

Beyond the Binary: Trans-Negotiations in Couple and Family Therapy

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Dualistic notions about gender and sexuality have permeated the field of couple and family therapy. These binary constructions have been limiting for everyone, especially those who fall outside the male/female dichotomy. This article examines the impact of these binary notions, especially on transgender and gender-creative individuals, couples, and families. Current theory and research in the field as they relate to gender identity, sexuality, and gender minority stress in couples and families are presented. Case examples are used to illustrate affirmative approaches to treatment issues such as coming out, safety, grief and loss, redefining relationships, and social/medical transitions that may arise for transgender or gender nonconforming (TGNC) individuals, couples, and families.

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The field of couple and family therapy, like much of the world, has become trapped in dualistic notions of gender. In couples therapy, we talk about same-sex or opposite-sex partners. On rare occasions, we contemplate those who are bisexual and have relationships with both men and women, but where does that leave those relationships where one or more of the partners does not identify as male or female? What labels do we use to describe these relationships? Furthermore, what are we actually describing with regard to gender identity, roles, etc., when we stick to binary constructions? How much do we miss in the nuances of couple dynamics or family processes when trapped in these constructions? How does this impact our children who do not conform to the societal expectations for their birth sex? It is time for us as family therapists to deconstruct these notions, not only for TGNC clients, but also for all of our clients and families who are trapped by gender straitjackets. I am not proposing that we throw out our constructs but rather that we expand our frameworks to include the diversity of identities and experiences that may be possible.

Although a majority of people across cultures and contexts experience something closer to a binary construction of gender, sexuality and gender are not so cut and dried for anyone. In terms of sexuality, it seems that a primary reason for condemning diversity in sexual orientation is that anything falling outside of a traditional heterosexual orientation challenges gender norms (Gordon & Meyer, 2007); it is not uncommon to hear anti-gay rhetoric that proclaims that LGB people are not “real” men or women (Giammattei &

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Green, 2012). These binary notions are simplistic and very limiting for everyone, especially for those who fall outside the gender binary.

To approach work with TGNC people, one must understand the natural diversity of gender and sexuality in human experience as well as what clinicians will invariably encounter in their work with such individuals and their families (Coleman et al., 2011). Across most cultures, the majority has a tendency to fear and discriminate against those who fall outside of the cultural standard. Yet, when one looks at the natural world, diversity is actually the norm (Roughgarden, 2004). It appears that what is naturally occurring is much more fluid and expansive than languages represent and most societies accept.

In most cultures, there is limited language or none for describing people who fall outside this binary construction of gender. For example, there is the word *Mahu* in Polynesian culture (Roughgarden, 2004), and some Native American cultures have words for the concept of being *Two-Spirit* (Williams, 1986), which both describe all who do not identify as their assigned sex at birth, play out gender roles opposite their assigned sex, or are attracted to same-sex partners (Roughgarden, 2004). Yet these terms do not fit for many; nor do they describe the nuances that distinguish one gender identity from another.

Transgender is a similar term and has distinctly different meanings depending on age and context. For adults, transgender is an umbrella term that encompasses a wide range of gender expressions and identities: Female-to-Male (FTM), Male-to-Female (MTF), agender, bigender, cross-dressers, drag kings/queens, genderqueer, etc. (Lev, 2004). Despite this, many therapists confuse the term with the older, more clinical term, *transsexual*. Although transsexuality falls under the transgender umbrella, it certainly does not describe all, or even the majority, of people who actually identify as transgender. In fact, many of those who have physically transitioned from one sex to another may no longer identify as transgender but as their affirmed gender; and they too may also identify with a binary construction of gender (Lev, 2004). For clinicians working with trans children and adolescents, transgender usually refers to youth that meet the DSM-5 criteria for *Gender Dysphoria* (GD; American Psychiatric Association, 2013) and have a strong desire to live in a different gender than the one assigned at birth. Children who do not meet the DSM criteria for GD but express their gender in ways that do not conform to society's expectation for their assigned sex at birth are usually referred to as *gender nonconforming* (GNC).

Under the transgender label is a complex and ever-changing range of identities, expressions, and naming systems that show the fluidity and diversity found in the community (Beemyn & Rankin, 2011). TGNC youth, in particular, tend to use more fluid and spacious terms to refer to themselves, such as gender queer and gender expansive. Many in the community find the term transgender too limiting and have moved toward using the terms *Trans** or *Trans* as an umbrella term when referring to the whole community. This article uses the term *trans* to be as inclusive as possible, and the term *trans couple* to describe all couples with one or more partners whose gender identity falls under the *trans* umbrella.¹ Despite outward appearances, trans couples may identify themselves as such or something else.

Obviously as a clinician, one can never know how a client identifies or what language they use to describe themselves unless you ask. If you assume nonbinary constructions of identity, you may offend a trans person who identifies with the binary; and on the other hand if you only hold two options, your client may feel misunderstood or rendered invisible (Malpas, 2006). It is good practice to ask clients their name, pronoun, and gender description, as well as honoring their language when interacting with them or discussing their

¹Definitions for italicized words can be found in the glossary (Appendix A) following the references section for this article.

case. It is considered very disrespectful to actively ignore a trans person's affirmed language and to do so may lose your client's trust. At the same time, this can become tricky when working with family members who are not yet accepting of their loved ones' gender identity, especially parents. Therapists may find themselves using different terms depending on who is in the session, especially if they have come in to deal with gender-related issues such as a social or medical transition (Stone Fish & Harvey, 2005).

