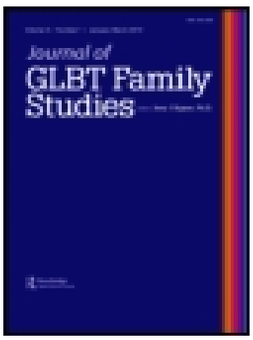

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Transforming Couples and Families: A Trans-Formative Therapeutic Model for Working with the Loved-Ones of Gender-Divergent Youth and Trans-Identified Adults

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Transforming Couples and Families: A Trans-Formative Therapeutic Model for Working with the Loved-Ones of Gender-Divergent Youth and Trans-Identified Adults

Rupert Raj

ABSTRACT. The recent emergence of gender-divergent youth and trans-identified adults presenting in therapy, in tandem with the scant clinical work with their partners and families, indicates a serious gap in the research literature. In addition, there is a critical need for an increase of clinically-sensitive and culturally-competent therapists who can provide support for these transforming couples and families. To be effective, such treatment interventions must be grounded in a sound body of gender-diverse and transgender knowledge. This paper identifies a number of clinical issues experienced by gender-normative partners and family members (who are often an integral part of the transforming process) who are working towards acceptance of their gender-anormative loved-ones. Effective psychotherapeutic and psychoeducational interventions to help meet the challenges facing these transforming families and couples are outlined by means of the author's Trans-formative Therapeutic Model (TfTM). The model demonstrates ways to support the partner or family member(s) in conjunction with the trans-identified or gender-divergent loved-one as a cohesive and dynamic systemic unit. Specific clinical application of the TfTM are illustrated through a case study of a young gender-divergent child and hir family.

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KEYWORDS. Transgender, gender divergence, Trans-formative Therapeutic model, transpositive support, families of transgender individuals

A literature review over the past four decades—when transsexuals and crossdressers first approached clinicians for help to resolve their intense, chronic sense of gender discomfort or Gender Identity Disorder—reveals scattered references to clinical work with the partners and families of transpeople. Fortunately, this gap was initially bridged in part by the self-help works of two male crossdressers (Prince, 1967, 1969, 1971; Roberts, 1995) and by the therapist wife of a crossdresser (Rudd, 1989, 1990, 1995). Clinical reports first began to appear in the 1980s (Docter, 1988; Peo, 1988; Weinberg & Bullough, 1988) and the 1990s (Brown, 1998; Brown & Rounsley, 1996; Bullough & Bullough, 1993; Cooper, 1999; Di Ceglie, 1998; Kelley, 1991; Miller, 1996; Ramsey, 1996; Rosenfeld & Emerson, 1998), resulting in continuing interest in working with families and partners of transgender individuals (Benestad-Pirelli, 2001; Carroll, Gilroy, & Ryan, 2002; Cohen-Kettenis & Pfafflin, 2003; Cole, Denny, Eyler, & Samsons, 2000; Ellis & Eriksen, 2002; Lev, 2004; Reynolds & Caron, 2000; Vitale, 2004). Most of these clinical studies, however, focus on research, e.g., assessment and data collection, rather than treatment modalities involving counseling and therapeutic support.

The rapidly growing emergence of both gender-divergent[1] and trans-identified[2] individuals (especially, children and adolescents) indicates a serious need for the increased availability of clinically-sensitive and culturally-competent therapists who are prepared to provide mutual support for gender-divergent and trans-identified people, their partners, and family members. To be effective, such clinical interventions must be grounded in a sound body of gender-diverse[3] and transgender knowledge which is now emerging with the recent definitive work of Ari Istar Lev (2004) and the promise of future contributions to the collective research effort.

This paper draws upon the author's clinical experience as a trans-identified psychotherapist working in a GLBTT[4] program in a community-based, health centre in Toronto, Canada. In this paper, I identify a number of issues experienced by: 1) gender anormative (gender-diverse) persons disclosing their gender-divergent or transsexual/transgender identity and/or their intent to reassign their sex or gender[5] to their partners, parents, grandparents, children, grandchildren, siblings and/or other relatives; and 2) gender-normative partners and family members who are working towards acceptance of their gender-diverse loved-ones. Effective psychotherapeutic

and psychoeducational interventions to help meet the challenges facing these transforming families (Boenke, 2003) and couples are outlined, and their specific clinical application demonstrated by means of a case study. Selected resources are included in Appendix A.

COMMON ISSUES FACING LOVED-ONES OF GENDER-DIVERGENT AND TRANS-IDENTIFIED PEOPLE

The partners and family members of transsexual and transgender people commonly experience a multiplicity of issues including discovery and disclosure, emotional flooding, loss and grief, current and future status of the couple or family, shifting identities and roles, possible change of status in community and society, cultural and religious concerns, and the need for support. Each of these is elaborated upon below.

Discovery and Disclosure

Discovery and disclosure can have serious impacts on couples or families including special challenges for extended family, in-laws, friends, neighbours, teachers, students, employers, and co-workers. Drawing upon the developmental stages delineated earlier in the literature (Cole et al., 2000; Ellis & Eriksen; 2002; Kelley, 1991; Kubler-Ross, 1969; Mallon, 1999; Rosenfeld & Emerson, 1998), Lev (2004) presents a four-stage model of family emergence which aptly describes this Trans-formative process that is discussed in greater detail in a later section. Lev's (2004) stages include: 1) discovery and disclosure; 2) turmoil; 3) negotiation; and 4) finding balance.

Disclosure and its management can vary considerably in terms of the subject and the object. A trans-identified parent telling a child (Anderson, 2003; Harris, 2003; Israel & Tarver, 1997; Lev, 2004) that sie[6] (the parent) is transsexual or transgender and/or that sie intends to transition to the other sex is quite different from a gender-divergent or trans-identified child telling a parent that sie (the child) identifies as the other sex, and/or wants to take cross-sex hormones to feminize or masculinize hir[7] body (Israel, 2005; Israel & Tarver, 1997; Xavier, Sharp, & Boenke, 2001), which is different again from a trans-partner telling hir partner (Harris, 2003).

Disclosure can be accidental or intentional; spontaneous or planned; erratic or strategic. The particular means of disclosing one's gender divergent or gender transforming secret to a partner or family member can vary in

terms of the sense of safety and degree of effectiveness anticipated by the gender-divergent or trans-identified person. Therefore, the revelation can take the form of in-person communication, a telephone conversation, or written communication. In-person revelation might occur in the sole presence of the revealer or with the support of an ally (partner, family member or friend). Although usually first-hand (especially to current partners and immediate family members), second-hand communication sometimes occurs with distant relatives (grandparents, grandchildren, step relatives, in-laws, etc.). Lev (2004) offers a useful set of guidelines for self-disclosure, which the transforming individual can practice with a friend or therapist, or by hirself in front of a mirror.

Emotional Flooding

A flood of feelings normally occurs upon discovery or disclosure. Some or all of these feelings are either suppressed or expressed, depending on a variety of factors: who is present at the time of revelation, how much time has elapsed, the particular temperament of the person experiencing these emotions and his or her unique expressive style as well as inherent cultural and religious values. This flooding reaction involves an overwhelming mix of emotions, such as shock, denial, anger, hatred, (Cole et al., 2000), hurt and betrayal (Reynolds & Caron, 2000), grief and mourning, (Kubler-Ross, 1969), despair and fear (Weinberg & Bullough, 1988), shame and guilt (Roberts, 1995; Zucker & Bradley, 1996), and anxiety, insecurity, uncertainty, ambivalence, confusion, and devastation (Lev, 2004).

