Caring for Transgender Adolescents in BC: Suggested Guidelines

Clinical Management of Gender Dysphoria in Adolescents

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Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents

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Copies of this manual are available for download from the Transgender Health Program website: http://www.vch.ca/transhealth. Updates and revisions will be made to the online version periodically. For more information or to contribute updates, please contact:

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Table of Contents

Introductory Comments

With the closure of the Vancouver Hospital Gender Dysphoria Program in 2002 and the subsequent adoption of a decentralized community-based model of care (Kopala, 2003), clinicians with varying degrees of training and experience are now responsible for care of transgender* individuals in BC. Like every population the adolescent transgender community is diverse and health needs vary greatly. This document is intended to assist health and social service professionals whose adolescent patients and/or family members ask for assistance relating to trans-specific concerns. It is written for professionals who are already familiar with basic terms and concepts in transgender care, and are seeking more advanced clinical guidance on transgender issues.

Adolescents struggling with transgender issues face many of the same concerns as transgender adults – societal marginalization, internalization of stigma, and gender dysphoria. However, clinical services and protocols must be tailored to the adolescent's physical and psychological development as well as the age-peer, familial, and cultural contexts of the adolescent's life.

The first chapter of this document, *Clinical Management of Gender Dysphoria in Adolescents*, offers an overview of the clinical issues in caring for the adolescent who wishes to undergo sex reassignment. Written by a highly experienced team of clinicians working at a clinic for gender dysphoric children and adolescents in Amsterdam, the protocols outlined by Drs. de Vries, Cohen-Kettenis, and Delemarre-Van de Waal underscore the need for dysphoric adolescents to be seen by specialists who have extensive training and experience relating to gender identity concerns in adolescence. In BC, these services are provided by adolescent mental health clinicians working in concert with a team at BC Children's Hospital that has experience with hormonal treatment of gender dysphoric adolescents. A clinical pathway for adolescents who are being assessed for the appropriateness of sex reassignment is being developed by the Transgender Health Program.

Not all transgender adolescents have gender dysphoria or wish to undergo sex reassignment. The second chapter in this document, *Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents*, is written by local professionals who work with a broader range of transgender adolescents in the community setting. It is intended to assist family physicians, community health nurses, social workers, school counsellors, and others providing more general care to transgender adolescents. This companion chapter aims to address regionally-specific concerns (including local legislation and system issues that affect options for care) as well as ethical, legal, and psychosocial issues for the non-specialist.

The recommendations in this document are consistent with but more detailed than the Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care* (Meyer, III, et al., 2001). Just as the HBIGDA *Standards* are intended as a flexible framework to guide the treatment of transgender people, the recommendations made in this document should not be perceived as a rigid set of guidelines. In any clinical practice it is paramount that protocols be tailored to the specific needs of each patient, and clinicians are encouraged to adapt and modify protocols to address changing conditions and emerging issues. Research in transgender health is still in its infancy, and there are widely diverging clinical (and consumer) opinions about "best" practice. In this document we offer suggestions based on a review of transgender health literature, interviews with expert clinicians, and the authors' clinical experience. Ongoing research and collegial meetings are needed to further develop practice protocols.

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* In this document, *transgender* includes any person who (a) has a gender identity that is different from their natal sex, and/or (b) expresses their gender in ways that cross or transcend societal expectations of the range of possibilities for men and women. This umbrella term includes crossdressers, drag kings/queens, transsexuals, androgynous individuals, Two-Spirit individuals, and individuals who are bi-gendered or multi-gendered.

Clinical Management of Gender Dysphoria in Adolescents

Annelou L.C. de Vries, Peggy T. Cohen-Kettenis, & Henriette Delemarre-Van de Waal

This chapter aims to provide professionals working with adolescents with gender-dysphoric feelings practical clinical guidelines for diagnosis and treatment. *Gender dysphoria* refers to distress caused by discrepancy between sense of self (gender identity) and the aspects of the body associated with sex/gender, other people's misidentification of one's gender, and the social roles associated with gender (Fisk, 1973). Apart from psychotherapy or other psychological interventions, treatment may include hormonal intervention, surgery, or other *sex reassignment* procedures to feminize/masculinize primary or secondary sexual characteristics to facilitate ease with self and presentation congruent with identity.

Ideally, work with gender dysphoric adolescents is done by a team of professionals from various disciplines, such as adolescent psychiatry and clinical psychology, psychotherapy, family therapy, and pediatric endocrinology. Clinicians who diagnose and treat gender dysphoric adolescents should have training in adolescent psychiatry or clinical psychology and experience diagnosing and treating the ordinary problems of adolescents (Meyer et al., 2001). The clinician must also be knowledgeable about transgender identity development, and the specialized counselling needs of family members and other significant others, as discussed in general terms in *Counselling and Mental Health Care of Transgender Adults and Loved Ones* (Bockting, Knudson, & Goldberg, 2006). This document focuses on the specific issues involved in care of adolescents.

First, we will describe the different phases of the assessment procedure and treatment process. Differential diagnostic considerations and possible psychotherapeutic treatment options are given. Physical interventions, including GnRH analogues to inhibit puberty and cross-sex hormones, are described with consideration of eligibility and readiness issues. We end with discussion of post-treatment evaluation.

The recommendations in this document are based on published literature and the authors' clinical experience. These guidelines are consistent with but not entirely similar to the *Standards of Care* of the Harry Benjamin Gender Dysphoria Association (Meyer et al., 2001) and the Royal College of Psychiatrists' guidelines for management of gender identity disorders in adolescents (Di Ceglie, Sturge, & Sutton, 1998). This document expands on both of these previously published works, including discussion of early diagnosis and intervention. Results of a May 2005 consensus meeting of pediatric endocrinologists, child psychologists, child psychiatrists, and ethicists (from Australia, North America, and Europe) on the hormonal treatment of gender dysphoric adolescents are incorporated (Gender Identity Research and Education Society, 2005). Ongoing interdisciplinary research and collegial meetings are important in further developing practice protocols.

Clinical Picture

Prevalence data are lacking for prepubertal children. Most epidemiological studies include older adolescents, but no separate data exist for this age group.

The clinician should be aware of the different sex ratios according to age. The majority of the prepubertal children attending gender clinics are biological males; this is believed to be primarily due to lower social acceptability of cross-gender behaviour in boys than in girls (Bradley & Zucker, 1997). The sex ratio of adolescents, however, approaches a 1:1 relationship.

Not all prepubertal children with gender concerns will seek sex reassignment after puberty. Unlike adolescent Gender Identity Disorder (American Psychiatric Association, 2000), Gender Identity Disorder (GID) in childhood is believed to be more strongly predictive of homosexuality than transsexualism (Bradley & Zucker, 1997). So a clinician meeting a child with GID is more likely seeing a future gay/lesbian than a future transsexual. Additionally, while adolescents with GID have usually had gender concerns since childhood, not all children with GID continue to have gender concerns in adolescence or adulthood (Zucker & Bradley, 1995). For this reason, it is important to understand the clinical picture for adolescents who may be in need of intervention, and to make a distinction between prepubertal children and adolescents.

Adolescents who seek treatment for gender dysphoria have often shown signs of gender dysphoria from very early in age. They may have repeatedly stated that they were members of the opposite sex, have had cross-gender preferences, and have been unhappy if not allowed to act on these preferences. When older, but still prepubertal, they might have stopped talking about their cross-gender feelings out of shame, and might also have shown less cross-gender behaviours in an attempt to conform to societal norms. Biological males who look or behave feminine are frequently teased or bullied, which increases the risk of developing social or other problems. Biological females who look or behave masculine tend to be less ostracized and teased in childhood, as cross-gender behaviour is far more accepted in girls than in boys.

Adolescents with gender dysphoria may suffer deeply from fears relating to the physical changes of puberty or, for older adolescents, distress relating to the changes already experienced in puberty. Some already cross-live by the time they seek sex reassignment and take age-appropriate developmental steps (e.g. dating). Other adolescents try to conform to gender typical norms, behaving as inconspicuously as possible.

Although many gender dysphoric adolescents who seek treatment already have a strong and persistent wish for sex reassignment, it is important to note that these adolescents are a *heterogeneous* group who may:

- request sex reassignment but have ambivalence about it
- express a strong wish for sex reassignment during the intake phase, but change their minds later
- have no real sex reassignment request, but are merely confused about their gender feelings
- have gender concerns secondary to a co-existing condition (e.g. pervasive developmental disorder)

The Desirability of Sex Reassignment for Adolescents: Three Views

The desirability of sex reassignment as a resolution for the psychological suffering of people with gender dysphoria, has, irrespective of the person's age, been controversial since the first surgeries were performed. Because gender identity seems to be fixed in most individuals after puberty, and psychological treatments are not particularly successful in changing gender identity once it is consolidated, changing the body to match the identity is often the treatment of choice for very gender dysphoric adults.

As discussed earlier, the outcome for children with gender concerns is far more variable than for adults (i.e., some have gender dysphoria that resolves spontaneously as the child ages). Additionally, it is extremely important to take into account that children and adolescents are in a rapidly changing developmental process. For this reason, there is clinical consensus that pre-pubertal children with GID

should not be offered any physical treatment – although psychotherapy may be indicated (Cohen-Kettenis & Pfäfflin, 2003) – and that surgery should not be performed before the age of 18. Although experts agree that mental or emotional maturity would probably be a more appropriate criterion for determining surgery eligibility than setting an arbitrary age, at this time there are no clear and objective criteria for how to define and assess readiness for sex reassignment surgery in adolescents. Because of the current stage of knowledge regarding the effects of irreversible interventions, most professionals consider it premature to perform surgery before the age of 18, irrespective of legislation in some regions relating to adolescent competence to make decisions relating to medical care.

At the aforementioned expert-meeting in London (Gender Identity Research and Education Society, 2005) it became clear that three different views exist on the hormonal treatment for adolescents between the ages of 12 and 18 who are seeking sex reassignment:

a) *No physical treatment, including hormones, should be given before legal adulthood*, (defined by most countries as 18 years of age). Clinicians holding this view argue that adolescents should experience all physical puberty stages and fully experience their adult physical characteristics. Only then are they believed to be able to fully appreciate their gender identity and capable of deciding on any physical treatment (Meyenburg, 1994).

b) *Adolescents should experience puberty at least to Tanner stage 4 or 5* (typically 15-16 years of age). They are eligible for GnRH analogues if they fulfill the DSM-IV criteria for GID, have had a strong cross-gender identity from an early age, are psychologically relatively stable, and live in a supportive environment (Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis & Van Goozen, 1998). At this time GnRH analogues may be given to prevent further pubertal physical development, and cross-sex hormones might or might not be added soon after (Viner, Brain, Carmichael, & Di Ceglie, 2005). Studies on the effects of this treatment policy show good results with disappearance of the gender dysphoric feelings, no regret relating to the reassignment, and psychological well-being in the normal range (Smith, Van Goozen, & Cohen-Kettenis, 2001).

c) *Adolescents may be eligible for hormonal suppression of puberty after Tanner stage 2 or 3* (typically 12-13 years of age) if they fulfill the DSM-IV criteria for GID, have had a strong cross-gender identity from an early age, are psychologically relatively stable, and live in a supportive environment (Cohen-Kettenis & Pfäfflin, 2003; Cohen-Kettenis & Van Goozen, 1998). Because thus far little is known about the psychological effects of pubertal sex hormones in adolescents with GID, the current policy is to start pubertal suppression only after Tanner stage 2 or 3 has been reached. There are several advantages for adolescents with GID receiving puberty-inhibiting hormones (Cohen-Kettenis & Van Goozen, 1998). First, it is a fully reversible process: if there is a change of mind during the process, the pubertal delay can be brought to end and the patient can continue to live in the gender role associated with phenotypic sex. Second, psychotherapy to more deeply explore gender concerns is easier if puberty is delayed, because the adolescent is free of fear of further physical development and has more psychological room to explore the inner world. Third, the delay provides more time to decide upon further treatment without having to commit to cross-gender living (although some already choose to do so and are able to function quite well). It has been our experience that whether the young adolescent is already cross-living or not, in both cases the chance of developmental problems and reactive depressive symptoms seems to diminish with this early intervention. Fourth, the suppression of puberty is considered as a useful aid in the diagnostic procedure: i.e., if the distress is eased by suppression of pubertal changes, this suggests that gender dysphoria is a primary cause of the distress. Fifth, for those who do go on to a full transition, the prevention of the development of unwanted and irreversible (after Tanner stage 2 or 3) changes in secondary sex characteristics typically means less medical intervention is needed to remove these features (as is the case when interventions start later in life).