Despite an increase in understanding of gender issues across the lifespan as a result of recent gender-affirming media coverage of trans youth and their families, the societal support of rigid gender roles and fear of anything outside binary constructions of gender often throws a family into crisis when it becomes apparent that a family member, partner, or spouse is trans. How these families deal with this crisis depends on their own notions of gender, parenting, and the family's level of social support (Giammattei & Green, 2012).

SEXUALITY

Another area that one must understand when working with gender diverse clients is the difference between gender identity and sexual orientation, and the diversity of sexual orientation identities in the trans community. First and foremost, transgender and transsexual are not sexual orientations. Trans people come in all sexual orientations: heterosexual, gay, lesbian, bisexual, *pansexual*, *omnisexual*, *asexual*, etc. In their study of over 3400 GNC people, Beemyn and Rankin (2011) found that respondents' sexual orientations were almost as diverse as their gender identities. One third identified as bisexual, 30% as heterosexual, 22% as gay/lesbian, and 16% as other. The younger participants were more likely to identify as other and included terms such as pansexual and *queer*. These findings are consistent with Savin Williams' (2005) findings of sexual fluidity in his study of gay youths and a recent study of trans male sexuality (Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013).

As stated earlier, sexuality can become difficult to define when a person does not fit neatly into the male/female binary. Furthermore, how someone identifies with regard to sexual orientation may shift if the person is transitioning from one gender presentation to another. For some, their sexual orientation will stay the same, but the object of their desire will shift. For others, they stay attracted to the same gender(s) but their description of their orientation will shift (Dickey, Burnes, & Singh, 2012; Meier et al., 2013). Most trans people appear to identify their sexual orientation based on *affirmed gender* rather than *assigned sex*.

GENDER MINORITY STRESS

Because of the high levels of discrimination and marginalization that are experienced by members of the trans community (Grant et al., 2011; Greytak, Kosciw, & Diaz, 2009), it is very important to understand the impact of minority stress, including both external and *internalized transphobia*, that may be affecting gender minority families in therapy (Hendricks & Testa, 2012; Nadal, Davidoff, Davis, & Wong, 2014). Trans people are at high risk for gender-related physical and sexual violence throughout their lives, with the types of hate crimes perpetrated against them being especially violent. Trans people also have found little support from authorities and in some cases further discrimination and violence (Nadal et al., 2014; Stotzer, 2009). Furthermore, having multiple minority statuses increases the likelihood of harassment. In two recent surveys of trans people, most of the harassment reported took the form of verbal assaults. Those who do not identify as heterosexual were more likely to have experienced harassment, and people of color

were much more likely to report being physically assaulted (Beemyn & Rankin, 2011; Grant et al., 2011; Greytak et al., 2009). To make matters worse, most participants who reported being assaulted were not likely to report it. Trans people also experience high levels of fear of physical harassment and workplace discrimination, especially if the participant is a person of color, is not heterosexual, is younger, or is out as trans (Beemyn & Rankin, 2011; Grant et al., 2011). The results of this onslaught of macro- and micro-aggressions are incredibly high levels of anxiety, depression, PTSD, and suicidal ideation (Clements-Nolle, Marx, & Katz, 2006; Grant et al., 2011; Greytak et al., 2009; Grossman & D'Augelli, 2006). While many of the issues that bring these clients into a therapist's office will likely not be related to gender directly, it is important to listen for the intersecting impact of these additional stressors as well as their actual or potential for resilience in the face of adversity.

TRANS YOUTH

Working with trans youth and their families requires that clinicians occupy many different roles. In some cases, especially with trans children, a therapist will want to be part of a team that includes medical, school, and legal professionals. In addition to meeting with the child and the family, the therapist may be called upon to conduct assessments, write reports and/or letters, provide resources and psychoeducation, as well as help families navigate social service, school, medical, and legal systems (Brill & Pepper, 2008; Ehrensaft, 2011). Children who are GNC may be brought to therapy by parents who are concerned about the meaning and impact of their child's gender expression. Some parents will seek treatment for their children because they see cross-gender behavior as problematic, while others come to learn how to support and protect their child (Brill & Pepper, 2008; Coolhart, 2012; Ehrensaft, 2011).

Most parents are well aware of the dangers that exist for their trans children. The effects of minority stress on trans youths can often be intolerable. Without positive role models, parental/family support, and resources to combat the harassment and discrimination, these youth are left with a burden that may appear insurmountable (Giammattei & Green, 2012). Trans youth who experience significant harassment at school and/or at home consistently show much higher rates of depression, suicide attempts, substance abuse, homelessness, high risk sexual behavior, and school absenteeism or drop outs (Greytak et al., 2009; Grossman & D'Augelli, 2006). The message is that your child is in danger and may well die, either at their own hand or the hands of another. As a result, parents are often desperate either to change their child's behavior or to get resources in place to protect them.