Grief and Mourning

Grief and mourning are reactions typically experienced by family members, especially parents, when a loved-one identifies as transsexual or transgender and transitions to the other sex/gender. Kubler-Ross's (1969) five-stage bereavement model—denial, anger, bargaining, depression and acceptance—can be aptly applied to understanding these particular reactions of loved-ones of transpeople (Ellis & Eriksen, 2002; Kelley, 1991; Rosenfeld & Emerson, 1998).

The process model of Rosenfeld & Emerson (1998) elegantly explains how each of these stages impacts on the transforming family and is described as follows:

Denial. Loved-ones of gender-divergent youth or trans-identified adults often experience shock and denial upon knowing of the person's transgender status or intention to transition. Such denial can persist for a protracted

time period if the trans-person keeps quiet about hir transgender identity and only presents in the gender-divergent role from time to time. Even family members who seem to be accepting and supportive may, in fact, be in denial, believing that the trans-person will revert to their birth-assigned gender/sex. Alternatively, initial support might dissolve prior to actual body transformation by medical means.

Anger. Anger and frustration on the part of partners or family members often follow upon the dissipation of denial. Scapegoating can occur by blaming the trans-identified individual—and hir "crazy" ideas and actions—for all of the problems of the family or couple. Partners especially might experience anger and betrayal at their transgender/transsexual partner, and wonder if there are more secrets to be found out. Sometimes the couple has very little else between them except the gender problem to sustain their relationship.

Bargaining. In this stage, relatives might make threats or promises to the trans-person: a partner might threaten to leave the relationship; parents might threaten to throw their child out of the home, or even disown or disinherit hir. Alternatively, promises might be made, offering the gender-divergent relative financial means to go to university or start a business if sie gives up all intentions to pursue gender reassignment and start to act as expected by one's biological gender role. Another kind of bargaining might involve persuading the trans-person to keep secret hir gender identity, behaviour, and/or intention to transition due to a belief that gender transgressive (anormative) behaviour is problematic (and thus, shameful).

Depression. Often partners or family members become depressed as the reality of the transgender experience becomes more concrete and immediate. The depression might involve grief as well as somatic symptoms and even physical illness. Alternatively, it might be the trans-person who becomes ill as a diversion from the focus on gender. Inappropriate and unhealthy acting-out behaviours, e.g., withdrawal, substance use, loss of employment, divorce, even suicidality, might occur—often in addition to guilt and blame—not only by the trans-person but also by the partner or other family members.

Acceptance. Loved-ones come to accept reality to the point where they no longer strive to change their transgender/transsexual partner or relative. Such acceptance, however, does not necessarily mean agreement with the trans-person, instead, it means a letting go of focusing on how things could be different. Significantly, there is a clear feeling of loss, especially, in parents. Such feelings of loss, however, can be positively transformed: for example, parents perceiving their child's gender reassignment as the death

of their son and the birth of their daughter. Family members might also start to express concern for the welfare of the transsexual/transgender loved-one with regards to hormone therapy, sex-reassignment surgery, inability to maintain a job and relationships, and to effectively integrate into a transphobic society.

Current and Future Status of Family Relationships

A change in the status quo poses a serious problem for most transforming couples and families. Exactly how that transition might affect the future status of the system largely depends on the pre-existing nature of the particular relationships between/among the trans-person and hir partner, parents, children, and siblings. In certain instances, couples and families have been able to remain intact by transforming at the same time as the trans-person. In some cases, specific roles and relationships might be modified as a result of naturally evolving changes in identities and presentations. Power dynamics might or might not be similarly impacted especially between children and the transitioning parent or between partners.

Shifting Identities and Roles

Loved-ones face the challenge of shifting roles and relationships as identities and presentations continuously evolve. More often, it is not only the trans-loved-one who is changing how they publicly identify and present to the world. This disruption within a family system often causes confusion for the partners, children, parents, and other family members. A possible change of status in the community and in society is frequently an issue for loved-ones of transpeople depending on location, sociocultural, ethnoracial, and religious affiliations. Concerns around potential or actual social stigmatization, community exclusion, or religious excommunication can manifest in partners or family members in addition to sentiments of embarrassment and shame.

Cultural and Religious Concerns

In certain ethnoracial cultures and religious communities, often those of patriarchal and fundamentalist or orthodox faiths, gender-divergent and trans-identified individuals are typically treated with ambivalence (Naranda, 1994) or extreme ostracism (Ghasemi, 2003). They are sometimes ousted from places of worship, their homes, communities, cities and countries of origin. This author has worked with a number of trans-children

whose parents rejected them on religious grounds causing a seemingly irreparable rift. These forms of cultural and religious stigmatization often extend to anyone who supports or is even associated with a gender-transgressive person. Equally important to many transpeople and their loved-ones is the need for a connection to a trans-positive spiritual community (Gapka & Raj, 2003).

The Need for Support

Just as many transpeople find they require support from others like themselves, many partners, parents, and children of transpeople need to normalize their feelings, share their experiences, and work together to make a safer world for their trans-loved-ones (Tuerk, 2003; Xavier, Sharp, & Boenke, 2001). Community-based groups for SOFFAs (Significant Others, Family, Friends, and Allies) often exist in large urban centres (see Appendix A) and can provide substantial aid to family members who are also going through their own transition.

SPECIFIC CHALLENGES FOR COUPLES AND FAMILIES OF TRANSPEOPLE

Partners

Specific issues for the partners of transpeople involve a potential change of gender roles, which might undergo various shifts in accordance with the changing gender role of the trans- partner. For example, the husband/butch and wife/femme/queen gender roles might reverse in some couples or alternatively each partner might move towards gender neutrality. In trans- couples (or butch-butch or femme-femme relationships), gender roles might evolve and modify in innovative and versatile ways. The interrelationship of four continuous dimensions of physical sex, gender identity, sexual orientation, and sexual-orientation identity will very likely have multiple impacts on both partners (Raj, 2002).

Further, the partner of the trans-person may undergo some changes in hir own sexual orientation and sexual-orientation identities given that some transpeople have reported switching their sexual attraction before, during, or after transition to publicly reidentify as gay, lesbian, or bisexual (Bockting, 1987; Coleman & Bockting, 1988; Devor, 1993; Feinbloom, Fleming, Kijewski, & Schulter, 1976; Nataf, 1996; Nettick & Elliot, 1996; Tully, 1992; Weinberg, Williams, & Pryor, 1994), or as heterosexual,

transensual,[8] or pansexual[9]. Undoubtedly, adaptations around sexually relating within these transforming couples are bound to occur.

Trans-identified Children

Particular concerns for the parents of trans-identified or gender-divergent children impact the parent-child relationship. What these specific issues are and exactly how a parent will react to hir gender-divergent or trans-identified child will be influenced by several factors including age, sex, gender, developmental stage, past history and current life situation of the child as well as the unique dynamics between the child and each parent and the family. In certain cases, the parents might be in conflict about how to react to their gender-divergent or transitioning child. In other cases, they might be mutually rejecting or supportive.

