

Gaslighting in the context of clinical interactions with parents of transgender children

Damien W. Riggs^{a*} and Clare Bartholomaeus^a

^a*College of Education, Psychology and Social Work, Flinders University, Adelaide, Australia*

*corresponding author

Postal address:

College of Education, Psychology and Social Work, Flinders University, GPO Box 2100, Adelaide, SA, 5001

Email addresses:

damien.riggs@flinders.edu.au

clare.bartholomaeus@flinders.edu.au

ORCID:

Damien W. Riggs: 0000-0003-0961-9099

Clare Bartholomaeus: 0000-0001-9843-8390

Damien W. Riggs is an Associate Professor in social work at Flinders University, and an Australian Research Council Future Fellow. He is the author of over 200 publications in the areas of gender, family, and mental health including (with Clemence Due) *A critical approach to surrogacy: Reproductive desires and demands* (Routledge, 2018).

Clare Bartholomaeus is an adjunct Research Associate in the College of Education, Psychology and Social Work at Flinders University. Her research interests include gender, diversity, children/young people, and families. She is the author (with Damien Riggs) of *Transgender people and education* (Palgrave, 2017)

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Abstract

Understood as a type of identity-related abuse, gaslighting is a form of manipulation where the perpetrator attempts to convince someone that their thoughts, perceptions, or beliefs are mistaken. In the clinical context, gaslighting is often seen as part of a broader constellation of abuse and violence between adults. However it can also happen in more subtle ways, and can present in ways that are difficult to detect. This paper explores instances where gaslighting may potentially occur in clinical interactions involving parents of transgender children. Three fictionalised case studies are presented drawing on the first author's clinical work, and demonstrate three overarching forms of gaslighting: 1) deferred action, 2) intentional forgetting, and 3) placing an emotional burden on the child. Having presented the three cases, the paper concludes by discussing how clinicians might identify and respond to gaslighting, emphasising 1) speaking with children on their own, 2) speaking on behalf of children to parents, 3) modelling advocacy to parents, 4) correcting misgendering in the clinical context, and 5) using peer supervision to discuss cases. In sum, the paper argues that whilst clinicians should not rush to "diagnose" gaslighting, clinicians should also not overlook its powerful effects upon transgender young people.

Keywords: transgender children; parents; gaslighting; identity-related abuse; case studies

Introduction

Parents' responses to a child's disclosure that they are transgender can be usefully grouped at two ends of a spectrum. On the one end are parents who, even after an initial period of uncertainty, are supportive of their child, and often become strong advocates for their child (Hill & Menvielle, 2009). On the other end of the spectrum are parents who refuse to recognise their child's gender, and who may ultimately distance themselves from their child (Grossman, D'Augelli, Howell, & Hubbard, 2005).

Researchers have consistently found that children who experience the former type of response do far better in terms of psychological outcomes when compared to children who are not supported by their parents (Olson, Durwood, DeMeules, & McLaughlin,

2016; Simons, Schrager, Clark, Belzer, & Olson, 2013). Researchers have also found that parents who are supported and encouraged to be affirming are more able to do so than are those who are met with pathologising responses to their children by mental health professionals (Menvielle & Rodnan, 2011).

Whilst the two ends of a spectrum outlined above likely encompass a significant majority of parental responses, there are likely a range of other responses possible. Of interest in the present paper are responses that may at first glance appear to fall on the positive end of the spectrum, but upon further consideration may more accurately reflect a less than supportive response. Specifically, in their clinical work as a psychotherapist who specialises in working with transgender children and their families, the first author has witnessed parents who often “talk the talk”, but don’t “walk the walk”. Such parents present as well informed about transgender people’s lives, and positive about their child. Yet as time passes, a number of red flags become evident, suggesting that the parent is more of a barrier to, than a facilitator of, their child’s transition.

This paper is an attempt at exploring this phenomenon of parents who present as affirming, but who in the long run may act in ways that undermine their child. Taking a strong approach to what is often a sensitive and delicate series of negotiations between the clinician and the parents, in this paper we argue that parents who present as affirming but who may in fact be struggling to support their child engage in a form of identity-related abuse, namely gaslighting. This argument is drawn from clinical work undertaken by the first author and aims to extend the limited existing literature in this area. In the sections that follow we first overview the literature on identity-related abuse as it pertains to transgender people, before then summarising what may be gleaned from the literature about parents of transgender children in terms of gaslighting. We then present three fictionalised case examples from the first author’s clinical work, in an

attempt at further outlining some of the subtleties that distinguish affirming responses from responses that may appear affirming, but which may instead be more usefully understood as less than affirming, or even unsupportive. We conclude the paper by providing recommendations for clinicians seeking both to identify gaslighting when it occurs, and how to respond to it.