These different views on hormonal treatment are rooted in large part in varying perceptions of adolescence and puberty. A decision about which to adhere to depends on the individual adolescent, the guiding principles of the institution or system in which a clinician works, and the personal view of the clinician. In every case a thoughtful decision should be made about what is best to offer the adolescent. In our clinical experience it is clear that waiting until the age of 18 for any physical treatment is not an option for adolescents with severe gender dysphoria, although it can be a reasonable course of action in other cases and may be the only option if the clinical picture is so complicated by co-existing conditions that a clear diagnosis cannot be made. The decision to postpone medical treatment until an adolescent with GID has experienced either puberty Tanner stage 2 or 3 or puberty Tanner stage 4 or 5 has to be made in the absence of objective criteria and consensus among professionals.

The Procedure: Diagnostic Assessment and Treatment

Although most cross-gendered adolescents come to clinics with a straightforward wish for sex reassignment, some have more open questions regarding their identity. In every adolescent the gender problem and potential underlying or related problems have to be examined comprehensively in the diagnostic phase.

The first (diagnostic) phase

Procedure

In this phase, information is obtained from both the adolescent and the parents/guardians on various aspects of the general and psychosexual development of the adolescent. Current cross-gender feelings and behaviour, current school functioning, peer relations, and family functioning have to be assessed (Goldenring & Rosen, 2004). With regards to sexuality, the subjective meaning of crossdressing, the type of crossdressing, sexual experiences, sexual behaviour and fantasies, sexual attractions, and body image should be explored.

In this diagnostic phase, the adolescent also has to be thoroughly informed about the possibilities and limitations of sex reassignment and other kinds of treatment to prevent unrealistically high expectations. This information is best given soon after the first sessions if the youth presents with a strong wish for sex reassignment. If the youth presents with confusion/ambivalence, or has gender problems but is not interested in sex reassignment, information on sex reassignment is postponed until this seems to become a realistic option. The way a patient responds to their understanding of the reality of sex reassignment can be informative diagnostically.

It is important to realize that even extremely cross-gender identified adolescents may lack the support or psychological resilience to handle the drastic life changes that accompany sex reassignment. Thus one should take potential psychological and social risk factors into account when making decisions relating to appropriateness of early interventions.

Instruments

Most instruments that measure aspects of GID have been developed for adults. Specific instruments that can also be used for adolescents are scarce. Some experience exists with the *Utrecht Gender Dysphoria Scale* (Cohen-Kettenis & Van Goozen, 1997), which is a short questionnaire dealing with the distress persons feel when confronted in daily life with the fact that they belong to their biological sex (see Appendix B). *The Body Image Scale* (Lindgren & Pauly, 1975), on which an individual can mark satisfaction with many different body parts as well as a wish to change these body parts, can be

used. A *Gender Identity Questionnaire* for adolescents has been developed by Zucker et al. (2005), consisting of questions concerning cross-sex behaviour and gender identity in the last 12 months and over the entire lifetime. On the *Draw-a-Person* test (Rekers, Rosen, & Morey, 1990), both children and adolescents with GID usually draw a person of their wished (opposite) sex first when asked to draw a person. This last instrument is primarily interesting because of its qualitative information, but it is not a diagnostic instrument with good psychometric properties. (For a recent review of measurements of gender identity and gender role at various ages, see Zucker, 2005.) Besides these specific instruments, regular instruments (personality scales, structured psychiatric interviews, intelligence tests) are also needed for the assessment of the adolescent's intellectual, emotional, and social strengths and weaknesses.

Differential diagnosis

As noted before, not all adolescents with gender concerns have a clear and explicit wish for sex reassignment. Some may simply be confused regarding aspects of their gender. For example, some young gays/lesbians/bisexuals have a history of cross-gender interests and behaviours (Green, 1987; Rottnek, 1999) and may have difficulty distinguishing sexual orientation issues from gender concerns. Individuals with *transient stress-related crossdressing* (crossdressing used in a ritualized fashion to alleviate stress) or *compulsive crossdressing* (for sexual or other reasons) may mistake their interest in crossdressing for a need for sex reassignment. This may also happen in patients suffering from *severe psychiatric conditions* (e.g. schizophrenia), accompanied by delusions of belonging to the opposite sex.

In cases involving confusion about gender feelings, psychotherapy and peer support can be helpful in resolving the confusion and coming to self-acceptance. If the wish for sex reassignment exists in an adolescent who has been extremely cross-gendered from early on and still exists after the other problems are adequately treated, it is likely the GID and other psychological problems co-occur. However, in cases of severe psychopathology one should be even more careful with sex reassignment than in other cases. Typically sex reassignment is postponed until a clear clinical picture emerges. In practice, this may imply that interventions do not take place before adulthood, to allow the evolution of the course of the psychiatric disorder and the level of psychosocial functioning to be evaluated over time.

Some individuals with gender dysphoria do not seek complete sex reassignment. Instead they try to integrate masculine and feminine aspects of the self, adopting an androgynous or bi-gendered form of expression. In such cases hormones or some form of surgery may be sought to minimize existing masculine or feminine physiologic characteristics (rather than to promote cross-sex development). In the experience of most clinicians, however, such a treatment wish is rare in adolescents. This might be because people who experience onset at earlier ages typically have more severe and extreme forms of gender dysphoria. Because the normal developmental process of adolescence often involves experimentation relating to identity and self-expression, caution is indicated if an adolescent presents seeking partial change.

The second phase: "Real life experience" and treatment

As explained earlier, different views exist about the appropriate age for initiation of sex reassignment. In each individual case, it is key to decide whether early physical treatment will be beneficial or that the risk of regret or adverse outcome will be too high. Adolescents who are merely gender-confused or whose wish for sex reassignment seems to originate from factors other than a genuine and complete cross-gender identity are served best by psychological interventions. Even in adolescents with clear GID, if psychological resiliency or adequate social supports are lacking sometimes it is better to postpone medical intervention and use psychosocial interventions to try to create the conditions that will be conducive to a positive outcome for eventual sex reassignment. In other cases the gender dysphoria must be treated concurrent with other interventions.

Psychological interventions

Psychotherapeutic treatment can be helpful both for adolescents who are unsure of the direction they want to take and also for those who have a clear wish to pursue sex reassignment. As there are numerous possible underlying concerns, the range of treatment goals is equally large.

Individual therapy is usually the treatment of choice, but for individuals who want to explore their options for coping with gender dysphoria, group therapy has also been advocated. The observation of other adolescents dealing with their gender concerns, the sharing of information, and the peer support seem to be particularly beneficial to group members. In the Netherlands a volunteer organization organizes meetings for 12-18 year old adolescents with gender dysphoria. These meetings do not have a therapeutic goal. Instead, the meetings give the opportunity to meet gender dysphoric peers in a safe and informal social setting.

For applicants who pursue sex reassignment, the process of sex reassignment is lengthy and intensive and even the diagnostic phase contains therapeutic elements. Adolescents with gender dysphoria need time to reflect on any unresolved personal issues or doubts regarding sex reassignment before embarking on somatic treatment. Any form of psychotherapy offered to adolescents who are considering sex reassignment should be supportive. This means that the clinician makes clear to the adolescent that any outcome of therapy (ranging from acceptance of living in the social role congruent with the phenotypic sex to sex reassignment) is acceptable as long as it ultimately contributes to the well being of the adolescent. After all, for the adolescent, a false negative decision (no medical treatment for someone who needs it) is as disastrous as a false positive decision (sex reassignment for someone who should not have it). Only in a supportive environment will an adolescent be likely to explore any doubts and ambivalence that may exist.

Therapists need to be knowledgeable about the different treatment options to be able to explain all the consequences of sex reassignment. They also should be accustomed to working with this age group and be able to discuss sensitive topics. During the diagnostic phase but also later, when some form of hormone treatment has been initiated, various issues have to be brought up repeatedly – including relationships, sexuality, and infertility. Views and experiences of the adolescent often change over time. A 13-year old interested in dating but not genital sexual touching or penetration will likely experience less discomfort relating to genital incongruence (or will find it easier to suppress the discomfort) than an 18-year old who is more interested in pursuing sexual relationships.

It has been our experience that quite a few adolescents with GID entirely refrain from dating and sexual activity. The adolescent may feel uncertain because they are afraid to tell the partner about their gender identity problem (if they still live in the original gender role) or about their biological sex (if they have already made the role change). If reluctance to disclose transgender identity to a partner only seems to be a matter of communication skill, it may be helpful to discuss pros and cons of various options, and to role-play or rehearse explanations to imaginary partners. There is no single ‘right moment’ or ‘right way’ for disclosure, but the better prepared and the more confident an adolescent is, the easier it will be to overcome the barriers. If other underlying factors – personality characteristics such as shyness, self-consciousness, or extreme perfectionism (“I can only have a relationship if my treatment is completed”); psychopathology (e.g., depression or personality disorders); or external factors (e.g., religious/cultural prohibitions) – are an issue, they should be addressed first.

Like other adolescents, adolescents with gender problems need adequate information about sexuality in general, including prevention of HIV and other sexually transmitted infections. If they are not very capable in judging other persons and situations, it may be necessary to point out the chances of aggressive reactions when they engage in sexual encounters, especially if the sexual partners are not aware of the adolescent’s sex of birth.

A very difficult matter that has an impact not only on relationships but also on many aspects of the self is body image. If secondary sex characteristics have hardly developed and an early social role change has been made, unhappiness about unwanted characteristics such as beard growth and a low voice (male-to-female, abbreviated as MTF) or breasts (male-to-female, abbreviated as FTM), typical concerns in older adolescents/adults, are virtually non-existent. Yet many adolescents who have had pubertal delay treatment feel frustrated even in the absence of unwanted secondary sex characteristics because, in their opinion, they have to wait too long for their estrogen or androgen treatment to feminize/masculinize in the same ways as their age peers. There are usually more internal conflicts and more intense negative emotions if secondary sex characteristics have already developed prior to treatment starting; this may result in breast binding (FTM) and wrapping the penis or testicles (MTF). In these cases there might be shame, frustration, and regret that treatment had not started earlier. Some adolescents undergoing sex reassignment find it increasingly confusing that they still have genitals of their original sex over time.

Another subject that has to be discussed repeatedly and over time is the life-long impact of sex reassignment. Adolescents who have been fortunate to have supporting parents, a protective school, and have been treated so early that they have no unwanted secondary sex characteristics do not always realize that life may be less easy in adulthood. Colleagues or acquaintances may discover the situation and be less accepting than their parents and current friends. When involved in serious relationships, they will always have to inform the partners about their infertility and, most probably, their sex reassignment. Conversely, adolescents who have been exposed to teasing and bullying, or who have a non-accepting family, may feel shameful about their cross-genderedness and overestimate the negative impact of sex reassignment on their lives. Adolescents will profit most from having a balanced view of the short- and long-term costs and benefits of sex reassignment. Therapists may be helpful in establishing the youth with such a view.

Both adolescents who are eligible for sex reassignment as well as those who are not may need psychotherapy to address the impact of teasing, bullying, violence, and social isolation (Burgess, 1999). As with other youth who have had similar experiences, such life histories may seriously hamper the development of a healthy self-esteem or trust in other people. It may even cause an internalized transphobia. In severe cases, clinicians may have to reduce the negative impact of these experiences before they can continue with the diagnostic work.

Family therapy may, in some instances, help to resolve conflicts between family members. For example, some adolescents want to be open about transgender feelings or express their gender in ways that other family members are not comfortable with; conversely, if an adolescent is already cross-living, parents may fear aggressive reactions if friends who are not informed discover the adolescent's history of transition. Another common cause of conflicts is that the family members find it hard to make a distinction between what is related to gender dysphoria and what is not; some families (the adolescents included) tend to attribute every mishap to gender issues, whereas other families tend to underestimate the impact of gender dysphoria on the adolescent's development. It may be helpful to emphasize that all adolescents, including those with gender problems, have certain responsibilities – having gender dysphoria is no excuse for not washing the dishes or failing to complete homework. However, this does not mean that parents should not try to be sensitive to the special needs of their children. Family therapists or family counsellors should try to help parents determine realistic demands and to work on the development of healthy boundaries and limits. Conflicts may also arise between parents when they have different views about how to handle their child. Fathers often find it harder to accept cross-gender behavior of their children, especially the boys, than mothers do; if the mother tries to protect her child against the criticism or aggression of the father, marital conflicts may occur. The adolescent may feel guilty about causing the marital discord. A family therapist or counselor may help in finding solutions for such disagreements.

In the Netherlands, there is an organization of parents of gender dysphoric children and/or adolescents. At their regular meetings they exchange experiences, try to support each other and sometimes invite professionals to give relevant presentations. Although not all parents attend the meetings and some do so only a few times, most parents find it very useful to know of other parents who are familiar with the problems a family with a gender dysphoric child may encounter.