An additional concern is the responsibility to do the right thing for their child—perhaps deriving from a sense of guilt connected to the perception that they were ineffective, abusive, or neglectful parents when confronted by opposing views espoused by teachers, guidance counsellors, family doctors, psychiatrists, social workers, probation officers, priests, or other faith leaders

Children of Trans-identified Parents

Challenges facing the children of trans-identified parents will inevitably revolve around the child-parent relationship including custody, access, and parenting issues. The actual impact on children in transforming families varies, depending on the child's age, sex, gender, the relationship with each parent, the sense of personal and familial security, developmental stage, cognitive ability, past history, and current life situation. Litigation around custody and visiting rights, especially in the United States, is one of the biggest challenges facing separated/divorced trans-identified parents and their children. Parenting is another issue for families in which an adult transitions, including single parenting or co-parenting, possible shifting of parent roles, and children potentially challenging parental authority.

Families

Lev (2004) highlights a unique challenge faced by those families in which both the child and the parent identify as transsexual/transgender (or

gender-divergent), as most trans-parents do not welcome gender divergence in their offspring (Brown & Rounsley, 1996). Attention needs to be focused on optimizing therapeutic support to these increasingly emerging family constellations.

Other family members might also be affected by the transitioning person, including siblings, cousins, uncles, aunts, nephews, nieces, grandparents, grandchildren, in-laws, and other distant relatives. These particular challenges and how they are met can be both complex and creative (Boenke, 2003; Gapka & Raj, 2003).

INTERVENTIONS FOR LOVED-ONES OF TRANSPEOPLE

The interventions for loved-ones of transpeople can be clinically-oriented—psychotherapeutic and psychoeducational—as well as community-based peer-support. Psychotherapeutic intervention can take the form of individual, couple, or family therapy and can be short- or long-term. Psychoeducational resources often involve population-specific bibliotherapy, e.g., books, articles, videos, DVDs, Web sites, as well as workshops and groups. Community-based peer-support is population-specific, including in-person (group meetings or one-on-one get-togethers), over the phone (private individual conversations) or online (listservs, Web sites, chatrooms) (see Appendix A).

As a more clinically-effective way to support the partners and families of transpeople and gender-divergent persons, in particular, the author has developed a treatment model specifically for this population which incorporates a series of educational and therapeutic strategies.

Trans-formative Therapeutic Model

The author's Trans-formative Therapeutic Model (TfTM) draws upon the earlier work of clinicians who support families of gender-divergent and trans-identified persons (Anderson, 2003; Benestad-Pirelli, 2001; Boenke, 2003; Cohen-Kettenis & Pfafflin, 2003; Cooper, 1999; Di Ceglie, 1998; Harris, 2003; Israel & Tarver, 1997; Lev, 2004; Mallon, 1999; Rosenfeld & Emerson, 1998; Tuerk, 2003). Integral to the TfTM, the author has formulated a specific psychoeducational tool (teaching model) for use in clinical practice with this population namely, the Continuum Strategy (described further below).

The word *trans-formative* means: "having power, or a tendency, to transform." (Guralnik, 1970). It is the adjectival form of the verb, transform: a) "to change in composition or structure;" b) "to change the outward form or appearance of;" c) "to change in character or condition." Essentially, the word transform implies a major change in form, nature or function and is an apt description for a therapeutic model as it relates to transforming couples and families.

The focus of this writer's Trans-formative Therapeutic Model is on supportive treatment interventions rather than on the developmental process experienced by the transforming couple or family, although both the therapeutic process and the family development process are inextricably bound together.

Background Models

Two examples of the latter include the Staged Treatment Model (Rosenfeld & Emerson, 1998) which parallels the Bereavement Model of Kubler-Ross (1969), and the Family Emergence Stages Model developed by Lev (2004). Rosenfeld and Emerson's (1998) model is made up of five stages**:** 1) Denial; 2) Anger; 3) Bargaining; 4) Depression; and 5) Acceptance (which are described in the earlier section on grief and mourning).

Family Emergent Stages Model (Lev, 2004). (1) Discovery and Disclosure. The first stage for most families involves the revelation of gender divergence or transgenderism/transsexualism in a loved-one. Shock, betrayal and confusion are commonly experienced by family members. Even when there is an awareness of the gender issue, the realization of its significance can be emotionally devastating. (2) *Turmoil*. This stage is often fraught with chaos and turbulence. Family members may withdraw or become emotionally volatile. This is typically a time of much stress and conflict for families struggling to come to terms with the reality of gender divergence. (3) *Negotiation*. This stage is a time of negotiation for families. Partners and family members come to realize that the gender issue will not go away and must somehow be adjusted to, so they engage in a process of compromise. This means determining what they are comfortable living with in terms of transition issues and what limits the family can set on the gender-divergent person's gender expression. (4) *Finding Balance*. In the final stage, there is a striving for balance in the relationship or family system. Balance does not necessarily mean gender transition for the

trans-identified loved-one nor does it automatically signify permanent resolution of the gender issues. It means that transgenderism/transsexualism is no longer a secret, that the family is no longer in turmoil, and has negotiated the larger transgender issues. A distinction between secrecy and privacy is understood and the family is now ready to re-integrate the transgender member—as a trans-person—into the normative life of the family.

Tuckman Model (1965). There exists an interesting parallel here between these transforming relationship and family dynamics and the classic stages of group development as conceived by Tuckman (1965): forming, storming, norming, and performing. These stages are described immediately below as highlighted by an innovative team of group dynamics researchers (Allen, Mehal, Palmateer, & Sluser, 1995): (1) *Forming*. This formative stage is analogous to infancy in human development. The family members are dependent on the leader. There can co-exist both excitement and anxiety about the unknown, and members will tentatively explore what behaviour is acceptable for the group and how they will fit in. There are concerns about inclusion, belonging, acceptance and rejection as well as goals and expectations and a wish to be oriented to the tasks at hand. Differences are emphasized over similarities at this preliminary stage and there is suspicion about what the group is about. Typical behaviors include polite, cautious small talk, dependence on the leader, hesitant participation, and intellectualism or evasion. (2) *Storming*. This is the stage of conflict, control and resistance, and resembles adolescence in developmental psychology. Some group members might feel that the group is not real. Some members might become hostile or overzealous as a way to exercise control because of their resistance to losing their individuality and becoming a group. This resistance sparks conflict in the group, which lacks unity and can create schisms. Pessimism and restlessness predominate. There are concerns about status, power, control, authority and conflict. Authority figure issues from the past often surface, and a resistance to performing tasks that are perceived as conflicting with personal needs. Behavioral reactions characteristically involve power struggles, criticism of the leader, conflict amongst members, polarization of group members, self-righteous and judgmental attitudes, as well as a move to more risky, controversial topics and ways of working together. (3) *Norming*. This is the Transformative stage which parallels young adulthood in human development. Group members experience a breakthrough in their process, whereby a catalytic event will transform a collection of self-serving individuals into a