Family members who are having difficulty accepting a child's presentation and seek treatment to change the child's gender may be strongly influenced by binary notions around gender. There may be cultural or religious proscriptions around cross-gendered behavior that are in direct conflict with their child's identity and expression. Helping these parents, siblings, and possibly even extended family understand the natural diversity of gender and find ways to support their child, even minimally, is key to healthy psychological outcomes for the child (Brill & Pepper, 2008; Erich, Tittsworth, Dykes, & Cabuses, 2008). For parents who are struggling to be supportive it can be quite helpful to share the studies showing that trans youths who have family support and positive role models are better able to navigate discrimination, and have significantly better mental and physical health outcomes (Simons, Schrage, Clark, Belzer, & Olson, 2013).

Trans youths are not the only ones who have to deal with discrimination. Families and parents who support their trans children may find themselves ridiculed and ostracized from their communities, friends, and sometimes even extended family for not "properly"

parenting their children (Brill & Pepper, 2008; Lev, 2004). Such isolation is especially true for those who live in conservative, rural areas or attend conservative religious organizations (Giammattei & Green, 2012). Parents, whether or not they struggle to support their child, may need to reconcile their beliefs, understand their fears, and grieve the loss of some dreams they may have had for their child before they can come to a place of acceptance and learn to truly nurture their trans child (Brill & Pepper, 2008; Ehrensaft, 2011; Stone Fish & Harvey, 2005).

These children will show up with identities that fall across the gender spectrum; the majority will be GNC with a gender identity and expression that defies binary constructions of gender, while a few will be transgender or cross-gender identified. Most GNC children do not grow up to be transgender; they may remain gender fluid or completely shift to align with their sex assigned at birth (Hidalgo et al., 2013). There is evidence that many of these children will grow up with a sexual orientation that falls outside of the heteronormative ideal (Lev, 2004; Steensma, van der Ende, Verhulst, & Cohen-Kettenis, 2012). Many trans children, especially those who are very young, may not experience distress with their gender identity and expression. In these instances much of the therapeutic work involves helping their families to understand, support, and protect the child (Coolhart, 2012; Ehrensaft, 2011). On the other hand, some trans children, especially those who are cross-gender identified and have stated this explicitly from a young age, may experience clinically significant GD. As a result they may present with a host of mood and behavioral difficulties. The dysphoria may abate with puberty, but if it persists into adolescence or appears with the onset of puberty, it is rare that it will change (Spack et al., 2012). Many of these children may require social transitions (nonmedical changes such as name, pronouns, hair, clothing, etc.) and medical interventions (puberty suppression, cross-sex hormones and sometimes surgeries in adolescence) to align their bodies and expression with their affirmed gender (Coleman et al., 2011). If a social transition is necessary, both the children and their families may need tremendous support to navigate the process (Brill & Pepper, 2008; Ehrensaft, 2011; Vanderburgh, 2009).

For the children who are GNC or gender fluid with very supportive parents, the binary notions around gender can create a different problem. Parents with children who identify with both or neither sex may find ambiguity difficult. They may struggle with using *gender-neutral pronouns* if their child insists on not being identified by either male or female pronouns. Ultimately, it may feel unsafe to have a child who is often questioned about their gender, and some parents may inadvertently push their child to align with one gender or the other (Ehrensaft, 2011; Malpas, 2011).

Grief and Loss

Regardless of the level of support that parents have for their trans child, there are some common difficulties that often arise. Most prominent is the experience of grief and loss a parent experiences when their child socially or medically transitions from one gender presentation to another (Brill & Pepper, 2008; Coolhart, 2012). It is important for parents to have the opportunity to discuss the hopes and dreams they had for their child, some of which may never happen. Parents may need permission to discuss these things if they fear it makes them seem unsupportive. For those having difficulty embracing and supporting their child, they will need an understanding and nurturing environment to share the conflicting feelings they may have toward their child (Malpas, 2011; Stone Fish & Harvey, 2005). Support groups for parents of trans children can be very helpful in these situations. Couple therapy and parent coaching may also be very helpful, especially when parents differ in their level of support for their trans child.

Trans Tweens and Teens

Parents with trans teens have a whole host of additional issues with which to contend. When teens come out as trans, it is often when the dysphoria is exacerbated by the effects of puberty. For many trans teens, the development of secondary sex characteristics that do not match their affirmed gender is disturbing and may send them into a crisis (Brill & Pepper, 2008; Ehrensaft, 2011). Other teens may come out later when their budding sexuality makes it clear that their body does not work sexually in a way that matches their gender identity. As one 17-year-old client described, "I tried to be a boy and date girls, but I couldn't connect with them sexually. When I fell in love with my best friend, I thought maybe I was gay, but then it became clear that I couldn't be sexual with anyone in this body. It just won't work!"

Many trans youth experience gender shaming as a result of repeated humiliations for not living up to cultural gender norms, and therefore may try to hide their gender identity (Stone Fish & Harvey, 2005; Wallace & Russell, 2013). The emotional fallout of this may lead to symptoms of depression, social anxiety, panic attacks, low self-esteem, self harm, and in some cases suicidality (Coolhart, 2012; Grossman & D'Augelli, 2006). Like many teenagers who are struggling with problems that seem insurmountable, trans adolescents may end up in therapy for seemingly unrelated issues such as drug use, risky behavior, school avoidance, and oppositional behavior. It is not uncommon for these issues to improve when gender-related difficulties are addressed (Brill & Pepper, 2008; Ehrensaft, 2011).

