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Children and Adolescents with Transsexual Parents Referred to a Specialist Gender Identity Development Service: A Brief Report of Key Developmental Features

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ABSTRACT

An investigation of the psychosocial development of children of transsexual parents provides a special opportunity to examine whether and how parental gender role influences children's own gender development, mental health, family relationships and peer relationships. Data on the presence or absence of gender identity disorder, depression, peer relationship difficulties and problems in family relationships among children of transsexual parents were collated from audit of a specialist clinical service. Only 1 female adolescent of the 18 children of transsexual parents recorded temporary concerns with respect to gender identity. Compared with children referred to the same clinical service regarding concerns about their own gender identity, the children of transsexual parents were less depressed and less likely to report peer harassment, persecution or victimization. However, the case notes of children of transsexual parents revealed that this group was more likely to have experienced marital conflict between their parents than were children referred with gender identity concerns and as likely to record difficulties in parent–child relationships and general difficulties with peer relationships. It is suggested that clinical work with children of transsexual parents needs to focus on the quality of family relationships.

KEYWORDS

children of transsexual parents, parenting, psychosocial development

Introduction

GENDER IDENTITIES AND gender roles provide much of the organizing structure in family life (Barnard & Martell, 1995; Parke, 1995). When a mother or a father is

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transsexual to what extent does this influence their relationship with their children, their parenting and key developmental outcomes for children? Recent estimates suggest that up to one-third of transsexuals attending a gender identity clinic have children (Di Ceglie, 1998; Tully, 1992). Although the number of children with a transsexual parent is small, this unusual situation may cast light on whether and how a parent's gender transition influences child development.

Different developmental theories give differential emphasis to the importance of mothers and fathers to the psychosexual development of the child (Golombok & Fivush, 1994). Some theories suggest that biological processes (both genetic and hormonal) influence both gender and sexual identity (Bailey, 1995). Social learning theories highlight modelling (particularly modelling behaviour of a same sex adult) and reinforcement as key processes through which development proceeds (Bandura, 1986). There is general agreement among different psychoanalytic schools that the intrapsychic resolution of the Oedipal conflict involving an internal representation of a parental couple, mother and father, is important for a heterosexual outcome, although the relative contribution of each parent's representation varies according to different theories (Fine, 1987; Rose, 1990).

In legal proceedings, for example in disputes arising from parental divorce, the above developmental theories and widespread assumptions surrounding transsexual parenting have been used to argue that continued contact with a transsexual parent may have detrimental effects on the child's psychosexual development. Furthermore, it has been argued that the child's mental health will be affected by difficulties in comprehending the transsexual parent's transition, the disruption to their relationship with their transsexual parent, and conflicts in the relationship between their parents. It has also been argued that the quality of the child's peer relationships may be adversely affected through the stigma attached to the transsexual parent. However, these arguments have not been empirically supported (Green, 1998).

Other psychological theories place less emphasis on parental influences (Tasker &

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Golombok, 1997). Social constructionist approaches attach importance to discourses present within the wider cultural environment (Kitzinger, 1997). Constructivist, or cognitive developmental approaches, emphasize the importance of the child's ability to integrate new information within his or her developing self-concept (Kohlberg, 1966) so that what the child understands about gender critically influences the way in which they react to their transgendered parent and how their parent's gender role might influence them.

Published research examining the psychosocial development of children of transsexual parents is limited. Green (1978) found that none of the 16 children (aged from 3 to 20 years old) of the 7 transsexual parents in his study had gender identity problems and all reported gender typical activities and interests. All of the 13 post-pubertal children reported heterosexual fantasies and relationships. Altogether, 12 of the children were aware of their parent's sex change. Data were not systematically recorded on other key aspects of children's experience with respect to parenting and family relationships, peer relationships and mental health. Green also recently published findings of 10 cases in which two family members were diagnosed with 'gender dysphoria' (Green, 2000). This report included three cross-generational cases of relevance here: a female to male transsexual with a transvestic father, a male to female transsexual with a gender dysphoric father, and a transsexual father with a gender dysphoric transvestic son. Two points, however, can be made; first, there is no known causative link in the cross-generational cases. Second, the cross-generational gender dysphoric families are very small in number compared with the total transparenting population.