Transgender people and identity-related abuse

Identity-related abuse refers to when a “perpetrator targets aspects of the victim’s identity as a means to control or belittle them” (Riggs, Fraser, Taylor, Signal, & Donovan, 2016, p. 2377). For people who are transgender, identity-related abuse can involve physical, emotional, and/or financial abuse in relation to gender and gender presentation. More specifically, this may involve denying that someone is transgender (or that it is possible to be transgender), rejecting someone from one’s family, commenting negatively about a person’s appearance or body, intentionally using the wrong pronoun and/or name, asking someone not to disclose they are transgender to others, threatening to tell other people that someone is transgender, withholding medicine, and/or withholding money for medicines or surgery (Riggs, Fraser et al., 2016; Rogers, 2017).

A number of recent studies have highlighted that transgender people experience high levels of identity-related abuse. A large scale survey in the US of 27,715 transgender adults, for example, found that participants experienced identity-related abuse across a range of settings, with one in ten reporting violence from family members (James et al., 2016). Nuttbrock and colleagues (2010) found that of the 571 transgender women who participated in their US survey about gender-related abuse, 78.1% reported psychological abuse at some stage during their life, most often from parents or other family members during adolescence. Their study strongly suggests that

identity-related abuse is linked to major depression and suicidality for transgender women during adolescence.

Importantly, identity-related abuse directed towards transgender people does not occur in a vacuum. It is not simply a reflection of individual beliefs. Rather, it is a reflection of societal ideologies more broadly, and specifically cisgenderism, understood as the ideology that delegitimises people's own understandings of their bodies and genders (Riggs, Ansara, & Treharne, 2015). Within the context of cisgenderism, it is seen as acceptable to question transgender people's experiences, to deny transgender people's rights, to attack and discredit transgender people's views, and to subject transgender people's bodies to ridicule. This can occur in seemingly mundane ways (i.e., expecting transgender people to explain their experiences, see Riggs, Colton, Due, & Bartholomaeus, 2016), or in intentionally violent acts towards transgender people, including murder. Identity-related abuse at the interpersonal level, then, whilst reflective of individual people's views and actions (for which they are responsible), is a product of a cisgenderist society.

Parents of transgender children and identity-related abuse

To date, only a small body of research has explored identity-related abuse perpetrated by parents against a transgender child. Research by Grossman and colleagues (2005) in the US with 55 transgender young people (aged 15-21) who were involved in a mixed methods study specifically reports on identity-related abuse in families. For example, they found that nearly two thirds of the transgender young men in their study were told to stop acting like a "tomboy" by their parents, and three quarters of transgender young women were told to stop acting like a "sissy" by their parents. More than half of the participants reported that their parents thought that they needed counselling about their gender expression, and more than half of the participants reported their parents reacted

negatively or very negatively. The authors note that identity-related abuse can impact on young people's access to medical care (including counselling and hormones), as parents are typically responsible for their children's medical care, which can include not allowing a child to attend appointments.

Other studies have found that transgender young people experience identity-related abuse from their parents in the form of trying to "cure" their child by forcing them into reparative therapy (e.g. Mallon & DeCrescenzo, 2006), questioning whether their child is actually transgender (Katz-Wise et al., 2017), and suggesting their gender is a cover for other issues (e.g. Wren, 2002). Researchers have also found that transgender adults report identity-related abuse from their parents. For example, an Australian study by Riggs, von Doussa, and Power (2015) found that nearly three quarters of their 160 participants had experienced at least some discrimination from their families of origin. This was most often done by refusing to use a person's correct pronouns and names, excluding them from family events, and responding to them in pathologising ways.

Gaslighting as a form of identity-related abuse

Gaslighting has been increasingly recognised as a form of identity-related abuse. The term gaslighting derives from the storyline of a 1938 play called *Gas Light* (adapted for two films in the 1940s, including the 1944 film *Gaslight* starring Ingrid Bergman). The play and film titles (and thus term) are derived from the plot narrative, in which the male protagonist tells his wife that she has imagined the gas lights in their house dimming, as one of the many ways he attempts to make her doubt her own sanity. In the story, the male protagonist deliberately manipulates his wife for a clear motive of financial gain.

