Bowen Family Systems Therapy with Transgender Minors: A Case Study

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Abstract

Clinicians have seen a continually increasing rise in the number of children and adolescents presenting with gender dysphoria. Many are requesting gender-affirming medical interventions before they possess the legal authority to give consent. Since only legal caregivers can provide informed permission for transgender-specific medical treatment for minors, therapists who see these youths need an approach mindful of the distress inherent to the lived experience of transgender minors and respectful of the fear and hesitation most guardians of trans youth experience. Due to the partial or fully irreversible nature of medical treatment for transgender minors, parents tend to be cautious about what they may view as extreme treatments. Sometimes well-meaning parents functionally "filibuster" their adolescent's transition which can cause a harmful delay in necessary treatment. Utilizing a Bowen family systems framework, this article employs a case study to demonstrate creative strategies clinicians can apply to help families through the transition process. Although, transgender minors may bring the family to initial therapeutic encounter, they are not "holding" family dysfunction. Their distress is due to their dysphoria which is outside their control. At the same time, the family system may experience increased levels of stress resulting from an inability to support a transgender child within a cisnormative world. Successful work with these families will create a new homeostasis. Therapists must earn the trust of both the youth and parents.

Keywords: transgender, gender diverse, adolescent, family systems, family therapy

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An increasing number of children and adolescents who identify as transgender are being referred to clinicians throughout the world (Chen, Fuqua, & Eugster, 2016; Olson-Kennedy et al., 2016), and the age at which transgender youth present for care has lowered (de Vries & Cohen-Kettenis, 2012). In many areas of the United States, persons under the age of 18 often are not legally recognized as fully autonomous medical-decision makers except in special circumstances (Coleman & Rosoff, 2013). Given the limited availability of providers in many areas of the United States, insurance coverage (or lack thereof), and cost, there are many transgender adolescents who do not have access to appropriate care (Shumer, Nokoff, & Spack, 2016). These conditions create a situation such that in order to receive appropriate and medically necessary care, parents, and family, become involved. Subsequently, the role of mental health care provider, who may also be the first point of care for the family, is to provide psychological support, education to the parents, and be able to advocate for the youth (Austin, 2018; Collazo, Austin, & Craig, 2013; Vanderburgh, 2009).

The manner in which transgender youth present for care varies, and these differences are also reflected in the use of terminology. That is, there is a distinction to be made between the terms *gender dysphoria* (GD) and *transgender* or *gender diverse*. Gender dysphoria is a psychological phenomenon. The term dysphoria is the antonym of euphoria, coming from the Greek ‘dysphoros,’ meaning, ‘hard to bear’ (Dysphoria, n.d.). Dysphoria as it relates to a person’s experience of their anatomical, embodied gender, by definition, means that the transgender person suffers, though, gender incongruence does not mean one is diseased nor is it inherently reflective of psychopathology. The terms transgender and gender diverse can be used broadly to refer to persons whose gender identity (i.e., internal sense of self) does not fully align with their sex assigned at birth. This may include gender identities that are not exclusively male or female (e.g., *genderqueer* or *non-binary*). The language of transgender experience is constantly evolving and changing (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2009). In recognition of this, therapists should check in with their clients so that they use the pronouns and labels that are most fitting (Budge, 2013).

The purpose of this Bowen Family Systems Therapy (BFST) case study is to demonstrate strategies clinicians can apply to help families through the transition process. First, we discuss reasons why families with transgender children may seek care. Then we argue why BFST is an appropriate clinical orientation for practice with these families. The primary content of this article, a detailed case study, is presented next. We conclude the article

with reflections on the case study.

Reasons Gender Diverse Minors and their Families Seek Treatment

Securing access to puberty suppression medication ("blockers") or hormone therapy for some transgender youth is a potentially lifesaving intervention (Gridley et al., 2016). For transgender children, blockers may be administered at the first signs of puberty (e.g., budding nipples, greater testicular volume; Hembree et al., 2017). Pubertal suppression is considered fully reversible and often allows the youth and family more time to make a thoughtful decision about next steps (Lev, 2013; Nealy, 2017). Gender-affirming hormones bring the body more in line with one's experienced gender identity, thus is an effective treatment for alleviating one's dysphoria (Nealy, 2017; de Vries et al., 2014). Clinical practice guidelines generally recommend that hormones be administered around the age of 16 (Coleman et al., 2012; Hembree et al., 2017), though there may be compelling reasons to initiate hormones earlier that should be judge on a case-by-case basis (Hembree et al., 2017).