"Real Life Experience" (RLE)

During the "real-life experience" (RLE) phase, adolescents live full-time in the role they are transitioning to, if they were not already doing so. The Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care* define the RLE as "the act of fully adopting a new or evolving gender role or gender presentation in everyday life", with the intention of experiencing *in vivo* the familial, interpersonal, socioeconomic, and legal consequences of transition (Meyer et al., 2001). The *Standards of Care* explicitly state that RLE is not a diagnostic test to evaluate whether gender concerns are present, but that the process tests "the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports". A fundamental premise of the RLE is that the person should experience life in the desired role before making irreversible physical changes.

For adolescents seeking sex reassignment, RLE includes informing family, friends, school and other social contacts about the wish for sex reassignment and the intention to undergo gender transition. Usually, a new name congruent with the adolescent's gender identity is chosen, and there is a concurrent switch in gender pronouns. There may also be a change in clothing, hairstyle, and gender-specific behaviours (including the use of the boys' washroom for FTMs, and the girls' washroom for MTFs). Essentially it is expected that the adolescent live as if physical transformation had already taken place.

During the RLE, the adolescent's feelings about the social transformation, including coping with the responses of others, is a major focus of the discussions and counselling. This is obviously less the case when an adolescent already lived in the desired role before applying for sex reassignment. It is difficult to give a general rule for the start of the RLE, as the personalities and life circumstances of adolescents are so different. Some wait until they have graduated from school, or after the feminization/masculinization of cross-sex hormones begins (after age 16). Others begin living in the desired role even before they have started with puberty-delaying hormones.

Physical interventions

Physical intervention (hormonal and/or surgical feminization/masculinization, discussed below) is a long-term process. It is a very strong recommendation that the adolescent undergoing physical treatment have adequate familial support and stability, both to ensure attendance at medical appointments and also to help cope with psychosocial stresses. The psychological and social burden placed on adolescents during the sex reassignment procedure deserves adult care and support.

Mental health professional involvement is a requirement for physical intervention in adolescence. The objective of this involvement is that treatment is thoughtfully and recurrently considered over time. Each developmental phase might bring up new issues and the consequences of sex reassignment as well as the wish for sex reassignment should be reconsidered and discussed again.

Informed consent is essential (as it is for any type of physical intervention). The different steps in physical interventions and the long duration of the process require that treatment information is repeatedly given and discussed. Each phase of this process results in a letter of recommendation from the mental health professional to the prescribing physician or surgeon.

The guidelines of the Royal College of Psychiatrists (Di Ceglie et al., 1998) and the HBIGDA *Standards of Care* (Meyer et al., 2001) distinguish between fully reversible, partially reversible, and irreversible stages of physical interventions for adolescents.

1. Fully reversible interventions: Pubertal delay

As discussed previously, different views exist on at what age and at what pubertal stage to start with puberty-delaying hormones. To let adolescents experience their physical puberty at least to some extent, some clinicians choose to wait until Tanner stage 2 or 3, whereas others believe it is better to wait until Tanner stage 4 or 5. In addition to standard readiness criteria relating to psychologic stability sufficient to withstand the stresses of sex reassignment, three additional criteria must be met for pubertal delay:

- throughout childhood the adolescent has demonstrated an intense pattern of cross-gender behaviours and cross-gender identity
- the adolescent has gender dysphoria that is significantly increased with the onset of puberty
- parents or guardians must consent to and participate in the therapy

Puberty-delaying hormone treatment should not be viewed as a first step that inevitably leads to gender transition, but as a diagnostic aid. Therefore, “real life experience” is not required prior to or during hormonal treatment at this stage.

Typically, GnRH analogues such as leuprolide or triptorelin are used to delay/suppress puberty (Gooren & Delemarre-van de Waal, 1996). These compounds bind so strongly to the pituitary GnRH receptors that the secretion of luteinizing hormone (LH) and follicle-stimulating hormone (FSH) is blocked. Eventually the gonadal production of sex steroids discontinues and a prepubertal state is (again) achieved. Height and bone density growth will be tapered off during GnRH analogue treatment, but there is some preliminary evidence that, once cross-sex hormone treatment is started and puberty of the opposite sex is induced, bone density recovers (Delemarre-van de Waal, Van Weissenbruch, & Cohen-Kettenis, 2004). GnRH analogues should be prescribed by a pediatrician specialized in endocrinology who can carefully decide which dose to give, following important body measures like height, weight, Tanner stages, bone age, skin folds, laboratory endocrine as well as metabolic blood parameters and bone density. More detailed guidelines on the treatment with GnRH analogues for GID are not available yet in print, but a publication on the procedure and the physical effects is in preparation and will be submitted for publication soon.

Alternatives may be preferred to delay specific elements of pubertal development. For example, low-dose progestins (e.g., 0.5 mg lynestrenol po qd) have been used to suppress menstruation in FTMs (Gooren & Delemarre-van de Waal, 1996). Cyproterone acetate has been suggested as a reversible intervention for MTFs seeking to avoid the development of spontaneous erections and nocturnal emissions (Gooren & Delemarre-van de Waal, 1996), but as androgen antagonists can also promote irreversible breast development we do not consider this to be a fully reversible form of treatment. Additionally, there is some concern that neutralization of all androgen effects may not be healthy for developing adolescents.

2. Partially reversible interventions: Cross-sex hormone therapy

Feminizing/masculinizing hormone therapy (estrogens/anti-androgens/progestins for MTFs, androgens for FTMs) is considered partially reversible, as some of the changes persist even if hormone therapy is discontinued. Some changes (breast growth in MTFs, pitch drop and facial hair growth in FTMs) require surgery or other treatment to “reverse”. It is not known whether hormonally-induced sterility is reversible. The expected effects and possible risks of cross-sex hormone therapy

are discussed in detail in *Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines* (Dahl et al., 2006).

Because of the risks involved in feminizing/masculinizing hormone therapy, it typically does not begin until the adolescent is 16 years or older. From a pediatric endocrinologist's point of view, it is argued that, irrespective of Tanner stage at presentation for treatment, adolescents undergoing sex reassignment should be treated with GnRH analogues first to keep their own sex-hormone production low. Cross-sex hormones are then gradually added to induce puberty of the desired sex.

As per the HBIGDA *Standards of Care*, the mental health professional coordinating care should be involved with the adolescent (and family, for younger adolescents) for a minimum of six months prior to making a recommendation to begin hormonal feminization/masculinization (Meyer et al., 2001). The number of sessions during this six-month period depends upon the clinician's judgment.

3. Irreversible interventions: Surgery

The details of surgical feminization/masculinization are explained in *Care of the Patient Undergoing Sex Reassignment Surgery* (Bowman & Goldberg, 2006). As discussed earlier, sex reassignment surgery is not carried out prior to adulthood. There is international clinical consensus that the risks of early surgical intervention far outweigh the potential benefits in virtually all cases.

The HBIGDA *Standards of Care* emphasize that the "threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention" (Meyer et al., 2001). At age 18, the eligibility for sex reassignment surgery should be reconsidered and discussed. If the adolescent is not functioning well, is ambivalent about the social role change or has experienced no relief relating to the changes brought about by hormones, there should be no referral for surgery.

As per the HBIGDA *Standards of Care*, a minimum of two years "real life experience" is necessary prior to surgery in an older adolescent. An 18-year-old who is felt to be a suitable candidate for surgery must have been cross-living since age 16 (or earlier). When an adolescent turns 19 the guidelines for adults will be followed (Bockting et al., 2006).

If a MTF adolescent has taken GnRH analogues from an early age it is possible that not enough penile skin will be available to allow for a deep vagina using the penile inversion method. In that case, additional skin may need to be used from other parts of the body, such as the groin or abdominal wall. This will be evaluated by the surgeon as part of treatment planning.

Other treatment

MTFs who have gone into puberty at a very young age or have started with GnRH analogues at a relatively late age might already have developed unwanted facial hair or gone through pubertal changes to voice by the time they present for treatment. There are currently no adolescent-specific guidelines for the provision of hair removal or speech therapy treatment as part of gender transition.

Hormonal treatment does not completely stop facial hair growth in adult MTFs. If facial hair persists, electrolysis, laser treatment, or other depilation treatments may be necessary.

As part of puberty, biological males experience numerous physiologic changes to the vocal tract that result in lowered pitch and changes to resonance and vocal quality. Additionally, there are gender-based differences in articulation, intonation, pragmatics, and other aspects of speech/voice. Speech therapy and pitch-elevating surgery as part of gender transition are discussed in detail in *Transgender Speech Feminization/Masculinization: Suggested Guidelines for BC Clinicians* (Davies & Goldberg, 2006).

Post-Treatment Evaluation

Psychotherapy for adolescents may be necessary during the whole sex reassignment period, including after surgery. Even after treatment psychosocial challenges may arise. For clinicians who work only with children and adolescents, care planning includes identification of resources the patient can call on as they transition from adolescence to adulthood. Clinicians who work with all age groups may be consulted by a patient long after gender transition has taken place, as there is already therapeutic rapport, trust, and an understanding of the history of a patient's transition process. For this reason, it is recommended that those who work with adolescents with gender dysphoria also have an understanding of issues that can emerge for transgender adults. *Counselling and Mental Health Care of Transgender Adults and Loved Ones* (Bockting et al., 2006) discusses the concerns of adults in greater detail.

Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents

Catherine White Holman & Joshua Goldberg

This chapter is a companion piece to *Clinical Management of Gender Dysphoria in Adolescents*. That document, written by advanced practitioners, offers important advice for gender specialists working with adolescents who need specialty care relating to gender dysphoria. In this chapter we focus on (i) care of transgender adolescents by the non-specialist working in primary care, family services, schools, child welfare, mental health, and other community settings, and (ii) BC-specific issues in gender dysphoria specialty services.

Complete care for transgender adolescents must be considered in the context of a holistic approach that includes comprehensive primary care as well as cultural, economic, psychosocial, sexual, and spiritual influences on health. The non-specialist can facilitate peer and family interactions that help the transgender adolescent learn emotional and relational skills, including tools to recognize, express, and manage emotion; resolve conflicts constructively; and work cooperatively with others (American Psychological Association, 2002). A positive youth development approach that focuses on building the adolescent's competence, confidence, and social connectedness can help promote resilience and healthy development (Lerner, 2002; Tonkin, 2002).

Adolescent health is an interdisciplinary field, and our recommendations are accordingly broad. Many of the discipline-specific protocols and recommendations discussed in other documents in this series (e.g., *Counselling and Mental Health Care of Transgender Adults and Loved Ones*, Bockting et al., 2006; *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*, Feldman & Goldberg, 2006) are also applicable to clinicians who work with older adolescents. We encourage adaptation of our recommendations to fit the specifics of clinical practice.

The Local Clinical Picture

To date, most demographic information about transgender adolescents is derived from research done by specialized clinics for gender dysphoric children and adolescents in Toronto, England, and The Netherlands (Bradley & Zucker, 1990; Cohen, de Ruiter, Ringelberg, & Cohen-Kettenis, 1997; Di Ceglie, Freedman, McPherson, & Richardson, 2002; Zucker, 2004). There is no systematic documentation of transgender adolescents who are not gender dysphoric, or who pursue sex reassignment outside the gender clinic system (e.g., obtaining hormones through internet purchase, friends, or street trade). In the absence of information about transgender adolescents in BC, it is impossible to do more than comment on trends within the population we have worked with. As the scope of our work involves general advocacy, crisis intervention, and counselling for people of all ages in urban community-based service settings, our client group is, not surprisingly, different than the highly specific population seeking service from the Amsterdam team's specialized hospital clinic for gender dysphoric children and adolescents. Regional differences in social attitudes towards gender-variance, supports for gender-variant adolescents, and general socioeconomic structural differences between western Canada and The Netherlands may also be factors.

As there is no empirical data to support generalizations about gender-variant adolescents, we limit our discussion to differences in client populations noted by Drs. De Vries, Cohen-Kettenis, and Delemarre-Van de Waal that we believe have implications for clinical assessment, care planning and

treatment. Further work is needed to gain a better picture of the clinical concerns of gender-variant adolescents throughout the province, particularly in rural and remote settings.

Initial presentation

In a gender clinic or other trans-specialty service, clients/patients are obviously transgender and have been referred for help to deal with gender concerns. This is not necessarily the case in a general community service setting, where the client base and the reasons for seeking service are far more diverse.