Clinical reports suggest that sex reassignment treatments bring into question the existing patterns of relating between the parent and child (Lightfoot, 1998; Sales, 1995). Transition has an impact on every aspect of life of the transperson (King, 1993; Tully, 1992) and the many changes, adjustments and confusions may relate directly to the parenting of children. For instance, the transsexual parent may be preoccupied with bodily and psychological changes and find it difficult to appreciate their son or daughter's difficulty in accepting and adjusting to the change. The child may also not know how to refer to their parent in different social contexts and whether (or how) to explain their parent's situation to others. The seeking of sex reassignment treatment brings the parent into contact with adult clinical services potentially influencing the way that the transsexual parent, the non-transsexual parent and their children handle issues connected with their transsexual parent's identity. For instance, the advice given by adult clinical services to transsexual people seeking sex reassignment treatment to make a complete and unambiguous change to living in the other role may conflict with the wishes of the child or non-transsexual parent for the changes to be gradual. Clinical work with children often explores the meaning of the parent's sex change: for instance, why this happened, whether the change be permanent, what is involved in hormonal/surgical treatment, and whether transsexuality is hereditary. Clinical work may also focus on the adjustments in family life surrounding the transsexual parent's decision to seek sex reassignment treatment, particularly if parents decide to separate.

Clinical audit of relevant case files provides one way of examining whether the children of transsexual parents experience mental health problems, have difficulties in family or peer relationships, or show signs of atypical gender identity development themselves. We report findings on these key aspects from a sample of children of transsexual parents obtained via clinical audit of one specialist service. Comparing clinical data on children of transsexual parents with a second sample of children referred to the same clinic with their own atypical gender identity concerns further addresses the question whether children of transsexual parents display similar or different developmental patterns to this latter group.

Method

Clinical service information

The Gender Identity Development Service (GIDS) for children and adolescents with gender identity issues in Britain was first established at St George's Hospital in south London in 1989 and transferred to the Portman Clinic in north London in 1996 (see Di Ceglie, 1998 for a detailed discussion of the therapeutic model employed). In addition to the primary work of the service there is a secondary, smaller group of case referrals, of children who have a transsexual parent.

At the time of the audit (March 2001) there had been 196 referrals to the GIDS and 32 of these cases involved a child of a transsexual parent (22 families were represented). The audit proceeded with data from the files of 13 families with 18 children for whom detailed records were available.[1] Ten girls and eight boys were referred. The age range of the children was 3 to 15 years with a mean average age of 9.2 years. Ethnic data were available on 12 children, all of whom were white.

Twelve of the transsexual parents were male to female and one was female to male. Three families had more than one child referred; two families had three children and one family had two children. Six referred children had 11 siblings or half-siblings not referred to the service ranging in age from under 1 year to 20 (an additional referred child had a deceased older sister); 3 non-referred children were aged 1 year or under and 2 were aged 18 and over and consequently too old to be registered with this service. There was no discernible pattern to the birth order of the referred child. However, the majority of the non-referred siblings were half-siblings where the non-transsexual parent had subsequently had children with later partners and the half-siblings were not related to the transsexual parent.

In two of the 13 families the child(ren) concerned lived with both their transsexual and non-transsexual parent. In the remaining 11 families the parents were now divorced or separated. In only two of the divorced/separated families was custody joint, in all others the non-transsexual mother had legal responsibility for the children. In nine families the child lived with their nontranssexual single parent mother (in two of these families the mother now lived with a new male partner) and only one child lived with their transsexual father. The child with a transsexual mother lived with other relatives. In the separated (or divorced) families the files recorded a great deal of acrimony between the parents in their own relationship and with regard to parenting.