Whilst this work of fiction gives name to the term gaslighting in a more limited sense (i.e., making someone doubt their sanity), the term is now used to describe other phenomena that are nonetheless all still about power and control. Abramson defines gaslighting as:

a form of emotional manipulation in which the gaslighter tries (consciously or not) to induce in someone the sense that her reactions, perceptions, memories and/or beliefs are not just mistaken, but utterly without grounds—paradigmatically, so unfounded as to qualify as crazy (2014, p. 2).

Gaslighting is about subtly conveying to a person that their own judgment is not to be trusted and that they are not competent, thus undermining their confidence in being able to trust their own views and experiences. This can have the effect of convincing someone that they are responsible for negative events in their lives, including poor mental health. Abramson (2014) further writes that the “gaslighter” is likely to benefit in some way from their behaviours, although may have multiple motivations for doing this. Importantly, the “gaslighter” may not act consciously, and often may not recognise their own motives for their behaviour. Gaslighting is likely to take place over time, involving multiple occurrences, and may be done by more than one person (Abramson, 2014).

Gaslighting may specifically take place, or at least be particularly effective, in the face of broader power inequities (Abramson, 2014). This relates both to power relations between people, such as parents and children, as well as factors such as social norms, including around gender. Gaslighting in relation to people who are transgender may take the form of expecting transgender people to explain themselves, and opening their lives up to debate or question, thus inferring that transgender people are not experts on their gender. It can involve conflating being transgender with a mental disorder, and can cumulatively produce negative mental health impacts that act as a

self-fulfilling prophecy (i.e., repeatedly questioning or undermining a person's gender may lead to poor mental health for the person who is questioned or undermined, which is then treated as the "real" issue at hand, rather than the lack of recognition or support of their gender).

Gaslighting as directed towards transgender children by their parents

Gaslighting is particularly complex when it comes to parents of transgender children. Given that children have historically been treated as property of their parents (Ariès, 1962), and given even in the present children are still treated as though they are too naïve or innocent to understand themselves (Robinson, 2013), the views of parents are often treated as the most legitimate, and indeed the default position, when it comes to understanding children's experiences. Given, as noted above, gaslighting is centrally about issues of power and control (as is true for any form of abuse), in contexts where power differentials are already significant (such as in parent-child relationships), this can exacerbate the likelihood that control techniques such as gaslighting will occur, and minimise the likelihood that they will be identified by others.

The existing literature on transgender children and their parents has not focused specifically on gaslighting, however several sources suggest, for example, that parents may overemphasise safety concerns for their child in an attempt to limit actions which affirm their gender. In particular, parents may depict themselves as supportive, yet instruct their child that they cannot do or wear something outside of the house due to safety concerns, what Hill and Menvielle (2009) call the "only at home" rule (see also Rahilly, 2015). Similarly, other studies have highlighted that parents may hesitate in moving forward with their child's social transition on the basis of safety fears (Kupalanka, Weiner, & Mahan, 2014). Whilst safety is important for transgender people of all ages (and for parents specifically, concerns about safety often need careful

consideration), a sole focus on safety may function as a form of gaslighting in that it potentially minimises the importance of affirming a child's gender unilaterally, instead positioning their gender as something that can be taken on or off at will (thus implicitly treating it as less than legitimate or real).

Parents may also draw on a range of other reasons to limit their children, whilst outwardly appearing to remain affirming. For example, Rahilly writes:

in a quarter of the cases [where parents limited their child's requests relating to affirming their gender], *parents confessed to cloaking their regulation of certain behaviors in excuses that did not have to do with gender*: Molly told Gil that his clothing preferences were too "sloppy," versus too masculine for a little girl, which she now recognizes was her "ulterior motive." Beth gave Tim's favorite dress-up heels to the dog so she didn't have to tell him they didn't want him wearing them. Theresa routinely framed pants as more comfortable for playtime with peers, versus more appropriate for boys. Parents' rhetorical moves to hide the true motives of their gender hedging is perhaps the most intriguing element of the practice: while parents felt bound to conform, they sought to avoid teaching that conformity explicitly to their children. (2015, p. 349, emphasis added)

Gaslighting undertaken by parents of transgender children may be difficult to identify if parents are outwardly supportive and affirmative. As McKinnon (2017) writes in relation to gaslighting by "allies" of transgender people, the perception that allies are supporters of transgender people means that things they do which undermine transgender people are not always recognised by others. Thus parents who are outwardly supportive of their transgender children may portray to their children (and others) that they are doing all they can to support them, and the child is simply being overly demanding if they ask for specific gender-related things.

