

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

Catherine White Holman
Joshua M. Goldberg

SUMMARY. 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. Not all transgender adolescents have gender dysphoria or wish to undergo sex reassignment. In this article we focus on general care of transgender adolescents by the non-specialist working in primary care, family services, schools, child welfare, mental health, and other community settings. doi:10.1300/J485v09n03_05 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Transgender, transsexual, crossdressing, gender variance, adolescent, adolescence

This article is a companion piece to *Clinical Management of Gender Dysphoria in Adolescents* (de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006). That article, written by advanced practitioners, offers important advice for gender specialists working with adolescents who need specialty care relating to gender dysphoria. However, not all transgender adolescents have gender dysphoria or wish to undergo sex reassignment. In this article we focus on general care of transgender adolescents by

the non-specialist working in primary care, family services, schools, child welfare, mental health, and other community settings.

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 rela-

Catherine White Holman is Community Counselor at Three Bridges Community Health Centre and Joshua Goldberg is Education Consultant at the Transgender Health Program, Vancouver, BC, Canada.

Address correspondence to: Catherine White Holman, Three Bridges Community Health Centre, 1292 Hornby Street, Vancouver, BC, Canada V6Z 1W2 (E-mail: Catherine.WhiteHoman@vch.ca).

This manuscript was created for the Trans Care Project, a joint initiative of Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program, with funding from the Canadian Rainbow Health Coalition. The authors thank Sheila Kelton, Roey Malleon, Gerald P. Mallon, Edgardo J. Menvielle, Daniel L. Metzger, Jorge L. Pinzon, and Wallace Wong for comments on an earlier draft, and Donna Lindenberg, Olivia Ashbee, A. J. Simpson, and Rodney Hunt for research assistance.

[Haworth co-indexing entry note]: "Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents." Holman, Catherine White, and Joshua M. Goldberg. Co-published simultaneously in *International Journal of Transgenderism* (The Haworth Medical Press, an imprint of The Haworth Press, Inc.) Vol. 9, No. 3/4, 2006, pp. 95-110; and: *Guidelines for Transgender Care* (ed: Walter O. Bockting, and Joshua M. Goldberg) The Haworth Medical Press, an imprint of The Haworth Press, Inc., 2006, pp. 95-110. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

Available online at <http://ijt.haworthpress.com>
© 2006 by The Haworth Press, Inc. All rights reserved.
doi:10.1300/J485v09n03_05

tional 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 articles (e.g., Bockting, Knudson, & Goldberg, 2006; 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 CLINICAL PICTURE

To date, most demographic information about transgender adolescents is derived from research performed by specialized clinics for gender dysphoric children and adolescents in Canada, 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 the broader spectrum of transgender adolescents, we can only comment on trends within the population we have worked with, noting in particular differences between our client base and the clinical picture described by de Vries and colleagues (2006). Further work is needed to document trends among the diverse range of transgender adolescents, both locally and in other regions.

Fluidity of Gender Identity

The Amsterdam team (de Vries et al., 2006) works primarily with adolescents who are strongly cross-identified transsexuals (i.e., na-

tal 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 the Trans Care 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.

Initial Presentation

In a gender clinic or other trans-specialty service, clients 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. As professionals providing advocacy, crisis intervention, and counseling for people of all ages in urban community-based service settings, it is not surprising that the types of services sought by out transgender clients are different than the patients entering the Amsterdam team's specialized hospital clinic for gender dysphoric children and adolescents.

Few of our transgender adolescent clients have sought our help specifically to deal with gender identity concerns. Most have 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 situations 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.

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. Trans-specific posters, magazines that include articles about transgender youth, and consumer information that describes terms relating to the diversity of transgender identity and experience can help adolescents name and express their feelings. Inclusion of transgender brochures and posters in public education materials also demonstrates a trans-positive and trans-inclusive approach. It is important that materials be reflective of the diversity within the transgender community (e.g., ethnicity, disability).