The family situation and developmental outcomes of the 18 children of transsexual parents were compared with those of the first 124 cases of children and adolescents referred to the clinic with gender identity concerns. The case files of children referred with gender identity concerns had previously been audited in early 1999 (Di Ceglie, Freedman, McPherson, & Richardson, in press). This group comprised 82 males and 40 females and 2 intersex children and adolescents (age range 3–18). Most of these children had a cross-gender identification. The majority of these children and adolescents were white (79%), whereas 13 percent were of Asian origin and the rest were from various ethnic groups.

Measures

The audit of the cases of children of transsexual parents used the same methods as the audit of children referred with their own gender identity concerns with minor adaptations where necessary (see Di Ceglie et al., in press for further audit details).

Briefly, the clinical features model derived from DSM-IV (American Psychiatric Association, 1994) was used to determine whether the children suffered from a gender

identity disorder (GID). DSM-IV descriptive criteria were adapted to fit the checklist format comprising the following specific items: wishes to belong to the other sex, preference for friends or peers of other sex, preference for toys/games stereotypically used by other sex, preference for other sex roles in play, displays behaviour/mannerisms of other sex, dislike of bodily sexual characteristics, avoidance of rough and tumble play (boys), wishes to participate in rough and tumble play (girls), refuses to wear stereotypically feminine clothes (girls), cross-dressing (boys), interest in cosmetics/jewellery (boys), and intent to appear masculine through dress (girls).

For associated clinical features the same tailored version of the clinical features list from the ACPP data set (Berger, Hill, Sein, Thompson, & Verduyn, 1993) was used. Additional checklist items for data collection were devised (by DF & FT) in order to collect relevant information on the reason for referral, source of referral and family interrelationships (whether the case notes mentioned difficulties in the child's relationships with each of their parents and/or relationship difficulties between the transsexual parent and non-transsexual parent).

Procedure

Case files of the children of transsexual parents were examined and the data collated by the first author (DF) who had been the principal data gatherer on the audit of children with gender identity concerns. In both audits, the case files were searched systematically and where data were found they were recorded in the above data sets. In general, no inference was made about the presence or absence of a feature from indirect information; data were only recorded where they were clearly identifiable in the case files. Where a feature was present it was recorded but no inference was made concerning severity.

Results

The data shown in Table 1 reveal that half the children of transsexual parents referred to the GIDS were involved in civil court cases (7 of the 13 families at the time of the audit). These court cases were contested and revolved principally around the issues of access to the children for the transsexual fathers – quantity of access, type of access, location of access – and also over the degree of involvement the father should have in all aspects of the child's life. The cases were often open to review at intervals and the GIDS was often involved in these cases for several years. Although in some cases documents within the file indicated that the reason for referral was a legal one instigated either by a solicitor or by the court, the formal letter of referral came from a health professional, usually a general practitioner (GP).

Features of gender identity disorder

At referral, 17 of the 18 children had no features of a GID. One girl met two of the behavioural criteria for a diagnosis of GID: wishes to belong to other sex and intent to appear masculine through dress. Neither of these behaviours persisted through her sessions at the clinic and by the last session she met none of the DSM-IV criteria for GID.

Only two of the adolescents were indicating a sexual orientation and in both cases this was heterosexual. One of these two was the adolescent girl referred with two clinical features of GID.

Clinical features and family relationships

In the clinical audit of transsexual parents the number of associated clinical features recorded averaged 6.6 per child, with a range of 1–14. Table 2 displays the percentages

Table 1. Reasons for referral and sources of referral for the children of transsexual parents referred to the GIDS

Reason for referral	*Number of children (number of families)*	*Source of referral*	*Number of children (number of families[1])*
Court case: expert opinion required and service intervention given	4 children (4 families)	General Practitioner	7 (5 families)
Court case: expert opinion required (no service intervention given)	5 children (3 families)	Consultant Psychiatrist	3 (2 families)
Family concern regarding child's response to transsexual parent	4 children (3 families)	Other mental health professional	1 (1 family)
Family concerns regarding telling a child that parent is transsexual	4 children (2 families)	Solicitor	4 (2 families)
Concerns over child's own gender identity	1 child (1 family)	Social worker	1 (1 family)
		Family member	1 (1 family)

[1]Data on one family was missing from the audited case notes for this variable.

of children of transsexual parents who were recorded as showing any of the various types of problems listed. Seven children recorded significant decreases in psychopathology during treatment. Included in the seven was the girl who met two of the GID criteria who showed a lessening of eight of her 10 associated features. None of the cases recorded increases in associated psychopathology during the time of treatment.