However, medical interventions are not a panacea for the wide range stressors transgender people may experience (Lev & Wolf-Gould, 2018). That is, transgender young persons tend to experience high rates of family and peer rejection, discrimination and violence (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). Transgender and gender-nonconforming K-12 students are more likely to experience bullying and name-calling, and more likely than their GLB counterparts to feel unsafe or afraid at school (Gay, Lesbian, and Straight Education Network & Harris Interactive, 2012). Environmental and social hostility is common (Kosciw et al., 2016). As a result, not only does the child suffer stigma, but so do parents, siblings, and the extended family by proxy (Wallace & Russell, 2013). Parental rejection appears to be one of the most significant risk factors of negative health outcomes (e.g., attempted suicide, high levels of depression, illicit drug use, transmission of sexually transmitted infections) (Ryan, Huebner, Diaz, & Sanchez, 2009). Conversely, family acceptance is foundational for optimal development (Ryan et al., 2010). Children and adolescents supported in their identities by parents tend to exhibit better outcomes (Olson, Durwood, DeMeules, & McLaughlin, 2016) and show higher levels of self-esteem, social support and general health (Ryan et al., 2010) and higher quality of life (Simons, Schrager, Clark, Belzer, & Olson, 2013). However, caregivers may feel shame, embarrassment and/or judgment by others in their social or familial circles (Johnson & Benson, 2014). They may also grieve over the loss of the child they thought they once had (Wahlig, 2015). Guardians can have difficulty using the child's pronouns or lack general knowledge about possible medical interventions. Thus, to work through and overcome barriers to care, an approach

that recognizes the role of the family, and can work with the family within their systems, is needed when providing therapeutic care to families with transgender minors.

Much has been written about lesbian, gay and bisexual affirmative practice (e.g., Alessi, Dillon, & Kim, 2015), but until recently, less has been written about transgender affirming approaches (Lev, 2013). It is important for mental health professionals serving transgender youth to remember that the work of gender-affirming mental health professionals is situated in a context wherein there is a clear historical, and current, pathologization of transgender individuals (ALGBTIC, 2009). Even today when mental health trainees learn about transgender persons, the topic is likely covered in a psychopathology course (Singh & dickey, 2016), which is a testament to the need for further affirmative training of mental health professionals as well as the field's tendency to pathologize gender diverse identities. With a gender-affirming model, gender health is defined as the youth's "opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection" (Hidalgo et al., 2013, p. 286). A youth whose transgender or gender diverse identity persist into adulthood is not viewed as an unwanted outcome (American Psychological Association, 2015). According to the World Professional Association for Transgender Health Standards of Care, Version 7, treatment approaches that try to change a person's gender identity and expression to become more congruent with the sex assigned at birth cause harm and are no longer considered ethical (Coleman et al., 2012).

Often, transgender minors come to the attention of parents or school officials during puberty. Throughout childhood they may have been coping with an awareness that something might be different about their bodies by using various forms of avoidance or compartmentalization. When their bodies begin to change, they often experience a sense of horror or great distress (Austin, 2018; Ehrensaft, 2012). Some transgender youth are able to redouble their efforts at denying dysphoric feelings; others less so. Frequently, young persons with GD turn to the Internet to research what they might be experiencing (Nealy, 2017). And through the Internet, it is not difficult for transgender youth to encounter the language which allows them to describe their experience. However, a transgender youth's desire (and need) for gender congruent bodily change may run counter to their parent's fears (Nealy, 2017). Many parents of minors who are experiencing gender dysphoria are unprepared for the intensity of the insistent, persistent and consistent manner in which GD may express itself.

