A qualitative study exploring the experiences of services of parents of pre-pubertal children who identify in gender diverse ways

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Contents

Abstract

In recent years, there has been an increased interest in families who raise children that express themselves in gender diverse ways alongside a dramatic increase in the number of referrals to clinics. Research on the experiences of parents is, however, very limited. Furthermore, gender diversity in very young children (i.e. pre-pubertal) raises many emotionally, ethically and morally charged dilemmas, which parents often seek help for. Learning about the experiences of supporting a child during social transition alongside professional help, may help to inform future clinical practice and enable families to be supported in a way they find most helpful. Ten parents (six mothers, four fathers) of pre-pubertal children who expressed themselves in gender diverse ways, and had socially transitioned, were recruited through a specialist gender clinic. Each parent participated in a face-to-face interview where they were asked about their experiences of raising their child while receiving help from professionals. Adopting a Constructivist Grounded Theory methodology, data were analysed through an iterative process of constant comparison, leading to the construction of a substantive theoretical model grounded in the data. The category of 'Transition' captured the essence of parents' experiences. It represents the time during which the parents did, or did not support the child through moving away from their assigned gender to the desired one; firstly on their own, and gradually with the support of friends, their community and professionals. The resultant model explicates the dynamic and relational process of 'Transition' as the core category which is directly influenced by, and influencing, many other factors. The model is considered in relation to extant literature and implications for clinical practice and future research are discussed.

Introduction

This study is concerned with the experience of parents of pre-pubertal children who are expressing themselves in gender diverse ways. It begins with the description of relevant terminology related to gender identity. Research into the aetiology of gender diversity is then summarised alongside the development of interventions and support such parents have been offered. The current social and political context in which support is offered and received is described. The chapter finishes with a systematic literature review of parents' experiences of bringing up a gender diverse child.

Language Related to Gender Identity

The language used to describe gender identity is very rich and many terms are loaded with a variety of meaning. I have aimed to take a broad view and review different positions. I would, however, like to acknowledge that some of the explanations below would be acceptable to some and not to others.

Gender

The term *gender role* was first defined by Money (1955) as:

> *All those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively. It includes, but is not restricted to sexuality in the sense of eroticism. Gender role is appraised in relation to the following: general mannerisms, deportment and demeanour; play preferences and recreational interests; spontaneous topics of talk in unprompted conversation and casual comment; content of dreams, daydreams and fantasies; replies to oblique inquiries and projective tests; evidence of erotic practices, and, finally, the person's own replies to direct inquiry*.

Diamond (2002) describes *gender* as socially and culturally constructed roles, behaviours, attributes and expectations that a given society considers appropriate for men and women. The term *gender identity* was first introduced in the 1960s by a gender identity research

group at the University of California and describes a person's subjective sense of congruence with a particular gender (Di Ceglie, 2010). Cohen-Kettenis and Steensma (2016) describe a wide spectrum of identity labels such as: third gender (neither male nor female) and gender fluid (alternating between male/female or at various positions between male/female). Gender variant, gender non-confirming, gender non-normative, or gender atypical are often used as umbrella terms for what clinical literature describes as transgender. Most recently, the term *gender diversity* became the preferred term (European Association for Transgender Health, 2019). This is also the term which will be used in this study as it is an inclusive category capturing a range of subjectivities, each with its own specificities, alongside the researcher's expression of a non-pathologising position of different ways in which gender can be expressed. Occasionally, this term will be replaced with 'transgender' in the result section, to reflect the same language the participants chose to use.

Developments in diagnosing gender diversity

In Western contexts, those whose identifications, behaviours and attributes are inconsistent with those expected for their biological sex, have a feeling of inappropriateness with it and experience significant distress, may receive a mental health diagnosis (Wiseman & Davidson, 2011). Over the past thirty years, five different diagnoses have been published. Firstly, Stoller (1968) created 'male childhood transsexualism' based on the fixed belief of a boy that 'he is a member of the opposite sex and will grow up to develop the anatomical characteristics of the opposite sex' (p. 195). In 1977, Rosen et al. distinguished between cross gender identification and gender-behaviour disturbance. This distinction was found unsatisfactory as many individuals present with both categories (Bentler et al., 1979). The *International Statistical Classification of Diseases and Related Health Problems* (10th ed., text rev.; *ICD-10;* World Health Organization [WHO], 2010) states that 'the diagnosis of Gender Identity Disorder requires a profound disturbance of the 'normal gender identity', and that mere 'tomboyishness' in girls and girlish behaviour in boys is not sufficient'. In 1992, the diagnosis of Gender Identity Disorder entered the *Diagnostic and Statistical*

Manual of Mental Disorders (4th ed.; *DSM-IV*; American Psychiatric Association [APA], 1994). This was defined as 'a strong and persistent cross-gender identification' and 'persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex'. What is important to note is that the diagnosis depends on what Wren (2000) describes as 'self-ascription criteria', meaning that the individuals must 'self-diagnose'. This has been troubling clinicians and academics and the validity and reliability of the concept has been heavily questioned (Wiseman & Davidson, 2012). Many also criticised the name and the presumptions of gender being 'disordered'. Following this, the name was changed to Gender Dysphoria in the fifth edition of the *DSM* (*DSM-5*; APA, 2013). This term aims to de-pathologise such experiences by acknowledging the discomfort associated with the incongruence as a clinical problem, rather than the incongruence itself. It further aims to recognise that such incongruence does not necessarily have to cause distress to the individual.

The diagnosis, however, continues to be criticised. Newman (2002) argues that the discourse of such a diagnosis divides the world into masculine and feminine resulting in hesitation to explore the variety of gender expressions and therefore it continuous to pathologise. Additional difficulties arise when diagnosing children as many of the behaviours described in the diagnostic criteria (see Table 1) are considered to be typical of children's development and gender/sex exploration.

Table 1.

Diagnostic Criteria of Gender Dysphoria in Children in the DSM-V (DSM-5; *APA, 2013*)

A. The child will have a significant incompatibility with the gender he identifies with and the gender he was born with, and it lasts a minimum of six months. Diagnosis is given if the child exhibits a minimum of six of the criteria below, which must include the first item: 1. An intense want to be the opposite gender or persistence that he is the opposite gender (or a different gender other than the one he was born as). 2. Boys who were born as males have a prevalence toward cross-dressing or wearing clothing that is seemingly more feminine. Girls who were born as females prefer

dressing in what would be considered men's clothing and are powerfully opposed to dressing in regular female apparel

3. When it comes to creative play or making up games, the child has the desire to be in the other gender's role.
4. The child would rather play with the toys or be included in the activities that are usually deemed appropriate for the opposite sex.
5. The child chooses to play with children of the opposite sex.
6. Boys will refuse to play with toys that are considered those that are usual for boys. Girls will rebuff games and toys that are generally meant for females.
7. The child will have an intense dismay with the sexual parts of his body.
8. The child wants the primary/secondary sex features that are equal to the experienced gender.

B. The child has extreme anxiety and stress, as well as problems with functioning in social circles, school and other situations.

Sex

Sex has, since classical times, been referred to biological factors determined through applying agreed biological criteria classifying people as females or males (Diamond, 2002). Paterski (2008) summarises physiological criteria determining sex as karyotype (a specific chromosomal combination, with 46 XX karyotype in females, 46 XY karyotype in males); gonads (ovaries in females, testes in males); external genitalia (labia and clitoris in females, scrotum and penis in males) and secondary sex differentiation in puberty. Le Roux (2013) explains that in everyday life, sex is most commonly assigned at birth on the basis of a child's external genitalia and follows a binary, dichotomous model resulting in humans being considered as perfectly dimorphic species of only two kinds. Such views have however been criticised (e.g. Fausto-Sterling, 2000; Kessler, 2000) and supported by the evidence of individuals who have 'intersex conditions', meaning that their bodies are insufficiently dichotomised on a chromosomal, gonadal, hormonal or genital level. The evidence therefore shows that sexual anatomies can vary considerably and the two-sex system limits our understanding of diversity within sexes.

Social transition

Social transitioning refers to a person making changes in appearance and social situations to reflect their gender identity. This may include changes to their name and the use of pronouns, hairstyle and clothing, and use of different bathrooms and other gender assigned facilities (Marneffe, 1997).

Approaches to social transition

There are three different ways in which social transition is approached in society: supporting social transition, discouraging it and the 'wait-and-see' approach. Each of these approaches is accompanied by different ethical dilemmas and even though these have been widely discussed, a consensus among professionals regarding the best solution is yet to be reached (Edwards-Leeper, Leibowitz, &Sangganjanavanich, 2016). The reasons underlying the supportive pre-pubertal social transition are that it helps the child to affirm their gender identity at the time; it provides the message that gender diverse identity is not pathological and is therefore thought to minimise shame. The *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7thed; World Professional Association for Transgender Health [WPATH], 2011) states that social transition leads to an initial improvement in mental health. Alternatively, the reasons to discourage social transition are based on the evidence that a large proportion of young people will not persist as gender variant and will later be faced with having to transition twice (Kohen-Kettenis&Steensma, 2016). The wait-and-see approach suggests neither encouraging nor discouraging gender behaviours and allows the child to be gender neutral or fluid. This approach has been highlighted as difficult to pursue due to societal influences which are very often presented as binary.

Physical transition

Physical transition refers to medical interventions which aim to alter the sex characteristics of the biological body to make it congruent with the gender identity the individual feels themselves to be (Hembree et al., 2009). These interventions include hormonal treatment and surgeries. In biologically assigned men these include penectomy

(removal of the penis), vaginoplasty (creation of a vagina) and breast augmentation. Individuals who began suppression early in puberty and do not have sufficient penile skin for vaginoplasty need adjusted surgical procedures, such as using colon tissue.

In biologically assigned women these include hysterectomy/ovariectomy (removal of uterus/ovaries), vaginectomy (removal of vagina), and phalloplasty (construction of a penis). Phalloplasty is still considered to be a complicated procedure and many opt for neoscrotum (scrotum created from the labia) with testicle prosthesis with or without a metaidoioplasty (transformation of the hypertrophic clitoris into a microphallus).

Young people's specialist gender clinics report that around 30-50% of adolescents are referred to adult services that offer such surgeries (Zucker& Bradley, 1995; Wren, 2000).

Aetiology

To date, no studies have been able to identify a single cause which would lead to the development of gender variance (Di Ceglie, 2000). There are, however, several theories exploring possible contributing factors.

Biological theories

Biological theories suggest prenatal hormonal influence on brain development (Stainton Rogers &Stainton Rogers, 2001). Studies in this area often examine individuals who have been inadvertently exposed to atypical hormonal levels whilst in the womb. Research by Auyeung et al. (2009) and Pasterski et al. (2011) suggests that if female babies are exposed to high levels of androgen-based testosterone in the womb, they are more likely to prefer stereotypical male activities. Further, some anatomic brain differences have been found by Zhou et al. (1995) and Goldstein et al. (2001). Their results revealed that magnetic resonance imaging scans of male and female brains show some differences. Similar differences were found in the brains of homosexual men. Furthermore a number of studies have noted greater concordance of gender diverse identities within families (e.g. Bill, 1981; Sabalis et al., 1974). Genetic factors have been measured by examining greater concordance of gender diversity in monozygoticand dizygotic twins. Studies have shown a

greater percentage of gender diversity in monozygotic twins (e.g. Veale, Clarke, & Lomax, 2009)

Hembree et al. (2009) concludes that despite some evidence supporting biological origins being found, it is insufficient and biological evidence cannot substantiate this perspective. Biological theories, however, have been found to be popular with parents (e.g. Wren, 2014) as they are perceived as non-judgmental and non-blaming. There is a body of research which criticises the biological model and its relation to the diagnosis of gender diversity (Brooks, 2000).

Psychological theories

Psychological theories often criticise biological approaches for a lack of consideration of individual factors as well as viewing gender as 'static' and factual rather than a fluid construct created by a human need to sense-make (Kitzinger, 2004). Psychological theories of gender diversity draw on social learning and psychodynamic approaches. Social learning theories propose that children learn 'typical' behaviours from the modelling of important others. These behaviours are then reinforced (Bandura, 1977). These theories are often criticised as they view the child as too passive. Psychodynamic approaches view gender as a fluid concept which develops in relation to others. This is based on Freud's concept of psychosexual stages and the unresolved Oedipus conflict (Tyson, 1982). Di Caglie (1998) also suggests that gender variation can function as a defence mechanism in relation to a traumatic event in childhood.

Social theories

Social theories often enrich the concept of gender by not only considering the individual's experiences but also the historical and cultural context in which they occur. They often explore cultural variation in relation to gender and how differently it can be conceptualised in different parts of the world. Robertson (1989) writes about the Mahu population in Hawaii and describes their views of those whose biological sex is incongruent with their gender identity as compassionate and creative. Newman (2002) suggests that these cultural and historical differences are indicative of there being no fixed relation

between the body, psychological identification and social manifestation of gender. Social theories therefore emphasise how inherently unstable binary gender understanding is and often challenge Western forms of classification. As such, social theories lean towards non-normative gender explanations and criticise medical and psychological theories for being 'narrow'. Further to this, gender as a fluid concept was influenced by feminist theory (Butler, 1990), closely related to post-structuralism. Butler (1993) questioned the idea of gender as a social construct directly linked to biological bodies and argued that this restricts our understanding that gender can be thought of separately from sex. Hines (2007b) explains that separating these two concepts would allow for greater diversity in gender expressions that are not necessarily associated with the assigned sex.

Similar to postmodern feminist thinking, queer theorists, heavily influenced upon by Lacan's psychoanalytic model of a de-centred self (2002) and Derrida's (1967) ideas of deconstructing binary linguistic structures, take the stance of gender identities being socially constructed. This offers a framework for thinking about gender diversity in a non-pathological manner by rejecting the idea of fixed gender identities and more generally 'the idea of normal behaviour' (Warner, 1993). This is based on Foucault's (1980) idea that the world is without a universal truth. He was interested in how we construct our individual truths and how we understand the multiple forms of difference in them. Concerned with how dominant discourses become 'natural' in cultural and historical context and thus lead to other ways of becoming perceived as 'unnatural', he believed that by deconstructing these dominant constructs, alternative ways of seeing the world would emerge. Critics argue however, that the deconstruction of identities has paradoxically led to a homogenous grouping of gender diversity as a distinct identity category (Seidman, 1993) and therefore fails to account for the variety of experiences gender diverse individuals report (Hines, 2006).

Development of Gender Diversity

Overall, childhood gender diversity has been found to be fluid and subject to various developmental outcomes (Saketopoulou, 2013).

The persistence and desistance of gender diversity

Studies concerned with the persistence and desistence of gender diversity have found only modest persistence rates of childhood dysphoria into adulthood. Drummond et al. (2008) found that only 12% of participants assigned as females at birth who expressed themselves as gender varied in childhood wished they had been born as boys and wondered if they would be happier as boys, however only one of them actually lived as a man. Similar results were reported by Wallien and Cohen Kettenis (2008) and Singh (2012). Overall, studies have reported that the percentage of children who persist falls between 12-27%. From these results, it could be concluded that the percentage of persistence of gender variance past puberty is fairly modest. It could also be suggested that there is plasticity in gender identification which might operate in childhood yet narrows considerably in adulthood.

The factors that specifically contribute to an intensifying or lessening of feelings of gender dissatisfaction were explored by Steensma et al. (2011). The main difference between the participants who continued to feel dissatisfied with their assigned sex and the participants who did not was the 'severity' of the cross-gender identification. While the first group felt that 'they were the other sex' ("I did not 'want' to be a boy, to me, I was a boy"), the latter group identified as 'girlish boys' or 'boyish girls' and only 'wished to be the other sex' ("I knew I was a girl, but one who wished to be a boy"). Further significant differences were reported during pubertal development. Firstly, participants reported noticing more distinct social differences between boys and girls resulting in either a strong sense of not belonging or becoming more comfortable in their assigned sex. Secondly, experiencing pubertal body changes resulted in either increased aversion towards them or disappearance of the discomfort. Thirdly, it was their first relationships which seemed to have an important role. Participants who continued feeling unsatisfied with their gender remembered feeling attracted to persons of the same assigned sex which to them confirmed their gender identity as they viewed this attraction as heterosexual. Others felt that falling in love with the opposite sex resulted in disappearance of gender variance. Furthermore, much of the

research shows that gender diverse adolescents (unlike pre-pubescent children) almost invariably become gender diverse adults (e.g. Stroller, 1992; Zucker& Bradley, 1995).

Due to the variety of results and frequent methodological limitations, it is however almost impossible to predict if gender diversity will persist into adolescence and beyond. One can appreciate the dilemma these unclear results present for parents of gender diverse children who seek help, as well as the professionals working with these families who often expect clear solutions.

Intervention and Support

Psychological support

Historically, behavioural and psychoanalytic approaches have been the most prevalent in the 'treatment' of gender variance. Currently such approaches are often viewed as pathologising by many families and professionals. Affirmative approach to care used by most gender clinics in the world will be discussed in light of recent societal and political developments.

Behavioural approaches

Historically, children who presented to clinics were treated by behaviour modification using positive reinforcement for gender 'appropriate' play and socialising. Bates et al. (1975), in describing their intervention with 'gender-disturbed boys', conclude that feminine behaviours expressed by males is problematic and requires professional help. It was further believed that gender diverse children were at high risk of developing homosexuality, transvestism or transexualism. It was also believed that gender variant children were unhappy and supporting them in living as their assigned sex would lead to their 'greater happiness' (Bates et al., 1975; Rekers, 1972). Parents of those children have also been targets of such corrections themselves and advised to discourage such behaviours (e.g. Green et al., 1972). Corrective interventions continue to be encouraged and report high success rates (Zucker, 2008; Zucker et al., 2012). Anthon (2010) however, reported contradictory evidence, calling such approaches unsuccessful and lacking in efficacy. More recently Wallace and Russell

(2013) analysed behavioural approaches and reported that such interventions foster shame which negatively impacts on the parent-child relationship.

Psychoanalytic approaches

Several psychoanalytic theories were used to explain gender diversity and often linked it to the primary relationship the individual has with their mother, especially their identification with her (e.g. Argentieri, 2009; Stroller, 1985). Tyson (1982) describes gender diversity in boys as a failure to dis-identify with their mothers and therefore a failure to resolve the Oedipus complex (Freud, 1905). Di Carlie (1998) observed that girls who perceived their mothers as weak identified with their physical masculine characteristics in order to allow the psyche to survive. This theory has since been developed by Zucker and Bradley's (1995) who found that the majority of gender variant children have insecure attachments and suggest that gender dysphoria is developed to reduce this anxiety. Coates et al. (1991) and Marantz and Coates (1991) reported that such insecure attachments are caused by mothers who often suffer with depression and/or 'personality disorder' and are emotionally unavailable to their child. They suggest that as a result a male child might over-identify with their mother to protect themselves from further maternal losses which might happen in the future. This was supported by a now dated audit from the Gender Identity Development Service at the Tavistock in London, which found that 42% of children referred to the service had lost at least one of their parents and 26% were in care (Di Ceglie, 2002). For the reasons above, traditional psychoanalysis is often considered to be unhelpful, pathologising gender diverse adults (Corbett, 2011; Salamon, 2010). It has been further criticised for its limited focus on the individual psyche and not giving enough attention to social aspects of a person's development (Grossman, 2002). Even though research into the views of parents of gender diverse children on such theories is limited, Corbett (2011) found that some parents of gender variant children experienced traditional psychoanalytic theory as challenging and often reject these ideas.

In the more recent years, psychoanalysis has begun to take up more curious position regarding gender diversity and has begun to move away from presumptions of pathology

and ‘curing’, challenging the ideas outlined above. Goldner (1991, 2003), Harris (2000, 2005), and Dimen (2003, 2005) argue for gender as a spectrum and suggest that all of us carry socially constructed feminine and masculine attributes within us. Furthermore, psychoanalysis has become more concerned with the interactions between in the inner world, body, society and culture in general. Contemporary gender theory no longer views gender diversity as a symptom but rather as a viable subjective reality (Saketopoulou, 2013). Interest has therefore moved away from aetiological factors and rather aims to understand unconscious phantasy and how it is mobilised to manage the painful incongruence between the gender and the body once it has already formed (Ehrensaft, 2009, 2011, 2013). Psychoanalytically oriented psychotherapists further support those parents who struggle with what their child might present them with. They allow parents to confront their own beliefs and anxieties related to gender diversity so they can enable their children to find their true gender identity. This is called ‘True Gender Self Therapy’ and it is based on three principles: ‘If you want to know a child’s gender, ask the child. It is not ours to tell but the child’s to say’; ‘Parents have little control over their child’s gender identity but tremendous influence over their child’s gender health’; ‘Children who are gender variant are not suffering from a disorder but are demonstrating a healthy, creative variation of gender ‘ (Ehrensaft, 2011, p.531).

Affirmative care

Affirmative care is a non-pathologising model of care which developed recently in the context of gaps in scientific evidence for the above approaches (Hidalgo et al., 2013). It is based on several premises: gender variations are not disorders; gender presentations are diverse and varied across cultures and require cultural sensitivity; gender involves an interplay of biology, development, socialisation, culture and context; gender may be fluid and it is not binary; if there is pathology, it more often stems from cultural reactions rather than from within the individual. Affirmative practice is defined as ‘a child’s opportunity to live in the gender that feels real or most comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection’ (Hidalgo, 2013, p. 286). It implies that

gender identity experiences asserted by the young person or their families are true, and that the professionals' role is to empathically support their assertions (Edwards- Leeper, Leibowitz,&Sangganjanavanich, 2016).

Research has shown that young people who are not allowed to assert their experiences by other systems (e.g. parents, schools) are at a higher risk of developing mental health difficulties and experiencing social adversities (Toomey, Ryan, Diaz, Card,& Russell, 2010). Even though affirmative care is yet to be supported by rigorous empirical evidence, the approaches we have so far have led to individuals being negatively impacted by professionals and families who insist on traditional gender expressions matching their birth assigned gender.

In accordance with the guidance published by the Royal College of Psychiatrists (1998) and the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7thed; WPATH, 2011), and more recently the American Academy of Pediatrics (Jafferty, 2018), the current treatment in many clinics around the world based on affirmative care is based on a four stage model (see Table 2). Stages 2-4 are discussed in detail in subsequent sections.

Table 2.

Four Stage Model of Management of Gender Variance

Stage	Description
1	Therapeutic exploration with several main aims (Di Ceglie, 1998a): - to foster recognition and non-judgmental acceptance of gender identity problems - to ameliorate associated behavioural, emotional and relationship difficulties (Coates & Spector Person, 1985) - to break the cycle of secrecy - to activate interest and curiosity by exploring the impediments to them to encourage exploration of the mind-body relationship by promoting close collaboration among professionals in

	different specialities, including a paediatric endocrinologist, - to allow mourning process to occur (Bleiberg et al., 1986) - to enable symbol formation and symbolic thinking (Segal, 1957) - to promote separation and differentiation - to enable the child or adolescent and the family to tolerate uncertainty in gender identity development - to sustain hope.
2	Wholly reversible interventions. This involves the use of hypothalamic blockers.
3	Partially reversible interventions such as cross sex hormones
4	Surgical procedures.

Medical Support

Even though medical treatment has been found to be helpful for many gender diverse individuals and supported by many professionals (Hembree et al., 2009), it has also been met with frequent critique and controversy as it could be seen as a biological answer to psychological distress (Raymond, 1979). For example, a comparison was made by McHugh (1995) between the diagnosis of gender dysphoria and anorexia nervosa. He argues that both individuals view their bodies as the source of distress and questioned why professionals amputate the genitals of gender diverse patients if they do not provide liposuction for patients with body image issues. Cohen- Kettenis et al. (2008) explained that the aim of medical procedures is not to relieve psychic pain, but rather interfere with the integrity of a healthy body. Medical treatment which alters the body has been viewed as even more controversial when treating young people due to the common belief that gender diversity is only fully consolidated in adulthood. Wren (2000) acknowledges a trend of more young people being interested in medical treatments as they become more sophisticated. There is some evidence highlighting the benefits of medical interventions. Spack et al.'s (2012) study suggests that "psychological functioning improves with medical intervention" (p. 422). Anecdotal observations from Ehrensaft (2013) suggest that the availability of hormone blockers has been a great gain for the gender diverse population as they eliminate what

could potentially be a traumatising experience in the development of secondary sex characteristics. These claims have been met with disagreements and challenges. Tanner (2012) discusses the ethical issues which could be breached in following these results blindly and without caution. They suggest for families' motives to be always examined.

Hormonal treatment

Hypothalamic blockers, which are gonadotropin releasing hormone (GnRh), suppress oestrogen and testosterone production and are used to prevent the development of puberty and therefore secondary sexual development (e.g. budding of breasts in girls, and testicular growth in boys) (De Ceglie, 2008). Their effects are wholly reversible and spontaneous pubertal development resumes immediately.

Hembree et al. (2009) published guidelines for endocrine treatment for gender diverse individuals. In light of research which indicates that young people's distress with their bodies becomes significantly enhanced by pubertal development which they describe as unbearable, many clinics around the world have decided to begin hormonal treatment for individuals younger than eighteen. Indeed, in the last ten years, hormonal treatment for gender diverse young people became increasingly accepted and part of physical intervention in a number of clinics in Europe, Australia, Canada and the USA (Cohen-Kettenis et al., 2011).

Hembree et al (2009) recommends that suppression of pubertal development should be initially undergone when the first pubertal signs are exhibited and confirmed by levels of estradiol and testosterone. Additionally, adolescents must fulfil the eligibility and readiness criteria. These include fulfilling the *DSM-V* (APA, 2013) diagnostic criteria, experiencing puberty till at least Tanner stage 2 (see Table 3), having pubertal changes that have resulted in an increase of gender dysphoria, not suffering from psychiatric comorbidity that interferes with the diagnostic work-up to treatment, having adequate psychological and social support during treatment and demonstrating knowledge and understanding of the expected outcome of GnRH. The Royal College of Psychiatrists' guidance (1998) recommends that young

people should have some experience of themselves in the post-pubertal state of their biological sex.

Cohen-Kettenis et al. (2008) put forward several arguments for pubertal delay. Firstly, they argue that postponing the start of medical treatment can lead to additional psychological difficulties such as depression (de Vries et al., 2011), self-harm (Dickey, 2011), suicidality (Grant et al., 2011; Sadowski& Gaffney, 1998) and social phobias (Di Ceglie et al., 2002). Secondly, they suggest that suppressing puberty gives the individuals and their families more time to explore their gender identity. Thirdly, children who decide to live permanently in the desired gender role would be spared from having unwanted secondary sex characteristics; which would avoid having to undergo some forms of surgery in later life. Lastly, if this treatment is not offered to the children, they and their families might try to access it through different means or withdraw from professional help.

Delay of pubertal development has, however, been criticised by other specialists. Hembree et al. (2009) warns about early treatment limiting the growth of a penis and scrotum possibly resulting in difficulties when creating a vagina from scrotal tissue. Further, questions have been raised about the experience of body development and one's reaction to it being necessary for the young person to make an informed choice. Some suggest that gender identity might still be fluctuating during adolescence (e.g. Korte et al., 2008; Viner, Brain, Carmichael and Di Ceglie, 2005). Additionally, the emotional and cognitive maturity of young people to give such consent has also been questioned (Wren, 2000). Lastly, Cohen-Kettenis et al. (2011) also acknowledge that most of the young people who were treated by GnRH are still in their 20s or early 30s and therefore very little is still known about the long-term effects of the treatment on young people. Wren (2000) encourages clinicians to consider what is being communicated to the individuals by postponing puberty development and further, and what it commits them to do next.

The next hormonal stage includes cross-sex hormones which can be administered to young people who wish to transition to the 'correct' gender. Unlike GnRh, the effects of cross-gender hormones are irreversible. Hembree et al.'s (2009) guidelines recommend for

pubertal development of the desired sex be initiated at the age of sixteen, using a gradually increasing dose schedule of cross-sex hormones.

Table 3.

Description of Tanner Stages of Breasts Development and Male External Genitalia

For breast development:

1. Preadolescent
2. Breast and papilla elevated as small mound, areolar diameter increased.
3. Breast and areola enlarged no contour separation.
4. Areola and papilla from secondary mound.
5. Mature, nipple projects, areola part of general breast contour.

For penis and testes:

1. Preadolescent.
2. Slight enlargement of penis, enlarged scrotum, pink texture altered.
3. Penis longer, testes larger.
4. Penis larger, glans and breadth increase in size, testes larger, scrotum dark.
5. Penis and testes adult size.

Sex-reassignment surgery

Sex-reassignment surgery is an irreversible intervention. Hembree et al. (2009) recommend it for adolescents who are receiving cross-hormone treatment and are satisfied with the effects alongside the social role change, and desire definite surgical changes. The age currently viewed as appropriate is eighteen years. The *Standards of Care for Gender Dysphoria* (6th ed.; Harry Benjamin International Gender Dysphoria Association, 2001), however, specify that the suggested age of eighteen should be seen as an eligibility criterion rather than an indication in itself for active intervention.