The parents' struggle to understand their teen's gender identity is similar to the struggle of parents of younger children, although parents of teens may be more confused if they did not recognize GNC behaviors earlier in their child's life. Once they come to understand their child's GD, they may then need help making decisions about whether or not to allow medical interventions to assist their teen, such as puberty suppression, cross-sex hormones, and surgeries (Coolhart, 2012; Spack et al., 2012). These parents often have to weigh their child's emotional distress with the potential for irreversible changes with cross-sex hormones or surgeries if the teen changes their mind. One of the biggest concerns for parents regarding medical interventions is making decisions that may lead to their child's infertility. If a child never enters the puberty of their biological sex and instead starts hormone replacement therapy to align with their affirmed gender, they will not have mature, viable gametes with which to reproduce (Hembree, 2011). In the end, their child's current psychological well-being may outweigh these concerns; as one parent stated regarding the decision to allow a medical transition, "It became clear to me that I had to help him do this, or I would lose him to suicide. It is hard to let go of my daughter, but I would rather have my child alive than lose him altogether."

TRANS COUPLES

Trans couples come in many configurations and sexual orientations. Often when a trans couple appears to be *cisgender* and heterosexual or gay/lesbian, they are assumed to be like every other couple in their community and may live an invisible existence, with similar costs and benefits (Denny, 2007). When one or both partners in the couple are obviously trans, they may deal with transphobia in both the heterosexual and LGB communities, be at risk for ostracism from their communities and families, and be targets for violence and discrimination (Grant et al., 2011). For trans couples that are not obviously trans, this very real risk may create a fear of being condemned, ostracized, and abandoned by their communities and lead the trans partner to make a conscious choice to live *stealth*. Living with this level of invisibility, especially if only one of the partners desires it, can

create similar difficulties for the couple as having an LGB partner who is still “in the closet” (Giammattei & Green, 2012). When other intersections of identity or life circumstances such as race, ethnicity, religion, disability, SES, location, etc., also marginalize the couple, then the difficulties can compound (Grant et al., 2011).

Trans couples may seek couples counseling for a myriad of issues beyond transition or gender expression-related difficulties. Many of the issues that bring them to therapy are similar to any other couple. They may need help dealing with disagreements around parenting, finances, household and childcare duties, romance, and other crises that commonly occur throughout the family lifecycle (Lev, 2004). They may also come for issues that are related to coping with the psychological impact of minority stress such as mood disorders, substance abuse, stress disorders, and suicidality (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014). In these cases, it is important to assess the impact that a trans experience has had on these issues or how it may have contributed to difficulties for the couple, but not to make it the focus of treatment if the couple is clear that their troubles are not related to a partner’s trans status. When trans couples seek counseling for issues that are not trans-related, one would handle treatment as with other couples, with the exception that one needs to acknowledge the clients’ affirmed gender identities and remain attentive to the potential influence of minority stress (Giammattei & Green, 2012). If a couple identifies outside of the gender binary, it will be important to create an affirmative atmosphere through the use of language, the focus of questions, and types of interventions that embrace a nondichotomous view of gender or gender norms (Malpas, 2006).

It was once assumed that a partner’s gender role transition would always lead to the end of a couple’s relationship, but this is not accurate. Many couples are staying together after disclosures of trans identities and through medical transitions (Alegría, 2010; Malpas, 2006, 2012). To look at the limited amount of literature, one would assume that partners who stay are only women (Alegría, 2010; Bethea & McCollum, 2013; Joslin-Roher & Wheeler, 2009). Although many trans men and women have male partners, currently there is very little data on the male cisgender partners of trans people. We do know that minority stress has been found to have a negative impact on the physical and mental health of trans women and their male partners (Gamarel et al., 2014). However, we do not know if the same is true for trans men and their male partners. Furthermore, we have no data on how many men stay with a partner who transitions or what issues may develop for trans couples with a male cisgender partner throughout the transition process. At this point, it is assumed that many of the issues will be similar to those of cisgender female partners, but since we do not have this information, we need to use the experience of female partners as a way to formulate questions to help understand trans couples with a male cisgender partner.

Working with Transitions and Shifts in Gender Expression

Trans couples that come to treatment as a result of one partner transitioning or coming out as trans may have a particular set of issues and obstacles to overcome if they are going to make it through the process intact (Lev, 2004; Malpas, 2006, 2012). In addition to many of the issues that same-sex couples deal with like coming out, relational ambiguity, and minority stress, these couples may have to negotiate the differences in their identities, the betrayal often experienced by the cisgender spouse or partner, the possible renegotiation of their sex lives, internalized transphobia, and shifts in sexual and/or social orientation (Giammattei & Green, 2012; Malpas, 2006, 2012; Raj, 2008).

Coming out

Trans people may enter relationships without acknowledging their struggles around gender. Sometimes, as a result of internalized transphobia, this is conscious and the trans

partner believes that the relationship will stop the dysphoria or the desire to engage in cross-gender behaviors, but often this is not intentional as the trans partner may come to this knowledge of being trans only after the relationship started (Lev, 2004; Malpas, 2006). As a result many trans couples will go through a coming out process starting with “coming out to self” (Lev, 2004). When a partner comes out as trans, and especially if they intend to transition or engage in cross-gender behaviors publicly, the couple may be thrown into a crisis. In some cases, a cisgender partner may know about the cross-gender identity or behaviors, but may believe it will be kept secret or not lead to a full transition (Malpas, 2006). Therefore, a crisis may occur even if the other partner knew about the gender issues before committing to the relationship (Giammattei & Green, 2012; Malpas, 2006; Samons, 2009). The potential changes in identity, community, sexuality, sexual orientation, definition of the relationship, parenting, and much more may become central issues for both partners (Giammattei & Green, 2012; Lev & Sennott, 2012; Malpas, 2006, 2012; Raj, 2008; Samons, 2009).

