Through personal narratives and case studies, *Social Work Practice with Transgender and Gender Variant Youth* explores the childhood and adolescent experiences of transgender and gender variant young people.

Addressing the specific challenges of transgender and gender variant youth from diverse races, cultures, social classes, and religious backgrounds, this compelling book offers practice guidance that will help social workers and the youths’ families learn more about the reality of transgender and gender variant youths’ lives. Some of the areas discussed in this work include:

- individual practice with transgender and gender variant children;
- group work practice with transgender and gender variant adolescents;
- family-centered practice with the families of transgender youth;
- internal and external stress factors for the transgender youth.

This fully updated second edition also features a new discussion of the legal issues that transgender and gender variant youth face, and a concluding section focusing on recommendations for clinical treatment with trans and gender variant youth.

The book discredits negative stereotypes surrounding these youths and offers a positive and alternative insight into their experiences. Additionally, the chapters openly address questions that practitioners may have about gender identity as well as offering concrete and practical recommendations about competent and positive trans-affirming practice with this population. *Social Work Practice with Transgender and Gender Variant Youth* will interest academics, advocates for youth, and social service practitioners.

**Gerald P. Mallon** is Professor and Executive Director of the National Resource Center for Family-centered Practice and Permanency Planning at the Hunter College School of Social Work in New York City, USA.
For Teresa DeCrescenzo
Contents

Notes on contributors xi
Acknowledgments xiii

Introduction to practice with transgender and gender variant youth 1
CARRIE DAVIS

Trans language 1
Definitions 2
Development of a trans identity for trans youth 6
Transgender space 9
Conclusions 17

1 Knowledge for practice with transgender and gender variant youth 22
GERALD P. MALLON

Introduction 22
An ecological approach 22
Sources of knowledge 23
Conclusions 33

2 Ethical issues in the mental health treatment of trans adolescents 38
STEPHANIE K. SWANN AND SARAH E. HERBERT

Introduction 38
Ethical decisions and legal decisions involving minors 39
Ethical issues in treating trans adolescents 41
Theoretical approaches to the treatment of a transgender adolescent 41
### 3 Internal and external stress factors associated with the identity development of transgender and gender variant youth

**W. Christian Burgess**

- Introduction 53
- Review of the literature 54
- Physical and psychological changes 57
- External pressures 58
- Implications for practice 61
- Areas for further study 62
- Conclusions 62

### 4 Social work practice with transgender and gender variant children and youth

**Gerald P. Mallon and Teresa Decrescenzo**

- Introduction 65
- Gender identity development in children 67
- Incidence of gender variant children and youth 68
- Transgender development for youth 70
- Is GID in childhood or adolescence really a disorder? 73
- Implications for practice 79
- Conclusions 82

### 5 Social work practice with female-to-male transgender and gender variant youth

**Sofia Pazos**

- Introduction 87
- Gender history and theory 88
- Trends experienced by FTMs during childhood 89
- Adolescence 91
- FTMs and high school 93
- FTMs and the family 95
- Current theories concerning treatment of transgender and gender variant youth 97
- Toward a strengths-based treatment model 97
6 “For colored girls only”: reflections of an emerging male-to-female transgender and gender variant youth consciousness

WENDELL D. GLENN

Editor’s prelude 104
Back story: the recognition of a sense of “difference” 105
Balancing internal and external factors 108
“For colored girls only …” 109
“Color me crazy” 111
“Keeping my craziness within” 112
Implications for practice with MTF transgender youth 113

7 Group-work practice with transgender and gender variant youth

GUS KLEIN

Introduction 115
Group-work practice 116
Assessing need 116
Establishing the purpose of the group 117
Strategies for effective intervention 118
Conclusions 120

8 Social work practice with transgender and gender variant youth and their families

KEN COOPER

Introduction 122
Sex, gender, attributes, and roles 123
Intersexuality in infants 124
Gender variation in children 126
Transsexuality 128
New gender options 131
Family transitions 132
Forming families 133
Building community, building family 134
9 Legal advocacy on behalf of transgender and gender nonconforming youth
COLE THALER, FLOR BERMUDEZ, AND SUSAN SOMMER

Introduction 139
Name changes and identity documents 140
Advocacy for transgender youth regarding employment, housing, and public benefits 144
Advocacy for transgender youth in schools 147
Advocacy for transgender youth in healthcare settings 150
Advocacy for transgender youth in foster care 152
Advocacy for transgender youth in juvenile justice settings 154
Advocacy for transgender youth in homeless shelters 157
Advocacy for immigrant transgender youth 158

10 A call for organizational trans-formation
GERALD P. MALLON

Introduction 163
Creating a trans-affirming culture 165
Trans-forming the organization’s culture 166
Concrete strategies 170
Conclusion 173

Summary of recommendations for the clinical treatment of transgender and gender variant youth
GERALD P. MALLON

Index
Notes on contributors

About the editor

Gerald P. Mallon, DSW, is Professor at the Hunter College Social Work in New York City.

For more than 33 years, Dr. Mallon has been a child welfare practitioner, advocate, and researcher. He is the author or editor of 20 books and numerous peer-reviewed publications in professional journals. His most recent publications include Social Work Practice with Lesbian, Gay, Bisexual, and Transgender People; Lesbian and Gay Foster and Adoptive Parents: Recruiting, Assessing, and Supporting an Untapped Resource for Children and Youth; and Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies, and Programs, coedited with Peg Hess.

Dr. Mallon earned his doctorate in Social Welfare from the City University of New York at Hunter College and holds an MSW from Fordham University and a BSW from Dominican College.

Dr. Mallon has lectured extensively in the United States, Ireland, Australia, Indonesia, Canada, Cuba, and the United Kingdom.

Correspondence may be sent to 129 East 79th Street, Suite 801, New York, New York 10021 or via email at gmallon@hunter.cuny.edu.

Contributors

Flor Bermudez is the Youth in Out-of-home Care Attorney based in the New York Office at Lambda Legal. She may be contacted via email at fbermudez@lambdalegal.org.

W. Christian Burgess, LMSW, is the Director, School Programs at Safe Horizon, New York. He may be contacted via email at wburgess@safehorizons.org.
Ken Cooper, LCSW, is Assistant Director of Adult Day Services at Service Program for Old People in New York City. He may be contacted via email at kcooper@spop.org.