collective (or microcosmic community) in which the focus shifts from self to group. Members start to accept the differences of others in the group and commit to the idea of working as a team. Implicit and explicit rules formerly agreed to by the group are now developed and solidified to help them work as a cohesive system. The major areas of focus include: enhancing group building and maintenance roles, a need to work interdependently, various leadership roles shared by many members, concern about rules and agreement, a sense of toleration for differences, efforts to achieve greater harmony, a new sense of team, members finding their places in the group, and increased comfort in making mistakes. Typical behaviors constitute a willingness to try new behaviors and take risks, an openness to listening and genuine sharing, a win/win approach, a sharing of ideas instead of grandstanding, and a commitment to change for the group's sake. (4) *Performing*. This stage focuses on action, and its analogue in the developmental process is adulthood. The group has developed a capacity to solve problems, resolve differences, make decisions effectively and work together in a cooperative fashion. This stage focuses on deep commitment, warmth and mutual caring; cohesion and commitment to the task and the group; and a preference to function effectively rather than be right. Characteristic behaviors comprise effective problem-solving, respectful joking, affection and playfulness, mutual encouragement and support, and the acceptance and valuing of differences. A final stage is added to this model (Allen, et al., 1995). (5) *Adjourning*. This is the leaving or adjourning stage which parallels late adulthood in human development. Groups about to disband often experience separation anxiety, and the letting go and grieving process is similar to that felt over other losses in life. Groups appreciate the leader taking charge and helping them through the final stage of dissolution. Characteristically, there are concerns about disengaging from one another, evaluating group and personal achievements, a sense of loss and grief, an eagerness to apply new knowledge and skills, preparing to leave and getting ready for the next steps sorting out old wounds and losses, and some fear for the future. Typical behaviors involve confusion about feelings, a return of dependence on the leader, tiredness, acting out and fight or flight responses due to grief, brainstorming ways to apply new learnings to the outside world, and an ultimate acceptance that the original reason for the group no longer exists and it is time to move on. (Of course, whether or not this last stage of dissolution will apply to the particular couple or family situation depends on the specific transformational dynamics at the time).

STEPS OF THE TRANS-FORMATIVE THERAPEUTIC MODEL

The steps of the Trans-formative Therapeutic Model include:

1. *Identifying Treatment Goals* (identify and prioritize the goals, needs and expectations of the couple or family),
2. *Hearing the Stories* (actively listen to the narratives of the partners/family members, tracing both the main and the back stories, as well as the primary themes and any metaphors that might arise),
3. *Validating* (validate the positive and negative affects of the loved-ones as well as the gender-divergent/trans-identified individual),
4. *Challenging* (debunk myths, stereotypes and assumptions around gender diversity, and challenge the status quo, as applicable, by employing such psychoeducational interventions as the continuum strategies and others),
5. *Reframing*(break down existing paradigms and shift the frame from entrenched to innovative thinking, e.g., crisis can mean a combination of danger and opportunity as in a critical opportunity for creating Trans-formative change),

7a. *Transforming*/*Resolving* (perturb the system of the couple/family by attempting to support and facilitate its developmental process to continuously adjust and adapt, evolve and transform, while reasonably intact, and work towards the ultimate resolution of ongoing conflicts over time), or

7b. *Transforming*/*Dissolving* (of course, the ideal is the resolution stage in which the systemic unit is somehow able to remain intact within a healthy dynamic; in the event, however, the couple separates or the family ousts or loses its trans-identifed member, strive to facilitate a supportive disengagement or dissolution process that is as mutually respectful and constructive as possible, with the possibility of alternative or future Trans-formative configurations: e.g., a separated/divorced couple who are committed to respectful co-parenting of their children, or a family that is still able to maintain some connection between at least some family members and the [perhaps] somewhat estranged gender-divergent member),

8. *Strategizing* (logistical management: help plan and implement strategies around disclosure management, identity management, shifting of relational/familial identities and roles, ensuring safety and privacy, etc.),

9. *Clinical Referrals* (refer to appropriate clinical resources, including *psychiatric* assessments, as indicated: e.g., you might need to make a referral to a "gender-affirming" and knowledgeable psychiatrist to assess the partner or family member [such as a young child or adolescent, as requested by the parents] for Gender Identity Disorder or another differential diagnosis),
10. *Community Linking* (link up with relevant community, peer and professional, e.g., legal supports as required),
11. *Liaison and Advocacy* (liaise with and advocate to relevant stakeholders as necessary),
12. *Ongoing Support* (provide emotional and practical support as needed),
13. *Evaluating Treatment Outcomes* (monitor and evaluate the therapeutic outcomes of the couple or family, as well as the efficacy of specific clinical interventions employed and the overall model).

An integral component of the Trans-formative Therapeutic Model is the systemic nature of the developmental and therapeutic processes involved in working with this client population. Several family therapists (Benestad-Pirelli, 2001; Mallon, 1998; Rosenfeld & Emerson, 1998) have applied Family Systems Theory to their clinical work with families of gender-divergent and trans-identified individuals:

- Mallon (1998) brings a holistic approach to his clinical work with gender-divergent children and their families. His ecological framework focuses on children and their environments as an inter-related system (dynamic unit) rather than imposing counter-intuitive interventions to try to correct the maladaptive child.
- A similar systemic framework is eloquently articulated by Benestad-Pirelli (2001) in both hir theoretical perspective and treatment approach. An openly bi-gendered physician and psychotherapist, sie views the world as the problem—not the gender-divergent or trans-identified youth. Further, sie applies a sociodynamic or systemic strategy when attempting to support not only the gender-diverse child or adolescent but also hir parents and other family members by calling upon the support of all stakeholders of the transforming family: principal, teachers, guidance counsellor, social worker, prospective employer, faith-leader, extended family members, the parents' friends, the child's friends (and their parents), neighbors, community members, etc. (as applicable).
- Rosenfeld & Emerson (1998) introduced the innovative strategy of having a family ceremony for families in which one member is reassigning

or has reassigned to the opposite sex as a way to publicly celebrate this transitional milestone (and rite of passage) for all members of the family system.

Not only does the systems-support approach benefit the gender-divergent or trans-identified child, adolescent, or adult, it also serves to substantially diminish the overwhelming feelings of concern, anxiety, confusion, uncertainty and isolation experienced by the partner, parents or other family member(s) and the burden of responsibility to do the right thing in relatively uncharted territory. This systems-support approach has also been effectively implemented by some parents of PFLAG (Parents and Friends of Lesbians and Gays).

The Continuum Strategies

Several continua for use in clinical practice with partners/families and gender-divergent and trans-identified people have been formulated as part of the Trans-formative Therapeutic Model: (1) Four Continuous Dimensions (Raj, 2002); (2) The Continuum of Denial to Acceptance to Celebration (Raj, 2003); (3) A Continuum of Transpositive Support (Raj, 2002); and (4) the integral Continuum of Transpositive Para-Medical and Medical Interventions (Raj, 2002). These continuum strategies constitute Step 4 (Normalizing) and Step 5 (Challenging) of the Trans-formative Therapeutic Model and can also be creatively applied, if indicated, in conjunction with other steps of the treatment model, such as Step 3 (Validating) and Step 6 (Reframing). Clinical experience, intuition and innovation will help determine more and more timely and efficacious uses of this psychoeducational application.