Table 2 also displays the rates of recorded problems from the audit of children referred to the clinic with gender identity concerns. The most common types of problems recorded for the children of transsexual parents were those involving marital conflict between their parents. Statistical comparisons between data from the two audits revealed that the children of transsexual parents were less depressed ($p < .01$) and less likely to report harassment, persecution or victimization ($p < .01$) or excessive social sensitivity ($p < .05$) than children referred with gender identity concerns. However, the case notes of children of transsexual parents revealed that they were more likely to experience marital conflict between their parents than were children referred with gender identity concerns ($p < .0001$). The case notes of the children in the two groups were as likely to record difficulties in parent–child relationships and general difficulties with peer relationships.

Discussion

Audit data from the children of transsexual parents were compared with data from a previous audit of children and adolescents referred to the service with gender identity concerns. None of the children of transsexual parents referred to the service developed any characteristics of a gender identity disorder. One child had been referred because of

Table 2. Comparisons between the clinical features and family relationships recorded in the case notes of children of transsexual parents and children referred with gender identity concerns

		Children of transsexual parents Number (%)	*Children referred with gender identity concerns Number (%)*	*Fisher's Exact Probability*
Depression/Misery	Yes	1 (6%)	51 (41%)	.003
	No	17	73	
Relationship difficulties with peers	Yes	6 (33%)	65 (52%)	.206 (NS)
	No	12	59	
Harassment, persecution or victimization	Yes	0 (0%)	41 (33%)	.002
	No	18	83	
Social sensitivity	Yes	1 (6%)	38 (31%)	.025
	No	17	86	
Relationship difficulties with parents or carers	Yes	11 (61%)	71 (57%)	.804 (NS)
	No	7	53	
Marital difficulties between parents	Yes	14 (78%)	20 (16%)	<.0001
	No	4	104	

displaying two characteristics of GID, however, these were no longer in evidence by the end of her sessions at the clinic. This concurs with Green's (1978, 1998) earlier conclusions that children of transsexual parents are not themselves likely to experience gender identity confusion or dysphoria.

Both audits clearly indicated that having a member of the family with gender identity concerns presented a challenge to family relationships, with both children of transsexual parents and children with their own gender identity concerns recording high levels of parent–child relationship problems. The case notes of children of transsexual parents also revealed high levels of conflict between their parents. However, the children of transsexual parents did not record high levels of depression or misery.

Although most of the children of transsexual parents did not seem to have major psychosocial problems, show excessive social sensitivity or report harassment, victimization or persecution by peers, there is some concern that some children of transsexual parents may experience general difficulties in peer relationships with a similar level of incidence on this variable being recorded in both audits. This result, however, requires replication with a larger more representative sample. Furthermore, audit data from this specialist clinic, in which many of the case referrals were made in relation to family assessment at a time of divorce, do not reveal whether this is particular to transsexual parenting issue (for example, fear of stigmatization if peers knew about their transsexual parent) or more generally associated with the high levels of marital conflict in these families.

The conclusions to be drawn from findings based on clinical audit are necessarily limited, not least because both audits are of the same clinical service and variations in the provision of services may well influence the well-being of children in either group. The findings not only await replication at other clinics, but also with a non-clinical sample of children of transsexual parents in whom a lower incidence of difficulties may be predicted. We also do not know whether the incidence of difficulties recorded through clinical audit are elevated in comparison with rates of marital conflict, parent–child relationship problems and peer relationship difficulties found in the general population. Furthermore, the factors associated with variability in developmental outcomes and

family situations of the children of transsexual parents remain unexplored as variation could not be effectively examined within the small sample available for audit.