Carrie Davis, LCSW, is Director of Mental Health Services at the Lesbian, Gay, Bisexual, and Transgender Center of New York. She may be contacted via email at carrie@gaycenter.org.

Teresa DeCrescenzo, LCSW, is Founder and President of GLASS in West Hollywood, California. She may be contacted via email at TerryD50@aol.com.

Wendell D. Glenn, MSW, is Director of GLASS Oakland Programs, Oakland, California. He may be contacted via email at wendellg@glassla.org.

Sarah E. Herbert, MD, is a Clinical Assistant Professor, PSYCH:Psychiatry, Professor Emeritus, PSYCH:Psychiatry, and a staff physician at Emory Hospital in Atlanta, Georgia. She may be contacted via email at sherber@emory.edu.

Gus Klein, LMSW, is a social worker in San Francisco, California. He may be contacted via email at augustklein@gmail.com.

Sofia Pazos, LCSW, is a social worker at the Hudson Guild in New York. She may be contacted via email at qgirl@earthlink.net.

Susan Sommer is Senior Counsel based in the New York headquarters of Lambda Legal. She may be contacted via email at ssommer@lambdalegal.org.

Stephanie K. Swann, Ph.D., is a Clinical Professor at the University of Georgia, School of Social Work, and a therapist in private practice in Atlanta, Georgia. She may be contacted via email at skswann@uga.edu.

Cole Thaler is the National Transgender Rights Attorney based in the Southern Regional Office of Lambda Legal. He may be contacted via email at cthaler@lambdalegal.org.
The original idea for writing this book came from discussions I had with Ray Berger, who was at the time this was first published the editor of the Journal of Gay and Lesbian Social Services and who is, although he is now retired, a great person to work with. His tireless quest to help practitioners and scholars to think about and write about gay, lesbian, bisexual, and transgender persons allowed me and many others to write articles and edit journal special issues that speak to the needs of persons whose voices have been marginalized. Eloise Cook from Routledge is responsible for my revisiting this work and for encouraging me to publish this second edition and shepherd me through the process. Her assistance has been invaluable.

My immediate thanks are due next to those practitioners and scholars who agreed to author the chapters that go to make up this volume. In asking each of these professionals to participate in this project, it was important for me that they be trained social work practitioners and educators. I am proud that many of the authors have been my former students at the Hunter School of Social Work or at another school of social work where I taught earlier in my career. All of these students had written in my classes so passionately about transgender persons that when I asked them to submit papers for this volume, their enthusiasm and their eagerness for contributing to this volume made this a very stimulating project for me to be involved in. Their willingness in reediting these papers written more than a decade ago was also a wonderful opportunity to reconnect.

Although I am grateful to all the authors who contributed, I must pay special homage to two of the authors. The first is Wendell Glenn from the Gay and Lesbian Social Services (GLASS) in Los Angeles. Wendell has been my mentor and my very best teacher about the lives of transgendered youth. One afternoon in a Taco Restaurant on Santa Monica Boulevard and Robertson, in West Hollywood, he changed my life. Wendell’s courage and honesty in sharing his story with me allowed me, for the first time, to really understand what it means for some people to identify as transgendered. Wendell’s deep commitment to transgendered youth and his ability to convey their experiences to me helped to free me from my
own ignorance and judgment. I will always be indebted to him for sharing this knowledge with me and for contributing to opening my mind and my heart to being a better practitioner.

Second, special thanks are also due to Carrie Davis, CSW, from the Lesbian, Gay, Bisexual, and Transgender Center in New York City. Carrie is one of the brightest social workers whom I have had the pleasure of knowing these past 33 years. Carrie’s commitment to working with trans persons in New York, and her gift for educating other social workers about how they could and should work more effectively with trans persons, are remarkable. I am delighted that I could include contributions by Carrie in this second edition so that she can share her vast knowledge of practice with trans persons with other professionals.

My thanks are also extended, as always to friends and family who supplied me with relationships that have sustained me and have given me a life outside of my work.

Finally, I would like to thank my colleague and good friend Teresa DeCrescenzo. More than two decades ago, when no one else was brave enough to do so, Terry opened the Gay and Lesbian Social programs in Los Angeles – the first group home programs for LGBT youth in the country. Terry and her partner, the late Betty Berzon, have a long history of deep commitment to the LGBT community in general and specifically to LGBT youth in need of a place to call home. Through the many joys and sometimes struggles of our lives and our careers, Terry has always been there for me whenever I have needed an ear or someone who knew what I was experiencing, and through it all, Terry has always been my good and loyal friend. For this reason and for others that are rooted in deep feelings and not always possible to express in words, this book is dedicated to her.

A word about language

The terms “transman” or “male-bodied” refers to female-to-male (FTM or F2M) transgender people, and “transwoman” or “female-bodied” refers to male-to-female (MTF or M2F) transgender people. There are some who note that terms such as “FTM” and “MTF” are subjugating language that reinforces the binary gender stereotype. In this book contributors utilized many terms to discuss the lives and realities of trans and gender variant youth, each did so with respect and with a full understanding of the current language and knowledge at the time this book went to press.
This chapter introduces knowledge which supports practice that social workers need to establish beginning competency in working with transgender and gender nonconforming youth. The concepts and variables explored in this collection require a common language. Traditional clinical social work language can often be “out of step” with the vernacular of trans communities themselves, which sometimes makes translation of ideas and concepts into practice more challenging. Trans communities have developed an inventive, expressive, and diverse language of preferred identities, terms, knowledge, and pronouns. Whenever possible, this chapter emphasizes the language, terminology, and vocabulary of trans culture, with a specific focus on trans youth, rather than the language or terminology used by social services providers.

Trans language

The trans community, as Burdge (2007, p. 243) notes, has generated a unique language with which to communicate its reality. Undoubtedly, keeping up with this changing lexicon can be challenging. Language, furthermore, is a critical component in the recognition of subjugated knowledge (Anderson, 2000; Aranda and Street, 2001; Hartman, 1990, 1992; Holbrook, 1995). Trans language is an evolutionary vocabulary that changes intergenerationally, geographically, and within a political context. Trans language is somewhat fluid and continually evolving. Some trans terms have emerged organically from within the community; others have been developed by science or academia.

