ABSTRACT

TITLE OF DOCUMENT: THE EMOTIONAL WELL-BEING OF MOTHERS OF TRANSGENDER AND GENDER NON-CONFORMING CHILDREN

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In recent years, mental health professionals have reported an upsurge in the number of referrals relating to transgender identities among children. While controversies exist among clinicians over treatment for these children, a growing number of practitioners are encouraging parents to accept their children's gender expressions. This practice, however, may be challenging for parents to embrace for a number of reasons, resulting in a vulnerable mental state. Using a combined theoretical framework of decentering heteronormativity within Meyer's minority stress theory (2003), the present study seeks to determine the association between various factors—gender non conformity, gender role beliefs, and child misbehavior—and the anxiety and depression in mothers of transgender and gender non-conforming children. Data were taken from Wave 1 of a longitudinal study of transgender and gender non-conforming children and their parents. Results indicated that only child misbehavior was significantly associated with maternal anxiety, and social support did not moderate this relationship. Complete findings and their implications are discussed, for both future research and further deconstruction of gender in the social sciences.

THE EMOTIONAL WELL-BEING OF MOTHERS OF TRANSGENDER AND GENDER NON-CONFORMING CHILDREN

By:

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Penultimate, I want to express my love and appreciation for various members of my family. As a family scientist, the word 'family' has myriad meanings in varying contexts—so, whether it was my family of origin, my blood family, my stepfamily, and/or my family of choice, I am indebted to so many loved ones, both near and far, who have provided me with camaraderie, humor, and support throughout the duration of this project.

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Dedication

To all those whose lives and experiences have been jarred by the patriarchy

"One *is* a sex and one *does* gender; sex typically represents what is between one's leg while gender represents what is between one's ears"

—Diamond, 2002, p.323

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Chapter I: Introduction

The past decade has brought with it growing attention, conversations, and interest in individuals with transgender and gender non-conforming identities in both popular culture and scholarly work. This growth in social and academic interest is likely due to several contributing factors, including—but not limited to—significant legal advancements in recognition of same-sex couples, improved laws protecting gay, lesbian, and transgender individuals in the workforce, and the proliferation of several iconic transgender characters on primetime television shows. While the terminology for transgender and gender non-conforming children varies widely, the term *transgender* typically refers to individuals whose gender identity does not match their assigned gender at birth (Brill & Pepper, 2008). More generally, *gender non-conformity* refers to behaviors and interests (e.g., clothing) that fall outside what is considered 'normal' for a person's assigned biological sex (Brill & Pepper, 2008).

Due to this increase in awareness and recognition of gender non-conformity, mental health professionals have reported an upsurge in the number of referrals relating to transgender identities among children (Malpas, 2011; Meyer, 2012). The escalation of interest in, acceptance of, and conversations about transgender children has compelled clinicians to reconsider the notion of gender conformity in children including what treatment, if any, they provide to the children themselves—and to their parents and families.

In the most recent edition of the Diagnostic and Statistical Manual (DSM-5), a change occurred to the previous diagnosable pathology of Gender Identity Disorder (GID)

in children (APA, 2013). In previous editions—including the most recent one (DSM-IV-TR)—Gender Identity Disorder was an overarching diagnosis that encompassed both Gender Identity Disorder in Children (GDIC) and Transsexualism, with different criterion for children, adolescents, and adults (APA, 2000). Now, GID has been replaced with Gender Dysphoria (GD): a change which is intended to "better characterize the experiences of affected children, adolescents, and adults" (APA, 2013).

Perhaps as a reflection of this change, it has been noted that a growing number of child clinicians and practitioners are encouraging parents and families to support their children's gender identities and expressions (Lev, 2004; Malpas, 2011; Menvielle, 2012; Ehrensaft, 2012). The reason for this growing encouragement stems from the knowledge that family acceptance—especially parental acceptance—has a significant positive influence on the emotional and behavioral health of transgender/gender non-conforming youth (Ryan et al, 2010; Ryan, 2009). Since transgender children are known to have an elevated risk of depression and suicidal ideation (Grossman & D'Augelli, 2007; Russell et al., 2011), these children's distress may be lessened with heightened familial support.

It is not uncommon, though, for parents to be reluctant in encouraging and supporting their transgender children. This may be due to the known resistance parents face from their relatives, school personnel, and community members when deciding to affirm their transgender or gender non-conforming children (Brill & Pepper, 2008; Drescher & Byne, 2012). Additionally, due to cultural and familial norms that are often resistant to atypical gender expressions (Pascoe, 2007), parental reluctance may reflect their own beliefs and confusion about what is normal, and what is best for their child.

Perhaps because of this, mothers of transgender children experience an array of negative emotions, including shock and intense grief (Kuvalanka, Weiner, & Mahan, 2014).

While there is a small body of research on the experiences of transgender children—and even less on their parents—it is known from extant literature on parents of gay and lesbian children that the mental and emotional states of mothers, as the primary caregivers, have a significant impact on their children's well-being (Floyd et al., 1999). In attempting to enhance and improve the experience of transgender children, it seems imperative to better understand factors related to the emotional and mental well-being of these children's mothers. If the mothers' well-being is improved, then the well-being of their children may be improved as well.

Although many factors could theoretically predict the noted higher levels of maternal anxiety and depression in mothers of transgender children, there are certain variables that stand out in their potential to predict psychological distress. First, the extent to which a child is gender non-conforming—or displays atypical behavior for his or her gender—has been found to be associated with strained parent-child relationships and parental rejection (Ehrensaft, 2011**;** Alanko et al, 2011, 2009, & 2008). It is also likely, therefore, that the level of gender non-conformity would impact maternal distress, with mothers whose children display higher levels of non-conforming behavior experiencing higher levels of anxiety and depression.

Along the same lines, gender role ideologies, defined as beliefs about appropriate behavior for men and women (Kerr & Holden, 1996), can have implications as to how these mothers navigate their child's gender non-conformity (Nguyen & Blum, 2014; Samarova et al, 2013; Holtzen & Agriesti, 1990). Because mothers who have stronger

gender roles ideologies will desire more traditional gender expressions, it is possible that these mothers will experience higher levels of depression and anxiety when they discover their children are transgender or gender non-conforming.

Lastly, a child's behavioral problems may exacerbate the mental health of his or her parents, as higher levels of behavioral problems are known to add higher levels of various hardships to a family system (Elgar et al, 2004; Renk, 2007). Consequently, a higher level of a child's behavioral problems could predict higher level of maternal depression and anxiety.

While some factors may contribute to mother's depression and anxiety, it is possible that some factors may minimize or ameliorate it. There is an abundance of literature that highlights the significance of social support on alleviating the effects of maternal depression (Leahy-Warren et al, 2012; Skipstein et al.ß, 2012) and maternal anxiety (Skipstein, 2012) for a number of etiologies, including discovering a child is gay or lesbian (Saltzburg, 2004). Therefore, perhaps social support may moderate the effects of the aforementioned three variables, with higher levels of social support resulting in lower levels of depression and anxiety in mothers of transgender children.

Considering the noted gaps literature, the current study will seek to identify factors associated with anxiety and depression in mothers of transgender and gender non-conforming children. Specifically, this research will examine the independent effects of three variables; maternal gender role beliefs, child gender nonconformity, and child behavior problems, on maternal anxiety and depression. Additionally, the research will study the possible moderating effect of social support on these relationships.

Chapter II: Review of the Literature

This thesis will investigate the mental health of mothers of transgender and gender non-conforming children. The general inquiry will focus on potential predictors of anxiety and depression in the mothers of such youngsters. As this study examines a variety of psychological, sociological, and familial dimensions, there are a number of different research literatures that were brought together to best understand and execute this research project. These literatures are discussed below.

Clarifying Terminology

Multiple interpretations and understandings exist for the concepts used throughout this paper. Therefore, prior to reviewing the literature, terminology will be clarified.

The defining characteristic of the sample used in this study is mothers of transgender and/or gender non-conforming children. As mentioned before, *transgender* refers to individuals whose gender identity does not match their assigned gender at birth (Brill & Pepper, 2008). *Gender identity* refers to one's *identification* as a boy/man, girl/woman, or some other self-identified gender (Edwards-Leeper & Spack, 2012). It does not refer to one's anatomical, natal sex, which will be referred to as *biological sex*. Some scholars have elucidated the difference between gender identity and biological sex: "one *is* a sex and one *does* gender; sex typically…represents what is between one's leg while gender represents what is between one's ears" (Diamond, 2002, p.323).

For the purposes of this study, the terms *transgender* and *gender nonconformity* will be used together and interchangeably, though the terms can refer to two different phenomena. Transgender children behave and express their gender in ways that are socially and culturally (i.e., typically) associated with *the other* gender, male or female

(Bailey & Zucker, 1995). Gender non-conforming children are less likely to identify consistently as either male or female, alternating between these two gender dichotomies or somewhere in between them. More generally, their behaviors and interests fall outside of what is considered "normal" for a person's assigned biological sex (Kuvalanka, Weiner, & Mahan, 2014).

The parents referenced in this study have a child, 13 or under, who is *significantly* gender non-conforming. In other words they have: (1) mostly or fully socially-transitioned to living as a gender different than their biological sex, and (2) verbally and actively expressed their desire to be gender non-conforming for a period of at least 6 months. It does not include children who have isolated and/or fleeting tendencies of gender nonconformity.

Transgender and gender nonconformity are always included together in this project, though they are not synonymous. Because transgender is a more specific identity, it is less common for children to assert such a distinct identity—or any distinct identity—at a young age. The term transgender is always used in tandem in this study with gender nonconformity due to their similarity, but the reality is that the children are likely more broadly 'gender non-conforming' rather than specifically 'transgender.' Further discussions about the distinctions and similarities between these two phenomena will be discussed further in Chapter Five.

As the newest DSM (5th edition) was published as this project was commencing, most, if not all of the literature reviewed here references studies of children with now obsolete diagnoses. So, while new diagnostic criteria and terminology is now available for issues of gender nonconformity (Gender Dysphoria), the studies reviewed here reference

older diagnostics systems (DSM-IV and DSM-III). In general, diagnoses will be capitalized (e.g., Gender Dysphoria, Gender Identity Disorder), whereas symptoms will not.

Theoretical Orientation: Minority Stress Theory and Decentering Heteronormativity

One of the theoretical orientations for the present study is minority stress theory. This theory posits that stress related to marginalized status is linked to psychological distress (Brewster, Velez, & Moradi, 2012), and is the theory most often used to drive research surrounding the mental and physical health of sexual minorities (Institute of Medicine of the National Academies, 2011). This theory is particularly pertinent for this study as transgender and gender non-conforming children and their families are very much included in the demographic of "sexual minorities." Specifically, minority stress theory outlines four stressors that can promote psychological distress for sexual minorities: experiences of discrimination, expectations of stigma, internalized heterosexism and cissexism, and concealment of sexual minority identity (Meyer, 1995; 2003).

The concept of *minority stress* was proposed in the mid-1990s, and referred to "psychosocial stress derived from minority status" (Meyer, 1995). With further research and understanding, the concept was broadened to include "stigma, prejudice, and discrimination that create a stressful social environment that leads to mental health problems in people who belong to stigmatized minority groups" (Meyer, 2003).

The model itself provides a framework for the impact of stress and coping on mental health outcomes of sexual minorities. Circumstances in the environment and minority status are closely and inextricably linked, and they form the foundation of the model. Such environmental circumstances refer to larger, sociological advantages and disadvantages— such as socioeconomic status— that affect sexual minorities' exposure to stress (Meyer,

2003). For example, sexual minorities who reside in poor, crime-ridden communities may often experience heightened stress when compared to the same sexual minorities in other neighborhoods. Conversely, affluent sexual minorities may have access to more resources and support communities than their poorer counterparts.

This linkage of environmental circumstances and sexual minority status leads to exposure of unique stressors to minority group members, which are separated into two distinct categories—distal and proximal. Distal stressors are external to the individual, and include discrimination, violence, harassment, and prejudice. Proximal stressors are within the individual's psyche, such as concealment of sexual identity and internalized homophobia (Meyer, 2003). In the present study, the parents of transgender youth experience such distal stressors in the reactions from their extended family, community members, and school personnel (Drescher & Byne, 2012b) and proximal stressors when navigating their own beliefs and expectations for their child, as well as their fears.

Coping is the effort to ameliorate the impact of stress from the proximal and distal stressors. In the current study, social support will be assessed as the coping mechanism. The outcome of this minority stress model—sexual minority status, environmental circumstances, proximal and distal stressors, and social support—results in the mental health status of sexual minorities, and in this study, their parents. For the purposes of the present study, the sexual minority framework will be utilized to couch the study's rationale, research questions & hypotheses, and data analysis in an attempt to better understand the mental health status of parents' of transgender and gender non-conforming children. A visual depiction of minority stress theory is included in Figure 1.

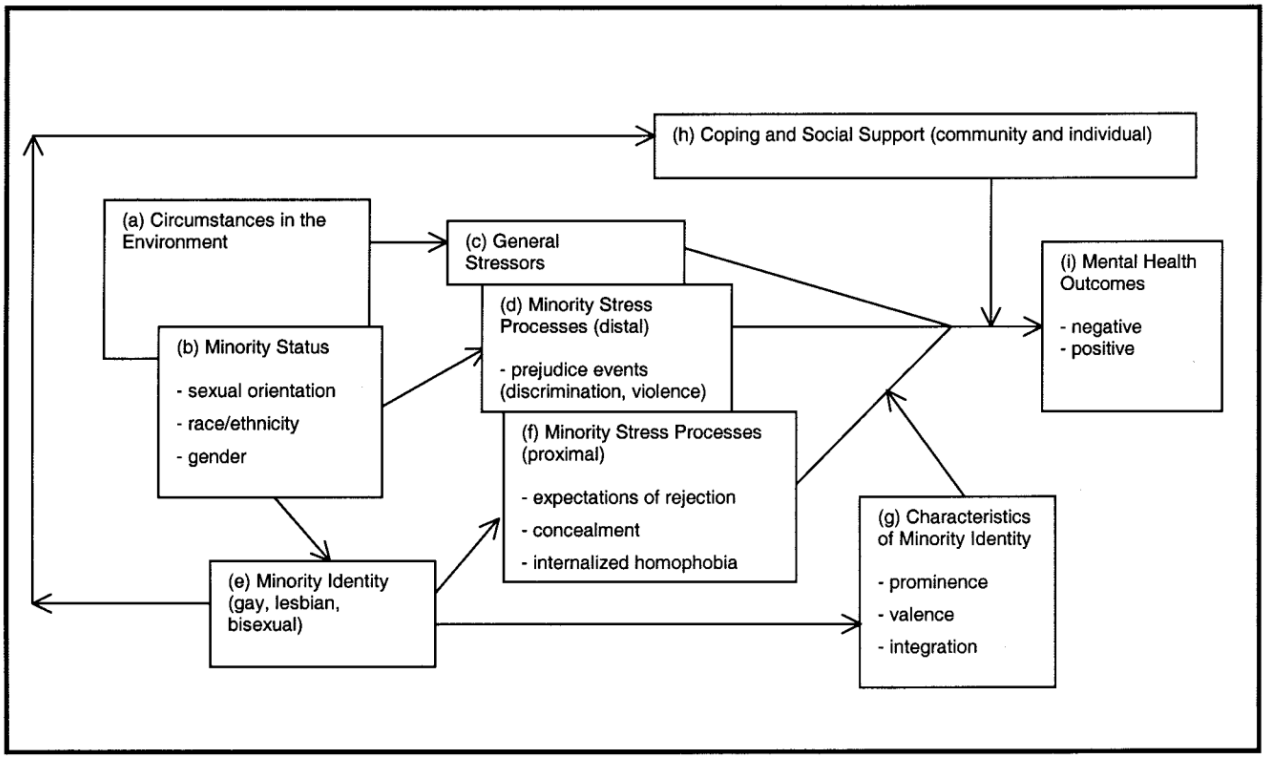

Figure 1: Minority stress theory (Meyer, 2013).

