

Gender Identity Disorder: Mental Illness or Child Maltreatment? Implications for Professionals

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Abstract

Transsexual children and adolescents may be diagnosed as suffering from gender identity disorder, as defined by the most recent edition of the Diagnostic and Statistical Manual. Parents, with the support of some professionals, may attempt to utilize this classification to secure treatment for their transsexual child. Depending on the nature of these efforts, the definition of emotional or psychological maltreatment that is utilized by a particular jurisdiction, and the child's response, such efforts may constitute emotional or psychological abuse of the child. This article examines our current understanding of transsexuality, the parameters of behaviors that may constitute abuse, and the significant legal and ethical issues facing professionals in such circumstances.

Introduction

Pamela was 14. Pamela had been born Paul, but always felt like Pamela and could not understand why she had a penis and had been named Paul, when she knew in her heart of hearts that she was really a lovely, graceful girl. When her father saw her dressed as a girl, he became violent and beat her, "to kick the devil out of her." Her mother dragged her off to see a psychiatrist, who agreed that Paul must be mentally ill to believe that he was a girl and should undergo treatment for gender identity disorder. In desperation, Pamela took to the streets, where she survived by selling her body and using drugs to forget that she was selling her body. She was eventually arrested and placed in a residential facility for juvenile offenders. There, the staff refused to allow her to keep her dresses, forced her to wear pants, and continually advised "him" that "he" would be going to hell to answer for his sins against nature.

Although the names have been changed, the story of Pamela-neé-Paul is true. This article explores the situation of transsexual youths, born into one biological sex but believing and feeling that they are of the other; the professional categorization of many of these youths as mentally ill; and the frequent parental rejection and degradation of these children. This article poses two critical questions: Can parental attempts to "reform" such youths through medical or psychiatric treatment ever be construed as a form of emotional abuse? If so, what is the appropriate

response of the many systems involved in caring for abused children? (A list of suggested resources and references for professionals, transsexual youths, and family members appears at the end of this article.)

Diverse Perspectives in Transsexuality

Transsexuality as Pathology: Gender Identity Disorder

The most recent version of the *Diagnostic and Statistical Manual*, the fourth edition, text revision (*DSM-IV-TR*), provides for the diagnosis of gender identity disorder (GID) when an individual maintains a "strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex" and, in addition, the individual experiences "persistent discomfort with his or her sex or sense of inappropriateness in the gender roles of that sex" (American Psychiatric Association, 2000, pp. 578, 581). To be diagnosed with this condition, the individual may not have a physical intersex condition, and the cross-gender identification must cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2000, p. 581).

Additional criteria are specified to warrant diagnosis. A child who has a cross-gender identification must display four of five characteristics: (1) a repeatedly stated wish or insistence that he or she is of the opposite sex; (2) an insistence on wearing clothing usually associated with individuals of the opposite sex; (3) a strong preference for taking on, in play or fantasy, the roles customarily associated with members of the opposite sex; (4) a strong desire to participate in games usually associated with those of the opposite sex; and (5) a strong preference for playmates of the opposite sex. Adolescents may state that they want to be a member of the opposite sex, may reveal that they have feelings and reactions similar to those of the opposite sex, or may express a wish to be treated like a member of the opposite sex (American Psychiatric Association, 2000).

The requisite sense of discomfort may be exhibited in boys by an assertion that the male genitalia are disgusting, or by an avoidance of stereotypically male games and toys. In girls, it is said to be manifested by a rejection of the seated position for urination, an assertion that she does not want breasts or does not

want to menstruate, and an aversion toward clothing associated with girls. Adolescents may express a wish to be rid of primary and secondary sex characteristics (American Psychiatric Association, 2000). Consider the descriptions of gender-disordered youth offered by the *DSM-IV-TR*:

In boys . . . there is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters They avoid rough-and-tumble play and competitive sports and have little interest in cars or trucks or other nonaggressive but stereotypical boys' toys Girls . . . display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes may be required. They prefer boys' clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress-up or role-play activity (American Psychiatric Association, 2000, pp. 576-577).

These children, it is explained, often suffer relationship difficulties at home and in school, and are frequently referred for professional help by their parents because of a failure to develop "age-appropriate same-sex peer relationships" (American Psychiatric Association, 2000, p. 579). Nonconformity, however, is insufficient to justify a diagnosis. Also, individuals suffering from other mental illnesses, such as schizophrenia, may experience delusions of being a member of the opposite sex (Rutter & Terndrup, 2002); such individuals would not be diagnosable as suffering from GID. Rather, the complete constellation of enumerated symptoms must be present to warrant a diagnosis of gender identity disorder, although marked distress or impairment is especially important.

One must, however, question the source of that distress and the cause of the existing impairment. Various mental health professionals have argued that mental illness is socially constructed (Scheff, 1966). This assertion is supported, to some degree, by the history of various mental illness diagnoses. As an example, homosexuality was included in earlier versions of the *Diagnostic and Statistical Manual* as a

mental illness. In 1973, the membership of the American Psychiatric Association eliminated homosexuality as a diagnostic category (Bayer, 1993). *By vote*, the mental illness no longer existed. The following rationale was provided for this decision:

The crucial issue in determining whether or not homosexuality per se should be regarded as a mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder. A significant portion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (unless homosexuality, by itself, is considered psychopathology), and are able to function socially and occupationally with no impairment. If one uses the criteria of distress or disability, homosexuality per se is not a mental disorder. If one uses the criterion of inherent disadvantage, it is not at all clear that homosexuality is a disadvantage in all cultures or subcultures (American Psychiatric Association, 1989, p. 380)

Accordingly, if the distress derives not from the youth's own belief that he or she is of the opposite sex, but from the reactions of others and their treatment of the youth, does the distress come within the meaning of this diagnostic requirement? If, for instance, the impairment in family relationships exists because the youth's self-perception is at odds with that of family members who insist that the child is of her or his biological sex, is the impairment a function of the youth's "condition" or, instead, of the family response to the youth's self-perception?