Transvestite and transsexual people were first assigned global meaning in a medical and historical context during the first quarter of the twentieth century. The clinical distinction that developed between transvestite and transsexual further enhanced the perception of these as psychopathological identities. In the light of this pathologizing, trans people have begun to utilize their voices to make claim to, or reclaim, these terminologies (Davis, 2008). The creation and use of the word “transgender” in the
1960s is one example. Although obvious, it bears stating that all-gender pronouns address some aspect of sexism and complement and complicate the complexity of identity.

In seeking to understand our own subjugated knowledge, we as practitioners must remain aware that this knowledge is also produced and later interpreted under the oppressive influence of the prevailing and dominant global knowledge (Kondrat, 1995) – one steeped in an irrational fear of gender difference or cultural transphobia, as well as sexism, racism, classism, bigenderism, and so forth.

For this reason, it is not uncommon for trans communities themselves also to use subjugating language. We routinely hear references to “real,” “genetic” and/or “bio(logical)” men or women. Clearly, these conflict with both the knowledge trans people have about their own lives, and our developing understanding of gender. Every individual, trans or non-trans, is real, genetic, and biological. When misused, terms such as these create a double standard applied by non-trans people and also by trans people themselves and enforce the existing cultural hierarchy, which structures and subjugates trans people as less real and less natural than non-trans people.

Given the dichotomy between a subjugating knowledge such as that authored outside the trans communities and the knowledge derived from trans individuals, it is not surprising that the relationship between the trans communities and non-trans communities have often been uncertain, and sometimes suspicious. In this manner, social service providers and researchers focusing their efforts on trans people for much of the past century have exacerbated the contradictory and uneasy power association between the marginalization of trans people by nontrans people.

**Definitions**

Social workers should keep in mind, before launching into a discussion about definitions, that in some cases trans youth – at least initially, before they emerge into their trans consciousness themselves – may not know or have access to these definitions. Nevertheless, language is important and assists social workers in developing a higher level of comfort in working with trans youth. Based on previous work (Davis, 2008), what follows is a quick review of Trans 101 definitions as they are near the start of the twenty-first century. To that end, gender comprises several different elements:

Sex refers to biological, anatomical, or organic sexual markers such as vagina, ovaries, eggs, estrogen levels, and menstruation for females, and penis, testis, sperm, and testosterone levels for males. We tend to think of these as very clear distinctions, yet the truth is more fluid. Variations in our sex include chromosomal variations, changing hormonal levels as we
age, biological changes due to illness (such as hysterectomy, mastectomy), changes related to choice, and the varied anatomical differences faced by intersex individuals born with characteristics of both sexes (who are typically forced to undergo genital surgery at birth to make them “normal,” long before they have the opportunity to confirm their own gender).

*Gender role* can be defined as social and perceived expectations of gendered acts or expressions. Examples include cultural notions that boys play with trucks, girls play with dolls; boys wear pants, girls wear skirts; boys date girls, girls date boys. Gender role changes over time and from cultural subgroup to cultural subgroup.

*Gender* had been conceived of as distinct from sex, or sexual identity, as early as the 1860s, but it is only relatively recently that a lucid conception of gender identity as distinct from understandings of sexual identity and sexual orientation has begun to evolve. This was articulated as a private, inner sense of maleness or femaleness (Hogan and Hudson, 1998; Money, 1987) and coincided with the emergence of a gay civil rights movement. Money (1987) further developed an understanding of gender which suggests that gender is a complex combination of many factors, including variations and combinations of organic and non-organic markers including chromosomal gender, gonadal gender, prenatal hormonal gender, prenatal and neonatal brain hormonalization, internal accessory organs, external genital appearance, pubertal hormonal gender, assigned gender, and gender identity. Despite this, transgender-identified persons would be conflated with the identities of those identified as lesbian and gay, within what was termed a “gay movement.”

*Gender identity* can be understood as the self-conception of one’s gender; it is about how I see myself, how I feel about my gender identity and myself, and may or may not have an organic component. We are still learning more about this.

All three of these, sex + gender role + gender identity, combine to create one’s gender. And while gender has typically been thought of as a binary construct, as man or woman, an alternative paradigm understands gender as a continuum – as an infinite series of individually defined genders, one for each living person.

The next concept is *sexual identity*. In adolescence, puberty is distinguished by physical growth and maturation, and the elaboration of the secondary sexual characteristics. Undeniable as these biological changes are, they are still subject to interpretation and assigned cultural meanings. Developmental theorists often make a strong connection between physical or biological developmental theory and psychosocial concerns. Legislators, clergy, physicians, researchers, and other clinicians have created various methods to quantify and value the sexes. But these imposed markers of sexual identity are often incongruent with each other. Legislated sex not only can vary on the basis of the actual physical constitution of a trans
body, but may also have a geopolitical component related to what state, city, or country a trans person may happen to enter, visit, or reside in, and what borders they might cross (Currah and Minter, 2000; Currah et al., 2006; Valentine, 2007). In this framework, an understanding of one’s biology as a social construction is reasoned, and sexual identity is understood as a social, not organic, construction (Butler, 1993). Despite this, organic markers have traditionally been used to categorize individuals as either male or female, though other individuals may also be considered intersex at birth. Sexual identity, and/or an understanding of biological sex, are replaced here with an understanding of the sex that the participants had been identified as at birth (assigned sex – typically based on genital appearance and gender of rearing), the sex that individuals understand themselves to be, and the legal sex that individuals currently understood themselves as.

Transition refers to the place one perceives oneself to be in the process, or vector, from living and being perceived as identified at birth (either male or female) to living and being perceived as the trans individual understands themselves. This often includes assessment of transition milestones, sometimes described as living part time, living full time, doing “drags,” and so forth. This assessment also considers access to gender-confirming surgery, described as operative or surgical status (non-operative, pre-operative, post-operative, partly operative); and access to gender-confirming hormones (endogenous, cross-gender hormones), described as hormonal status (pre-hormones, using hormones).