It is important to note, as we did with regard to identity-related abuse more broadly, that in some ways gaslighting by parents of transgender children is socially supported within the context of cisgenderism. For example, parents are widely treated

as correct in their assumption that a child will be cisgender, and that they are right in having “dreams” normatively associated with their child’s assigned sex (Riggs & Bartholomaeus, 2017). When a child discloses that they are transgender, parents are widely affirmed in experiencing this as a “loss”. The prevalence (and affirmation) of such narratives of loss may in turn suggest to parents that it is acceptable to make requests that their children be empathetic towards them, and that parents should not be rushed into being affirming.

Finally, it is important to note that the clinical literature itself is complicit with the forms of cisgenderism outlined above that make gaslighting possible. Specifically, literature on “desistance” and “persistence” with regard to transgender children – literature which has been prominent and which is consistently used to question the validity of transgender people’s experiences – provides parents with what are perceived as legitimate grounds to question their child’s gender. Similarly, research that misgenders children (i.e., by referring to samples of transgender girls as ‘natal males’) is complicit in making this seem acceptable. This phenomenon is widespread within academic research on transgender young people, as identified in a comprehensive analysis by Ansara and Hegarty (2012).

Fictionalised clinical examples

For over a decade the first author, a psychotherapist working in private practice in Australia, has specialised in working with transgender children and their parents. The first author’s clinical work involves supporting children through gender transition, supporting parents to be affirming of their child, and linking families in with other support services. The following three case studies are derived from case notes kept by the first author, but have been fictionalised so as to preserve the anonymity of the clients. As such, the cases presented are composite examples, combining materials from

across multiple sessions, and from across multiple clients. Whilst the instances of gaslighting described are reflective of actual examples from across a number of families, the broader case details are fictionalised. All references to children's gender are to their affirmed gender, not their assigned sex. As the below are derived from the first author's case notes, they are written in the first person.

Documentation and deferred action

Mary and Tom contacted me expressing concern that their eight-year-old child Sarah had been increasingly stating that they were a girl, and were seeking support in how to best facilitate their child's social transition. At our first appointment, Mary in particular presented as very knowledgeable about transgender people's lives, though Tom too presented as very supportive and informed. Both parents appeared open to supporting their child, and asked for clear information about the best course of action to pursue.

At our second appointment, Sarah joined us, and we discussed her experiences and needs, where she placed a strong emphasis on the desire to socially transition, expressing that she felt intensely uncomfortable having to wear a school uniform that was incorrect for her. Sarah also outlined her decision making about a new name, and asked for her parents' support in changing her name legally. I outlined for the parents the pathways to making such a change, emphasising that it is relatively easy in the state that we live in, and costs relatively little. I also outlined school policies that facilitate social transition, and provided contact details for support programmes whose role it is to engage with the school and facilitate awareness about the needs of transgender students. The parents left the session with promises to attend to all of the agreed upon actions before our next appointment (a month away), and stated that they would work with the school to decide the best time to begin the social transition.

Ahead of our third appointment, I received many emails from Tom, asking for contact details for various organisations which could support his family. Tom also asked me to reiterate my thoughts on the matter, and expressed a desire for a “diagnosis”. I replied that a diagnosis was not necessary, and reiterated my position that affirming responses are the best approach, rather than subjecting a young child to an unnecessary experience of psychosocial assessment that is always subjective, and does not provide an any more objective take on the child’s gender than that already provided by the child. When the third appointment arrived, at the last minute Mary let me know that Tom was unable to attend. During our appointment Mary informed me that an “unexpected bill” had arrived, meaning they hadn’t been able to do the legal name change. Mary also cited a number of mitigating circumstances that meant they had been unable to engage with the school, nor had they been able to find time to discuss together as parents when the social transition might occur. We finished this session with a commitment from Mary that the parents would actively pursue the agreed upon actions ahead of the next appointment.