It has also been argued that this classification may produce stigma that can lead to internalized shame and, for children and adolescents, may lead to forced treatment in an attempt to impose gender norms (Osborne, 1997; Wilson, 1997; cf. Glenn, 1999; Tigert, 1999). Proponents of the diagnosis have countered these concerns by arguing that the classification and its criteria are necessary for individuals to satisfy the prerequisites for sex reassignment surgery, as a validation of the experiences of transsexual individuals, and to provide practitioners with a framework from which to operate (Osborne, 1997; Steiner, 1985).

Transsexuality: A Nonpathological Perspective

The term *transgender* encompasses a vast array of gender-nonconforming identities and behaviors, including transsexuals (preoperative, postoperative, and those who are uninterested in gender reassignment surgery); transvestites; male and female

impersonators; and “gender-benders,” those individuals who challenge prevailing gender norms for personal, political, or cultural reasons (Ryan and Futterman, 1997). The term *transsexual* is used to refer to individuals who may be of one biological sex, but who feel that they are of the other. Accordingly, transsexuals may be said to be transgender, but not all transgender individuals are transsexuals. Transsexuals, like other individuals, may be of any sexual orientation, including heterosexual, gay or lesbian, bisexual, asexual, or pansexual (attraction to other “gender-bending” individuals, such as a male-to-female transsexual who has had hormone treatments to enlarge breasts but has decided against genital reassignment surgery). The interrelationship of these concepts is illustrated in Figure 1.

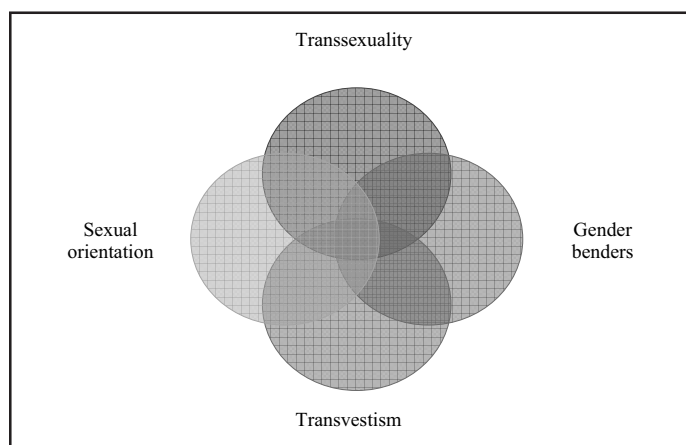


Figure 1. The interrelationship of various forms of transgenderism

The actual incidence of transsexuality is unknown, and estimates vary. Transsexuality has been estimated to affect approximately 1 in every 30,000 males and 1 out of every 100,000 females (American Psychiatric Association, 2000). However, others believe that female-to-male transsexuality is as common as male-to-female transsexuality (Perrin and Spack, 2002). Transsexuality has been documented across cultures and eras (Bullough and Bullough, 1993; Lewins, 1995; Nanda, 1994; Roscoe, 1994, 1998). The causes of transsexuality are unknown, but numerous theories have been advanced, including the conscious or unconscious rearing of a child in opposition to his or her biological sex (Goh, 1991); an overcontribution by the mother to a boy’s development (Docter, 1988); and the influence of neonatal hormones (cf. Benjamin, 1966). It has also been asserted that transsexuality exists as a construct because of the manner in which society dichotomizes roles and sexes:

Scientists construct dimorphisms where there is continuity. Hormones, behavior, physical characteristics, developmental processes,

chromosomes, psychological qualities have all been fitted into gender dichotomous categories Biological, psychological, and social differences do not lead to our seeing two genders. Our seeing two genders leads to the “discovery” of biological, psychological, and social differences (Kessler and McKenna, 1985, p. 163).

Many transsexuals report that they knew they were different from others as early as the age of five (Lewins, 1995; Scholinski, 1997). Children may engage in magical thinking and daydreaming, believing that somehow their sexual organs will metamorphose and they will awaken as children of the other sex. This magical thinking and daydreaming may continue into adolescence (Pazos, 1999). Personal accounts of transsexuals detail their constant struggle to reconcile the conflict between what their minds tell them and their bodies indicate, as well as their difficulties dealing with social responses to their disclosures of their transsexuality (Lewins, 1995). Leslie Feinberg, a transsexual activist, related how she felt as a child:

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

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

I was ten years old. I was no longer a little kid and I didn’t have a sliver of cuteness to hide behind. The world’s patience with me was fraying, and it panicked me. When I was really small I thought I would do anything to change whatever was wrong with me. Now I didn’t want to change, I just wanted people to stop being mad at me all the time (Feinberg, 1993, pp. 13, 19).

A number of models have been developed to describe the developmental process through which transsexuals “come out” to themselves and others as transsexuals (Lev, 2004; Lewins, 1995). One model has identified six stages in the process of transitioning from male to female: abiding anxiety, discovery, purging and delay, acceptance, surgical reassignment, and invisibility (Lewins, 1995). Individuals do not necessarily experience all stages, and progression through one stage may extend into the next.

Characterization of “abiding anxiety” is based largely on recollection. Accordingly, it is unclear to what extent these recollections are constructed to be consonant with current events and circumstances. The experience of anxiety may start as early as age seven, with feelings of discomfort that may be relieved initially through cross-dressing. The feelings of anxiety are often exacerbated by punishment for being different. Individuals may attempt to reduce or eliminate these uncomfortable feelings during later years, in adolescence and early adulthood, through substance use or abuse. It is believed that the majority of individuals remain at this stage for a decade or more before transitioning to the next stage, that of discovery.

Discovery involves the recognition by the individual of who he or she is. One transsexual commented: “I lacked confidence and was always crying. I didn’t know why. Then, when I was 17, I read a book about a girl who had undergone a sex change and for the first time I understood what was wrong with me” (Anonymous, 1989, p. 12).