In our experience working in a range of general community services, few transgender adolescents seek help specifically for a gender issue. More commonly, transgender issues have surfaced in the context of counselling, support, or advocacy relating to general psychosocial concerns. Our transgender adolescent clients have most often presented seeking assistance for the same range of concerns as non-transgender adolescents – abuse, anxiety, depression, difficulty at school, disordered eating, drug and alcohol use, family stress, financial worries, homelessness, loneliness, peer or relationship violence, questions about sexual orientation, relationship difficulties, and suicidal ideation. In some cases transgender identity has had no bearing on our client's concern, while in others there have been trans-specific components requiring evaluation and incorporation into the care plan.

Regardless of the presenting concern, we have found it important to evaluate the impact of trans-specific issues on the adolescent's overall health and well-being. This can be challenging in the community setting when gender concerns are suspected but the adolescent has not disclosed transgender identity. Techniques to facilitate discussion of transgender issues are discussed on pages B6-B7.

Fluidity of gender identity

The Amsterdam team works primarily with adolescents who are strongly cross-identified transsexuals (i.e., natal males who identify as young women and natal females who identify as young men). Many of our transgender adolescent clients – including those who have sought sex reassignment – have identified outside a gender binary of male/female, using terms such as *gender-fluid*, *gender-bending*, *genderqueer*, and *pangender* to describe their sense of self. A similar trend was noted by clinicians at the Dimensions youth clinic in San Francisco (Dimensions, 2000a; Dimensions, 2000b), as well as by clinicians at other North American health centres who were interviewed as part of this project. It may be that this is a population trend specific to North America; it is also possible that transgender youth who are not transsexual tend to engage with the health and social service system in ways that are different than transsexual youth. Regardless of the reason for the difference, local clinicians should be aware of the gender diversity among the local transgender adolescent population as part of the general sensitivity and awareness needed for any work with the transgender community.

Psychosocial issues of concern

Clinical Management of Gender Dysphoria in Adolescents focuses on psychosocial issues in the gender dysphoric adolescent. As discussed in the previous paragraph, it has been our experience that the local transgender adolescent population is comprised primarily of adolescents who are not transsexual. Many non-dysphoric transgender adolescents struggle with the same psychosocial issues as those described by Drs. de Vries et al. (e.g., body image, relationship/sexuality concerns); both groups also share psychosocial struggles related to societal marginalization (e.g., identity confusion, internalized stigma, shame, guilt, isolation, discrimination, harassment, and violence). In

the following section we briefly identify psychosocial concerns commonly expressed by the transgender adolescents we have worked with.

Safety

Visibly gender-variant people and those who have disclosed their transgender identity to others are vulnerable to hate-motivated harassment and violence by dates/acquaintances, family members, school-age peers, co-workers, and strangers (Kenagy, 2005; Kosciw & Cullen, 2001; Lombardi, Wilchins, Priesing, & Malouf, 2001; Odo & Hawelu, 2001; Wyss, 2004). Violence against transgender people is not formally tracked in most jurisdictions in North America, but newspaper and anecdotal reports collected by community organizations suggest that transgender people of colour in the male-to-female (MTF) spectrum are particularly vulnerable to violence as a result of the triple burden of transphobia, sexism, and racism (Currah & Minter, 2000; Goldberg & White, 2004). We have also observed heightened risk of interpersonal violence among transgender people who are financially dependent on another person, cognitively impaired, physically disabled, homeless, or involved in the sex trade. Adolescents are particularly vulnerable to violence due to their limited options for economic independence, the prevalence of age-peer violence in schools, and power differentials between adults and youth. Violence in school is further discussed in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).

In the preceding chapter, Drs. De Vries, Cohen-Kettenis, and Delemarre-Van de Waal noted the need to discuss safety relating to disclosure of transgender identity in sexual relationships. We also routinely assess transgender adolescents' potential risks for violence and their perception/awareness of safety at school, home, the workplace, and general public settings (e.g., public transit) and, where necessary, create safety plans (e.g., a safe place to go, trans-positive emergency services, and group safety).

Poverty and homelessness

In discussion about this project, Drs. De Vries, Cohen-Kettenis, and Delemarre-Van de Waal commented that their adolescent clients typically did not struggle with economic concerns as our adolescent clients often do. Within the published literature there is recognition that gender-variant adolescents are vulnerable to abuse, neglect, and parental rejection, with resulting poverty and homelessness (de Castell & Jenson, 2002; Estes & Weiner, 2001; Klein, 1999; Leichtentritt & Arad, 2004). Cross-gender behaviour may be met with scorn, ridicule, abuse, or violence, and the adolescent may have to choose between living in a way that is not congruent with identity or leaving home. The adolescent may attempt to suppress transgender feelings as a way of coping, or may leave home or be forced to leave. Gender dysphoric adolescents without family support face numerous psychological and socioeconomic challenges and it may be impractical to begin sex reassignment until stability has been regained. In other instances the clinician may feel that sex reassignment should proceed along with interventions focused on psychosocial stability.

For transgender adolescents who have left home (voluntarily or involuntarily), it can be a challenge to find safe and affordable housing. Trans-specific advocacy relating to foster care and emergency shelter is discussed in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006). While homeless transgender adolescents may in some cases wish to reunite with their families of origin, in other cases reunification is not appropriate (e.g., high risk of familial abuse) or feasible (e.g., no willingness to accept the adolescent back into the home). Adolescents whose family members were unaware of transgender identity prior to leaving home and who wish to reconnect with family members may need support around management of disclosure.

Sex work

For both MTF and FTM adolescents without financial support from family, the sex trade may offer a means of financial survival (Klein, 1999; Pazos, 1999). A study of North American adolescents in the sex trade concluded that the financial costs of sex reassignment and the low earning power of adolescents left transsexual youth without family economic support few choices other than the sex trade (Estes & Weiner, 2001). In addition, the sex trade can appeal to young transgender women as a way to find community, validate identity as a woman, and feel desirable (Worth, 2000). In BC, the combined impacts of colonization, poverty, racism, and violence as well as a lack of accessible and relevant supports have led to high numbers of Aboriginal youth among adolescents involved in the sex trade (Social Services and Community Safety Division – Justice Institute of British Columbia, 2002).

The BC government defines exchange of sex for drugs, money, food, shelter, or other goods as commercial sexual exploitation (CSE) if a youth 18 years or younger is involved (Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 2000). While in BC the term "sexual exploitation" is used by some former sex workers who are now advocates (Tubman & Bramly, 1998), transgender adolescents involved in the sex trade typically do not use the term "sexual exploitation" to describe their situation (Klein, 1999), and many of the older adolescents we have worked with reject the term as patronizing. Like Klein, we have found adolescents are most receptive to discussing involvement in the sex trade when they are confident that the clinician is non-judgmental about their involvement in sex work. For this reason we use the term "sex trade" here rather than CSE.

In our experience there is great diversity of gender identity among adolescents who work in the sex trade. We have worked with three groups of transgender adolescents in the sex trade:

a) *Adolescent MTFs who strongly identify as women:* Some work as women, while others feel it is too dangerous to do so prior to genital surgery and work in the sex trade as men (but present in other settings as women). A small number have been able to work openly as transgender women in escort agencies or on the street "tranny track". In our experience the trans-specific concerns of this group primarily relate to validation of female identity and obtaining sex reassignment.

b) *Adolescent males who do not identify as women, but work crossdressed*: This group crossdresses only for work purposes, and outside of work identifies as male. Many of our clients in this circumstance did not identify as transgender but needed assistance to deal with transphobic violence or harassment they experienced while working. Some have also sought counselling relating to confusion about gender identity or sexual orientation.

c) *Adolescent FTMs working as women*: We have worked with a few FTMs who, while personally identifying strongly as masculine/male and living as male in their personal/social life, worked in the sex trade as women. FTMs in the sex trade have been a more hidden population and it may well be that some FTM adolescents are able to work as men, despite not having access to genital surgery. The number of FTM sex workers in our client base is too small to identify service themes.

Clinicians working with transgender adolescents have the opportunity to engage in positive interventions that make it possible for youth to get sufficient social and economic supports to have alternatives to the sex trade, and also provide support for transgender adolescents already involved in the sex trade (Social Services and Community Safety Division – Justice Institute of British Columbia, 2002). A detailed discussion of prevention and support strategies is outside the realm of this document, but clinicians working with transgender adolescents should be aware of the possibility of sex trade involvement, and ensure that services for transgender adolescents are both relevant and accessible to youth who are involved in the sex trade. Klein (1999) suggests services for transgender youth in the sex

trade should include assistance with education, employment, and life skill development; psychotherapeutic interventions aimed at exploring transgender identity and building resilience to deal with conflict, relationships, shame, stigma, depression, safer sex, and peer pressure; and facilitation of connections with peer support. It is also important that involvement in the sex trade not be considered an exclusionary criterion for youth who are seeking sex reassignment, as this leaves adolescents who are economically dependent on the sex trade unable to access care (Raj, 2002).

Sexual health

Drs. de Vries, Cohen-Kettenis, and Delemarre-Van de Waal identified the need to discuss sexuality with adolescents undergoing sex reassignment. In our experience this is also a key issue for transgender adolescents who are not undergoing reassignment.

Sexual health education with transgender adolescents should involve frank, explicit, and sex-positive discussion about the actual practices an adolescent is engaged in, with no assumptions about the gender of partner(s) or sexual activities. While some transgender adolescents are strongly dysphoric about their genitals, others are not. Both male-to-females (MTFs) and female-to-males (FTMs) may engage in receptive or insertive oral, vaginal, and anal intercourse. The same sexual health topics that are routinely discussed with non-transgender adolescents (e.g., sexually transmitted infections, contraception) should also be discussed with transgender adolescents, using language that corresponds to the adolescent's identity (i.e., ask the adolescent what words they use for their genitals). While cross-sex hormones decrease fertility and may cause permanent sterility, hormones taken as part of sex reassignment are not failsafe contraceptives (see *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*). MTF adolescents who are taking feminizing hormones and engage in penile penetration should be aware that the hormones typically reduce erectile firmness, and condoms may therefore be more likely to slip or leak.

Body image

As noted by Drs. de Vries, Cohen-Kettenis, and Delemarre-Van de Waal, body image problems are common in adolescents with gender dysphoria. For adolescents with intense frustration or distress about body image, in addition to a general screening tool for eating disorders such as the SCOFF questionnaire or the Eating Disorder Screen for Primary Care (Kagan & Melrose, 2003) it may be appropriate to inquire about excessively tight breast binding (FTM) or tucking of the penis/testicles (MTF). If binding/tucking is causing pain or skin rash, peer support or information resources may be helpful in discussing less physically harmful techniques that can be used.

It has been our experience that transgender adolescents who have had few positive transgender role models tend to have a distorted self-image, compounded by media stereotypes of MTFs and the invisibility of FTMs in popular culture. General societal norms and standards for non-transgender women and men also affect transgender people. In particular we have noticed a struggle with North American values of thinness and standards of attractiveness among adolescent MTFs, with high value placed on ability to "pass" as a non-transgender woman and conformity to beauty norms for non-transgender women. Exploration of transgender identity may be important as part of intervention. Transgender community involvement and peer support may also be useful in exploring myths and stereotypes about transgender "attractiveness" and worth.

Facilitating Discussion of Transgender Issues

While some transgender adolescents are open about being transgender and may talk about this on the first visit, others are more wary initially, or unsure how to discuss it. We have found the following strategies useful in creating an environment conducive to discussion of transgender issues with adolescents.

Promoting adolescent awareness of transgender issues

Although public awareness of transgenderism has greatly increased in the last decade, many individuals with transgender feelings do not know how to articulate their concerns. Magazines that include articles about transgender youth and consumer information that describes terms relating to the diversity of transgender identity and experience (available from the Transgender Health Program) can be included in reading material in your waiting room to help give adolescents language to talk about their feelings.

Active demonstration of transgender awareness and sensitivity

Adolescents may fear a negative reaction upon disclosure of transgender identity, or may assume that you will not be able to relate to their concerns. Emphasis on non-judgmental attitude, reassurance about confidentiality, and active demonstration of transgender awareness and sensitivity helps convey to the adolescent that you are safe and approachable. Listing your services in the Transgender Health Program's resource guide (http://www.vch.ca/transhealth/resources/directory) lets adolescents know that you have an active interest in transgender issues. Including transgender brochures and posters (available from the Transgender Health Program) in your waiting room helps demonstrate that you are trans-positive. It is important that materials be reflective of the diversity within the transgender community (e.g., ethnicity, disability).

Asking a question about transgender identity on an intake form is a simple way to encourage disclosure of transgender identity. Some clinicians use "Choose as many as apply: M / F / MTF / FTM / other (please specify)", or give the options "M / F / Transgender". This not only demonstrates understanding of transgender issues, but also raises adolescents' consciousness that there are options beyond a binary gender system.