In attempting to build the strongest and most salient foundation to execute this study, an additional theoretical framework was utilized: decentering heteronormativity. Within this model for family studies, Oswald, Blume, and Marks (2005) assert that heteronormativity is as an ideological composite fusing together three ideologies— gender, sexuality, and family—into a single theoretical complex. Their conceptual model 'queers' traditional binaries for each of these ideologies into "complex" genders, sexualities, and families, respectively. Within that process, these ideologies are decentered from any heteronormative binaries, assumptions, or configurations, and are rather proposed to be *constructed*. As the authors assert: "family is best understood as something we *do,* because to set it as something we *have* is to beg the question of what family is in advance of knowing what the family-making process has created" (p.149). The authors call this

transition from the binary family (genuine vs. pseudo) to the complex family as "doing family," where tensions emerge and are negotiated (Oswald, Blume, & Marks, 2005). A visual representation of the model is included in Figure 2.

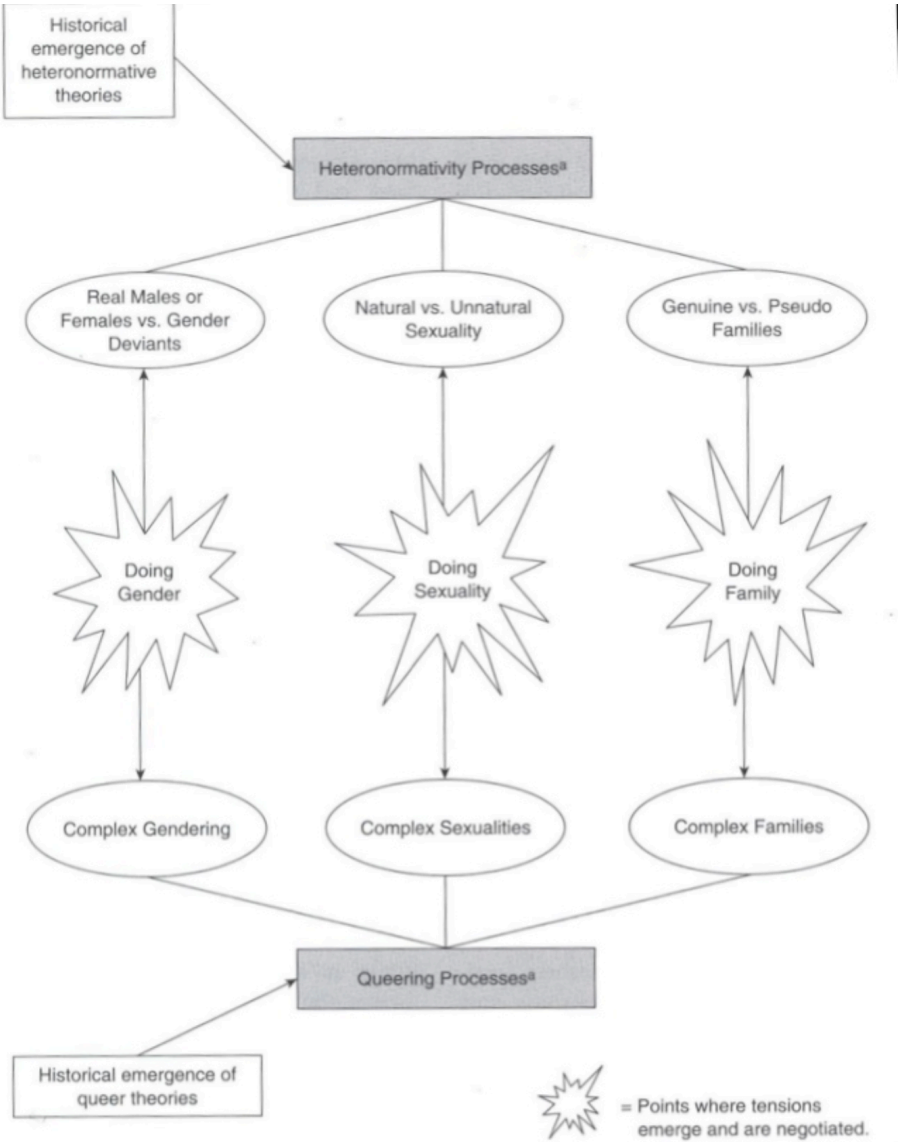

Figure 2: A model for decentering and queering traditional understandings of gender, sexuality, and family (Oswald, Blume, & Marks, 2005).

To create an ideal framework for this study, it is best to sync this model with the aforementioned minority stress theory. On a broader scale, though the families recruited

for this study conform to the heteronormative binary of 'family'— structurally, legally, and, in most cases, biologically—their interactions, or creative constructions of "family," occur in ways that make them complex. The level of nonconformity in the children's gender elicits a description—albeit a broad, inclusive one—of "complex gender." Because doing gender properly is inseparable from doing family properly (Oswald, Blume, & Marks, 2005), if gender is complex, then the interactions within these families are innately complex, too. As a result, their process of doing complex gender produces a process of doing complex family, as outlined in the model above.

It is precisely this process of "doing" wherein the phenomena of the minority stress model occur. Psychological distress for sexual minorities occurs through an interaction of environmental circumstances, sexual minority status, and the resulting stressors, both proximal and distal (Meyer, 2003). Through interactions with the families' intrinsic environments and the people within them is where minority stress is produced for these families. The same interactions that result in a complex family in Oswald and colleagues' model also result in the emergence of minority stress from Meyer's (2003). How that stress is negotiated and coped with is also dependent on those interactions—a continued piece of Oswald's et al. process of doing gender, sexuality, and, of course, family.

Transgender Histories

Etymology. The term *transgender*, which has come into widespread use only in the past two decades, has had a subtle shift in meaning since its initial appearance in the late 1960s. During that decade, various forms of the term *transgender* (e.g., transgenderal, transgenderist) were limited to male cross-dressing communities, and referred to individuals who lived in one social gender but had a bodily sex conventionally associated

with the other (Stryker, 2008). According to historical records, such individuals aimed for a conceptual middle ground between transvestism (merely changing one's clothing) and transsexualism (changing one's sex) (Hill, 2007). Over the ensuing thirty years, the specific term *transgender* grew increasingly popular—first as an ideological, political movement that resisted the hyperconstricted gendered framework in our society and challenged the bifurcated nature of human beings, and then as a psychological phenomenon, as people publically struggled with a disconnect between their assigned sex at birth and their true gender identity. Nowadays, while there still is some subtle variation in the meaning of the term, the prevalent understanding of the term refers to individuals whose gender identity does not match their assigned gender at birth (Brill & Pepper, 2008). While the ideological and political movements remain present today, *transgender* has come to refer much more to the psychological phenomenon over the past ten years (Stryker, 2008). This phenomenon refers to individual identities as opposed to the larger social movements.

As such, the past decade has shown an increased growth in attention to, conversations about, and interest in transgender individuals. Such growth is apparent in legal proceedings (social and occupational discrimination laws, healthcare coverage), media (films, television productions, documentaries), literature (both academic and recreational), and mental health (less punitive diagnoses surrounding gender non-conforming individuals) (Minter, 2012). It has been noted that, in addition to this growing attention, there has also been increased acceptance of transgender people in American society (Edwards-Leeper & Spach, 2012). This includes children (Minter, 2012; Menvielle, 2012).

However, it is perhaps more important to note that this acceptance is not ubiquitous. Resistance on the social, political, and therefore familial level has left many transgendered individuals and their allies vulnerable to many forms of discrimination. Although there certainly has been an upsurge both in attention to and acceptance of transgender individuals, controversy surrounding such people is still fairly rampant. This controversy is especially poignant for children (Dreger, 2009), which is discussed in more detail in the treatment section, below. As a result, this project will examine families with gender non-conforming children, where the controversy is strongest.

Diagnostic history. While *sexual orientation* and *gender identity* are now regarded as separate categories, this distinction is a somewhat-recent phenomenon as many cultures routinely conflate homosexuality with transgender or gender-variant identities (Drescher, 2009). The reasons for this differ between cultures and societies, but largely, atypical gender behavior is not an infrequent occurrence in the histories of gay men and women (Mathy & Drescher, 2009). Therefore, expressions of gender variance or gender nonconformity have historically been associated with homosexuality.

There was no pathological diagnosis specific to gender nonconformity until the third edition of the Diagnostic and Statistical Manual. In the first two editions of the DSM, as there was no specific diagnosis relating to gender nonconformity, any form of gender variance was pathologized under the diagnosis of "homosexuality." In the DSM-I, homosexuality was classified as a "sociopathic personality disturbance," and in the DSM-II, it was reclassified as a "sexual deviation" (APA, 1952; APA, 1968). That diagnosis, however, was revised in 1973, when the APA's Board of Trustee's voted to remove homosexuality from the DSM by a 58% majority (Bayer, 1981). This was fueled by growing scientific

research that argued for a non-pathological view of homosexuality in the late 1960s and early 1970s (Drescher, 2009).

It was not until the third edition of the DSM when two psychiatric diagnoses pertaining to gender nonconformity appeared: Gender Identity Disorder of Childhood (GDIC) and Transsexualism, which was used for adolescents and adults (APA, 1980). Seven years later, in the DSM-III-R, a third diagnosis was added: Gender Identity Disorder of Adolescence and Adulthood, nontranssexual type (APA, 1987). However, by the time the DSM-IV was published in 1994, all three of these diagnoses were collapsed into one overarching diagnosis of Gender Identity Disorder, with different criteria for children versus adolescents and adults (Zucker & Spitzer, 2005).

As of October 1st, 2014, the most recent edition of the Diagnostic and Statistical Manual (DSM-5) was published. In this edition, a significant change occurred to the previous diagnosable pathology of Gender Identity Disorder (GID) in children (APA, 2013). Now, GID has been replaced with Gender Dysphoria (GD): a diagnostic change that not only avoids stigma by replacing "disorder" with "dysphoria," it also does not pathologize gender nonconformity as a mental disorder. It merely refers to the distress that accompanies individuals whose gender nonconformity is pervasive. The critical element of Gender Dysphoria is the presence of clinically significant distress associated with the condition (APA, 2013). Other diagnostic criteria include a (a) marked difference between the individuals' expressed/experienced gender and the gender others would assign him or her lasting for 6 months or more, and (b) this difference resulting in significant distress or impairment in social, occupational, or other important areas of functioning. For children specifically, the desire to be of the other gender must be present and verbalized (APA,

2013). This change in the DSM was intended to "better characterize the experiences of affected children, adolescents, and adults" (APA, 2013).

Treatment for Gender Dysphoria

Adults. Currently, for adults over the age of 18 who are diagnosed with Gender Dysphoria, there exists a treatment consensus. In a report disseminated by the APA's Task Force on the treatment on Gender Identity Disorder (2012), the authors performed a critical review of the literature on the treatment of GID in adults, and found ample research to support evidence-based psychiatric guidelines for the treatment of Gender Identity Disorder in individuals over 18 (Byne et al., 2012). Such guidelines include proper assessment of the individual, addressing their needs with psychotherapy (resilience, social support, navigating social stigma, etc.), and ensuring that individuals who are in the process of transitioning—or who are considering or planning to do so—receive counseling from a qualified professional about the full range of treatment options, their physical, psychological, and social implications, and a full range of their potential benefits, limitations (e.g., loss of reproductive potential), risks, and complications. It is important to note that the best therapeutic protocol for adults with GID is to help them "improve their sense of well-being and overall functioning" (Byne et al., 2012, p.766). It does not include attempting to alter their gender identity and expression.

Similar guidelines were iterated by The World Professional Association for Transgender Health (WPATH). In 2012, the association published a "Standards of Care" for transgender and gender non-conforming individuals. In it, WPATH scholars provide a variety of therapeutic options in treating Gender Dysphoria in adults. Such options include: social transitioning (living part- or full-time in another gender role consistent with one's

gender identity), hormone therapy to feminize or masculinize the body, surgery to change primary and/or secondary sex characteristics, and psychotherapy for purposes such as exploring gender identity and addressing the negative impact of gender dysphoria and stigma on mental health (Coleman et al., 2012). Again, treatment protocols do not endorse attempting to align one's gender identity and expression with their biological sex in treating Gender Dysphoria.

Adolescents. In regards to treatment of Gender Dysphoria, adolescents are distinct from adults over the age of 18 in that they are pubescent, but still minors. Most gender dysphoric adolescents do not experience gender dysphoria in childhood: the majority (77%-94%) of gender non-conforming children's gender dysphoria disappears before, or early in, puberty (Zucker & Bradley, 1995). For those children whose gender dysphoria persists into adolescence, and for those adolescents who encounter dysphoria for the first time as adolescents, their dysphoric symptoms can be exacerbated due to the development of secondary sex characteristics inconsistent with their gender identity (Coleman et al., 2012). The WPATH has enumerated a treatment consensus for such adolescents.