The subsequent change, that of purging and delay, reflects a conscious decision to avoid a decision to live as a woman and the “non-conscious postponement of that decision” (Lewins, 1995, p. 77). Purging one’s identity as a female can be thought of as an active form of denial, effectuated, for example, by attempts to deny feeling female through participation in “male” activities, such as bodybuilding, heavy drinking, marriage to a female, and securing “male” employment (law enforcement, military service, etc.). Unsuccessful purging may produce even greater levels of anxiety. Delay may result, in part, from concerns about the reactions from family members, coworkers, employers, and friends, and difficulties reconciling who one is with one’s religious beliefs.

At least one researcher characterized the acceptance stage as that point in time when a male-to-female transsexual acknowledges that the feelings of gender confusion can be resolved only by living as a woman and seeks referral to a gender dysphoria clinic (Lewins, 1995). One must question, though, whether such a referral is a necessary component of acceptance, or if, instead, its mandated inclusion as a criterion further medicalizes transsexuality. This stage may or may not be followed by surgical reassignment and attempts at invisibility, during which the postsurgical transsexual individual attempts to limit public access to her past history. This may be accomplished by changing jobs, moving to another city, severing ties with friends and acquaintances, and reducing social contact with other transsexuals.

Children and adolescents cannot undergo sexual reassignment surgery. The physiologic changes that accompany puberty may be devastating to a transsexual adolescent and may lead to depression, self-mutilation, and suicidal gestures (Perrin and Spack, 2002). Adolescents may wear bulky clothing in an attempt to hide these changes, and may bind their breasts and genitals. In extreme cases, they may try to castrate themselves or may pound their breasts. Male-to-female (MTF) adolescents may self-inject with silicone in their lips, chests, buttocks, or thighs, while female-to-males (FTMs) may abuse bodybuilding powders and anabolic steroids in an attempt to develop a more masculine musculature (Brown & Rounsley, 1996; Ryan & Futterman, 1997).

Dating is, for many transsexual adolescents, a frustrating experience (Pazos, 1999). Among FTMs, experiences tend to follow one of two patterns. Those who self-identify as heterosexuals regard boys as friends and may be disappointed or shocked to find that some of these boys view them romantically or sexually. Dating girls may not be seen as a viable alternative. Others may date boys in an effort to quell rumors that they are lesbian and/or in an attempt to live vicariously as boys through their boyfriends (Pazos, 1999).

Many transsexual children experience parental rejection, which may be due, at least in part, to an aversion to gender ambiguity (Fausto-Sterling, 1993). Family relationships often become tense (Devor, 1997). In an effort to ameliorate the emotional pain, the child may turn to drugs or alcohol, at which point parents may force him or her into therapy (Pazos, 1999). Parents may withdraw financial support of their child, forcing the transsexual child to become homeless or to become part of the foster care system, where he or she may become a target of abuse (Mallon, 1998).

In North America, it is still relatively uncommon for an adolescent under the age of 18 to receive hormonal treatment under a physician’s care. By that time, the effects of androgen on the development of the body are well established. In the United States, services available to transsexual youth may include, depending on the community, counseling, support, and hormonal therapy following the growth spurt. A list of resources available to transsexual adolescents appears at the end of this article.

In contrast, physicians in the Netherlands are more likely to be aware of transsexuality and various approaches to treatment and are consequently more likely to provide evaluation, counseling, and treatment services to transsexual adolescents. As an example, medications may be administered to delay pubertal

maturation until the youth reaches an age when he or she can decide whether to authorize treatment with the requisite hormones (to induce desired changes in the larynx, hair follicles, and/or breasts), or to undergo sex reassignment surgery (Cohen-Kettenis & van Goozen, 1998). It has been argued that we all, in some way, alter our bodies in an attempt to match our gender identities more accurately:

[N]early everyone attempts to reshape their anatomy to bring it more comfortably close to the sex and gender ideal. Most women shave their legs and underarms because it is not only unfeminine, it is somehow unfemale to be hairy. The moustached woman will almost certainly contemplate a change of anatomy through depilatories or electrolysis to avoid being addressed as "sir," to rid herself of the confusing sensation of stubble, to ease the mixed signals. A small chested woman may receive breast implants to help her feel more womanly. A short man may wear elevator shoes and a small man may devote himself to body building to create a more "manly" physique. All are trying to fix a conflict between social and sexual identity and anatomical reality (Chapkis, 1986, p. 155).

The concept of sexual reassignment surgery stems from the realization that transsexualism cannot be cured. Referring to male-to-female transsexualism, Harry Benjamin, the endocrinologist and proponent of sexual reassignment surgery, stated:

Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man . . . is a useless undertaking . . . Since it is evident, therefore, that the mind of the transsexual cannot be adjusted to the body, it is logical and justifiable to attempt the opposite, to adjust the body to the mind. If such a thought is rejected, we would be faced with therapeutic nihilism (Benjamin, 1966, p. 116).

It is believed that, for a variety of reasons, only a minority of transsexuals request sex reassignment surgery when, as adults, they are able to do so. Impediments to such surgery include the high cost of the procedure; the lack of coverage available through either private health insurance plans or Medicaid; the necessity of repeated surgeries, with prolonged and painful recovery times; the dissatisfaction with the results that is often expressed by individuals who have had this surgery; and the difficulty locating primary service providers with an understanding of transsexuality who are able and willing to provide

appropriate referrals. Further, for many transsexuals, reassignment surgery may not constitute the optimal resolution to their conflict. As one writer noted,

The mental health field is accustomed to thinking of only two solutions [for gender dysphoria] . . . either changing the identity to match the body (i.e., accepting completely one's given gender and gender role) or changing the body to match the identity and adopting completely the identity of the other gender. Increasingly clinicians and transgender individuals themselves are finding that these categories are inadequate to describe the possible resolutions to cross-gender experience (Carroll, 1999, p. 129).

Transsexual individuals often experience severe discrimination and prejudice. Adolescents may have a particularly difficult time participating in physical education activities and sharing locker rooms with individuals whom they perceive to be of the opposite sex. This presents difficulties not only for the teen, but also for the school's teachers and administrators (Perrin & Spack, 2002).