Professional Support to Families Whose Children Express Gender in Diverse Ways

The model of care at Gender Identity Disorder Development, Tavistock, London

The Gender Identity Development Service (GIDS) at the Tavistock Clinic, London developed a model which aims to assist the development of the children and young people so that they do not acquire other difficulties. They also support the families to understand that their child might be feeling differently to other children about their gender and help them to communicate openly to break the cycle of secrecy often surrounding these issues. Their

further hope is to invite different possibilities during the course of development and enable the child and the family to tolerate some uncertainty about the possible outcomes of their gender identity development. Table 4 describes the aims in more detail. It is recommended that these are achieved through a combination of family therapy, child psychotherapy, parental support/counselling, consultation with the network, reviews to monitor gender identity development, group work for parents, possible referral to the paediatric liaison clinic for physical assessment. The practice of GIDS adheres to the four stage model described in detail above in Table 2.

Experiences of professionals working with gender diverse children and their parents

Increasingly high numbers of gender diverse children and young people have been reported to seek support from services over the past ten years. The rise of referrals to GIDS was reported as increasing from 97 in 2009 to 2,519 in 2018. Professionals are faced with the challenge of providing best practice in the absence of a strong evidence base on what the best treatment might be. They are therefore in a position to guide very important decision-making at critical points in young people's lives. They have to take into consideration the complex interplay of developmental, psychological, familial and social factors. As a result, many important ethical and clinical implications need to be considered when thinking about the appropriate support for gender variant children and their families (Dresher & Pula, 2014). Wren (2000) summarises the evidence and discourse impacting on the decisions made (Table 5).

Table 5.

Evidence and Discourse Impacting Treatment Decisions

Arguments for early physical intervention	Arguments against physical intervention
Powerful message from young people and their families that their lives are unbearable without physical treatment	Possible regrets when irreversible decisions were made
No evidence that psychological treatment can alter gender identity	Possibility that desistence might be triggers by puberty itself
Evidence from only one study of a good outcome of early intervention	Risk that lowering the age of treatment may increase the incidence of what are euphemistically called ‘false positives’
Knowledge of the risks of more radical surgeries if treatment is postponed until adulthood	Uncertainty about the long-term implication of physical treatment
No credible accounts of aetiology that allow to rule in gender dysphoria as a physiological illness	

While considering the above, many difficult questions need to be considered. Knowing about the distress it causes, should we, as professionals, ‘treat’ it or try to prevent it? What are the implications of staying with uncertainty and helping families to wait before important decisions are made? And what would be the implications of this for children whose dissatisfaction does persist? Di Ceglie (2008) acknowledges that professionals working in such service often experience pressure during their work, related to becoming involved in approaches which might be unhelpful or potentially harmful alongside pressures from wider systems, such as user or activist groups, the media, and the management team of their service. This is likely to contribute to the challenges of making such decisions.

Recently, articles have been published in national newspapers scrutinising the work of GIDS, suggesting rushed affirmation and failure to thoroughly assess the psychological and social factors that could lead to young people wishing to change their gender. In one recent article it was suggested that the reason behind this was to reduce staff caseloads (which had significantly increased in recent years) and 'fast track' young people to adult services where physical intervention is provided. The GIDS refused such allegations. Furthermore, a leading charity for families with gender diverse children offered a contrasting yet still critical view, suggesting the GIDS uses a 'watchful waiting' approach. It was argued that this involves an unnecessarily long assessment process resulting in long delays in physical intervention, which can have a negative impact on the young person and those around them (Bruskell-Evans & Moore, 2018).

It appears that trans-critical groups (e.g. 4th Wave, Purple Sage, YouthTransCriticalProffessionals, GenderCriticalDad) have begun to form recently in response to the affirmative approach becoming the dominant discourse. They resist it and actively promote resistance to it. A group of parents, Gender Critical Support Forum, recently heavily criticised those clinics which strictly follow affirmative approach as a response to the recent policy statement about medical treatment for gender diverse children issued by the American Academy of Pediatrics (Jafferty, 2018). Members of the Gender Critical Support Forum assert that affirmation therapy is a potentially harmful approach and urge the professionals to continue to be mindful of the contrasting evidence (GenderCriticalSupport, 2018).

Alongside the difficulties highlighted above, clinicians also need to carefully consider informed consent to treatment given by the young person, which comes with additional complicated factors. Wren (2000) highlights three key issues in relation to this. The first is related to the evidence suggesting a high percentage of desistance post puberty and therefore whether the young person needs to undergo the experience of puberty before they are able to make an informed choice. Secondly, whether it is truly possible for informed consent to be given considering how little scientific evidence we have about the impact of

the hormonal treatment. And thirdly, whether the young person has the emotional and cognitive maturity required to give consent.

Taking into account all of the above, Di Ceglie's (2008) metaphor of 'working at the edge' might explain why professionals often end up feeling similar to the individuals: being pulled in different directions, feeling confused and as if many decisions can be risky ones, often feeling that no decision is good enough, *'wishing to paint a coloured landscape when only white and black paints are available.'*

Experiences of Parents of Gender Diverse Children

Introduction

Whilst in the recent years, there appears to have been an increase in the interest in gender diverse children and their families in the media, the research exploring the experiences of said parents continues to be very limited (Gregor, Hignley-Jones, & Davidson, 2014).As stated above, raising a gender diverse child often comes with navigating the complexities of gender diversity, overcoming many challenges and making difficult decisions for them and those around them (Coulter, 2010). Additionally, it often raises emotive reactions and it is those reactions that alongside other factors might have an impact on their development. As the support of others, especially parents, has been shown to be essential in promoting the well-being of gender diverse children (e.g. Travers, Bauer, Pyne & Bradley, 2012) understanding their experiences may be valuable as it might help us to understand how they impact the children and their gender expression and its development.

Aim

A literature review was conducted to answer the following question: What are the experiences of parents who raise a gender diverse child?

Method

A search to identify the most relevant literature to answer the research question was completed using the exclusion and inclusion criteria. Articles were included if they looked at first hand experiences of parents who raise a gender diverse child. Given the nature of this particular thesis question, only qualitative studies were included in the search.

(Appendix A). Eight studies were selected and critically evaluated using the appraisal tools from the Critical Appraisal Skills Programme (2006). Both database and hand searches were included, however hand search yield no additional articles (Appendix A).

Results

Table 6 summarises the main information from the studies selected.

Literature characteristics

The search terms were informed by the researcher's thorough knowledge of area of gender diversity with a specific focus on researching the history of language development in the field, taking into consideration the change in society and politics. The search yielded eight peer-reviewed qualitative research articles sampling 113 people. The eight qualitative research articles had sample sizes ranging from five to forty-two. Six articles collected data through face-to-face individual interviews; one study used focus groups and one analysed written contributions in online forums. Two of these studies were conducted in the United Kingdom, two in Canada and six in the USA. Broader aims, methodology and results are summarised below. Further more, the findings of the studies were evaluated against the guidelines specified for good qualitative research in the Critical Appraisal Skills Programme (2006).

Literature appraisal

Overall, the qualitative research studies were of high quality. Aims were stated clearly and appropriate methodologies were adopted. Rigorous data analyses were undertaken and

findings were reported clearly. The amount of participant transcript data that was reported varied but the majority of studies chose appropriate quotes to support their findings. The main limitation for a considerable number of studies was a biased sample as most participants were recruited through specialist clinics and support groups with particular philosophies and approaches to treatment and support. Furthermore, a notable absence in almost all studies was a thorough commentary of the relationship between the researcher/s

and the participants and further evidence of reflexivity. This was especially important when the researcher was employed by the clinic through which the participants were recruited. Ethical issues were mentioned by some but not all studies.

Table 6.

Reviewed Literature

Author/s, Year, Title	Literature type	Location	Participants	Aim(s)	Methodology	General findings
Gray, S.A.O., Sweeney, K.K., Randazzo, R., & Levitt, H. M. (2015). "Am I doing the right thing?": Pathways to parenting a gender variant child	Qualitative research paper	United States of America	11parents (8 mothers and 3 fathers) to a 6 gender variant male, 3 gender variant females, two males and transitioning female	How does raising a gender variant child affects the family and the decision they make about their care	Grounded Theory	Parents attempt to pave the way to non-stigmatising childhood for the gender variant child 1. Through rescuing them from fear and stigma, 2. Through advocating for a more tolerant worlds.
Gregor, C., Hingley-Jones, H., Davidson, S. (2014). Understanding the experiences of parents of pre-pubescent children with gender identity issues	Qualitative research paper	United Kingdom	8 parents (5 mothers, 3 fathers) to 3 assigned females and 2 assigned males	Exploring how it might feel for families to parents a child with gender identity issues	Free Association Narrative Interviews/ Grounded Theory	Key themes: Loss, Uncertainty, Ambivalence, Being unable to think and Acceptance
Hill D. B., &Menvielle, E. (2009). "You got t give them a place where they feel	Qualitative research paper	United States of America	43 parents	Document issues faced by parents of gender varied children	Grounded theory	Core category: invisibility and non-recognition

protected and safe and loved": The views of parents who have gender-variant children and adolescents						
Kuvalanka, K. A., Weiner, J. L., Mahan, D. (2014). Child, family, and community transformations: Findings from interviews with mothers of transgender girls.	Qualitative research paper	United States of America	5 mothers of 5 assigned males	Describing the experiences before, during and after the children's social transition	Thematic Analysis	1. Children's demeanour and well- being improved 2. Improvement in responses in wider family and community over time
Norwood, K. (2012). Transitioning Meanings? Family members communicative struggles surrounding transgender identity.	Qualitative research article	United States of America	Unknown.	Experiences of transitions for transgender individuals and their families	Relational dialectics analyses of online posting	3 themes: presence vs. absence, sameness vs. difference, self-vs. other
Pyne, J. (2016). "Parenting Is not a job…It's a relationship": Recognition and Relational	Qualitative research article	Canada	15 parents	Explored the knowledge underneath affirmative stance, towards their gender non-	Grounded theory	Analysis revealed a process of recognition and knowledge of the children's needs is acquired though

knowledge among parents of gender non-conforming children.				conforming children.		relationship.
Sansfacon, A. P., Robichaud, M. J., Dumais-Michaud, A. A. (2015). The experience of parents who support their children's gender variance.	Qualitative research article	Canada	42 parents to 23 born males and 8 born females.	To understand the challenges facing parents in the process of supporting their children and effecting change around them.	Thematic analysis of over the phone interviews	Paths to acceptance were varied impacted by parents fear for their child's safety and self-education.
Wren, B. (2002). 'I can accept my child is transsexual, but if I ever see him in a dress I'll hit him': Dilemmas in parenting a trans-gendered adolescent.	Qualitative research article	United Kingdom	26 parents (14 mothers, 12 fathers) to 7 assigned females and 4 assigned males. All British.	How do parents with transgender children build an intelligible story of the child's gender identity How does this story shape their coping strategies.	Grounded Theory	Five main findings: 1. Communication about gender issues was handled with care, 2: Parental response to transgender was a moral issue, 3: iterative relationship between acceptance and active meaning making, 4: belief in biological causation of transgenderism, 5: difference between mothers and fathers.

Thematic summary

Thematic summary was guided by the thematic synthesis method outlined by Thomas and Harden (2008). Individual sources of literature were analysed using thematic analysis (Braun & Clarke, 2006).The analysis resulted in five broad themes and several subthemes summarized in Table 7.

Table 7.

Overview of Categories

Category	Subcategory
Acceptance	Journey to acceptance
	They were born like that
	Differences between mothers and fathers
	Ambivalent feelings
I lost my child	
Who will support us?	Professional service
	Schools
	Wider community
I am scared	

Acceptance

Acceptance emerged as a significant and rich theme. For clarity, it was divided to further four sub categories.

Journey to acceptance

"It was very tough adjusting to that and probably took me a year…or so, maybe a little bit more to realise that I wanted her to be happy."

Wren (2002) was the first to discuss the theme of acceptance and its importance. Even though non-acceptance emerged as a theme for some in her study, it was not as present, possibly as parents who wished to not engage with the issue were less likely to take part in

the study. Furthermore, an interaction between making-meaning and the tasks of practical coping was observed. Accepting parents were more likely to be active, not only being able to utilise help and support from others, but also by offering help. Non-accepting parents on the other hand had repetitive and inflexible strategies and hoped that the issue would disappear. They struggled to accept help from others and would easily become frustrated with professionals' lack of clear solutions. Hill and Menvielle's (2009) findings were similar to those discussed by Wren (2002). Some parents were able to manage their child's gender variance in a short time, whilst others went through a longer process. The latter group hoped for change and even monitored their child's gender choices, feeling that that they needed to 'draw a line' about which behaviour was acceptable and which was not. Sansfacon, Robichaud and Dumais-Michaud (2015) found that parents reported the necessity to recognise and accept the children as gender diverse. Participants were clear that it was not acceptable to deny their child's preferred gender, however acknowledged that the acceptance varied and could take some time. Gray, Sweeney, Randazzo, and Levitt (2015) further discussed about parents' dynamic journeys to rescue their children from being gender variant and/or accept their children and support them.

They were born like that

"I think now it's got a label it's easier perhaps than just the unknown. But I don't think it's helpful to have blame laid at the mother."

Wren (2002) discussed a belief in biological causation being supportive to the parents in the process of acceptance as it was found to be associated with a more benign view of their child. It appeared that biological views were often voiced by accepting parents and freed them to support their children as unlike psychological explanations, they were not understood as holding somebody to blame. Similarly, Sansfacon, Robichaud, and Dumais-Michaud (2015) found that parents' articulation of the medical understanding was popular as it lent certain legitimacy to their child's difference. However, even though labels were

understood as helpful especially when accessing services, it was in contradiction with how parents actually felt about their children, which was that they did not have illnesses.

Ambivalent feelings

"I can accept my child is transsexual, but if I ever see him in a dress I'll hit him."

Ambivalent feelings appeared to be an important part of the acceptance journey mentioned by many. Parents reported that when they first began to notice cross gender interests they predicted their child to be homosexual, and for many, this was more acceptable (Hill &Menvielle, 2009). Norwood (2016) discussed similar dilemmas. Parents in their research spoke about wanting to be supportive to their children, but often found it hard to do so because of their own beliefs and moral stands, emotional issues and lack of knowledge. Gregor, Hingley-Jone and Davidson (2014) found a theme which they called 'no thinking'. This theme talked to a similar issue of ambivalence about how and when to support their children. Parents talked about denial and disbelief leading the authors to suggest that a level of anxiety about what else they might discover being present. As a solution, parents often reported relying on others, such as teachers or mental health workers to broach the conversation about gender diversity.

Parents also reported wanting clear answers about aetiology. The medical model, as previously mentioned, appeared to fit well with many families, whereas psychological factors which might have contributed were widely rejected. However, participants did appear to be aware of Drummond et al (2008) and Wallien and Cohen-Kettenis's (2008) studies showing that the frequency of gender variance desisting. Some hoped that their child would revert back to their biological gender identity, others were certain they would persist. Holding a position of uncertainty appeared to be difficult. Ambivalence was characterised by parents wanting to do what was best for their child yet also feeling forced to only respond in one way. Kuvalanka, Weiner and Mahan (2014) also discussed parents' difficulty with a position of uncertainty. They reported that mothers dealt with this by moving from not knowing to

becoming experts and advocates for their children. Most of the knowledge they gained was reported to come from the internet and they felt that it helped them to reach acceptance more easily. Pyne (2016) described contrasting results about uncertainty and not knowing. The parents in their study reported adopting an open approach of not knowing and remaining open to the different possibilities of future outcomes. The authors summarise by acknowledging that even though the parents reported not knowing their child's experience of gender, they knew what the children needed from them. The final theme talked about just that. The parents explained how attuning to their children and being aware of their nonverbal language and affect in turn enabled them to know what the right thing to do was. Their relationship with their child was essential for them to be able to engage in this process and continue to offer affirmation despite all the challenges.

Differences between mothers and fathers.

"It seems like a man has a little more of a hard time and I tell him what I think and he just ignores it."

Some differences between the mothers' and fathers' accounts were found. The mothers felt that their task was to maintain the relationship with the child and foster understanding. Even though some fathers were broadly accepting, overall, their job did not seem to be engaging in the child's emotional journey, but rather to represent conventional moral and behavioural expectations. Hill and Menvielle (2009) also reported different paths to acceptance between mothers and fathers which often led to disagreements. Fathers again, were found to find acceptance harder, with some reporting ignoring the issues and others disapproving. It was found that empathy and acquiring wisdom by educating themselves supported them on their journey to acceptance. Lastly, Kuvalanka, Weiner, and Mahan (2014) observed that fathers struggled more than mothers and their journey to acceptance was noticed to be more complicated, but would eventually present. Mothers felt that they had to lead the way of supporting the fathers with this and fighting for their child.

I lost my child

"I just hate when she's dressed like that because, ummm, it just, it's not the same child. It's like somebody's taken my child and put back one that's not mine. "

Norwood (2012) found a theme of presence versus absence which described the experience of parents grieving the child they had lost, and then gaining another. Kuvalanka, Weiner, and Mahan (2014) reported siblings and wider family having similar experiences of loss. They reported that noticing how much happier the children were helped them to overcome the loss. Gregor, Hingley-Jone and Davidson's (2014) presented contrasting findings of painful emotions related to the loss of the child they thought they had which even the happiness of their child did not soothe. The loss of a child was not the only theme which emerged from the analysis. Sansfacon, Robichaud and Dumais-Michaud (2015) also discussed the loss of the wider family and networks which were not willing to support the journeys the families were on.

Who will support us?

Professional services

"We took Robin to see this person who was supposed to be working with her to find her and get self-esteem and confidence…and she [counsellor] said, 'Well I see Robin more as a boy' and I said: 'Who the fuck asked you?'"

Pyne (2016) reported that experiences with professionals varied. Some parents felt they could not trust them, yet were able to find support from others experiencing the same difficulties. Unhappiness with health services (e.g. general hospitals) and lack of preparation of staff was reported by Sansfacon, Robichaud, and Dumais-Michaud (2015). Kuvalanka, Weiner, and Mahan (2014) conversely described a theme of community transformation which was mainly characterised by health professionals who were reported to be helpful overall. Mothers reported valuing professionals who were open to learning; something mothers were happy to provide. Sansfacon, Robichaud, and Dumais-Michaud (2015) further

described challenges in accessing services. Participants found it difficult to find specialist services as the resources were reported to be limited.

Schools

"The school basically said: 'Well, we don't have a gender neutral bathroom, she had to go the boys' bathroom'…so we pulled out of that place."

Negative experiences with school and other parents were widely discussed. The mothers in Kuvalanka, Weiner, and Mahan's (2014) study felt they had to fight hard and often resorted in children being home schooled. They further believed that the schools were not providing the child with what they felt they needed. It was reported that schools' approaches lacked flexibility and security. Sansfacon, Robichaud, and Dumais-Michaud's (2015) findings mirrored these results. In their study parents expressed severe criticism of schools, particularly their ill preparation and insufficient skills which could not address their children's needs.

Wider community

"We lived in a …very conservative area and Nicole was, you know, getting the message that it wasn't ok to be herself"

Social intolerance was identified as a factor which contributes to the stressors of raising a gender variant child by Gray, Sweeney, Randazzo, and Levitt (2015). Indeed, the biggest struggle reported was one with wider communities by Kuvalanka, Weiner, and Mahan (2014). Bullying and stigmatisation was found to be so profound that families felt they had to move to a place where they felt more liberal views were fostered. Pyne (2016) talked about the experiences of their children and they themselves being harassed after the decision of affirmation was made. They felt that even though affirmative care brought many challenges they were able to stay with the position of the problem being located in the outside world and

refused to find the difficulty within their child. Affirmation was reported to be searched for through communities, expertise and language they chose to use. For many parents in this study, finding other families like their own was crucial. Kuvalanka, Weiner, and Mahan's (2014) participants had similar experiences and reported that it was through making contact with other families raising gender diverse children, attending groups, and attending camps and conferences, that they found allies and reassurance. This helped them to recognise that what they were doing was right and allowed them to stick only with the affirmative approach. A strong belief in the affirmative approach was further reported by Sansfacon, Robichaud, and Dumais-Michaud (2015).

Parents' suggestions of how to tackle difficulties in wider communities were discussed by several authors. Gray, Sweeney, Randazzo, and Levitt (2015) described parents' desire to challenge the binary narrative and advocate for their children and transgender community.

A different approach was described to be helpful by Pyne (2016) where parents reported that when a challenge arose (e.g. dilemma about wearing a different school uniform), they felt that they should not assert authority, but rather support their child by making their own decision by exploring different options with them. Parents in Sansfacon, Robichaud, and Dumais-Michaud's (2015) study suggested a push for legal recognition and inclusion of gender identity in the Charter of rights and freedoms as one of the solutions to the harms coming from the wider systems.

I am scared

"He is going to be a target throughout his life I think…he is going to be ridiculed, bullied, teased and hurt."

Hingley-Jones , Davidson, and Gregor (2014) discussed a common theme of parents' fears about their children's safety. Parents worried about others hurting their children verbally and physically. They further worried about their children's future and having a 'hard life'. Fears of mental health difficulties and suicide were mentioned by a few. Kuvalanka, Weiner, and

Mahan (2014) found a very similar central theme of fears. It was summarised as seeking a non-stigmatised childhood for their gender variant child, rescuing a child from the fear of stigma and hurt, and advocating for a more tolerant world. Gray, Sweeney, Randazzo, and Levitt (2015) spoke to the difficulties parents experience with struggling to create a 'normal' childhood for their children by rescuing them, by hoping they achieved stealth to avoid stigmatisation. Parents talked about physical intervention possibly helping with these fears. Physical intervention was reported as giving parents hope, that their children would be accepted and have developed meaningful intimate relationships. Parents in Pyne's (2016) study experienced some fears about the child's safety as mentioned by many authors before. Overall it was felt that living an authentic life with risks was better than living in a lie.

Conclusion

The thematic analysis revealed that bringing up a child who expresses themselves as gender diverse can be an emotionally difficult and an uncertain process. Parents discussed their journey to acceptance of their child's expression of their gender and factors which enabled them to fully accept their child, for example coming to terms with the losses associated with the transition. Challenges and stigma from extended family, professionals, schools and wider community were discussed. Finally, it was felt the experiences of mothers and fathers differed.

Clinical implications

Several clinical implications were drawn from the findings above. One of the first challenges parents faced was their inability to 'know' what is happening in the child's early stages of the journey (Greg, Hingley-Jones, & Davidson, 2014). This might have made it very difficult for them to know what help to access in the first instance. A solution suggested by Sansfacon, Robichaud, and Michaud (2015) is for clinicians to be aware of gender issues so they can recognise the challenges such families might face. They suggest that to be able to do so effectively, professionals need be better educated about gender variance. Then they can offer help which is flexible to accommodate for the uniqueness of the stories of these families rather than stigmatise and pathologise. Parents who struggle with their child's

gender expression might need extra support. Wren (2002) feels that supporting parents in developing an empathic approach to their child's gender difficulties is important as this might help them actively listen and support them to understand their child's difficulties. She acknowledges that parents often need time to review development of their child; their hopes, fears, expectations, and their own parenting. Frank (1998) further warns clinicians not to attempt to push parents to a more accepting position when they are not ready to make such a change for themselves. It might be important for clinicians to help them be clear about the story they are telling, to reflect on it and to make any changes to it.

Further discoveries were made in relation to family relationships being affected. The interactions of parents with their children is likely to vary, leaving some parents unsure about what the right way of interacting is (Norwood, 2012). It might be important for the clinicians to support parents to think these through and support families with certain coping strategies (e.g. Wren 2002). It was found that separating such coping strategies and parents' personal beliefs about gender is very difficult as it is often necessary to encourage parents to get to know their beliefs which would then lead to different ways coping. In clinical work it might be necessary to help parents thinking creatively about how a family can connect with novel information and views which they might come across during their journey through gender issues.

As some discrepancies between mothers and fathers were reported, clinicians might have to be mindful of this and use their clinical judgement to decide what might be helpful to whom in the family. Risk and safeguarding should be kept in mind in situations when disagreements feel problematic or concerning.

Many parents described experiences of fear of stigma, and possible abuse of their children. This led to further dilemmas. Striving for balance between protecting their children and allowing them to express themselves in an authentic way might at times be a difficult task. Malpas (2011) suggests that it might be helpful for parents to have the support of clinicians when moving from an 'either/or' position towards a 'both/and' position and engage parents in not only supporting their child but also function as a mediator between the child's

wishes and the social reality. It was felt that it is not enough for a clinician to be interested in the coping strategies the family adopts, but also in the interactions with the wider social environments and how these affect the family's development of ways of coping. Sansfacon, Robichaud, and Dumais-Michaud (2015) suggest that connecting families to others with whom they can share similar experiences and advice might be empowering.

Rationale for the Study

Through conducting this review of the literature on parental experiences when raising a gender diverse child a particular gap in the literature has been identified. That is, the experiences of parents' of *pre-pubertal* children who express themselves in a gender diverse ways, which is an unexplored area.

It might be that the pre-pubertal stage is particularly difficult for parents as many important decisions are yet to be made and this may be the source of some anxiety, e.g. how to approach social transition, beginning secondary school and decisions about physical intervention. Anecdotally decisions have been experienced as very pressing which might mean that parents struggle to think different options through. Cohen-Kettenis (2008) observed very strong parental support for the process of full transitioning before puberty emerging and her clinic offers not only hormonal but also surgical treatment to selected individuals younger than 18. This has been reported in academic journals as well as the media. Increased pressure from gender diverse individuals and their families on clinicians to provide physical intervention at an early age has also been observed (Wren, 2002). Furthermore, trans-critical groups of parents and professionals have been challenging the established affirmative way of working and questioning not only the ethics but potentially harmful impact on gender diverse children.

Given the urgent feel of the pre-pubertal time, and the different views and values surrounding gender diversity and its treatment, one must appreciate the difficult position parents are placed in when trying to raise and support their children. Even though many families often start from a point of not knowing what to do, many who engage in this journey come to have a clearer idea of what it is their child needs. Many suggestions have been

made by academics and clinicians about how their journey can be supported, yet the experience of parents who have received professional help and their experience with it is an unexplored area. This is in keeping with traditional approaches to academic research whereby the experiences of those who have lived the very phenomena under study tend to be neglected (Hjelmeland&Knizek, 2010). However, understanding the experience of navigating such a journey would be a valuable contribution to our existing knowledge and can only be provided by the parents of children who present as gender diverse. Learning about such experiences would enrich the existing literature base and enable professionals working with such families to support them in the most helpful way.

Aim of the Study

The purpose of this study is to examine the views of parents on appropriate support for their pre-pubertal gender variant children. The research questions will be as follows:

- How do parents think their child's gender identity developed?
- How do parents make sense of their child's gender identity?
- What challenges do parents have to face and what has helped them do this?
- What do parents think appropriate support from services should look like?
- Why did they opt to think about early physical intervention?
- What do parents think the future will bring?

Method

This chapter aims to describe the rationale for selecting the research method used, the process of recruitment, data collection and analysis. Ethical issues are considered and reflexive notes included.

Methodology Overview

Qualitative versus quantitative approach

A long-standing debate exists in the social sciences concerning the relative merits of quantitative and qualitative research (Henwood&Pidgeon, 1995). Two types of debate were identified by Bryman (1988) – *technical and epistemological.*

The *technical* debate is concerned with the question of which approach is best suited to answer the research questions. Quantitative methods are often seen as helpful in answering questions looking at relationships between predetermined variables and hoping to make broad and generalisable conclusions. The goal of qualitative methods is to gain a rich understanding of a very particular phenomenon within its specific context (Barker et al., 2002). Qualitative methods have therefore been found to be helpful when exploring under-researched or under-theorised areas, where explorative, open questions are better suited (Corbin & Strauss, 2008).

The *epistemological* debate involves more fundamental questions concerning the very nature and practice of science (Henwood & Pidgeon, 1995). Epistemology refers to a branch of philosophy which is concerned with the theory of knowledge, specifically how we can know and what we know (Harper, 2012). The epistemological position of a research study therefore determines what kind of factors can be learnt about (Lloyns & Coyle, 2008). In the epistemological debate, qualitative and quantitative approaches are therefore viewed as opposed paradigms as at their very core they disagree about how knowledge can be acquired. As a result, when conducting research, one's epistemological assumptions need to be questioned as they can have a significant impact on how a research question will be answered (Harper, 2012). This is further elaborated on below.

Epistemological position

Epistemological positions can be viewed along a continuum between two poles: 'positivism' and 'interpretivism' (Harper,2012). Historically, psychology has often been closely identified with the assumptions of positivism. Positivism is described as a position assuming that it is possible to obtain accurate and objective knowledge about the world around us through our senses*("Everything that exists, exists in some quantity, and if it exists in some quantity, in can be measured" [Constantinople, 1973: 389]*). It aims for objectivity, neutrality and generalizable conclusions found through hypothesis testing. Researchers who adopt the positivist paradigm therefore aim to discover causal links and make predictions about the external world. Positivism further assumes that the researcher is able to stay completely detached from the data and therefore not influence the results in any way (Charmaz, 2008). Interpretivists, on the other hand, focus mainly on discourse and its effect. The interpretivist position holds that reality is not objectively accessible knowledge but rather a discursive construction that is partial and subjective. Critics however argue that interpretivism came in as a strong reaction to positivism and suddenly there were no truths, only perspectives and discourses.

In between positivism and interpretivism lies a range of further epistemological positions. They include a 'critical realist' position, which assumes the existence of a reality independent of human consciousness, yet also holds that such a reality is not directly accessible, and that it is socially constructed (Oliver, 2011). In psychology, the example of this might be our unobservable 'inner worlds'.