Clinical implications

At the time they were being seen at the clinic many families with a transsexual parent were in considerable turmoil. Relations between parents, and between parents and children were in a state of flux and under some strain. The revelation to a family of a parent wishing to seek gender reassignment is usually a great shock. The family, whether it stays together or not, has to see the parent gradually changing, undergoing medical treatment including surgery (which in a non-trans family can cause considerable anxiety for children), and then has to find a new configuration in order to fit this changing and changed person back in. Many non-transsexual parents do not want the transsexual parent to have contact with the children. There are also other pressures of disapproval and stigmatization from outside the immediate family, perhaps from other relatives and their wider social, educational and work circles. Although a few children in the audit were positive in their response to the news of having a transsexual parent, most of the children responded with either mixed or generally negative feelings which often continued as they adjusted to the new family situation. There may be some similarities in response to common experiences of loss and disruption between children of transsexual parents and children who have experienced other losses and disruption in family life, for example, when parents separate, when a parent finds a new partner, or when a parent undergoes medical treatment. These adjustments are difficult both for children and parents, and we must also remember that the children will be going through significant changes themselves over time as they grow older. The parent's sex, the child's sex, the child's age and cultural background are thought to influence the child's reactions to their parent's sex reassignment. Different children in the same family may react very differently to their transsexual parent. The way in which reassignment is managed by the parents and explained to the child, the impact of changing gender role on the relationship between the child's parents, the attitudes and support offered to the child by other family members, and the response of the child's peers and the wider community (real or imagined) will all be associated with the child's capacity to make sense of family changes and to cope with them (Di Ceglie, 1998).

The high rate of family problems in the case files of children of transsexual parents suggests that clinicians should be particularly sensitive to relationship difficulties between the transsexual and non-transsexual parent and carefully consider the child's relationship with each of their parents. If the findings from this clinical audit can be generalized (and this requires replication) then it is difficulties with family relationships, and perhaps concerns about their peer relationships, that challenge children of transsexual parents rather than difficulties with depression or gender identity development.

An effective clinical service needs to be able to work with all parties involved: to understand all the different perspectives and to broker negotiations between the parents. The interests of the children need to be kept at the forefront of therapy so that, in most cases, the children can continue to have meaningful relationships with both their transsexual parent and their non-transsexual parent. In some cases the child may not want to continue to have contact with their transsexual parent. This can create a dilemma for the clinician deciding whether (and how far) to try and push the child into maintaining contact, or whether to accept the child's apparent choice. In any case the clinician needs to be open to the possibility that the child's and other family members' choices may change over time.

Clinicians may need to flexible in offering sessions to different family members at

different times. At the Gender Identity Development Service sessions were offered to each family as the team felt was most appropriate for their needs and/or as directed by the court. Thus, a whole family might meet together, or the child(ren) might meet separately from the parent(s). The transsexual parent might come with, or meet with, their child(ren) at the clinic. Or the child(ren) might have a session with their non-transsexual parent and then have a therapeutic session separately from their non-transsexual parent. The transsexual parent and the non-transsexual parent might come for a joint session, have separate sessions, or have a combination of joint and separate sessions with the child(ren) being present. Sometimes a new partner of one of the parents was also involved because of their parental responsibilities in relation to the referred child(ren). However, step-siblings and half-siblings, who did not share the transsexual parent were not involved with the service.

Conclusions

Findings from clinical audit suggest that children of transsexual parents are not themselves likely to develop features of gender identity dysphoria, nor do they experience mental health problems associated with GID. However, there are indications that children of transsexual parents may experience difficulties in family relationships, particularly in relation to high levels of conflict between their transsexual and non-transsexual parent. It is suggested that clinical work with children of transsexual parents focus on helping family members adjust to change following the revelation that a parent is transsexual and work towards improving family relationships in ways appropriate to the particular family context.

Notes

1. Nine families with 14 children were excluded from the audit analyses because there was no clinical input from the GIDS subsequent to the initial assessment (either because the families and children did not take up the service offer or because the request for guidance made by the family or court was of a purely general nature).

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