These difficulties do not cease in adulthood. In one study, 60% of the adult transsexual respondents reported harassment and violence, and 37% indicated that they had experienced various forms of economic discrimination (Lombardi, Wilchins, Priesing, & Malouf, 2001). In yet another study, researchers found that more than half of the transsexual adults were clinically depressed and almost one-third had attempted suicide at one time (Clements-Nolle, Marx, Guzman, & Katz, 2001). Individuals may experience judgmental responses from health care providers and, in an effort to avoid such unpleasant encounters, may obtain hormones and injection equipment on the street for self-medication to transform secondary sexual characteristics (breasts, facial hair, etc.). The use of contaminated needles can lead to infection with HIV/AIDS, hepatitis B or C, and a variety of other bacterial infections (Sbordone, 1994). In some sample populations of male-to-female transsexuals, more than one-third of the individuals were found to be HIV-infected (Clements-Nolle, Marx, Guzman, & Katz, 2001). Improper use of hormones can result in serious health complications, including thromboembolism, cardiovascular disease, and hypertension (Bidwell, 1992; Boxer, 1997).

The discrimination may assume the mantle of legal legitimacy. As an example, many states prohibit even postoperative transsexuals from amending their birth certificates to indicate the new sex. As a consequence, individuals are forever prohibited from marrying. As

an example, consider a situation in which a male undergoes sexual reassignment surgery to become a female. She is a heterosexual, and is attracted to a male whom she wishes to marry. However, her birth certificate indicates that she is a male, her betrothed is a male, and almost all states now prohibit same-sex marriage.

Identifying Emotional and Psychological Maltreatment

Defining Emotional and Psychological Maltreatment

Table 1 summarizes many definitions of emotional and psychological abuse, maltreatment, and neglect. *Emotional abuse* has been said to occur when there is an “actual or likely severe adverse effect on the emotional and behavioral development of the child caused by persistent or severe emotional ill-treatment or rejection” (UK Department of Health, 1991); when the child experiences damage to his or her “psychological development and emerging personal identity, primarily caused by the parent’s (primary caretaker’s) immaturity, dependent life-style, and conscious or unconscious aggression towards the child” (Firestone, 1991); when the child suffers “hostility, persistent coldness, or rejection by the parent or caregiver, to such an extent that the child’s behavior is disturbed or their development impaired” (Community Services, 1989); or when there is a “severe adverse effect on the behaviour and emotional development of a child caused by persistent or severe

emotional ill-treatment or rejection” (Creighton, 1992). Emotional abuse is also said to occur when parents subject their children to “verbal assault (belittling, screaming, threats, blaming, sarcasm, unpredictable responses, continual negative moods, constant family discord and double-message communication)” (California Attorney General’s Crime and Prevention Center, 2000).

These definitions share various features. First, they focus both on the repetitive nature of the adult behaviors that are labeled abusive and on the detrimental effects of these behaviors on the child. It has been hypothesized that it is the *pattern* of behaviors, rather than a particular abusive act, that is detrimental to the child, because the accumulation of the psychological effects may make the child more vulnerable and less able to defend himself or herself from psychological attacks (Van der Kolk, 1987). However, the actual impact on the child may not be clearly detectable for some time. Second, the elements of emotional abuse appear to overlap with what some researchers and clinicians have termed *psychological abuse*, which encompasses rejection, degradation, isolation, exploitation, emotional nonresponsiveness, and terrorization (Baily & Baily, 1986; Hart & Brassard, 1987; 1991).

Despite the similarities among definitions, significant and critical differences exist. At least one definition requires that the action against the child be

Table 1. Definitions of Emotional and Psychological Abuse, Maltreatment, and Neglect

Term	Definition
Emotional abuse	<p>Hostility, persistent coldness, or rejection by the parent or caregiver, to such an extent that the child’s behavior is disturbed or . . . development impaired (Community Services, 1989, p. 18)A severe adverse effect on the behaviour and emotional development of a child caused by persistent or severe emotional ill-treatment or rejection (Creighton, 1992,)Actual or likely severe adverse effect on the emotional and behavioural development of the child caused by persistent or severe emotional ill-treatment or rejection (UK Department of Health, 1991, p. 11)Damage to the child’s psychological development and emerging personal identity, primarily caused by the parent’s (primary caretaker’s) immaturity, dependent life-style, and conscious or unconscious aggression towards the child (Firestone, 1991, p. 1)Hostile or indifferent parental behaviour which (if severe and persistent) damages a child’s self-esteem, degrades a sense of achievement, diminishes a sense of belonging, and prevents healthy and vigorous development (Iwaniec, 1997, p. 372)The sustained, repetitive, inappropriate emotional response to the child’s expression of emotion and its accompanying expressive behaviour (O’Hagan, 1993, p. 28)Habitual verbal harassment of a child by disparagement, criticism, threat, ridicule, and the inversion of love, and the substitution of rejection and withdrawal by verbal and non-verbal means (Skuse, 1989).</p>