Critical realism is the epistemological position which resonates with me. Pilgrim says: *"We think and feel. We have fantasies awake and we dream asleep. Our passion at times prompts irrational action but also source creativity."* In my clinical practise I have experienced how limiting empirical evidence is, yet how destabilising it would be for individuals to hold to uncertainty all of the time. Even though the truth within our inner worlds might not be readily accessible, it does not mean that it cannot be accessed at all, and often not through evidence-based methods, but though other means, such as the arts.

Furthermore, I feel that critical realismis also consistent with a very complex, multi-factorial, biopsychosocial view of gender diversity. More specifically, even though I appreciate people's individual experiences and their meaning-making of what is it like to be a parent of a child whose gender gets expressed in diverse ways, I also feel that there is a reality to their story which would be imbedded in the observable, biological body.

Implications for methodology

Given that the focus of this research is concerned with understanding the experiences of affirmative parents of pre-pubertal children who identify in gender diverse ways, a qualitative, interview-based study with the population of interest was found to be the best suited when answering the research questions. This decision was made because, as mentioned above, qualitative methods are often used for initial explorations of novel areas which have not been excessively researched. Furthermore, the existing literature on the parental experiences of having children who express their gender in diverse ways is limited. Specifically, affirmative parents and their experience with service have not been studied before. There are some studies concerned with similar questions and this research has no doubt offered important contributions to the field, however, it is proposed here that focusing more specifically on the experiences encountered by parents of pre-pubertal children, who have received help from others, including specialised services, would greatly enrich the literature on which support is needed to enable such families to thrive. I further wanted to use a method that is compatible with a critical realist epistemological position as it fits with the multi-factorial view of gender diversity and my philosophical position. Lastly, my focus was the content and meaning of participants' experiences, rather than discourse. Even though other methodologies, such as Interpretative Phenomenological Analysis (Smith et al., 2009) would have also explored how such life events are experienced and given meaning, it was felt that constructivist approach to grounded theory (Charmaz, 2006; Corbin & Strauss, 2008) was most appropriate given how heavily under-researched this area is. This approach is described in detail below.

Grounded Theory

Historical context

Grounded theory developed during the 1960s in the USA under the context of tension between quantitative and qualitative research methodologies in sociology. Charmaz (2014) reports that during the period, the divide between quantitative and qualitative research widened. She explains that despite being described by several critical theorists thinking about the consequences of quantifying research, it was still mainly defined in quantitative terms. She reports that qualitative research was in need of a new sophisticated methodology.

Grounded theory emerged from the collaboration between Glaser and Strauss, who studied deaths and dying in hospitals, a topic which was largely ignored by researchers at the time (e.g. Glaser & Strauss, 1965, 1968). Through having long analytical conversations and exchanging notes, they developed systematic methodological strategies which future researchers could adopt. In 1967, '*The Discovery of Grounded Theory: Strategies for Qualitative Research*' was published which offered a critique of the hypothetico-deductive method and proposed a method of discovering theory inductively from research data. Glaser and Strauss (1967) believed that quantitative studies were impoverished by lacking context-specific knowledge domains (Pidgeon, 1996). The term grounded theory was therefore chosen to express the idea that the theory is truly grounded in qualitative data by simultaneously sampling and analysing (Pidgeon, 1966). The term therefore describes not only the final product but also the method of investigation.

Developments in grounded theory

Since Glaser's and Strauss' publication of the 'original version' of grounded theory in 1967, their respective views on how the researcher should conduct the analysis went in different directions. This was mainly triggered by some of the ambiguities of how an analysis should be conducted. Strauss and Corbin (1990) published a more explicit version of the analytical procedures, however this was criticised by Glaser, who found it overly prescriptive. Despite Glaser's criticism, many researchers today still rely on the original work as the basis for how to carry out grounded theory.

Even though originally Glaser and Strauss fought the dominance of positivism in the 1960s, grounded theory became popular partially for its positivistic assumption. This resulted in postmodern critics (e.g. Conrad, 1990, Ellis, 1995) undermining the method and criticising it for fragmenting the participants' story, relying on the researcher's voice as authority and uncritically accepting narratives about science, truth and universality. This soon began to change, with many researchers shifting from the positivist position; grounded theory began to develop in the constructivist turn (Charmaz, 2014). Charmaz's (2014) view is that neither data nor theories are being discovered and emphasises the importance of acknowledging that the researcher's position is part of the study and that it is us who construct our grounded theories based on our past experiences.

Charmaz (2014) explains that even though constructivist grounded theory follows Glaser's and Strauss's (1967) inductive, comparative, emergent approach and includes Strauss's iterative logic, it further highlights the flexibility of the method and resists mechanical applications of it. Charmaz (2014) further argues that researchers can use grounded theory strategies without the assumptions of an objective external reality, but instead start with the assumption that reality is multiple and constructed. Therefore, it is very important to attend to the researcher's position and foster their reflexivity. Clarke (2005) suggests that the research reality is created between the researcher and the participant in a particular context. To summarise, Charmaz (2014, p. 13) argues that *"the constructivist approach treats research as a construction but acknowledges that it occurs under specific conditions – of which we may not be aware and which may not be of our choosing"*.

Le Roux (2014) helpfully explains the slight confusion between the terms 'social constructionist' and 'constructivist' which have been found to be used interchangeably to describe the same grounded theory approach (e.g. Harper, 2012; Tweed &Charmaz, 2012).Le Roux explains that there is a clear difference between constructivist and social constructionist perspectives in the UK and disagrees with Tweed and Charmaz (2012) who argue that constructivist grounded theory "is consistent with a contemporary UK social constructionist approach" (p. 132).She explains that "*Constructivists focus on individuals'*

constructions of their worlds and use self-reflexivity to consider how they are constructing participants' constructions. In grounded theory the latter is typically done via the use of reflective memos, and is made transparent. Social constructionists, on the other hand, focus on how social discourses, discursive interactions and power relationships produce people's ways of being-in-the-world and seeing- the-world. Put differently, constructivists co-construct, whilst social constructionists deconstruct". I agree with Le Roux's (2014) views and would like to stress that this study took constructivist approach underpinned by a critical realist epistemology as it was especially important for me to understand the participants' meaning-making.

Grounded theory procedures

Different branches of grounded theory suggest different sets of procedures when analysing data. This study followed procedures suggested by Charmaz (1995; 2006; 2014) which are an accepted form in a constructivist grounded theory approach:

- an iterative, non-linear analytical process
- theoretical sampling and theoretical saturation
- coding
- memo-writing

An iterative, non-linear analytical process

Data generation and analysis proceed simultaneously to inform each other. Initial codes and concepts derived from the first interview are further explored and refined during subsequent interviews, while new concepts and ideas derive from later interviews, to inform one's analysis of preceding interviews via a process of constant comparison and an exploration of similarities, differences and relationships between concepts (Charmaz, 1995). The grounded theory process thus starts with an inductive logic, but moves into abductive reasoning as the researcher seeks to arrive at the most plausible explanation of the empirical observations (Charmaz, 2008).

Theoretical sampling and theoretical saturation

As mentioned previously, grounded theory does not rely on notions of statistical representatives to make claims about generalisability of the results. Participants are usually selected purposefully as it is believed that their characteristics can contribute to the topic that is being researched (Payne, 2008). In this study, purposeful sampling was initially used and as some preliminary categories emerged, theoretical sampling began to take place. Theoretical sampling is defined as a process of ongoing data collection for the purpose of generating theory and refining one's conceptualisation (Charmaz, 1995). According to Charmaz (2014, p. 205), it helps to check on the quality of the categories, elaborate on the boundaries of said categories and to understand the relationships between them. It is therefore suggested that data gathering continues until the categories are "saturated". Holton (2007) defines this as categories being robust and no new characteristics and patterns being found. Some grounded theorists therefore argue that the sample size is not important as long as one is confident their categories are sufficiently saturated (e.g. Stern, 2007). Glaser and Strauss (1967), however, highlight that changes in one's perspective is always possible and theoretical saturation can therefore be infinite. Corbin and Strauss (2008) emphasise how external circumstances might make it challenging to follow theoretical sampling and suggest making every effort to apply the principles to the data which is available. Dey (1999) views the term 'saturation' as problematic, he understands it as incongruent with the method that "*stops short of coding all of the data"* (p.257) and it relies on the researcher's opinion that the categories are saturated. He therefore suggests that the term 'theoretical satisfaction' took a position of 'theoretical sufficiency'. Charmaz (2014, p. 215) elaborates on this view by warning that the process of saturation itself can result in researchers only 'following the guidelines like recipes' and closing their thinking to other possibilities emerging from the data. She concludes by suggesting flexibility and openness, and using grounded theory guidelines as suggestions rather than a set of rules which would deduct the theory for the researcher. This is the position I tried to adopt.

Coding

According to Birks and Mills (2011) *codes* are defined as a form of shorthand used by researchers to identify conceptual reoccurrences and patterns between them. Groups of codes then form a *category*. Coding is therefore an active process by which codes and categories are developed and refined. This process is influenced by the researcher's knowledge, experience and the extant theory. Further to this, Birks and Mills (2011) explain that part of the essential component of grounded theory, and the thing which distinguishes it from other interpretative methods, is the concurrent data collection and analysis using these codes and categories.

In the early stages of the data analysis, an initial coding, (Charmaz, 2006) also called open coding by Glaser (1978) and Strauss and Corbin (1990), was adopted. Initial coding was used to segment data, compare code with code and begin to name initial patterns and the relationships between those. Strauss and Corbin (1990) argue that initial coding should be a reflexive activity, as this will help the researcher not to subconsciously apply personal theoretical codes. In this study, the initial coding was completed by using line-by-line analysis. Such a concentrated approach is recommended by Glaser (1978) as it encourages the researcher to become fully acquainted with the data as well as allowing time to ask questions. Codes are taken from the language used in the data and Charmaz (2006) argues for the use of gerunds when coding as a way to acknowledge the process in the data as well as participants' experiences.

Focussed coding was the second main stage (Charmaz, 2006). The key task of this coding is to make links between the categories generalised from the initial coding, using constant comparison of data and categories, and questioning the relationship between them. By engaging with this, one begins to notice which initial codes make the most sense and, through noticing this, the more significant categories emerge and one is able to start to explain broader concepts. It was during this process when gaps were identified and these guided the researcher to find the answers by theoretical sampling (Berks & Mills, 2011).

Memo-writing

Lempert (2007) describes memo-writing as a fundamental part of the development of grounded theory. It consists of recording feelings, insights and ideas in relation to the research project. Birks et al. (2008) explains that memo-writing enables one to articulate and explore one's interpretations as the data is engaged with. It is thought to increase one's sensitivity to better prepare the researcher to answer Glaser's (1978) question: What is actually happening in the data? Clarke (2005) explains that recording the process of memo-writing enables one to take risks and free oneself up to challenge their developing analysis. Many others (e.g. Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 1978) agree that flexibility and freedom are indeed central to the process of memoing and that writing with a natural flow about whatever comes into one's mind is very important. Corbin and Strauss (2008) further suggest that memo-writing helps the researcher to identify potential gaps in their analytical thinking.

Following Bryant and Strauss' (2008) suggestions, I engaged in the process of memo-writing from the time this study was first conceptualised until the end when theory was being constructed. Starting the process before the data collection commenced helped to recognise the value of memo-writing. At the beginning of the process a reflective diary was used (Appendix B) as a way of memoing initial thoughts and feelings. These memos were very fragmented and I was unsure how helpful these notes would be. It was, however, noticed that as my confidence grew with the process the memos became richer and gradually linked together (Appendix C). The handwriting of memos was found to be more creative and it allowed for noting things down anywhere. Even though handwriting memos felt more inspiring it might have been less practical than electronic notes.

Procedure

Inclusion criteria

The inclusion criteria were as follows:

a) Participants had to be affirmative parents of pre-pubertal (i.e. occurring in the period of development before preceding puberty) children who fulfilled the criteria for DSM-V Gender Dysphoria and had socially transitioned

b) They had to be able to be fluent in English
c) They had to be considering or already started early physical intervention for their children

Exclusion criteria

The exclusion criteria were as follows:

a) Individuals with social communication or learning difficulties which could impair the interview process

Recruitment

Potential participants were identified through the Gender Identity Development Service (GIDS, The Tavistock and Portman NHS Foundation Trust). Firstly, the project was introduced and discussed in a multi-disciplinary team meeting. Twenty-one participants from their current case loads who met the inclusion criteria were identified. Consequently, a cover letter (Appendix D), information sheet (Appendix E) and reply envelope were posted to potential participants.

Screening

Twelve potential participants who were contacted via letter responded. I discussed the research with them by telephone and ensured I answered any questions they had. I further screened for participation eligibility as per the inclusion/exclusion criteria. Of these people, 10 participants took part in the research process.

Interview arrangements

Participants were given the option to be interviewed at the GIDS or in their home at a time that was convenient for them. Eight participants were interviewed at the GIDS. Two participants were interviewed in their home. All interviews were conducted face to face.

Participants

Participants were mothers (*n*= 6) and fathers (*n*= 4) of pre-pubertal children who met the criteria for the Gender Dysphoria diagnosis and had fully socially transitioned. Two participants were individual mothers, other parents were in couple. Further information about all the participants are summarised in the Results chapter to provide context for the results.

Interviews

Interviews are considered to be a suitable method of data collection for grounded theory as they build on the everyday experience of having a conversation, tend to generate a higher response rate and also result in less missing data than when using questionnaires (Payne 2008).

Data was collected by means of intensive interviewing. Intensive interviewing is described by Charmaz (2014) as gently-guided, one-sided conversation that explores research participants' perspectives on their personal experiences, during which the participants talk and the researcher encourages, listens and learns. It is a popular way of data gathering when using grounded theory.

Before the interview commenced, the information sheet was discussed with the participants, any questions were answered, and the issues of confidentiality were explained. They were then asked to read and sign two copies of the consent form (Appendix F); one copy for themselves and one copy for the researcher. Importantly, King and Horrocks (2010) suggest that consent means more than just signing the forms, it further includes attending to non-verbal clues and attending to what might feel too intrusive. I tried to keep this in mind. The interviews were guided by a schedule of topics (Appendix G). Traditionally, grounded theory suggested that the researcher should avoid knowing about the topic they are researching to prevent them from imposing existing theories or knowledge on to the study process (Birks and Mills, 2011). Since then, however, there have been developments with some suggesting that the researcher should engage with the area but not with the specific topic (Glaser, 1992), and others suggesting that not knowing might actually lead to the researcher not examining their own positions and prejudices (Urguhart, 2007). Willig (2001) also explains that learning about the area confirms that the topic has not already been understood and to ensure the study contributes to new knowledge. Pragmatic reasons, such as having to submit a proposal and gain ethical approval, also means that learning about the area often needs to occur beforehand. I felt that learning about transgender issues prior to conducting the interviews was justified. It allows for reflecting on values and assumptions.

The researcher also felt that it was important to learn the language of the transgender community, which she was not familiar with prior to starting the project. Baldwin (2011) suggests that some background knowledge could contribute to the comfort of the participants during the interviews and foster more detailed responses.

All participants were interviewed individually. All interviews were audio recorded. The duration of the interviews ranged from 45 minutes to 67 minutes. The mean average duration was 52 minutes. After each interview, the participants were debriefed and given the opportunity to reflect on the interview process. The need for further support was explored. All participants were thanked for their time.

Transcription

Even though some alternative positions in grounded theory suggest that the analysis should be conducted directly from the spoken word, as it ensures access to the prosodic and paralinguistic features of the data, others, such as O'Connell and Kowal (1995), describe the transcription of audio recordings into written text as a very important first stage of data analysis. Payne (2008) stresses the importance of transcribing the speech of both; the participant and the researcher verbatim. The researcher chose to conduct, transcribe and analyse the interviews personally and felt that her intimate familiarity with the data ensured the prosodic and paralinguistic features were attended to. The program *ExpressScribe* was used for the transcriptions.

A simple transcription scheme, adapted from Banister et al. (1994), was used. The transcriptions were punctuated to facilitate reading and all lines were numbered.

Dissemination

Summarised findings of the research will be provided to the service through which participants were recruited. Furthermore, the parents who expressed interest in the summary of the findings of this research will be sent the summary via their preferred contact method. The current research was undertaken as part of a Doctorate in Clinical Psychology and submitted as a doctoral thesis. As such, the final draft will be available at the University of Essex for future trainees, students and staff to read and make use of. The researcher

intends to submit the study for publication in a peer reviewed journal that has published research in similar areas, such as *Journal ofChild Psychology and Psychiatry.*

Ethics

Ethical approval was granted by the University of Essex Research Ethics Committee (Appendix H), the NHS Research Ethics Committee (Appendix I), and theNoclor Research & Development committee for the Tavistock (Appendix J). Careful consideration was given to the following: consent of the participants, their potential emotional distress during the research process, confidentiality, risk and the well-being of the researcher. A set of procedures was developed to follow in the event of participants becoming distressed.

Informed consent

It was ensured that the subject of the research, the potentially emotive nature of the interview process, and the possible emotional effects were outlined in the participant information sheet. Furthermore, participants were assured that the content of the interview would have no impact on their eligibility to access support/care in the future.

Emotive content may lead to feelings of distress for the participant

The consent form reiterated the possibility of this to ensure participants were able to provide informed consent. The researcher was available to discuss any questions and the participants were able to opt-out of the research at any stage. Furthermore, the participant information sheet includedtelephone numbers for agencies to contact if the person felt distressed later. Additionally, whilst the researcher's role was not one of 'therapist', she was mindful to conduct a primarily participant-led method with attention to respect and empathy. Ample time was also planned in the event of an extended debrief. Follow up debrief sessions were also available at a later timein person or by telephone.

Emotive content may lead to feelings of distress for the researcher

The researcher is a practicing clinical psychology trainee and has experience of discussing sensitive topics and being mindfully and emotionally present with those in distress. She further received regular supervision, and engaged in both reflective writing and personal psychotherapy throughout the research process.

Data protection

All collected data was stored in accordance with Trust policy and the *BPS Code of Ethics and Conduct* (British Psychological Society (BPS), 2009). Additionally, all data were anonymised. Electronic data was password protected, and hard copies stored in a locked place.

Personal Reflexivity

Wiling (2008) stresses the importance of personal reflexivity in qualitative research. Such reflexivity facilitates reflection upon the impact of one's own assumptions and reactions to the process and the subsequent insights and understandings. Throughout the process of this research I ensured I kept a reflective journal and memos which encouraged me to remain open to what 'belonged to me' and how it interacted with the research process.
I view myself as a cis-gendered, heterosexual mother of white European origin. I have never experienced bullying or abuse and even though I live in the UK as an immigrant I have never been directly made to feel unwelcomed by another individual or group; regardless, I have felt like I do not belong many times. I feel that this helped me to really listen out for the difficult feelings parents might have, especially the fears and worries which come naturally with being gender diverse in a binary world and perceived or even treated differently.

I was brought up in the Czech Republic where gender and gender roles are thought about in a very traditional way. My mother is a teacher, my father trained as a car mechanic. Being a woman meant being sensitive and caring, being a man meant being strong and practical. Even though the binary narrative was very clear in my culture, I feel that I understand them more as feminine and masculine parts which are present in both, females and males, regardless of their assigned gender. I have always valued freedom of expression above anything else due to coming from a post-communist culture which was very much in conflict with my family values. Furthermore, I feel that moving to the UK around the age of 17 broadened my mind. I began to learn about what it is like to be part of a different culture and what it feels like to allow that culture to change your stance and feelings. I have become to be more mindful of how this experience alongside learning and

using new language shape my reality, yet how my long-standing relational patterns remain the same no matter where I go in the world.

My adult life followed a very conservative trajectory of becoming engaged and later married. I fell pregnant while half way through this project. Having a baby allowed me to experience love, happiness, pride and worries I have never felt before and this had a significant impact on *how* I was able to listen during the interviews. Previously, when childless, as a clinician I had a longstanding interest in working with children and have met many who were awfully hurt by the adults around them. Theoretically, psychoanalysis resonates with me strongly and the impact of the past on the individual has always fascinated me. I often had to work very hard on seeing family dynamics as complex rather than siding with the child who was suffering. Since becoming a mother myself, I have experienced irrational thoughts and reactions due to the rawness of the strong emotions listed above. This deepened by developing empathy for parents in general. It further allowed me to experience how even though the way I raise my baby up impacts on her very significantly there appear to be moments when something from within her just 'shows up', something which has always been there, no matter how much we might try to change it. Being able to observe my child in such a way strongly resonated with the experiences the parents in this study described. I have gradually noticed my stance moving from *'you must always allow your child to express themselves how they want'* to *'you must find a way which works for the whole family and work as a team'*.

One notion which I noticed remained unchanged was my position of diagnosis. I personally do not find labelling people's experiences in terms of symptoms very useful. Even though I can see some helpfulness of those in my clinical practise, my mind does not naturally gravitate towards this way of thinking and I find it very reductionist. I had to be mindful about this and not let my position interfere with the interview process. On several occasions I noticed a need to ask further questions when diagnosis was brought up by participants, even though I knew there were more helpful questions to be asked. I felt that my reflexivity stopped me most of time, however listening back to the recordings, I learnt that

this was not always the case. Getting familiar with the recordings helped me to reflect further and learn for future practice.

Through my own psychoanalytic therapy, I have experienced what it feels like to be asked sensitive questions and how much courage it takes to speak the truth. Even though these interviews were not a therapeutic endeavour, I hoped to create a space in which difficult thoughts and feelings could emerge. I feel that my own therapeutic journey has helped me to avoid being stuck in my own truth and losing touch with curiosity. I would hope that this experience has enabled me to really hear the stories the families brought and allow them to take a lead in the interview process without feeling overwhelmed by uncertainty.

Results

This chapter describes the analysis of the ten interviews conducted for this study.

Participants Demographics

Participants were mothers (*n*=6) and fathers (*n*=4) of pre-pubertal children who met the criteria for gender dysphoria diagnosis and fully socially transitioned. Further information about all the participants and their children are summarised in Table 1.

Table 1.

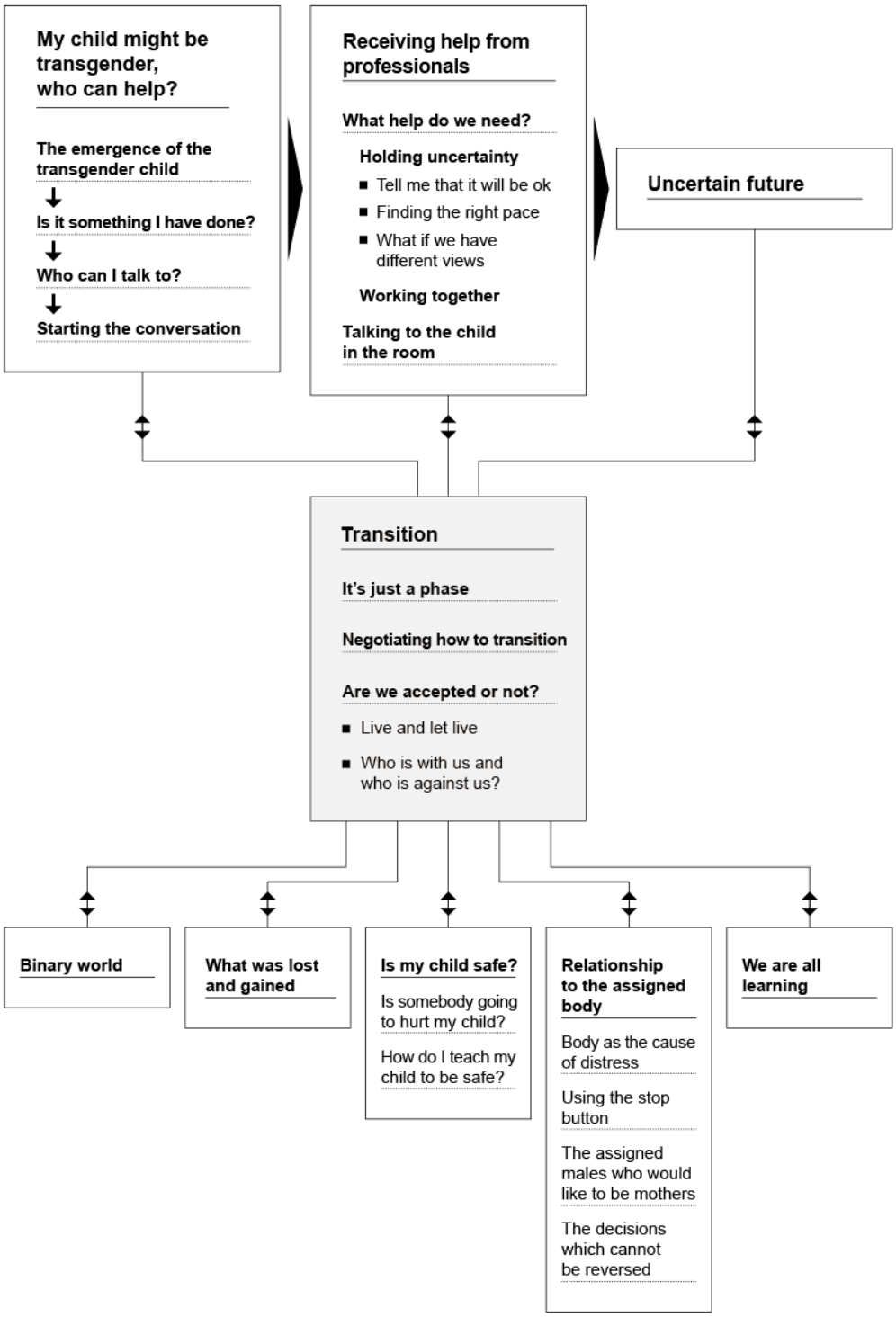
ParticipantDemographics

	Parent's pseudonym	Sex	Ethnicity	Gender identity description of their child	Child's pseudonym	Child's age
1.	Chantal	Female	White British	Male to Female	Chelsea	6
2.	Helen	Female	White British	Female to Male	Mark	12
3.	Bill	Male	White British	Female to Male	Mark	12
4.	Kelly	Female	White British	Male to Female	Eli	13
5.	Alison	Female	White British	Female to Male	Kevin	9
6.	John	Male	White British	Female to Male	Kevin	9
7.	Clare	Female	White British	Male to Female	Emma	10
8.	Mike	Male	White British	Male to Female	Emma	10
9.	Becky	Female	White British	Female to Male	Ronnie	9
10.	Danny	Male	White British	Female to Male	Ronnie	9

Initial coding yield 360 open codes for the entire data set. Further focused coding enabled for those to emerge into higher-level categories, resulting in the identification of seven sub-catogories with 13 furhter minor categories. These continued to be explorer in further interviews (Charmaz, 2014). The final stage, theoretical coding, led to the identification of nine major conceptual categories.

As described in the previous charter, frequent memo-writing alongside constant comparative analysis facilitated the recording and elaboration of conceptual and analytical ideas (Charmaz, 2014). This process was fundamental in developing an understanding of the parameters of conceptual categories and the variances both within and between participants in their experience of them. Furthermore, memo-writing helped to explicate the relationship and interaction between major categories amalgating them in a substatantive theoretical model explaining the expriences the participants. The model was presented to the last two participants participants and impacted on the discussions in thein interviews. No new codes emerged from those. The finalf model is presented in Figure 1 and each aspect of the model shall each be discussed in detail below.

Figure 1. Diagrammatic representation of the tentative model representing experiences of parents' of pre-pubertal children who express themselves in gender diverse ways where arrows represent directional relationship between categories



Overview of Main Categories

The framework that was constructed was developed through a process of open, focussed, axial and selective coding (Charmaz, 2006; Corbin & Strauss, 2008). During the coding process, a central category, as suggested by Corbin and Strauss (2008), emerged. It was felt that the category of 'Transition' captured the essence of the research. It describes the time during which the parents did, or did not, support the child through moving away from their assigned gender to the desired one, firstly on their own, and gradually with the support of friends, their community and professionals. This category is connected to the three time periods described below to capture that it is an on-going process. It is further interconnected with all the other categories described below as it was those that shaped it and vice versa. This hoped to illustrate the experiences the parents recalled of themselves and others around them transitioning alongside the child, and such journeys being impacted by many factors. Furthermore, experiences of the transition having an impact on such factors simultaneously (e.g. the child's transition would impact a school policy) were reported as significant. These relationships are illustrated by the resonance arrows.

For the purpose of clarity, it was decided to describe the journey of transitioning in chronological order. The first period is called 'My child might be transgender, who can help?' and is seen as the time in the past when the parents began to notice first gender non-confirming behaviours in their child, and tried to make sense of this experience. The following category is 'Receiving help from professionals'. This was the time period from the first contact with services and it describes parents' feelings and thoughts in relation to the help they received. The final category is labelled 'Uncertain future'. It describes the experience of not knowing what the future holds.

Alongside these categories sit others which emerged as important in shaping the transition process. These are discussed as follows: 'Binary world', 'What was lost and gained', 'Is my child safe?', 'Relationship to the assigned body', 'We are all learning' and 'Should we be speaking the truth?'

The categories and codes will be discussed in detail. Quotes will be used to illustrate those using pseudonyms of the participants and the line numbers from the transcripts. An overview of the categories is captured in Table 2. Further relationships between categories is summarised in Figure 1.