Parents who have taken an active role in their transgender child's health may have heard that their child is at higher risk for suicide, self-harm, and violence (Alegría, 2018). This, understandably, may induce anxiety in

many parents. It is essential that all mental health professionals working with transgender youth and their families keep current with the research on the risk and protective factors regarding transgender youth and suicide. Because parental support has been consistently shown to be a protective factor against suicide (Klein & Golub, 2016) and promote beneficial mental health outcomes (Simons et al., 2013), therapists may confidently adopt the strategy of reassuring parents that they can have an active role in keeping their transgender child safe.

Why Family Systems Therapy with Transgender Minors and Their Families?

For transgender youth, the rapid hormonal and biological changes at puberty often induce a sense of urgency (Hembree et al., 2017). One goal of gender-affirming therapy is to address insistent and persistent GD. Family therapy, in general, is useful because it provides the clinician access to the youth as well as their family, especially in situations that feel urgent. In BFST the notion of differentiation of self captures one aspect of the process that may occur as a youth transitions from their assigned gender to the one they know themselves to be. Differentiation means that a person is able to distinguish between thoughts and feelings, and is able to behave in a rational manner, free from undue anxiety (Murdock, 2017). This has also been known as defining a self (Bowen, 1978; Kerr & Bowen, 1988). Murray Bowen's approach to family therapy is well-suited to helping transgender minors define and present an authentic self, something particularly salient to transgender youth.

Unfortunately, gender diverse youth can face more societal stressors and challenges such as extreme and pervasive systemic and institutional discrimination as well as higher rates of interpersonal violence than cisgender (i.e., non-transgender) youth (Dank, Lachman, Zweig, & Yahner, 2014). *Dysfunction* in the framework of BFST is understood as the result of chronic anxiety in the family exceeding family members ability to adapt to the anxiety (Kerr & Bowen, 1988). Systemic thinking allows us to orient the youth and their families to the profound effects society can have on individual functioning and anxiety. It could be noted that a minor who experiences gender dysphoria is not an "identified patient" in the traditional meaning because gender dysphoria is not the product of dysfunction within the family. However, the family lives in a cisnormative world. If a family is unable to support their transgender child, then the distress experienced by the child could be seen as a symptom in the family system--whereby the anxiety, created also by a lack of communication and parental understanding, becomes bound within the family system. Nonetheless, the child functions to bring the family to a therapeutic encounter. If well facilitated by the therapist, a young person's transition can lead to a new homeostasis in the family. The youth's transition becomes part of their individuation and can help them achieve autonomy. A healthy reorganization of relationships

in a family system can create more authentic communication and lower anxiety (Nichols, 2012). The following case study is about a transgender youth and his family in a metropolitan suburban region. The case does not represent any specific individual or family, instead it is an amalgam of clinical experiences. Any and all potentially identifying information has been either altered or omitted.

The Case of the Filibustered Transition

James came to realize he was male at age twelve, despite being assigned female at birth and given the name Janis. He was thirteen when he told his parents. James had begun using an Ace bandage to bind his developing breasts where much of his dysphoria centered. Once an avid swimmer, he was now refusing to go to the pool or join the school swim team. His mood had plummeted. He was spending an inordinate amount of time in his room, online and playing video games. James and his father, Peter Kaplan, enjoyed watching basketball together, but now James avoided watching games with father. His parents were understandably distraught. Peter was an information technology specialist at a local hospital. James' mother, Sara Kaplan, was a local newspaper journalist. At the time James told his parents about his feelings, representations of transgender experience were becoming more frequent in the media. His parents were educated and alert people. They wanted to do the right thing for their child. However, the family's health insurance was limited to those providers who were part of the hospital's healthcare system. There were no gender specialists on the hospital's panel of providers.

Peter and Sara decided to bring James to a therapist at the hospital's mental health center. The first few visits with the therapist were useful for James; he had someone to talk to about his feelings, and she was a good listener. He was still using Ace bandages to bind his breasts, but as they continued to develop, the bandages were less effective and more uncomfortable. This was not something he felt he could tell the therapist. He wasn't ready to talk about his body even though his bodily preoccupations took up most of his thoughts.

