclrights.org/publications/gvchildren.htm.
- Money, J. (1973). Gender role, gender identity, core gender identity: Usage and definition of terms. *Journal of the American Academy of Psychoanalysis*, 1, 397-403.
- Pazos, S. (1998). Practice with female-male transgendered youth. In G. P. Mallon (Ed.), *Social services for transgendered youth* (pp. 65-82). New York: Haworth Press.
- Pleak, R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek, (Ed.), *Sissies and tomboys: gender nonconformity and homosexual childhood*. (pp. 34-51). New York: New York University Press.

- Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence is the effective support of transsexual and transgendered clients. *International Journal of Transgenderism* 6(2). Accessed March 15, 2004, at www.symposion.com/ijt/ijtvo06no02_04.htm.
- Rekers, G. A. (1977). Assessment and treatment of childhood gender problems. In B. B. Lahey & A. E. Kazdin (Eds.), *Advances in child clinical psychology* (pp. 268-306). New York: Plenum.
- Rekers, G. A. (1988). Psychosocial assessment of gender identity disorders. *Advances In Behavioral Assessment of Children and Families*, 4, 33-71.
- Rekers, G. A., Bentler, B. M., & Lovaas, O.I. (1977). Child gender disturbance: A clinical rationale for intervention. *Psychotherapy: Theory, Research, and Practice* 14(1), 2-11.
- Scholinski, D. (1997). *The last time I wore a dress*. New York: Riverhead Books.
- Schope, R. D., & Eliason, M. J. (2004). Sissies and tomboys: Gender role behavior and homophobia. *Journal of Gay and Lesbian Social Services*, 16(2), 73-97.
- Stoller, R. J. (1965). The sense of maleness. *Psychoanalytic Quarterly*, 34, 207-218.
- Stoller, R. J. (1968). The sense of femaleness. *Psychoanalytic Quarterly*, 37, 42-55.
- Swann, S., & Herbert, S. E. (1998). Ethical issues in the mental health treatment of adolescents. In G. P. Mallon (Ed.), *Social services for transgendered youth* (pp.19-35). New York: Haworth Press.
- Wren, B. (2000). Early physical intervention for young people with atypical gender identity development. *Clinical Child Psychology and Psychiatry* 5(2), 220-231.
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder in children and psychosexual problems in children and adolescents*. New York: Guilford Press.

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