Table 2.
Overview of Categories

Overall category	Category	Subcategory
My child might be transgender, who will help?	The emergence of the transgender child	
	Is it something I have done?	
	Who can I talk to?	
	Starting the conversation	
Receiving help from professionals	What help do we need?	Holding uncertainty Tell me that it will be okay Finding the right pace What if we have different views
	Working together	
	Talking to the child in the room	
Uncertain future Transition		
	It's just a phase	
	Negotiating how to transition	

	Are we accepted or not?	Live and let live Who is with us and who is against us
Binary world What we lost and gained		
Is my child safe?	Who is going to hurt my child?	
	How do I teach my child to be safe?	
Parents' relationship to the assigned body	Body as the cause of distress	
	Using the stop button	
	The assigned males who would like to be mothers	
	The decisions which cannot be reversed	
Should we be speaking the truth? We are all learning		

Detailed Analysis

My child might be transgender, who can help?

This category contains four codes which illustrate the journey thatparents appeared to have experienced prior to receiving support from professionals. Similar experiences were reported. The linear process is demonstrated below by the codeswhich followed one after each other.

The emergence of the transgender child

All participants described an experience of observing their child not conforming to typical gender stereotypes from a very young age. The nonconformity was manifested in

several ways. Parents described how their children seemed to prefer clothing or accessories typically associated with their desired gender or to actively reject those associated with their assigned gender. This was all experienced as rather out of the control or influence of the parent. These behaviours just 'showed up'.

> There is a wardrobe full of clothes, dresses and stuff which have never been worn [ ] and [ ] he just point blank refused to wear them, anything with sparkles, or bangles or butterflies. He wanted to wear football tops, rugby tops. [Bill, 278-282]

> She would go down to her jewellery box and she wouldn't knick them, but she would ask 'Nanny, can I have these? ', or few nail vanishes, and handbags and all stuff like that. [Chantal, 530-533]

The children's play was also described as 'non-typical'. Kelly [9-10] reported:*"*When she did role play or played a computer game she quite often chose girl characters." Others said:

> They used to have these story bags they used to give out, a book, few books all on a little theme, and you would borrow them for a week and then you will give them back. And we had the Cinderella once and in it was a blue princess dress and Alex would not take it off, he would not take it off and I am referring to him as he 'cause that's at that time, you know, how I thought. [Clare, 15-20]

In addition, parents described their children verbally communicating that they are not the gender the others see them as from a very young age: *"I would say 'Come on girls' and Ronnie would cross his arms and go 'I am a boy, not a girl' and that was obviously when he was very little"* [Becky63-66]

Is it something I have done?

In this study, some mothers wondered if having difficult feelings when they found out that their child is not the gender they hoped for, could have contributed to their child presenting with gender diversity:

> I mean, I blame myself a little bit, well, I blame myself a lot, because when I have had Thomas, my eldest, I didn't really want any more children, I will be honest, I was quite happy with just one, whereas my husband was very keen on having another one. So [ ] um [ ] I got pregnant very quickly, after we decided to have another one and I wanted a boy, I really really wanted a boy, and we were living in Cyprus at that time and when they told me I was having a girl, I was devastated, and I couldn't think about names or [ ] I know it sounds awful but I think I just got my heart set on having this boy. [Alison, 198-207]

Who can I talk to?

Observing the development of the child's gender diversity raised many questions and difficult feelings for parents. Most of them, especially the mothers, described initially struggling to ask for support. Chantal felt that she tried to manage it all on her own: *"I didn't go to anyone"* [716].

They reported feeling worried that they would be judged and did not want to be seen as a burden:

> I don't, I don't tend to [ ] keep on about it, I try and [ ] (crying) [ ] I don't like to go on about it because I don't [ ] I don't want people [ ] you know how it is, when you keep burdening other people, I don't want to do that, so we don't tend to, we try to keep it within family, I don't try [ ] you know, people ask, how we are doing, then of course I would talk to them about it, but you know [ ] that's about it [Helen, 265-267]

They described that, eventually, they found a solace in their partners and close family with whom they shared their experiences with:

> Well, I tried to approach my husband and I tried to speak to my sister, 'cause she was a tomboy [ ] um [ ] when she was younger [ ] I was told that [ ] um [ ] I was exaggerating, so I didn't really feel like I could turn to anybody without feeling like I was being judged myself [Alison, 234-238]

Starting the conversation

As explained above, the experience parents described was of the child expressing their gender incongruence initially through non-verbal, and subsequently verbal communication. Once they began to make sense of it within their core family, they reported taking some time to start a conversation about this with their other networks, especially professionals. The first conversation was not easy and many parents struggled to initiate it:

> Um [ ] so [ ] this [disagreements about clothes] went on for a while and it didn't feel right and my husband and I began to play with the idea of just letting her wear only girls' clothes and let the chips fall as they may, but never quite got the bravery to just go for it. And then I went to the doctors one time with a bad knee or something and at the end of the consultation I said 'By the way, I think that my child is trans' and it just came out. I hadn't even been aware that I had been thinking about this a lot [Clare, 84-93]

Other families did not feel able to approach the professionals and the conversation was driven from the outside, usually school:

> It was the teachers in school, Mrs Smith, she is the SENCO up there, and she drove it for us, really. She saw it all happening with us and the she called a meeting and

> ask Alison if Kevin was a well, tomboy and Alison was like 'Well, I believe he might be transgender' and she was like 'Oh, okay, great, well I am the SENCO I can do this and that' and she got all this in place [John, 386-394]

Some families explained that taking a while to discuss the issue with others was due to a fear of pushing their own anxiety onto the child; they felt that they needed more time to be certain that it really was something they and their child needed help with. Mike [180-182] said:"Where is Emma going with this? Before we publically said this is who Emma is, we wanted more certainty."

Others explained:

> Well [ ] it was [ ] we [ ] we knew that he dressed as a boy, he played as a boy, he did boys' stuff, but we didn't want to […] basically force on the issue, we wanted him to find his own path, we wanted him to be like 'Yeah that's cool, that fits with me' [Danny, 56-59]

Some described wanting to discuss it with a professional, but not knowing where to seek help:

> I mean, I went to the doctors' about something else and I mentioned Kevin and they just said 'Well, you can bring him in and we will have a chat with him and make it sound like we are not talking about gender' [ ] but I thought [ ] 'Well, he is not unwell' and I just didn't know where to turn to' [Alison, 34-38]

Transition

The experience the parents described was one of an on-going process of transition. For most families this had been a very gradual process with the signs getting stronger over

time and their child's dissatisfaction with their natal sex causing more distress. Nevertheless, the journey through transition had appeared to follow a similar trajectory for all families. The subcategories describe the different phases of this journey.

It's just a phase

All families described a belief that the expression of non-traditional gender behaviours was only a phase when it was first observed. Bill [28-29] said:*"We thought it was one of those things that will pass, it will go away."*

> I guess it just evolved [ ] I mean [ ] Ronnie was always [ ] in nursery school, if you asked him to queue up he would get in with the boys, and we were like 'Oh she is a tomboy, it's just a phase' [Danny, 3-5]

This belief was often also reinforced by others, such as friends and school staff:

> And you know, at the beginning, everybody was like, 'I think he will grow out of it, he will grow out of it' and as the time went on we were like, 'He is not going to grow out of it' [Helen, 210-213]

> 'Look, what are we going to do when Alex starts school, all this girls' stuff, how are we going to manage it? Because I really don't want my child to be bullied.' And they were like 'Oh, it's really normal, all the little boys here like dressing up, and it's just a phase' [Clare, 28-33]

Negotiating how to transition

The experience described was of changes related to social transition, gradual at first, but escalating with time. Parents talked about guiding the child as well as being guided by the child throughout the process. Kelly explained: "I mean I said to Eli 'If you wanted to use, wear your sister's clothes, that's fine by me', so she did start doing that sort of weekends."

> I think that we have always done it in stages and sitting down and talking. As I said first of all started off with knickers, then it was tights, then it was vests, then it was nighties, then when she started to sneak the clothes to school, it was like we try a different way now. So [ ] it was [ ] doing it gradually [Chantal, 508-511]

Throughout the social transition, many parents struggled with a conflict of thoughts; should they allow their child to lead the transition, fully accepting the journey they had begun, or should they put boundaries in place to influence how the transition develop:

> By this point, um [ ] we had a girl Emma and a boy Emil, so that would be the outward, public face of Emil and then at home, it would be wigs and costumes and you know, very much wanting to be a girl [ ] um [ ] and [ ] we kind of had boundaries to where we thought it was appropriate or not appropriate [Mike, 12-15]

> He wanted his hair cut short and he has got this most beautiful dark, thick, curly hair and I didn't want it to be cut off [ ], it was almost my [ ] um [ ] my little [ ] still the girly bit of him that I really wanted to keep hold of [ ] and [ ] and I think he said something to me and I just dismissed it [Alison, 16-20]

This conflict seemed to have been impacted by personal, difficult feelings (e.g. shame), which they needed to process over time:

> The next few years I would battle with Emma about what she could wear out and I mean, I think of myself as quite liberal, but you know, I drew the line and letting Emma then a boy go out in a full on dress, dressed fully as a girl. I felt that that was crossing a line, that, I mean, I didn't really care, but I just thought that she would get really teased. And around the time we were looking into buying a bigger house and I remember thinking 'No, we can't have that garden, it's too overlooked, we need

> somewhere really private, so when Emma is dressing himself in girls' clothes, nobody would see [Clare, 55-64]

They also worried about their child being bullied and hoped to protect them:

> And we were quite cool about it, you know, we just let him wear dresses and stuff but then we started to have few tassels, as he got older, sort of three, four, there would be time when I thought 'Well, I don't want you to get teased when we go', I don't know, to a family do or something, and I know everybody is really nice, but I just said 'Could you just wear jeans and a t-shirt? Or at least little shorts' and […] um [ ] and she would do it, but very reluctantly [Clare, 20-27]

Feelings of guilt were often reported to be associated with putting such boundaries in place:

> We were going on holiday and I said to Eli 'You need to have a haircut, we are going on holiday to Italy, you will be hot and sweaty if you don't have your haircut', trying to bribe him into a haircut, and he said 'So, you are going to get Stacey to have her hair cut short, then' and I was like 'Um […] no' and he was like 'Well, why do I have to have mine done then?' [ ] so I was obviously fighting this child who I thought was just a pain in the bum child, who didn't want to have a haircut, but once I realised and she started to say 'I want to grow my hair' and I went 'Okay', and when I realised I kind of felt guilty [Kelly, 18]

> I see her little face when she used to look at dresses in Primark and I used to be like 'No you can't' and you know, she used to be so sad about that, and I am doing that to her, I am doing that to her, I am making my own child sad [Chantal, 359-363]

There was a minority of families who allowed their child to lead the transition completely and explained that changes occurring or requested did not bother them:

> We allowed him to do anything he wanted to do, so you know [ ] if he wanted to go and dress as a boy, that was never a problem, we got on with that, that was never an issue [Bill, 53-56]
>
> If I take them shopping I let them choose what they want to wear, and Ronnie would, from again, two, three, straight into the [ ] I mean he would be looking at girls' things and he would be like 'No, not interested', so he was like 'This is Poppy's section and this is my section'. So yeah, we were quite happy to go with whatever, I mean, its clothes at the end of the day, you don't want to sort of, I would hate to put them into something they don't want to be in [Becky, 33-46]

Are they accepted or not?

This was felt to be a very rich theme and it was therefore decided to organise data by subcategories for clarity.

Live and let live

All participants reported eventually fully accepting their child's journey and supporting them on it. Parents talked about loving their child no matter whom they are and whom they want to become. All children had fully socially transitioned by the time the interviews took place:

> I met Becky, she is a hippie at heart, as she would say her religion is kindness, you know, and yeah [ ] it's just the way we are. You got to be accepting of people, 'cause you know, if you start judging people on appearance and looks and that, I mean, it's not really not the way to go, is it? We are world full of people and we should be decent to each other. If you, like I said, if you stop somebody from being who they want to be, they are just going to be unhappy and the by-product of that is that the

> family is going to be unhappy, so you just have to live and let live. Let people be who they want to be and nurture them and give them what they need, really. It's pretty simple to me that one. Let's just be decent, be kind, look after each other. And that's what we do with Ronnie [Danny, 41-52]

Who is with us and who is against us

Throughout the transition, experiencing the reactions of others to a gender diverse child was felt to be very significant and was discussed by all the participants several times. It appeared that parents felt strongly that if others were not supportive of the child's transition, then they were against it. Overall however, all families reported supportive reactions:

> The teachers were great and then by year four [ ] he went in and they done like a talk in school and had a policy put in and yeah, they were brilliant, so they put in a policy not just for Ronnie but anybody, 'cause they haven't had a transgender staff or pupil or parent [Becky, 104-107]

> This mum I don't really know she comes up to me and says 'Oh, do you want some girls' clothes? I got loads if you want, I have few bits of uniform, would that help' and I was like 'Yeah, that would be absolutely amazing', and we went out and when we came back there was this bag on our doorstep [Clare, 216-221]

Some families feared not being accepted by particular groups with more conservative beliefs and were pleasantly surprised by positive reactions:

> And there are loads of families as well who, you know, like my friends are devout Muslims and you know, their interpretation in their faith that it is not oaky, absolutely not okay, but yet to her, it's completely okay, she makes her faith work around it and

> she [ ] and you know most of our friends and family have been really, really accepting and really kind [Clare, 336-341]

> But we did tell Scouts, and Scouts have had policy on it for years, it's to do with support and also keep safe not just the children but the seniors too. Yeah, I guess the policy is there to protect the transgender person. So they were like 'That's not a problem, and if we go camping he will be staying with the boys' [Becky, 406-410]

Interestingly, it appeared that the method some parents chose to disclose their child's transition, to groups who they perceived to be potentially non-accepting, differed. Some found the use of medicalization of the issue helpful when reaching acceptance and support:

> And my nan and granddad are strict Catholics and not particularly keen on anybody who is not white, not particularly keen on anybody who is not straight, so this is going to be difficult (laughing). But I spoke to my nan, I went up there and saw them on my own and I explained everything to nan and granddad and she basically accepted on the basis that it's a mental affliction basically. So she was like 'Oh okay, well, that's terrible that you have to go through this, but I can see why you would have to go along with this, we don't want Emma to be upset' and then we went to see them, my nan was amazing, she was all over it, she was calling her 'Beautiful lovely little girl' and was calling her she, so it was fine [Mike, 290-300]

Even though the experiences were very positive overall, some families doubted the genuineness of such support and feared that their child was not as accepted as it seemed. Chantal [482-486] reported: "I guarantee that there are teachers in that school that think I am an absolute lunatic for letting my child go to school like that (laughing), um [ ] but obviously they are not allow to say that."

> Yeah [ ] she [ ] awkwardly, she beat the girl that she her friend from the year, who is like a really good runner and trains and goes to athletics class and all of that. And Emma left her in the dust. And it was sort of like (hiding her face), but her parents were so nice. But maybe deep down they are thinking 'Yeah, but she is a boy' [Clare, 407-411]

Very few incidences of non-acceptance were reported. Some of these were often described as "minor" or "unimportant". Mike [72-73] said: "There have been a few raised eyebrows in the cricket team, but no one said anything to my face [ ] negative about it. Others explained:

> Yes so it's really been positive you know. It's been a surprise for me, really [ ] I would have expected somebody by now to go [ ] you know [ ] I mean, when I talk to the guys at work they still say 'she' and I am like 'he' and they are like 'whatever' and I am like (rolling his eyes) [Danny, 156-160]

Other experiences were described as hurtful, resulting in serious consequences, such as breakdowns of family relations:

> And she wanted us all to go but she wanted Chelsea to be a page boy. And I said no, that's not happening and she said that 'Don't come to the wedding then', and I said 'Fine then, see you later.' So that's when it all that stopped. When we stopped seeing everybody [Chantal, 61-65]

Parents often talked about ignorance or not knowing leading to these experiences rather than viciousness:

> We heard this family in this caravan near our tent calling Emma 'it' [ ] 'Well, I don't know what it is.' [ ] and it was okay, 'cause they had a really large child and he came

> out, he was the one who said it I think, and he came out and he had a massive fried plate full of food and he just went like this (mimicking looking shocked) and his food slid off the plate. And I thought 'Bam', that happened because he had bad thoughts, bad things happen. But you know, it's ignorant, and it's not having met anyone like that and it's [ ] it's Brexit [Clare, 617-625]

Some experiences were described as 'battles' and they all occurred in school environments. Parents managed to deal with them promptly and, on the whole, received the outcome they hoped for:

> I said this to the school, I said, what happened one day was one of the children drew Chelsea with a penis and decided to send it around the classroom and everybody was having a look and a giggle, so obviously she told me and I went up there and I said 'What's going on?' 'Well, it's little bit hard because it's kind of stating the obvious.' I said 'Alright I get where you coming from, so if my twins come to school tomorrow and they draw miss Brown as short, fat and ugly with freckles, are you going to have something to say about it?' And they went 'Oh yeah.' It's the same thing. She is short, fat and freckled, so it's not about that, it's about you teaching the children in your care that you don't deliberately do something or say something to hurt somebody's feelings [Chantal, 150-163]

Experiences of indirect non-acceptance were also reported. Some parents called it singling out:

> At school, like even things like swimming, if they went swimming with the school, Ronnie changes with the boys, but he uses a cubical, I mean, he is not stupid, he knows he has female body, but you know, sometimes the teacher would be almost like highlighting him 'Ronnie is going in first' (shouting), almost like an arrow pointing

> at him. I mean, he manages to get into the cubical, he doesn't need people to sort of draw attention to it, I mean they were like 'You can't come out until everybody is changed', he doesn't care! He is nine! [Danny, 122-129]

Others reported similar experiences:"She is changing [for P.E.] with the girls but kind of in the corner being surrounded by three girls, very close friends who kind of stick together." [Mike, 210-212]

Binary world

Throughout the transition many parents noticed just how binary the outside world is, which was eye-opening. On many occasions they found this challenging and struggled to find a solution to this. They felt that their child did not fit into either ofthe female/male categories and was made to feel as if they did not belong.

The difficulties with using the 'right' public toilets were raised over and over again:

> Um [ ] oh, the biggest challenge is toilets. When we go out it's fine until he needs a toilet. Um [ ] I have always said 'Look, you are a girl [ ] you have a body of a girl, you gonna look like a girl, go to girl toilets' but he goes 'I don't want to go to girls' toilets'. So Helen takes him to the girls' toilets sometimes. And she said its [ ] it's like a rabbit caught in a headlight. He just [ ] literally [ ], you can see he is on edge, and he is looking everywhere, you know [ ]. When he goes to the boys' toilet, he just shoots right in and he does his stuff and he comes out [Bill, 495-503]

Another common struggle was with physical education (P.E.) classes and sports. Even though some parents reported to believe that prior to puberty, the physical abilities for children were similar and separation was unnecessary, it was felt that this belief would not be held by the public:

> She is really good at cross country running; I said to the P.E. teacher 'Oh my God, is there not enough? Not enough that she is trans, on top of that, she is going to be one of those athletes that pisses off all these radical feminists, aah', excuse my French. So she ran for the county, she ran the cross country national championships and [ ] but that kind of sneaked up on me as well, 'cause they have this lovely P.E. teacher and he said 'Oh, brilliant, she is really fast, she can beat all the girls' and I was like 'Aah, Mr Johnson, it's quite a difficult thing' [ ] and he was like 'Nah, she will win, so let's put her with the girls', so I was like 'Oh man, okay, but please don't win, don't win' [Clare, 547-556]

Medical appointments and notes were also frequently experienced as very binary and therefore not fitting for their child:

> Hmm. You know it's probably the 'male' [ ] I mean, on forms I really tick 'male' [ ] I guess it's probably medical having to have one [ ]. Like if I went to A&E, I guess it would be quite nice to have some sort of other box or a note [Becky, 560-563]

What was lost and gained

This theme was very significant. Even though the experiences have varied and not everybody has experienced this, strong emotions were present for those who did. A few mothers reported going through a grieving process when their child decided they wanted to socially transition:

> Really hard and still hard, I have to say. I do [ ] I still do feel like I lost my daughter and do feel in a way that [ ] I don't know, it's kind of, every so often I get really, really upset, as I think what could have been [ ] and [ ] you know [ ] and the timeline of

> events [ ] what might or might not happened and your expectations and I will always remember the day she was born [Helen, 242-247]

Some mothers became upset during the interviews. It was felt that even though they were supportive of their children, they continued to hope for a different outcome and for the child to revert back to their assigned gender. Being 'only gay' was suggested as one way how their loss could be resolved:

> I still hold on to the fact that maybe he will grow out of it [ ] I still hold on to that [ ] 'cause it would be an easier result, I think that selfishly, but yeah, I do still think that maybe that is what is happening as well [he is gay] yeah, it is quite possible [ ] and I would know how to deal with that [ ] um [ ] 'cause it could happen so [ ] you know [ ] we got two paths, either he is gay and that's fine, or he needs to peruse the change of his gender, which is also fine but just [ ] just [ ] I don't know how [ ] to deal with that [Alison, 177-183]

In contrast, there were some parents who were not able to relate to this experience. The idea of grieving for their child was reported to be confusing, or even offensive. Rather, they felt the very opposite. Gaining a happier child was the experience they had:

> Yeah. And you know how some parents talk about the loss of their daughter or son [ ] I just don't feel like that. No, not at all.Never. I mean, no, just no. Nothing. I haven't got a loss of a child, I still have a child, my Ronnie is there, all the time, sometimes I wouldn't mind losing him for a bit (laughing), you know, half a day would be quite nice on a Saturday afternoon, would be lovely going to do something else. But no, I haven't had those feelings at all [Becky, 483-494]

Is my child safe?

All parents talked about their fears of their child being hurt in some way, physically or psychologically.

Is somebody going to hurt my child?

The experiences reported felt to be of predominantly negative predictions of how the children will be treated as they get older. Parents feared their child being discriminated against or abused. These images were very distressing and evoked strong emotions during the interviews:

> Yeah, yeah, so yeah, being beaten up, knickers being pulled down, people standing around laughing and her hair being cut. I think these will be the three most damaging things that could happen [Chantal, 606-609]

Abuse and bullying were often discussed in relation to the children leaving the 'safe bubble' of primary school and starting secondary. Parents felt that teenagers had more potential to engage in hurtful behaviours:

> I think our biggest fear is secondary school. When the kids are starting to become [ ] it's a place with snarky remarks and horrible comments and I just think that he is a sensitive lad, there is no doubt about that, he is sensitive little lad, and I just worry [John, 59-64]

Another common fear was the school staff not accommodating their needs as well as the primary schools had done. This is something many parents worked very hard on and feared that they would have to start from scratch:

> And then come September, I think I will give them a ring just to ask if there is anything that we need to do, I just want to make sure that they are prepared and they

> don't have to put any policies in [ ] I think I would have to keep him at home. If they turned around and said 'Actually, he can't use the male facilities', I think I will end up home schooling him or something 'cause I think that would be awful but hopefully, that would be my worst case scenario [Anita, 329-335]

Other parents reported their anxiety over secondary school changing over time based on their positive experiences with acceptance thus far:

> She said to me 'Yeah, primary is lovely, it's all lovely and then they start secondary' and I felt this kind of icy hand grab my heart, 'cause I know that that's going to be hard where we are, but then I tell myself you know what, I turned myself inside out worrying about primary and I wish I hadn't, 'cause it was fine. So I actually refuse to worry about secondary school, I refuse. I refuse to accept that she is going to get bullied; I refuse to accept that she is going to have a crappy time [Clare, 476-481]

Other parents were more optimistic. They felt that society has changed, continuous to do so and that a brighter future than they originally imagined was awaiting their child:

> No, I don't worry anymore. I mean I used to, when we first started this journey. I used to worry about her future, but the more I see how people react when they find out that Emma's trans and how accepting everybody is of it, I think society has moved on a long way since when I was a child, I mean, you could have not done that like twenty years ago [Mike, 250-254]

How do I teach my child to stay safe?

Different families used different ways to protect their child from being emotionally or physically hurt. Some parents wished they had prepared their child for the harshness of adulthood, yet others felt they needed to let them find out for themselves:

> If I could only look after him all day, but I can't do that so [ ] and we are willing to let go and make him make his own choices, so fingers crossed, it's going to be okay for him [John, 557-559]

Anger was often expressed when this issue was discussed. Some advocated for harsher punishment to prevent hateful behaviours:

> It [abuse] should be punished with harsher sentences at school [ ] but yeah, this is the thing, I don't think you can just wait for a child to get to ten, eleven, before the police can intervene [ ] um [ ] it needs to be made very clear to everybody that you cannot behave like that in society you know, but it needs to be taught from nursery upwards, not waiting till [ ] we hit secondary and we do sex education and it will all be introduced, it's too late. Children are most susceptible to learning at younger stage so that's where we need to put our efforts. And like I said, if the parents are not on board, that I think social services needs to be involved, because [ ] you are not doing your kid any favour to letting them to half their age like that anyway [Chantal, 612-623]

Others felt that anger was not the right way to deal with unkind people and saw such experiences as an unfortunate, yet typical, part of life as one grows up. Being associated with radical activist groups was experienced as uncomfortable:

> I mean, you get very prejudiced, horrible things said [on social media], which I would never respond to, 'cause there is just no point, I mean, people don't really mean it anyway, I don't think and then you have the other side, you think for some reason that we should be free from prejudice, but everybody should be free from that, we are not exclusive, and sometimes, they [parents of gender variant children] are like little

> warriors, little gender warriors sometimes (laughing). But if you can't let people to have a difference of opinion then you are just going to be angry all the time and that's not healthy, is it, really [Alison, 475-481]

Even though all parents worried about their children, most made a conscious decision not to share their anxieties because they felt they did not belong to the child and could impact the way their future turns out:

> As far as he is concerned, this is his life; there is no issue or problem. We only see being adults, we know what the world is like, we know that in the future, there can be problems, we are anticipating the problems, and we got to a stop this [ ], how we are feeling, as it might never happen. If it does, we will deal with it but there is no point pre-empting things that might never happen and pass our anxieties on to him, that wouldn't be fair [Helen, 131-136]

Relationship to the assigned body

This theme describes the experiences and dilemmas that arise when the parents have to support a child who feels that the mind and the body do not match. Parental views and hopes of medical interventions to bring these two together are also described.

Body as the cause of distress

The experience of parents that their children were at peace with their assigned body was a united one. Parents often reported their children not to have displayed distressing feelings towards their body.