As time in therapy went on, James began to think his therapist knew little about transgender people. She told him she had counseled "a few," and knew what "needed to happen," but she never mentioned hormone therapy or surgery. By this time James was beginning to feel betrayed by his body; unwanted breast development induced in him a feeling of helplessness. He asked the therapist for help in finding a binder for his chest. She showed curiosity about what binders were and how they worked but did not know where they could be purchased. She spent the next few sessions trying to get James to explain what was wrong with his breasts, how they made him feel, and what they represented to him. He began to feel like an object of curiosity, not a person in need of support and help.

James was getting impatient and realized that he was relying too much on the therapist to take charge, so he took matters into his own hands. After learning from a friend that he could simply buy a binder on Amazon, he ordered one and had it delivered to his home. His mother intercepted it, and this became the first family crisis. James insisted on wearing it. As the parents perceived him, he was being quite defiant. A Bowen family systems therapist might recognize James' behavior as a manifestation of his *solid self*; the part of the individual that is clearly defined by one's beliefs about oneself and is non-negotiable even under emotional pressure from the relationship system (Kerr, 1981). The parents, unsure of themselves, agreed to allow him to wear it if the therapist agreed.

The therapist met with James' parents for a few minutes at the end of the session. James never found out what was discussed, but his parents allowed him to wear the binder. In James' mind this was his first victory. The counseling continued, uneventfully, for several more months. James began eluding the therapist. He became taciturn and evasive. He talked about superficial, adolescent topics. James was experiencing some relief by binding, but he could no longer tolerate his menstrual cycle, which had become a source of horror for him. His mother minimized his experience, telling James that "all girls hate their periods! I still hate mine!" James had read in a transgender advice blog that through starvation he could make his periods could go away. He knew that his mother did not understand what it was like for a boy to have a monthly period, so again, he took matters into his own hands.

Several months later, James' therapist began to address the weight loss. She told James that eating disorders are common in teenage girls. She asked James questions about his body, but they were all the wrong questions. Concerned that James might have an eating disorder, the therapist was trying to assess body dysmorphia, not gender dysphoria. James did not care about looking too thin; he wanted his periods to end. Feeling hungry was not nearly as bad as how he felt when he was menstruating. He was doing the best he could to live in his body until he was eighteen, when he could see a doctor to correct what he experienced as a physical problem, not a mental one. After months of watching James lose weight, his therapist told his parents that she believed he had an eating disorder. She recommended an inpatient program offered by the hospital. This became the second family crisis. Against his will, James was admitted to an inpatient program for teenagers with eating disorders. Most of his inpatient cohort were cisgender girls, upsetting James even further. He was being immersed in a world he had been trying to escape.

James' social worker, Ms. Goldberg, quickly recognized that James was not typical of a girl with an eating disorder. In fact, she sensed James' dysphoria. Ms. Goldberg conducted a second interview with James after his

admissions evaluation. James knew this therapist was very different from the one who had sent him there. He felt relaxed with Ms. Goldberg and decided he could trust her. Knowing that using correct names and pronouns is essential to respecting the client and affirming their identity (and not as simple as a "preference") (Nealy, 2017; Russell, Pollitt, Li, & Grossman, 2018), she asked James, "what pronouns do you use?" While also adding, "I thought I saw the hint of a binder. I couldn't help but notice, and I prefer to be direct about something as important as your gender expression and identity, especially when we may have limited time to work together." He felt relief surge through him. He allowed himself to be open with the social worker, tearfully telling her everything. Ms. Goldberg presented her findings to the treatment team and recommended James be discharged as soon as it would be medically sound. She recommended an out-of-network family therapist, Dr. Estes, who specialized in working with transgender youth and their families. She had already spoken to the therapist who had agreed to see James as a single case contract because the family's resources were not robust.

First Session with James and his Family

At the first session, Dr. Estes invited the family to sit wherever they felt comfortable. Dr. Estes was careful to not begin the session with a discussion of the presenting problem, as some parents of transgender youth might be initially reactive to the topic of sex, gender, and transitioning as a "hard start" to the first visit. He wanted the family to feel as relaxed as possible first. After some friendly chatter, Dr. Estes gently asked, "so, who would like to tell me how I can be helpful?" James replied, "didn't Ms. Goldberg from the hospital tell you everything?"