Repeating the third appointment, ahead of the next appointment I again received many emails from Tom requesting assurance that the family was doing the right thing, asking what a diagnosis might look like (and whether Sarah would meet the diagnostic criteria), along with assurances that he would attend the fourth appointment. At the fourth appointment, however, Tom was again not present, and Mary was again apologetic that “life had gotten in the way”, and that none of the agreed upon actions had been progressed. Sarah was in attendance, and she expressed both frustration and sadness that nothing had happened, noting that she felt she wasn’t being listened to, and that she couldn’t see an end in sight as her parents had yet to provide her with a timeframe when the agreed upon actions would occur. We finished the session with

Mary again pledging to action the agreed upon decisions, and promising that Tom would attend the next session.

This pattern of Tom not attending appointments repeated for the fifth appointment, though it did allow me to spend some time alone with Sarah, learning more about her feelings about her parents' lack of action. Thankfully Tom attended the sixth session, so, with Sarah's permission, I spoke to the parents about her feelings, and also drew upon research evidence indicating differential outcomes for children who are actively supported as opposed to those who are unsupported by their parents. I had also printed out a potential timeframe that I had drawn up, with a list of action items for the parents and contact details for individuals who could further support them. When we met for our seventh appointment, the parents had taken Sarah to an appointment for a legal name change, and had organised a meeting with the school principal, who had already contacted the support programmes who had scheduled a training event with the school.

Intentional attrition and forgetting

Jane contacted me asking for support for her eleven-year-old son Adam, who had already socially transitioned at school. Adam was approaching puberty, and was expressing considerable anxiety about what would happen if puberty began. At our first appointment I outlined for Jane and Adam the pathways available to assessment for commencing puberty suppression. Adam was already well aware of this information, having researched the topic on the internet and spoken to an older friend who had already commenced puberty blockers. Jane expressed a number of concerns about whether or not blockers would have a negative impact upon her son's growth, and questioned whether or not it might be useful for him to begin puberty, so that he didn't have regrets later in life. I clearly outlined for Jane the research evidence with regard to

the impact of blockers on young people's bodies, including that research clearly indicates that requiring a child to begin puberty before commencing puberty suppression can have serious mental health consequences. Jane and Adam left the appointment with information about referral pathways to psychiatrists for assessment and subsequent referral to an endocrine team.

Ahead of the second appointment, I made contact with a psychiatrist colleague to whom I had referred Jane and Adam, just to let her know to expect a call. She noted that she had not heard from Jane thus far. On the day of the second scheduled appointment Jane and her son did not present for the session. I rang Jane later that day and rescheduled the sessions for the following fortnight, which Jane and her son also did not present for. Thankfully I had Adam's email address as he had asked me to send him some information directly. As I had permission to contact him, I emailed to check that all was okay, only to be told that Jane had reported to him that I had cancelled the appointments due to being unwell. I contacted Jane again and strongly encouraged a follow up appointment, and reiterated that the psychiatrist was awaiting her call. Jane reported that she had lost the details of the psychiatrist, which I provided to her again. At the end of the call we scheduled another appointment for the following week.

Jane and Adam arrived for the second appointment 20 minutes late, and Jane stated as soon as the session started that they would need to leave early. For the small amount of time I was able to see them Jane questioned some of the research that I had shared with her son, misremembering key aspects of the research, and misquoting information about outcomes of puberty blockers. I reiterated to Jane the information I had provided in the first session, and spoke about the time sensitive nature of the process (i.e., the time it takes to undertake assessments, and the waiting times for appointments). Jane stated firmly that she was "clearly being supportive" of her son

given she had “allowed” him to socially transition at school. She felt that puberty suppression was a big step and that she wanted to do her due diligence before going down that path. I affirmed that she was right in wanting to understand the process fully, but also reminded her that the information was available to her already. Jane cancelled the next appointment and did not return my calls to reschedule, though I was able to follow Adam’s progress through his attendance at appointments with the psychiatrist, though again I was told that these were often cancelled, and that when he eventually commenced puberty blockers this was later than the endocrinologist would have ideally preferred.

Placing emotional burden on children

Mark and Amanda requested an appointment with me in order to talk through strategies for sharing with extended family members the news that their fourteen-year-old child Angela is transgender. The parents noted that whilst Angela had socially transitioned in terms of her school, they had yet to attend an extended family event with Angela. At the first appointment both parents expressed considerable concerns about how their own parents and siblings would respond to the news, worrying that rejection would further upset their daughter. We spoke about a range of strategies that they could use to introduce the topic to their family, and a range of safety practices they could implement should things become negative. We also agreed that I would meet with their daughter at the next appointment to provide her support and resources.