When a partner comes out as trans, there can be a distancing between the partners, feelings of betrayal, confusion, and hurt, especially if the trans partner discloses after the relationship is well established. Cisgender partners may feel betrayed, even if there has been no infidelity, and may vacillate between anger and denial (Lev, 2004; Malpas, 2012). The support of family and friends as well as the cultural messages surrounding transsexuality and transphobia may have a profound impact on how cisgender partners handle this information and their decision to stay with the trans partner (Lev, 2004; Malpas, 2012). These couples may find themselves without community support, especially if they try to maintain their couple relationship (Giammattei & Green, 2012; Lev, 2004).

Negotiations and seeking clarity

Following the disclosure, an initial task with these couples is to help the trans partner clearly state their gender identity, what they will need to achieve congruency, and what this may mean for the future of the couple (Lev, 2004; Malpas, 2012). The needs of a cross-dresser will be quite different from those of a person who needs to medically transition. Once this is clear for both partners, they will then need help exploring all of the ramifications and whether or not the cisgender partner is willing and able to deal with these changes (Malpas, 2006, 2012). If not, the trans partner may postpone the process or they may choose to end the relationship. Many couples will be motivated to stay together.

Case example

For one trans couple, normalizing their experience in the context of diversity and clarifying both their needs led to a mutually workable solution. They were a middle class, heterosexual, White couple in a long-term marriage, living in a rural and conservative community, with grown children. They experienced difficulties after the husband disclosed a need to have his wife accompany him while he cross-dressed in public.

Although she had come to tolerate his cross-dressing, which he had disclosed much earlier in their relationship, she was terrified at the thought of others finding out that he wore women’s clothes. She feared for her husband’s and her own safety, both physically and financially. As we explored the issues, it became clear that he had a tendency to take risks in a way that disregarded her feelings, leading her to react by shutting down conversations about cross-dressing. His reaction was to feel trapped and afraid to approach the topic. He would then try small changes she had not agreed to that left her feeling manipulated.

I helped him listen to her fears and acknowledge her wisdom in the area of taking risks around his cross-dressing. As he became clearer with her about his identity and his needs, she was better able to voice her own needs and as a result, felt more empowered in this

process. They came to an agreement that they would not take any steps forward without her being fully involved in the plan. He allowed her to take charge of risk management, and they were eventually able to successfully explore adventures together with him “*en femme*.”

The experiences of the previous couple are much different from those whose partners disclose they are planning a medical transition. Although a trans partner seeking to transition may slow things down to help their partner go through their own transition process, the issues that arise challenge much more than safety. A transition may dramatically change the nature of the relationship and everyone’s experience of it.

Redefining the relationship

After the initial shock and anger following disclosure subsides, the cisgender partner may struggle to make sense of what staying in the relationship may mean with regard to their own gender or sexual identity (Malpas, 2012). Can they manage the social transition from a previous heterosexual couple to one that will be perceived as lesbian or gay? How might this change their access to their community and friends? If in a same-sex relationship, how might this affect their connection to the lesbian or gay community? How will this transition change their parenting roles and affect their children? These are difficult issues to navigate, and there may be significant grief and loss experienced by both partners, whether or not they stay together.

Much like parents of trans youth, partners usually go through a grieving process (Bethea & McCollum, 2013; Lev, 2004; Malpas, 2006, 2012; Raj, 2008). There may be a sense of profound loss, especially if much of their identity was associated with their partner’s gender. For example, many gay and lesbian people who are out of the closet have fought hard for their identity and community. If their partner transitions, they may struggle with being perceived as heterosexual, once again, becoming invisible not only to the general population but even worse, to the queer community (Lev, 2004). Creating a safe environment for cisgender partners to come to terms with both the losses and gains of staying in the relationship is very important to their success as a couple (Malpas, 2006, 2012).

Usually by the time trans partners come out, they may feel an urgency to transition that will conflict with the cisgender partners’ need to slow things down. The trans partner also may struggle to understand the cisgender partner’s difficulty with the transition and feel betrayed by their grief (Malpas, 2006). Nevertheless, it is important for the cisgender partner to take time to sort out their feelings and embrace their own transition process to stay with their trans partner.

Social/sexual orientation shifts

For couples that stay together through a transition, the partners may identify differently with regard to sexual orientation. For example, if a therapist is treating a trans couple that began their relationship as two gay men, the trans female partner may identify as heterosexual, whereas the cisgender male partner may still identify as gay or bisexual. In these cases, the therapist may be working with a mixed-orientation trans couple, and it will be important to not only be open to a diversity of gender experiences but also be aware of the therapist’s potential heteronormative notions around coupling, such as assuming the couple adheres to traditional gender roles. For a couple from a traditional heterosexual marriage, it is not uncommon to still identify as heterosexual rather than lesbian after the husband transitions, even though both partners identify as female. Therefore, it is important that therapists always ask about partners’ sexual orientation identities rather than make assumptions because even in the most heteronormative looking couples, there are wide ranges of identities and configurations that appear.