Routinely screening for gender concerns

Internal conflict related to gender identity is not always immediately apparent. To date, no screening tools have been developed to facilitate detection of gender identity concerns in the general community setting. The gender dysphoria measurement instruments discussed on pages A4-A5 (Cohen-Kettenis & Van Goozen, 1997; Ljndgren & Pauly, 1975; Zucker et al., 2005) are designed for use by the gender specialist where there is already suspicion of distress about gender identity. In the absence of formal screening tools, we recommend incorporating a brief question about gender into your intake process with all clients/patients (not just those who look gender-variant or who you think may be transgender). We recommend making a short normalizing statement followed by a simple question that can be answered without directly declaring transgender identity. For example:

> "Many people struggle with gender. Is this an issue for you?"

Asking in this indirect way creates an opening for adolescents who are not sure about their identity or are embarrassed or ashamed of transgender feelings, and would be intimidated by a direct question. It also avoids a negative response by non-transgender adolescents who would be

confused or angry if asked a direct question about transgender identity. A positive answer should be followed by a more detailed evaluation, as outlined in the table below.

Table 1: Evaluating Gender Concerns in Adolescents

Nature of gender concerns	• What is the adolescent concerned about (e.g., discrepancy between body and identity, social perceptions, social roles, sexual arousal from crossdressing)? • When did these feelings start? • Are the feelings constant, or do they come and go? Does anything make them better/worse? • How intense are the feelings?
Impact on the adolescent's life	• How are the gender concerns impacting on the adolescent's overall well-being (including mental health and developmental progress)? • What is the impact on peer and family relationships? • What is the impact on school/work? • What are the adolescent's coping strategies? Are there any concerns about escalating substance use, self-harm, binge eating, compulsive exercise, or other potentially harmful coping mechanisms? • How aware is the adolescent of community resources and options for support?
Feelings about transgenderism	• What is the adolescent's belief structure about transgenderism? • How does the adolescent feel about the possibility that they may be transgender? • What is the adolescent's information about transgenderism based on (e.g., talk shows, peer opinion, cultural/religious beliefs, internet, movies)?
Related or co-existing factors	• Are there any other physical or psychosocial concerns that are contributing to the adolescent's distress? • Do these seem related to the gender concerns? If so, how?

For the adolescent who is confused, questioning, or unsure about gender issues, counselling by the non-specialist and referral to age-appropriate community resources are often sufficient. As with lesbian, gay, bisexual or questioning adolescents, this level of support typically focuses on normalization of feelings, discussion of options for identification and expression, exploration of fears and anxiety, and discussion of non-destructive ways to cope with societal stigma (Fontaine & Hammond, 1996). To alleviate the isolation commonly experienced by gender conflicted adolescents, community peer support groups, internet resources, and other options for social connection should be identified. This is further discussed on pages B12-B13.

Evaluation by a mental health clinician specializing in gender identity concerns is recommended if the adolescent:

- is so distressed about gender issues that health and well-being, relationships, or school/work are negatively affected
- expresses feelings of gender dysphoria, an aversion to aspects of their body associated with sex/gender, discomfort with gender identity, or a wish to live as the opposite sex
- is compulsively crossdressing or pursuing validation of gender identity (e.g., through compulsive sexual or online encounters)
- has a co-existing or pre-existing condition that complicates evaluation of gender concerns (e.g., schizophrenia or other thought disorder, personality disorder, cognitive disability due to injury or developmental disorder)

Dilemmas in diagnosis of gender concerns in adolescence

The *DSM-IV-TR* (American Psychiatric Association, 2000) defines two conditions relating to gender concerns: Gender Identity Disorder (GID) and Transvestic Fetishism (TF). GID is divided into two age groupings – GID of Childhood (302.6) and GID of Adolescence and Adulthood (302.85) – with both referring to a discrepancy between felt sense of gender and the gender assigned at birth. GID Not Otherwise Specified is used when the client/patient is felt to have GID but does not meet criteria for GID of Adolescence. Transvestic Fetishism (302.3) refers to erotically motivated crossdressing that has become so obsessive/compulsive as to cause problems in other aspects of life.[*] Diagnostic criteria for GID and TF are provided in Tables 2 and 3 below.

Table 2: *DSM-IV-TR* Diagnostic Criteria for Gender Identity Disorder (in Adolescents) (American Psychiatric Association, 2000)

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):
Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include:

1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

[*] The *DSM-IV-TR* definition of Transvestic Fetishism limits the diagnosis to heterosexual males. However, compulsive crossdressing for sexual purposes can be a concern for people of any gender or sexual orientation. Erotic crossdressing is not a concern, but if it becomes so consuming that it is affecting a person's ability to function, the compulsivity and obsessive qualities are of clinical significance. Regardless of the utility of a TF diagnosis, recognition of compulsive crossdressing and application of treatment used for other compulsive behaviours (including pharmacologic and behavioural therapy) is important. This is discussed in greater detail in *Counselling and Mental Health Care of Transgender Adults and Loved Ones* (Bockting et al., 2006).

Table 3: *DSM-IV-TR* Diagnostic Criteria for Transvestic Fetishism (American Psychiatric Association, 2000)

A. Over a period of at least 6 months, in a heterosexual male, recurrent intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: With Gender Dysphoria: if the person has persistent discomfort with gender role or identity.

There is controversy about these diagnoses (Bartlett, Vasey, & Bukowski, 2000; Burgess, 1999; Hill, Rozanski, Carfagnini, & Willoughby, in press; Langer & Martin, 2004; Menvielle, 1998; Minter, 1999; Moore, 2002; Newman, 2002; Wilson, Griffin, & Wren, 2002). Some clinicians feel that a diagnosis of GID or TF is fundamentally important in guiding clinical consideration of options for treatment in adolescents, and that a formal diagnosis enables understanding and acceptance that the distress is clinically serious and that treatment may be required. Others have expressed concern that these diagnoses pathologize transgender identity and erotic crossdressing, fail to differentiate between distress caused by gender dysphoria and distress caused by societal pressures (internalized stigma, societal marginalization, etc.), and are not scientifically valid or reliable as psychiatric diagnoses. The characterization of gender dysphoria as a disorder of identity may lead parents of young gender-variant adolescents to seek “normalizing, “conversion”, or “reparative” therapies that reinforce stigma and shame by attempting to change the adolescent’s identity or behaviour (Raj, 2002; Rosenberg, 2002).

Regardless of clinical or political position on GID and TF diagnoses, it is important to thoroughly assess the gender conflicted client’s history and current concerns as the basis for an informed opinion relating to care, and to record this in a way that facilitates understanding by other clinicians (to promote continuity of care). This includes formal charting of the nature, severity, and persistence of gender concerns over the duration of a client/patient’s care.

By definition, the clinical threshold for GID requires not only cross-gender behaviour but also “clinically significant distress or impairment in social, occupational, or other important areas of functioning”. This is a subjective judgment that has been applied to include youth who are unhappy when forced to conform to prevailing gender norms. We do not believe it is helpful to apply the distress criterion to parents’ distress that their child is atypical, or to an adolescent’s distress about other people’s transphobic reactions. These are societally-caused situations that can be addressed by supportive intervention with the parents focused on building acceptance for gender diversity (Menvielle & Tuerk, 2002), along with intervention for the youth to build resilience and address stigma issues.

While untreated gender dysphoria can result in anxiety, depression, and other mental health problems, not all mental health concerns stem from gender dysphoria. Overall, adolescents with gender dysphoria do not show more psychopathology than other adolescents (Cohen et al., 1997; Cohen-Kettenis & Van Goozen, 1997), but there is variation individually (Smith et al., 2001) and co-existing mental illness should be screened for and appropriately treated as part of the care plan. Behaviours that may have been adopted as mechanisms to cope with gender dysphoria (e.g., cutting/burning, binge eating, substance use) should be addressed and monitored as the dysphoria is treated.

Conducting a detailed trans-inclusive psychosocial evaluation

There are various tools that can be used to evaluate psychosocial concerns in adolescents. HEEADSSS is a way of organizing the evaluation of the adolescent to assess psychosocial concerns in eight areas: **H**ome, **E**ducation/employment, **E**ating, **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety (Goldenring & Rosen, 2004). The full list of HEEADSSS questions is included as Appendix C. While none of the HEEADSSS questions include trans-specific content, many of the questions are conducive to disclosure of transgender concerns for the closeted adolescent.

For the adolescent who has already disclosed transgender identity, the HEEADSSS interview can be modified to include trans-specific content, as in Table 4 below (continuing on the following page). As in the original HEEADSSS protocol, the wording, pacing, and number of questions used should be adapted in consideration of the needs of each client/patient.

Table 4: Sample Trans-Specific Modification of HEEADSSS Psychosocial Interview
adapted from Goldenring & Rosen, 2004

Home	• Do the people who live with you know that you are transgender? (Who?) How did they find out, and how did they react? • How much do you feel you can be yourself at home?
Education/ employment	• Do people at school/work know that you are transgender? (Who?) How did they find out, and how did they react? • Are there people at school/work you feel you could talk to if you needed to talk about transgender issues? (Who?) • Do you skip or miss classes? How often? What do you do instead? • Have you ever been harassed or attacked at school/work? • Do you ever worry about your academic/work future as a transgender person? • Has anyone ever offered you money, clothes, alcohol, or drugs in exchange for sex? Has anyone ever tried to get you involved in the sex trade?
Eating	• What do you like and not like about the way you look? Do you wish you looked different? (How?) • Do you ever daydream about your body being different than it is now? What is your ideal image? • Do you eat more (less) when you are under stress?
Activities	• Do any of your friends know that you are transgender? How did they find out, and how did they react? • Do you know any other transgender people? How did you meet them? • How much time do you spend on the internet in a week?
Drugs	• Do you ever use drugs or alcohol to cope with stress? • What do you think is a safe limit for drug and alcohol use? Have you ever crossed that limit? (How often?) • Have you ever done things when you were drunk or high that you regretted afterwards?
Sexuality	• Have any of the people you've dated known that you are transgender? How did they find out, and how did they react? • Is being transgender part of your sex life? (How?) • Are you attracted to boys, girls, other transgender people? • Are there parts of your body that are off-limits sexually? *continued on next page*

Suicide/ depression	• Do you worry about people finding out you are transgender? • Do you ever wish you weren't transgender? • Does thinking about transgender issues ever make you feel stressed, sad, or lonely? • Do you ever feel that your situation is hopeless?
Safety	• Has anyone ever threatened to "out" you as transgender? Do you worry about this happening? • Have you ever been threatened or attacked because you are transgender, or for other reasons? Do you worry about this happening? • How safe do you feel in your neighbourhood or the places where you hang out?

Supporting Transgender Emergence in Adolescence

Even in the absence of gender dysphoria, transgender youth may struggle with identity development. Lev (2004) characterizes *transgender emergence* as a developmental process of realizing, discovering, identifying, or naming one's gender identity. This does not necessarily mean a transition from male-to-female or female-to-male; for some adolescents (and adults) transition involves emergence as a bi-gender, pan-gender, or androgynous person – a challenging task in a society that has a binary and polarized gender schema.

The distinction of transgender emergence from typical gender identity development is a culturally-derived phenomenon, stemming from the societal assumption that there are two genders (corresponding to two sexes) and that there are norms of appearance and behaviour for each. While transgender adolescents typically do not struggle with denial, avoidance, or repression to the same degree as transgender adults (Lev, 2004), youth who do not fit the dominant gender norms must still find a way to consciously articulate their difference and find language to express their identity.

Transgender emergence is often considered analogous to the process of "coming out" as lesbian, gay, or bisexual. While both processes involve disclosure of a personal secret that may evoke a negative response by others, transgender emergence is not just a matter of declaring membership in a stigmatized group. The existence of homosexuality and bisexuality is generally recognized; in contrast, transgenderism is not widely recognized or understood, and challenges societal beliefs about sex, gender, and sexuality in a way that can be disorienting to the transgender individual and the people around them (Brown & Rounsley, 1996). For most transgender individuals, a search for language is a key element in the emergence process.

The following discussion of interventions to support transgender emergence in adolescence is adapted from Lev (2004)'s model of six stages of transgender emergence in adults undergoing gender transition. Lev warns that her model may not apply to adolescents; the levels of intervention described below are not intended as a model for transgender adolescent development, but rather to help the non-specialist consider appropriate strategies for clinical assistance. A *Stages of Change* approach (Prochaska, DiClemente, & Norcross, 1992) may also be useful in guiding clinical interventions.