After extensive psychological assessment, family counseling, and supportive psychotherapy, mental health professionals may refer gender dysphoric adolescents towards physical interventions. This consensus, thus far, is similar to that of gender non-conforming adults mentioned above. However, because adolescents' development through puberty is rapid, physical interventions should be addressed in the context of each adolescent's specific pubertal development (Coleman et al., 2012). There are three types of physical interventions for adolescents: (1) fully reversible interventions, most commonly manifested as hormone-suppressing medication that delays physical changes of puberty,

(2) partially reversible interventions, such as hormone therapy to actively masculinize or feminize the body, and (3) irreversible interventions, such as surgical procedures. For all adolescents with Gender Dysphoria, treatment consensuses include a steady, staged process through these interventions, monitoring any change in an adolescent's desire to transition from their natal sex as they develop physically, mentally, and emotionally. Moving from one procedure to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully to the effects of earlier interventions (Coleman et al., 2012). Full, irreversible transition should only happen when the adolescent has reached legal age of majority in the country of surgery, and only after the adolescent has lived comfortably and happily as their desired gender for 12 months.

Children. Unlike adults, a consensus does not exist for children with GID/Gender Dysphoria (Dreger, 2009). This is due to the heightened controversy surrounding gender non-conforming and transgender children. Treating children is particularly controversial for several reasons.

First, a long history of pervasive cultural understandings surrounding cisgenderism—an individuals' biological sex needing to align with their psychological sense of being male or female—leads people to believe that a person's resulting expressions must also match that aligned biological sex and psychological consciousness (Winter et al., 2009). Adults feel compelled to communicate these expectations to their children, who are notably more susceptible than their mature counterparts. Due to this vulnerability, guidelines for treating children are yet to be developed—it is unclear whether it is the parents' wishes or the child's that should guide treatment. There is concern as to whether supporting parents' preferences for gender conformity is potentially

harming a child in their primary years or helping them adjust to the society in which they live.

Second, it is important to recognize that part of the controversy is the continued struggle in understanding the developmental course of gender nonconformity to transgenderism. Should all children who experience gender dysphoria and/or significant gender nonconformity be allowed—or even encouraged—to socially transition? Should such a transitions be discouraged? Considering the prevalent belief that children's gender identity is fluid and moldable, gender nonconformity in childhood may be viewed as a phase that will not become a permanent component of that child's adolescent and adult gender identity. Therefore, perhaps gender variant behavior is a fleeting stage of development, part of a child's imagination and/or play, and will therefore change eventually. If that is the case, how long may this play go on before interventions are implemented? Should they ever be? How does one know if the non-conforming expression is a manifestation of a child's genuine transgenderism, playful imagination, or both? These rhetorical questions are ones that have yet to be answered in agreement by the top scholars in the field. However, this is merely one piece of the controversy surrounding transgender and gender non-conforming children.

Additionally, compared to adults and adolescents, there is notably less research surrounding treatment guidelines for children with GD (Drescher & Byne, 2009). Specifically, there is a lack of randomized controlled treatment outcome studies of children with GID or any presentation of gender variance (Zucker, 2008). From a purely scientific and empirical point of view, this limits the ability for a treatment consensus.

Lastly, children must rely on their caregivers to make treatment decisions for them: often times decisions that will influence the course of their lives long-term (Drescher & Byne, 2012). Since children have a limited capacity to participate in their own decision-making about their psychological or medical treatment, and they have no legal recognition in providing informed consent, treating pre-pubescent children with GD is more controversial than treating the same phenomenon in adults (Bryne et al., 2009).

While the controversy over how to manage and/or treat children with GD has been the case for many years, it is rapidly becoming a more significant situation as individuals are declaring their gender variance at younger ages (Edwards-Leeper & Spack, 2012; Minter, 2012). Relatedly, there is a noted rise in the number of referrals to mental and physical health professionals regarding issues of gender nonconformity and transgender identities in children (Malpas, 2011; Meyer, 2012; Zucker, 2008).

As previously mentioned, there is insufficient research for a consensus in treatment for children with Gender Dysphoria, in addition to being a contentious diagnosis on several levels. Given the inconsistency in guidelines for treating children, parents can find themselves at a loss for how to proceed with a transgender or gender non-conforming child (Edwards-Leeper & Spack, 2012). Correspondingly, physicians and mental health providers have reported a dramatic increase in requests for information and guidelines from parents of transgender or gender non-conforming children (Minter, 2012). At this point in time, there are two primary schools of treatment when it comes to treating transgender children (Dreger, 2009).

*The first approach: The therapeutic approach***.** The first of two primary schools of thought surrounding treating transgender children—the "therapeutic approach"—aims at

altering the child's gender identity and expression to match their biological sex. Zucker, Wood, Singh, & Bradley, who are prominent proponents of this approach, provide and promote a developmental and psychosocial model to treat children with Gender Identity Disorder. The emphasis of this model is using psychodynamic mechanisms and various forms of psychotherapy to help emphasize the child's biological sex. In an article summarizing their therapeutic model and approach, Zucker, Wood, Singh, & Bradley (2012) describe their assessment, diagnosis, and treatment protocols used in the Gender Identity Service at the Centre for Addiction and Mental Health in Toronto. They provide various clinical examples and case studies from the nearly 600 children evaluated for their services since 1980. Further case studies involving this model are cited by the same author in other places (e.g., Zucker, 2006, 2008).

Meyer-Balhburg (2002) published 11 case studies of biological boys under the age of 12 diagnosed with Gender Identity Disorder who underwent treatment for their GID. His case studies illuminate the treatment protocol of these boys that include psychosocial interventions with both the boys' parents and their same-sex peer groups. This protocol, as stated by the author, is an attempt to emphasize the boys' biological sex and helps expedite the "fading" of their GID before they reach puberty (2002).

In a 2008 study, Drummond, Bradley, Badali-Person, & Zuker performed a follow-up study of 25 transgender girls, who contacted the Toronto Centre for Addiction and Mental Health between 1980 and 2004. At time of contact, the girls were between 2 and 12; at the follow-up, the children were at least 17 years of age. The follow-up study included a re-assessment of the children's concurrent gender identity and sexual orientation, and then a comparison to those assessments at the initial contact. It was hypothesized that perhaps a

portion of the distress and gender nonconformity at initial contact would manifest not at transgenderism, but as sexual deviance instead. Significant findings were two-fold: first, the number of girls who identified a later bisexual or homosexual orientation was higher than those orientations, pre-treatment, and second, 88% of the girls did not report any distress about their gender identity at follow-up (Drummond et al., 2008). Conclusively, Drummond and colleagues promote the therapeutic approach in emphasizing child's biological sex as opposed to affirming their transgender identity, as it limits their gender dysphoria in adolescence and adulthood.

Many of these particular therapeutic or reparative approaches not only attempt to reinforce more typical expressions and activities related to the child's biological sex, they also aim to extinguish "atypical" gender behaviors and identifications (Ruckers, 1995). The rationales for such attempts vary from clinician to clinician, but include such things as preventing homosexuality (Reckers, 1995), limiting social ostracism and adult transgenderism (Meyer-Bahlburg, 2002), and the alleviating underlying or associated psychopathologies (Zuker & Bradley, 1995).

*The second approach: The Accommodation Model***.** The second approach to treating children with Gender Dysphoria focuses less on the treatment of a child's gender variance and more on (a) affirming the child's own unique gender identity and (b) encouraging their respective families to foster that authentic gender—the "accommodation model" (Dreger, 2009). This has also been referred to as the "affirmative approach" (Malpas, 2011), and is being undertaken by a growing number of clinicians (Kuvalanka, Weiner, & Mahan, 2014). This model assumes that there is nothing wrong with a child who may be gender variant, but rather, they consider the culture as flawed in coercing a child's gender expressions and

identity to reflect their biological sex. The individual management (not *treatment*) of Gender Dysphoric children varies slightly between American and Dutch clinicians.

In Holland, the general recommendation for children under 12 experiencing Gender Dysphoria is watchful and supportive waiting—including encouraging psychotherapy—as the child enters the first stages of puberty; called the "wait and see" method. If gender dysphoria persists into early adolescence, those minors can be considered for puberty suppression and subsequence cross-sex hormones when they reach the age of 16 (De Vries & Cohen-Kettenis, 2012). They do not encourage a full transition in childhood.

This method is slightly different in the United States, represented by several interdisciplinary clinics treating youngsters with GD (Edwards-Leeper & Spack, 2012; Menvielle, 2012). One such clinic in the Northeast provides both psychological and hormonal treatment for gender dysphoric children and adolescents. For adolescents who have had strong and persistent Gender Dysphoria since childhood, the hormonal treatment involves pubertal suppression of children undergoing the second stage of Tanner's pubertal development (Tanner, 1976). Similar to what is done in Holland, these adolescents must have continued Gender Dysphoria into adolescence and must undergo ongoing mental health counseling during their suppression. If, at age 16, these adolescents still firmly and consistently identify with the other gender, they may proceed with more intensive hormonal treatment (Edwards-Leeper & Spack, 2012).

For pre-pubescent children with GD, however, the same clinic has "treatment" guidelines for such youngsters, which promotes and supports the children and their families:

> "[For gender-variant children]…early individual and family therapy that encourages acceptance of the child's budding gender

> development while simultaneously emphasizing the importance of remaining open to the fluidity of his or her gender identity and sexual orientation is our [recommendation and practice]…also important is the thoughtful decision regarding when and if a child should socially transition to his or her affirmed gender. Our clinical recommendation is that ever effort be made to support the child by allowing them live in their affirmed gender to the extent that is deemed safe" (Edwars-Leeper & Spack, 2012, p.330).

The clinicians at this institution then comment on the "societal shift that must occur" (p.334) for these patients to truly be able to live without increased risk of psychological distress and potential physical harm caused my intolerance and discrimination (Edwars-Leeper & Spack, 2012). This recommendation hints to more macro-level approach to dealing with transgender children, adolescents, and their families.

A third variation of the "accommodation" approach is called True Gender Self Therapy (TGSF), designed and perpetuated by Diane Ehrensaft. TGSF, according to Ehrensaft, has a simple, two-pronged goal:

> "(a) helping a child build gender resilience and explore his or her authentic gender identity while acknowledging social constraints that may work against its full expression, and (b) facilitating acquisition of a psychological tool kit that will allow a child to internalize a positive self-identity while recognizing situations in which that identity may be in need of protection from an unwelcome or hostile environment" (2012, p.343-344).

Through her work as a clinician, Ehrensaft enables children experiencing Gender Dsyphoria to express their *true gender selves*—their inner sense of being female, male, or some other gender identification, which results from a complex combination of both internal and external processes (Ehrensaft, 2012). This runs counter to the *false gender self*, or the face the child puts on for the world based on the expectations of the external

environment and the child's interpretations and internalization of either appropriate or adaptive gender behaviors.

According to Ehrensaft, every child can and has developed a false gender self, "running the gamut from the cisgender boy who put on a macho mask to empower himself and please his Marine father, to the transgender child who hides dressed in the closet to avoid punishment from disapproving parents" (2012, p.342). Ehrensaft believes it is the false gender self's attempt to strangulate the true gender self that results in the poor mental and emotional wellbeing of transgender and gender non-conforming children (discussed in detail below).

In expressing their true gender selves, children use *gender creativity*—a term also coined by Ehrensaft (2012). According to her, gender creativity is defined as:

> "each individual's unique crafting of a gender self that integrates body, brain, mind, and psyche, which, in turn, is influenced by socialization and culture, to establish his or her authentic gender identity and expressions…the little child is drawn to make something of gender that is not based just on the inside, nor the outside, but a weaving together of the two, with the child in charge of the thread that spins the web" (2012, p.343).

Ehrensaft also associates gender creativity with the child's knowledge to distinguish when it is and is not safe to express their true gender self, and the corresponding techniques to help cope with that inhibition—that child's own psychological tool-kit:

> "Gender creativity works actively to circumvent the false gender self and privately keep the true gender self alive, *even* in situations where is not safe to let it come out…[a transgender boy] negotiates this conflict through reverie…his musings let his gender creativity reign, asserting in fantasy the girl he knows himself to be but cannot yet express" (Ehrensaft, 2012, p.343).

By enabling children to do this, Ehrensaft helps alleviate their tendency to amass high levels of mental and emotional distress. Ehrensaft asserts that her practice of

encouraging open expression and gender creativity must be met with tolerance and acceptance within the child's immediate surroundings (2012, p.344).

This model of allowing children to express themselves fully—and to have that expression accepted by those around them—is shared by other researchers and scholars alike (e.g., Lev, 2004; Malpas, 2011; Menvielle, 2012; De Vries & Cohen-Kettenis, 2012; Edwars-Leeper & Spack, 2012). Such perspectives consider gender as a fluid spectrum and claim that (1) gender nonconformity is not a pathology but a normal human variation, (2) gender non-conforming children do not systematically need mental health treatment, and (3) care-givers of gender non-conforming children can benefit from a mixture of psycho-educational and community-oriented interventions (Cohen-Kettenis & Pfafflin, 2003; Corbett, 2009; Mallon, 2009; Hill et al., 2010), which aim at de-stigmatizing and normalizing their experiences while offering tools to negotiate their children's safety, well being, and optimal development in their familial and natural environments (Malpas, 2011).

Mental Health

Transgender children. Although research on transgender and gender non-conforming youth is relatively recent, it is well established that they experience poor levels of mental and emotional health. Adolescents that identify as transgender or gender non-conforming are known to have an elevated risk of negative outcomes, including, but not limited to, depression and suicidal ideation (Grossman & D'Augelli, 2007; Russell et al., 2011).

In their 2007 study, Grossman & D'Augelli assessed various aspects of 55 transgender youth's life-threatening behaviors. Of their sample (n=55), nearly half reported having seriously thought about committing suicide, and over one-quarter

reported suicide attempts. In assessing the factors contributing to these phenomena, it was found that suicidal ideation and suicide attempts were linked to their transgender identity, verbal and physical abuse from both families and peers, and body self-esteem (Grossman & D'Augelli, 2007). The authors conclude that sexual minority status is a key risk factor for life-threatening behaviors among transgender youth (p.535). This heightened state of suicidal ideation is certainly one component of the poor mental wellbeing of transgender and gender non-conforming youth.

Similarly, transgender and gender non-conforming youth experience high rates of verbal and physical victimization, both at home and at school (Grossman, D'Augelli, & Salter, 2011; Greytak et al., 2009). In a 2011 study, Grossman, D'Augelli, and Salter assessed thirty-one male-to-female transgender youth and their gender identity, gender expression, gender atypicality, as well as the responses from their parents (2011). The authors found that the children who were more atypical in their gender expression reported the most abuse—both verbal and physical—from their parents; nearly all of the participants were called 'sissies' by their parents and were told to change their behaviors before age ten (Grossman, D'Augelli, & Salter, 2011). All of the participants reported 'victimization' from either their peers, parents, or both—measured by ever being called names, teased, or threatened because they were transgender or perceived to be transgender (2011).