Term	Definition
Emotional neglect	Refers to the passive ignoring of a child’s emotional needs; to lack of attention and of stimulation; and to parental unavailability to care, to supervise, to guide, to teach, and to protect. Emotional neglect more often than not originates from parental unawareness and ignorance, depressive moods, chaotic life-styles, poverty, lack of support, and lack of appropriate child-rearing models (often based on parental childhood experiences), unwittingly impairing child development and well-being (Iwaniec, 1995, p. 5) .
Psychological abuse	Behavior is considered psychologically abusive when it conveys a culture-specific message of rejection or impairs a socially relevant psychological process (Garbarino, Guttman, and Seeley, 1986, p. 5). Psychological abuse is concerned with cruelty demonstrated by verbal and nonverbal acts, repeated or singular, intended or not, from a close other in a position of power or responsibility over the child. These have the potential for damaging the social, cognitive, emotional, or physical development of the child and are demonstrated by behaviors which are humiliating/degrading, terrorizing, extremely rejecting, depriving of basic needs or valued objects, inflicting marked distress/discomfort, corrupting/exploiting, cognitively disorienting, or emotionally blackmailing. The perpetrator behaviors involved in psychological abuse exclude physical or sexual attack, although psychological abuse may accompany these. They also exclude those forms of maltreatment identified as neglect, antipathy, role reversal, high discipline, or lax supervision . . . (Moran, Bifulco, Ball, Jacobs, and Benaim, 2002, p. 213). The sustained, repetitive, inappropriate behaviour which damages, or substantially reduces, the creative and developmental potential of critically important mental faculties and mental processes of a child; these include intelligence, memory, recognition, perception, attention, language and moral development (O’Hagan, 1993, p. 33)
Psychological maltreatment	A repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another’s needs Psychological maltreatment includes (a) spurning, (b) terrorizing, (c) isolating, (d) exploiting/corrupting, (e) denying emotional responsiveness, and (f) mental, health, medical, and educational neglect (American Professional Society on the Abuse of Children, 1995, pp. 2, 4). A concerted attack by an adult on a child’s development of self and social competence (Garbarino, Guttman, and Seeley, 1986, p. 8)A repeated pattern of damaging interactions between parent(s) and child that becomes typical of the relationship . . . [that] conveys to a child that he or she is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another’s needs (Kairys, Johnson, and the Committee on Child Abuse and Neglect, 2002, p. 1). Acts of omission and commission, which are judged on the basis of a combination of community standards and professional expertise to be psychologically damaging. Such acts are committed by individuals, singly or collectively, who by their characteristics (e.g., age, status, knowledge, and organizational form) are in a position of differential power that renders a child vulnerable. Such acts damage immediately or ultimately the behavioral, cognitive, affective, or physical functioning of the child. Examples of psychological maltreatment include acts of rejecting, terrorizing, isolating, exploiting, and missocializing (International Conference on Psychological Abuse of the Child, 1983, p. 2).

“concerted,” implying intentional and deliberate abuse or maltreatment. The majority of definitions do not address the issue of intent at all. Some, but not all, require that an identifiable adverse effect be linked to the action of the adult for the behavior to constitute abuse or maltreatment. However, an injurious effect of the action or inaction may not be apparent for some

time, perhaps even into the recipient’s adulthood. Other definitions assume that the maltreatment may be effectuated only by the parent or primary caregiver, whereas still other definitions recognize abuse in the context of any relationship characterized by a difference in power between the child and the adult.

This wide variation and lack of consistency similarly characterize the legal definitions that have been adopted by the states. Most state statutes relating to the emotional and psychological maltreatment of children follow one of three patterns: they do not address emotional or psychological maltreatment at all; they prohibit emotional maltreatment, in addition to prohibiting physical maltreatment, but fail to provide any statutory guidance as to when such maltreatment exists; or they both prohibit emotional or psychological maltreatment and provide a standard by which to assess alleged abuse (Levesque, 1998; Neeley, 2000). Table 2 displays a sample of these definitions to illustrate the differences that exist. These variations across states may ultimately affect the frequency with which emotional/psychological maltreatment is reported and addressed (Loue, 1998).

The prevalence of emotional or psychological abuse of children is most likely underestimated. Differing and sometimes overlapping definitions of emotional and psychological abuse increase the difficulty of achieving an accurate estimate of the incidence and prevalence of such abuse. Additionally, some states do not define emotional or psychological abuse or maltreatment in their statutes, thereby diminishing the likelihood that such cases will be reported (Hamarman, Pope, & Czaja, 2002; National Clearinghouse on Child Abuse and Neglect Information, 2003; United States Department of Health and Human Services, 1997). Nevertheless, it appears to be a serious and growing problem.

A study published by the American Humane Association (1988), based on a sample of cases that

Table 2. Examples of State Statutory Definitions of Emotional and Psychological Abuse, Maltreatment, and Neglect

State	Term	Definition
Alaska	Mental injury	An injury to the emotional well-being, or intellectual or psychological capacity of a child, as evidenced by an observable and substantial impairment in the child’s ability to function. (Alaska Stat. § 47.17.290(2) (2006))A serious injury to the child as evidenced by an observable and substantial impairment in the child’s ability to function in a developmentally appropriate manner and the existence of that impairment is supported by the opinion of a qualified expert witness.(Alaska Stat. § 47.17.290(9) (2006))
California	Adjudication of child as dependent child of court	The child is suffering serious emotional damage, or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care. (Cal. Welf. & Inst. Code § 300(c) (2006))
Florida	Mental injury	Any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child’s physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions (Fla. Stat. § 39.01(2) (2006)).Mental injury: an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior (Fla. Stat. § 39.01(41) (2006))
New Jersey	Abused or neglected child	Includes “a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, or such other person having his custody or control, to exercise a minimum degree of care” in enumerated domains and functions (N.J. Stat. Ann. §§ 9:6-8.9, (2006))

State	Term	Definition
Pennsylvania	Serious mental injury	A psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment, that: (1) renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic or in reasonable fear that the child's life or safety is threatened; or (2) seriously interferes with a child's ability to accomplish age-appropriate developmental and social tasks (Pa. Stat. Ann. tit. 23, § 6303(a) (2006)) Child abuse: An act or failure to act by a perpetrator which causes nonaccidental serious mental injury to or sexual abuse or sexual exploitation of a child under 18 years of age (Pa. Stat. Ann. tit. 23, § 6303(b) (2006))
Utah	Child abuse	Includes "chronic or severe emotional abuse" (Utah Code Ann. § 62A-4a-101(1)(a), (8) (2006) [<i>emotional abuse</i> undefined])

were reported to official child abuse prevention agencies, concluded that the incidence of psychological maltreatment was 0.54 per 1,000 children. Among a nationally representative sample of 1,250 parents, researchers found that 45% had insulted or sworn at their children that year (Daro & Gelles, 1992). Data from the second National Family Violence Survey indicated that approximately 63% of the parents surveyed had used some form of psychological abuse in their interactions with their children during that year (Vissing, Straus, Gelles, & Harrop, 1991). If the criterion for emotional or psychological maltreatment is set at 10 or more incidents of verbal or symbolic aggression, the incidence of emotional/psychological maltreatment becomes 267 per 1,000 children (Brassard & Hardy, 1997). Using a more conservative estimate of 20 incidents as the threshold for emotional/psychological maltreatment, the incidence is still alarming, at 113 per 1,000 children (Brassard & Hardy, 1997). In 1999, the California Department of Social Services received 540,577 reports of child abuse incidents; of these, 9.1% were for emotional maltreatment (Santa Clara County, 2004). In 2002, the same agency received complaints involving 706,627 children; of these, 62,180 (8.7%) were for emotional abuse alone (California Attorney General's Crime and Violence Prevention Center, 2004).