Table 5: Non-Specialist Interventions to Support Transgender Emergence in Adolescence

	Clinical focus
Level 1	Awareness of diversity of gender identity and expression
Level 2	Congruence between gender identity and daily life
Level 3	Integration of transgender identity into core identity

Awareness of diversity of gender identity and expression

Some adolescents have only been exposed to information about transsexuality and are not aware of other options for transgender identity or of ways other than physical change to express or affirm a transgender identity. With adolescents who have already made a decision to pursue sex reassignment, we do not try to dissuade them but do try to focus on keeping options open and promoting awareness of diverse possibilities for gender identity and expression. Books and movies that include transsexual and non-transsexual transgender individuals can be useful in demonstrating a breadth of identity and expression. Contact with a diverse range of transgender individuals (age peers and appropriately screened older role models) can also help demonstrate options for gender identity and expression that include but are not limited to sex reassignment. This includes discussion of challenges, risks, and societal limits if the adolescent expresses increasing interest in moving beyond private exploration to integrate transgender identity or expression into life at home, school, or work.

With adolescents who are in early stages of questioning or exploring their gender, we encourage ways of exploring identity and experimenting that do not involve disclosing transgender identity to others or making decisions about transition or sex reassignment (Lev, 2004). If asked we provide information about transition options, but the focus is exploration rather than decision-making. This may include journaling, collage or other artistic/creative expressions, trying out a new name or pronoun in the clinical setting to see how it feels, reading or watching movies that portray various kinds of gender expression, or attending trans-inclusive community events (e.g., drag queen and king performances). It has been our experience that many youth who are early in exploration or questioning find peer contact overwhelming and need time to explore on their own; others are more social and want peer contact earlier in the process.

Drs. de Vries, Cohen-Kettenis, and Delemarre-Van de Waal suggest group therapy for adolescents undergoing sex reassignment. Given the relatively small population base and geographic dispersion of the transgender community in BC, group therapy may not be feasible. For those who want peer support but are uncomfortable in a group setting, individual peer support is available from transgender community groups and the Transgender Health Program (Appendix A). The Transgender Health Program also sponsors a social and support drop-in for gender-variant youth and their friends/partners/siblings similar to the group mentioned by the Amsterdam team in the preceding chapter.

With transgender adolescents who have a generally stable core sense of self (i.e., no evidence of dissociation, thought disorder, or personality disorder) we actively encourage experimentation with fluidity of gender identification and expression as part of the exploration process. This may include experimentation with gender pronouns, name, and aspects of appearance. Some adolescents who are considering gender transition bring cross-gender clothing, wigs, shoes, or makeup to our appointments to try interacting with another person as their imagined self. We do not suggest that adolescents try a form of gender expression they are uncomfortable with, but rather encourage them to try experimenting as a way of deciding who they are and what feels right. We find that adolescents usually relate easily to the concept of experimentation and are excited by the possibility of trying out ways of expressing themselves that are in keeping with their (possibly shifting) sense of self.

For both questioning adolescents and those who already have a strong sense of self, the emphasis is on self-understanding rather than reaching towards a preset goal. If there are concerns about fragmentation of identity or if the process of experimentation seems to be increasing distress, we suggest involvement of an advanced mental health clinician with experience in treatment of co-existing gender concerns and mental illness.

Increasing congruence between gender identity and daily life

For the adolescent who has a clear and consistent sense of self, the next step is the identification of strategies to reconcile discrepancies between identity and daily life. The hormonal and surgical interventions discussed in *Clinical Management of Gender Dysphoria in Adolescents* are, for many gender dysphoric adolescents, a necessary treatment to alleviate the dysphoria. However, not all transgender adolescents are dysphoric, and sex reassignment is not the only course of action a transgender adolescent may take to bring daily life into closer congruence with felt sense of self. The Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care* (Meyer et al., 2001) identify a range of non-medical possibilities transgender individuals may explore, spontaneously or with professional support:

- learning about transgenderism (from the internet, guidelines for care, lay and professional literature, peers, etc.)
- participation in peer support/self-help groups or in the transgender community
- counselling to explore gender identity and to deal with psychosocial pressures
- coming out: disclosing transgender identity to family, friends, and other loved ones
- integration of transgender awareness into daily living
- change in gender pronoun or name
- episodic crossdressing or cross-living
- temporary and potentially reversible changes to appearance: e.g., changes in hairstyle/makeup, temporary removal of facial/body hair or applying facial hair, wearing prosthetic breasts or penile prosthesis, tucking/binding chest or genitals, crossdressing, changes to speech/voice

This list is not meant to be exhaustive, but simply to illustrate that there are multiple options that may be considered by transgender adolescents. Some options require a high level of cognitive and social sophistication and will likely not be spontaneously pursued by young adolescents. Whatever options are considered, there should be thought as to how changes will realistically be integrated into daily life, and what reactions there might be by others.

Disclosing transgender identity to others

For some transgender adolescents, increased congruence between identity and daily life involves disclosing transgender identity to others. "Coming out" as transgender may be prompted by a desire to make feelings or identity known to others, or by planned changes in social role and/or appearance. Disclosure is not only an issue early in transgender emergence: throughout life, transgender adolescents need to consider how much to disclose. Clarity about what the adolescent wants to convey is an important part of decision-making regarding disclosure.

In "coming out" literature there is often an emphasis on disclosure as a necessary stage in self-acceptance, and adolescents may feel they have to come out to be a "real" transgender person. In our experience it is viable for some transgender individuals to live comfortably and in a congruent way without disclosing their identity to others. The decision not to disclose is not necessarily evidence of shame or embarrassment; it may be based on concern about the likely response of others, or may be a reflection of the adolescent's feeling that this aspect of their identity is private. We encourage adolescents to consider disclosure as only one of many possible paths in transgender emergence, and to focus on self-acceptance as the primary goal.

The adolescent who is considering disclosure should be supported to think about the likely reactions of the people they are telling, and possible resources to help facilitate understanding and adjustment. Loved ones often go through stages of adjustment involving feelings of shock, disbelief,

denial, fear, anger, and betrayal, followed by sadness and, in some cases, eventual acceptance (Ellis & Eriksen, 2002; Emerson & Rosenfeld, 1996). This is important for transgender people of all ages to be aware of but is particularly important to discuss with adolescents, as there is often dependence on others for financial and emotional support.

In our experience adolescents are often aware of potential risks of disclosure and are willing to engage in discussion about possible negative reactions. When there are concerns about possible violence or eviction from the home we include a crisis/safety plan as part of the preparation for disclosure. In some cases a safety plan includes discussion of the possible consequences of involuntary discovery of transgender status. We have worked with several adolescents who transitioned early in life and whose teachers and age peers were not aware of transsexual history. As genital surgery is not recommended prior to age 18, there is a risk for any cross-living adolescent that their transgender status will be discovered. In these cases the benefits of controlled disclosure are important to discuss.

With the adolescent's consent, the clinician may be involved in the disclosure process. For example, the clinician may offer to meet with family members or other professionals in the adolescent's life to provide information about transgender issues or referral to peer/professional resources. As discussed in the preceding chapter, family therapy can be useful in helping both the transgender adolescent and their family members reach a deeper understanding of each other's perspectives and concerns.

Ethical and legal issues in disclosure to parents/guardians

In BC, as with any other type of non-emergency medical treatment, sex reassignment of adolescents is governed by the *Infants Act*. Medical treatment for "infants" (defined in provincial legislation as a person under the age of 19) can be provided in the absence of parental consent if: (a) the health provider has explained the treatment options to the adolescent and is satisfied that the adolescent "understands the nature and consequences and the reasonably foreseeable benefits and risks", (b) the health provider has made "reasonable efforts to determine and has concluded that the health care is in the infant's best interests", and (c) the patient has provided consent. With sex reassignment, decisions about the risk and benefits of proceeding without parental consent must be carefully considered, as there is the potential for negative psychological, social, and economic consequences in addition to the normal health risks of any medical procedure.

In the preceding chapter Drs. De Vries, Cohen-Kettenis, and Delemarre-Van de Waal "strongly recommend" that adolescents undergoing sex reassignment have adequate familial support and stability. For adolescents who are already living independently when treatment starts, it may be appropriate to assess social supports independent of family, particularly if the adolescent is estranged from the family-of-origin.

Managing the "real life experience" (RLE) at school and work

As described in the preceding chapter, adolescents who are not already cross-living prior to sex reassignment will undergo "real life experience" (RLE) – living as the desired gender in every aspect of life – as part of the reassignment process. For adolescents this often involves transition at school and/or work settings.

Some transgender youth undergo role transition prior to puberty and enter high school already cross-living full-time. For adolescents whose puberty has been suppressed, while there may be teasing or gossip about the lack of development of secondary sex characteristics, a noticeable transition will not be an issue. For adolescents who were not cross-living prior to starting high school, the transition from

male-to-female or female-to-male is more complex. Advocacy with teachers and school administrators is often necessary during this stage of the transition process, particularly if the adolescent wants to remain at the same school throughout transition or has no alternative (e.g., in rural areas). Discussion topics with school staff may include decisions relating to disclosure (to staff and students); the need for accommodation relating to washrooms, change rooms, and gender-specific activities; change of name on school records and in verbal interactions; use of preferred pronoun; and, if there are concerns about peer violence, anti-harassment and safety planning measures. These issues are discussed further in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).

We have worked with several adolescents whose schools were sufficiently supportive to make it possible to stay during the process of change. In other cases, the harassment experienced at early stages of transition was so intense that our clients have decided to drop out of school and start fresh at a new school where peers are not aware they are transgender, sometimes waiting to return until hormonal changes had reduced their visibility as a gender-variant person.

In some circumstances adolescents have already left school by the time they seek treatment, and/or may be living independently outside the parental home. While it is a violation of provincial human rights legislation to be fired for being transgender, it is not uncommon for transgender people (of all ages) to experience employment discrimination, including termination of employment and difficulty finding work (findlay, Laframboise, Brady, Burnham, & Skolney-Elverson, 1996; Lombardi et al., 2001; Nemoto, Operario, Keatley, & Villegas, 2004; Odo & Hawelu, 2001). This possibility should be discussed with the adolescent and thought given to possible strategies that could be used to prepare an employer, disclose identity to co-workers, and otherwise manage the workplace transition. Workplace advocacy is discussed further in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).

Some of our older adolescent clients have been strongly dysphoric, committed to transition, and yet unable to cross-live in their current employment or school. In difficult situations such as these the clinician must consider whether the inability to live full-time in the desired role is simply a mature and reasonable accommodation of difficult circumstances, or ambivalence about full-time cross-living. Planning around RLE must include consideration of the adolescent's safety and the relative risks and benefits of undergoing RLE.

Feminizing/masculinizing hormones

American studies suggest that transgender individuals who cannot get medical assistance with hormone therapy will find ways to get hormones without medical approval (Hope-Mason, Conners, & Kammerer, 1995; Dean et al., 2000), and the HBIGDA *Standards of Care* (Meyer et al., 2001) also recognize this risk. Estrogen and testosterone can be purchased illicitly or through the internet, or shared among friends. The risks associated with cross-sex hormones (discussed in *Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines,* Dahl et al., 2006) are exponentially increased when there is no screening for health conditions that may be made worse by hormone use, and no monitoring of side effects. For those taking hormones by injection, improper injection technique or needle sharing poses additional health hazards such as abscess and transmission of HIV/Hepatitis C. Non-prescription-grade hormones are often poor quality and may be diluted with toxic substances.

It has been our experience that transgender individuals who take hormones without medical assistance often do so because they don't know who to approach for help, cannot access hormones in any other way, or believe that the process for hormone assessment is so lengthy that their transition will be greatly delayed. The Transgender Health Program has produced consumer factsheets (written at a level appropriate for older adolescents) explaining the process of hormone

assessment, and can assist in helping adolescents understand options for medically assisted hormone therapy. Appropriately screened older peer mentors may be helpful in providing perspective about the temporary wait involved in hormone therapy.

The Transgender Health Program (Appendix A) is developing training and a clinical pathway to facilitate timely assessment of adolescents seeking hormonal feminization/masculinization. Endocrinologists at BC Children's Hospital have experience with pubertal delay and cross-sex hormone prescription, and can provide endocrinologic support to adolescents who have been recommended for hormonal treatment by appropriately experienced adolescent mental health specialists. Consultation with the Transgender Health Program may be useful in expediting referral for the adolescent who has disclosed use of hormones without medical assistance.

Feminizing/masculinizing surgery

While feminizing/masculinizing surgery is typically not indicated prior to age 18, as noted by Drs. De Vries, Cohen-Kettenis, and Delemarre-Van de Waal it is important to begin discussion about surgery early on if the adolescent has expressed a clear intention to transition. Treatment options, impacts, and limitations should be clearly explained, as some adolescents believe that surgery is a simple process that will magically resolve all of their problems. *Care of the Patient Undergoing Sex Reassignment Surgery* (Bowman & Goldberg, 2006) offers clinical information about the processes involved in surgical feminization/masculinization; consumer education materials (appropriate for older adolescents) are available from the Transgender Health Program.