This victimization is perhaps the reason why transgender and gender non-conforming youth tend to exhibit low self-esteem and a lack of self-worth. In one study that reports various characteristics of transgender youth referred to a pediatric medical center, Spack and colleagues described 97 patients of under the

age of 18 (Spack et al., 2012). Through a number of self-report questionnaires, these scholars gleaned that over 75% of their sample reported self-harming behavior, suicidal ideation, and low self-esteem (2012, p.424). Though no research to date has found a correlation between the known higher levels of transgender-based discrimination and low self-worth, many scholars have hypothesized such a relationship (Spack et al., 2012; Grossman, D'Augelli, & Salter, 2011).

In the same report by Spack and colleagues (2012), gender variant children and adolescents frequently report being socially isolated and rejected by peers and adults, including many instances of teasing, bullying, and harassment (Spack et al., 2012). This sentiment is reiterated by some of the aforementioned studies, as well (Grossman & D'Augelli, 2007; Grossman, D'Augelli, & Slanter, 2011). It is no doubt, then, that over half of children who are diagnosed with GD have been found to comorbidities with other psychiatric diagnoses, including depression, anxiety, and ADHD (Wallien et al., 2007). In that study, Wallien, Swaab, & Cohen-Kettenis (2007) assessed the psychopathology (according to DSM-IV) of two groups of children—one group consisted of children diagnosed with Gender Identity Disorder (n=120), and the other consisted of children diagnosed with ADHD (n=47). The authors found that 52% of the children diagnosed with Gender Identity Disorder had one or more diagnoses other than GID (2007). Though the children with ADHD has a similar rate of comorbid diagnoses, the children with GID were more likely to have an externalizing psychopathology (disruptive disorders) compared to the children with ADHD. As the authors assert in their discussion, such pathologies make a child with GID more vulnerable to social ostracism (Wallien, Swaab, & Cohen-Kettenis, 2007).

An even larger percentage of children with GID exhibit poor social competence and behavioral problems. One study examining the social competence and behavior problems in clinic-referred children with Gender Identity Disorder, found, via a subscale on the Child Behavior Checklist (CBCL), poor peer relations for both boys and girls with GID (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003). Additionally, these poor peer relations were found to be the strongest predictor of behavior problems.. It seems that transgender and gender - children not only have poor mental and emotional heath, their relationships suffer, too.

All of these findings present the poor mental and emotional health of transgender and gender non-conforming youth. Perhaps, though, they are indicative of the broader experience of gender dysphoria for these youngsters—distress with current and/or anticipated physical sex characteristics and an ascribed gender role that is incongruent with persistent gender identity (Ehrbar, Winters, & Gorton, 2009). It is this distress that often leads to the clinical diagnosis of Gender Dysphoria in the new DSM-5 (Kuvalanka, Weiner, & Mahan, 2014), though the cause of the distress these youth experience is uncertain, i.e., is inherent to their condition, or due to the negative reactions they receive from family and society.

Families of transgender and gender non-conforming children. In light of (a) the growing social acceptance of transgender individuals (Edwards-Leeper & Spack, 2012), (b) the growing awareness of the mental/emotional vulnerability of transgender children (Spack et al., 2012), and (c) the increasing clinical encouragement for parents and families to support their children's gender identity

and expressions (e.g., Malpas, 2011), many families have committed to accepting, affirming, and accommodating their children's gender nonconformity.

Family acceptance has recently been shown to have a strong positive influence on the emotional and behavioral health—e.g., self esteem—of transgender and gender non-conforming youth. In their study, Ryan, Russell, Huebner, Diaz, & Sanchez assessed family accepting behaviors in response to lesbian, gay, bisexual, and transgender adolescents' sexual orientation and gender identity, via child-self report (2010). Their sample of 245 young adults was recruited from nearly 250 LGBT venues from within California (e.g., community, social, and recreational agencies; bars and clubs) who met the study criteria: ages 21-25, self-identification during adolescence as LGBT, homosexual, or nonheterosexual (e.g., queer), and knowledge of this identification by one parent. It was found that family acceptance was a predictor for higher levels of self-esteem, social support, and physical health, in addition to be a protector against depression, substance abuse, suicidal ideation, and self-harming behaviors (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In a similar study, Hill and colleagues found a similar phenomenon via a parent self-report: transgender children experience "less distress" when their families exhibit more accepting behaviors (Hill et al., 2010). The parents (n=42) of 31 transgender children were part of an "affirmation and accepting" program at a U.S. clinic, in which the parents were "tolerant and accepting" of their children's gender variance (p.15). The parents completed questionnaires that assessed their child's mental health and internalizing/externalizing tendencies, and their own levels of genderism & transphobia (Hill et al., 2010). While the parents in this study were not the

parents of the adolescents in the aforementioned study, the findings of both underscore the positive association between family acceptance and gender non-conforming youth's mental and physical health.

Additionally, the anxiety and distress (i.e., dysphoria) that gender non-conforming children experience has been shown to dissipate after families allow gender non-conforming children to express themselves as they so desire. In her book, *Gender Born, Gender Made*, Diane Ehrensaft, a clinician, provides case examples from her own practice that underline one of her primary tips to parents who are raising "healthy" gender non-conforming children (2011). In her experience, children's gender dysphoria dissipated when they are able to freely express their gender identity. Because parents control how children behave and express their gender (i.e., through clothing, toys, games, activities, etc.), they therefore also have the ability to mitigate the potential negative outcomes that gender non-conforming youth are known to experience by allowing and affirming and their child's true gender identity and expression (Ehrensaft, 2011). Ehrensaft seems to support the findings from empirical studies mentioned above that encourage parental acceptance in an effort to help lessen transgender children's poor mental and emotional health.

If parents choose to encourage and support their gender non-conforming child's true gender identity, however, there are a number of components of such acceptance that may be difficult for them to confront. For example, in has been learned from many case examples that parents are known to face resistance in affirming their children's gender identities and expressions (Brill & Pepper, 2008; Drescher & Byne, 2012). Such resistance

can comes from a variety of places, including relatives, community members, neighbors, and school personnel (Drescher & Byne, 2012). Additionally, cultural, religious, and familial norms that promote a gendered lifestyle and resist atypical gender expressions are pervasive in American society (Pascoe, 2007). This phenomenon, beginning at birth, "genders" children: subtly and overtly teaching them what is socially acceptable and unacceptable for boys and girls to do, respectfully (Fine, 2010; Pascoe, 2007; Kimmel, 2008; Eliot, 2010). While this phenomenon directly impacts gender non-conforming children, parents of these children are likely to have similar beliefs about what is traditionally "normal" when it comes to gender, stemming from the same sociological norms. When dealing with gender non-conforming children, parents and families often feel urged to normalize a child, shaping them into a more conventional gender role, as the parents experience discomfort, fear, disgust, denial, sadness, and sorrow (Menvielle, 2012). On top of this, it is important to note that parents likely have concerns about their child's wellbeing and safety if he or she is gender nonconforming. Findings from clinical samples include the fact that parents may face confusion in how to best handle a gender non-conforming child, trying to navigate societal norms, their own beliefs, communal resistance, and the child's self-interest, among other things (Lev & Alie, 2012).

While the above-mentioned reports of clinical cases note the experiences of parents who seek to affirm the gender expressions of their gender non-conforming children, there have been very few large community-based studies of such parents (Kuvalanka, Weiner, & Mahan, 2014). Hill and Menvielle (2009) performed one such study, conducting telephone interviews with 42 parents of gender non-conforming children and adolescents who had been involved with an affirmative intervention program. Riley and colleagues similarly

collected data from parents of gender non-conforming children and adolescents, though they did so via an Internet survey and exclusively with Australian families (Riley et al., 2011). Findings from both these studies revealed that parental experiences are not identical, change over time, and are influenced by a number of factors, including knowledge of transgender issues and the child's age.

In light of these studies, Kuvalanka at her colleagues (2014) desired to "better document parents' experiences as they aim to affirm their transgender and gender non-conforming children's gender identities and expressions" (p.5). Through interviewing mothers of transgender/gender nonconforming children between the ages of 5 and 11, the authors attempted to examine the various interacting contexts that undoubtedly affect their experiences. In regards to the mothers of such children, it was found that their feelings were mixed, but included such emotions as shock, intense grief, and shame (Kuvalanka, Weiner, & Mahan, 2014). It is clear that the parents of transgender and gender nonconforming children tend to experience some form of distress when navigating the variant gender expressions of their children

Variables: Potential Predictors & Moderators

It is clear from the few empirical studies and various clinical reports in the literature that the mental health of parents of transgender and gender non-conforming children is vulnerable, similar to that of their children (e.g., Hill & Menvielle, 2009; Zucker, 2006; Wren, 2002). And while the body of literature examining the parents' experience—particularly the mothers'—in navigating the difficulties associated with their transgender or gender non-conforming child is growing, it is unknown what, specifically, predicts the mental health of these caregivers. As mothers continue to serve as the primary

psychological caregivers in the United States (Kuvalanka, Weiner, & Mahan, 2014), it is important to understand these predictors as a way to help these mothers, and, as a result, their children.

Gender nonconformity. One factor to consider in trying to understand mother's mental health is a child's level of gender nonconformity. As mentioned earlier, parents often feel urged to normalize a gender non-conforming child, as the parents experience discomfort, fear, disgust, denial, sadness, and sorrow (Menvielle, 2012). The root of these negative feelings is uncertain, though it is likely linked to the gendered nature of our society (Kimmel, 2008). However, what is noteworthy here is that gender nonconformity is, of course, a spectrum, as highlighted by many scholars (e.g., Ehrensaft, 2011; 2012; Johnson et al., 2004). Perhaps because parents experience known negative emotions when facing a gender non-conforming child, the argument could be made that higher levels of gender nonconformity may lead to higher levels of maternal anxiety and/or depression in mothers of gender non-conforming youth. Though this has not been tested with gender non-conforming youth specifically, maternal distress has been found to be impacted by sons who are gay or bisexual: identities that are often expressed with levels of gender nonconformity (Sandfort, Melendez, & Diaz, 2007).

Gender role beliefs. Similarly, the attitude that mothers have towards what is "normal" gender behavior may also impact their level of distress if dealing with a gender non-conforming child. Gender role ideology, defined as prescriptive beliefs about appropriate behavior for men and women (Kerr & Holden, 1996), has been used for many decades as a way to explore various issues relating to sexism, feminism, traditionalism, and egalitarianism (Kalin & Tilby, 1978; Beere, 1990; Kerr & Holden, 1996). In light of the

prevalent gendering that occurs in the United States, individuals develop various levels of these gender beliefs about how males and females "should" behave; beliefs that cause parents to "normalize" their children to their own, desired gender behaviors and expressions (Lev, 2004; Brill & Pepper, 2008; Menvielle, 2012). Consequently, perhaps higher levels of "traditional" gender role ideologies (Kerr & Holden, 1996) would result in higher levels of distress in mothers of gender non-conforming youth.

Child's misbehavior. Finally, the literature is replete of the effects of a child's behavior problems on the distress experienced by their mothers or primary caregivers. Regardless of the population being studied, when children exhibit high levels of problematic behavior, be it internalization (Connel & Goodman, 2002), or externalization (Suarez & Baker, 1997), mothers experience higher levels of distress, be it depression (e.g., Hastings, Daley, & Beck, 2006), anxiety (Gray, Indurkhya, & McCormick, 2004), or some other reliable measure of "distress" (e.g., "parenting dissatisfaction," in Podolski & Nigg, 2001). While there is no reason to suspect, and certainly no research to argue, that gender nonconformity causes behavior problems in children, it is known that there are higher rates of depression and distress in gender non-conforming children, particularly when they are unable to express their preferred gender (e.g., Grossman & D'Augelli, 2007). Thus, it is likely that gender-non-conforming children may have higher rates of internalization, as traditionally defined, than gender conforming children. It is therefore very likely that a gender non-conforming child's level of misbehavior will be associated with mental health problems for the mother.

Moderator: social support. While the mothers of transgender and gender non-conforming children may experience difficulties and psychological distress adjusting to the

changes and behavioral “abnormalities” exhibited by their children, certainly there may be factors that alleviate these difficulties. The concept of social support has long been associated as a moderator of life stress (e.g., Cobb, 1978; Lubben & Gironda, 2000; Wills & Fegan, 2001). In the past 40 years, various specific benefits of social support have been analyzed using a number of valid social support measures. Social support has been found to mediated the negative of many stressors, such as chronic physical and mental disease (Kornblith et al., 2001; Karels et al., 2007), aging (Kiely & Flacker, 2003), and overall mortality risk (Holt-Lunstad, Smith, & Layton, 2010). The idea of social support as a moderator of stress stems from research performed during the late 1970s and 1980s. During that time, a noteworthy hypothesis surrounding social support and its effect on stress was proposed called ‘the buffering hypothesis.’ Initially theorized by Cassel (1976), the hypothesis borrows from the phenomenon of a buffer solution in the field of chemistry, in which the buffer is able to maintain the pH of a given solution with the addition of strong acid or base. When first suggested, the hypothesis was criticized for a lack or empirical support (Andrews, Tennant, Hewson, & Vaillant, 1978). However, as more and more scholars became interested in the hypothesis, further studies found stronger, more reliable support for it (Lin et al., 1979; Wilcox, 1981). The hypothesis states—and proves—that social support serves as a buffer between stressful life events and psychological distress (Wilcox, 1981; Cohen & Wills, 1985). The ‘buffer’ links resources, association, and a sense of belonging, through the channels of community, social network, and intimate relationships (Lin, 1986).

Perhaps even more relevant than these general findings for social support is the research on the impact of social support on gay, lesbian, bisexual, and transgender

(including gender non-conforming) youth, and their parents. Some of this research dates back to the first cohort of HIV-positive gay men, and the inverse relationship between social support and depression (Hays, Turner, & Coates, 1992). Since then, the research has included the positive impact social support has on the mental health of all elements of the LGBT population, including young children (Russel, 2002), teenagers (Munoz-Plaza, Quinn, & Rounds, 2002), and even the elderly (Grossman & D'Augelli, 2000). For the parents of LGBT youth, studies examining their experiences didn't really take off until the late 20th and early 21st century (e.g., Hurdt & Koff, 2000). However, when studying resiliency among these parents, social support is found to enhance this resilience in almost all the relevant literature (Coenan, 1998; Thompson, 1999; Saltzburg 2009). Saltzburg, in particular, emphasizes the importance of social support in ameliorating the sense of disarmament, panic, and despondency that occurs to parents when they learn that their child is gay or lesbian (2004; 2009).