Dr. Estes: "Yes, she did. She and I talk often. I think she would agree with me that this is your project. Maybe you ought to nudge us out of the dock. We will get to where we need to be, and I will meet with you alone and with your parents alone during this visit. I want to get a sense of how you all talk about the gender issue…"

Peter: "We don't. She (James) never brings it up, and we don't want to upset her by discussing it if she is not ready."

Sara: "Well, she talks to me. She wants to be called James, not Janis. I'm not ready for that. This is all so sudden. I've been looking things up online. I keep reading posts on blogs from parents who claim that the dysphoria is a trend, they call it 'desisting,' I think."

Dr. Estes: "This all seems so sudden to you. You worry that as James grows, he may cease to identify as transgender."

From experience, Dr. Estes knew that James' parents had been hit with a bombshell. Using reflection

allowed for the parents' concerns to be acknowledge. Failure to adequately acknowledge parental concerns may contribute to misconceptions or shame and hesitation they have about offering James support and understanding (Rafferty, 2018). They would need to feel safe, in order for Dr. Estes to be allowed to help James. The role of the therapist is to "*stay detriangulated* from the emotional process" (Kerr, 1981, p. 255; emphasis in original). Dr. Estes had to be careful to avoid becoming triangulated. Directly confronting parents during a first session could give parents the impression the therapist has sided with the child. No one would benefit from that.

The family sat quietly. Dr. Estes told them the ground rules: anything James tells him in confidence will stay between James and him, likewise, anything the parents tell Dr. Estes in confidence will not be repeated to James without the parent's consent. To help James' feel as comfortable as possible, which includes the practice of using appropriate names and pronouns (Austin, 2018), Dr. Estes clarified to the parents that he would use the name and pronouns James chose. The therapist promised them that he would be direct in his communication and thorough in his evaluation. He looked at James and explained, "while you are the reason we are here, I will always yield to your parent's authority. They are responsible for you. That's a big job." He then looked at Mr. and Mrs. Kaplan and added, "James is clearly suffering, and I believe you want what's best for him. I'm responsible for giving you my best counsel and advice towards that goal. James, I know you are feeling terrible, but your parents will be in your life a long time—much longer than I will be. You need them, and I will do the best job I can to help you communicate your needs to them."

Dr. Estes met with James alone next, assuring him he saw the boy in James. Regarding the therapeutic alliance, he told James, "I can't do this alone. I need your help. I have a lot of experience with parents of transgender youth. If I am going to do my job well, I need them to trust me, and I need you to trust me. You probably feel torn between what you need to feel better about yourself, and a fear that you could lose their support." Dr. Estes was aware of the academic literature which has consistently emphasized the importance of parental support in the lives of transgender youth (e.g., Nealy, 2017) as well as the high risk of transgender youth for losing such support (Ryan et al., 2010). He continued, "not to mention all the therapy you've been through lately. I can imagine this experience has been very intense for you. Let's work together to make sure this is the therapy that gets the job done."

James asked him what he meant by "working together." Dr. Estes replied, "there were things you told Ms. Goldberg your parents will need to understand. That might be hard for you to do. I want to help you tell your parents about how bad your periods are for you, and how bad your breasts make you feel. Things like that. I know from

experience that most trans youth want their therapists to do that part for them—it is difficult to talk about this stuff with parents. But, if they are going to support hormone therapy, a name change, using correct pronouns, things of that nature, then you will have more credibility than me. We can do it together, I will help you."

Peter and Sara

Developing a genogram was the first thing Dr. Estes did with James' parents. Genograms offer a visual representation of family history, health, relationships, and can provide some insight into patterns of interaction (Lev & Wolf-Gould, 2018). The parents enjoyed the process. They were relaxed and appeared to appreciate the curiosity about their life as a family and about the family history. Both Peter and Sara were of mixed European descent. Peter was raised Jewish. Sara was raised Protestant. Neither were particularly religious, but both have strong beliefs in family. They were raised in the same region where they now lived and met in high school. They attended different colleges but returned home to be close to their parents. They began dating after they returned from college, having been reacquainted at their five-year high school reunion. Peter has an older brother who is gay. He lives in a European city with his partner. Peter and his brother are on good terms, but distance keeps them from seeing each other frequently. Peter shared that having a gay brother has helped him to be comfortable with "diversity." Dr. Estes made a mental note that this could be useful information as the family's therapy evolved.