Given that sexual orientation is closely tied to the gender of one's partner, a trans partner will more than likely experience a shift either in perceived sexual orientation or in the focus of their desire (Lev & Sennott, 2012; Malpas, 2012; Meier et al., 2013). For those who stay attracted to their partners, the shift will be a social one. For example, they may appear to shift from being a heterosexual couple to a gay couple. If their partner remains attracted to them as they physically change, the dynamics between the couple may not change much even if their sexual behavior does. However, some trans people find that as they transition, the focus of their desire shifts. They may still identify as the same sexual orientation, but as their body changes, so do their sexual attractions. For example a trans man, who was previously only attracted to women, now may find as he transitions that he is predominantly attracted to men; or a trans woman who after years in a heterosexual marriage to a woman finds herself solely attracted to men (Lev & Sennott, 2012; Malpas, 2012; Meier et al., 2013). In these instances, or in instances where the cisgender partner finds that they are no longer attracted to their trans partner, the couple may have to negotiate the parameters of their sexual lives if they are to stay together (Giammattei & Green, 2012; Malpas, 2006). Some may choose to stay in a monogamous, but nonsexual relationship; others may choose to open up their relationship (nonmonogamy) for one or both partners (Lev, 2004; Malpas, 2006). Despite how daunting this may sound, many trans couples find creative ways to navigate these and many other changes that may accompany gender-affirming transitions (Malpas, 2006).

TRANS PARENTS

Trans parents historically have had a difficult time maintaining access to their children (Carter, 2006). For couples who stay together, the issues are far different than for those who divorce. Regardless, it appears that children fare well with the transition of a parent if the child has close emotional ties with either or both parents, the parents cooperate with regard to child-rearing, the extended family is supportive of the transparent, and there is ongoing contact with both parents (White & Ettner, 2004). Teenagers appear to struggle the most with the news; the earlier they are told, the better. Children who do not fare as well tend to be those who experience an abrupt separation from either parent, have one parent extremely opposed to the transition, experience a lot of inter-parent conflict regarding the transition, or have one or more parents with a personality disorder (White & Ettner, 2004). Therefore, it is in the best interest of the children to help these parents navigate the process, especially if the relationship is ending, by helping the parents become cooperative and active co-parents.

A newer development with the help of reproductive technologies has been the possibility for trans people and their partners to become parents after they have transitioned (Murphy, 2010). Trans women who have banked sperm before transitioning and later are in a relationship with a cisgender female have been able to have their own biological children. In some cases, they also may be able to help breastfeed the child, creating a close bond for both parents and the child. This same scenario is more difficult for trans men, who either need to have their eggs harvested, which is very expensive, or bear their own children. A few trans men opt for the latter option and have given birth to healthy children (Polly & Polly, 2014). For trans men who wish to have children with a female partner, the process can be both very rewarding and very difficult.

Case Example

After their first child was born, a young couple appeared to be going through a fairly normative crisis that many couples deal with when they are new parents (Cowan & Cowan, 1995) and sought treatment. Unique issues quickly unfolded as we explored their

difficulties. The parents were a trans male and a cisgender female who both identified as Native American and Two-Spirit. Before becoming parents, both strongly identified as genderqueer and reported challenging gender norms. After getting married and becoming parents, they had fallen into very traditional gender roles. Having a child had put the father in the position of being the primary bread-winner while the mother stayed at home with their son. This shift in duties brought up fears in each of them of becoming stuck in heteronormative gender roles. Instead of discussing this shift, they had come to blame each other for the expectation to perform these roles. Although the experience of shifting roles is not uncommon to new parents (Cowan & Cowan, 1995), for this couple the process rendered their gender identities invisible and left both feeling invalidated.

To address this issue, we externalized heteronormativity and unpacked its influence on their perception of the roles they had taken after their child was born, thus removing the blame from each other. In working with this couple, it was important to work from within their cultural system and help them find common themes that resonated with their Native American upbringing and belief systems. They came to identify the problem of heteronormativity as a spirit entity well known to their community for wreaking havoc. They united to take a stand against this entity through a combination of tribal rituals and redefining the tasks of their roles to fit with their two-spirit identities (i.e., the bread-winning role was a temporary shift not required because one partner is male but rather a role that a two-spirit person would take on). They were also able to shift the division of labor so that it was more equitable and matched their sensibilities as a genderqueer couple, thus allowing the father more time in a nurturing role with his son and the mother more time outside of the home. The result was that both partners felt validated for their identities and were able to embrace their current role in the family, knowing that this was up for negotiation. They also found a common bond in not letting the spirit entity, "heteronormativity," create problems between them.

Helping this couple resolve the issues that arose for them as they transitioned to parenthood required that I not only understand and relate to this transition as a normative process but also that I be aware of the influences of heteronormative beliefs around coupling, the impact of GD, and the potential in the couple's cultural and religious beliefs for externalizing the problem as a spirit entity. Through this process, they were able to stay together, rekindle the nurturing aspects of their relationship, and embark on a more equitable parenting relationship.

TRANS ISSUES IN AGING

Aging trans couples and families are faced with greater levels of discrimination than their younger cohorts or elders in the LGB community (Fredriksen-Goldsen et al., 2011; Kimmel, 2014). Recent studies have shown that trans older adults face tremendous challenges and significant disparities in all areas of life including employment, housing, financial and legal resources, health and health care access, physical and mental health, etc. (Auldrige, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012). As with their younger cohort, intersections of other marginalized identities such as race, ethnicity, poverty, location, or being in a same-gender relationship often increase these disparities (Grant et al., 2011).