While sexual orientation and gender identity are two separate entities, they often manifest is similar, gender non-conforming behaviors, as noted earlier in this chapter. However, in addition to the research mentioned above, there has been one study on the role of social support in the lives of parents of transgender youth. In Riley, Sitharthan, Clemson, & Diamond's (2011) study of a community sample of Australian parents of transgender/gender non-conforming youth (n=31), the parents' overall experience was gleaned and documented via Internet survey. Data were analyzed using content analysis to establish the needs of the parents. Results included a near-unanimous need for social support, in addition to professional assistance and parenting strategies (Riley et al., 2011). It is important to note that this study was not one of moderation, but of parents' desire for

social support. However, it appears possible that social support may moderate the distress that is inevitably experienced by the mother of transgender and gender non-conforming youth.

Literature Review: Purpose of the Study

Research regarding the mental health of mothers of gender non-conforming children is a relatively new topic in the social sciences. Considering the noted growth in both awareness and acceptance of gender nonconformity over the past decade, it seems reasonable that interest in this area of research as similarly grown. Additionally, considering the very recent change in diagnoses pertaining to gender nonconformity in the DSM, there is fertile ground for new research.

For a plethora of reasons, treatment and care guidelines for a gender non-conforming child are ambiguous and contentious, much more so than decisions surrounding gender nonconformity in adults. Though the mental and emotional health of gender non-conforming youth has been widely studied and acknowledged as notoriously poor, also acknowledged is that their parents potentially experience distress, too. The reasons for this are abundant, and include such things as societal pressure, lacking relevant treatment guidelines and consensuses, and being unsure as to what is best for the wellbeing of their child.

Though maternal distress of gender non-conforming youth is being further understood, the fact remains that their distress is significant and impacts both themselves and their children. However, as expressed in this chapter, the knowledge about what predicts this noted distress is still unknown. For this reason, the proposed study will

attempt to discern what predicts—and moderates—maternal anxiety and depression in mothers of transgender and gender non-conforming children.

Hypotheses

It is hypothesized that higher scores on measures of mothers' anxiety and depression will be predicted by (1) higher levels of gender nonconformity in their children (2) more traditional gender stereotypes of mothers and (3) more behavior problems in their children. It is also hypothesized that community and family support—henceforth referred to as "social support"—will moderate the relationship between each of the predictors and mothers' anxiety and depression.

Chapter 3: Methods

Sample

The present study utilized data from the TransKids Project, a longitudinal study of 49 families with transgender and gender non-conforming children (Kuvalanka, Weiner, & Goldberg, 2008). The project, initiated in 2008, created an advisory board that assessed gaps in the literature and the needs of families with transgender and gender non-conforming children (12 years of age and below). Child-, family-, and community-level factors were assessed with the ultimate goal of enhancing the wellbeing of such children and their families.

Data for this particular study were taken from Wave 1, which was collected in 2011. At Wave 1, parents and primary caregivers with transgender and gender non-conforming children were recruited via purposive and snowball sampling. However, the final sample for this study included only the mothers, of which six were omitted from data analysis due to failing to complete all measures (n=39; 80% of the larger study's sample). The mothers were between 31 and 67 years old (M=42.4 years; SD = 7.1), all but two of the mothers identified as white or Caucasian, and over 75% held Bachelors' or graduate degrees. The sample demographics are included in Table 1, below.

The mothers' children were between 6 and 12 years of age (M = 8.5 years; SD = 1.8), and most were biological males (*n*=28; 62%). Nearly 80% of the children (*n*=36) were reported to have first exhibited gender nonconformity before the age of 3. The children's demographics are included in Table 2, below.

Table 1
Demographic Charaacteristics of the Sample

	Mean or %	**Range, (SD) or *n***
Mothers' ages	42.4 years	31-67 years, (7.1)
Geographic locale:		
West	49%	21
Midwest	18%	7
Northeast	18%	6
South	13%	6
Canada	2%	1

Table 2
Demographic Characteristics of the Sample's Children

	Mean or %	**Range, (SD) or *n***
Children's age	8.5 years	6-12 years, (1.8)
Children's natal sex		
Male	62%	28
Female	38%	17
Age of exhibited gender nonconformity		
0-3 years	80%	36
4-6 years	16%	7
7-12 years	4%	2

Procedure

The investigators of The TransKids Project recruited participants through various social and professional networks. Information about the study was disseminated on several listservs geared for parents and families of transgender and gender non-conforming children, and with prominent clinicians who are known for their work with such populations and issues. Initial participants were asked to share information about the study with other parents they knew of gender non-conforming children. Potential

participants were told that a longitudinal study was taking place in an attempt to learn more about the unique experiences of families of transgender and gender non-conforming children, with the ultimate goal of improving the well-being of transgender and gender non-conforming children and their families. Ultimately, 49 parents/caregivers consented to participate in the project, of which only 45—the mothers—were used in the present study. Due to six mothers failing to complete the entirety of assessments, those six were omitted from the data analysis (final N=39).

Each participant completed six assessments, three pertaining to their own experiences, and three pertaining to the perception of their child's. These assessments included the *Child Behavior Checklist* (Achenbach & Rescorla, 2001), the *Parent-Report Gender Identity Questionnaire for Children* (Johnson et al., 2004), the *Gender Role Beliefs Scales* (Kerr & Holden, 1996), the *Center for Epidemiological Studies-Depression Scale* (Radloff, 1977), and the *State-Trait Anxiety Inventory for Adults* (Spielberger et al., 1983). Details on these measures are included below.

In addition to the aforementioned assessments, each of the participants participated in a telephone interview with either the principal investigator or one of the co-investigators. The interviews lasted for approximately 60 minutes and were digitally recorded. The principle investigator, another faculty member at the PI's institution, and six graduate students between the two faculty members later transcribed the interviews (eight total transcribers). The participants were given a $25 gift card towards one of three retail stores of their choice for their time participating in the study.

Measures

All measures used in the current study are available in Appendices A-E.

Independent variables. Emotional well-being has numerous definitions and understandings depending on the context or the particular study. For this project, the level of emotional wellbeing of the participants was assessed by two phenomena, their anxiety and their depression.

Anxiety. Anxiety was self-reported by each participant using the *State-Trait Anxiety Inventory for Adults* (Spielberger et al., 1983). The inventory is a 40-question survey, and includes measures of both types of anxiety: state anxiety, or anxiety about a particular event or situation, and trait anxiety—anxiety level as a personal characteristic. Each type of anxiety has its own scale of 20 different questions. Items include "anxiety absent" items—questions that represent the absence of anxiety (e.g., "I feel secure," "I am calm") and "anxiety present" questions: questions that represent the presence of anxiety (e.g., "I am worried," "I am tense"). Each item is rated on a 4-point Likert scale ranging from "not at all" to "very much so" for the state anxiety scale, and from "almost never" to "almost always" for the trait anxiety scale. For the current study, only the state subscale was used. Scores for the state subscale range from 20-80, and higher score on the inventory are positively correlated with higher levels of anxiety. Internal consistency coefficients for the scale ranged from .86 to .95; test-retest reliability coefficients have ranged from .65 to .75 over a 2-month interval (Spielberger et al., 1983).

Depression. Depression was self-reported using the *Center for Epidemiological Studies-Depression Scale* (Radloff, 1977). The questionnaire is a 20-item survey, and includes major components of depressive symptomatology: depressed mood, feelings of guilt, worthlessness, helplessness, & hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance. To emphasize current state, all questions are prefaced with

"how often this past week…." Examples of questions include, "how often this past week did you feel hopeful about the future?" and "how often this past week was your sleep restless?" Each response is scored from zero to three based on frequency of the symptom: answers range from "rarely or none of the time (less than 1 day)" (score of 1) to "most or all of the time (5-7 days)" (score of 4)**.** Total scores range from 20 to 80, with higher scores indicating higher levels of depression. Internal consistency was high for the general population (.85) and even higher in the patient sample (.90).

Dependent Variables. For this analysis, three variables were considered for their potential effect on the emotional wellbeing of parents of transgender and gender non-conforming children: child's level of gender nonconformity, gender role beliefs of mothers, and child's behavioral problems.

Gender nonconformity. Gender nonconformity, or the extent to which an individual expresses and behaves unlike his/her biological sex, was measured by the *Parent-Report Gender Identity Questionnaire for Children* (Johnson et al., 2004). There are two versions—one for natal males and one for natal females—and each participant was given the form corresponding to their child's natal sex. The questionnaire, which covers aspects of the core phenomenology of Gender Identity Disorder, contains 16 questions, each with a 5-point Likert scale ranging from "As a favorite activity" to "Never." Examples of such questions include: "He experiments with cosmetics" and "he imitates female characters as seen on TV or in movies." Each question is scored one to five, with scores ranging from 16 to 80. A lower score on this questionnaire reflects a higher level of gender nonconformity (or less same-gendered behavior). The measure was found to significantly differentiate between children who were referred for gender identity issues and controls

($F(1,822) = 1167.9$), $p < .001$). The Cohen's *d*-test effect size was 3.7 Further, the measure was able to differentiate between referred youth who met the full DSM-IV criteria for Gender Identity Disorder, and those who were sub threshold for GID ($F(1,318)=57.0$, $p<.001$). Measure reliability was established through mother-father correlations ($r=.90$, $p<.001$) (Johnson et al., 2003).

Gender role beliefs. As mentioned in chapter two, gender role beliefs—or gender role ideologies— refer to the prescriptive beliefs about appropriate behavior for men and women (Kerr & Holden, 1996). Kerr & Holden published an empirically tested assessment of such beliefs called the *Gender Role Beliefs Scale* (1996). Each of the participants completed this 20-question survey, which has output scores between 20 and 140. Items are assessed on a 7-point Likert scale ranging from "strongly agree" to "strongly disagree." Higher scores indicate "feminist responding" (p.8). In a study evaluating the psychometric measures of the GRBS, the measure was found to significantly differentiate between the three criterion groups —traditional, undifferentiated, and feminist ($F(2,188=37.1$, $p<.001$). The measure was found to be internally reliable with a coefficient alpha of .89 (Kerr & Holden, 1996).

Child misbehavior. The *Child Behavior Checklist* (Achenbach & Rescorla, 2001) was used to assess how each participant perceived his or her child's behavior. A higher score on the checklist implies a higher level of behavior problems exhibited by the child. The checklist includes 113 questions assessing common behaviors and expressions of children (e.g., "acts too young for his/her age," "gets in many fights"). Each questions is scored between 0 and 2, with answers ranging from "not true" (0) to "very true" (2). Total scores for the checklist range from 0 to 226, and higher scores indicate a higher level of behavioral

problems for the child being assessed. The measure was found to have very high reliability. Both inter-interviewer reliability (r=.96, p < .001) and test-retest reliability over a seven day period (r=.96, p < .001) were significant (Achenbach & Rescorla, 2001). Internal consistency was evidenced by alpha coefficients of .63 to .79.

Moderator variable. When considering potential predictors of parents' emotional wellbeing of parents of transgender and gender non-conforming youth, it is prudent to consider a variable that may moderate the effects of such predictors. For this analysis, social support was that variable.

Social support. While there was no quantitative assessment used for the moderator variable in this study, "social support" will be assessed via analysis of the interviews with the participants. The interviewers asked the following question clusters to each participant in attempting to elicit their experience of such support:

1) What has been your reaction to your child's gender identity/expression? How have you felt about your child's gender non-conforming identity and/or expression? What were the reactions of other family members (both immediate and extended family)? Have your and other family members' feelings changed over time in this regard? If so, how?
2) How are you choosing to approach or deal with (name of child's) gender identity/expression? What are your feelings about how supportive you should or shouldn't be of your child's gender identity/expression? Are all of (name of target child's) parents and extended family members dealing with it in the same way – or is there disagreement among family members?

3) Is the way that you've handled/approached your child's gender identity/expression *within* your home differed from how you've handled/approached your child's gender identity/expression *outside* your home? Is (name of target child) happy with how the family has dealt with it? If no, how would (name of target child) have preferred it to be handled?
4) SCHOOL: How have things been for your child at school? How supportive of an environment has school been? Has the child transitioned in school? If so, when/how did this happen? Who initiated it? Was the school supportive? Were health care professionals or advocates/lawyers involved?
5) PEERS: How have your child's peers reacted? Does your child get along well with other children? Does s/he have friends? Go to sleepovers, parties, etc.? (If negative:) How have your child and your family dealt with this? COMMUNITY: How open and accepting are other people in your community, such as your neighbors, church community, etc.? What have been their reactions?

The in-depth interviews with the participants were recorded and transcribed. Based on past literature and the transcribers' own understanding of the interviews, it was decided to consider family support and community support as themes within them. The transcribers developed a scale to try and capture the variation in family and community support, which was tested with several participant interviews. The scale was adjusted and the interviews were fit to the scale. This process was done several times.

FAMILY ACCEPTANCE

This theme measured the degree of acceptance/affirmation from other family members for the child's transgender identity/gender nonconformity. This was done by

comparing family members' degree of acceptance of the child's transgender identity/gender nonconformity to the mother's.

Definitions:

- Participant: Mother who participated in interview
- Child: The transgender/gender-nonconforming child who is the focus of the study
- Immediate family: All people living in the home (e.g., participant's partner, other children), child's other parent (even if not living in the home), and participant's own parents.
- Extended family: People living outside the home who are not any of the above.

Currently…

0 = No one is accepting/affirming

- No one in family (immediate or extended) is as accepting as the participant is of the child's transgender identity/gender nonconformity

1 = Some are as accepting/affirming

- No immediate family members are as accepting as the participant, but some extended family members are OR some immediate family members are as accepting as the participants but most are not

2 = Most are as accepting/affirming

- Most immediate family members are as accepting as the participant, but at least one is not OR all immediate family members are as accepting as the participant, but some extended family members are not as accepting

3 = Everyone is as accepting/affirming

- All immediate and extended family members as accepting as the participant is of the child's transgender identity/gender nonconformity

COMMUNITY ACCEPTANCE

This theme measures the degree acceptance/affirmation from the community for the child's transgender identity/gender nonconformity or transgender individuals in general (if the child is stealth). This was done through assessing the degree of acceptance from the community for the child's transgender identity/gender nonconformity, or the degree of acceptance of transgender identities/gender nonconformity in general.