The language used to describe sexual orientation (sexual, affectional, or romantic attraction) is sometimes elusive when perceived in the context of the trans communities. Terms such as straight, gay, lesbian, and bisexual/pansexual/omnisexual traditionally require agreement about individual conceptions of gender, as well as sexual identity, and are frequently framed around understandings of genitalia. Within the trans communities, these choices and language are often also valued as independent of transition milestones such as access to gender-confirming hormones or surgery.

In this phraseology, trans women attracted to men and trans men attracted to women may identify as straight, while trans women attracted to women identify as lesbian, and trans men attracted to men identify as gay irrespective of genital configuration and/or access to gender-confirming surgeries. This further develops the significance of viewing people with people with transgender histories as sexual minorities. Other choices can include queer, asexual, pansexual, omnisexual, and questioning.

In addition, there are few, if any, affirming and representative terms for individuals who prefer and are attracted to trans people, commonly referred to in the trans women’s communities with pejorative terms such
Introduction to practice

The dearth of representative terminology can confound clinicians, researchers, social scientists, and others who seek to “bag and tag” the trans communities and who attempt to label trans partners as straight, lesbian, gay and bisexual against their will, ignoring the complexities of representative identities.

Though the term transgender was not created or used until the late 1970s, transgender-identified people have been present in all cultures and at all times (Feinberg, 2001). When the modern conception of differing sexual orientations began to emerge in the 1860s, people who were seen to express their gender differently were bundled into Karoly Maria Kertbeny’s evolving definition of homosexuality (Hogan and Hudson, 1998). This has been an awkward fit, as people of transgender experience have historically sought out a variety of sexual partners, including those of the same or differing sexes.

What others have written and what I am suggesting here is clearly a modern and evolutionary language. Both “transvestite” and “transsexual” were first assigned meaning in a medical context by Magnus Hirschfeld. Transsexual was later given prominence in both Cauldwell’s “Psychopathia Transsexualis” (1949) and Benjamin’s “Transsexualism and Transvestism as Psycho-somatic and Somato-psychic Syndromes” (1954). The clinical distinction made at this time between transvestite and transsexual further enhances the perception of these as psychopathological identities.

In the light of this, trans people have begun to utilize their voices to make claim to, or reclaim, these terminologies. The reconfiguration by some trans people of the word most commonly read as “transsexual” to read as “transexual” (with a single “s”) is a poignant example of the reclamation of trans identities by trans people. Riki Ann Wilchins (1997), one of founders of Transsexual Menace, notes that

[t]his … seemed a way of asserting some small amount of control over a naming process that has always been entirely out of my hands – a kind of quiet mini-rebellion of my own. I think transactivist Dallas Denny captured the spirit of the whole enterprise; “Yeah, we’ll change it to one ‘s’ until they all start using it. Then we’ll go back to two, or maybe to three.”

(p. 15)

Popularized by Virginia Prince in the late 1970s, “transgender” (or “transgenderist”) originally referred to someone who did not desire gender-confirming medical intervention and/or who considered that they fell “between” genders. Prince and others conceived transgender as a challenge to older terms that hinted at pathology or medicalized identity such as terms like “transsexual” and “transvestite.”
Transgender, created by people with trans histories to refer to trans people, is now generally considered an umbrella term encompassing many different identities. It is commonly used to describe an individual who is seen as gender different. Outside the transgender communities, people identified as transgender are usually perceived through a dichotomous lens and are commonly described as transgressing gender norms, gender variant, or gender deviant. This traditional misreading is predicated on a conception of transgender within a pathologically oriented perspective framed in a language layered in heterosexist, sexist, bigenderist, and transphobic context and meaning.

In this definition, gender difference is not regulated. A person who is identified, or self-identifies, as transgender may, or may not, live full time in a sex different from the sex that they were assigned at birth – sometimes referred to as the “opposite sex.” Being seen as transgender may, or may not, have anything to do with whether that individual has had any sort of gender-confirming surgery (GCS), also commonly known “sex reassignment” surgery (SRS). Individuals who are seen as gender different or gender questioning may, or may not, personally identify themselves as transgender.

In this way, care needs to be taken not to label or identify anyone as transgender who does not perceive themselves that way. This is particularly true for trans youth who may not have access to these terms and who may in fact initially refer to themselves as “gay,” “lesbian,” or “bisexual.”

By using the words “transgender” and/or “trans,” this chapter looks for a common language, communities, and purposes and is not seeking to erase any of the diverse identities of those individuals who identify themselves and/or are seen as androgyne, bi-gendered, butch queen, CD, crossdresser, drag king, drag queen, female-to-male, femme queen, FTM, gender-bender, gender-blender, gender challenged, gender fucked, gender gifted, gender nonconforming, gender queer, male-to-female, MTF, new man, non-op, non-operative transsexual, passing man, passing woman, phallic woman, post-op, post-operative transsexual, pre-op, preoperative transsexual, sex change, she-male, stone butch, TG, third sex, trannie/tranny, trannie-fag, trans, trans-butch, transsexual/transsexual, transgender, transgenderist, transie, trans man, trans person, transexual, transexed man, transexed woman, transsexual man, transsexual woman, transvestic-fetishist, transvestite, trans woman, tryke, TS, two-spirited, and the like. The framework provided by “transgender” as an umbrella term then serves as a transitory and common idiom, useful to connect communities and purposes.

**Development of a trans identity for trans youth**

Imagine if some non-trans children were randomly reared in a gender role opposite to that of their sexual identity – boys as girls, girls as boys (see
Colapinto’s 2001 work for a discussion of this). For many children, that event would be highly troubling and traumatic. The public, as well as mental healthcare providers, would most certainly consider this an abuse perpetrated by these children’s caretakers. Yet on some level this is what all transgender-identified children, youth, and adults encounter until they finally muster the reserves to express their actual gender identity (see Chapter 5 by Mallon and DeCrescenzo for a full discussion of the issues facing transgender children).

Coming out for trans youth begins with an increasing awareness that one is different, the sense that how one sees oneself in terms of gender and how others perceive one do not match up. In these early stages, trans individuals may be forced to compartmentalize their lives, to hide the true parts of themselves, to remain closeted at all costs – to manage their gender. Coming out is a continuous process. While it begins with acknowledging the truth of one’s identity to oneself, every trans individual finds themselves continually confronted with the risks and possibilities of coming out to family, friends, religious groups, teachers and classmates, employers and coworkers, and medical and mental health professionals.