Active Demonstration of Transgender Awareness and Sensitivity

Adolescents may fear a negative reaction upon disclosure of transgender identity, or may assume that the clinician 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 safety and approachability. Inclusion of a statement such as "Transgender people are welcome" in

crisis line or resource guide service listings lets adolescents know that you have an active interest in transgender issues.

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 (male-to-female)/FTM (female-to-male)/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. Gender dysphoria measurement instruments (Cohen-Kettenis & Van Goozen, 1997; Lindgren & 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 the intake process with all clients, not just those who look gender-variant. 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 unsure of 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 Table 1.

For the adolescent who is confused, questioning, or unsure about gender issues, counseling 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 ex-

TABLE 1. Evaluating Gender Concerns in Adolescents

Topic	Areas to Explore
Nature of gender concerns	<ul style="list-style-type: none"> • 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 or worse? • How intense are the feelings?
Impact on the adolescent's life	<ul style="list-style-type: none"> • 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 and 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	<ul style="list-style-type: none"> • 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 or religious beliefs, Internet, movies)?
Related or co-existing factors	<ul style="list-style-type: none"> • 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?

pression, 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. Evaluation by a mental health clinician specializing in gender identity concerns is recommended if the adolescent (a) is so distressed about gender issues that health and well-being, relationships, school, or work are negatively affected; (b) expresses feelings of gender dysphoria, an aversion to aspects of their body associated with sex or gender, discomfort with gender identity, or a wish to live as the opposite sex; (c) is compulsively crossdressing or pursuing validation of gender identity—for example, through compulsive sexual or online encounters; or (d) has a co-existing or pre-existing condition that complicates evaluation of gender concerns—for example, schizophrenia, personality disorder, or cognitive disability.

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 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 or compulsive as to cause problems in other aspects of life.

There is controversy about these diagnoses (Bartlett, Vasey, & Bukowski, 2000; Bockting & Ehrbar, 2005; Burgess, 1999; Hill, Rozanski, Carfagnini, & Willoughby, 2005; 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 accep-

tance that the distress is clinically serious and that treatment may be required. Others have expressed concern that these diagnoses pathologize transgender identity and erotic cross-dressing, 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’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: Home, Education/employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety (Goldenring & Rosen, 2004). 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 2. 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.

COMMON PSYCHOSOCIAL CONCERNS

Many non-dysphoric transgender adolescents struggle with the same psychosocial issues as those described by de Vries and colleagues (2006), such as concerns about body image, relationships, or sexuality. Both dysphoric and non-dysphoric transgender adolescents share psychosocial struggles related to societal marginalization, including 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

TABLE 2. Sample Trans-Specific Modification of HEEADSSS Psychosocial Interview (adapted from Goldenring & Rosen, 2004)

Topic	Sample questions
Home	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Do people at school or work know that you are transgender? (Who?) How did they find out, and how did they react? • Are there people at school or 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 or work? • Do you ever worry about your academic or 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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?
Suicide/ depression	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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?

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.

De Vries and colleagues (2006) note 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 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

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 and client may feel that sex reassignment should proceed along with interventions focused on psychosocial stability.

Transgender adolescents who have left home voluntarily or involuntarily may struggle to find safe and affordable housing. While some homeless transgender adolescents may wish to reunite with their families of origin, for others reunification is not appropriate (e.g., high risk of familial abuse) or feasible (e.g., no willing-

ness 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. Trans-specific advocacy relating to foster care and emergency shelter is discussed elsewhere (White Holman & Goldberg, 2006).

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 British Columbia, 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).