Definitions:

- Participant: Mother who participated in interview
- Child: The transgender/gender-nonconforming child who is the focus of the study
- Segments of community: Child's peers, participant's friends, family's neighbors, school personnel/staff, health care providers, church/faith community

Currently…

0 = Not at all accepting affirming

- The community is not at all accepting; no segments of the community are accepting/affirming of the child's transgender identities/gender nonconformity; if child is "stealth," then participant perceives community to be hostile to trans people in general

1 = Somewhat accepting/affirming

- The community if somewhat accepting/affirming of the child (some segments are accepting/affirming); if child is "stealth," then participant perceives community to be somewhat accepting/affirming of trans people in general

2 = Mostly accepting/affirming

- The community is mostly accepting/affirming of the child (most segments are accepting/affirming); if child is "stealth," then participant perceives community to be mostly accepting/affirming of trans people in general

3 = Completely accepting/affirming

- The community is completely accepting; all segments of the community are affirming; if child is "stealth," then participant perceives community to be accepting/affirming of trans people in general

Each participant was given a score (from 0-3) for "family support" and "community acceptance," respectively. The two scores for each mother were then averaged to produce the moderating variable of "social support."

Chapter 4: Results

The purpose of this study was to examine the association between three variables and the anxiety and depression of mothers of transgender and gender non-conforming children. Those three variables were the child's level of gender nonconformity, the mother's gender role beliefs, and the child's level of misbehavior. Additionally, this study considered the moderating effect of social support on these relationships. The hypotheses tested in this study were the following:

1. Higher scores on measures of maternal anxiety and depression will be associated with:
    a. Higher levels of gender nonconformity in the children
    b. More traditional gender role beliefs in the mothers,
    c. More behavior problems in the children.
2. Social support will moderate the relationship between each of the independent variables and dependent ones.

Prior to testing these hypotheses, frequencies of the scores were calculated. A summary of the distribution is included in the table below.

Table 4
Descriptive Information about Variables and Measures

	Child's Level of Gender Nonconformity*	**Mother's Gender Role Beliefs***	**Child's level of Misbehavior***
Measure	Gender Identity Questionnaire (GIQ)	Gender Role Belief Scale (GRBS)	Child Behavior Checklist (CBCL)
Range of Possible Scores	16-80	20-140	0-224
Range of Reported Scores	17-54	91-140	6-86
Mean	32	121.03	33.57
Standard Deviation	9.44	14.99	21.71

***Denotes an independent variable (IV)

	Family and Community Support (moderator)	**Maternal Anxiety****	**Maternal Depression****
Measure	Qualitative coding from interviews with the mothers	State-Trait Anxiety Inventory (only the State Subscale)	The Center for Epidemiological Studies—Depression Scale
Range of Possible Scores	0-3	20-80	20-80
Range of Reported Scores	1-3	20-64	21-43
Mean	2.21	34.95	27.87
Standard Deviation	.571	10.15	6.78

**Denotes a dependent variable (DV)

Primary Analysis. To begin the analyses, correlations were completed for the independent and moderator variables to check for multicollinearity. Findings are included in Table 4, below. There were two significant relationships among these correlations: higher levels of child misbehavior were significantly correlated with both lower levels of gender nonconformity (i.e., behaviors more traditional to the children's natal sex; p=.032),

and lower levels of social support (*p*=.007).

Table 4
Correlations Among Predictor Variables (n=39)

	Gender Role Beliefs	Gender Nonconformity	Child Misbehavior
Gender Role Beliefs	___		
Gender Nonconformity	.159	___	
Child Misbehavior	-.068	.344*	___
Social Support	-.078	-.127	-.422**

*Denotes significance at the 0.05 level
**Denotes significant at the 0.01 level

Given that in no case did the independent and moderator variables share more that 18% of the variance, it was decided that all variables would be used in testing hypothesis one.

To test hypothesis one, correlations were computed between the independent variables, and the dependent variables of maternal anxiety and depression. Results are depicted in Table 5, below, which included one significant relationship: higher levels of child misbehavior were significantly correlated with higher levels of maternal anxiety (*p* =.028; *r* =.353). All other relationships were insignificant. These results shed light on hypotheses one: while none of the three independent variables were significantly associated with maternal depression and two were not with maternal anxiety, child misbehavior was significantly correlated with maternal anxiety. Therefore only hypothesis

1c was partially supported; 1a and 1b were not.

Table 5
Relationships Among IVs and DVs (n=39)

	Anxiety	**Depression**
Gender Role Beliefs:		
r	-.012	.060
p	.458	.071
Gender Nonconformity:		
r	.042	-.022
p	.112	.688
Child behavior:		
r	.353	-.018
p	.028*	.570

*Denotes significance at the 0.05 level

Hypothesis two was tested using stepwise multiple linear regression. In the first step, the independent variables and social support were entered into the equation. To test for moderation, the independent variable was multiplied by social support and that product was added in the second step of the equation. Due to the small sample size and the number of variables under consideration, a decision was made to only test for the moderation effect of social support if a significant relationships existed between an independent and dependent variable. Thus, the moderation effect was only tested for child misbehavior and maternal anxiety. While the regression equation was significant $F(1,37)=5.3$; $p=.028$; adjusted R squared=.101, only child behavior remained in the equation, with both social support and the interaction variable being excluded (see Table 6). Results indicated that social support did not moderate the relationship between child

misbehavior and maternal anxiety.

Table 6
Results from the Regression Analysis: IVs and Anxiety (n=39)

	Beta	R squared	P-value
Included Variables in Final Equation:			
Child Misbehavior	.353	.101	.028*
Excluded Variables in Final Equation:			
Social Support	-.159	N/A	.355
Social Support*Child Misbehavior	-.146	N/A	.656

*Denotes significance at the 0.05 level

Supplementary Analysis. In light of the positive association between the child misbehavior and maternal anxiety, the researchers were curious if particular types of misbehavior were more or less associated with maternal anxiety. Knowing what types of specific problem behaviors are most potently associated with maternal wellbeing is beneficial for improving the health of this population. The Child Behavior Checklist (Achenbach & Rescorla, 2001)—the instrument utilized to measure child misbehavior—includes two primary subscales classifying two types of child misbehavior: internalizing and externalizing. Internalizing behaviors are negative, problematic behaviors that are directed toward the self; they often reflect withdrawal, anxiety, dysphoria, and somatic complaints (Hinshaw et al., 1992). Conversely, externalizing behaviors are directed toward the external environment, represented by overactivity, defiance, noncompliance, and

aggression (Hinshaw et al., 1992). These particular types of child misbehavior were considered for an analysis identical to the one conducted for child misbehavior with the dependent variable of maternal anxiety

While externalizing was not significantly correlated with maternal anxiety (r = .23, p > .05), a significant relationship was found for internalizing behavior (r = .41, p < .01). Accordingly, multiple linear regression was then used to test for moderation. Because of the decision to test for moderation only among relationships that are significant, the moderation effect was only tested for internalizing behavior, which was entered into the first part of the equation with social support. Internalizing behavior was multiplied by social support and that product was added in the second step of the equation. Results indicated that social support did not moderate the relationship between internalizing behavior problems and maternal anxiety (see Table 7).

Table 7:
Results from the Regression Analysis (N=39)

	Beta	R squared	P-value
Included Variables in Final Equation:			
Internalizing	,412	.147	.009**
Excluded Variables in Final Equation:			
Social Support	-.173	N/A	.277
Social Support*Internalizing	-.633	N/A	.182

**Denotes significance at the 0.05 level

Chapter 5: Discussion

The purpose of the current study was to examine the independent effects of three variables—maternal gender role beliefs, child gender nonconformity, and child misbehavior—on the anxiety and depression of mothers of transgender and gender non-conforming children. Based on an extensive review of the relevant literature, it was hypothesized that higher levels of child gender nonconformity, more traditional levels of maternal gender role belief scales, and higher levels of child misbehavior would result in higher levels of maternal anxiety and depression. Additionally, it was hypothesized that social support would moderate the relationship between the three independent variables and maternal anxiety and depression. The goal of this study was to add to the nascent body of literature on the parents of transgender and gender non-conforming children, perhaps providing some insight on the mental health of these parents and, subsequently, their children.

Only child misbehavior was significantly associated with maternal anxiety; a higher level of one was correlated with higher levels of the other. Gender nonconformity and gender role beliefs were not significantly correlated to maternal anxiety, and none of the three were significantly correlated to maternal depression. Social support did not moderate the relationship between anxiety and misbehavior. Upon further analyses, the internalizing behavior subscale of child misbehavior—but not the externalizing behavior subscale—was also positively associated with maternal anxiety. However, similar to the full measure itself, social support also did not moderate this relationship.

Although most of the hypotheses were not supported and are discussed at length below, there was one hypothesized relationship in this study that was in line with the

extant literature: the positive association between child misbehavior— especially internalizing child misbehavior—and maternal anxiety. This relationship between child misbehavior and maternal distress (i.e., anxiety, depression, parenting dissatisfaction) has been examined previously, separate from gender nonconformity, as discussed in the literature review (e.g., Connel & Goodman, 2002). Considering it is known that there are higher rates of depression and distress in transgender youth (Grossman, D'Augelli, & Salter, 2011; Spack et al., 2012), it is no surprise that these children exhibited such misbehaviors, or that their mothers experienced more anxiety because of it.

What is most interesting about this segment of the findings, however, is the fact that only internalizing behavior was significantly associated with maternal anxiety, whereas externalizing behavior was not. As stated in Chapter Two, both internalizing (Connel & Goodman, 2002) and externalizing (Suarez & Baker, 1997) behaviors in children are associated with higher levels of distress in their mothers, be it depression (Hastings, Daley, & Beck, 2006), anxiety (Gray, Indurkhya, & McCormick, 2004), or some other reliable measure of "distress" (e.g., "parenting dissatisfaction," in Podolski & Nigg, 2001). However, the current study only found significance between internalizing behaviors and maternal anxiety. This finding produces inquiries into why this was the case. Initial consideration of this finding examined the scores of externalizing behaviors and maternal anxiety within the sample, both of which are considered to be in the "healthy" and "non-clinical" range (Knight et al., 1983; Heflinger et al., 2000). Perhaps because the mothers in the sample were rather accepting of their children's gender expression, their children did not exhibit externalizing misbehavior. As for why specifically these children's internalizing behavior resulted in their mothers' anxiety, possible explanations are numerous. Perhaps mothers are most

worried about, and hypersensitive towards, how their child feels about his or herself, particularly in situations where the mother knows or suspects their child is being bullied or struggling to "fit in." Alternatively, considering the known suicide rates among sexual minority children (Grossman & D'Augelli, 2007; Russell, 2003), it is possible that these mothers were particularly concerned when their children behaved in ways akin to such catastrophes.

There were two other significant associations among the findings, though both were not involved in any of the study's hypotheses. The first was a significant negative correlation between child misbehavior and social support: as one increased, the other decreased, and vise versa. It is interesting to consider this result in light of the support the mothers were receiving—what, specifically, about their community and/or family acceptance is associated with lower levels of child misbehavior? Perhaps mothers who had high levels of support and acceptance were more tolerant of their child's gender expression, allowing them to express their true gender selves, which, as mentioned in the literature, results in less behavior problems among gender non-conforming children (Menvielle, 2012; Ehrensaft, 2012).

The second of the non-hypothesized yet significant findings concerned the association between level of gender nonconformity and child misbehavior. At lower levels of gender nonconformity—as children expressed themselves more traditionally to their natal sex—more child misbehavior was observed. This is in line with extant literature, particularly that children have heightened levels of depression and suicidal ideation when they are unable to express their preferred gender, as mentioned above. In light of this, when children express their gender nonconformity, they tend to exhibit behavior problems

less which results in improved mental health of their mothers. This conclusion from this study's findings yields further support for parents allowing their child to be more expressive of their true gender identity (Menvielle, 2012; Ehrensaft, 2012; Malpas, 2011). Such a situation seems to result in better mental health for transgender and gender non-conforming children and their parents.

Though these relationships are significant and support extant literature, considering them with a more critical lens may yield a much deeper understanding of gender, families, and the interface of the two. While past research has concluded that transgender children's mental health declines when they are unable to express their true gender, their poor mental health has been attributed to their parents' rejection and intolerance of their gender expression (Ryan et al., 2010). While it may have been that the mothers in this study who "allowed" more expression of gender nonconformity had children with fewer behavior problems, this may be too simplistic an interpretation, as most of the mothers in this study were rather accepting of their child's gender expressions. Perhaps the children's poor mental health (i.e., internalizing behavior problems) is not merely because of parental rejection of their gender expression, but some other phenomena occurring within the children's psyches.

As mentioned at the beginning of Chapter Two, it may be worth reconsidering the way the field thinks about transgender and gender non-conforming children. For the purposes of this study and in much of the existing literature, the terms were always used together and interchangeably, in that the children of the mothers in the sample behave and express their gender in ways that are different from—i.e., non-conforming to—their natal sex. It is possible, however, that there is a distinction to make between these two types of

children. Transgender children behave and express themselves explicitly *opposite* to their natal sex on the binary (i.e., Sam who was born with a penis and socialized as a boy decides that he is really a female and begins living socially as Samantha, a girl). These children appear to have distinct convictions of their gender identity that also conform to the gender binary used and understood so widely in our society. It may be, however, that gender non-conforming children lack this identity conviction as either boy or girl, and do not consistently demonstrate the resulting conforming behaviors. They express themselves in ways untraditionally associated with their gender, but may not consistently identify as one sex or the other.

The extant literature on these types of children does not seem to make or consider such a distinction. The majority of scholars studying this population use different ways to refer to all types of gender non-conforming children, both transgender and otherwise. Some classify them pathologically using the relevant DSM diagnoses, both past and current (e.g., Zucker et al., 2012; de Vries & Cohen-Kettenis, 2012). Many use the term "transgender" to refer to all types of gender variant youth (e.g., Edwards-Leeper & Spack, 2012; Grossman & D'Augelli, 2007). One scholar in particular used the phrase "children with gender variant behaviors and gender identity disorders" (Menvielle, 2012). While other terms exist in the literature to describe the same demographic, there seems to be a lack of distinguishing between youth who, perhaps, experience gender differently than simply "boy" and "girl." Only in some of the published clinical data are distinctions being made between children of different gender non-conforming behaviors (see Ehrensaft's *True Gender Self Child Therapy*, 2012).

Considering this proposed distinction between transgender and gender non-conforming children offers two possible explanations for these children's psyches and their resulting implications. First, perhaps gender non-conforming experience identity ambiguity, in which they truly don't feel entirely as either a boy or a girl, and experience distress because of this possible ambiguity. Alternatively, these children may feel as neither 'boy' nor 'girl' suits their true gender identity, and feel more inclined towards some type of "gender hybrid" identity (Ehrensaft, 2012), one that undermines the binary of boy-girl, and places them somewhere along a gender continuum. Navigating a family and a world in which their potential non-binary identity is misunderstood or rejected could likewise cause these children distress. Either one of these scenarios, therefore, could have clinical implications for these children—distress as a result of ambiguity associated with their gender, or their desire to identify as a gender that transcends the gender binary that is understood and used so widely in our society. This, of course, could also have implications for their mothers, too. A proposed model of the distinction between transgender and gender non-conforming children in this study's sample and their potential implications are included below (Table 9).