> She is quite at home with her body, she still stands up for her wee, she has the best from both worlds, she will nip into a bush on her way from school (laughing), I am not joking. So we don't have any dysphoria or anything like that just yet [Clare, 312-316]

Parents described being happy with their child's naivety and continued to protect their children from too much information about how will their body develop. Their adult knowledge of the future led them to feel many anxieties. These were however experienced as theirs and as above tried to shelter their children from it:

> I mean, I try not to go too much into it, 'cause I don't like to depress him. It is something for me to worry about anyway, and I am sure he has plenty of things and thoughts in his head, let alone having a mum constantly going on 'As you grow older, you will grow boobs' [Becky, 548-552]

For those parents of children who began to develop first signs of puberty, the experience was of tentative conversations to protect their children yet not creating unnecessary anxieties. This was reported to be very difficult:

> Well, it's been a bit of an issue in that his breasts are now developing, even though they are quite small at the moment, they are there. And sometimes when he has a t-shirt on, you can actually see. So we are having this thing at the moment about what do we do about that. And he says 'I'll just wear boys' vests', but it's not really disguising the fact that his boobs are growing. So we have gone on the internet, we looked everywhere, I don't want him to get into the whole binding thing as I don't want him to damage any areas and things like that, but I don't want him physically walking around school looking like a boy with breasts. So, it is an issue and he [ ] although [ ] he knows it's an issue, he refuses to wear anything. Well, you know, I think that the mistake I made was that I said 'You can wear a sports bra as that would flatten them a little bit but not damage you in any way' and things like that. But because I used the word bra, he associates it with being a girl and he says that he

> doesn't want to wear it, he says: 'I would never wear any form of bra whatsoever, how stupid would I look' [Helen, 380-396]

A contrasting and difficult experience was, however, reported by those whose child communicated a strong dislike for their body from a very early age. This was experienced as concerning to the parents who worried about the child potentially causing permanent damage to their genitals:

> She was in a bath with her twin and she said 'Mum can I Sellotape my penis down?' Well, willy, woo woo we call it, 'Can I sellotape my woo woo down?' And I was like 'No babe, you can't babe, you would damage it.' [Chantal, 243-246]

Using the stop button

Even though the parents did not report their children to strongly dislike their assigned body, they all felt that their children were keen to start hormonal blockers to stop their body developing any further once puberty starts. Parents experienced puberty as a possible threat to the content relationship their children had with their bodies and were therefore supportive of the medical intervention. They communicated that their child needed help assessing all the pros and cons, and that it was ultimately their child's decision to make:

> Hmm [ ] well, it's up to Emma, really. I mean it does seem to be, that she is happier as a girl, and we will help her assess what the right decision is for her, but at the end of the day, it's got to be her decision. And finding, you know, what interventions need to be taken [ ] I mean, if you are born with, this is a bit of a crass analogy, but if you are born with let's say a bad leg, and you do something to make your leg better, you wouldn't see that as intervention in a negative way. And I don't see this much different, of course it's different, but making things better for yourself as you were not born quite right [Mike, 229-238]

The primary thing parents hoped for, in allowing their child to take the blockers, was to halt the natural development of their body, in turn avoiding additional, unwanted features associated with their assigned sex. This would also allow them more time to decide if this was the course for the child:

> I just hope that it […]um [ ] by going on them, obviously physically it would stop him looking like a girl, which would hopefully have a good impact on his mental health and things like that. Um [ ] another thing is, yes, it gives us a little more time to decide whether this is the right path that he wants to be on [ ] um [ ] so that's basically it [Helen, 411-416]

There were concerns surrounding the use of the blockers, but these were largely outweighed by the positives:

> I mean, yeah, they have given us some [ ] the gender service people have given us some information about obviously the negative sides to it, and all the possibilities of the things they don't know the results of, 'cause they have not been used long enough to do a research on it [ ] um. [ ] But I mean, I have spoken to Eli about the negative sides we were given by the gender service and she […] she doesn't really care about it, I mean, she says [ ] 'If there is 50:50 chance that I will have weak bones when I am fifty [ ] but I could be happy now and now is important not when I am fifty' [Kelly, 16]

Only one parent was against the blockers due to his fear about how they will impact his child's development:

> Well, they told us about the bone development and that it can still grow well, not so much his growth, but it could affect his bones, could affect his attitude, and [ ] and [ ] so to me, that's a big decision. Now [clinician] said something really key the last time we were here, she said 'You do know, that you don't have to stop being a woman in physical terms, because there are women out there, who just hide it, and deal with it and then there are no issues, it's just you doing it, but the blockers would stop x, y, z.' But also, there are side effects and yes of course it can reversed, but once you started [ ] I don't know at this age, you don't want be mucking about with your body [ ] at a very young age [ ] um [ ] I, as a dad, as a parent, I am not too sure about it [John, 346-366]

The assigned males who would like to be mothers

Parents talked about their male assigned children wanting to have babies and breastfeed:

> We do have one problem and that is that she firmly believes that she would be able to have a baby. That kills me, but then, you know (crying), loads of people can't have babies, that's the sad reality, that you will have deal with in your own way [Clare, 295-299]

The experience parents described was one of sadness. Even though parents knew their children's wishes will not be met, they often felt the need to lead ambivalent conversations with them to protect them from difficult feelings:

> I mean, she talks about having a baby and she said she wants it in her tummy and she said 'Why can't I even if I had the operation?' (laughing) and I go 'No'. Which is [ ] it's kind of sad, I mean, she wants to be fully female, not just half, but obviously, it's not something that's going to happen in her lifetime, unfortunately [ ] I mean, they are

> doing womb transplants in some countries, but it would be obviously from a dead female to a female, that can't have babies, or maybe lost their womb because of an illness or something, so Eli was like 'Why can't I have one of them? Why can't I have a womb transplant?' (laughing). But it's like 'It won't happen in your lifetime, there aren't even trials now, it will take years and years and years before it happens' and she is like 'Can I be part of the trials?' So I said 'When you are old enough, if you are still interested, it is something we can look into'. So yeah, she would really like to, yeah [ ] but its [ ] She has gone as far as asking 'If I had a baby would I be able to breastfeed?' So yeah, she really wants to be a complete female [Kelly, 327-339]

For some it appeared important to hold on to the hope alongside the children, possibly to protect themselves from their own feelings of sadness of their child not having the life they would like:

> She talks about will she be able to have a baby and that that's confusing as your standard answer would be 'Well, no' but by the time Emma is 20 or 25, god knows what will happen. So I said 'Well, you will have to see what science does between now and then' [ ] yeah [Mike, 222-225]

The decisions which cannot be reversed

Even though most parents had some thoughts about cross-sex hormones and possible surgeries, they all felt that this was something in the distant future and their children were too young to have a discussion about this. The parents experience appeared to be one of trying to allow their child to be autonomous yet ensuring their safety. Overall, however support was expressed and parents were able to engage with the thoughts that their child will inevitably become independent:

> Yeah, it's been discussed in the fact that, we won't stop him [having an operation]. Um [ ] that's his choice. Obviously he cannot do it until he is old enough to make these decisions, but it is not something we will do. We won't be saying 'Right, you need to go and do this' but if he would to come and say 'I need to do this, that and the other' then we [ ] um [ ] would support him. […] It's not really been discussed with Mark, Mark's not really sort of grasped that just yet [ ] um [ ] but it's been discussed by us. We are quite happy to go with wherever he goes [Bill, 148-169]

Should we be speaking the truth?

This theme was recognised as an important one. All the parents mentioned it on several occasions. Some families felt that the right thing for their child to do was to be honest about their gender diversity, especially when entering a serious relationship. They felt that this would lead them to relationships that are 'worth it':

> I feel that he needs to tell people about his past and just be honest before getting into serious friendship groups and um [ ] um [ ] any form of relationship with anybody, because I firmly believe that relationships should be built on trust, honesty and I said to him, 'If those people then want to be your friend [ ] that's great, they want to be your friend because of who you are. And if they don't want to be your friend, then they are not worth knowing anyway' [Helen, 170-175]

For many parents, the importance of telling the truth outweighed their worries about the consequences of one saying the truth, e.g. being rejected or hurt. Some actually felt the opposite. They felt that telling the truth would keep their child safe:

> Cause I [ ] I know from myself that if I was [ ] single and I went to a night club and I met a guy and I have seen the surgery on these guys and its absolutely brilliant, and if I had a sexual intercourse with somebody that I thought was a guy, then I found out

> via online that they were born a girl, I would go mental, I really would and I would expect them for them to be honest to be quite fair. So we always said to Chelsea, you have to be honest about who you are [ ] um [ ] and Jack said the same: 'If I buffed a bird and then I found out that it was a guy I would want to kill them, I would absolutely want to kill them, because your choice was taken away.' If you know, that it's your personal choice if you can go there or not. And even though these [ ] these operations are so good [ ] and they really are [ ] I do, I really think you have to be honest with people for your own safety [Chantal, 583-589]

In contrast, some parents felt that honesty would not guarantee the child's safety. They appeared to struggle with what the best way forward was for keeping their child's safety at the core of it:

> I don't know if it would be worse for him to be open about who he is or does that leave him wide open to criticism and unsafe behaviours or does he go in stealth and just be Kevin [ ] I am not too sure at the minute [Alison, 270-274]

Situations in which the parents did not feel they had a choice and had to talk about the past honestly were mentioned. These were often related to seeking help from medical professionals. Parents felt these were necessary; however, they tried to do it in a way that protected their child's feelings:

> If we see a locum doctor or something I tell Ronnie 'When we go in, mummy will just tell them you are transgender, otherwise they will look at the screen and go (confused face)', so I think sometimes it is just better to get it out there rather than not say anything at all [Helen, 473-476]

We are all learning

Many parents described a process of learning throughout this journey. At the beginning this was mainly factual learning about gender variance. The internet was the predominant source of information:

> Um [ ] I knew a little bit about transgender 'cause I have seen some things on the TV [ ] um [ ] so that's what I said to her 'Well, it sounds like it might be this'. The first thing was googling it and reading [ ] um [ ] and then some of the things that I have read were like signs of and some of the things made me go 'Oh my gosh, she had all these signs' [Kelly, 347-350]

Later on, they also learnt from their children by listening to them:

> We were taught as kids, seen but not heard, you were not really listened to, in this day and age, we're supposed to talk to our children, find out what's going on and because society is changing that way, that's why the kids are comfortable saying these things. Back in the 50s, 60s, 70s there is no way you could say 'Mum I want to wear a dress', you know. I think it's all this listening to children, when that's come a long way in society that's why we are getting such a breakthrough with it and unfortunately it wasn't like that many, many moons ago [Chantal, 543-550]

> I don't want him to go down that route of having suicidal thoughts as nobody really understands how he really feels. You have to listen to your child and you have to act on it, don't ignore it. We did, we did buried our heads in the sand, he will grow out of it, hormones will kick it and then when even other people were realising that something was different about him, so then we were like ok, alright, well, we have known for a long time, let's do something about it now, rather than deal with problems [Helen, 568-580]

Some parents made reflective comments about their own self-learning and the things they noticed or changed as their child transitioned:

> So I have been more dogmatic at the start when Emma was being younger and her outwardly facing the world as a boy until [ ] we had our first session here [gender service] and [ ] I can't remember what it was about the first session here but I tried to explain my stance to them I doubted it more myself. So then I kind of became a bit more [ ] relaxed [Mike, 428-433]

> Realising what's important and what isn't, realising [ ] loads of stuff about my own gender, that I never really thought through, about how it is to be female and how lucky I am that my insides and outsides match, if you see what I mean, um […] but how I refuse, completely refuse to think about these situations as sad, I mean, it makes me sad and I do you know, I am a mum, so I have moments of emotions [Clare, 531-567]

The majority of parents said that they were keen to pass their knowledge and experience on:

> I mean I've got one sister who has gone a bit [ ] like that about it, but that's fine you know, she has got the right to not really understand, I said to her if you want to chat about it, talk to me, don't [ ] don't read articles or anything like that because it be little bit misleading, and every family is different [ ]. I think a lot people get it mixed up with transvestites. Somebody said to me 'Does he have a willy there?' and I go 'No, that's the whole point' (laughing) [Alison, 492-505]

> What I have signed up for was to be an ally of an organisation called Spectrum, where it helps to call for diversity and that kind of thing. I just felt that it might be a little hypocritical if I didn't try to help [Mike, 363-366]

Most were pleasantly surprised others (such as teachers or medical professionals) were keen to learn alongside them:

> ‘So I said, you know what, I think that we do split gender stuff too much’, so in her classroom she said ‘I am not going to do boys and girls anymore even though it’s the easier way’, you know [ ] all the boys to go first or you know [ ] so she started splitting up to do eye colour or hair colour [ ] yeah, she was saying that she was speaking to a lot of the kids about doctors and nurses and she said she was shocked how boys thought doctors are more men than woman, so she said actually I now want to make it a bit more [ ] you know neutral. So yeah, she was really inspired [Becky, 159-168]

> My GP got in contact to make sure we were going in the right direction and that everything was happening, I guess she wasn’t , you know, it was the first case for her and she said If it happens again, I will know exactly what to do (laughing) [Becky, 234-238]

Comments about society learning and changing over time were present, too. Overall, the experience was of one of support and the world moving in the ‘right’ direction:

> You would have the […] you would have the gay and transvestite comedians and TV presenters that were national treasures, but there was still a lot of homophobia, so you didn’t dare be any different at school, otherwise you would be gay and that was it. And all the words that were associated with that. So how we got from that, being widely accepted [ ] I don’t know [ ] I don’t know how that evolution occurred in my lifetime [ ] it felt like nothing happened and suddenly it happened [Mike, 310-318]

> It will be fine with us, ‘cause luckily, thank the lord, society has changed enormously in the past [ ] even ten years, five years, even last couple of years, the media, it is all over now and everybody says ‘Oh did you see the transgender programme last night?’ Everybody is talking about it, so it’s now not the wrong thing it’s now [ ] I wouldn’t say normal, we are nearly there, we are not far off, I think another five to ten years and people would be like ‘Alright, oh yeah, that’s cool’ and that would be the only conversation we have [John, 136-144]

Receiving help from professionals

This category describes the journey of the parents working with professionals to support them on their journey. It involved not only the specialist clinic they were all referred to and working with, but also children’s mental health services, GPs, paediatrics and endocrinologists.

What help do we need?

This theme summarises the individual expectations each parent had when dealing with services. What one found very helpful, the other felt was unhelpful or even damaging. It seems that each individual story called for a slightly different professional approach. Firstly, contrasting views were raised on the issue of a specialist services having to be involved at all. Some parents felt that their child and the transition process did not need any intervention and that the support from specialist services was therefore unnecessary. They mainly remained in contact to access the hormone blockers and often wished they could do this without the regular meetings in the service:

> Yes, I mean I feel like we walk away, and we have re-discussed what we have already discussed [ ] yeah, next time we go, it’s like repeating what we said last time, so I kind of feel that the last few sessions were pretty much the same. It’s a bit of a waste of time if I am honest [Kelly, 468-470]

Others disagreed with this. They felt that, as a family, despite having not met many challenges so far, most decisions were serious ones and needed a lot of thinking through which the professionals were equipped to help with:

> Well, I can see why people would say that [that attending regular sessions was unnecessary], but also, but I kind of disagree with a sense that you need to [ ] I mean, it's not just about going and getting some blockers, otherwise everybody would be doing it, wouldn't they. Loads of people would be making very bad decisions, they might have other issues that take them down that road, and how many times can you change gender? Well…not often I don't think! [Danny, 403-413]

The distance to the clinic was often mentioned. Even though many parents understood that this was resource driven, they still expressed the wish for the help to be closer or to have more of it across the country:

> It would just make it a little bit easier [ ] and I just think Kevin wouldn't get here shattered from the car journey [ ] 'Tell me all about it' 'Uff, what? I am not interested' [ ] and then hour later, we have to get in the car and we have to drive straight back, we can't hang around or have a cup of tea, we got to get back, otherwise the day goes into a silly place and they don't get to bed on time, so yeah [ ] if that can be done, if the gender service can do a clinic in Birmingham, or however we can work it, even if it's a day every six months, I am pretty sure the business would be there. [ ] Ahh, and life would be just little bit easier. And I am not thinking the driving, I am thinking about getting Kevin in a comfortable zone, where he can think, 'cause like I said, by the time we get here, he is shattered. He spends six hours in the car, we stop once for a toilet break and a quick brew and then [ ] you know [ ] it's a lot, he is only a little lad[John, 310-323]

Others felt differently and said they found a way how to turn the long travels into a positive:

> Again [ ] if there was more places like these it would be fantastic, but I don't need one on my door step, I am quite happy coming here. It's a nice day out for us, it's nice to spend a bit of time with Ronnie [Danny, 490-493]

Holding uncertainty

Parents often found that simple solutions to their answers and worries did not exist. One of the parents described the journey like this: "A lot of this is a waiting game isn't it". [Alison, 292]

The experience of uncertainty and doubt was a very common one. Parents felt that the specialist service had helped them to understand that many of these issues do not have simple solutions and allowed them to feel more comfortable during times of uncertainty, allowing change to crystallise over time.

> We have always have been able to ask what we wanted to ask, get advice on what we needed to get advice on [ ] um [ ] and I think it was really smart the way nothing has been told with certainty [ ] and it still isn't [ ] I mean, as we go along it is more and more evident that she is probably trans but that reluctance to give a label, it's been living in the moment and what will be will be but let's not try to force into anything [ ] and I think that's really good. And it changed the way I thought about it dramatically [Mike, 331-339]

> I came in and I was like 'Are we doing it right?' and they were like 'There is not wrong and right' and I remember feeling 'Thank goodness' 'cause I was worried if we were doing it right and everything else, so it was quite nice to get 'Actually there is no

> wrong or right, you sort of go with them' and it made me go 'Actually yes, that is true, its fine' [Clare, 315-320]

'Tell me that it will be okay', 'Finding the right pace', 'What if we have different views?' demonstrate the experience the parents reported of how services tried to manage their doubts.

Tell me that it will be okay

Even though many of the families talked about not needing a lot of support from the specialist clinic, as their journey was often described as easy or smooth, many felt that the reassurance was very helpful and made for a calming experience. In times of doubt and uncertainty, they found it helpful to be told that they were doing okay and things would work out:

> Obviously the gender service has not given us as much support, but reassurance, that [ ] there is […] this life out there [ ] and there is an outcome to this life and it's normally okay, you know [ ] there is a start and there is an end, you know, and you will get to the end and you will be happy at the end, we don't know what the end is [ ] but whatever it is, you will be happy with it. And that's the reassurance we got from the gender service [Bill, 383-389]

> There has been times when I wanted to pick up the phone and phone the support organisation, and I have rang here once before in floods and I spoke to [clinicians] once and I was just like [ ] I could hardly talk for crying I was so worried about everything and I was so overwhelmed and they were so lovely and they always make me feel better, whenever we come here for a meeting, I never go away thinking 'Oh my god', I always felt like 'Yeah, you are right', it's always really practical and positive. It makes me feel 'Yeah, of course this is manageable situation' and

> [clinicians] would say ‘I know people who are’ [ ] you just want to know that there are other people out there and that they are okay, so we will be too [ ] isn’t that what we all want? And you want to know that your child is going to have a great life [Clare, 680-692]

Finding the right pace

Many felt that the specialist service would often slow things down to allow time in order for families to make the right decision. Some parents appreciated this; it made them feel safe and allowed for thinking time. Jane [124-126] said: “What I liked was that they have eased me into this motion of having a transgender child.”

In contrast, others experienced this as frustrating; they wanted the service to move along with their needs:

> I had to fight [ ] the gender service, well, the two people we were seeing over having the appointment for the blockers, which is really frustrating and Eli got quite upset about it, from the way they have handled it, because we had a meeting with them and they said ‘Okay, so next time you come we will refer you to the people who will do the test to see if you need to blockers’ [ ] and it was like ‘Great!’ [ ] then it went to the next one, and obviously they are like two months apart, so obviously Eli and I expected them to refer and they said ‘Well, we won’t refer you this time, what we want to do is to see mum and dad on their own without you Eli and then we will refer you’, so Eli was like ‘Oh’ and I was like ‘That’s cool’ and [ ] you know I understand they have some kind of thing they have to stick to, so that’s fine. And then dad and I went and they said ‘Okay, so we will see you just before Christmas’ and I said ‘And what about the referral?’ and they said ‘Okay, we will refer you after you have come in’ [ ] yeah, so Eli felt like ‘Well, they said they were gonna do it not last time, the time before and then we have come back again and they still didn’t do it, why aren’t they doing it?

> Why don't they want to do it? Why don't they want to refer me? What's wrong? Why can't I be referred?' And I said to her 'I don't know' [Kelly,479-593]

What if we have different views?

Many of the decisions the families faced were serious and needed a lot of thought. Several of the parents experienced the services as challenging their views to help them think things through fully. Some families experienced this as helpful:

> And obviously, we need to wait for puberty to start, and gender service point of view is that they are going to challenge all the way, which is fine, good, perfect way, how it should be done. You don't want someone to go down an avenue which turns out they didn't actually want to go down. But at the same time [ ] it's going to be organic process I think, it will just evolve as we go [Danny, 487-492]

Alternatively, others experienced this as unsupportive and negative:

> I found the gender service when we were seeing them [ ] before and even with the people we see now [ ] I find it difficult, because they obviously give her all the pros and the cons of stuff, but it always seems quite [ ] in my head, it seems quite negative. Um [ ] and I think Eli finds it difficult, 'cause they always say [ ] 'if you change your mind' and if this and if that and 'Are you sure you don't want to tell people, you should tell people, you shouldn't keep a secret' [Kelly, 11]

Working together

The one thing all families agreed on was that the most helpful point was when different services worker together and holistic care was provided:

> The pastoral care for Emma then became a joint effort between the gender service and the school, that was really vital. The school has learnt from the gender service about how to handle the situation and they, you know, have done a really good job of managing it [Mike, 136-140]

> I mean the transitioning at school happened with the gender service as well and they came in and met the teachers to give a bit more support, so I guess they were a bit nervous about doing it all [Clare, 299-302]

One mother noticed frequent battles between the gender service clinic and support organisation on social media. It was felt that this split was unhelpful and made her scared when their journey began as she was not sure who to trust. She hoped that further research would enable her to find the answers about what the right help is, and that different services would work together rather than compete to provide stability and security:

> This was very important to me, I just want to help, 'cause then we can help the next generation coming through [ ] if there is an easier pathway for them and a lot more studies done on it, then we can all agree on it, the gender service, the support organisation [ ] as this is it. This is it. And there are always exceptions to the rules but you know, but it would be good for everybody working together rather than bashing heads all the time. When I first joined the support organisation, [clinician] rang me up and I was very excited about coming to the gender service and the first telephone conversation was 'Well, don't expect much', so I was a new person coming to this new world [ ] um [ ] and I was really deflated and I thought [ ] um [ ] well, sometimes I find it very negative place to be [Alison, 554-572]

Talking to the child in the room

The experience of how the parents perceived their child to be related to in the room was varied. Several parents shared difficult experiences. They felt that these conversations were far too adult for their child and they were not able to understand them:

> I think he knows some of it, but a lot of it is very grown up and I don't think he gets it. But [ ] hmm [ ] don't gets it is probably not the right word, but I just don't think he fully understands [ ] I mean [ ] I don't remember when I was ten years old, I remember when I was ten years old, I was riding bicycle when I was ten years old, that's all I probably remember, but having to make a decision that can change your life [ ] no, I don't think so [John, 366-377]

More often, parents felt that, it was the way their children were spoken to which led to them not understanding and not being able to engage with the conversations:

> With CAMHS [ ] I guess it was difficult, 'cause the gentleman we spoke to [ ] spoke in my opinion in very grown up terms. So a lot of the questions he asked [ ] Eli didn't understand them. So a lot of the time it was like [ ] 'Hmm, maybe', 'Hmm, I guess so'. Whereas I was like [ ] 'This is what he is actually asking you' and I was trying to break it down differently so Eli would actually understand the question [ ] and then she would answer it a bit more clearly. So yeah [ ] the language, that was being use to then probably a nine year old really wasn't helpful [ ] in my opinion [Kelly, 10]

> Talk to a child like they are a child, she called a man's penis appendage, so she goes 'Oh, so you are missing an appendage (laughing) and I was like [ ] (laughing), I didn't even know what it was (laughing) [Alison, 399-402]

Others felt that their child was present, discussed, yet ignored:

> He was just talking to us and asking us questions, rather than [ ] and she was in the room [ ] and at one point I stopped the session, and I said 'Tom, dad, take her downstairs. 'cause I felt like she was spectacle, we were talking about her, but she was there! And I felt highly uncomfortable with it. If you want to interview us, you should have said leave her in school for the day, we will talk to you first as parents and then bring the child in and then we will speak to your child. But there was no interaction with her[Chantal, 250-258]

Some described that the children were given unnecessary attention, which was felt to be intrusive and counterproductive:

> So you know, you got this young child, ten years of age, he was nine when he went in, who doesn't understand that language, and it just feels like he is being probed all of the time, you know. You are sitting him down in a chair and everybody is just want to have a look at him. You know [ ] and when we do go, like sometimes we have been to the doctors, I think he went in, because he had a lump inside his mouth and they were interested in the lump obviously, but they wanted to talk about his gender straight away, so they were quite interested [Alison, 402-411]

Uncertain future

Many parents brought up the topic of the journey continuing on with many challenging dilemmas to be faced and questions yet to be answered. All parents agreed that the future felt uncertain for them; however they all agreed that further development will be led by their child and they planned to be flexible and supportive.

> Lots of things can change and I am really open to that concept, that he might grow out of it, because it is a possibility, you know, it's not that because he has expressed

> to play with boys toys at a young age that he has to be a man when he is older. He might be in that [ ] place at the moment, but you know, but we all go on different paths, and we are allowed to change our mind. And I think that's what I try to instil in Kevin no matter which route he goes down, we support him, but I just want to make sure that it's definitely the way he wants it to go [Alison, 465-474]

> We say, you are who you are, we are accepting this part, but if you want to go back, swing backwards and forwards, it's like [ ] it's up to you [ ] as long as you follow the other rules of the house (laughing) you can get away with it, you know, it's fine, we are not [ ] we don't [ ] we don't really mind [ ] either way [Bill, 322-326]

They felt that services will play an important role in their ongoing journey:

> But I quite like coming here with Ronnie 'cause I think it's a good and healthy thing to keep coming regularly, I wouldn't want to go longer than six months. Um [ ] probably 'cause he will have to spend longer, more time up here as he gets older, I am presuming, don't know [ ] um [ ] and the will have a lot of talking to do and thinking to do, a lot of medical intervention [ ] as he gets older, if that's his choice, so yeah [ ] I guess it's a healthy start, to get used to all this, talking to people, and feeling comfortable talking to people [Becky, 514-520]

Chapter Summary

This chapter began with an overview of key characteristics the final participant sample included in the study. A summary of the analytical process the data was subjected to was provided, following which the resultant theoretical model was introduced and discussed in detail with reference to the dimensions of and interactions between the major, minor, and sub-categories subsumed within the model. The inclusion of participant quotes demonstrated how the model is grounded in the data, and helped to evidence the model's

utility in explaining the experiences of compassion to self and others among participants. The outcome of member checking procedures was described. The following and final chapter of this study will build on the these results through the consideration of the tentative model in the context of other literature, before discussing the strengths and limitations of the current research, along with the implications for research and clinical practice.

Discussion

Overview of Chapter

The final chapter begins with an overview of the research findings detailed in chapter three. The theoretical model of the experiences of parents of pre-pubertal children who express their gender in diverse ways, which emerged from the data analysis, will then be discussed in relation to the extant literature reviewed in chapter one. The strengths and limitations of this study will be highlighted and clinical and research implications will then be described. A reflexive account of the research is included.

Summary of findings

The analysis resulted in a substantive theoretical model that sought to explain the experiences, and their meaning, of parents of pre-pubertal children who express themselves in a gender diverse ways (see Figure 1). The model consists of nine major conceptual categories: My child might be transgender, who can help?; Receiving help from services; Uncertain future; Transition; Binary world; What was lost and gained?; Is my child safe?; Parents' relationship to the assigned body; and We are all learning. 'Transition' was the very core, dynamic and relational category connected to all the others to demonstrate that it was an on-going journey which was directly interacting, impacting and being impacted upon by many factors. The following section aims to discuss the key aspects of the model within the context of the existing literature to examine the differences in the specific experiences of affirmative parents of pre-pubertal children who express themselves in gender diverse ways.

Discussion of model in relation to extant literature

My child might be transgender, who can help?

When interviewing the families, what appeared to be very important to them was being able to share their experience of their children's gender diverse story at the very beginning; in a place where their transgender child 'emerged'. From then onwards, their stories seem to follow a similar trajectory and particular phases were being recalled over and over again, by both mothers and fathers. These phases will be discussed below.

The emergence of the transgender child

The families described experiences of observing their child not conforming to typical gender stereotypes from a very young age. These behaviours were described as 'just appearing' without the parents feeling they had any control over them. This is in contrast with previous studies which report that children do not come out as transgender often till adolescence (Sansfacon, Robichaud,&Dumais-Michaud, 2015). Ehrenshaft (2012) describes similar experiencesto those reported in this study. In her clinical practice she met with families whose children 'not coming *out* but rather coming *to* the parents'; 'showing up' so to speak, and parents being left watching it unfold over the years, often in extreme contrast to other children in the family. Similar experiences are discussed by Wren (2002), who describes this as the child 'presenting itself to the parents'. These experiences appear to be in contrast to the psychological theories concerned with the aetiology of gender diversity described in chapter one. These locate the significant influence within the parent or at least the parent-child relationship and suggest that gender diversity might be a product of trauma or attachment disturbances (Coates, Friedman, & Wolfe, 1991), an unresolved Oedipus complex (Tyson, 1982), expression of internal conflicts (Zucker& Bradley, 1995), or unresolved parental mental health difficulties (Coates et al., 1991). Previous research found that even though parents were aware of the psychological theories, they were often rejected (Coutler, 2010). The biological explanation – the perspective of 'being born this way' – would better account for the experience of the 'child presenting itself to the parents' as it suggests that gender diversity is rooted in biological factors which are innate and free from the influence of the parents (Spack, as cited in Spiegel, 2008). As discussed previously, no research to date has however been able to explain the current causation of gender diversity and the 'nature-nature debate' continues to be highly relevant (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). This is in accordance with the experiences of the parents in this study, which appeared to be complex and speak to multi-factorial influences on how their child's gender developed.

Is it something I have done?

Even though parents' views on aetiology are yet to be empirically reported, some initial findings (e.g. Sansfacon, Robichaud, &Dumais-Michaud, 2015; Wren, 2002), as well as observations of professionals working in specialist services (Wren, 2014) indicate that parents find the biological explanation of gender diversity best fitting as it places the 'blame' on the 'disorder' rather than their own enactments. The analysis of interviews in the current study however suggests that this issue is more complex than just simply 'picking' a reason as to why the child's gender developed the way it did. There have been times when parents, especially mothers, engaged with the biological way of understanding yet also wondered about difficult questions around their own impact and feared that they 'turned their child trans'. For example, there were some who expressed feelings of guilt in relation to hoping for a child of a different gender and disappointment when the assigned gender was revealed to them. Overall however, it could be argued that parents experience conflicting feelings when coming to terms with such developments and that these ideas are not static, but rather fluid and changeable over time as parents grapple with them. There are some studies describing a strong blame culture towards mothers especially (Zucker, Wood, Singh,& Bradley, 2012) which continues to be supported by social media (Manning & Adams, 2014). This might, in part, explain why eventually biological theories come to be more appealing to some. Similar shifts in understanding, from psychological to more biological understandings have occurred in psychology for decades (e.g. autism and 'schizophrenia' were once believed to be caused by the 'refrigerator mother', a mother who did not provide their child with enough emotional warmth, [Kanner, 1943]) and this has to always be understood in the social, political, and scientific contexts in which such shifts occur. A deeper exploration of the relative roles of psychological and biological (and diagnostic) ways of understanding human experience is beyond the scope of this work. However, it may be helpful to consider that the essentialist explanation that biological understandings offer allow people to circumvent exploration of more interpersonal and experiential aetiological factors (Haslam, 2000). Thus people have motivated psychological relationships to explanations.