For BC adolescents, discussion about surgery should include information about the BC Medical Services Plan (MSP)'s eligibility criteria for surgical coverage, as most adolescents and young adults are not able to pay privately for surgeries. As of November 2005, MSP provides coverage for MTF genital surgery and some cases of breast augmentation, and for FTM chest surgery, hysterectomy/oophorectomy, and vaginectomy. The criteria and available coverage can change over time, and clinicians working with transgender adolescents should stay advised of changes to the system of care. MSP currently requires evidence of two years "real life experience" (RLE), defined by MSP as full-time work, schooling, volunteering, or a combination of the three (although exceptions to the "full-time" aspect have been made for people who are housebound as a result of disability). As MSP requires written evidence to confirm completion of the RLE, the start date of RLE should be documented, with letters from teachers, employers, or others outside the therapy team who know the adolescent in the role that they are transitioning to. Issues relating to documentation of RLE are discussed further in *Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians* (White Holman & Goldberg, 2006).
MSP currently does not provide coverage for surgical construction of a penis or scrotal implants for FTMs of any age. This has been highly distressing for FTM adolescents we worked with who transitioned early in life and were under the impression that they would qualify for surgical coverage at age 18. Appropriately screened older peer mentors may be helpful in sharing information about ways to cope with not having the desired genitals. MTFs should be made aware that MSP only provides coverage for breast implants if there has been no development after two years taking feminizing hormones, or if breasts are significantly asymmetrical. There is no coverage for pitch-elevating surgery or facial feminization surgery.

Integration of transgender identity into core identity

Integration relates to awareness of the self as a whole person, of which transgender identity is a part rather than the consuming focus (Lev, 2004). Transgender issues are not necessarily completely resolved or static, but the adolescent feels relatively settled and content in terms of gender issues. Some clients describe this as being "able to imagine a future".

Integration does not necessarily mean development of a fixed gender identity. Some individuals retain a fluid identity throughout life, or have periods of ambivalence about identity. For some adolescents integration includes acceptance of ambiguity and the shifting nature of their feelings. When these shifts occur without distress, integration has been achieved.

For the adolescent undergoing sex reassignment, integration does not always depend on completion of surgical changes. As Lev (2004) states,

> In the beginning of this journey some transsexuals focused exclusively on “getting the surgery,” as if surgery validated their gender transition....In the integration stage, most transsexuals, including those who are postsurgical, accept that “the surgery” is neither the end all or be all of their identity. Although they may choose surgery, their gender identity does not depend on their genitalia, but on who they know themselves to be. (p. 268)

The clinician’s role in this stage depends on the adolescent’s overall development. In some cases regular appointments stop because the adolescent no longer needs clinical assistance. For other adolescents, resolution of gender issues reveals areas of development that have been hampered by concerns about gender identity (e.g., development of social skills) or the existence of psychosocial concerns unrelated to transgender concerns. As discussed in the preceding chapter, psychotherapy may continue after surgery.

In our experience integration is a long-term process that is rarely achieved during adolescence. We are encouraged by outcome data from the Amsterdam clinic (Cohen-Kettenis & Van Goozen, 1997; Smith, Cohen, & Cohen-Kettenis, 2002), where supportive treatment of gender-variant adolescents is more easily accessed at an earlier age. These studies suggest that with appropriate treatment and supports, even highly dysphoric transgender adolescents can reach an integrated state.

Concluding Remarks

Synchronized care for transgender adolescents is a challenge for clinicians in BC, where there is no single clinical program that can address all needs of transgender youth. Careful communication is needed to ensure that transgender and gender-questioning adolescents have adequate access to clinical and peer resources, particularly in rural regions. While specialists should coordinate care of youth who are gender dysphoric or highly distressed about gender identity issues, the non-specialist should expect to be involved in care of transgender adolescents at some point in their practice. Both the specialist and the non-specialist can have a significant positive influence in promoting healthy psychosocial development of transgender adolescents. We hope this document helps clinicians in BC to feel more confident in working with this underserved population.

Summary of Recommendations

Clinical Management of Gender Dysphoria in Adolescents

Annelou L.C. de Vries, Peggy T. Cohen-Kettenis, & Henriette Delemarre-Van de Waal

Comprehensive care

1. Mental health professionals typically play a primary role in providing and coordinating care of the gender dysphoric adolescent. However, involvement of clinicians from other disciplines (e.g., social work, family practice, pediatric endocrinology) is essential.

Clinical competence

2. Clinicians who diagnose and treat gender dysphoric adolescents should have training in adolescent psychiatry and/or clinical psychology and experience diagnosing and treating the ordinary problems of adolescents, as well as specific expertise relating to transgender identity development and gender identity concerns.

3. Therapists working with transgender adolescents must be accustomed to working with adolescents and be able to discuss sensitive topics, including sexuality.

Assessment

4. An adolescent who presents with a wish for sex reassignment should be thoroughly assessed to determine the history of gender concerns and potential underlying or related problems. Ideally, parents/guardians will be involved in providing collateral information.

5. Assessment areas include the adolescent's general and psychosexual development, historical and current cross-gender feelings and behaviour (including crossdressing), school functioning, peer relations, family functioning, sexual experiences, sexual behaviour and fantasies, sexual attractions, and body image.

6. The possibilities and limitations of sex reassignment and other kinds of treatment should be discussed both to give the adolescent accurate information about treatment options and also to aid in assessment.

7. Distress relating to gender identity/gender dysphoria should be distinguished from confusion relating to sexual orientation, shame relating to crossdressing or other stigmatized transgender behaviour, transient stress-related crossdressing, erotically motivated crossdressing, gender concerns secondary to a psychiatric condition (e.g., schizophrenia), or adolescent experimentation.

Treatment planning

8. Strategies for management of gender dysphoria include a variety of means of acknowledging and incorporating the felt identity into everyday life. These may (but do not always) include physiologic changes and/or social role changes.

9. Physical treatment is not an option prior to puberty, although psychological treatment including (supportive) psychotherapy may be offered.

10. Adolescents who are confused about their gender or whose wish for sex reassignment seems to originate from factors other than a genuine and complete cross-gender identity should be offered psychotherapeutic treatment.
11. Potential psychological and social risk factors should be taken into account when considering the viability of sex reassignment. If psychological resiliency or adequate social supports are lacking, treatment may focus on creating the conditions that will be conducive to a more positive outcome for eventual sex reassignment.

12. Any co-existing psychopathology unrelated to gender dysphoria should be appropriately treated, and psychosocial supports put in place prior to initiation of physical intervention.

13. In addition to the involvement of other clinicians, mental health professional involvement is a requirement for physical intervention in adolescence. Treatment should be thoughtfully and recurrently considered over time, with the consequences of sex reassignment as well as the wish for sex reassignment reconsidered and discussed again with each new developmental phase.

14. Care planning includes identification of resources the client can call on as they transition from adolescence to adulthood.

Psychosocial interventions

15. Psychotherapeutic treatment can be helpful both for adolescents who are unsure of the direction they want to take and also for those who have a clear wish to pursue sex reassignment.

16. Any form of psychotherapy offered to adolescents who are considering sex reassignment should be supportive: i.e., the purpose of therapy is to contribute to the well-being of the adolescent, not to achieve a specific outcome. Psychotherapy should not have the underlying goal of promoting conformity with gender norms.

17. For adolescents undergoing gender transition, psychosocial issues that tend to be impacted over the course of gender transition or to change as part of general adolescent development (e.g., relationships, sexuality, infertility, disclosure of transgender identity, body image) need to be revisited periodically.

18. Sexual health education should be offered as part of treatment.

19. Family therapists or family counsellors should try to help parents determine realistic demands and to work on the development of healthy boundaries and limits. In some cases it may be appropriate to involve a second clinician in work with parents to avoid compromise of the therapeutic alliance with the adolescent.

20. Psychotherapy for adolescents may be necessary during the whole sex reassignment period, including after transition.

"Real Life Experience" (RLE)

21. "Real-life experience" (RLE) – living full-time in the role the adolescent is transitioning to – allows the adolescent to directly experience the familial, interpersonal, socioeconomic, and legal consequences of gender transition, as well as the experience of living in a different role, prior to making irreversible changes.

22. During the RLE, the adolescent's feelings about the social transformation, including coping with the responses of others as well as management of disclosure in the school/workplace, is a major focus of counselling.

23. The timing of RLE depends on the adolescent's personality and life circumstances. RLE may take place at an early age, or after hormonal feminization/masculinization begins to take effect.

Endocrine therapy

24. GnRH analogues may be prescribed to prevent development of secondary sex characteristics shortly after the onset of puberty (Tanner Stage 2) if:
    - throughout childhood the adolescent has demonstrated an intense pattern of cross-gender behaviours and cross-gender identity, *and*
    - the adolescent has gender dysphoria that is significantly increased with the onset of puberty, *and*
    - parents or guardians consent to and participate in the therapy

25. Feminizing/masculinizing endocrine therapy typically does not begin until the adolescent is 16 years or older, and should be preceded by GnRH treatment regardless of Tanner Stage of the adolescent, with a gradual phase out of GnRH agents as estrogen (MTF) or androgens (FTM) are phased in.

26. The mental health professional who is coordinating care should be involved with the adolescent for a minimum of six months prior to making a recommendation to begin hormonal feminization/masculinization, with the number of sessions during this six-month period depending on the clinician's judgment of what is needed to ensure that treatment is thoughtfully and recurrently considered over time.

Sex reassignment surgery

27. Sex reassignment surgery should not be performed before the age of 18.

28. A minimum of two years "real life experience" is necessary prior to surgery in an older adolescent – i.e., an 18-year-old who is felt to be a suitable candidate for surgery must have been cross-living since age 16 (or earlier).

Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents

Catherine White Holman & Joshua Goldberg

Comprehensive care

1. Complete care for transgender adolescents must be considered in the context of a holistic approach that includes primary care as well as cultural, economic, psychosocial, sexual, and spiritual influences on health.

2. The non-specialist can facilitate peer and family interactions that help the transgender adolescent learn emotional and relational skills, including tools to recognize, express, and manage emotion; resolve conflicts constructively; and work cooperatively with others.

Clinical competence

3. Regardless of the presenting concern, the clinician should be able to evaluate the impact of trans-specific issues on the adolescent's overall health and well-being, and incorporate this into the overall care plan.

4. Clinicians should be aware of the gender diversity among the local transgender adolescent population as part of the general sensitivity and awareness needed for any work with the transgender community.

Facilitating discussion of transgender issues

5. As gender concerns are not always obvious, techniques to facilitate discussion of transgender issues should be used with all adolescents.

6. To promote awareness of transgender issues and help give adolescents language to talk about their concerns, reading materials and posters in the waiting room and office should include trans-specific content.

7. The clinician should emphasize non-judgmental attitude, reassure the adolescent about confidentiality, and actively demonstrate transgender awareness and sensitivity.

8. A brief screening question about gender concerns should be incorporated into the intake process for all clients/patients (not just for those who look gender-variant). A short normalizing statement should be used, followed by a simple question that can be answered without directly declaring transgender identity. For example: "Many people struggle with gender. Is this an issue for you?"

Determining level of treatment needed for gender concerns

9. If an adolescent discloses concerns about gender, the clinician should explore the nature of the concerns, the impact on the adolescent's life, the adolescent's feelings about transgenderism, and related or co-existing factors contributing to the adolescent's distress.

10. For the adolescent who is confused, questioning, or unsure about gender issues, counselling by the non-specialist and referral to age-appropriate community resources are often sufficient.

11. Evaluation by a mental health clinician specializing in gender identity concerns is recommended if the adolescent:

    - is so distressed about gender issues that health and well-being, relationships, or school/work are negatively affected
    - expresses feelings of gender dysphoria, an aversion to aspects of their body associated with sex/gender, discomfort with gender identity, or a wish to live as the opposite sex
    - is compulsively crossdressing or compulsively pursuing validation of gender identity
    - has a co-existing or pre-existing condition that complicates evaluation of gender concerns

Differential diagnosis

12. The usefulness of a diagnosis of Gender Identity Disorder (GID) or Transvestic Fetishism in treatment and care planning is a decision that should be made on a case-by-case basis, with care to distinguish both compulsive crossdressing and GID from gender-variant behavior that is not intrinsically problematic.