At the second appointment Angela informed me that in fact many of her family members already knew that she was transgender through Facebook, and had been very supportive and affirming. She was unsure what her parents were so worried about, and also related to me that her parents continued to struggle with using the correct pronouns. She told me that despite constantly being corrected by herself and her siblings (who had

no problems using the correct pronouns), her parents continued to misgender her, though were very apologetic after this occurred.

At the third appointment the parents and child attended together. With Angela's permission I spoke about some of her concerns about misgendering, and both parents asked for forgiveness and understanding, and spoke at length about their sadness and loss, and implied that they felt their daughter was not being empathetic enough towards them. Some of her requests (to buy more dresses) were treated as reasonable, whilst other requests (legal name change, telling family members) were treated by the parents as unreasonable demands. I outlined for the parents the difference between a need (gender affirming responses) and a want (a new iPad), and that whilst as parents they should be cautious about always complying with the latter, the former is essential to ensuring the wellbeing of transgender children. The parents left the session with the promise that they would "work harder" on using the correct pronouns.

At the fourth appointment the parents monopolised the session, again focusing on their sadness, and again providing justifications for why using the correct pronouns was so difficult for them. Angela was very confident and assertive in responding to them, outlining how their actions made her feel, and that what she needed from them was, in her opinion, very simple. The parents were able to agree that her requests were reasonable and simple, but still continued to bring the conversation back to the suggestion that their daughter was somehow being unreasonable (because she wouldn't empathise with their loss). In a follow up session with the parents alone, I spoke to them about kindness in relationships, and how Angela actually was showing a considerable degree of understanding and kindness towards her parents. We also spoke about how other family members were managing not to misgender Angela, and acknowledged that whilst the parents might be experiencing barriers to moving forward, they needed to

focus on strategies that we had discussed earlier for managing negativity, and apply that to themselves.

Discussion

In presenting the three case studies above, we have drawn attention to three distinct forms of gaslighting evident in the fictionalised cases. The first form of gaslighting pertains to a parent seeking a ‘diagnosis’ in order to warrant affirming their child, which mirrors research findings related to parents questioning the veracity of a child’s gender (e.g., Katz-Wise et al., 2017). The second form of gaslighting centres upon appointment attrition, both in the form of ‘forgetting’ appointments, and then refusing to return for follow up appointments. This echoes the findings of Grossman and colleagues (2005), some of whose young participants reported that their parents served as gatekeepers to appointments. The third form of gaslighting involves parents placing an emotional burden upon their child, and in so doing passing off their lack of action as arising from the child’s purportedly unreasonable demands. Narratives of ‘loss’ as voiced by parents have been found in previous research as significant barriers to being supportive (Riggs & Bartholomaeus, 2017).

We are aware, of course, that in framing the cases through the lens of gaslighting, the case materials could be read more generously: they could be read as the gender-related and life-related struggles of parents trying to do their best. And in a sense this is the case. We know there are many other parents who do not even agree to take their child to an appointment so that they can talk about their gender. We know that there are many parents who refuse their children’s accounts of their gender. But even acknowledging that, we feel that in these cases (and others like them that the first author has witnessed) there is most definitely a sense in which systemic power imbalances

between the parents and children paved the way for subtle forms of gaslighting that could too easily be dismissed or naturalised as part of a normal trajectory from not being supportive or understanding to affirmation. Why we are unwilling to dismiss the cases in this way is because the children voiced that their parents' actions were upsetting, and because the first author has also seen many cases where parents did *not* engage in any of the actions above, whilst still, privately in sessions with me, expressing their fears and concerns. In other words, fears and concerns are acceptable, the problem is when this impacts upon actions. What follows are a number of suggestions for how to recognise and challenge gaslighting in the clinical space, extending on from existing literature which advocates for supportive clinical work for transgender children and their parents (e.g. Ehrensaft, 2016; Lev, 2004).

In terms of recognising gaslighting, and as we noted above, it is important not to accept the cisgenderist assertion that a transgender child is a loss, nor that any feelings of loss experienced by parents should be the responsibility of the child. When clinicians see parents acting in ways that differ from what they have said, or when a child tells clinicians that they feel their parents are stymieing them in terms of their gender, or when parents slip off the radar in terms of appointments, clinicians need to be mindful that gaslighting might be occurring. Importantly, our suggestion here is not to leap to “diagnose” gaslighting, nor is it to presume that if gaslighting is occurring, that it is only the tip of the iceberg of more substantive concerns about identity-related abuse. As Abramson (2014) notes, sometimes perpetrators of gaslighting may not be aware of their actions, or may see them in benevolent or kindly ways, rather than as forms of identity-related abuse. Regardless of their awareness or intent, however, responding to gaslighting requires concerted clinical action.