Many trans elders came of age during a time when trans people were much more heavily stigmatized and pathologized. Some came out and transitioned during these years, while many others felt the need to hide their identities to maintain jobs or families and are just now coming out and transitioning later in life (Auldrige et al., 2012; Cook-Daniels, 2006). According to a recent study of trans elders 65 years of age and older, 70% reported having delayed a gender confirming transition to avoid discrimination in employment (Grant et al., 2011). Although this may seem extreme, it is a sad reality that

many who have transitioned struggle to maintain sustainable employment (Grant et al., 2011). Trans elders and couples who did transition earlier or were able to hide their trans identities had to live stealth lives to avoid such discrimination. It is important to note that a person who transitioned many years ago will have had a different life experience than one who is doing so currently. A person who has not had *gender confirming surgery* (GCS) or one who has taken no steps at physical changes but lives outside the binary may experience more difficulty in an aging culture that holds binary constructions around gender (Witten, 2009).

Trans elders may have a deep distrust of mental health professionals as a result of a long history of being pathologized and disempowered by the psychiatric establishment, subjected to humiliating treatments, having treatment withheld, or having to meet arbitrary rules about who was a good candidate for a GCS (Lev, 2004). In addition, mental health professionals have been put in the difficult position of being the gate-keepers to medical treatment for trans people because transitioning physically requires a psychological assessment, diagnosis, and a letter confirming that these interventions are medically and psychologically necessary (Coleman et al., 2011). Trans people resent the requirement to see a mental health professional to get access to medical treatment, and trans elders may require more time to form a strong, positive psychotherapeutic alliance if they have had negative interactions with providers.

Health Care and Residential Facilities

LGB elders often feel the need to go back into the closet to receive services as they age. Unlike LGB elders, trans elders may not be able to hide their trans status to access medical care and housing. According to the latest reports, trans elders often contend with a health care system and a national elderly care network that are not prepared to provide culturally competent services or create residential environments that are affirming of diverse gender identities and expressions (Auldridge et al., 2012; Grant et al., 2011). As a result, trans older adults may delay necessary care and suffer from poor health and related disabilities at a much higher rate than the general population or their LGB counterparts (Auldridge et al., 2012; Fredriksen-Goldsen et al., 2011; Grant et al., 2011). When trans elders, their spouses, and families do seek care, they frequently are subjected to ignorance, prejudice, discrimination, hostility, and sometimes even violence in the settings meant to support them (Auldridge et al., 2012).

As trans elders become more dependent on others, their connection with family becomes more important (Cook-Daniels, 2006), yet many trans elders may have had to cut ties with family to transition or may have been ostracized from their families who were not supportive of them (Grant et al., 2011). When families do step in to help, it is not uncommon for unsupportive family members to ignore the trans elder's affirmed gender and refer to them as their assigned sex at birth or to challenge the legal status of their marriage if the elder has a spouse. The result can be further isolation and a higher potential for abuse if the elder is placed in a typical residential assisted living environment that is not well versed in culturally competent trans care (Cook-Daniels, 2006; Kimmel, 2014).

Helping aging trans couples and their families with these issues may involve discussions about how to come out to health care providers and residential facilities (Kimmel, 2014; Witten, 2009). Trans patients may have to remind medical providers of the importance of preventive procedures that may be ignored by those who are unaware of trans bodies—such as monitoring trans women for prostate cancer, doing pelvic exams for trans men, and helping trans patients navigate medical treatment systems if illness is detected. Clients may have experienced humiliation by medical providers previously, and therapists need to explore clients' discrimination histories to help them assert for the care

they need. Direct advocacy by therapist may be required so that other health providers understand the unique issues that may arise when a trans elder seeks care.

Mental Health Concerns

Aging trans elders, couples, and families have many similar mental health issues as their cisgender and LGB counterparts, which may be compounded by the discrimination and mistreatment they receive by those who are meant to care for them (Cook-Daniels, 2008). Thirteen percent of trans elders report abusing alcohol and drugs to cope with mistreatment, and 16% report attempting suicide at least once in their lifetimes (Auldridge et al., 2012). Family support may go a long way to ameliorate these outcomes. As family therapists, we can educate families to understand the unique needs of their elder trans relatives, making them better advocates for their care, and keeping them vigilant in protecting against potential abuses in care facilities. Family members may need help exploring their own gender identities as well as navigating their own biases and preconceived notions around trans people before they will be able to take on a helping role. Therapists can help elder trans couples develop strategies to deal with the unique discriminatory situations they may encounter. Therapy also may need to address internalized transphobia and trans-related traumatic experiences, thereby encouraging clients' self-respect and helping them seek the care and resources they need (Witten, 2009).

CONCLUSION

There is very little literature exploring the usefulness of family and couple treatment protocols with trans couples and families (Lev, 2004; Malpas, 2006, 2011, 2012; Samons, 2009). Treyger, Ehlers, Zajicek, and Trepper (2008) used a solution-focused approach that appears to be effective with couples who are coming out in mixed-(sexual)orientation relationships. Other authors have introduced entirely new models (Raj, 2008) for working with trans couples and families or an integration of different theories (Malpas, 2006, 2011, 2012).