Research findings from outside the United States similarly indicate that emotional and psychological maltreatment of children is a significant problem. A survey of 504 adults in a British community found that 29% had been emotionally abused as children by their caregivers (Doyle, 1997). An examination of England's Child Protection Register on March 31, 2000, found that 18% of all children listed on the register had been placed on that register as children in need of protection because of emotional abuse alone (Government

Statistical Service, 2000). The register is not a complete listing of all children known to be abused, but only those deemed to be in need of protection.

A number of factors that increase the risk of child emotional and psychological maltreatment have been identified. These include child aggression, child delinquency, interpersonal problems of the child, older age of the child, lower family income, greater number of children in the family, reduced affection between the parents, increased levels of physical and verbal aggression between the parents, increased maternal levels of anxiety, lower levels of verbal reasoning among mothers, and parental childhood experience of verbal aggression (Black, Slep, & Heyman, 2001). Boys have been found slightly more likely to be the targets of psychological abuse than girls (Vissing, Straus, Gelles, & Harrop, 1991).

Emotional and psychological maltreatment of children may result in significant adverse effects. Depression, lowered self-esteem, aggression, conduct disorders, withdrawal, incompetence or underachievement, failure to thrive, difficulties in forming relationships, and enuresis have been reported in children who experience emotional or psychological maltreatment (Crittenden, Claussen, & Sugarman, 1994; Dance, Rushton, & Quinton, 2002; Garbarino, Guttman, & Seeley, 1986; Hart & Brassard, 1991; Hart, Germain, & Brassard, 1987; Lefkowitz, Eron, Walder, & Huesmann, 1977; Navarre, 1987; Stone, 1993). Emotional maltreatment has been shown to be associated with various problems in adulthood, including depressive illness, anxiety, interpersonal sensitivity, obsessive-compulsive disorder, dissociation, personality disorders, eating disorders, substance use, and suicidal behavior (Braver, Bumberry, Green, & Rawson, 1992; Briere & Runtz, 1988; McCord, 1983; Kent, Waller, & Dagnan, 1999;

Park, Imboden, Park, Hulse, & Unger, 1992; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Rorty, Yager, & Rossotto, 1994).

Parental Rights and Transsexual Children

Certainly, one might ask, why wouldn't a parent seek to protect his or her child from a difficult and demanding existence as a transsexual individual? One might think that medical treatment or therapy would "cure" a child of his or her apparent delusion that he or she is a member of the opposite biological sex. Additionally, one could argue, it is the right of every parent to dictate how to best raise his or her child.

Indeed, this right has long received protection under the law. It has been stated that the "right of natural parents to raise their children is founded on the long tradition of history and the culture of Western civilization" (Cressler, 1994, p. 795), and the right to control and direct a minor's upbringing was considered a "sacred right" at common law (Witte, 1996, pp. 190-191). Commentators have alternatively situated this right in the constitutional right to privacy in the family (Culbertson, 1994; McMullen, 1992) or in the Ninth and Fourteenth Amendments (Witte, 1996). The United States Supreme Court has recognized that parents have a "fundamental liberty interest" protected by the Fourteenth Amendment "in the care, custody, and management of their child" (*Santosky v. Kramer*, 1982, p. 754). Additionally, courts have assumed that the "natural bonds of affection lead parents to act in the best interests of their children" (*Parham v. J.R.*, 1979, p. 602).

Parental rights have been found to be so basic as to warrant protection. The Supreme Court observed that "the private interest here, that of a man in the children he has sired and raised, undeniably warrants deference and, absent a powerful countervailing interest, protection" (*Stanley v. Kramer*, 1972, 651). Indeed, the state may supplant parental authority only when "an important and clearly relevant governmental or societal interest [is] at stake" (McMullen, 1992, p. 581). Accordingly, large variations in approaches to childrearing are tolerated and accepted, reflecting both these underlying principles and the wide cultural diversity in values and beliefs that exist in relation to childrearing and parent-child communication (Ahn, 1990). It cannot be assumed that difference equates with deficiency.

Parental attempts to cure or treat transsexual children of their transsexuality have included involuntary institutionalization (Goishi, 1997), electroconvulsive therapy (ECT) (Burke, 1996),

conversion therapy, aversion therapy (Oprah Winfrey Show, 1996), and spiritual healing (cf. Merrick, 2003; Tigert, 1999). Such attempts, however, may do more harm than good to the child. One individual remarked:

When I was growing up, people who lived cross-gendered lives were pressured into hiding deep within the darkest closets they could find. Those who came out of their closets were either studied under a microscope, ridiculed in the tabloids, or made exotic in porn books, so it paid to hide. It paid to lie. That was probably the most painful part of it: the lying to friends and family and lovers, the pretending to be someone I wasn't (Bornstein, 1994, p. 177).

As indicated by the preceding, the distress or impairment that the child or teen experiences often reflects the inability of those around him or her to accept or address the child's disclosures. Negative social labeling has been shown to be a precursor of depression, and the exclusion of a child by his or her peers may result in alienation, social isolation, and associated behavioral difficulties (Weinrich, Atkinson, McCutchan, & Grant, 1995; Zucker & Bradley, 1995). One clinician, critical of such reparative efforts, remarked:

As there are no treatment models for curing transgendered feelings, needs, and behaviors, one is left to wonder what types of treatment transgendered children endure at the hands of parents and professionals. Such treatment approaches are little more than abuse, professional victimization, and profiteering under the guise of support for a parent's goals (Israel and Traver, 1997, pp. 134-135).