Sara was an only child. She was close with her mother, who passed away when Sara was fourteen, the age James is now. Her mother's death was unexpected; she died of an aneurysm. This loss had a substantial impact on Sara, making her particularly sensitive to loss, and fearful of change. After the death of his wife, Sara's father raised her, and remained close by. Sara and her father, Edward, are close. Edward and Peter get along well. In fact, they are friends. Edward shows great affection for James and is worried about James' "depression."

A Crucial Session

Dr. Estes met with James several times to assess how he experiences his dysphoria, to explore how social stressors influence his mental health, and to gain a better understanding his strengths. In laying the initial groundwork for an effective therapeutic relationship, it was essential that Dr. Estes' assessment with James was sensitive and rooted within gender affirmative framework (e.g., one that does not pathologize the client, is sensitive to language, and highlights strengths) (Collazo, Austin, & Craig, 2013). Dr. Estes' recognize that James' had many strengths, including: a willingness to engage in therapy, being creative and open to learning how to assert himself and his needs more fully, and he possessed an awareness of self. Despite these strengths, James was in distress. He

still was binding, and his recent period induced feelings of hopelessness. He continued to eat regularly to keep his weight up but withdrew into himself further. Given James' level of distress, Dr. Estes had also been coaching James on how to be more assertive with his parents about his needs. His parents had begun to sense James' despair and requested that the next scheduled session, a family session, be pushed forward. Dr. Estes accommodated the request.

Peter: "I don't know what to do about Janis. She is feeling worse–I can tell that–but we can't get her to talk to us. We are hoping you can tell us what's going on with her. You have seen her several times...."

Sara: "It's not like we don't try to talk with her. She just looks away or goes up to her room. I am glad she is eating, that's a good thing. She won't even talk with my father. He is heartbroken over this. He has noticed she cut her hair and dresses like a boy. We are doing our best to give in to what she wants, but she always wants more. She still wants us to call him James. I just can't. It's not real to me."

Dr. Estes: "James, you and I have been talking about how to tell your parents what you are feeling. How is that going?"

James: "It's not. I try to bring it up, especially when they ask me what is wrong. All they do is act like I am telling them something crazy. They keep saying that I can't be a boy, that there must be a psychological explanation or something. They said they think I should see a therapist who analyzes more than you do."

Dr. Estes: "Alright. Tell them here and now some of the things you have told me."

James looked at his parents directly and told them about his recent menses cycle. About how he wears his binder all night even though he knows it is not good for him over the long term. How he wears underwear when he showers to avoid encountering his vagina and the corresponding dysphoria. And, how he is doing his best but that things are taking too long.

Sara: "Too long? How? What do you mean? What are we supposed to do? You are only fourteen!"

James: "That's the point. I'm fourteen…almost fifteen. I was thirteen when I first told you about being transgender. What do you think, you can filibuster my life and what I need? Wait until I am 18? It can't work that way. Neither of you have any idea what it is like to be me. You will consider any explanation but the one I have been telling you for almost two years now! Oh, and will you please tell Grandpa Ed to stop bugging me? It's like the three of you are ganging up on me. He used to be my friend when the two of you drove me crazy before all of this." Looking at Dr. Estes, "now all I have is a therapist–no offense–but you coddle my parents too much. You said that you have worked with many parents of kids like me, but all you want to do is help me cope and give me coaching

that doesn't work. Sorry. I know you are trying to help."

Dr. Estes: "No offense taken. Interesting word, filibuster. And you are right–I have been coddling your parents, and maybe you, too. You are clearly able to speak up. Maybe you should do more of that. Why not tell Grandpa Ed yourself? Maybe he can be on your side again."