One action, as was evident in the case studies, is to try to speak with the child on their own. Of course it is well known that in abusive contexts perpetrators will try to segregate themselves and the person they are abusing off from others. This means it is possible that parents may refuse individual appointments for their children. Requests for individual appointments, however, can be couched in clinical terms, for example in regards to building rapport. Depending on the age of the child, it may also be possible to explore other avenues for contact, such as email. Of course this must be done with express permission of the child and ideally the parents should be aware if a clinician has contact details for a young child. Nonetheless, finding creative ways to reach out to a child in non-hostile and non-accusatory ways can open up opportunities to explore whether what clinicians are seeing is indeed gaslighting.

A second action, again as evident in the case studies, is to “ventriloquise” a child’s thoughts and feelings, with permission from the child. If a child feels they are unable to challenge their parents, a clinician may do this on their behalf, in careful and respectful ways that do not set the child up for further negativity after the session. The clinician may ask the parents to reflect on how they might feel if similar things were said or done to them, and to reflect on what it would mean if key aspects of their being were devalued or not affirmed. Importantly, “ventriloquising” is most typically a time- or incident- limited clinical tool. Ideally clinicians want to facilitate conversations between children and their parents directly, so should not speak for children at all points in a session. But at key moments, when parents are struggling to hear, or children feeling unable to speak, clinicians can usefully step in.

A third action is to offer parents who are struggling some very clear directives for action. This might involve doing up a timetable, or helping set up an appointment, or asking for permission to speak with a school. A parent who is struggling is often

spurred into action if someone else is acting alongside them. Direct advocacy and engagement work can often be vital to ensuring that children's needs are met, and to model for parents what action can look like and how it can be achieved. It can also involve advocating to the parents about how to engage with their child, specifically here including keeping children informed about decision making. So, for example, rather than saying to a child "we will get to that at some point", having a clear agreement about time frames, marked on a calendar, will mean that the child can know what to expect, and when they can reasonably hold their parents to account for any lack of action.

A fourth action also involves being a clear advocate for a child directly to the parents in terms of their actions in the clinical space. This is different to ventriloquising, which involves speaking for the child when they cannot, using their specific views as analytic material. By contrast, advocacy involves the clinician speaking from their own standpoint, drawing on practice wisdom and research evidence. For example, the first author has a practice of stating to parents that they will always politely correct misgendering. Even with parents who are struggling the most, this practice is always well received, and again is a form of modelling where parents are shown what an advocate can look like. Of course this must, in individual sessions with parents, be paired with an empathetic ear to their fears and struggles, but it is entirely possible to be an advocate and to also be an empathetic listener. Being reminded of their misgendering, and not being given an opportunity to apologise or make excuses for it, can be a useful tool in helping parents to recognise when their behaviour may slip from an oversight to a form of gaslighting. Blumer, Ansara and Watson (2013) too advocate for a similarly firm approach in the context of family therapy, in order to address cisgenderism.

Finally, and as was evident in the second case study, working as part of a multidisciplinary team can often be key to identifying whether a particular action (or lack of action) constitutes gaslighting, or whether it is a genuine oversight. With client permission and in the context of ethically negotiated peer-to-peer supervision, it can be highly beneficial to discuss cases, not simply to ensure a unified care approach, but also to identify problems that clinicians as individuals may overlook, or pass off as not important. Discussing cases where gaslighting may be occurring can help a group of clinicians, as a team, identify where an intervention might be necessary, and what that might look like. Indeed, the first author became aware of the possibility of gaslighting by parents when discussing a shared case with a colleague, where we both identified similar concerning behaviours.

In conclusion, and different to the play or films on which the term is based, gaslighting in practice is often subtle, and can be difficult to detect, especially in the context of parent-child relationships where imbalances of power are often taken for granted norm. As we have suggested in this paper, whilst different to other forms of identity-related abuse, gaslighting can still have a considerable negative impact on transgender young people. Given that clinicians have a remit to support and affirm young people, it is important to be active in looking for a range of potential situations where young people's genders may be unsupported or dismissed, even if unintentionally. Challenging gaslighting when clinicians see it is thus an important part of clinical work that aims to foster wellbeing.

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