Indeed, at least one professional has argued that teens should be permitted to transition from one sex to the other during their teen years. Griggs (1998) noted that the use of hormonal therapy during adolescence will retard the development of undesirable secondary sex characteristics, thereby reducing or eliminating the need for extensive cosmetic surgery later. The early identification of transsexuality may reduce the likelihood of long-term emotional trauma. Finally, in the legal domain, adolescents have less-developed bureaucratic histories (licenses, professional credentials, etc.) that would require revision, thereby facilitating their legal transition.

Courts may be similarly critical of parental efforts to "reform" their sexual minority children and may find that such attempts constitute abuse. In one New York case, a family court judge found that a 14-year-

old boy was emotionally abused by his parents as a result of his father's direction to him of an "unrelenting torrent of verbal abuse" that included calling him a "fag," "faggot," and "queer," although the youth continually denied being gay (*In re Shane T.*, 1982). The court specifically rejected the father's argument that he had a right to discipline his son for his "girlie behavior," noting that the child also had constitutional rights. In yet another New York case, a mother attempted to have her teenage daughter declared "in need of supervision" because of her association with an adult lesbian (*In re Lori M.*, 1985).

Implications for Professionals

Two major questions are raised for professionals working with transsexual children and adolescents. First, if a transsexual child presents for assistance, what courses of action are possible or recommended? Second, if it appears that the child may be the target of emotional or psychological abuse from his or her parents or caregivers, what are the ethical and legal obligations of the professional to whom the child turns?

Counseling Transsexual Children

Several issues are raised in the context of providing care to transsexual children. First, to what extent may a professional provide treatment to a transsexual child without parental knowledge or consent? Second, what are the implications of affixing a diagnosis of gender identity disorder to the child or adolescent?

The Ethics Code of the American Academy of Child Psychiatry (AACP, 1980) specifies that decisionmaking responsibility usually rests with the parent or legal guardian. The American Psychological Association's Code of Ethics (APA, 2003) directs those working with minors to "take special care" to protect the best interests of these patients. The Code of Ethics of the National Association of Social Workers (NASW, 1996) is silent regarding the treatment of children and adolescents. Unfortunately, it appears that no clear guidance is available to physicians, counselors, and other professionals who may be consulted by a transgender youth seeking advice.

Nevertheless, it may be possible to provide diagnosis and treatment, absent parental knowledge and consent, when the requested consultation involves the provision of diagnosis and treatment of a suspected sexually transmitted infection. State laws provide that minors may obtain such care without a requirement of parental notification. Additionally, depending on the youth's particular circumstances

and the law of the relevant state, a youth may be considered emancipated, thereby obviating the need for parental consultation and consent. As an example, Illinois law provides that a child under the age of 18 but who has attained the age of 16 may be found to be emancipated if he or she is either a "mature minor" (meaning that he or she has demonstrated the ability to manage his or her own affairs and to live wholly or partially independent of his or her parent or guardian) or a homeless minor (Emancipation of Mature Minors Act, 2004).

The Harry Benjamin International Gender Dysphoria Association has enumerated 10 tasks required of mental health professionals delivering an adequate standard of care to transsexual individuals:

1. to diagnose the gender disorder accurately
2. to diagnose accurately any comorbid psychiatric conditions and have them treated appropriately
3. to provide the individual with information about the full range of treatment options available and the implications of each
4. to engage in psychotherapy
5. to assess the client's eligibility and readiness for hormone therapy and/or surgery
6. to make formal recommendations for medical and surgical colleagues
7. to document the individual's history in a letter of recommendation
8. to participate as a colleague on a team of professionals interested in gender identity disorders
9. to provide education about gender identity disorders to family members, employers, and institutions
10. to be available to follow up with previously seen gender patients (Meyer et al., 2001).

To meet these standards, it has been recommended that mental health professionals develop an understanding of gender identity issues, including *DSM* criteria; become aware of issues that are being raised within the transgender liberation movement regarding the construction of gender identity; develop an understanding of human development; obtain training in a variety of psychotherapeutic techniques; develop an understanding of the impact of stress on individuals experiencing gender conflicts and refrain from pathologizing stress-related symptoms; become knowledgeable about issues related to sexual

development, sexual identity, gender identity, sexual orientation, and gender role; be sensitive to family systems; and maintain an adequate listing of resources for clients, including referrals to psychiatrists, endocrinologists, gender clinics, support groups, and Internet resources (Lev, 2004).

Several professionals have stressed the need to work with both the child and his or her family whenever possible (Brown & Rounsley, 1996; Lesser, 1999; Lev, 2004). Information about transsexuality and referrals to appropriate professionals and resources should be provided to the parents as well as to the child (Lev, 2004). These authors note that the family must be afforded sufficient time to grieve the loss of the relationship with the child that they believed had existed; to process feelings of shame, guilt, embarrassment, and betrayal; and to rebuild a new relationship, using new pronouns to describe their transsexual family member (Brown & Rounsley, 1996; Lesser, 1999).

Supportive psychotherapy may also include advocacy with entities external to the family. This may be particularly critical for parents who, in attempting to be supportive of their child, inadvertently incur the wrath of school and legal authorities (Lev, 2004). For instance, parents may permit their child to cross-dress, in an attempt to alleviate some of his or her discomfort and anxiety. This may provoke school officials, who perceive the child's behavior as disruptive and the parents' approach as neglectful or abusive, resulting in a referral to child protective services. In fact, in August 2000, an Ohio court removed a six-year-old child from her home after her parents attempted to enroll their child, who had been born a boy, as a girl. The child had self-identified as a girl since the age of two. The parents had been following the guidance of the child's therapist, who had counseled them to accept the child's cross-gender identity. Nevertheless, the court removed this child from her home (GenderPAC, 2000).

Addressing Issues of Emotional and Psychological Maltreatment

Whether parental efforts to cure a child of his or her transsexuality would be determined by a court to constitute emotional or psychological maltreatment or abuse is a function of the nature of those attempts, the relevant state's definition of such abuse, and the child's response to such treatment. Treatment modalities such as electroconvulsive therapy, conversion therapy, and reparative therapy have been discredited as "cures" for transsexuality, although a minority of practitioners continues to advocate their use (Rutter & Terndrup, 2002). In addition, almost all

states have some form of religious exemption in their child abuse and neglect laws (Loue, 1998). Such provisions most likely decrease the possibility that parents' "spiritual treatment" to cure their child of his or her transsexuality would be found to constitute a form of emotional or psychological abuse, notwithstanding the harm to the child.