Admittedly, Dr. Estes recognized that this was a gamble. Edward, Peter and Sara were aligned against James. Previously, when James felt ganged up on by his parents (or felt like an outsider; i.e., the third corner of a triangle in a high anxiety emotional field), he could go to Grandpa Ed. His grandfather would talk with Peter and Sara. When Grandpa Ed would talk to Peter and Sara, it functioned to diffuse their tension and anxiety, which in turn would break up triangulation. But now, things were more complex as James had not yet disclosed that he is transgender to his grandfather. If James could once again utilize Grandpa Ed to alleviate anxiety (and to help facilitate communication), then the anxiety in the family might reduce to such a degree where they can begin to work out their struggles. It could be the beginning of a new homeostasis, or balance in the system. One more flexible and based on openness. If not, then things could get more stressful for the family, and for James.

Sara: "No—I don't want my father to know about any of this. He can't handle it. And please stop calling her James in front of us. It's… indulgent."

Dr. Estes: "Peter, you and your father-in-law are close. What do you think about Grandpa Ed knowing about James?"

Peter: "I think it might help. But, I want to tell him."

Dr. Estes: "I have to admit, I wasn't expecting you to offer that. Sara, I know you don't want to call your child James. I'm not trying to be indulgent, or provocative. I've never asked this, but now I'm wondering if it's the name 'James' that bothers you?"

Sara began to tear up. James looked confused. Dr. Estes asked him to sit in the waiting room. He wanted some time with his parents. Sara regained her composure.

Sara: "Thank you. That was the right thing to do. It has nothing to do with the name 'James.' If I allow myself to see Janis as James, I would grieve the loss of my daughter. I'm not sure I can handle that. And, I'm definitely not ready to let my father know what's going on, either. Janis' problem should be kept secret."

Dr. Estes: "At the risk of being too blunt, I must point out that James went to the length of starving himself to end his menses cycle. He risked his life and health to show you both who he is and how he feels. His dysphoria is

serious. New names and appropriate pronouns are not indulgences; they are part of the treatment he needs. I do not believe he can go for another three-plus years being seen as Janis. Certainly, you would experience grief for the loss of your daughter. Most parents of transgender minors do experience grief as they adjust to a new, often improved relationship with their children. In my experience, we often have greater fear of grief and loss because we forget to remember that we have the capacity to mourn and recover from losses. Additionally, your father has been an integral part of the family since James was born. In my experience, grandparents are often wiser than we think."

Peter: "I really believe I ought to tell your father what's going on. There shouldn't be any secrets. Sara, I understand how you must feel about losing a daughter. I'd feel the same way if Janis was born male but needed to transition to female. It would be like losing a son. Fathers and sons, mothers and their daughters—those are special relationships. But I believe we can get through this. We need to be a family again."

Dr. Estes: "Peter, if I recall, you mentioned that having a gay brother helped you to be more attuned to diversity—I assumed you meant sexual, but could that include gender diversity, too? Is there a way for us to tap into your accepting views? I know Sara is afraid that her father won't be able to accept James as a grandson, but perhaps you could take the lead on this, for both your father-in-law as well as Sara?"

Peter, Sara, and Dr. Estes talked about how Peter came to an accepting stance towards his brother, and how it helped him to grow as a person. Peter wished he could see his brother more often and was considering contacting him for support in dealing with James. They also discussed the importance of clear communication. Dr. Estes used James' term, filibuster (referring to a harmful delay in access to medical treatment), to highlight how essential communication is to mutual understanding between family members. James' early knowledge of his gender identity, and the accompanying dysphoria, upset the dynamics of the relational connections in the family. Dr. Estes suggested to Sara that James could be happy, and thrive, and that she could enjoy a new relationship with her child. Dr. Estes also shared research findings that indicate youth who receive gender-affirming medical interventions tends to experience improved psychological outcomes.

James' parents followed Dr. Estes' advice in the wake of that crucial session. Peter spoke with Edward; whose reaction was one of relief. Grandpa Ed feared that James was depressed. In his mind, something could be done about gender dysphoria. Dr. Estes hunch—that grandparents have wisdom—was correct, in this case. Little is known about the etiology of transgender experience, but Grandpa Ed felt comforted by knowing there could be a medical solution that would help make his grandchild happy again. Within several weeks, Peter and Sara

successfully advocated for their health plan to provide the medically necessary hormone therapy James needed.