Specifically, the continua strategies operate as a combined educational and therapeutic tool which serve to normalize (and validate) the natural diversity of both human and animal behaviour as well as the cultural diversity of human experience. As part of the Trans-formative Therapeutic Model, these continua put into practice a series of critical interventions that will ideally help the partner/family member(s) of transforming individuals to incrementally move from denial to acceptance and hopefully beyond to celebration. These interventions constitute the heart and soul of the TfTM model: validating, normalizing, challenging, reframing, and transforming (each of which are described in the previous section, Steps of the Trans-formative Therapeutic Model).

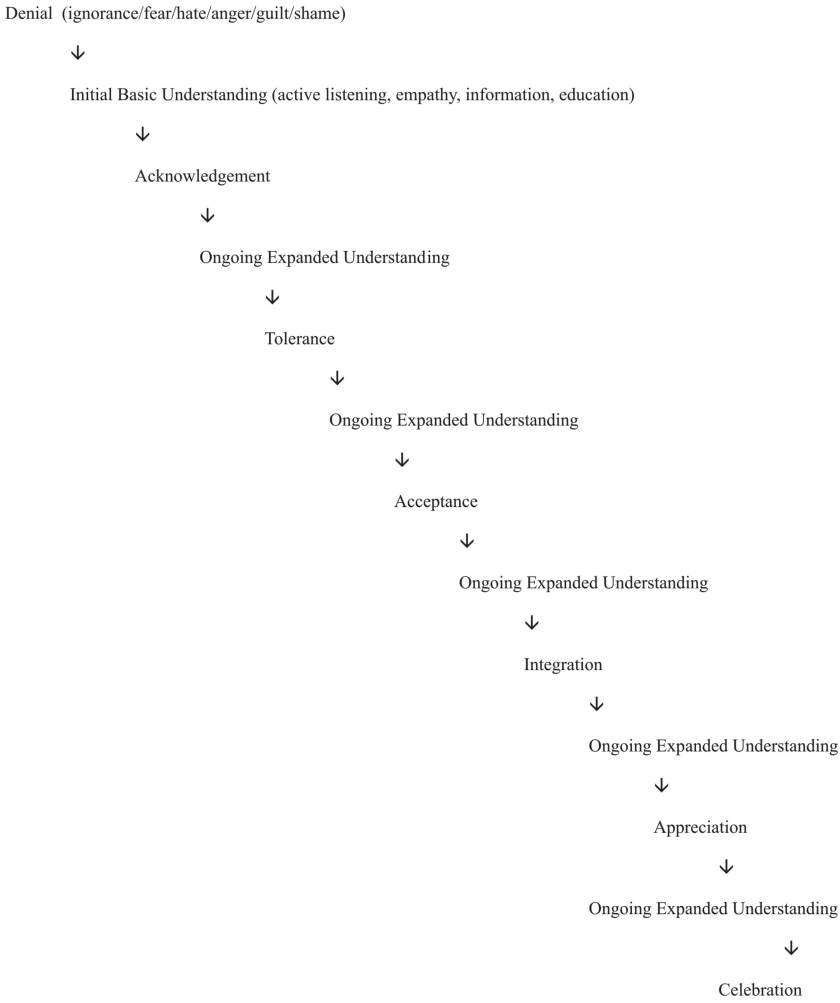
These four continua can effectively illustrate both the distinctiveness of and the intersectionality among physical sex, gender identity, sexual orientation, and sexual-orientation identity or body, mind, affectional attraction, and sexual persona.

The Continuum of Denial to Acceptance to Celebration. Building upon the clinical work of earlier researchers (Cole, Denny, Eyler, & Samsons, 2000; Ellis & Eriksen, 2002; Kelley 1991; Lev, 2004; Rosenfeld & Emerson, 1998) and particularly inspired by the Bereavement Model formulated by Kubler-Ross (1969), the author schematized a dynamic continuum (staged process) of denial to graduated acceptance of the loved-one's anormative gender identity and/or transformation to another sex potentially culminating in the ultimate ideal of celebration (see Figure 1).

This continuum is partly inspired by the Rainbow Flag (which represents sexual orientation and gender identity diversity by virtue of its graduated colors of the spectrum) and is specifically designed as a clinical and psychoeducational tool to be used with partners and family members of transpeople who are transitioning, considering doing so, or who have already transitioned. Such an intervention can be equally effective when used in couple or family counseling sessions or given as a take-home resource to foster future clinical work. The usefulness of such a schema is the opportunity it provides for developing insight and for acting as a catalyst to potentially modify/transform illogical beliefs (myths, stereotypes, assumptions) and learned values to an attitude of greater acceptance for diversity, including gender and sexual diversity.

A Continuum of Trans-positive Support. The continuum of trans-positive support is especially useful for parents (including adoptive parents) and their gender-divergent or trans-identified children and those adolescents who are under 18 years of age[10] (including those who are wards of the state). It involves non-medical and paramedical interventions as well as (potential) subsequent medical treatments (as indicated). These graduated interventions can also be utilized for young adults (ranging from age 18 to mid-20s) who might or might not be still living with their parents as a contracted means to effect the multi-staged process of transitioning to the other sex/gender. The proposed treatment plan for youth under 18 can be a staged or graduated process comprising specific dimensions of support, including, initially, non-medical supports, and gradually, over time (months or years) resulting in possible medical interventions in the future, if still desired. Non-medical (or pre-medical) supports can include psychotherapeutic/counseling, psychosocial, legal, spiritual/existential and para-medical interventions (Raj, 2002). Medical interventions might involve psychological, psychiatric, hormonal and/or surgical treatment interventions.

FIGURE 1. The Continuum of Denial to Acceptance to Celebration (Raj, 2003)



WORKING WITH PARTNERS AND FAMILIES

Transgender and Non-Transgender Partners

There is a dearth of clinical material which focuses specifically on support for partners of transsexual and transgender people (Brown & Rounsley,

1996; Carroll, Gilroy, & Ryan, 2002; Cole et al., 2000; Ellis & Eriksen, 2002; Israel, 2005; Lev, 2004; Miller, 1996; Reynolds & Caron, 2000), and very little is related to support for wives and their male crossdresser husbands (Bullough & Bullough, 1993; Docter, 1988; Peo, 1988; Prince, 1967, 1969, 1971; Roberts, 1995; Rudd, 1989, 1990, 1995; Vitale, 2004; Weinberg & Bullough, 1988). While there has been some focus on the sexual orientation, identities, and behaviors of transpeople themselves (Coleman & Bockting, 1988; Devor, 1993; Feinbloom, Fleming, Kijewski, & Schulter, 1976; Israel & Tarver, 1997; Lev, 2004; Nataf, 1996; Nettick & Elliot, 1996; Raj, 2002; Tully, 1992; Weinberg, Williams, & Pryor 1994), their partners were not always included in studies.

Based on this author's experience, there are at least five distinct partner trans-identified populations which present in therapy: 1) heterosexual husband-and-wife marriages where the husband is a non-trans-identified or non-transitioning male crossdresser; 2) heterosexual married couples in which one spouse is transitioning to the other sex/gender; 3) queer (lesbian or gay) relationships, in which one of the same-sex partners is now identifying as transsexual or transgender; 4) bi/polysexual unions in which one partner is reassigning their sex/gender; and 5) a trans-identified partner whose partner also identifies as transgender either concurrently or subsequently.