	Proposed Reality	***Potential Child Mental/Emotional Outcome***	***Possible Mother Mental/Emotional Outcome***
Transgender	Acting explicitly opposite to their natal sex	"I know I'm a girl, my parents mostly accept me; life is alright."	Eventual acceptance, relief, content
Gender Non-conforming	Acting consistently inconsistent to their natal sex.	"I don't know what my gender is;" resulting distress *or* "I know my gender and express it accordingly, but those around me are not comfortable with it in our binary-obsessed culture;" resulting distress	Frustration, anxiety, anger, uncertainty

Table 9: *A proposed gender model for this study's sample and their children*

Turning now to the unsupported hypotheses, it is curious that most of the hypothesized relationships were insignificant in light of the extensive literature discussed in Chapter Two. It is imperative to consider factors that may have contributed to this scarcity of significant findings.

Particularly surprising were the lack of findings involving gender nonconformity. In Chapter Two, a number of scholars were cited for referencing the caustic nature of parents' experience when they have a child who is gender non-conforming, forming the basis of hypothesis 1a (Menvielle, 2012; Ehrensaft 2012, 2011; Alanko et al., 2009, 2011; Grossman et al., 2005). It seemed reasonable to assume, therefore, that higher levels of gender nonconformity would result in higher levels of maternal anxiety and/or depression.

Similarly, it seemed quite reasonable that more traditional gender role beliefs would result in more anxiety and/or depression when mothers have a transgender or gender non-conforming child. Justification for this reasoning stems from broad sociological patterns

about gender, and how parents 'gender' their children (Fine, 2010; Kimmel, 2008; Pascoe, 2007). Seemingly, parents with stronger, more traditional gender role ideologies (Kerr & Holden, 1996) would desire very traditional, gender conforming behaviors for their children, forming the basis of it was hypothesis 1b.

Only one of the predictor variables (child misbehavior) was significantly correlated with one of the dependent variables (anxiety), which helped support hypothesis 1, but social support did not moderate this relationship in any significant fashion, which did not support hypothesis 2. Though no research to date has explicitly underscored the effect social support has on maternal well-being of mothers with misbehaving children, the literature does state extensively the role social support has in alleviating various hardships in mothers of LGBT children (Saltzburg, 2009).

Perhaps this dissonance between past scholarship and this study's results could be explained by its sample. With only 39 mothers, the sample was rather small, especially considering the number of variables that were used in this study. In addition to the sample's size, the sample's demographics could likewise justify the study's findings. All but two of the mothers were Caucasian, and nearly 80% of them had at least a bachelor's degree. This is noteworthy, because numerous studies have highlighted the positive association between both level of education and race—respectively—and acceptance of homosexuality/gender nonconformity. Higher levels of education are significantly correlated with higher levels of acceptance of homosexuality and gender nonconformity (Kozloski, 2010; Loftus, 2001). Similarly, when compared to Caucasians, African Americans are more disapproving of homosexuality and of gender nonconformity (Lewis, 2003). In fact, transgender people of color have reported hostility, aggression, neglect, and rejection

when coming out to their families (Koken, Bimbi, & Parsons, 2009). Perhaps because of the racial composition and educational attainment of the mothers in this study's sample, their tendency to tolerate and accept their children's gender nonconformity is not representative of the larger population, providing another explanation for this study's results.

Related to these aforementioned realities of the study's sample, the way in which the participants became involved in this research might also have implications for this study's results. As mentioned in Chapter 3, the current study assessed data collected during Wave 1 of a longitudinal study of transgender and gender non-conforming children and their parents. The impetus for this project actually came from one of the mothers in the study's sample, who desired to have her family's experiences studied by local scholars with the appropriate resources. The rest of the mothers in the cohort were self-selected, in that they volunteered to participate after responding to listerv announcements and word-of-mouth. Given the mothers' willingness to participate in such a study, it is possible that they would already be accepting of their child's gender nonconformity, and/or more engaged in relevant support networks than the general population.

Even if this were not the case, perhaps at the time of data collection the mothers already had adequate time to process their child's gender nonconformity, or acquire adequate social support to mitigate any hardships they were facing. This possibility reflects a phenomenon in the very small body of literature on parents of gender nonconformity children, in that their experiences with their children's gender expressions *change over time*. One model posits that parents' initially experience turmoil when learning of a gender non-conforming child, but eventually negotiate and find balance among their family members (Lev & Alie, 2012). Other studies have noted a similar change in attitude over

time: from crisis to empowerment (Brill & Pepper, 2008) and from intense grief to accepting, protecting, and advocating for their child (Kuvalanka et al., 2014; Pepper, 2012). It is possible that by the time the data was collected for this study, the mothers already had some time to undergo these aforementioned changes, with or without social support.

When considering the notion of *time*, it is relevant to recall, and perhaps critique, the theoretical orientations used to frame this study. Nowhere in either Minority Stress Theory (Meyer, 2003) or decentering heteronormativity (Oswald, Blume, & Marks, 2005) is time considered as a component of the framework. However, upon analysis of this study's results, it seems as though *time* may have significant implications for both the mothers and their gender non-conforming children. Within Oswald's (2005) model, "doing" family and gender produces complex families and genders that undermine traditional binaries of each of these constructs. For this study, Meyer's Minority Stress Theory (2003) was said to take place within those processes of "doing" family and gender, in which gender non-conforming children, their mothers, and their families interact with both proximal and distal stressors producing their unique minority stress. However, what is not explicit in either of the models is the notion of *time*, and, more specifically, the changes that take place within it.

As just discussed, it is possible that the mothers in this study at the time of data collection had already "changed" since they first learned of their child's gender expression. According to the literature to date, parents' initial reactions and mental states fare worse immediately after children begin to express their nonconformity than those after some time—time, perhaps, to process their child's situation and/or engage with social networks. If this is the case, the mothers' "doing" of family and gender, and their resulting minority

stress, are not, by any means, consistent: on the contrary, they change over time. In a similar vain, *time* may also have relevance to transgender and gender nonconforming children. Just as the mothers' attitudes and mental states likely change over time, it is also likely that the children's gender expressions change, too. Because of these changes over time, the minority stress stressors are not consistent, the processes of "doing" complex genders and families are not consistent, and, as a result, the mental and emotional states of the mothers and their children are not consistent, either. Reconsidering the theoretical framework in light of this study's findings implores future theories used to study such populations to consider *time* more explicitly. Considering time would be considering changes that are potentially occurring for these mothers, these families, and these children's gender expressions.

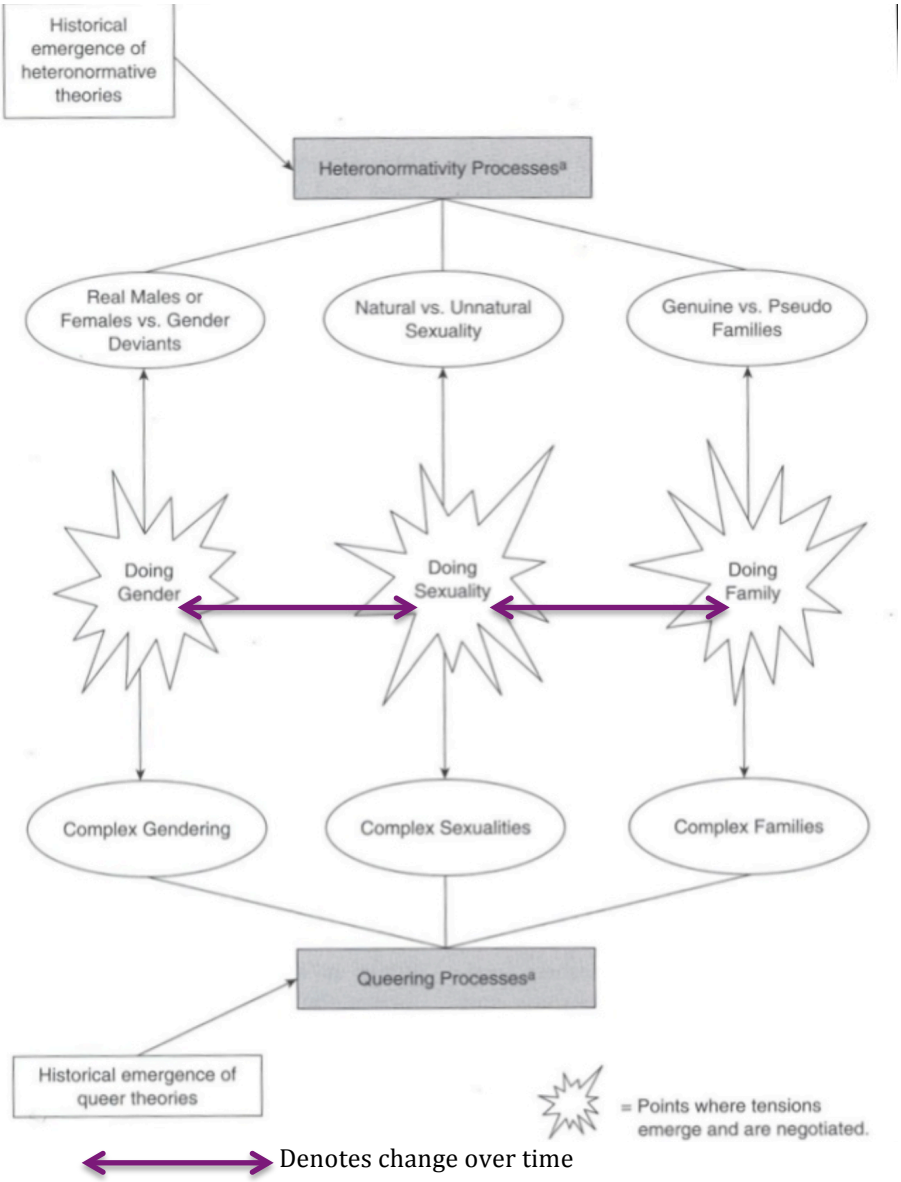

Figure 3: A critiqued model for theorizing these families (taken from Oswald, Blume, & Marks, 2005).

As stated earlier, there is a noteworthy body of literature on the association between maternal anxiety and child behavior problems (Renk, 2007) within the larger population. The same association is known about the moderating effect of social support on parents' well-being of parents of lesbian and gay (Saltzberg, 2009) and gender non-conforming (Riley et al., 2011) children. However, social support did not moderate the

relationship between child misbehavior and maternal anxiety in this study. Perhaps the positive effects of social support on mothers of lesbian, gay, and gender non-conforming children are positive for other aspects of the mothers' experience, and not directly related their children's misbehavior. Additionally, as these mothers had volunteered to participate in this study—which has its own implications, mentioned above—it is possible that they were already tolerant of their child's gender expressions, reducing their child's misbehavior, and limiting its effect on their anxiety. Perhaps the situation would look quite different with a cohort of parents who are not as White, educated and likely tolerant as this study's mothers are.

Limitations

First, as noted previously, the size of the sample was small, particularly in light of the number of variables used in this study. This limited the power of the analyses for the entire sample of mothers. Second, the racial and educational diversity of the mothers was unsubstantial, possibly impacting the results as suggested by the literature. The findings from this study, therefore, may have skewed the representativeness of this study's sample to the larger population of mothers of transgender and gender non-conforming, as the sample included mostly White, educated mothers and those who voluntarily enrolled. Perhaps this limitation can also account for the relatively low scores of child misbehavior (mean=33.6; non-clinical range < 40). Perhaps the sample's demographic has implications for the children's misbehavior, in that more educated mothers who volunteered to participate in this study have allowed their children to express their true gender identity (a la Ryan et al., 2010).

Additionally, though all of the measures used for this study have demonstrated both reliability and validity in previous research (see Chapter 3), in retrospect, The Gender Role Belief Scale (GRBS; Kerr & Holden, 1996) may have been a poor choice to adequately measure gender role ideologies within this study's sample. Created in 1996, the GRBS aims to assess how "traditional" one's beliefs are about men's and women's roles in societies. However, in the nearly 20 years since the scale's creation, historical gendered beliefs have evolved and progressed, particularly among educated Americans (Apple, 2013). Anecdotal evidence suggests that the assessment no longer has the same validity as it had two decades ago, particular not with this study's White and educated sample.

Furthermore, the way in which the mothers were recruited for this study could be considered a limitation, too. Because the researchers sent a call for participants on listservs and in relevant providers' offices, the mothers were intrinsically and undoubtedly already seeking some form of assistance for their child and family's situation. This implies, and is strengthened by the literature, that these mothers had either time and/or support they needed to become more accepting and tolerant of their child's gender nonconformity. The results gleaned from the study's results and analyses may be further skewed further for these reasons, and do not represent all mothers of transgender and gender non-conforming children.

Lastly, it is important to consider the way in which the qualitative data was transformed into quantitative codes for the social support measure. First, it is possible that the transformation flattened or reduced variation in the data such that relationship between social support and other variables was more difficult to detect. Second, this transformation, though informed by scholars familiar with this project and various

methods of qualitative analysis, may have resulted in changes in meaning within the original transcripts. This may have resulted in skewing the potential for any significant relationships among the variables in this study. These issues are not unique to this study but can be problematic anytime one attempts to transform qualitative data to quantitative data.

Implications For Future Research

In light of this study's results and its limitations, future research could consider parents and families of transgender and gender non-conforming children of different racial, ethnic, and socioeconomic backgrounds. It is known that tolerance and acceptance of gender nonconformity varies across different races and socioeconomic statuses, and the resulting stress families of other racial or socioeconomic backgrounds face may differ quite significantly from this study's. It would be prudent for future research to assess these differences across various races and socioeconomic statuses in families with transgender children. Even within same ethnic and socioeconomic groups, future research should examine differences between mothers who are comfortable and/or accepting of their child's nonconformity versus those who are not, as most of this study's mothers were both comfortable and accepting of this phenomenon. In fact, during the coding and analysis of the qualitative data, the researchers considered using "mother's comfort with their child's gender identity and/or expression," as a predictor variable of maternal anxiety and depression. Though it could not be used for this study, it certainly supports the implication to perform future research with samples of mothers with differing comfort levels.