Conclusion

In many ways, the characteristics of the family made this an easy case for Dr. Estes. Most of the filibustering occurred prior to the start of therapy. James was an expressive adolescent who was willing to assert himself in one very crucial session. Peter and Sara were truly concerned and frightened parents, but ultimately were able to address the needs of their child and sought out gender-affirming medical interventions for James. This case highlights what can happen when a case goes well. It is often more instructive to examine what works, as opposed to what does not work. Dr. Estes was able to use his system's perspective to involve the Grandfather and help James' mother to begin addressing her anxiety.

If Dr. Estes was working with parents who insisted on filibustering their child's transition, he would most likely need, at some point, to confront the parents on their neglect of their child's medical needs. Because he focused on gaining the parents trust immediately, and showed respect for Sara's fears, he was able to avoid the unpleasant task of having to initiate a confrontation. His ability to not be engulfed by emotional reactivity to the family and instead use humor (such as when James' accused him of coddling his parents and criticized his approach) and the language of the family (e.g., incorporating James' use of the word 'filibuster' into the treatment) allowed Dr. Estes to be effective in his work.

Certainly, Dr. Estes had a number of choices regarding how to approach therapy. First was his stance as an ally. He took the position that the transgender experience does not reflect psychopathology (Austin, 2018; Nealy, 2017). Clinically, one option was to see James individually and offer support and resources until he had the legal capacity to consent to treatment. The clinical, and ethical, problem with this approach was that James' dysphoria was insistent and persistent and would not likely remit. This choice would function to delay James' medically necessary treatment, and would collude with a non-affirmative stance. Another option would be to meet James once for an assessment and follow up with his parents only, with sessions focusing on the need for medical intervention. Such an approach would have required the therapist be able to leverage his expertise powerfully enough, in a limited time, to convince the parents to follow through. The obvious problem with this approach is that the parents could simply refuse to follow through, leaving James' GD untreated. Either way, James would suffer during the much longer interim.

The choice to approach the case from a BFST perspective allowed the therapist to take a transgender

specialist's stance as well as a therapeutic stance which prevented a power struggle over who knew what was best for James. The difficulty in this kind of case is that untreated gender dysphoria for the adolescent could increase the likelihood of depression, anxiety, and other behavioral and emotional symptoms. Dr. Estes chose an approach respectful of James' parents and supportive of James. Respect towards James' parents helped create a context in which his parents could provide the acceptance and support he needed (Lev & Wolf-Gould, 2018). Because the BFST approach eschews therapist primacy, James and his family were able to reach the best solution on their own. Through improved communication there was a reduction in anxiety leading towards more flexible thinking (Nichols, 2012). A corresponding shift in the homeostasis of the family's internal dynamic allowed for growth and a way for the system to move forward in a transgender affirming manner.

There are benefits and drawbacks to using a case study to illustrate clinical phenomena. One natural limitation of case studies is they can be too specific, and thus not fully generalizable to the broad range of similar clinical situations. At the same time, case studies can offer unique insights that can be applied in other clinical case situations. For example, when Dr. Estes told James that he wanted James' help in working with his parents, he was introducing a salient truth that all adolescents need to accept (assuming parental competency): the family relationship will be active far longer than the adolescent realizes. For transgender adolescents, parental consent is essential for medical interventions. When communication is avoided in emotionally difficult situations, it is easy for people to lose perspective and for anxiety levels to raise in the family system (Kerr & Bowen, 1988). The clinical value in encouraging James to share his own understanding of his gender, and his dysphoria, in session with the parents is that it helped the parents gain another perspective—his perspective. Ultimately, this functioned to reduce their anxiety. Concurrently, parents may be more likely to consent to gender-affirming medical care for their child when communication is open and anxiety levels in the family are lowered.

Compliance with Ethical Standards

Conflict of Interest: None to declare.

Ethics Approval: This article does not contain any studies with human participants or animals performed by any of the authors. Moreover, this case study does not represent any specific individual or family, instead it is an amalgam of clinical experiences of over 35 years of combined practice by the authors. For this type of article, formal consent is not required nor applicable.

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