Ehrenshaft (2012) suggests that perhaps the child's non-conformity might be best understood as rooted neither in the brain, nor the genitalia, but in the psyche. This introduces a different way of understanding the experience of the child 'showing up' and how it might come about in a family context, which some families might find helpful. As described in chapter one, Ehrenshaft (2002) adapted Winnicott's (1960, 1965) concept of the true and false self. The true self is identified as the authentic core of one's personality which when given a nurturing space, unfolds. In contrast, the false self is fostered by environments in which the child has to accommodate the demands of the family beliefs. Within family life parents, if responsive, enable the child's true self to creatively flourish which results in a feeling of authenticity and 'being real'. In contrast, if parents do not enable this, the creativity of the true self is taken over by compliance, resulting in the true self being suffocated and in individuality being unable to blossom.

Overall, what felt more important than the cause of the gender diversity, was the experience of the children shaping the parents and the family rather than the other way round. Whether it was due to biological, psychological, societal factors, or the interplay of all of these, the process was experienced as a child making the initial steps and parents merely responding and shaping it further. In this study the aetiology was not directly explored by the parents. It was felt that many did not feel consciously concerned with why their child was the way they were even when directly asked. Therefore, it could be argued that for these parents the aetiology was not as important as it is felt to be for academics and critical theorists. Perhaps our Western understanding and theories fall short and we need to search outside of them to be able to get a glimpse of what it might feel like. Hillman (1997) says:

> There is more to human life than our theories of it allow. Sooner or later something seems to call us onto a particular path. You might remember the 'something' as a special moment in childhood when an urge out of nowhere, a fascination, a peculiar turn of events struck like annunciation: This is what I must do, this is what I have got to have. This is who I am. (p.3)

The idea of something being called to become alive was echoed by Meadow (2012). She describes the conversation of a parent with their gender diverse child about how the child knew she was a girl. When she was asked what it was that told her, she was given a choice of either her brain or her heart. However, she replied, "*Mommy, it's my soul. My soul tells me I am a girl, deep down where the music plays"* (p. 740).

It is important to note, however, that there are others, who strongly critique the possibility of the child having a deeper innate idea of not only 'soul' but also who they are and wish to be. Davies-Arai (2018) suggests that the idea that children know themselves best, that they are born with a fully developed self, and that it is the parents' job to enable its expression, stems from the culture in which attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978) has emerged as an influential theory, a culture which privileges the needs of the child above other concerns. She warns that applying such 'child-knows-best' practice to gender identity fuels the child's idea that their feelings are the full reality and that things could have developed differently if the parent reacted in a different way. It is perhaps important to hold in mind that there may be an interaction between the two; the self and needs of the child and the influence of the parents.

Starting the conversation

Following the journey above, parents described an experience where they felt the 'new' child was here to stay and some serious questions had to be raised and explored. Many parents described this as a difficult time. Making the initial steps to start the conversation felt uncomfortable for several reasons. Some were not sure where to go and speak about this. A similar finding was reported by Hill and Menvielle (2009) who learned that parents felt 'in the dark' and lonely, failing to find others who they felt they could open up to. In this study, those who did manage to find a listening person at this time, reported feeling misunderstood or even rejected. What emerged from the data in this study, was a common experience of parents avoiding, or at least not actively seeking, to overcome the hurdles described above, leaving them 'in the dark' by default. It might perhaps be that they

feared what would happen if things were articulated aloud and the impact this might have on the homeostasis of the family that they were perhaps trying to hold on to. Philips states

> If you can find someone who can bear what you've got to say, and who happens to be able to not need to give you advice, cure you, or get you to behave differently, it's very, very powerful. Because then you can hear what you say. And find out what you feel in the saying of it (London Review of Books, 2015)

Parents in this study often felt they could not find such a person and therefore remained silent, waiting for others to start the conversation for them. Wren (2014) suggests that beginning such conversations with others is potentially difficult not only due to factors mentioned above but also due to the idea that once this discussion has started, parents must have a clear idea of where they position themselves in relation to gender diversity in order to account for themselves in such conversations. Parents reported, however, that once the conversation began – with schools most often the initiators – it was a relief.

Receiving help from professionals

What help do we need?

Previous research has shown that the experiences of adults who express themselves in gender diverse ways with professionals were unsatisfying. Gender diverse adults have been found to often report negative experiences with medical and mental health services (e.g. Poteat, German, &Karrigan, 2013). A lack of expertise on gender issues from medical professionals was reported and thought to have led to the use of incongruent pronouns, derogatory comments, violation of confidentiality and an avoidance of touching clients (Lambda Legal, 2010). Experiences with medical treatment were described as blaming, shaming and objectifying (Poteat, German, &Karrigan, 2013). A lack of knowledge, a lack of cultural sensitivity and discrimination were found to be common themes in research by Sperber and Lawrence (2005). They found that psychotherapists overly focussed on gender issues when the reason for attending therapy was considered unrelated by the client. Further difficulties were reported by Caroll and Gilroy (2002) and included enforcement of a gender binary split and labelling transgender identity as repressed homosexuality. Others reported

that such experiences were triggering of mental health symptoms and often led to individuals avoiding mental health services (Mizock and Lundquist, 2016; Shipherd et al., 2010). Studies exploring parents' and children's experiences with professionals are very limited. In the current study, some comments were made about professionals being ill-educated about gender identity issues, however most parents reported affirmative and supportive care. This might not be surprising given that in recent years, as discussed in chapter one, the clinical treatments in many services around the world lean towards affirmative care, in accordance with published medical guidance (e.g. American Academy of Pediatrics, 2018; Royal College of Psychiatrists, 1998; Standards of Care by the World Professional Association for Transgender Heath, 7th ed.; 2011). It is important to note, however, that even though affirmative care and such guidance is supported by many, it has been challenged by transcritical groups (professionals and parents). While they believe that the intention behind such recommendations is to protect the health of the gender diverse youth, they express concerns that the clinicians using affirmation therapy are inadvertently inflicting physical and psychological harm. They call for a critical perspective and consideration of contrasting evidence (e.g. evidence of desistance and de-transition), when assessing the needs of gender diverse children before 'blindly' affirming their preferred gender. Furthermore, most parents in this study were connected to specialist help through a school referral and several few through their GP. For reasons discussed above, most reported feeling happy that someone took control of this and signposted them to a place where they hoped to find containment, reassurance and support in times of uncertainty. Different experiences were reported about different types of services and these will be discussed below.

Experience with the specialist gender service

To date, there are no studies exploring the helpfulness of specialist services to such families. In this study, overall, parents reported trusting the expertise of professionals in the gender specialist clinic and felt supported by them. However, different experiences were reported when the usefulness of the service was discussed. Experiences of receiving help from the specialist gender service were of two kinds. One group of parents described finding

it very helpful and necessary. They appreciated the reassurance and companionship on a journey which at times felt very uncertain. They valued the relationships they built and were pleased with professionals raising difficult questions as it was those people who often helped them think things through. The position of uncertainty was challenging but possible for them to hold. The other group, however, even though they described the experience as pleasant overall, did not feel that it offered much beyond what they had already considered and knew. They felt that the meetings were unnecessary, even a 'waste of time', and they found them repetitive. The reason these families continued to engage was to be able to access medical treatment later on. Similar differences were found before, however between accepting and non-accepting parents (Wren, 2002).

The findings in this study are very interesting given that all the parents affirmed their child's preferred gender and supported their children through social transition prior to the interviews. It seems, however, that the first group were able to accommodate their views and values throughout the continuing process of transition, appreciated being challenged by professionals and continued to ask themselves and others challenging questions. The latter group appeared, on the other hand, less flexible. They seemed to convey a clear idea of how, and by whom, their child should be supported and were not willing to consider different views. This meant that at times they would be unreceptive to professionals questioning the status quo and further, they might exclude others (e.g. friends and family) who were unsympathetic to the way they chose to support their child. For this group, holding a position of uncertainty appeared to be more difficult. Perhaps, it is sometimes easier to live a life in accordance with a world set in binary terms, than to try to find a more authentic way to live outside of these boxes. Wiseman and Davidson (2011) suggest that "*a binary discourse of sex and gender provides concrete predictability where there actually may be a great deal of uncertainty and fluidity, both temporal and contextual*" (p. 31). West and Zimmerman (1990) explain that only very few of our experiences in the world can be separated from gender, as our gender is inescapable and present in everything we do. It is forever present not only in the concrete world around us, but in the stories we have been telling for generations, in our

fantasies and dreams. Practically, it is how we choose to identify and classify ourselves and others. As human beings, the uncertainty which is created when this binary is compromised is very difficult to bear. It appears to create an anxiety which we resolve by finding a way to split the world in to the feminine and masculine. Evidence to support this was found by Lev (2006) who reported that children who are born with ambiguous sex characteristics (e.g. intersex children) are at times unnecessarily medically treated and forced to belong to one category only. This can often happen even without the parental understanding or permission.

Experiences with children's mental health service

Experiences with children's mental health services often evoked difficult emotions. Parents felt that not only were professionals not knowledgeable enough about the issues the family was bringing, but more importantly, they struggled to attend to and engage with the child in the room, even though they requested for the child to be present. Some parents felt that this resulted in a feeling of discomfort and experienced their child as being treated like a spectacle by being observed but not engaged with. Steiner (1985) describes the psychic defence of *'turning a blind eye'* to a state of mind in which one is capable of observing reality, but can nevertheless misrepresent it to themselves and to others, and consequently live in an unreal world of phantasy and illusion. Such a concept may help to begin to understand how it can be that a child can be in a room yet their experiences are not being engaged with by professionals. Hegel (1807/1977) talks about the 'recognition' of the other as a necessary precondition for nonviolent social relations. The lack of the act of recognising and being recognised has been evidenced as harmful (Taylor, 1994). These ideas speak to the fundamental importance that professions attempt to understand the child's experiences form the child's point of view. Parents' experience of their child not being recognised created feelings of anger, sadness and disappointment.

Furthermore, parents often raised complaints about professionals'' lack of gender knowledge. Gray, Sweeney, Randazzo, and Levitt (2015) and Kuvalanka, Weiner, Mahan (2014) also reported parents being upset by this. Some did not mind professionals who did not know as long as they were willing to learn, which again speaks to the idea of

professionals perhaps engaging in curious stance when meeting with such families and sometimes moving out of an ‘expert’ position.

It could hypothesised that the above complaints, the lack of knowledge and inability to be with the young person, are connected. During clinical psychology training, an emphasis is often given to evidence-based knowledge. Clinical psychologists are told to be scientist-practitioners. Even in Child and Family Clinics where a variety of professionals work, the current political and cultural climate reinforces the idea that clinicians *should know* what the best approach is and they *should know* how to soothe and sooth as quickly as possible. However, gender diversity is a topic many professionals know little about, and as it is a ‘difficulty’ which cannot be simply ‘fixed’.

Ryle (1949) distinguishes between ‘knowing that’ (i.e. theoretical understanding) and ‘knowing how’ (i.e. capacity to think one’s own thoughts). This is elaborated by Shon (1983) who suggests that the predominant academic and managerial paradigm is characterised by the application of a pre-determined body of technical knowledge, embodied in a set of procedures and rules, forgetting what they were designed to be in service of and of the role about the unconscious processes. This overreliance on technical-rational forms of knowing can be understood as a manifestation of the unconscious defence against not knowing (Armstrong & Rustin, 2015). When clinicians are experiencing anxiety and uncertainty about what to do, they may often adopt a psychic position similar to what Deutch (1934) called the ‘as if personality’. In this state of mind a person acts into a role (in this case ‘being a clinician’) to manage anxiety, thus directing anxiety into action. By ‘remaining professional’ they may avoid questions which could create more anxiety, despite the family hoping they would be asked. This is perhaps an attempt for the professional to feel they are safe in a ‘knowing that’ position. This then disables professionals from listening, hearing and learning from the person sitting before them (a ‘knowing how’ position).

It may be that professionals ‘turn a blind eye due to processes similar to those that underlie the phenomenon of internal racism (Lowe, 2013). Rustin (1991) sees racism as a akin to a state of mind in which mechanisms split objects into loved and hated, which then

becomes feared and therefore attacked. Such splitting mechanisms include idealisation as well as denigration. In this case, the latter would be mobilised in the clinical room, where the child is ignored and the family leaves feeling judged. The former has been also reported on one occasion. One mother remembered a dentist who once she told her about her child's new gender expression commented by saying "*That is fantastic, good for her"*. Even though such encounters were experienced pleasantly by the family, this may be a way of avoiding the anxiety that accompanies deeper thinking about the situation.

Transition

Transition was commonly described as being an on-going process, a journey the family was on with many uncertain decisions already made and many to come. As this is the first study exploring specifically the experiences of affirmative parents of pre-pubertal children who have socially transitioned no model exists in the literature to describe this journey for this group. However, Lev's (2004) model of 'transgender emergence' on the development of gender acceptance in a family is the dominant more generally in the field, and so findings will be considered in the light of this to discuss its relevance for this population.

The first stage is called 'discovery and disclosure' and describes the time during which the family first acknowledges the child's gender diversity. This is followed by 'turmoil' when the family tries to make sense of their child's gender diversity, process difficult emotions and manage conflicts with others. The third stage is a period of 'negotiation' where families describe bargaining around boundaries within which the transition should take place. The final stage is described as 'acceptance', during which the parents come to terms with changes and allow the child to take a lead.

Discovery and disclosure

Overall, the results in this study only somewhat supported the above model. Firstly, the term 'discovery or disclosure' did not quite fit the experience described by the participants. Parents instead experienced their child arriving with ease, and naturally without

serious conversations or uncovering taking place. The way in which this was experienced has been discussed in detail above.

Turmoil

The phase of 'turmoil' somewhat fitted. Even though on the surface, many families described the journey as 'smooth' or 'easy', indicators that this might have not always been the case were found. Once the gender diverse child was met, parents described a time during which they felt that this was 'just a phase'. This belief was often reinforced by others. Even though all parents in this study fostered an overall affirmative approach, such language might suggest that there was some ambivalence about these changes and potentially an unconscious hope that things would eventually disappear and all would return to its previous state of affairs. Such ambivalent emotions were described by Hill and Menvielle (2009) as common and would be considered 'normal' even though often uncomfortable for the parents. External conflicts (with families, school and wider communities) were reported to be minimal, unlike in other studies (e.g. Cook- Danies, 2011; Sansfacon, Robuchaud, & Dumais-Michaul, 2015). Parents' experiences of feedback from others were overall, and often to their surprise, reported to be overwhelmingly positive, accepting and kind. This was not only towards the child but also to their affirmative care.

However, a particular contrasting experience was described by many. This was an experience of what they called 'singling out'. This involved a people showing acceptance of their child in a rather clumsy way which often drew unnecessary attention to the child and made the family feel uncomfortable. Similar experiences have been widely described as *microaggressions*. Sue (2010) defines microaggressions as brief verbal or behavioural indignities which might be intentional or unintentional, conscious or unconscious, and communicate hostile derogatory or negative slights towards an oppressed group. Nadal et al. (2012) identified different types of microaggression specifically linked to gender diverse individuals. The covert forms of discrimination described by the families in this study could also be identified as institutional as it was often schools or medical professionals who in an attempt to be helpful drew unnecessary attention to the child which made them feel

uncomfortable. Indeed, previous studies concerning LGBT minorities have found that subtle discrimination, such as a pejorative use of the term ‘gay’, and the spreading of sexual rumours, is more common in educational settings (Kosciw, Greytak, Palmer, &Boesen, 2014). Nadal et al. (2014) examined the various ways that gender diverse people cope with, and react to microaggression. The results revealed that emotionally, participants responded with anger, betrayal, distress, hopelessness, and not feeling understood. Although these emotional reactions were experienced as short-term, it is possible that an accumulation of these experiences may have significant effects on people’s mental health. There are no studies describing the *indirect* (i.e. parental) experience of microaggression as described in this study; however the interviews revealed experiences of similar emotions. Furthermore, these incidences were often described as ‘unimportant’ or ‘minor’ suggesting that for some perhaps, they were quickly repressed in order for parents to rid their anxiety about this so the positive, supportive experience could prevail.

Furthermore, even though stigma is very commonly linked to the experiences of gender diverse community (e.g. Henrich and Testa, 2012), such language and experiences have not been reported by the parents in this study. The explanation for this might be related to the findings above, however it is also important to remember the young age of the children. Research shows (e.g. le Roux, 2013) that gender diverse adolescents and adults feel that as children they had greater freedom were more accepted. This greater freedom might be partly because a certain amount of gender fluidity in children is considered typical, whilst they progress towards establishing gender constancy (Kohlberg, 1966). Additionally, le Roux (2015) also argues that the nature of children's bodies mean that they are gendered to a lesser extent: the visible criteria that is used to 'determine' one's sex and gender, i.e. secondary sexual characteristics and genitalia, are not on display or have not yet developed. This allows gender diverse children to present as stealth more easily. This might provide a further explanation for parents’ overall positive, non-stigmatising experiences and explain their fear of puberty, during which things can change, as discussed below.

Negotiation

The next stage of the model, negotiation, was found to fit the experiences described very well. Most parents talked about having to work out boundaries within which the transition could take place. Many parents described an internal conflict between allowing the child to express themselves freely and lead on the journey, and feeling the need to establish boundaries to influence what form the transition should take. For example, parents would actively discourage some of their child's choices and encourage them to find a compromise instead (e.g. only allowing them to dress as their preferred gender at the weekends), mainly due to concerns about the physical and emotional safety of their children. They described feeling worried about how accepting the outside world would be. Similar fears were reported by Kuvalanka, Weiner, and Mahan (2014). As such, the process of transitioning from a boy to a girl and vice versa was often described as gradual. Discussing particular steps and rules kept the family thinking together.

Research by Fonagy, Steele, and Steele (1991) showed that self-reflective parents are likely to have children who have a similar capacity. Wren's (2002) research suggests that families who have such capacities and are able to consider their own thoughts and feelings as well as the thoughts and feelings of others are able to face each other and work through times of opposite views while a transition is being negotiated. But what is it that allows some families to submit themselves to a process in which they confront their own presumptions, judgments and anxieties? Ehrensaft (2011) describes three types of parents depending on the way they relate to their children's gender expression based on their own reflective capacity. 'Transformers' are parents who have the capacity to absorb and digest their child's anxieties and recognise them as a separate person, who might have a different gender authenticity to their own. This capacity to 'mentalise' (Fonagy et al., 1991) may help to process any difficult feelings they might have towards their child's transition and therefore by likely not only to meet their child wherever they are on their journey but also take up the role of an advocate. 'Transphobics' on the other hand are often not at ease with their own gender identity and view their child as their own extension. When met with conflicting views, they

experience them as personal attacks and are not able to call on their love, but use primitive defences such as splitting and thus disavow the child's experience out of feelings of disgust or despair. Lastly, 'Transporters' purge themselves of any transphobic ideas and do embrace their child's gender diversity yet when examined closer, their acceptance is rather manic and forceful as a reaction to a denial of anything difficult which might need reflecting upon. Wren (2002) further suggests that if acceptance is 'too ready', it can encourage the child's phantasy that the change to the bodily sex can be achieved very easily. This might indirectly prevent the child from engaging with ideas and questions about what it might be like to live as both genders, and further fail to consider the difficulty such transition is likely to bring about. In this study, all parents could be described as transformers. They all recalled an experience of knowing they wanted and needed to support their child, yet they also acknowledged some painful feelings and challenges they met along the way. It is however important to note, that the model described above might be criticised for being too categorical. It might be that parents move in between these categories and they could be better understood for parents in this study as 'positions' or 'states of mind'.

Acceptance

A final stage of full acceptance was reported by all parents. All children were supported to socially transition and they lived as the other gender at the time of the interviews.

Unsurprisingly, the extant literature suggests that parental support is essential when promoting good mental health including preventing self-harm and suicidal behaviour (Travers, Bauer, Pyne, & Bradley, 2012) and unsupportive parenting has been shown to contribute to mental ill-health. Further to this, it has been found that non-acceptance makes very little difference to the evolution of the child's gender journey (Zucker& Bradley, 1995).

Previous research suggests several factors which enable parents to accept their gender diverse children and affirm their choices. Hill and Menvielle (2009) suggest that parents who affirm their child's gender do so to protect them from mental ill-health. Indeed, in this study, questions about the child's safety were also raised. Even though the

experience overall was positive, parents had some negative predictions for the future. Mostly, they feared secondary school, the school's approach to their child's gender and also bullying and abuse. Even though previous reports of stigma, bullying and even violence are undeniable (Grant et al., 2010) and alarming rates of discrimination and violence have been reported by research (e.g. Grossman, D'Augelli, & Salter, 2011; Kosciw, Greytak, Palmer, & Boesen, 2014), and in the media, in this study the fear of this was an interesting finding given the experiences so far were so overwhelmingly positive. It could be argued that parents' fear of the stigma from the outside is in part a projection[1] of their own difficult feelings. Projection onto the others would allow the parents to keep such conflicts at bay and help them manage their anxiety of having a child who is different and to allow their love to find space for expression. This explanation could be for similar reasons supported by the finding that many parents also doubted the genuineness of overwhelming support and worried they, their children, and their parenting approach were stigmatised privately. Another factor which contributed to the families moving from a stage of negotiation to acceptance was empathy. In addition, some mothers described recognising that it was themselves and the boundaries they established that were making their child unhappy. Taking responsibly for that allowed them to change their mind-set and move past their own fears and prejudice, allowing the child to take a lead on further steps in the transition. Sansfacon, Robichaud, and Dumais-Michaud (2015) describe similar findings of parents who came to fully accept their children once they realised the upset they were being exposed to.

Lastly, a particular experience which was difficult for parents to formulate and conceptualise was that of supporting the child 'no matter what' just 'because they are your child'. This theme was revisited many times during interviews. This resonated strongly with Payne's (2016) finding that parents felt certain about the correct way to be with their child. Their experience was that they did not need to learn it, they felt it. Payne (2016) quotes one of the mothers from his study: *"I know what my child needs from me, I know it through my*

[1] The Kleinian concept of 'projective identification' is a defence mechanism by which unmanageable experiences (feelings and parts of oneself) get evacuated and put into another person or place in phantasy (Spillius& O'Shaughnessy, 2012).

relationship with them. Parenting is not a job, it is a relationship." Even though parents in this study appreciated the reassurance from others, that they were 'doing the right thing', they felt it from within themselves. They described that they knew this was the right path for the family. However, some parents felt the need to call upon specialist services to receive reassurance. It might be that the parents who did not call upon specialists services had disavowed feelings of anxiety about what was is a very complicated situation. Perhaps these feelings were able to surface when the opportunity to access support became available.

What was lost and gained?

The theme of loss was widely discussed by all participants and even though there were a variety of experiences within it. The majority of mothers reported grieving for the child they felt they had, when he or she was born. Such losses would often be related not only to losing the child per se, but also the future the families hoped for. Freud (1917) describes how mourning can be a reaction not only to the loss of a loved person, or other tangible objects, but also to the loss of things in the mind, such as an ideal. Similar results were reported by others in previous research (Gregor, Hingley-Jones, Davidson, 2014; Norwood, 2012) and were discussed in relation to Kubler-Ross's (1969) five stage model of grieving. The model describes how people move through states of denial, anger, depression and bargaining before acceptance is reached. Even though this model has been reported as a helpful way to understand and normalise some of the reactions parents share (Pearlman, 2006), it did not fully capture the experiences parents were describing in the present study. This ill-fit may be due to the fact that, even though parents might feel as though they lost their daughter or their son, they still have the child. There is no body to be buried, no death has actually occurred. Their child is now expressing themselves in a different way in particular aspects of their life, but is still there, to be cared for and loved and to care and love back. Such a conflict has often been reported to bring about feelings of confusion and ambiguity. Norwood (2012) found that the tension between the *present and absent child* is the most salient for families. Wahling (2015) examined the ways parents reconciled the fact that their child is still there, yet a part of that person is lost and how they make sense of how

much of their loved one is the same and how much of them is now different. They suggest that a more helpful way to think about the experience of loss is to use Boss's (1999) framework of ambiguous loss. This theory proposes a way of understanding losses which are not 'clear' either because the absence is physical but not psychological (e.g. a child goes missing), or vice versa (e.g. family member with a dementia diagnosis). Even though this model is not typically considered when thinking about the transitioning of gender diverse children, Wahling (2015) proposes its fit due to Boss's (2004) basic criterion *"that people are unclear about the absence or presence of a loved* one" (p. 240). In this study, parents echoed this experience. Indeed, the conversations suggested that even though parents, especially mothers, were able to courageously open up and reflect on difficult feelings they had towards the gender change, they were able to hold a balanced view of positive feelings alongside their pain. They often reported missing their child on the one hand, yet saying things like '*he/she is still here'*. It seemed that the negative feelings were difficult to acknowledge and process, almost as if parents felt guilty to be missing something which, in the physical sense, they still had.

Furthermore, sadness about the loss of the imagined (often gender normative)future, has been reported by previous research (Pearlman, 2006). Further studies report that parents felt they lost the idea about their children's romantic relationships and continued to hope their children would be 'only gay' (e.g. Kuvalanka, Weiner,& Mahan, 2014). The present study did not support such findings directly, rather the loss of an imagined future was communicated in a different way. Further, interesting differences were found between the experiences of parents bringing up female-to-male and male-to-female children. Families bringing up male-to-female children often reported their children yearning to becoming mothers and parents experienced this as heart-breaking, with some hoping for progress in science which would make this possible. For female-to-male children, the dilemmas were related to fertility treatments and parents' worries about making decisions which will be one day regretted. It appeared that the experience of loss in this instance was very complicated as parents might have been supporting their child with their grief (e.g. not being able to carry

a child or breastfeed) as well as managing their own internal conflicts (e.g. hopes for their at-birth assigned son to become a father, rather than a mother).

The confusion was also heightened by the fact that many parents reported gaining a child who is happier, and more confident. This change in the child's demeanour as they socially transitioned has been reported previously (e.g. Kuvalanka, Weiner, & Mahan, 2014) and noticed not only by the parents, but also others. Both of the models of grief could be criticised for not considering the positive gains described above.

It is important to note however, that not all participants were able to relate to such experiences. Some even reported feeling offended by the idea of a loss. It could be argued, as mentioned above, that such strong positive reactions might be related to parents' unconscious fear of their difficult feelings towards their child's transition. It would therefore be easier to deny these feelings than allow a space for them to be explored. Yet, it may also be that the changes they experience are in keeping with their values and beliefs or that they had been able to process their feelings and reach a firm position before even meeting a professional. This may be due to their existing cultural understandings and practices as well their own experiences of being parented.

Body as the cause of parents' distress

Dislike for one's body, especially genitals, has been reported as a common early sign of gender dysphoria (National Health Service [NHS], 2018). Even though this study did not explore the experiences of the children, such reactions were only observed by a few of the parents. They reported having to have difficult conversations with their children who expressed wishes to damage their genitals. In the majority, however, parents were not able to relate to this. They experienced their children as being at peace with their assigned bodies. Similar findings were reported by Le-Roux (2013) and Steensma et al. (2011). Both studies reported that none of the participants felt any bodily discomfort until puberty began. It was only then, when it was felt their development was moving in the 'wrong' direction. Indeed, in this study, parents predicted puberty leading to distress and puberty was often labelled as one of their main fears. Parents worried about their child's mental well-being

once secondary sex characteristics begin to develop as well as difficulties 'hiding' their assigned sex. Parents were not sure if their child was mature enough to understand what was coming, however, difficult conversations were being had. Parents struggled especially with the balance of being honest with their children about the upcoming changes, yet protecting their children from unnecessary anxieties.

Using the stop button

Even though experiencing their children as disliking their assigned body did not emerged as a common theme, all parents reported being keen to start hormonal blockers to stop their child's body developing any further for fear of this occurring later. Parents felt that their child needed help assessing all the pros and cons of such treatments, but believed that it was ultimately their child's decision to make; as one mother described, it was her child who would 'who have to live it.'

This approach is in contrast with the views of transcritical parents (e.g. GenderCriticalDad, 2018) who connect with more authoritative approaches and argue against physical intervention. GenderCriticalDad (2018) compares the wish to alter the physical body to rebelling behaviours adolescents engage with, such as drug use, crime and abusive relationships. He argues that in such instances, society is supportive of parents who put boundaries in place for the child's well-being, yet when parents question the child's wish to make drastic changes to their body, they are attacked by being called 'transphobic' and 'bigoted'. He, for those reasons, even though actively fighting against affirmative care, remains anonymous. One father in the present study alluded to some concerns about physical intervention saying, *"as a dad, as a parent, I am not too sure about it."* It might be that other parents had similar thoughts yet these could not be articulated for fear of being perceived as unsupportive.

Furthermore, even though there is some evidence that medical transition does not prevent suicide (e.g. Dhejne et al., 2011), contrasting evidence (Grant et al., 2011; Sadowski& Gaffney, 1998) about serious risks (e.g. self-harm, suicide) attached to puberty emerging when children have not medically transitioned is often highlighted by the media. It

may be that the parent's fears for their child's safety underlie their agreement to physical intervention.

These results are even more interesting in the context of other findings which suggest that most parents agreed that the future development of their child's gender remained uncertain. It appeared that some parents did truly experience hormonal blockers as a pause button with no further consequences, something which can be removed and treated as if it never happened, should the child feel they wanted to detransition. Even though the effects of hormonal blockers are fully reversibly, the true impact of them is yet to be established (Wren, 2014). Further, Cohen-Kettenis and van Goozen (1998) found that young people who received such interventions often understood it as a guarantee of further irreversible treatments (i.e. cross hormone and surgeries). They also argue that pubertal delay could cause a widening of the social gap these young people already experiencing resulting in further bullying and teasing. Interestingly, none of these issues were raised by parents in this study. It might be that such issues are not shared with them by professionals or parents are (unconsciously) choosing not to consider them. Due to the overwhelmingly positive experience, it might be that parents are hoping to 'freeze' time, avoiding potential challenges ahead.