As indicated previously, the child protection provisions of some states do not encompass emotional or psychological abuse or maltreatment. Illinois law, for example, fails to include emotional or psychological maltreatment or abuse as a category of abuse or neglect, except to the extent that the emotional harm results from nonaccidental physical injury or sexual abuse (Abused and Neglected Child Reporting Act, 2004). In other jurisdictions, such as California, the law may be sufficiently broad in scope to encompass parental efforts that result in emotional trauma to the child (see Table 2).

In jurisdictions that do provide for the reporting of emotional abuse or maltreatment, the professional must ascertain whether he or she is a mandated reporter, or whether the filing of a report is discretionary. In most jurisdictions, certain professionals, such as educators and health professionals, are specifically enumerated as mandatory reporters. Unfortunately, the laws of many jurisdictions often do not provide adequate guidance to these specified individuals who are charged with the responsibility to report abuse or neglect. This is particularly problematic when state law requires demonstrable impairment to the child to establish emotional or psychological abuse. Few professionals who learn of the possibility of emotional abuse have either the opportunity or the requisite ability to conduct a formal assessment to substantiate the abuse. Must the professional, then, report suspected emotional abuse in the absence of such evidence? Even those jurisdictions that attempt to provide some guidance to mandated reporters often fail to provide sufficient specificity to guide decisionmaking. As an example, the District of Columbia requires mandated reporters to inform the police or child protective services if they know or have "reasonable cause to suspect" the occurrence of child abuse or neglect (D.C. Code Annotated, 2006)—but "reasonable cause" is not defined.

Conclusions

Transsexual children and youth often experience confusion and isolation in their struggle to understand who they are. Their sense of being is pathologized through the categorization of transsexuality as a

disorder, despite the fact that much of the internal conflict they experience is often due to the responses of those around them. Parents and other family members may find it extraordinarily difficult to understand and accept their child as a transsexual. Even parents with the best of intentions for their child may embark on a course of action that results in stigmatization and isolation of their child, and inadvertently exacerbates the emotional trauma that he or she is experiencing. In the best-case scenario, a health professional can work with the child and parents to reach a mutual understanding and

acceptance of who the child is. In the worst-case scenario, parents may verbally torment their child and/or pursue discredited therapies to cure him or her of transsexuality. In such instances, the health professional may be the child's only credible advocate. When such parental efforts appear to be inflicting emotional or psychological trauma on the child, it is incumbent upon the professional to consider the possibility of emotional or psychological abuse or maltreatment and pursue an appropriate corrective course of action.

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Resources

Suggested Films

The Adventures of Priscilla, Queen of the Desert. Avant Garde Cinema. Rated R; 103 minutes. The adventures of two gay men and an MTF transsexual as they cross the Australian outback.

Boys Don't Cry (1999). Hart-Sharp Entertainment. Rated R; 188 minutes. The true story of Brandon Teena, born Tina Brandon, who moved to a small town in an attempt to live his life as a male, and his murder by several men.

Ma Vie en Rose (My Life in Pink). By Alain Berliner. In French, with English subtitles. Rated R; 89 minutes. Golden Globe Best Foreign Language Film. The story of a small boy who believes he is a girl and his parents' struggle to come to terms with who he is.

Southern Comfort. By Kate Davis. A 90-minute docudrama that received awards from the Sundance Film Festival, the Seattle International Film Festival, and the Berlin Film Festival. A documentary about a FTM transsexual, the challenges he faces with relationships, and his struggle to obtain care for breast cancer.

Suggested Readings

Bullough, B., Bullough, V. L., and Elias, J. (1997). *Gender blending*. New York: Prometheus Books.

Feinberg, L. (1997). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston: Beacon Press.

Garber, M. (1992). *Vested interests*. New York: Routledge, Chapman, and Hall.

Suggested Resources

American Psychological Association:
<http://www.apa.org/topics/orientation.html>
 Provides information relating to sexual orientation

American Psychological Association:
<http://www.apa.org/topics/transgender.html>
Provides information relating to transsexuality and transgenderism.

Forum on Transgender Health:
<http://www.lgbtchannel.com/transgender>
Provides information on health care and mental health guidelines, gender identity disorder, hormone therapy, and sex reassignment surgery.

Go Ask Alice!:
<http://www.goaskalice.columbia.edu>
Question and Answer Internet service providing information about sexuality and health-related information; developed by Columbia University's Health Education Program.

The Kinsey Institute:
<http://www.kinseyinstitute.org/library/>
Resource for information and scholarly materials.

MTV:
http://www.mtv.com/thinkmtv/sexual_health/
Provides answers to questions relating to sexual health and HIV transmission and prevention.

National Transgender Advocacy Coalition:
<http://www.ntac.org>

National Youth Advocacy Coalition:
<http://www.nyacyouth.org>
Hotline: 1-800-541-6922 ext. 12

National Youth Crisis Hotline: 1-800-HIT-HOME

New York Online Access to Health (NOAH):
<http://www.noah-health.org>
Provides information on sexuality, sexual health, and other health-related topics; developed by New York City library organizations.

PFLAG (Parents and Friends of Lesbians and Gays):
<http://www.pflag.com>
e-mail info@pflag.org
A national network of organizations and individuals supportive of gay, lesbian, bisexual, transgendered, and transsexual individuals, their friends, and families.

Planned Parenthood Federation of America:
<http://www.plannedparenthod.org>
Provides information about family planning, population, sexual health, and sexuality education.

TransGender Care:
<http://www.transgendercare.com>
Provides information on male-to-female gender transitioning, including hormone treatment, electrolysis, and surgical care.

Trans-Gender Expressions:
<http://www.tg2tg.org>
Peer based support organization by and for transgendered persons; Provides resource listings by state for support groups, legal aid, medical services, therapists, and other resources.

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