Regardless of which models are chosen, it is important that the work with these families addresses the issues presented by the couple or family without inadvertently blaming the clients for the impact of discrimination and internalized transphobia. Postmodern/social constructionist models such as feminist and narrative approaches may be very useful with trans couples and families because they directly address the system from a sociopolitical perspective and can tap into the resilience that is often found in these families (Giammattei & Green, 2012; Malpas, 2012). It is also important regardless of the model used that intersections of identity and experience be addressed simultaneously. It is impossible for clients to separate one aspect of their identity without dealing with the way it is influenced by all the other aspects. For those who deal with multiple levels of oppression related to age, disability, size, racial/ethnic group membership, and religious beliefs in addition to the experience of being trans, these issues can become compounded, and resources for social support may be even more limited (Gamarel et al., 2014; Grant et al., 2011).

Trans clients may have experienced repeated traumas over their lifetimes. The effect of these experiences will have a profound impact on their relationships with partners, families, mental health professionals, the legal system, and medical care personnel. For some, there may be a long history of ruptured attachments that make approaches like Emotionally Focused Therapy and Accelerated Experiential Dynamic Psychotherapy look especially promising, but we are still waiting to see studies evaluating these models in practice with trans couples.

The family therapy model used is less important than for the treatment to be gender-affirming, nonbinary, and embracing of all aspects of clients' identities. It should

also be respectful of clients' preferred names, pronouns, and sexuality, as well as knowledgeable about the levels of discrimination, violence, and abuse many in the community have experienced directly or witnessed. The model should be collaborative, empowering, acknowledge the potential for resilience, and be able to embrace nonheteronormative configurations of relationships. As a clinician, one needs to be able to create a safe and accepting environment for the various stances family members may be taking on conflictual issues. Such intense conflict does not necessarily signal the end of a relationship but is a natural process in coming to understand, nurture, and accept one another as a trans couple and/or family.

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APPENDIX A GLOSSARY

Affirmed Gender: A person's internal sense of oneself as a gendered being, regardless of their anatomical sex. Is used with people whose internal gender and anatomy do not match.

Agender: Without gender. Often used as an identification for people who do not identify with or conform to any gender.

Asexual: People who lack sexual attraction or interest in sexual activity.

Assigned Sex (or gender): The sex or gender a person is given at birth based on their physical anatomy.

Bigender: One who identifies as two genders. They may identify as both at the same time or go back and forth between two genders.

Cisgender: People who identify with the gender they were assigned at birth; nontrans.

Cross-Dresser: A person who dresses in clothes normally only associated with the opposite gender.

Drag Kings/Queens: Are performers. Drag Kings are female bodied or identified performance artists who dress in masculine clothing as part of their routine. Drag Queens are male bodied or identified performance artists who appear in clothing associated with the female gender. Both often exaggerate certain characteristics for comic, dramatic, or satirical effect.

En Femme: When a person is in a feminine gender presentation, most often referring to bigender people or male bodied cross-dressers who switch between being en femme and their masculine role.

Female-to-Male (FTM): Used to identify a person who was female bodied at birth and who identifies as male, lives as a man, or identifies as masculine.

Gender Confirmation Surgery (GCS): This refers to any surgery used to align one's body with their gender identity. Most often it is used in reference to genital reconstruction, but also refers to chest reconstruction (mastectomies) for trans men. Also referred to as Gender Reassignment Surgery; Sex Reassignment Surgery; Gender Affirmation Surgery.

Gender Dysphoria (GD): A condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity.

Gender-Neutral Pronouns: Pronouns that do not refer to a specific gender. Pronouns are an ongoing issue in the trans community. Gender specific pronouns (he/him/his & she/her/hers) do not properly refer to people who identify outside of the binary. There are many gender-neutral pronouns in usage, but the most common in usage appear to be the singular they/them/theirs and ze/hir/hirs (pronounced “zee/here/here’s”).

Gender Nonconformity: Behavior or gender expression by an individual that does not match masculine and feminine gender norms for one’s culture.

Genderqueer: Although this has several meanings in the trans community, in this context it refers to individuals who identify as neither entirely male nor entirely female.

Internalized Transphobia: It refers to how some people, often outside of their awareness, hate the trans part of themselves and are ashamed of it, internalizing and believing in negative messages about trans people.

Male-to-Female (MTF): Used to identify a person who was male bodied at birth and who identifies as female, lives as a woman, or identifies as feminine.

Omnisexual: A person who is attracted to all genders and bodies.

Pansexual: A person whose is attracted sexually to or falls in love with people regardless of their gender or anatomical body. Gender is not part of the attraction.

Queer: Originally a pejorative term for gay that is now being reclaimed by some gay men, lesbians, bisexuals, and trans persons as a self-affirming umbrella term. It is still extremely offensive when used as an epithet or to some older members of the community.

Stealth: When a trans person lives completely as their affirmed gender and presents as such in the public sphere without others being aware of their trans status.

Transsexual: An older medicalized term that refers to a person who psychologically identifies with the opposite sex and may seek to live as a member of this sex often through the use of medical interventions such as surgery and hormone therapy to obtain the necessary physical appearance.

Two-Spirit: A Native American term that describes all who do not identify as their assigned sex at birth, perform gender roles opposite their assigned sex, or are attracted to same-sex partners.

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