Trans-Identified and Gender-Divergent Children and their Families

Abuse, neglect, rejection, and abandonment are some of the major concerns facing gender-divergent or trans-identified children. Sometimes children decide to run away from the home, in effect abandoning their families before their families abandon them. An effective treatment model is based on a Family Systems Theory framework—one that focuses on these complex, interdynamic relationships and strives for a cohesive and ever-evolving, transformational system. Benestad-Pirelli (2001) prefers universal systemic supports in her clinical work with gender-divergent or trans-identified youth and their parents, siblings, teachers, classmates, guidance counselors, social workers, faith and community leaders, prospective employers. This also is true for Mallon (1999) in his ecological framework of holistic therapy with trans-children and their family members. The British (Di Ceglie, 1998) and Dutch (Cohen-Kettenis & Pfafflin, 2003) treatment approaches are similar insofar as they strive for the amelioration of emotional, behavioral, and relationship difficulties, and work toward breaking

the secrecy around gender divergence/distress, thus overcoming barriers to the development of healthy family functioning. In addition to the more psychodynamic therapies, treatment interventions might include cognitive behavioral therapy, social skills training, mediation therapy, parenting skills training, and play therapy.

Given the combined significance of the complexity of childhood and adolescent development, the uncertainty factor of later adult gender identification, and the fact that most gender-divergent children do not grow up to be transsexual as adults (Zucker & Bradley, 1996), but rather identify as gay, lesbian, straight or bisexual (and as non-transsexual) (Xavier, Sharp, & Boenke, 2001), this developmental predictor should urge caution when considering any form of premature, irreversible or high-risk intervention for young children or adolescents under 16 or 18 years of age on the part of parent and/or clinician.

Trans-Identified Parents and their Families

One of the outstanding challenges confronting trans-identified parents is that of the very real possibility of a family break-up, potentially including child custody battles, negotiation of visiting rights and co-parenting roles and responsibilities. Should the family remain reasonably intact or in those situations where the trans-parent retains some form of parenting function, additional issues might arise within the parent-child relationship(s), as the family dynamics change and possibly change again.

As the bulk of family therapy has involved the parents (and other family members) of gender-divergent and trans-identified children, clinical researchers must now expand their focus to support the needs of trans-identified parents (and grandparents) and their families.

APPLYING THE TRANS-FORMATIVE THERAPEUTIC MODEL

Case Study: Adrien(ne),[11] hir Parents and Brother

Adrienne (age seven years), is an African-Canadian, gender-divergent girl who identifies as a boy, sometimes dresses in boy's clothing at home, and likes to be called Adrien. The parents are both professionals and quite highly-educated. Adrien(ne) has one sibling, an older brother named Sebastien (age 10 years). The presenting problem is that Adrien(ne) would like to go to school as a boy but is ambivalent about taking practical steps

because sie is afraid of possible discrimination by hir teachers and confrontation (e.g., name-calling, beating up) by hir classmates. Sie desires to go to school dressed in masculine clothing, be addressed by hir boy name and male pronouns, and to be perceived as a boy. Adrien(ne)'s father and mother simply want to do what is best for their child in terms of hir gender congruity, physical and psychological safety, and overall emotional well-being. They want to have their child clinically assessed for Gender Identity Disorder [sic], and more specifically, for transsexualism along with a prescription of how to best support their child's gender identification, presentation and behavior. The parents are striving to balance Adrien(ne)'s wishes—by considering permitting hir to live as a boy outside of the home—against the potential risks of being emotionally or physically endangered at school or out in the community. Other issues include Adrien(ne)'s acting-out behaviour at home—disobeying parental authority on routine matters unrelated to gender—and the existence of sibling rivalry between Adrien(ne) and Sebastien as a result of the latter's perception of parental neglect in favour of his younger brother. The parents of this family specifically sought out the clinical assistance of gender specialists on the advice of their family social worker (who was currently providing them with therapeutic support for both Adrien(ne)'s gender- and non-gender-related issues but who felt somewhat out of his depth because of his lack of experience in this area). Given that the parents were unable to access regionally-available clinical expertise in childhood gender divergence, they searched for and eventually found the author who suggested co-therapy for the family with a psychiatrist in Toronto.

Treatment Goals. Four clinical objectives were identified: (1) to conduct a psychiatric assessment of Adrien(ne) for Gender Identity Disorder (and specifically, for transsexualism); (2) to challenge the parents' belief of being responsible for producing a gender-divergent child and reassure them that they are not blameworthy; (3) to provide the parents with some practical strategies on how to best support their gender-divergent child as sie develops over time; and (4) to offer a long-range treatment plan for Adrien(ne), hir parents, and brother in the ongoing family therapy work with their local clinician.

Treatment Interventions. The circle of care comprised a trans-identified psychotherapist, a trans-positive child, a physician specializing in adolescent psychiatry who was experienced in gender identity issues, and a clinical social worker without trans-specific experience. The clinical interventions directly involving the psychotherapist and psychiatrist were compressed within a six-week period consisting of a pre-session e-mail

contact and telephone calls, five in-office sessions, and a single telephone and several e-mail follow-up interventions, respectively. Of the five office sessions, two were conducted with Adrien(ne) alone, two with the parents alone, and one session with the three family members. (Note: Sebastien did not accompany his family to Toronto but was able to access limited clinical support by means of the family therapy sessions conducted by the clinical social worker in his hometown).

The Trans-formative Therapeutic Model was the overall treatment framework employed in this case, incorporating specific interventions with each step (described below) to address each of the treatment goals:

1. *Identification of Treatment Goals* (see the four treatment objectives cited above),
2. *Validation* [the co-therapists validated the mixed feelings, queries and concerns of the parents, while also validating the experiences, hopes and fears of Adrien(ne)],
3. *Psychiatric Assessment* (see below regarding the initial treatment goal),
4. *Normalizing* (see the second treatment goal below),
5. *Challenging* (see the second treatment goal below),
6. *Reframing* (see the second treatment goal below),
7. *Transforming* (see below in terms of the third treatment goal; further work will have to be done with this family if Adrien(ne)'s gender-divergent behavior persists and/or if a transgender/transsexual identity manifests itself in the future),
8. *Strategizing* (see below in terms of the third treatment goal),
9. *Linking*/*Referrals* (see below with respect to the second and third treatment goals),
10. *Liaison*/*Advocacy* (see final treatment goal below),
11. *Ongoing Support* (see final treatment goal below).

Regarding the initial treatment goal, the psychiatrist assessed Adrien(ne) stating that sie appeared to meet the criteria for Gender Identity Disorder for Children but without a definitive diagnosis for Transsexualism at this time.