Certainly, it seems reasonable to recognize that perceiving one’s identity as non-normative, or in this way being restricted from expressing, having to repress, or being unable to recognize one’s gender in childhood, as well as adolescence and adulthood, is in itself traumatic and, possibly, abusive.

This would then posit that the first, and perhaps most overlooked, abuse trans people experience is at the hands of (often loving) parents and caregivers in childhood. Many, if not most, trans people as children consciously or unconsciously struggle with the understanding that their gender identities are considered socially and parentally inappropriate or deviant. Since children who display differing gender roles and identities are usually punished harshly and rarely parentally reinforced, the bonds of attachment and trust between child and caregiver are certainly going to be affected.

Trans youth are consciously or unconsciously aware that gender-different behavior rarely brings about a nurturing and caretaking response from parents and other caregivers (Brooks, 2000). This can elicit a pattern of blame and guilt. Related as a protective dissociation, this could be seen as one of the first adaptive tools trans people might utilize to endure the trauma of being unable to actualize their gender identity.

**Gender management**

To survive this form of gender trauma, trans youth typically employ adaptive and maladaptive strategies of gender management. These are
usually functional, though often only temporarily, and can engender acute confusion, anxiety, and despair, often characterized as depression. Family members may overtly or covertly participate in this process of negotiation and denial. Gender management can include:

- **Repression or erasure of gender identity** by consciously or subconsciously deciding to pass quietly and invisibly in the birth-assigned gender and sex. This may involve extensive defenses, often aspects of sublimation.
- **Negation of gender identity and gender reconstruction** by consciously or subconsciously denying one’s gender and adopting behavior and expression that confirm the gender assumptions made by others about one’s identity and birth-assigned gender and sex. This often includes admission to gender-polarized groups and engaging in what is coded as hypergendered behavior such as joining the military, parenting children, and so forth.
- **Modification of gender identity** to fit within cultural norms where possible – adopting “moderately” masculine- or feminine-vectored behavior so as to express an aspect of one’s gender but still be able to fit as well as possible.

Imagine how difficult it would be to a youth to have to manage, rather than explore, one’s gender identity, through childhood, through adolescence, and possibly through adulthood. Imagine the absence of control and the feelings of helplessness this might engender. This is the context most trans youth must negotiate at a critical point in their lives when adolescent development alone can be a challenging period.

“**Transitioning**”

LGB persons sometimes have the ability to “pass,” but many trans-identified individuals do not have that privilege. Coming out for trans youth calls forth tremendous personal resources; maintaining one’s own sense of identity in the face of invisibility, oppression, and discrimination challenges one’s inner strength and determination. At the same time, one can never overestimate the stress of the closet. Having to hide one’s identity always takes a toll spiritually, emotionally, socially, and sometimes physically.

“Transitioning” brings its own stresses and emerging strengths. Think for a minute about the challenges of shifting identities. Consider as you read this for yourselves; how would you manage a transition of this magnitude? Imagine the struggle you might endure, even now, as an adult, with all the resources you have at your disposal; imagine the loss of privilege.
Now consider the same situation at age 15. What forces would confront you? How would your family and friends respond? What about your school and your place of worship? What about money and economic influence? Consider how all these forces and more would seek to erase who you are and deny your sense of self. Now consider how you might respond.

It is clear that gender difference and gender transition have the power to lead to feelings of disconnectedness from the trans person’s own family and from their family of origin due to ignorance and lack of acceptance. Trans youth can find themselves feeling disconnected from family affirmation and supports.

Though we know identification with one’s cultural group is a significant component in the development of an individual’s self-concept, many trans people delay in developing a trans self-concept— which is a devastating disconnection.

Trans youth lack suitable and positive trans role models. In the dominant culture, positive trans role models are rare. Trans people, when visible, are typically portrayed in a pejorative sense. In addition, some trans-identified people may have never met another trans person.

In addition, peer networks can be tenuous for most trans people. Peer rejection and/or isolation is one of the most dangerous aspects of a trans identity.

While trans people often experience multiple disconnections from community, trans youth of color may experience even greater disconnectedness, often feeling cut off from their racial or ethnic communities or forced to choose between their ethnic communities and whatever trans community they have begun to connect with.

**Transgender space**

Transgender and gender nonconforming individuals, particularly trans youth, typically pose a challenge to public space and how it is made available via the use and misuse of gender (Namaste, 2000). In this way, transgender youth can be at risk within ordinary public space, which refuses to overtly incorporate what could be termed trans space. Trans youth soon come to understand that trans spaces, and the trans communities that inhabit these spaces, are difficult to discover, are exceedingly fragile, and are often migratory. Those who do uncover some element of trans space, whether it be social, physical, online/electronic, or temporal, are always aware of the invisible borders, as well as the extremely hostile territory, that surround them at all times.

Anzaldúa (1999) describes space such as this as a “borderland.” Borderlands are resonant cultural zones of conflict and exchange populated by border citizens living both on the threshold and within the threshold of
that space – the borderland. Such “borderlands are physically present whenever two or more cultures edge each other, where people of different races occupy the same territory, where under, lower, middle and upper classes touch, where space between two individuals shrinks with intimacy” (Anzaldúa, 1999, p. 19). In this way, the search for enduring trans space becomes a search for an enduring trans community.

Trans space may not be readily visible or appropriate for youth. Social spaces may include clubs and bars, performance spaces, and outdoor spaces such as parks or sex-work strolls. Because of a dearth of safe public trans space, providers who serve trans communities often become de facto trans spaces, whether or not they are equipped for social or community purposes. Some trans space may be electronic and reside online – in websites, message boards, or chat rooms. Trans space may also be perceived as temporal; it varies with the day of the week and the time of day. Trans space is often subjected to police scrutiny and may close or shift its boundaries without warning. Like much of Western culture, trans spaces are usually segregated by gender (where trans men and trans women often occupy different space), class, race and ethnicity, and age. Like the dominant, non-trans culture, trans communities are ethnically heterogeneous. The experiences and histories of trans women of color are noticeably different from the experiences and histories of white trans women. The construction of an African-American or Latino/a person’s experiences of, and struggle against, multiple oppressions needs to be considered within the context of the possible construction of the existence of the trans person of color as irreconcilable with the struggle against racism, sexism, and heterosexism. In this model, the power of stereotypical images of trans people as prostitutes, as mentally ill, as men in dresses and women in suits, and as confused gay or lesbian people, cannot be discounted. The resulting erasure of the identities of trans people of color and the silencing of their voices often preclude the consideration and inclusion of their concerns.