13. The "distress" criterion of GID as defined in the *DSM-IV-TR* should not be applied to parents' distress that their child is atypical, or a child's distress about other people's transphobic reactions. These are societally-caused situations that can be addressed by intervention with the parents focused on building acceptance for gender diversity, along with intervention for the adolescent to build resilience and address stigma issues.

14. Adolescents should not be diagnosed with GID solely because they display behaviours that are contrary to societal gender norms.

Psychosocial concerns

15. Psychosocial assessment should include evaluation of transgender adolescents' **H**ome life, **E**ducation/employment, **E**ating, **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety (HEEADSSS). For the adolescent who has disclosed transgender identity, the standard HEEADSSS interview should be modified to include trans-specific content.

16. Services for transgender adolescents should be relevant and accessible to youth who are involved in the sex trade. Involvement in the sex trade should not be considered an exclusionary criterion for adolescents seeking sex reassignment, as this leaves youth who are financially dependent on the sex trade unable to access care.

17. When discussing sexuality clinicians should engage in frank and explicit discussion about the actual practices an adolescent is engaged in, rather than making assumptions about the gender of partner(s) or sexual activities. The transgender adolescent should be asked about preferred terms for genitals to ensure sexual health discussion is respectful of self-defined gender identity.

18. For adolescents with intense frustration or distress about body image, in addition to a general screening tool for eating disorders it may be appropriate to inquire about excessively tight breast binding, wrapping of the penis/testicles, and compulsive or excessive exercise. Intervention may include exploration of transgender identity, transgender community involvement, and peer support.

Supporting transgender emergence in adolescence

19. For both questioning adolescents and those who already have a strong sense of self, the emphasis is on self-understanding rather than reaching towards a preset goal. The adolescent should not be pressured to try a form of gender expression they are uncomfortable with, but rather encouraged to try experimenting as a way of deciding who they are and what feels right.

20. Adolescents who are in early stages of questioning should be encouraged to explore identity without making decisions about transition or sex reassignment.

21. Experimentation with fluidity of gender identification and expression is encouraged if the adolescent has a generally stable core sense of self. If there are concerns about fragmentation of identity or if the process of experimentation seems to be increasing distress, referral should be made to an advanced mental health clinician with experience in treatment of co-existing gender concerns and mental illness.

22. Adolescents who have already made a decision to pursue sex reassignment should not be dissuaded, but should be made aware of diverse possibilities for gender identity and expression (including but not limited to sex reassignment).

23. For the adolescent who has a clear and consistent sense of self, the next step in identity development is the identification of strategies to reconcile discrepancies between identity and daily life. Whatever options are considered, there should be thought as to how changes will realistically be integrated into daily life, and what reactions there might be by others.

24. The adolescent who is considering disclosure should be supported to think about the likely reactions of the people they are telling, and possible resources to help facilitate understanding and adjustment. When there are concerns about possible violence or eviction from the home a crisis/safety plan should be included as part of the preparation for disclosure.

Sex reassignment in adolescence

25. Parents or legal guardians (e.g., foster parents) must consent to and participate in medical intervention for a legal minor. Parental consent is preferred but not required for adolescents considered capable of providing medical consent as defined by the *Infants' Act*.

26. It is beneficial to make a plan for disclosure prior to gender transition in school or in the workplace. This may include education and clinical advocacy.

27. Planning around "real life experience" (RLE) must include consideration of the adolescent's safety and the relative risks and benefits of undergoing RLE. When an adolescent cannot cross-live full-time as part of gender transition, the clinician must consider whether the inability to live full-time in the desired role is simply a mature and reasonable accommodation of the limited socioeconomic options open to adolescents, or ambivalence about full-time cross-living.

28. To prevent use of hormones without medical assistance, adolescents who express the intention to pursue transition should be given information about options for care, including the process for hormone assessment. Assessment by a trans-competent pediatric endocrinologist should be sought for the adolescent who has disclosed use of hormones without medical assistance.

29. Older adolescents who are intending to pursue sex reassignment surgery should be informed of eligibility criteria and coverage provided by the BC Medical Services Plan.

Recommendations for Future Work

30. Ongoing research and collegial meetings are needed to further develop practice protocols.

31. Future work should include:

    - practice protocols for care of gender-variant children under 13 years of age
    - more detailed protocols for counselling of family members of adolescents
    - consumer and clinician information about the anticipated effects, adverse effects, and questions about long-term impact of GnRH analogues, as well as any effects of cross-sex hormones that are different in adolescents than in adults

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Appendices

Appendix A: Resources

Appendix B: Utrecht Gender Dysphoria Scale

Appendix C: HEEADSSS

Appendix A: Resources

Transgender Health Program

The Transgender Health Program is an anonymous and confidential free service for anyone in BC who has a transgender health question or concern.

Services for clinicians include:

- training in transgender health and transgender medicine
- assistance in care planning for transgender clients/patients and loved ones
- information about best practice guidelines and standards of care
- assistance with development of trans-inclusion policies and procedures
- information about transgender health research findings and implications for practice
- joint program planning and research initiatives

Services for transgender adolescents and family members include:

- information about transgender community groups and community resources
- a monthly social drop-in for transgender youth and partners/friends/siblings
- help finding health/social services, and assistance to navigate health/social service systems
- peer-based exploration of gender identity, gender expression, and life stresses in a non-judgmental setting
- support and information for family members, partners, friends, and other loved ones
- free condoms and needle exchange
- outreach to transgender people working in the survival sex trade
- free training sessions for peer support volunteers
- information about practice guidelines, standards of care, and client/patient rights

The Transgender Health Program is an initiative of Vancouver Coastal Health.

For more information, contact:

Transgender Health Program
#301-1290 Hornby Street, Vancouver, BC V6Z 1W2
Phone/TTY/TDD: 604-734-1514 or 1-866-999-1514 (toll-free in BC)
Fax: 604-633-4241
Email: transhealth@vch.ca
Web: http://www.vch.ca/transhealth

Harry Benjamin International Gender Dysphoria Association

http://www.hbigda.org

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) is a professional organization devoted to the understanding and treatment of gender identity disorders, with 350 members from around the world in fields such as psychiatry, endocrinology, surgery, psychology, sexology, counseling, sociology, and law. HBIGDA provides opportunities for scientific interchange among professionals through biennial conferences and publications, and develops and publishes Standards of Care for the treatment of gender identity disorders.

Appendix B: Utrecht Gender Dysphoria Scale, Adolescent Version

Female-to-Male Version

Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items 1, 2, 4-6 and 10-12 are scored from 5-1; items 3 and 7-9 are scored from 1-5.

1. I prefer to behave like a boy.
2. Every time someone treats me like a girl I feel hurt.
3. I love to live as a girl.
4. I continuously want to be treated like a boy.
5. A boy's life is more attractive for me than a girl's life.
6. I feel unhappy because I have to behave like a girl.
7. Living as a girl is something positive for me.
8. I enjoy seeing my naked body in the mirror.
9. I like to behave sexually as a girl.
10. I hate menstruating because it makes me feel like a girl.
11. I hate having breasts.
12. I wish I had been born as a boy.

Male-to-Female Version

Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items are all scored from 5-1.

1. My life would be meaningless if I would have to live as a boy.
2. Every time someone treats me like a boy I feel hurt.
3. I feel unhappy if someone calls me a boy.
4. I feel unhappy because I have a male body.
5. The idea that I will always be a boy gives me a sinking feeling.
6. I hate myself because I'm a boy.
7. I feel uncomfortable behaving like a boy, always and everywhere.
8. Only as a girl my life would be worth living.
9. I dislike urinating in a standing position.
10. I am dissatisfied with my beard growth because it makes me look like a boy.
11. I dislike having erections.
12. It would be better not to live than to live as a boy.

Scoring and Evaluation

As can be expected most non-transsexuals score close to the minimum score, which is 12. Most transsexuals score close to the maximum score, which is 60. Problematic applicants in terms of eligibility for sex reassignment and in terms of treatment course tend to score in the middle range of the scale.

Appendix C: HEEADSSS Psychosocial Evaluation

HEEADSSS is a structured interview to evaluate **H**ome, **E**ducation/employment, **E**ating, peer-group **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety in adolescents (Goldenring & Rosen, 2004). Questions are divided into those that are considered essential and should be used in every evaluation, those that should be asked if time permits, and (for education/employment and eating) those that can be added as needed to facilitate more in-depth exploration.

Table C1: HEEADSSS Psychosocial Interview Structure

	Essential	As Time Permits	Optional/As Required
Home	• Who lives with you? Where do you live? Do you have your own room? • What are relationships like at home? • To whom are you closest at home? • To whom can you talk at home? • Is there anyone new at home? Has someone left recently? • Have you moved recently? • Have you ever had to live away from home? (Why?)	• Have you ever run away? (Why?) • Is there any physical violence at home?	
Education/ employment	• What are your favorite subjects at school? Your least favorite subjects? • How are your grades? Any recent changes? Any dramatic changes in the past? • Have you changed schools in the past few years? • What are your future education/employment plans/goals? • Are you working? Where? How much?	• Tell me about your friends at school. • Is your school a safe place? (Why?) • Have you ever had to repeat a class? Have you ever had to repeat a grade? • Have you ever been suspended? Expelled? Have you ever considered dropping out? • How well do you get along with the people at school/ work? • Have your responsibilities at work increased?	• Do you feel connected to your school? Do you feel as if you belong? • Are there adults at school you feel you could talk to about something important? (Who?)
Eating	• What do you like and not like about your body? • Have there been any recent changes in your weight? • Have you dieted in the last year? How? How often? • Have you done anything else to try to manage your weight? • How much exercise do you get in an average day? Week? • What do you think would be a healthy diet? How does that compare to your current eating patterns?	• Do you worry about your weight? How often? • Do you eat in front of the TV? Computer? • Does it ever seem as though your eating is out of control? • Have you ever made yourself throw up on purpose to control your weight? • Have you ever taken diet pills?	• What would it be like if you gained (lost) 10 pounds?
Activities	• What do you and your *friends* do for fun? (With whom, where, and when?) • What do you and your *family* do for fun? (With whom, where, and when?) • Do you participate in any sports or other activities? • Do you regularly attend a religious group, club, or other organized activity?	• Do you have any hobbies? • Do you read for fun? (What?) • How much TV do you watch in a week? How about video games? • What music do you like to listen to?	

	Essential	As Time Permits
Drugs	• Do any of your friends use tobacco? Alcohol? Other drugs? • Does anyone in your family use tobacco? Alcohol? Other drugs? • Do you use tobacco? Alcohol? Other drugs? • Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?	• Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco *CRAFFT questions* • Have you ever ridden in a **C**ar driven by someone who was high or had been using drugs or alcohol? • Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in? • Do you ever use drugs or alcohol when you're **A**lone? • Do you **F**orget things you did while using drugs or alcohol? • Do your family or **F**riends ever tell you that you should cut down your drinking or drug use? • Have you ever gotten into **T**rouble while using drugs or alcohol?
Sexuality	• Have you ever been in a romantic relationship? • Tell me about the people that you've dated *OR* Tell me about your sex life. • Have any of your relationships ever been sexual relationships? • Are your sexual activities enjoyable? • What does the term "safer sex" mean to you?	• Are you interested in girls? Boys? Both? • Have you ever been forced or pressured into doing something sexual that you didn't want to do? • Have you ever been touched sexually in a way that you didn't want? • Have you ever been raped, on a date or any other time? • How many sexual partners have you had altogether? • Have you ever been pregnant/gotten someone pregnant, or been worried that that might have happened? • What are you using for birth control? Are you satisfied with your method? • Do you use condoms every time you have intercourse? • Does anything ever get in the way of always using a condom? • Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?
Suicide/ depression	• Do you feel sad or down more than usual? Do you find yourself crying more than usual? • Are you "bored" all the time? • Are you having trouble getting to sleep? • Have you thought a lot about hurting yourself or someone else?	• Does it seem that you've lost interest in things that you used to really enjoy? • Do you find yourself spending less and less time with friends? • Would you rather just be by yourself most of the time? • Have you ever tried to kill yourself? • Have you ever had to hurt yourself (e.g., by cutting yourself) to calm down or feel better? • Have you started using alcohol or drugs to help you relax, calm down, or feel better?
Safety	• Have you ever been seriously injured? (How?) How about anyone else you know? • Do you always wear a seatbelt in the car? • Have you ever ridden with a driver who was drunk or high? When? How often? • Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)? • Is there any violence in your home? Does the violence ever get physical? • Is there a lot of violence at your school? In your neighborhood? Among your friends? • Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)	• Have you ever been in a car or motorcycle accident? (What happened?) • Have you ever been picked on or bullied? Is that still a problem? • Have you gotten into physical fights in school or your neighborhood? Are you still getting into fights? • Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?