With respect to the second treatment goal, the author presented the parents with the Four Continuous Dimensions (Raj, 2002) as psycho-educational tools to help them normalize their child's gender divergence while also relinquishing their doubts about being bad parents for having a gender-anormative child (an internalization of psychiatric parental psychopathology). Several psycho-educational resources, i.e., this writer's

schematization of The Continuum of Denial to Acceptance to Celebration (see Figure 1) (Raj, 2003), the brochure, *Our Trans Children* (Xavier, Sharp, & Boenke, 2001), a book, *Evolution's Rainbow: Diversity, Gender, and Sexuality in Nature and People* (Roughgarden, 2004) and the recent episodes of the Oprah Winfrey Show featuring young trans-identified children and their supportive parents were also made available to Adrien(ne)'s parents to help them further de-pathologize, normalize, and validate their child's gender divergence. This was with a view towards eventual acceptance of however Adrien(ne) might manifest hirself in the near or distant future. The author also connected the parents with relevant peer-supports, i.e., Transceptance: a community-based, peer-support group in Toronto for parents of trans-children; and PFLAG. A final intervention in terms of this treatment goal and the subsequent one below involved reframing, encouraging the parents to switch frames, i.e., instead of perceiving Adrienne as a troubled and potentially trouble-making daughter, why not try seeing Adrien(ne) as a tomboy who is trying to explore hir gender identity within a supportive family and a safe school and community environment as a way to ultimately finding hirself (as a girl/woman, boy/man or as a transgender person) and learning how to be happy in the world?

Regarding the third treatment goal, the author and the collaborating psychiatrist suggested several practical strategies for the parents to pursue in support of Adrien(ne): 1) providing reassurance of their unconditional love and support for their child no matter what gender sie is or chooses to identify as in the future; 2) strategic planning and disclosure management around possibly transitioning at school, i.e., drafting of a transpositive policy and guidelines, to be utilized as a template for school officials if/when Adrien(ne) chooses to present as a boy at school; 3) linking Adrien(ne) with diverse peer-supports, i.e., preadolescent transsexual and gender-divergent youth, respectively, to help hir explore a variety of options around gender identification and presentation; and 4) providing future potentialinterventions as indicated, i.e., a continuum of transpositive support for youth which includes both pre-medical and non-medical supports (Raj, 2002).

For the final treatment goal, the author and the collaborating psychiatrist made a recommendation to the family to continue working with their regular family social worker for ongoing therapeutic and advocacy support with additional assistance from this writer, as required. A Continuum of Trans-positive Support (Raj, 2002) could also be incorporated into the long-range treatment plan, as appropriate.

Treatment Outcomes. Adrien(ne) (as reported by hir parents) is still using this preferred (masculine) name at school and out in the community but also

answers to both male and female pronouns. Sie continues to dress at home in boys' clothes but has decided to delay (for the present time) wearing masculine attire outside of the home instead opting for more androgynous dress. The family is still engaged in therapy with their local clinical social worker and appears to have resolved some of the presenting problems, e.g., Adrien(ne)'s cross-dressing and cross-gender behaviour and attendant safety issues outside of the home, and are still in the process of working on the remaining issues, e.g., Adrien(ne)'s occasional acting out at home and the sibling rivalry between the two brothers—both behaviours of which have progressively diminished. The parents periodically communicate with the author regarding the ongoing progress of Adrien(ne) and hir family.

CONCLUSION

This paper has highlighted some of the common issues facing the loved-ones of trans-identified and gender-divergent people as well as the corresponding need for relational and familial acceptance of transpeople. A number of treatment interventions were presented to help support the partners and family members who (very often) are an integral part of the Trans-formative process. These interventions were clearly illustrated in the case example of Adrien(ne) and hir family.

This author's over-arching Trans-formative Therapeutic Model, building on earlier clinical research such as Rosenfeld & Emerson's 1998 Staged Treatment Model and Lev's 2004 Family Emergence Model, demonstrated how to support the partner or family member(s) in conjunction with the trans-identified or gender-divergent loved-one as a cohesive and dynamic systemic unit. Specific interventions incorporated into the model include psycho-educational and psychotherapeutic tools devised by this writer for use with these transforming couples and families, i.e., Four Continuous Dimensions, The Continuum of Denial to Acceptance to Celebration, and a two-tiered treatment strategy of The Continuum of Trans-positive Support and The Continuum of Para-Medical and Medical Interventions.

Similar to the queering of psychology and psychotherapy, it is hoped that recent research and practice in the area of work with gender-divergent and trans-identified people and their loved-ones will spark further interest in researchers and clinicians alike to focus on this challenging client population.

NOTES

1. Gender-divergent (aka gender-diverse or gender-variant) is distinguished from that of trans-identified (i.e., transsexual or transgender) insofar as it is not possible

for either parents or behavioural scientists to definitively determine whether a child or adolescent (especially under the age of 16 or 18 years) will subsequently identify as a trans-person in adulthood.

2. Trans-identified is a descriptor for either transsexual or transgender persons.

3. The terms gender-diverse and gender-divergent are preferred by many gender-anormative, i.e., gender-variant and trans-identified individuals to that of gender variance or gender-anormative, which is often viewed by activists as a pathologization similar to the earlier terms of sexually deviant or sexually inverted in reference to gays, lesbians and bisexuals.

4. GLBTT is an acronym for gay, lesbian, bisexual, transgender, and transsexual.

5. A distinction is made in this paper between sex and gender in terms of transitioning and reassignment to alert the reader to the fact that most transgender people wish to alter their gender (psychic identification and public presentation) but not their sex (body), whereas most transsexuals urgently desire to modify their anatomy (physical sex) to accord that of their mind or mental identity (gender).

6. Pronounced like *see*. A gender-neutral alternative to the nouns he or she coined by Feinberg (1998).

7. Pronounced like *here*. A gender-neutral alternative to the pronouns, his/him or her.

8. 1.*n*. An individual who is sexually and/or romantically attracted to transpeople. A form of sexual orientation distinct from hetero-, homo- or bisexual. Transensuals include transpeople who are primarily or exclusively attracted to their trans-identified peers; 2. *adj*. A label to describe the attraction/preference for transpeople and/or an existing relationship between two transpeople. The word was probably coined by Divinity (an American trans-identified person), as used in her Carolina Trans-Sensual Alliance of 1992. (Raj, 2002, Appendix A: Glossary).

9. Pansexual means an attraction to individuals of any of the five sexes (male, female, intersexed, transsexed); additionally, it is a term which goes beyond the self orientation identity of bisexual to include the orientation of transensual.

10. Although most primary care providers will not agree to prescribe hormone therapy for transsexuals under the age of 18, some few physicians in Canada, the UK and The Netherlands, have prescribed in the past (and still currently prescribe) cross-sex hormones for highly-selected, trans-identified youths of 16 and 17 years of age, provided that: there is no evidence of psychological instability, the applicant holds realistic expectations around transitioning and hormone therapy, is aware of alternate available options, understands the potential risks of hormones and/or transitioning (at this time in hir current life situation), and appropriate supports are in place (preferably and most typically, the parents or parent-surrogates).

11. Pseudonym

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APPENDIX A: RESOURCES FOR LOVED-ONES OF GENDER-DIVERGENT AND TRANS-IDENTIFIED PEOPLE

BOOKS/BOOKLETS:

Just, E. (1998). *Mom, I need to be a girl.* Imperial Beach, CA: Walter Trook Publishing.

Lev, A. I. (2004). *The complete lesbian and gay parenting guide*. Berkeley Trade.