Somatic characteristics

Somatic characteristics may play a role in the provision and access to services, especially those related to “passability.” Passing refers to the ability to be perceived and identified as a non-transgender person. The ability to pass as non-trans is seen as directly related to economic and social privilege. Aspects of passing for trans persons include facial features, height, weight, body morphology, surgical status, hand and foot size, hair, body and facial hair, and so forth. In this regard, the trans communities are very heterogeneous, with some members passing very easily as non-trans people and others being seen routinely as trans
people. Jessica Xavier (1999) describes passing and its significance to the transgender communities:

Passing affords all [trans people] physical safety in public spaces, and for those of us living full-time, job security and access to the social, economic and professional pathways of the nontransgendered. Thus the vast majority of MTFs [male-to-females] and many if not most FTMs [female-to-males] become careful observers of those with birth privilege in their chosen genders.

**Age**

Transgender youth typically confront minimal age requirement barriers for access to services, requirements for parental consent, and medical ethics issues. It is generally acknowledged that “the effectiveness of a healthcare intervention may best be measured in terms of the quality of life of the patient” (Wren, 2000). Early hormonal treatment and/or gender confirmation surgery has been shown to significantly improve the lives of trans adolescents, avoiding sometimes immutable physical changes that are the result of a puberty associated with that individuals presumed biological sex, not their identified gender. In addition, trans youth who are able to access medical care to resolve some of their intense gender concerns may be better able to complete some of the developmental tasks of adolescence, enter into satisfying peer and interpersonal relationships, and continue in school like other youth their age (Cohen-Kettenis and van Goozen, 1997; Gooren and Delemarre-van de Waal, 1996; Wren, 2000).

Despite the value of the early affirmation of self-identity and respect for self-determination that intervention can offer, minor children typically cannot access medical care without parental consent. The instances where they can, such as sexually transmitted diseases, pregnancy, and substance abuse treatment, are usually narrowly defined. In addition, emancipated minor status is not universal, subject to interpretation, and difficult for youth to accomplish easily (Russo, 1999; Swann and Herbert, 1999).

Minors encounter unique barriers to care that are presumed to end when they achieve majority status – typically at age 18. Despite this, barriers to care are perceived to extend to trans individuals in early adulthood. Education may also play a factor in barriers to care. As such, the ability to stay in school, financial means, type of schooling, and so forth are considered. Financial means is a factor in all health care and includes income, health insurance, and so forth. Aspects of support affect access to and efficacy of care. Support comprises parental consent as well as levels of support from family, community, trans families and friends, positive role models, and so forth.
Professional ethical concerns also play a role in determining treatment for trans youth. The unique situations presented by trans and gender nonconforming people often do not neatly fit into ethical codes. Ethical codes for organizations such as the American Academy of Child Psychiatry (AACP), the American Psychological Association (APA), and the National Association of Social Workers (NASW) either place responsibility for youth with their respective parents or guardians, are ambiguous, or are silent on the matter (Swann and Herbert, 1999). Though the NASW recently published a policy position supporting the needs of trans communities, the issues and concerns of trans youth were conspicuously absent (Lev and Moore, 2000).

Medical providers and clinics are often cautious when working with trans youth. “Every day, I feel torn between wanting to empower my patients and wanting to be sure not to harm them,” says Jayne Jordan, a physician’s assistant in the [Michael Callen-Audre Lorde Community Health] Center’s transgender medicine program” (Russo, 1999). In addition, not all youth that identify as transgender, gender different and gender questioning during adolescence will continue to identify themselves as transgender or transsexual in adulthood (American Psychiatric Association, 1997; Cohen-Kettenis and van Goozen, 1997). The legal ramifications of providing such care to minors in a litigious society are not well understood yet. So, while research may indicate the value of early medical treatment and care for trans youth, legal and ethical concerns and possible conflicts may erect potent barriers to that care. The role of social workers and other mental health providers can be integral to the interdisciplinary provision of services in these instances. Social workers may be able to offer information and support to youth, parents, and providers in these cases and often ameliorate legal concerns.

Absence of services

Trans people, especially trans youth, confront a critical shortage of services. In most areas, this includes a near-total absence of trans-positive providers offering medical and social services, and services concerned with mental health, substance abuse, domestic violence, shelter, HIV/AIDS, hormone-confirming therapy, and trans-masculine-specific services. In addition, trans people encounter few transgender-identified service providers. A scarcity of services in rural, suburban, or no-urban areas serves as a barrier as well as a factor exacerbating the isolation of trans people (Lombardi, 2001; Pazos, 1999).

The impact of harm reduction should also be examined in these situations. Many trans youth are acutely aware of the physical and social
problems they will later face by undergoing the masculinizing or feminiz-
ing puberty that is associated with their presumed birth or biological sex. When faced with barriers to treatment, trans youth may seek hormones from non-medical or discreditable medical providers who provide them with injectable and non-injectable “street” medications. The actual consist-
tency of these preparations is unknown to the end user and they are rarely taken under medical supervision and monitoring. In addition to the typical physical and mental health risks associated with any form of hormone-
confirming therapy, trans people who self-medicate using these substances may be subject to many of the same health risks as intravenous drug users (Denny, 1994, 1995, 2002, 2006; Haymes, 1998; Israel and Tarver, 1997; Lombardi, 2001; Russo, 1999).

Transgender identity as pathology

Identity concerns frequently obscure the identities of trans youth. Despite an increasing awareness of the harmful role that transphobic, judgmental, and discriminatory behavior by healthcare providers plays in the relation-
ship between care providers and transgender-identified people, this behav-
or is still prevalent.