Strengths and limitations

It is believed that this study makes a significant contribution to the existing literature exploring parental experiences when raising a gender diverse child as it responds to the identified gap on what is unique about raising a gender diverse child who is also pre-pubertal. This is important as it is believed that it is at this time when parents are often faced with challenging decisions and often seek help from professional services. This is the first study exploring the experiences of such help. Additionally, this study adhered to several principles which are important when conducting a methodologically sound qualitative study.

Firstly, I feel that I kept close to the data by following the important procedures outlined by Charmaz (2006) and Corbin and Strauss (2008). These include axial and focussed coding and memo-writing through which one can demonstrate how their ideas

were developed. Furthermore, to ensure a saturation of the theory and the model, I employed negative case analysis.

Transferability refers to the extent to which the findings are considered to have more general significance. Guba (1981) suggests that the researcher make the context of their research explicit, in order for readers to make their own judgements about transferability (Guba, 1981). The contextual details of the current research are outlined in the Method chapter. It should also be noted that the intention of the current research was not to develop a model which is transferrable but rather elucidate the idiosyncrasies of such experiences and their meaning. Nevertheless, it does highlight future ideas for research which are discussed below.

Lastly, I hold a critical realist perspective on gender and this would have impacted the way I interpreted the experiences of the parents interviewed. As explained before, I engaged in reflective journaling and memo writing in order to understand my thoughts and feelings throughout the research processes. This enabled me to explore whether my own position impacted too heavily on one aspect of the analysis, while possibly neglecting others. For example, when memoing about the meaning of the gender dysphoria diagnosis, I realised that I had become too agreeable with a parent who disagreed with the concept and unnecessarily followed up with further questions on the topic. This experience led me to return to the data and discover a more balanced view. I found memo writing and journaling had slightly different benefits. Memoing was helpful when assessing my relationship to the data, whist reflective journaling was a private conversation with myself about the way I found myself relating to the participants in the room. This is discussed further below.

It is, however, necessary to acknowledge some potential limitations to the current study. Firstly, it is important to address the context in which participants were recruited and interviewed. All parents were recruited through the specialist gender service and volunteered to take part in the project. This was to ensure they had a professional support network should the interviews evoke difficult emotions and raise questions. Though there were some differences in how they experienced this, overall it was reported to positive. However, it is

possible that parents that access different forms of helps (e.g. charities, spiritual groups) may have had different experiences. Learning about these could have enriched the model.

Furthermore, even though it was explained to the participants that I was not part of the specialist service and the information they provided was confidential, most of the interviews took place in the therapy rooms of the specialist clinic, which might have led participants to feel that certain things could not be, or should not be, raised for fear that it would have an impact on any further care in the clinic. In addition, the families who did not have positive experiences with the service might not have volunteered to participate. They may not have wanted to engage in activities associated with a service. Others, who may have been having a difficult time, might have struggled to find space to engage with the study. In addition, the fact that these participants did volunteer suggests that they were the kind of parents who were willing to think with a researcher about complex experiences, indicating they might be especially cooperative, and articulate. A similar impact might have been caused by the fact that the parents affirmed their child's gender choices and supported their transition.

It must also be noted that the researcher had some existing knowledge of the literature concerning parents' experiences, gender diversity and the support families can receive. This was due to procedures (e.g. submission of research proposal, ethical approvals) which had to be followed for the research to commence. This is likely to have influenced the analysis in terms of the sensitising concepts (Charmaz, 2014) adopted by the researcher. However, all attempts were made to limit this through on-going self-reflexive practice such as memo writing, journaling and transparency of reporting.

Having such limited diversity in the sample was also a significant limitation of the study. Even though both mothers and fathers were interviewed, they were also all from a white British background. Practically, this was very difficult to overcome as there is a strong a predominance of referrals of families from a white-British background with only 10% of families coming from black and ethnic minority backgrounds (Graaf, Manjra, Hames, &Zitz, 2018). Nevertheless, interviewing participants from different cultural backgrounds and

learning about their experiences could have developed the model further and enriched the understanding gained.

Willig (2008) highlights that whilst a social constructionist version of grounded theory recognises the active role of the researcher in the research process this does not extend to an analysis of the way in which the researcher and interviewee interact during the interviews. The on-going process of questioning and answering that the researcher experiences with the participant is always specific to that particular interaction in the room, in that particular time and context (Rapley, 2001). Knowing this, I tried to be mindful of my own reactions to particular answers and tried not to direct the interview process in a particular way, but remain open to what the parents were bringing. On some occasions, while listening to the recordings I did however notice my own interest influencing the process. My reflective journal was especially helpful in responding to this and it helped me to avoid this in subsequent interviews. Such influences, however, are a natural part of any interaction and can never be eliminated fully.

Implications of the Study

Important implications for both clinical practice and research can be drawn from this research. These shall be addressed in turn below.

Clinical implications

Even though positive experiences with raising their children were recalled again and again, upon closer examination, it appeared that many conflicting emotions were present and that these had led to important realisations on the journey to acceptance. This is something professionals can learn from.

Are we all really accepting?

All parents in this study were affirming their child's expressed gender before they first contacted a specialist service. With affirmative care being the recommended treatment supported by some research evidence as well as the media in general, it might be reasonable to predict that many families raising such children arriving to specialist services would have a clear idea of what they want. New challenges might therefore stem from

working with such families. Even though evidence suggests that supporting such children has a positive impact on their well-being, it might be important for clinicians to be mindful of continuing to explore how a position of such acceptance was reached, what helped and what did not, and also what the reactions of others surrounding the child have been. It may also be important for professionals to consider the psychological experience underlying a spoken 'acceptance'. Perhaps, an overly positive acceptance, one which is too ready, might suggest that parents have not been able to examine their possibly difficult feelings.

The very same principle would also apply to the clinicians themselves, who might find that they are uncritically accepting of positive stories, forgetting to reflect on their own reactions and consider the psychological experience underneath spoken words of acceptance.

Who has the answers?

There appeared to be a significant discrepancy between the experiences of specialist services and other professionals offering help. Understandably, the specialist service has been valued for its expertise not only in terms of knowledge but often, also for the way its clinicians related to the families. Due to the dramatic increase of referrals to the specialist service, it is reasonable to predict that many other professionals (e.g. general practitioners, paediatricians, psychotherapists) will be in contact, assess or work with such families. A lack of knowledge on the part of clinicians in children mental health services was raised by many parents and described as upsetting. It might be that such services feel that they function only as gatekeepers to a more specialist service. If that is the case, the danger might be that such services are not willing to work with such families for fear that they are 'not specialist enough' leading them to avoid up-skilling themselves to a point where they would be more confident to have conversations around gender. Nevertheless, children's mental health services will have contact with these families and should familiarise themselves with gender diversity. This could be done by training but also by studying and adhering to standards of (WPATH, 2011) and the guidelines of the specialist service.

However, many parents welcomed a position of ‘not knowing’ as long as the professionals were willing to learn. Professionals might find Cecchin’s (1987) concept of a curious stance valuable. This is defined as an active position which respectfully queries all descriptions and explanations in order to appreciate the multiple views which make up the complex situation and the social context in which they exist. For professionals working with families who are raising a gender diverse child, this would mean hearing different perspectives from everybody attending the meetings and listening with an open mind to their experiences. Similarly, Bion (1967) writes about the importance of the unknown in meeting with clients. He suggests that in every meeting an evolution takes place where meaningful forms emerge out of darkness and therefore the purest way of listening is ‘without memory and desire’. This means not letting past knowledge, or future hopes of what one wants to achieve, shape the meaning of the person’s experience as they share it. For Bion (1967), one must learn to cultivate a capacity to listen in a state of relative ‘ignorance’. It might then, only be when one is truly able to sit with the anxiety of not knowing that one is able to attend truly to what is before oneself.

Even though the parents knew that affirming their child’s gender felt like the correct way of approaching it, they did at times experience uncertainty and ambivalence and sought reassurance from professionals. Solutions, when possible, were valued, however parents understood that on many occasions uncertainty was something needed to be tolerated. At times when this is not possible, anxieties become overwhelming, and clear solutions are not possible, professionals should be able to act as containers. The concept of containment (Bion, 1962) is based on a mother functioning as a container for the infant’s needs, feelings and unwanted parts which get projected into her. The aim of the container is to not only survive taking this in, but to be able to process it and return it as something useful that can be taken back and thought about, in order to help the person continue to think about it themselves (Vaspe, 2017). Such an approach is also very much in keeping with practice guidelines promoted by the gender specialist service (Di Ceglie, 1998).

Who supports the parent?

Even though the overall experience was one of families and professionals working together, the focus of the work was the child's well-being, and the well-being of the parents was not given as much attention. However, some parents in this study disclosed their own emotional pain which was mostly triggered by the complicated feelings attached to the 'loss of the child they had' and fears for their child's emotional and physical safety. Even though the stage model of grief (Lev, 2004) and Boss' (2015) idea of loss might have limitations, as discussed previously, it might be helpful for clinicians to keep those in mind when meeting with parents who might need to be supported by normalising their reactions and educating them about such processes as they have appeared to fit well with the experiences found. This needs to be done in a mindful way as not all parents were able to relate to this, and some found it offensive. Other ways of exploring some of these difficult feelings might be through professional's signposting families to parent support groups. Further, peer support groups have a long history of being helpful to people who can share common experiences and create meaning together (Mead & Filson, 2016).

Research implication and future directions

The findings of this study are in keeping with some of the themes from previous research, however important differences were highlighted in the context of the unique experiences of parents' of pre-pubertal children who expressed themselves in gender diverse ways and who have socially transitioned. It appears that the journey to acceptance has been influenced by many important factors (see Figure 1). Furthermore, it appears that the journey to acceptance of parents of younger children follows a slightly different trajectory than that described by Lev (2004). Many previous studies (e.g.Kuvalanka, Weiner, & Mahan, 2014; Pyne, 2016) have also reported negative experiences related to affirmative care by parents. In contrast, the present study reported generally very positive experiences with only 'minor' difficulties, which has been considered in the light of unconscious processes. Based on the results, several research areas were heighted for future research.

Firstly, our current understanding of raising a gender diverse child relies on retrospective studies. This has several limitations, including faded memory and biased recall.

This might have an impact on the understanding of the development of gender diversity in the family and the factors which influence it. Following families from the child's younger age, when the child first began to express themselves in gender-normative way, might bring a richer, and more reliable, understanding. Additionally, continuing longitudinal observation over the life course, would add valuable information about the future development of their gender diversity, especially in relation to physical interventions which parents reported feeling keen to start.

Secondly, building on the previous suggestion, the area of early physical intervention is highly ethically and morally charged and set within a very interesting social and cultural context. Even though this study offered a glimpse of the factors that might lead parents to consider it (e.g. fear of abuse and mental health difficulties), it might be important to explore this further. Understanding the underlying issues could help to create further frameworks for working with such families. This might also encourage more critical thinking for all parties involved before decisions with serious consequences are made.

Thirdly, several studies reported fear to be one of the common experiences of parents of gender diverse children. Even though fear was a significant theme in this study also, it was considered to be an interesting finding giving that these families had received such positive feedback from others, including the extended family, school, wider community and most clinicians. It could be valuable to explore this further and learn from the families where they think the fear is originating from and how it affects them. Further to talking with families, important findings could be yielded by analysing online media/newspapers/television programmes discourses around gender diverse youth and how this shapes experiences and behaviour.

Fourthly, it is believed that this study describes important experiences of parents with professionals. Suggestions for the development of current practice were made as some parents reported negative experiences with professionals. It would therefore also be important to understand professionals' experiences of working with these families and what underlies their behaviour and the types of relationships they have with parents. This could

contribute to better working relationships between the service and the families to ensure the best possible care for children.

Lastly, the current study used a grounded theory methodology due to its unique inclusion criteria which have not been explored before. Using phenomenological analysis would allow for deeper understanding of the idiosyncrasies of subjective experience. Further, discursive approaches could be used to study how language shapes the experiences in these contexts.

Researcher's Reflexivity

I believe that the main reason I was drawn to the area of gender diversity is my belief that everybody should be made to feel comfortable enough to express their difference. I view difference as a creative part within in us which when given room to grow can bring about meaningful experiences for the individual as well as those around them. As mentioned before, I come from the Czech Republic, from a family who prior to the Velvet Revolution was very much against the communist regime and what it stood for. Growing up alongside parents who would have been punished for 'stepping out of line' and 'sabotaging the eastern, socialist system' by wearing jeans or listening to the Beatles, I was brought up to believe that freedom of expression is necessary not only for the individual's good mental health, but also for the healthy functioning of society.

The other reason I felt drawn to the area was my dislike of labelling and diagnosing individual experiences. Even though, as a clinician I can see the benefit of it at times, I find it very reductionist. I feel that it often stops us from listening to the story and its meaning. I found the concept of medicalising gender expression very odd and I feel that unconsciously I hoped to find something which would challenge the system.

Lastly, I have a long standing passion for psychoanalysis and I hoped to learn about its helpfulness when understanding the topic. Learning about stigmatising and unhelpful experiences from those who describe themselves as gender diverse has been a tricky process to grapple with. It still is now. At times I almost felt ashamed to admit that I was interested in psychoanalysis and found many psychoanalytic ideas thought provoking and

helpful even though they would not necessarily fit with the common idea that one is ‘born transgender’.

When the option of research within the GID service arose, I was drawn to its complexity. I was curious to explore the variety of factors which play a part in gender diversity; not only individual factors (e.g. biological and psychological [conscious and unconscious]) but also broader ones, such as the environment the society creates for its expression, the politics surrounding it and the function of the diagnosis. I was mainly fascinated by its aetiology.

Later, when I met with the parents, and began to hear their stories, my interest began to shift. I was no longer concerned with where gender diversity was stemming from; it no longer felt as important as it was not something the parents were bringing. They wanted to talk about themselves, their fears, their pain, pride and hopes. I felt privileged to be spending time with them and listening to their experiences and I wanted to do them justice. Through listening with an open mind, I have begun to see just how limiting some of my ideas were. I feel that it was the courage of the parents, to open up to a stranger and express their difficult feelings which enabled me to really connect with their ideas, try to leave my own agenda out of the room and allow them to tell it as they wish.

When I fell pregnant I noticed a further shift. Prior to this, I kept the child at the centre of my thinking, something I feel stemmed from my work and interest in child development. This at times impacted on my data analysis and I needed supervision to remain connected to the parents’ experience and not to draw conclusions about the children. Once pregnant, I began to feel a deep connection to the parents. The fears about their children being hurt particularly resonated with me. Returning from my maternity leave, I revisited all the audio recordings and I noticed that I was able to listen to them differently. Now I had my own experience of being with my own child and watching it grow and change in front of my eyes. I recognised the ‘power’ I have to influence my baby’s journey, but also experienced powerlessness in not being able to change some things and having to allow them to just unfold in front of me. I feel that this experience was the most significant one as it, for the first

time, brought my attention to the innate, to the tangible, and to the body rather than just the mind and soul. I feel that this helped me to appreciate the topic more fully, with its physiological factors, too. Without these, I do not think I would have been able to understand it as deeply.

Conclusion

This study was the first, to the researcher's knowledge, to explore the experiences of parents who affirm the diverse gender expression of their pre-pubertal children who have also socially transitioned. The results indicated that social transition is a gradual process that is influenced by several factors which also dynamically influence each other (see Figure 1).

Overall, families affirmed their child's gender expression and despite receiving very positive feedback from others around them, they continued to feel fear for their children's well-being and safety.

Experiences with services were frequently explored and discrepancies between specialist services and mental health services were discovered. Even though not everybody found the help of the specialist services necessary, parents agreed on finding them supportive and reassuring. Children and family mental health services were however generally experienced as unhelpful, judgmental and incompetent. Many families further discussed their worries about their child's changing body and early physical intervention, especially hormonal blockers, were described as the next natural step families were keen to take.

Chapter Summary

This chapter provided a summary of the findings from the research, with a discussion of the main findings described in the theoretical model in relation to the extant literature. Strengths of the study were described as well as the limitations which should be considered when applying the findings. Clinical and research implications were outlined, and suggestions for future research were made. Finally, the chapter closed with a reflexive account from the researcher, highlighting their thinking, positioning and learning development throughout the process.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

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

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Anthon, B. S. (2010). Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist, 65,* 385-475.

Argentieri, S. (2009). Transvestism, transsexualism, transgender: Identification and imitation. In G. Ambrosio (Ed.), *Transvestism, transsexualism in the psychoanalytic dimension* (pp. 1-40). London, England: Karnac Books.

Armstrong, D., & Rustin M. (Eds.). (2014). *Social defences against anxiety: Explorations in a Paradigm*. London, England: Karnac Books.

Auyeung, B., Baron-Cohen, S., Ashwin, E., Knickmeyer, R., Taylor, K., Hackett, G., Hines, M. (2009). Fetal testosterone predicts sexually differentiated childhood behaviour in girls and in boys. *Psychological Science, 20,* 144-148.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice Hall.

Banister, P., Burman, E., Parker, I., Taylor, M., &Tindall, C. (1994).*Qualitative methods in psychology: A research guide.* Buckingham, England: Open University Press.

Barker, C., Pistrang, N., & Elliot, R. (2002).*Research methods in clinical psychology* (2nd ed.). Chichester, England: Wiley.

Bates, J. E., Skilbeck, W. M., Smith, K. V. R., &Bentler, P. M. (1975). Intervention with families of gender disturbed boys. *American Journal of Orthopsychiatry, 45,* 150-157.

Bentler, P. M., Rekers, G. A., & Rosen, A. C. (1979).Congruence of childhood sex-role identity and behaviour disturbance.*Child: Care, Health and Development, 5*, 267-283.

Bill, J. R. (1981). Thirty years of experience with transsexualism. *Australian and New Zealand Journal of Psychiatry, 15*, 3-43.

Bion, W. R. (1962). *Learning from experience*. London, England: William Heinemann.

Bion, W. R. (1967). *Second thoughts*. London, England: William Heinemann.

Birks, M., & Mills, J. (2011).*Grounded theory: A practical guide.* London, England: Sage.

Bleiberg E., Jackson, L., & Ross J. L. (1986). Gender identity disorder and object loss. *Journal of the American Academy of Child and Adolescent Psychiatry, 25*, 58-67.

Boss, P. (1999).*Ambiguous loss*. Cambridge, MA: Harvard University Press.

Boss, P. (2004).Ambiguous loss. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss: Death in the family* (2nd ed., pp. 237-246). New York, NY: W. W. Norton.

British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society*. Retrieved from http://www.bps.org.uk/publications

Brooks, F. (2000). Beneath contempt: The mistreatment of non-traditional gender atypical boys. *Journal of Gay and Lesbian Social Services, 12*, 107-116.

Bryant, K. (2006). Making gender identity disorder of childhood: Historical lessons for contemporary debates.*Sexuality Research and Social Policy, 3*, 23-39.

Bruskell-Evans, H., & Moore, M. (2018).*Transgender children and young people: Born in your own body* (2nd ed.). Newcastle upon Tyne, England: Cambridge Scholars Publishing.

Bryman, A. (1988). *Quantity and quality in social research*. London, England: Unwin Hyman.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity.* London, England: Routledge.

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex"*. London, England: Routledge.

Carroll, L., & Gilroy, P. J. (2002). Transgender issues in counsellor preparation. *Counsellor Education and Supervision, 41*, 233-242.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002).Counselingtrangendered, transsexual, and gender-variant clients.*Journal of Counseling and Development, 80*, 131-138.

Cecchin, G. (1987). Hypothesising, circularity, and neutrality revisited: An invitation to curiosity. *Family Process, 26*, 405-413.

Charmaz, K. (1995). Grounded theory. In J. Smith, R. Harré, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49) London, England: Sage.

Charmaz, K. (2008). Grounded theory.In S. Hesse-Biber, & P. Leavy (Eds.), *Handbook of emergent methods.*(pp. 155-170). New York, NY: The Guildford Press.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-193).

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London, England: Sage.

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn.* Thousand Oaks, CA: Sage.

Coates, S., Friedman, C., & Wolfe, C. (1991). The etiology of boyhood gender identity disorder: A model for integrating temperament, development, and psychodynamics. *Psychoanalytic Dialogues,1,* 481-523.

Coates, S., Moore, M. S. (1998). The complexity of early trauma: Representation and transformation. In D. Di Ceglie, & D. Freedman (Eds.),*A stranger in my own body: Atypical gender identity development and mental health* (pp. 39-62). London, England: Karnac Books.

Cohen-Kettenis, P. T., Delemarre-van de Wall, H. A., &Gooren, L. J. (2008). The treatment of transsexual adolescents: Changing insights. *Journal of Sexual Medicine, 5*, 1892-1897.

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., &Delemarre-van de Waal, H. (2011). Puberty suppression in a gender dysphoric adolescent: A 22 year follow up. *Archives of Sexual Behaviour, 40*, 843-847.

Cohen-Kettenis, P., Steensma, T, &Vries, A. (2011).Treatment of adolescents with gender dysphoria in the Netherlands.*Child and Adolescent Psychiatric Clinics of North America,* 20, 689-700.

Conrad, P. (1990). Qualitative research on chronic illness: A commentary on method and conceptual development. *Social Science and Medicine, 30*, 1257-1263.

Corbett, K. (2011). Gender regulation.*Psychoanalytic Quarterly, 80*, 441–459.Corbin, J. M., & Strauss, A. L. (2008).*Basics of qualitative research: Technique and procedures for developing grounded theory* (3rd ed.). London, England: Sage.

Coulter, S. (2010).*Parenting a child with gender identity issues.*(Unpublished doctoral dissertation).University of East London, London, UK.

Critical Appraisal Skills Programme.(2013). Ten questions to help you make sense of qualitative research. Retrieved from http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf

deMarneffe, D. (1997). Bodies and Words: A study of young children's genital and gender knowledge. *Gender and Psychoanalysis, 2*, 3-33.

Derrida, J. (1967). *Of grammatology.* (G. C. Spivak, Trans.). Baltimore, MD: Johns Hopkins University Press.

Deutsch, H. (1934). ÜbereinenTypus der Pseudoaffektivität ("Alsob").*Internationale Zeitschriftfür Psychoanalyse, 20*, 323-335.

deGraaf, N. M., Manjra, I. I., Hames, A., &Zitz, C. (2018). Thinking about ethnicity and gender diversity in children and young people. *Clinical Child Psychology and Psychiatry*.

deVries, A. L. C., Doreleijers, T. A., Steesma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents.*Journal of Child Psychology and Psychiatry, 52*, 1195-1202.

deVries, A. L, Steensma, T. D., Doreleijers, T. A., Cohen-Kettenis, P.T (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine. 8*, 2276-83.

Dey, I. (1999).*Grounding grounded theory.* San Diego, CA: Academic Press.Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One 6(2)*.

Diamond, M. (2002). Sex and gender are different: Sexual identity and gender identity are different. *Clinical Child Psychology and Psychiatry, 7*, 1359-1045.

Di Ceglie, D. (2000). Gender identity disorder in young people.*Advances in Psychiatric Treatment, 6*, 458-466.

Di Ceglie, D. (2010). Gender identity and sexuality: What's in a name? *Diversity in Health and Care, 7*, 83-86.

Di Ceglie, D., Freedman, D., McPherson, S., & Richardson, P. (2002). Children and adolescents referred to a specialist gender identity development service: Clinical features and demographic characteristics. *International Journal of Transgenderism, 6*(1).

Dimen, M. (1995). Introduction..*Psychoanalytic Dialogues, 5,* 157-163.

Dimen, M. (2003).*Sexuality, intimacy, and power.* Hillsdale, NJ: The Analytic Press.

Doward, J. (2018, November 3). Gender identity clinic accused of fast-tracking young adults, *The Guardian*. Retrieved from https://www.theguardian.com/society/2018/nov/03/tavistock-centre-gender-identity-clinic-accused-fast-tracking-young-adults

Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children.*Hastings Center Report, S17-S22.*

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., &Zucker, K. J. (2008).A follow-up study of girls with gender identity disorder.*Developmental Psychology, 44*, 34-45.

Edwards-Leeper, L., Leibowitz, S., Sangganjanavanich, V. F. (2016). Affirmative practise with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity, 2*, 165-172.Ehrensaft, D. (2009). One pull makes you boy, one pull makes you girl. *International Journey of Applied Psychoanalytic Studies, 6,* 12-24.

Ehrensaft, D. (2011). Boys will be girls, girls will be boys. Children affect parents as parents affect children in gender nonconformity. *Psychoanalytic Psychology, 4,* 528-548.

Ehrensaft, D. (2012). “Look, mom, I am a boy – Don’t tell anyone I was a girl”. *Journal of LGBT Youth, 10*, 9-28*.*

Ellis, C. (1995). Emotional and ethical quagmires of returning to the field.*Journal of contemporary Ethnography, 24*, 69-98.

Fausto-Sterling, A. (2000). *Sexing the body: Gender politics and the construction of sexuality*. New York, NY: Basic Books.

Fonagy, P., Steele, H., Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development, 62*, 891-905.

Frank, S. J. (1998). Just listening: Narrative and deep illness.*Families, Systems and Health 16*, 197-212.

Freud, S. (1953). Three essays on the theory of sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 125-243). London, England: Hogarth Press. (Original work published 1905)

Foucault, M. (1980).*Power/knowledge: Selected interviews and other writings, 1972-1977.* New York, NY: Pantheon Books.

GenderCriticalSupport. (2018, November 15). Gender Critical Support Board. Retrieved from https://gendercriticalresources.com

Glaser, B. G. (1978). Theoretical sensitivity: *Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1965).*Awareness of dying*. Chicago, IL: Aldine.

Glaser, B. G., & Strauss, A. L. (1967).*The discovery of grounded theory.* Chicago: Aldine.

Glaser, B. G., & Strauss, A. L. (1968).*Time of dying.* Chicago, IL: Aldine.

Goldner, V. (1991).Toward a critical relation theory of gender.*Psychoanalytic Dialogues, 1*, 249-272.

Godlner, V. (2003).Ironic gender/authentic sex.*Studies Gender and Sexuality, 4*, 223-250.

Goldstein, J., Seidman, L., Horton, N., Makris, N., Kennedy, D., Vainess, V. (2001). Normal sexual dimorphism of the adult human brain assessed by in vivo magnetic resonance imaging.*Cerebral Cortex, 11,* 490-497.

Grant, J. E., Mancebo, M. C., Eisen, J. L., Rasmussen, S.A. (2010). Impulse-control disorders in children and adolescents with obsessive-compulsive disorder. *Psychiatry Research, 175*.

Grossman, A. H., &D'Augeli, A. R. (2007).Transgender youth and life-threatening behaviours.*Suicide and Life-threatening Behaviour, 37*, 527-537.

Grant, J., Mottet, L., Tanis, J., Herman, J., Harrison, J., &Keisling, M. (2010).*National transgender discrimination survey, report on health and care*. Retrieved from https://cancer-network.org/wp-content/uploads/2017/02/National_Transgender_Discrimination_Survey_Report_on_health_and_health_care.pdf

Gray, S. S., Sweeney, K. K., Randazzo, R., Levitt, H. M. (2016). "Am I doing the right thing?": Pathways to parenting a gender variant child. *Family Process, 55*,123-38.

Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality.* New Haven, CT: Yale University Press.

Gregor, C., Davidson, S., &Hingley-Jones, H. (2014). The experience of gender dysphoria of pre-pubescent children and their families: A review of the literature. *Child and Family Social Work, 21*, 339-346.

Gregor, C., Hingley-Jones, H., & Davidson, S. (2015). Understanding the experience of parents of pre-pubescent children with gender identity issues.*Child and Adolescent Social Work Journal, 32,* 237-246.

Grossman, A. H., &D'Augelli, A. R. (2007).Transgender youth and life-threatening behaviors.*Suicide and Life-Threatening Behavior, 37*, 527–537.

Kosciw, J. G., Greytak, E. A., Palmer, N. A., &Boesen, M. J. (2014).*The 2013 national school climate survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. Retrieved from https://www.glsen.org/sites/default/files/2013%20National%20School%20Climate%20Survey%20Full%20Report_0.pdf

Guba, E. G. (1981).Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal, 29*, 75–91.

Harper, D. (2012).Choosing a qualitative method.In D. Harper, & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 83-97). Oxford, England: Wiley-Blackwell.

Harris, A. (1991). Gender as contradiction.*Psychoanalytic Dialogues, 6*, 197-220.

Harris, A. (2005). Gender as a soft assembly: Tomboys' stories. *Studies of Gender and Sexuality, 1,* 223-250.

Harry Benjamin International Gender Dysphoria Association. (2001). Standards of care for gender dysphoria (6th ed.). Retrieved from http://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf

Haslam, N. (2000). Psychiatric categories as natural kinds: Essentialist thinking about mental disorder. *Social Research, 67*, 1031-1058.

Hegel, G. F. (1977). *Phenomenology of spirit* (Trans. A. V. Miller). Oxford, England: Clarendon Press. (Original work published 1807)

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waai, H. A., Gooren, L. J., Meyer, W. J., III, Spack N. P., … Endocrine Society. (2009). Endocrine treatment of

transsexual persons: An endocrine society clinical practise guideline. *Journal of Clinical Endocrinology and Metabolism, 4*, 3132-3154.