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VIDEOS/DVDS:

The Adventures of Sebastian Cole. (1999). (Note: family comedy-drama about an American stepfather becoming a woman and her 17-year-old stepson). (112 mins.).

+All About my Mother. (1999). (Note: family drama about a Spanish father transitioning to womanhood and her wife and son).

+Different for Girls. (1997). (Note: romantic comedy about a British transwoman and her boyfriend).

+ + +Health on the Line III: Gender Identity (Episode 3157). (2003). Toronto: Canada: Alliance Atlantis Productions. (Note: Canadian cable-TV show aired on the Discovery Health Channel featuring a transgendered teacher/author/parent of a gender-diverse child, a trans-identified psychotherapist, a child psychologist, a child psychiatrist and a public school teacher). (60 mins.). (Order video from: http://www.discoveryhealth.ca in Canada or http://www.discoveryhealth.com in the US).

++Just Call me Kade. (2001). (Note: short featuring an American, trans [ftm] teenager and his family and friends). (26 mins). (Order from Frameline Distribution: http://www.frameline.org/distribution).

+Ma Vie en Rose. (1997). (Note: family comedy-drama about a French European, 7-year-old transgirl [mtf] and her family).

++Myth of Father. (2001). (Note: film about an American father transitioning to womanhood and her son). (28 mins.). (Order from Frameline Distribution: http://www.frameline.org/distribution).

++Nina. (2003). (Note: short featuring an Australian transgirl who wants to meet the man of her dreams). (10 mins.). Order from Frameline Distribution: http://www.frameline.org/distribution).

++No Dumb Questions. (2001). (Note: comedy-drama featuring an American uncle transitioning to aunthood and her 3 nieces). (24 mins.). (Order from: New Day Films: www.newday.com)

+Normal. (2003). (Note: TV film about an American husband and father transitioning to womanhood and her wife and children).

+ + +The Oprah Winfrey Show: The Husband Who Became A Woman. (May 6, 2003). (Preview show online or order transcript from: http://www2.oprah.com/tows/pastshows/200305/tows_past_20030506_b.jhtml).

More Husbands Who Became Women. (May 7, 2003). (Preview show online or order transcript from: http://www2.oprah.com/tows/pastshows/200305/tows_past_20030507.jhtml). "The 11-Year-Old Who Wants A Sex Change." (May 12, 2004). (Preview show online or order tran-

script from: http://www2.oprah.com/tows/pastshows/200405/tows_past_20040512.jhtml).

++Princesa. (2003). (Note: romantic comedy about a Brazilian transwoman prostitute who goes to Spain). (short). (Order from: Strand Releasing: http://www.strandreleasing.com).

++Rewriting the Script: A Love Letter to our Families. (2001). Toronto, Canada: Friday Night Productions. (Note: educational video featuring a number of Canadian South Asian queers and their family members, incl. a Canadian Eurasian transman and his sister). (Order from: Vtape: 416-351-1317; chrisak@vtape.org; http://www.vtape.org or Toronto Women's Bookstore:1-800-861-8233; info@womensbookstore.com).

++Sir: Just a Normal Guy. (2002). (Note: romantic drama featuring an American transman and his ex-husband and lesbian girlfriend). (57 mins).

+"Southern Comfort." (2000). (Note: docudrama about an American transman who dies from ovarian cancer due to transphobic medical providers and also a moving love story between a transman and a transwoman). (90 mins.).

++"TransParent." (2005). (Note: short about 19 American transmen/ftms who gave birth to their kids). (10 mins.). (Order from: http://www.transparentthemovie.com).

+Witness: The Wrong Body. (1996). (Note: TV documentary featuring a teenaged trans female transitioning to a boy and his supportive parents and therapist).

KEY

++XX to XY: Fighting to be Jake. (2003). (Note: short featuring a British, trans [ftm] teenager and his family). (18 mins.).

+mass-produced films commercially available in most video/dvd stores *or* from Amazon.com

++independent shorts/films/videos available online from the independent distributor or from Amazon.com

+ + +video-taped television programs directly available from the program producer

WEB SITES AND LISTSERVS:

Families Like Mine (US) (for children of LGBTT parents): http://www.familieslikemine.com/

Family Pride Canada: http://familypride.uwo.ca

Family Pride Coalition (US): www.familypride.org

Kids with Transgender Parents: http://www.colage.org/kids/kids_w_trnsgndr_prnts.html

LGBT Parenting Network News (David Kelley Services, Family Service Association of Toronto):

Pre-Adolescent Gender-Variant Children and their Families: http://www.dcchildrens.com/gendervariance

Queer Parenting Exchange (David Kelley Services, Family Service Association of Toronto): http://www.fsatoronto.com/ programs/dks/ workshops.html#five

Rainbow Families (US): www.rainbowfamilies.org

TransFamily: http://www.transfamily.org

Transgender Network of Parents, Families and Friends of Lesbians and Gays (TGS-PFLAG)

(US): http://youth-guard.org/pflag-tnet

Note: to subscribe, send a message to: listproc@youth-guard.org with subscribe tgs-pflag YOUR OWN NAME in the body of the message or contact the list owner: robynw.@hotmail.com

TransParentcy: www.geocities.com/transparentcy/index.htm

INDIVIDUAL AND GROUP PEER-SUPPORT:

For Gender-Divergent and Trans-Identified People and Families

Mermaids (UK): family support group for children and teenagers with gender identity issues: http:// www.mermaids.freeuk.com/

Transgender Network of Parents, Families and Friends of Lesbians and Gays (TGS-PFLAG) (US): support for transpeople and their families: Karen Gross: (216) 691-4357 or IMATMom@aol.com

For Parents of Gender-Divergent and Trans-Identified Children

Berdache (The Netherlands): peer-support group for parents of gender-divergent children

Transceptance (Canada): peer-support group for parents of trans-identified children; Primary Facilitator: Catherine: transceptance_group@yahoo.ca; Assistant Facilitator: Rupert Raj: (416) 324-4174, rraj@sherbourne.on.ca; meets 4th Thursday of the month, 7-9 pm, at Sherbourne Health Centre (Toronto, Canada). [Note: New parents, please e-mail Catherine beforehand to ensure group is meeting that week].

For Trans-Identified and Queer Parents

LGBT Parenting Network: David Kelley Services, Family Service Association of Toronto, Canada; (416) 595-0307, x270; http://www.fsatoronto.com

Parents and Friends of Lesbians and Gays (PFLAG) (Toronto, Canada): (416) 406-6378; http://www.pflag.ca

Queer Parenting Program: 519 Church Street Community Centre (Toronto, Canada); (416) 392-6874; http://www.the519.org

For Children of Lesbians and Gays

Children of Lesbians and Gays Everywhere (Toronto, Canada): (416) 767-2244; http://www. colage.org

For Partners of Transpeople

SOFFA Voices: a support group for partners of FTMs and transmen: (416) 392-6878, x325; foxylittlepeanut@yahoo.ca; meets 3rd Friday of the month, 7:30–9:30 pm, at the 519 Church Street Community Centre (Toronto, Canada) (Note: Individual peer-support for partners of MTFs and transwomen (Toronto, Canada): disclosed by discretion.)