In addition, trans youth often encounter hostile stares and comments, as well as stigmatizing, pathologizing, and insensitive treatment from staff at all levels of the medical and social services systems. Colucciello (1999) reports that nurses typically are unaware of the complexity of trans identi-
ties, making pejorative and dehumanizing comments such as “‘Why are they doing this?’ and ‘I do not know how to address them.’” Grimshaw (1998) warns of nurses who do not use the client’s pronoun of choice, refer to clients as “it,” or “[avoid] talking to them by always being busy.”

Disclosing one’s trans identity has many risks, including institutionaliza-
tion, violence and abuse, harassment and, possibly, homelessness. The therapy or counseling that trans people encounter is often reparative in intent or designed to obstruct or discourage the client’s stated goals and self-determination. As such, the problems that transgender youth face are similar to those faced by lesbian, gay, bisexual, and questioning youth, where much of the oppression that is casually related to homophobia is actually a fear of gender nonconformity, or genderphobia. In many instances, discrimination and oppression based on sexual orientation is often indistinguishable from that based on gender or gender identity (Mallon, 1999a). In addition, Gender Identity Disorder in Children is still used to institutionalize gender-different youth – most of whom will eventually identify as lesbian, gay, bisexual, and/or transgender (Minter, 2000; National Gay and Lesbian Task Force, 1996).

The Board of Trustees of the American Psychiatric Association’s vote to delete a previously defined mental illness by removing the diagnosis of
“homosexuality” from its Diagnostic and Statistical Manual of Mental Disorders, second edition (DSM-II) in 1973 signaled the invigoration of the gay civil rights movement. Conversely, the APA has resisted the removal or reform of gender dysphoria (which first appeared in the DSM-III in 1980), later remodeled in the DSM-IV in 1994 as the Gender Identity Disorders (GID): Transvestic Fetishism 302.3, Gender Identity Disorder in Children, 302.6, Gender Identity Disorder Not Otherwise Specified, 302.6, and Gender Identity Disorder in Adolescents or Adults, 302.85 (American Psychiatric Association, 1994). The importance of depathologizing homosexuality has been considered critical in the understanding of lesbian and gay development (Butler, 2006; Dean et al., 2000).

An understanding of a normative transgender identity may not be possible until that identity is uncoupled from its pathological underpinnings. Today, much of the focus on the pathologies exhibited by lesbian and gay people is formally directed toward the developmental concerns, stigmatization, and fear they encounter in an unaccepting and dominant culture. A similar, clinical focus toward the concerns of transgender people may also seem appropriate. Despite this, the belief that “homosexuality is a treatable, pathological condition” is still “widely held” (Olsen and Mann, 1997, p. 153) by medical students and can be assumed to translate to similar attitudes about transgender-identified people, affecting the care available to both communities. The social worker is not innocent in this discourse, and the resistance to GID reform marks a major challenge for social work practice within the transgender communities. These diagnoses continue to stigmatize trans individuals and the trans communities as suffering from mental illness, as well as severely hindering transgender civil rights efforts (National Gay and Lesbian Task Force, 1996; Lombardi, 2001; Minter, 2000; Wilchins, 1997). Blumenstein et al. note that “for many transgender people, societal stigma and the tendency for mental health professionals to continue to pathologize the trans-experience, results in secrecy, shame, depression and fear” (2000, p. 183).

Identity erasure

Few screening, intake, and assessment procedures recognize trans identities. The subsequent erasure of the consumer’s trans identity renders trans people and their unique concerns invisible, making the connection between trans identity and health needs obscure. In addition, the diversity and complexity inherent in the identities that trans people inhabit, many of which challenge clinical definition, may constitute a factor in care, as well as an access concern. Zevin (2000) notes that request to “transgender is somewhat in between, as the patient defines where they want to be. And to some doctors that has been very disturbing.”
As of this writing, many in the healthcare communities use the phrase “transsexual women” to refer to female-to-male individuals, whereas the reverse is true in the trans communities themselves, where such people are referred to as transsexual men, or as trans men. Similarly, many care providers commonly use the phrase “transsexual men” to refer to male-to-female individuals while the trans communities refer to these people as transsexual women, or as trans women. The creation and use of the word “transgender” by people with trans histories to refer to trans people is another example of this friction. Non-clinical identities such as transgender continue to make some in the psychiatric and medical communities, as well as the industries they are a part of, uncomfortable.

Ignorance of transgender identities may also confuse erstwhile allies. While the concerns of lesbian, gay, bisexual, and transgender youth overlap, many clinicians and other providers continue to stigmatize transgender, gender-questioning, and gender-different youth as “gender deviant” and “provocative.” The consequence of these transphobic attitudes is the consistent erasure of the identities of transgender individuals. The challenge, then, is to recognize that adolescence is not too early for youth to identify, or be identified, as either trans women or trans men. Dean et al. report that “within the health care system, transgendered youth probably encounter ignorance and prejudice similar to and greater than that experienced by lesbian and gay youth” (2000, p. 133). To this end, Haymes (1998) notes that “it is ironic that while the medical profession has advanced to the point of being able to effectively and appropriately treat transgender individuals, there is an internalized system-wide [trans]phobia that prohibits it from embracing the challenge.”

**Personally established barriers**

**The economic barriers of oppression**

The oppressions that trans youth face have severe economic repercussions. Trans youth may look different, or abnormal, leading to a lack of recognition of a trans morphology (Wilchins, 1997, pp. 33–35). In this way, trans youth can be “spotted,” isolated and separated from non-trans people. The violence, harassment, and discrimination associated with a perception of trans youth as exhibiting a form of deviance or pathology can deprive them of legally sanctioned employment. The resulting underemployment or unemployment, poverty, homelessness, and diminished educational opportunities create severe economic hardship.

Adolescents “are the most uninsured and underinsured of all groups” (Gay and Lesbian Medical Association and LGBT health experts, 2001). Yet economic barriers to care exist even when trans youth are covered by health insurance. Almost all health insurance explicitly excludes coverage
for any and all transgender-related mental and medical care, on the arbitrary premise that such treatment is experimental in nature (Middleton, 1997). In contrast, psychiatric diagnosis of GID conveys little formal disability protection and is specifically excluded from the protections of the Americans with Disabilities Acts (ADA).