Hendricks M. L, Testa R.J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology Research and Practice. 43*(5).

Henwood, K., &Pidgeon, N. (1995).Grounded theory and psychological research.*The Psychologist*, 8, 115-118.

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S., M., … Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56,* 285-290.

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirming intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy, 36*, 6-23.

Hillman, J. (1996). *The soul's code: In search of character and calling.* New York, NY: Random House.

Hines, S. (2007). *Transforming gender: Transgender practices of identity, intimacy and care*. Bristol, England: Policy Press.

Hingley-Jones, H., Davidson, S., Gregor, C. (2015).Understanding the experience of parents of pre-pubescent children with gender identity issues.*Child and Adolescent Social Work Journal, 32*, 237-246.

Hjelmeland, H., Knizek B. L. (2010). Why we need qualitative research in suicidology. *Suicide Life Threatening Behaviour, 40*, 74-80.

Holton, J. (2007). The coding process and its challenges.In A. Bryant & K. Charmaz (Eds.).*Handbook of grounded theory* (pp. 265-289). London, England: Sage.

Kanner, L. (1943). Autistic disturbances of affective contact.*Nervous Child, 2*, 217-50.

Kessler, S. (2000).*Lessons from the intersexed.* New Brunswick, NJ: Rutgers University Press.

King, N., &Harrocks, C. (2010).*Interviews in qualitative research.* London, England: Sage.

Kitzinger, C. (2004). The myth of the two biological sexes.*The Psychologist, 17*, 451-454.

Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E.E. Maccoby (Ed.) *The development of sex differences*. (p. 52-173), Stanford, CA: Stanford University Press.

Korte, A., Lehmkuhl, U., Goecker, D., Beier, K. M., Krude, H., &Grüters-Kieslich, A. (2008). Gender identity disorders in childhood and adolescence: currently debated concepts and treatment strategies. *DeutschesArzteblatt international, 105*, 834-41.

Kubler- Ross, E. (1969). *On death and dying*. New York, NY: Simon & Shuster.

Kuvalanka, K. A., Weiner, J. L., & Mahan, D. (2014). Child, family, and community transformations: Findings from interviews with mothers of transgender girls. *Journal of GLBT Family Studies, 10*, 354-379.

Lacan, J. (2002). The mirror stage as formative of the I function. In Écrits: A selection (Bruce Fink, Trans., pp. 3-9). New York, NY: W. W. Norton. (Original work published 1949)

Lambda Legal (2010).*When health care isn't caring: Lambda Legal's Survey of discrimination against LGBT people and people with HIV*. New York, NY: Author.

Le Roux, N. (2013) Gender variance in childhood/adolescence: gender identity journeys not involving physical intervention. (Doctoral dissertation).Retrieved from ROAR University of East London. (10552/3493)

Lempert, L. B. (2007). Asking questions of the data: Memo writing in the grounded theory tradition.In A. Bryant, & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 245-64). London, England: Sage.

Lev, A. I. (2004).*Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghampton, NY: Haworth Clinical Practice Press.

London Review of Books. (2018, October 3). *Adam Phillips: 'Against self-criticism' (with Q&A)* [Video File]. Retrieved from https://www.youtube.com/watch?v=a8mcaCWGFmg

Lowe, F. (Ed.). (2013). *Thinking space: Promoting thinking about race, culture and diversity in psychotherapy and beyond*. England, London: Karnac Books.

Lyons, E., & Coyle, A. (2008).*Analysing qualitative data in psychology*. London, England: Sage.

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender non-confirming children and their families. *Family Process, 50*, 453-470.

Manning, S., & Adams, S. (2018, November 3). NHS to give sex change drugs to nine-years-old: Clinical accused of 'playing God' with treatment that stops puberty, *Mail Online*. Retrieved from https://www.dailymail.co.uk/news/article-2631472/NHS-sex-change-drugs-nine-year-olds-Clinic-accused-playing-God-treatment-stops-puberty.html

McHugh, P. R. (1995). Witches, multiple personalities and other psychiatric artefacts. *Nature Medicine,1*, 110-114.

Mead, S., &Filson, B. (2016). Becoming part of each other's narratives: International peer support. In J. Russo, & A. Sweeney (Eds.), *Searching for a rose garden: Challenging psychiatry, fostering mad studies* (pp. 109-117). Monmouth, England: PCCS Books.

Meadow, N. (2012). 'Deep down where the music plays': How parents account for childhood gender variance. *Sexualities, 14*, 725-747.

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counselling and psychological practise. *Psychology of Sexual Orientation and Gender Diversity, 2,* 148-155.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology*, *4*, p. 29–41.

Nadal, K., Davis, L. S., Davidoff, K. C., & Wong, Y. Emotional, behaviour and cognitive reactions to miscoaggressions: Transgender perspective. *Psychology of Sexual Orientation and Gender Diversity, 1*, 72-81.

Nadal, K. L., Rivera, D. P., & Corpus, M. J. H. (2010). Sexual orientation and transgender microaggressions in everyday life: Experiences of lesbians, gays, bisexuals, and transgender individuals. In D. W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. 217–240). New York, NY: Wiley.

National Health Service. (2018). *Symptoms: Gender dysphoria* [webpage]. Retrieved from https://www.nhs.uk/conditions/gender-dysphoria/symptoms/

Newman, L. (2002). Sex, gender and culture: Issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology and Psychiatry, 7*, 1539-1045.

Norwood, K. (2012). Transitioning meanings? Family members' communicative struggles surrounding transgender identity.*Journal of Family Communication, 12*, 75-92.

O'Connell, D. C., &Kowal, S. (1995). Basic principles of transcription.In J. A. Smith, R. Harré,& L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 93-105). London, England.

Oliver, C. (2011). Critical realist grounded theory: a new approach for social work research. *British Journal of Social Work, 42*, 371-387.

Pasterski, V., Geffiner, M. E., Brain, C., HIndmarsh, P., Brook, C., & Hines, M. (2001). Parental hormones and childhood sex segregation: Playmate and play style preferences in girls with adrenal hyperplasia. *Hormones and Behaviours, 59,* 549-555.

Payne, S. (2007). Grounded theory. In E. Lyons, & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 65-86). London, England: Sage.

Pearlman, S. F. (2006). Terms of connection: Mother-talk about female-to-male transgender children. *Journal of LGBT Family Studies, 2*, 93-122.

Pidgeon, N. (1996). Grounded theory: Theoretical background. In J Richardson (Ed.), *Handbook of qualitative research for psychology and methods for the social sciences.* (pp. 75-85). Oxford, England: BPS Blackwell.

Poteat, T., German, D., &, Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science and Medicine, 84*, 22-29.

Pyne, J. (2016). “Parenting is not a job… It’s a relationship”: Recognition and relational knowledge among parents of gender non-conforming children. *Journal of Progressive Human Services 27*, 21-48.

Rapley, T. (2001). The art(fulness) of open-ended interviewing: Some considerations on analysing interviews. *Qualitative Research, 1*, 303-323.

Raymond, J. G. (1979). *The transsexual empire.* London, England: The Women’s Press.

Rekers, G. A. (1972). *Pathological sex-role development in boys:Behavioural treatment and assessment* (Unpublished doctoral thesis). University of California, Los Angeles, CA.

Robertson, C. E. (1989). The Mahu of Hawaii.*Feminist Studies, 15*, 313-327.

Rogers, W., &Stainton Rogers, R. (2001).*The psychology of gender and sexuality: An introduction*. Buckingham, England: Open University Press.

Rosen, A. C., Rekers, G.A., Friar, L. R. (1977). Theoretical and diagnostic issues in child gender disturbances. *Journal of Sex Research, 13*, 89-103.

Royal College of Psychiatrists.(1998). *Gender identity disorders in children and adolescents – Guidance for management*. London, England: Author.

Rustin, M. (1991).*The good society and the inner world*. London, England: Verso.

Ryle, G. (1949). *The concept of mind.* Oxford, England: Barnes & Noble.

Sabalis, R. F., Frances, A., Appenzeller, S. N., & Moseley, W. B. (1974). The three sisters: Transsexual male siblings. *American Journal of Psychiatry, 131,* 907-909.

Sadowski, H., & Gaffney, B. (1998).Gender identity disorder, depression and suicidal risks. In D. Di Ceglie& D. Freedman (Eds.), *A stranger in my own body: Atypical gender identity development and mental health* (pp. 126-136). London, England: Karnac Books.

Saketopoulou, A. (2013). Mourning the body as bedrock: Developmental considerations in treating transsexual patients analytically.*Journal of the American Psychoanalytic Assication, 62*, 773-806.

Salaman, G. (2010). *Assuming a body: Transgender and rhetorics of materiality*.Columbia University Press.

Sansfacon, A., P., Robichaud, J., &Dumais-Michaud, A. (2013).The experience of parents who support their children's gender variance.*Journal of LGBT Youth,* 12, 39-63.

Schon, D. (1983). *The reflective practitioner*. London, England: Temple Smith.

Segal, H. (1957). Notes on symbol formation.*International Journal of Psychoanalysis, 38*, 391-397.

Seidman, S. (1993). Identity and politics in a 'postmodern' gay culture: Some historical and conceptual notes. In M. Warner (Ed.), *Fear of a queer planet: Queer politics and social theory.*University of Minnesota Press.

Shipherd, J., Green, K. E., &Abramovitz, S. (2010). Transgender clients: Identifying and minimalizing barriers to mental health treatment. *Journal of Gay and Lesbian Mental Health, 14,* 94-108.

Shipherd, J. C. &Maguen, S.(2010) Suicide risk among transgender individuals. *Psychology and Sexuality, 1*, 34-43.

Singh, D. (2012). *A follow-up study of boys with gender identity disorder* (Doctoral dissertation). Retrieved from TSpace (Singh_Devita_201211)

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London, England: Sage.

Spack, N., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012) Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics, 12,* 418-425.

Sperber, J., Landers, S., & Lawrence, S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. *International Journal of Transgenderism, 8,* 75-91.

Spiegel, A. (2008).*Parents consider treatment to delay son's puberty: New therapy would buy time to resolve gender crisis* [Radio transcript]. Retrieved from https://www.npr.org/templates/story/story.php?storyId=90273278&t=1543692273405

Spillius, E., & O' Shaughnessy, E. (2012).*Projective identification: The fate of a concept*. Abingdon, England: Routledge.

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry, 16,* 499-516.

Steiner, J. (1985). Turning a blind eye: The cover up for Oedipus.*International Review of Psycho-Analysis, 12*, 161-172.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz (Eds.), *Handbook of grounded theory* (pp. 114-126). London, England: Sage.

Strauss, A. L., & Corbin, J. M. (1990).*Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: Sage.

Stroller, R. J. (1968).*Sex and gender.The development of masculinity and femininity.* London, England: Karnac Books.

Stroller, R. J. (1976).Primary femininity.*Journal of American Psychoanalytical Association, 24,* 59-78.

Sue, D. W. (2010). *Microaggression in everyday life: Race, gender and sexual orientation*. New York, NY: Wiley.

Taylor, C. (1994). The politics of recognition. In A. Gutmann (Ed.), *Multiculturalism: examining the politics of recognition* (pp. 25-73). Princeton University Press.

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 41*, 1580-1589.

Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, K., Papadimitriou, M. (2012).*Impacts of strong parental support for trans youth* [Newsletter]. Retrieved from http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf

Tweed, A., &Charmaz, K. (2012) Grounded theory methods for mental health practitioners. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 131-146). Oxford, England: Wiley-Blackwell.

Urquhart, C. (2007). The evolving nature of grounded theory method: The case of the information systems discipline. In A. Bryant, & K. Charmaz (Eds.), *The sage handbook of grounded theory* (pp. 339-359). London, England: Sage.

Vaspe, A. (Ed.). (2017). *Psychoanalysis, the NHS, and mental health work today*. London, England: Karnac Books.

Veale, J. F., Clarke, D. E., & Lomax, T. C. (2010).Biological and psychosocial correlates of adult gender-variant identities.*Personality and Individual Differences, 48*, 357- 366.

Viner R. M., Brain, C., Carmichael, P. & Di Ceglie D. (2005). Sex on the brain: Dilemmas in the endocrine management of children and adolescents with gender identity disorder. *Archives of Disease in Childhood, 90*, A78.

Wahling, J. L. (2016). Losing the child they thought they had: Therapeutic suggestions for an ambiguous loss, perspectives with parents of transgender child. *Journal of LGBT Family Studies, 11*, 305-326.

Wallace, R. & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: Towards a theoretical framework for evaluating clinical interventions. *International Journal of Transgenderism, 14,* 113-126.

Wallien, M. S. C., & Cohen-Kettenis, P.T. (2008).Psychosocial outcome in gender dysphoric children.*Journal of the American Academy of Child and Adolescent Psychiatry 47*, 1413-23.

Warner, M. (1993).*Publics and counterpublics.* Cambridge, MA: Zone Books.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, England: Open University Press.

Wiseman, M., & Davidson, S. (2012). Problems with binary gender discourse: Using context to promote flexibility and connection in gender identity. *Clinical Child Psychology and Psychiatry*, *17*, 528-537.

World Professional Association for Transgender Health. (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people* (7thed.). Retrieved from https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf

Wren, B. (2000). Early physical intervention for young people with atypical gender identity development.*Clinical Child Psychology and Psychiatry, 5,* 220-231.

Wren, B. (2002). 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemas in parenting a transgendered adolescent. *Clinical Child Psychology and Psychiatry, 7*, 377-397.

Wren, B. (2014). Thinking postmodern and practising in the enlightenment: Managing uncertainty in the treatment of children and adolescents. *Feminism and Psychology, 24*(2), 271-291.

Zhou, J., Hofman, M. A., Gooren, L. J. G., &Swaab, D. F. (1995).A sex difference in the human brain and its relation to transsexuality. *Nature, 378,* 68-70.

Zucker, K. J. (2008). Children with gender identity disorder: Is there a best practise? *Neuropsychiatrie de l'enfanceet de l'adolescence, 56,* 358-364.

Zucker, K. J., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex and Marital Therapy, 34,* 287-290.

Zucker, K. J., Wood, H., Singh, D., & Bradley, S. (2012). A developmental, biopsychological model for the treatment of children with gender identity disorder.*Journal of Homosexuality, 59,* 369-397.

Appendix A

Literature Review Search Strategy

Criteria

Database search	CINAHL Complete, eBook Collection (EBSCOhost), E-journals, MEDLINE with full text, PsycARTICLES, PsychINFO
Search run	21st September 2016
Limiters	Full text available, peer-reviewed articles

Search

Search	**Search terms**	**Results**
1.	"parent* experience" OR "carer* experience" OR "bring* up child*" OR "rais* child" OR "parent* view*" OR "carer view*" OR "parent* child* OR "*mother experience*" OR "father* experience*"	969969
2.	"transgender*" OR "MTF" OR "FTM" OR "GID" OR "gender identity disorder" OR "gender dysphoria" OR "gender queer" OR "gender non-conforming" OR "bigender*"	8281

	OR “gender fluid”	
3.	#1 OR #2	56

Inclusion criteria:

Peer reviewed journals

Qualitative research only

Data reported focus on experiences of raising gender diverse child

Exclusion criteria:

Studies which focused on experience of gender diverse adults

Studies with primary focus on different area of gender diversity (i.e. physical intervention, gender diversity and mental health, evaluation of affirmative approach)

Results of search :

- 1 study was a duplicate
- 1 study was in French
- 33 studies were not relevant (i.e. did not focus on parents experiences)

33 studies were read in full to find the focus laid else-where to parental experiences. ***8 studies were selected as meeting all inclusion criteria.***

Appendix B

Reflective Journal Entry

September 2016, Interview 1

First interview done. Upon arrival the mum was very welcoming and pretty much began to tell me her story before I even took my shoes off. She seemed desperate to show me around the house. She showed me the child's stereotypically pink bedroom and all her favourite toys and also all the 'before' and 'after photos. I felt bad asking her to repeat it when we eventually sat down and the dictaphone was on.

I was stuck by her endless love and warmth towards her child which she was so expressive about. I was also struck by her passion which could turn into feistiness and anger ever so quickly when challenging experiences were recalled. Her anger stayed with me, her black and white thinking, 'you are in or you are out', it felt very powerful and I will try to remember it during the next interview.

I was wondering what such thinking does to her daughter's development? What happens to child's mind and soul when they are the ones leading on everything and anybody who disagrees with them get deleted from their life?

Is affirmative care as helpful as it is feels like when one is first presented with it?

Also. I must become better at listening for data. I feel like I behaved like such a therapist constantly hearing for unspoken messages.

Appendix C

Memo

7.4.2017 – Two more interviews to go. Will they see it differently?

I have listened to all the interviews twice now, they are all transcribed. I feel like some clear themes in my mind. One especially standing out – 'loss'. I have been curious about the differences between mothers and fathers – how come the mothers 'miss their child' and the father don't. I will try to in cooperate this into the next interviews; so far, it feels like something is missing, I cannot quite put my finger on it. The analysis of loss has been bitty and hard. Emotionally as well as practically. It might related to me being quite heavily pregnant now?

The process of saturation has been so interesting. I am surprised how strongly the common these come through at times. How quickly some areas do become saturated. I always allow the parent to take the lead on the interview and they always begin with the first signs they noticed. Every single time. Perhaps it is quite natural to tell a story from its very beginning but I have been wondering about it being more than that. The experience, I feel like I am getting, is one which is a journey, a process and to be able to understand it, it has to begin at the very start. It really feels like the parents wanted to get across that they had nothing to do with this, the child 'just arrived'. From then on, they tentatively allowed the child to lead on.

Appendix D

Invitation Letter

Invitation letter

[Name]
[Address]
[Date]

Dear [],

We are writing to invite you to take part in a research study. We are keen to learn more about the experiences of parents of pre-pubertal gender variant children, who are seeking early physical intervention. This knowledge can help organisations improve the way in which they support people who are unhappy with their gender and their families, and it can also be helpful to people who experience such unhappiness themselves.

Participation would involve taking part in an interview, which involves an informal conversation with Iva, the researcher, about your experiences. The interview can happen at the Tavistock Clinic or in ata place that is convenient for you.

We include an information sheet which provides more information about the study. You are welcome to contact Iva by phone, text or email for further information; her contact details are provided below. Alternatively you can complete the enclosed reply slip and post it in the freepost envelope.

Thank you very much for reading this far. We look forward to hearing from you.
Yours sincerely,

Iva Roberts
Trainee Clinical Psychologist
University of Essex

Dr Susan McPherson
Senior Lecturer and Thesis Supervisor

Email: isimko@essex.ac.uk

Enclosed: Information sheet, reply slip, prepaid envelope

Appendix E

Information Sheet

PARTICIPANT INFORMATION SHEET

Title

A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children

An invitation to participate in a research study

We would like to invite you to take part in a research study which is being undertaken as part of a professional doctorate in clinical psychology. Before you decide we would like you to understand why the research is being done and what it would involve for you if you decide to participate. 'If you are interested, you are welcome to contact the researcher to discuss the information sheet if you wish to do so you are welcome to talk to others about the study if you wish.

Part 1 tells you the purpose of the study and what will happen if you take part. Part 2 gives you more detailed information about how the study will be done.

Part 1

What is the purpose of the study?

The reason for the study is that there has been limited research into experiences of parents who face dilemmas when facing challenges brought about their children's gender variance.
The aim of the study is to get a better understanding of the experiences of parents who are seeking physical intervention for their gender variant children. This knowledge can help services and voluntary organisations improve the way in which they support people who experience gender variance. It can also be of value to the children who experience gender variance and their families.

Are you eligible to take part?

If you answer YES to all four statements below, then you are eligible to take part.

1. I am a parent of a child who meets the criteria for the diagnosis of Gender Dysphoria.
YES/NO

2. My child has socially transitioned into the opposite to their inborn gender.
YES/NO

3. I am a fluent English speaker
YES/NO

4. I have a learning disability which would stop be from being able to engage in the interview process
YES/NO

Do I have to take part?
Participation is entirely voluntary. If you agree to take part, I will then ask you to sign a consent form. You will be given a copy of the consent form and the information sheet. You are free to withdraw at any time, without giving any reason. This will not affect the standard of care you and your child receive.

What will happen if I take part?
Participation would involve meeting Iva Roberts the researcher, for approximately an hour, at a time and a place that is convenient for you. This could be at your home or at the Tavistock Gender Identity Development Service. The meeting will be similar to having an informal conversation, although the emphasis would be on hearing about your experiences of seeking physical intervention for your child. With your permission the conversation will be audio recorded – this is done because it is important that the researcher gets what you say exactly right.

Expenses
If the meeting is not at your home, you will be reimbursed for your travel expenses to get to the meeting place.

What are the possible benefits of taking part?
We anticipate that it will be interesting for you to talk about your experiences. Secondly, you will be providing valuable information that can be helpful to other people who have experience gender variance, as well as to gender services and voluntary organisations.

What are the possible disadvantages of taking part?
You may have had upsetting experiences, which can be difficult to talk about. Please note that you do not have to talk about anything you do not want to.

Will my taking part in the study be kept confidential?
Yes. Ethical and legal practice will be followed and all information about you will be handled in confidence. The detailed information on this is given in Part 2.

What if there is a problem?
Any complaint you have will be addressed. The detailed information on this is given in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I no longer want to carry on with the study?
You can let the researcher know via the contact details below. Your audio recordings and transcripts would be destroyed. The researcher would need to be notified of your withdrawal before the 1st of April 2017, which is when the doctoral thesis is due for submission.

Will my taking part in the study be kept confidential?
Electronic data will be encrypted and password protected, and paper files and audio files will be kept in a locked filing cabinet. The audio files will be transcribed (i.e. written out) and then deleted. All information that could identity you (or people mentioned by you) will be removed so that no-one could be identified. Only the researcher, supervisors and examiners will have access to the transcribed material. The researcher will only break confidentiality following her meeting with you in the unlikely event that she has very serious concerns about your safety or the safety of others. If this is the case, she will discuss this with you where possible.

What if there is a problem?
If you require support and/or have any concerns, please do not hesitate to discuss with the researcher. If you have concerns that you do not wish to discuss with the researcher, please contact:
Dr Susan McPherson, Senior Lecturer and thesis supervisor :smcpher@essex.ac.uk
If you remain unhappy and wish to complain formally, you can do this by contacting the University of Essex Research Governance and Planning Manager, Sarah Manning-Press (sarahm@essex.ac.uk).

What will happen to the results of the study?
The results will be written up for the purpose of a doctoral thesis, journal articles and presentations. You will be offered the opportunity to receive a summary of the results. Any reports or written articles resulting from the study will not reveal the identity of anyone who took part.

Who is organising and funding the research?
The research is organised and funded by the University of Essex, in collaboration with the Tavistock and Portman Gender Identity Development Service.
Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by _____Research Ethics Committee

How do I express my interest or ask for further information?
We would greatly appreciate if you could complete the slip that is included and send it back to me in the envelope provided. This will help me know who is interested, who would like more information. Alternatively, you can email Iva Roberts on isimko@essex.ac.uk. I look forward to hear from you.

Thank you very much for considering taking part in this study. We look forward to hear from you.

Yours sincerely,

Iva Roberts Dr. Susan McPherson
Trainee Clinical Psychologist Senior Lecturer at University of Essex
email: isimko@essex.ac.uksmcpher@essex.ac.uk

_ _

Reply slip

For attention of: Iva Roberts /Dr Susan McPherson

Re: A qualitative study to examine the experiences of parents of pre-pubertal gender variant children who are seeking early physical intervention.

Name: _____________________________________

Please tick which option applies to you:

□I am interested in taking part; please contact me

□I would like further information; please contact me to discuss

Please indicate how best to contact you:

Telephone: ________________________________

Email: __________________________________

Appendix F

Participant Consent Form

CONSENT FORM

Title of Project

A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children

Name of Researcher: Iva Roberts

Please initial all statements

1. I confirm that I have read and understand the information sheet dated … (version ...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected.

3. I understand that my involvement in this study and particular data from this research, including audio recordings, will remain strictly confidential. Only the researcher involved in this study will have access to identifying data.

4. I understand that any identifiable information will be removed from all data and that the researcher's supervisors will have access to the anonymised data.

5. I understand that any quotations used in subsequent reports will be anonymised.

6. I agree to take part in the above study.

Name of
Participant……

Date ……

Signature……

Name of person taking
consent……..

Date ……

Signature……

Appendix G

Interview Schedule

- Information sheet + questions
- Confidentiality and anonymity
- Consent form
- Ask about pronouns to be used in a write-up

Current situation:

- Tell me little bit about your child (e.g. first name, age, school experiences, friends)
- What is your living situation like?

Gender:

- How would you describe your child?
- When did you find your child was gender variant?
- How did you make sense of it?
- What were the challenges?

Appropriate support from services

- How do you think appropriate support from service look like?
- How did you find out about physical intervention?
- What led you to feel that physical intervention was the way forward?
- What were the dilemmas you had to face?
- How would you feel if your child prefers to return to their natal sex later in life?
- What do you think the future holds?

Debrief

Appendix H

University Ethical Approval

University of Essex

Research and Enterprise Office
T 01206 872922
F 01206 873894
E reo@essex.ac.uk

www.essex.ac.uk/reo

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom
T 01206 873333
F 01206 873598

www.essex.ac.uk

22 February 2016

To whom it may concern

A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children

I am pleased to confirm that the University of Essex will act as Sponsor under the Department of Health Research Governance Framework for Health and Social Care for the following research project undertaken by one of our postgraduate students:

Chief Investigator:	Mrs Iva Roberts
Department:	School of Health and Human Sciences
Project Title:	A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children
Academic Supervisor:	Dr Susan McPherson, University of Essex
Work Place Supervisor:	Dr Natasha Prescott, Tavistock and Portman NHS Foundation Trust

The University will provide indemnity against negligent harm caused as a direct result of our employees' and students' actions.

Yours faithfully

Sarah Manning-Press
Research Governance and Planning Manager

Appendix I

NHS Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales REC 6
Floor 8
36 Orchard Street
Swansea
SA1 5AQ

Telephone : 01792 607416
Fax : 01792 607533
E-mail : penny.beresford@wales.nhs.uk
Website : www.nres.nhs.uk

03 March 2016

Mrs Iva Roberts
Trainee Clinical Psychologist
North Essex Partnership NHS Foundation Trust
66 Hawkins Drive
Chafford Hundred
RM166GG

Dear Mrs Roberts

Study title: **A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children**
REC reference: **16/WA/0081**
Protocol number: **N/A**
IRAS project ID: **195735**

Thank you for your email of 03 March 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 01 March 2016

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other [topic guide]	1	13 January 2016
Participant consent form	2	03 March 2016
Participant information sheet (PIS)	2	03 March 2016

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity letter]	1	05 August 2015
Interview schedules or topic guides for participants [Interview Schedule]	1	21 January 2016
IRAS Checklist XML [Checklist_25022016]		25 February 2016

Letter from sponsor [Sponsorship confirmation]	1	22 February 2016
Letters of invitation to participant [Invitation letter]	1	21 January 2016
Other [topic guide]	1	13 January 2016
Participant consent form	2	03 March 2016
Participant information sheet (PIS)	2	03 March 2016
REC Application Form [REC_Form_25022016]		25 February 2016
Research protocol or project proposal [Thesis proposal]	1	21 January 2016
Summary CV for Chief Investigator (CI) [Iva Roberts CV]	1	21 January 2016
Summary CV for supervisor (student research) [Susan McPherson CV]	1	08 February 2016

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

16/WA/0081 **Please quote this number on all correspondence**

Yours sincerely

Penny Beresford
REC Manager

E-mail: penny.beresford@wales.nhs.uk

Copy to: *Ms Sarah Manning-Press*
Angela Williams, Noclor

Appendix J

Noclor Ethical Approval

noclor
RESEARCH SUPPORT

1st Floor, Bloomsbury Building
St Pancras Hospital
4 St Pancras Way
NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

25 May 2016

Mrs Iva Roberts
North Essex Partnership NHS Foundation Trust
66 Hawkins Drive
Chafford Hundred
RM166GG

Dear Mrs Iva Roberts

This NHS Permission is based on the REC favourable opinion with conditions given on **01 March 2016** and the conditions met on **03 March 2016.**

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in **the trust(s) identified below**:

Study Title: **A qualitative study examining the views of parents on appropriate support for their pre-pubertal gender variant children**
R&D reference: **195735**
REC reference: **16/WA/0081**

Name of the trust	Name of current PI/LC	Date of permission issue(d)
Tavistock & Portman NHS Foundation Trust	Dr Natasha Prescott	25 May 2016

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Specific Conditions of Permission (if applicable)
The researcher will observe the Trusts Lone Working Policy when conducting interviews at participants homes

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Mabel Saili
Research & Development Manager

Cc: Principle Investigator(s)/Local Collaborator(s), Sponsor Contact

noclor
RESEARCH SUPPORT

1st Floor, Bloomsbury Building
St Pancras Hospital
4 St Pancras Way
NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830/5788
www.noclor.nhs.uk

May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly / Annually Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website: http://www.crn.nihr.ac.uk/can-help/funders-academics/nihrcrn-portfolio/recruitment-data/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment. If your study is Portfolio Adopted, amendments must be submitted for R&D review via the NIHR CRN (CSP), please refer to the Amendments Guidance for Researchers: http://www.crn.nihr.ac.uk/can-help/funders-academics/gaining-nhs-permissions/amendments/
- **Audits:** each year, noclor select 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.