Due to the anachronistic nature of The Gender Role Beliefs Scale, which was used in this study to measure gender role ideologies of the mothers in this study, future research

could use a more modern and valid instrument to accurately measure mothers' gender role beliefs in the current era. This instrument could be used to reassess gender role ideology's impact on mother's anxiety and depression of mothers of transgender and gender non-conforming children. It could also be used in many other research projects—ones not necessarily pertaining to transgender children and their families—that would benefit from a more accurate assessment of gender role ideologies. To date, no known adaptations or revisions of the GRBS have been created; this can be a future research project in and of itself.

Relatedly, as briefly mentioned above, discussions surfaced amongst the coders about the mothers' comfort level with their child's gender identity and/or expression. Perhaps such comfort levels could be assessed in future research with these mothers and replace gender role ideologies (Kerr & Holden, 1996) via the GRBS. In addition to the assessment being rather dated, it is possible that a mother with more progressive/less traditional gender role beliefs would still be uncomfortable with a gender non-conforming child, and vise versa. Considering these mothers' comfort level with their child's gender nonconformity as a predictor of maternal distress in place of, or in addition to, a more modern assessment of gender role beliefs, could prove fruitful in discovering associations between gender non-conforming children and their mothers' well-being.

As mentioned earlier in this chapter, a distinction was proposed between transgender and gender non-conforming children: the former being a child who socially transitioned to living as the gender opposite to their natal sex, and identifies as such. Gender non-conforming children do not identify as the "opposite" of their natal sex, but express themselves in ways that are simply different from—and not necessarily opposite

to—their biological sex. Their gender is more fluid, in a sense in line with Ehrensaft's (2012) category of *gender fluid children, "*who do not abide by the binary norms of gender prescribed by the culture but instead flow along the spectrum from male to female" (2012, p.348). While this distinction is important enough just for the sake of validating the child's *true gender self* (Ehrensaft, 2012), it is also extremely relevant to future studies like this one.

For children who are gender non-conforming but would not be classified as transgender, results from this study leave questions unanswered about their unique and potentially distinct experiences from transgender children, whose identities are more salient and gender expressions are more conforming to the gender binary. Future research could explore clinical differences between specifically transgender children and ones who are gender non-conforming. Such research could inquire if these children have a sense of gender ambiguity: ambiguity that may cause them distress. If their identity is more resolute, one that is counter to the gender binary but not necessarily 'boy' or 'girl,' perhaps these children—and their mothers—encounter distress from the pressure to adhere to the gender binary, or from the stigma of not doing so (Meyer, 2003). Based on this study's findings and past literature, interviews with these distinct cohorts of children may produce a new depth of understanding that would have implications for the children, their mothers, and the way society approaches gender as a whole. Though some of these gender discussions may seem epistemological in nature, future research could inform the academy of the potentially real consequences of such distinctions.

Such distinctions have begun to surface among some advocates in the field. In the Human Rights Campaign's report on Gender Expansive Youth (2014), the investigators

aimed to discern how current young people are defining and describing their own gender, and how their gender is related to their overall well-being at home and in school. The study illuminated emerging concepts of gender, and demonstrated that many of our dominant culture's most common beliefs and practices around gender do not adequately apply to all youth. They proposed using the term "gender expansive" for gender non-conforming youth, which includes a wide variety of gender expressions that are neither traditionally male nor female.

Both the current study and the HRC survey echo a similar sentiment: "[beyond these questions], one thing is clear: we need a deeper exploration of the many ways in which youth are coming to understand, define, and describe their own gender" (2014, p.4). The author of this paper asserts that the implications of such understandings and definitions are crucial to improving this population—and their families'—wellbeing.

Conclusion

This study aimed to better understand factors that predict the mental health of mothers of transgender and gender non-conforming children. Three such factors were considered—child gender nonconformity, mother gender role beliefs, and child misbehavior—as predictors of maternal anxiety and depression. Social support was considered as a moderator of these relationships. Only child behavior problems was significantly associated with maternal anxiety, and social support did not moderate this relationship.

Though the data did not support most of the hypothesized relationships, both the significant and insignificant findings are independently illuminating on this study, on

worthwhile future research, and on reconeptualizing gender nonconformity and its familial implications. Firstly, the size, demographic, and voluntary nature of the mothers in the sample to participate in this research study, are all factors of the sample that need to be reconsidered for future studies of mothers of transgender and gender non-conforming children. Because race, ethnicity, and socioeconomic diversity have implications on the well-being of sexual minority youth and their families, such diversity and its implications needs to also be considered for these families in the future. Additionally, the majority of this study's mothers were accepting of their child's gender expression, which undoubtedly had implications for the study's results. In future research, considering the mothers' level of comfort with their child's gender nonconformity may serve as a potent distinction in assessing the mothers' mental health.

Lastly, it is curious to consider children who are specifically transgender in comparison to those who are merely gender non-conforming. In addition to this study, initial inquiry into these children's lives potentially insinuates that there are experiential differences between the two types of children (e.g., The Human Rights Campaign, 2014). Further inquiry into these children's' experiences, and understanding the possible differences between them, would provide justification for this study's results and provide significant implications for future research. Such knowledge could inform clinicians and interventionists, sociologists and health researchers, on better treating these children, their families, and their individual gender experiences.

Appendix A: Center for Epidemiological Studies-Depression Scale (CES-D)

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way **during the past week**.

Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite is poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
14. I felt lonely.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people dislike me.
20. I could not get "going."

Appendix B: State Trait Anxiety Inventory (STAI – state subscale)

Directions: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

1 = NOT AT ALL 2 = SOMEWHAT 3 = MODERATELY SO 4 = VERY MUCH SO

1. I feel calm ……..	**1**	**2**	**3**	**4**
2. I feel secure ……	**1**	**2**	**3**	**4**
3. I am tense ……	**1**	**2**	**3**	**4**
4. I feel strained ……..	**1**	**2**	**3**	**4**
5. I feel at ease ……	**1**	**2**	**3**	**4**
6. I feel upset …….	**1**	**2**	**3**	**4**
7. I am presently worrying over possible misfortunes ……	**1**	**2**	**3**	**4**
8. I feel satisfied ……	**1**	**2**	**3**	**4**
9. I feel frightened …….	**1**	**2**	**3**	**4**
10. I feel comfortable ……	**1**	**2**	**3**	**4**
11. I feel self-confident …….	**1**	**2**	**3**	**4**
12. I feel nervous ……	**1**	**2**	**3**	**4**
13. I feel jittery ……	**1**	**2**	**3**	**4**
14. I feel indecisive …….	**1**	**2**	**3**	**4**
15. I am relaxed ……..	**1**	**2**	**3**	**4**
16. I feel content …….	**1**	**2**	**3**	**4**
17. I am worried ……..	**1**	**2**	**3**	**4**
18. I feel confused ……	**1**	**2**	**3**	**4**
19. I feel steady ……	**1**	**2**	**3**	**4**
20. I feel pleasant …….....	**1**	**2**	**3**	**4**

Appendix C: Parent-Report Gender Identity Questionnaire for Children (GIQ)

PRGIQ (Natal Female)

Instructions: Please answer the following behavioral statements as they currently characterize the behavior of your child. For each question, circle the response that most accurately describes your child.

1. His/her favorite playmates are
    a. always boys
    b. usually boys
    c. boys and girls equally
    d. usually girls
    e. always girls
    f. does not play with other children

2. S/he plays with girl-type dolls, such as "Barbie"
    a. as a favorite toy
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

3. S/he plays with boy-type dolls, such as "G.I. Joe" or "Ken"
    a. as a favorite toy
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

4. S/he experiments with cosmetics (makeup) and jewelry
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

5. S/he imitates female characters seen on TV or in the movies
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

6. S/he imitates male characters seen on TV or in the movies
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

7. S/he plays sports with boys (but not girls)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

8. S/he plays sports with girls (but not boys)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

9. In playing "mother/father," "house," or "school" games, s/he takes the role of
    a. a girl or woman at all times
    b. usually a girl or woman
    c. half the time a girl or woman and half the time a boy or man
    d. usually a boy or man
    e. a boy or man at all times
    f. does not play these games

10. S/he plays "girl-type" games (as compared to "boy-type" games)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

11. S/he plays "boy-type" games (as compared to "girl-type" games)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

12. In dress-up games s/he likes to dress up as

a. a girl or woman at all times
b. usually a girl or woman
c. half the time a girl or woman and half the time a boy or man
d. usually a boy or man
e. a boy or man at all times
f. does not play these games

13. S/he states the wish to be a boy or a man
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

14. S/he states that he is a boy or a man
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

15. S/he talks about not liking his/her sexual anatomy (private parts)
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

16. S/he talks about liking his/her sexual anatomy (private parts)
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

PRGIQ (Natal Male)

Instructions: Please answer the following behavioral statements as they currently characterize the behavior of your child. For each question, circle the response that most accurately describes your child.

1. His/her favorite playmates are
    a. always boys

b. usually boys
c. boys and girls equally
d. usually girls
e. always girls
f. does not play with other children

2. S/he plays with girl-type dolls, such as "Barbie"
    a. as a favorite toy
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

3. S/he plays with boy-type dolls, such as "G.I. Joe" or "Ken"
    a. as a favorite toy
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

4. S/he experiments with cosmetics (makeup) and jewelry
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

5. S/he imitates female characters seen on TV or in the movies
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

6. S/he imitates male characters seen on TV or in the movies
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

7. S/he plays sports with boys (but not girls)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely

e. never

8. S/he plays sports with girls (but not boys)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

9. In playing "mother/father," "house," or "school" games, s/he takes the role of
    a. a girl or woman at all times
    b. usually a girl or woman
    c. half the time a girl or woman and half the time a boy or man
    d. usually a boy or man
    e. a boy or man at all times
    f. does not play these games

10. S/he plays "girl-type" games (as compared to "boy-type" games)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

11. S/he plays "boy-type" games (as compared to "girl-type" games)
    a. as a favorite activity
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

12. In dress-up games s/he likes to dress up as
    a. a girl or woman at all times
    b. usually a girl or woman
    c. half the time a girl or woman and half the time a boy or man
    d. usually a boy or man
    e. a boy or man at all times
    f. does not play these games

13. S/he states the wish to be a girl or a woman
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

14. S/he states that he is a girl or a woman
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

15. S/he talks about not liking his/her sexual anatomy (private parts)
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

16. S/he talks about liking his/her sexual anatomy (private parts)
    a. everyday
    b. frequently
    c. once-in-a-while
    d. rarely
    e. never

Appendix D: Child Behavior Checklist (CBCL)

Below is a list of items that describe children and youths. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0.** Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)
1 = Somewhat or Sometimes True
2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe):
_____

0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts

0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet

0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long

0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe):
_____ _____

0 1 2 10. Can't sit still, restless, or hyperactive

0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness

0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot

0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others

0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide

0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things

0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home

0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well

0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving

0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere

0 1 2 29. Fears certain animals, situations, or places, other than school (describe):

_____

0 1 2 30. Fears going to school

0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect

0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her

0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights

0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble

0 1 2 40. Hears sounds or voices that aren't there (describe):

_____

0 1 2 41. Impulsive or acts without thinking

0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating

0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense

0 1 2 46. Nervous movements or twitching (describe):

_____

0 1 2 47. Nightmares

0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels

0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded

0 1 2 52. Feels too guilty
0 1 2 53. Overeating

0 1 2 54. Overtired without good reason
0 1 2 55. Overweight

0 1 2 56. Physical problems ***without known medical cause***:
0 1 2 a. Aches or pains (**not** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (**not** if corrected by glasses) (describe):

_____

0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches

0 1 2 g. Vomiting, throwing up
0 1 2 h. Other
(describe):_____

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skins, or other parts of body
(describe):_____

0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids

0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain actions over and over; Compulsions
(describe):_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot

0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe):
_____
0 1 2 74. Showing off or clowning

0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids

0 1 2 77. Sleeps more than most kids during day and/or night (describe):
_____
0 1 2 78. Inattentive or easily distracted

0 1 2 79. Speech problem (describe):
_____
0 1 2 80. Stares blankly

0 1 2 81. Steals at home
0 1 2 82. Steals outside the home

0 1 2 83. Stores up too many things he/she doesn't need (describe):
_____
0 1 2 84. Strange behavior (describe):
_____
0 1 2 85. Strange ideas (describe):
_____

0 1 2 86. Stubborn, sullen, or irritable

0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot

0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language

0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe):

_____

0 1 2 93. Talks too much
0 1 2 94. Teases a lot

0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much

0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking

0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe):

_____

0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy

0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud

0 1 2 105. Uses drugs for nonmedical purposes ***(don't*** include alcohol or tobacco) (describe):

_____

0 1 2 106. Vandalism

0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed

0 1 2 109. Whining
0 1 2 110. Wishes to be the opposite sex

0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries

113. Please write in any problems your child has that were not listed above:

0 1 2 _____

0 1 2 _____

0 1 2 _____

Appendix E: Gender Role Beliefs Scale (GRBS)

Instructions: Please respond to each of the following items by circling the number that represents how much you agree or disagree with each statement.

1. It is disrespectful for a man to swear in the presence of a lady.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

2. Women should not expect men to offer them seats on buses.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

3. Homosexual relationships should be as socially acceptable as heterosexual relationships.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

4. The initiative in courtship should usually come from the man.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

5. It bothers me more to see a woman who is pushy than a man who is pushy.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

6. When sitting down at the table, proper respect demands that the gentleman hold the lady's chair.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

7. Women should have as much sexual freedom as men.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

8. Women should appreciate the protection and support that men have traditionally given them.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

9. Women with children should not work outside the home if they don't have to financially.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

10. I see nothing wrong with a woman who doesn't like to wear skirts or dresses.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

11. The husband should be regarded as the legal representative of the family group in all matters of law.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

12. I like women who are outspoken.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

13. Except perhaps in very special circumstances, a gentleman should never allow a lady to pay the taxi, buy the tickets, or pay the check.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

14. Some equality in marriage is good, but by and large the husband ought to have the main say-so in family matters.

1	2	3	4	5	6	7
Strongly Agree			Undecided			Strongly Disagree

15. Men should continue to show courtesies to women such as holding open the door or helping them on with their coats.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

16. It is ridiculous for a woman to run a locomotive and for a man to darn socks.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

17. A woman should be as free as a man to propose marriage.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

18. Women should be concerned with their duties of childrearing and housetending, rather than with desires for professional and business careers.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

19. Swearing and obscenity is more repulsive in the speech of a woman than a man.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

20. There are some professions and types of business that are more suitable for men than women.

1 2 3 4 5 6 7
Strongly Agree Undecided Strongly Disagree

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