In this context of economic and societal marginalization, sex-work and its derivations – exhibition and entertainment – have been the only historical employment opportunities permissible for many trans women, especially trans youth. This includes working as prostitutes, escorts, strippers, lap dancers, streetwalkers, telephone sex-workers, showgirls, performers, and as models or actresses for masturbatory-oriented print, film, and video materials (Dean et al., 2000; Klein, 1999, Mallon, 1999b). Scant parental support combined with absence of insurance coverage often converge and lead trans youth to sex-work to pay for the exigencies of gender transition. Despite the risk, few trans youth can fund their medical and living costs without engaging in prostitution, stripping, or other forms of sex-work. In addition, the economics of sex-work puts youth at risk for HIV/AIDS and sexually transmitted diseases, exploitation and violence, and chemical dependency.

Isolation

Social isolation may be considered one of the most significant and dangerous aspects of a trans identity (Israel and Tarver, 1997). “Isolation keeps most transgendered youth from seeking essential health and medical care until crises occur” (Dean et al., 2000).

Many trans youth quickly understand that gender-different behavior rarely elicits adult caring, and the result is an attachment problem, especially as shown in the lifelong guilt and blame that trans people experience. One might consider whether inability to live out one’s gender role in childhood is, in itself, a childhood trauma. This is what almost all transgender-identified youth typically encounter until they are finally able to express and seek support for their actual gender identity – typically during their post-adolescent development.

Identification with one’s cultural group is a significant component in the development of an individual’s self-concept. Despite the importance of this, peer networks can be tenuous for most trans youth. While support services and groups for lesbian, gay, bisexual, and questioning youth appear with increasing regularity in schools and community centers, the stigma associated with expressing a trans identity prevents most trans youth from accessing these groups and resources.

In the dominant culture, positive trans role models are rare. Many trans youth have never met another trans person. When trans people do appear in the media, it is often in a pejorative sense. These portrayals usually depict trans people as sex-workers, mentally ill, freaks, self-mutilators,
cripples, criminals, and as unlovable. In this context, trans people (1) are sought out and regularly appear on daytime talk “shock” television shows; (2) are often used to jar the conventional viewer’s sensibilities in advertising, news, and in films; (3) appear with increasing frequency on street corners and sex-work strolls (Mallon, 1999a), as well as in jails and prisons nationwide; (4) appear in the classified advertising sections of local newspapers, and in pornographic films and magazines (Rodgers, 1995); and (5) appear in anti-trans writings and rhetoric and are labeled as male saboteurs by some vocal personages in the radical lesbian feminist movement, or appear in pro-trans writings and rhetoric and are labeled as heroic gender crusaders by some vocal personages in the postmodern feminist movement (Stone, 1994). The absence of trans peers and a trans social network can reinforce the maladaptive behavior that most trans youth utilize to erase or reconstruct their identities.

Clearly, social work practice with trans youth requires a critical rereading of the relationship between the typically oppressive sources of global knowledge and the subjugated knowledge of the trans communities. The process by which trans-identified individuals and the trans communities recognize and value knowledge lies at social work’s core of valuing the “dignity and worth of the person” and the individual’s right to “self-determination” (National Association of Social Workers, 1999, pp. 4–5).

In this context, very little has been written about actual social work practice with the transgender communities. Other than Mallon’s useful Social Services with Transgendered Youth (1999a), Lev’s Transgender Emergence: Therapeutic Guidelines for Working with Gender-variant People and their Families (2004); and Brill and Pepper’s (2008) wonderful work titled The Transgender Child what is available is either outdated or very limited in scope and various program descriptions, what is available is either dated or very limited in scope (Blumenstein, Davis, Walker, and Warren, 2000).

**Conclusions**

As the social work profession moves toward developing more affirming practice models for working with transgender youth, professionals must be attuned to the complexity of working with this population and must be committed to their own continued education to work more effectively with trans youth.

It is the hope of this author and the others who have written for this publication that the information contained within these pages is a bold step toward encouraging affirming services for transgender youth and their families.
References


References

Introduction to practice with transgender and gender variant youth


Pazos, S. (1999). Practice with female to male


Chapter 1: Knowledge for practice with transgender and gender variant youth


2 Chapter 2: Ethical issues in the mental health treatment of trans adolescents


Disorder and Psychosexual Problems in Children and Adolescents. New York: Guilford Press.
Chapter 3: Internal and external stress factors associated with the identity development of transgender and gender variant youth


Chapter 4: Social work practice with transgender and gender variant children and youth


Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence is


Wren, B. (2000). Early physical intervention for young


Chapter 5: Social work practice with female-to-male transgender and gender variant youth


Chapter 7: Group-work practice with transgender and gender variant youth


Chapter 8: Social work practice with transgender and gender variant youth and their families


Riviera, S. (1999). I never thought I was going to be a part of gay history. New York Times Magazine, June 27, p. 49.


Chapter 9: Legal advocacy on behalf of transgender and gender nonconforming youth


Canell v Lightner, 143 F.3d 1210 (9th Cir. 1998).

DeShaney v Winnebago County Dep’t of Soc. Serv., 489 U.S. 189 (1989).

Doe v Bell, 194 Misc.2d 774 (N.Y. Sup. Ct. 2003).


Gilliam, J. (2004). Toward providing a welcoming home for all: Enacting a new approach to address the longstanding problems lesbian, gay, bisexual, and transgender youth face in the foster care system. Loyola of Los Angeles Law Review 37, 1037-1063.
Hawaii Youth Correctional Facility Policy. 1.43.04. (2007). Non-Discriminatory, Developmentally-Sound Treatment of Lesbian, Gay, Bi-Sexual and Transgender (LGBT) Youth.

Hernandez-Montiel v Immigration and Naturalization Service, 225 F.3d 1084 (9th Cir. 2000).


In re Guido, 1 Misc. 3d 825 (Civ. Ct. N.Y. Co. 2003).

In re Lovo, 23 I and N Dec. 746 (BIA 2005).

In re McIntyre, 715 A.2d 400 (Pa. 1998).


Nabozny v Podlesny, 92 F.3d 446 (7th Cir. 1996).


10 Chapter 10: A call for organizational transformation