In Canada, provincial governments typically define 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 British Columbia 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 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 different populations of transgender adolescents in the sex trade:

1. *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.
2. *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 wanted support relating to transphobic violence or harassment they experienced while working. Some also sought counseling relating to confusion about gender identity or sexual orientation.
3. *Adolescent FTMs working as women:* We have worked with a few FTMs who, while personally identifying strongly as masculine or male and living as male in their personal and 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 clini-

cians 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

De Vries and colleagues (2006) 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 MTFs and FTMs may engage in receptive or insertive oral, vaginal, and anal intercourse, as well as sexual activities that do not involve penetration. 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 (Feldman & Goldberg, 2006). 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 de Vries and colleagues (2006), body image problems are common in adolescents with gender dysphoria. It has been our experience that non-dysphoric transgender adolescents who have had few positive transgender role models also 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.

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 and testicles (MTF). If binding or 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.

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 per-

son—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 in our experience transgender adolescents have not typically struggled with denial, avoidance, or repression for the same length of time or 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. 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.

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 (appropriately screened age peers as well as 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 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-themed community events (e.g., drag 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.

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 by de Vries and colleagues (2006) 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 World Professional Association for Transgender Health's (WPATH) *Standards of Care* (Meyer et al., 2001) identify a range of non-medical possibilities transgender individuals may explore, spontaneously or with professional support: (a) learning about transgenderism from the Internet, lay and professional literature, or peers; (b) participating in peer support or self-help groups, or in the transgender community; (c) counseling to explore gender identity and to deal with psychosocial pressures; (d) disclosing transgender identity to family, friends, and other loved ones ("coming

out”); (e) integrating of transgender awareness into daily living; (f) changing gender pronoun or name; (g) episodic crossdressing or cross-living; and (h) undertaking temporary and potentially reversible changes to gender expression, such as changing hairstyle, makeup, or clothing; removing facial and body hair, or applying facial hair; wearing prosthetic breasts or penile prosthesis; binding the chest or tucking the genitals; and changing speech and 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 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 potential 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 possibly 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 and safety plan as part of the preparation for disclosure. In some circumstances a safety plan includes discussion of the possible consequences of involuntary discovery of transgender status. For example, 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 types of situations 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 or professional resources. 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 relating to parental consent to treatment. Transgender adolescents who are questioning or exploring their gender identity are often fearful that the clinician will disclose information to family members, teachers, social workers, or others involved in care. As with any other sensitive area of care (e.g., substance use, sexual health) the adolescent should be reassured that clinical professions have strict rules governing confidentiality and

privacy. We have found it helpful to candidly review the legal limits of confidentiality (e.g., duty to report child abuse), and the process that we use when there is information that must be disclosed to a third party.

Legislation relating to consent by parents or guardians in medical treatment of adolescents varies greatly across jurisdictions. In British Columbia, as with any other type of non-emergency medical treatment, sex reassignment of adolescents is governed by the *Infants Act*. Medical treatment for mature minors (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. De Vries and colleagues (2006) “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. 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 (de Vries et al., 2006; Meyer et al., 2001). For adolescents this often involves transition at school and 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 (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 situations, 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. Some clients have waited until hormonal changes had reduced their visibility as a gender-variant person before starting at a new school.

In some circumstances adolescents have already left school by the time they seek treatment, and may be living independently outside the parental home. While human rights legislation in some jurisdictions offers protection against termination of employment on the basis of sex, gender, and disability, even when these grounds are held to extend to transgender individuals (or there is explicit protection against discrimination on the basis of gender identity or expression) 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. With adolescents who are new to the workforce we may provide information relating to employees' rights and responsibilities, and discuss trans-specific issues (such as asking an employer for time off for sex reassignment procedures).

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 or masculinizing hormones. There are documented reports of transgender individuals obtaining hormones without medical approval (Dean et al., 2000; Hope-Mason, Conners, & Kammerer, 1995), and the WPATH *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 are exponentially increased when there is no screening for health conditions that may be made worse by hormone use, or regular medical monitoring of adverse effects after hormones are started (Dahl, Feldman, Goldberg, & Jaber, 2006). Non-prescription-grade hormones may be poor quality and may be diluted with toxic substances. For those taking hormones by injection, improper injection technique or needle sharing poses additional health hazards such as abscess and transmission of HIV and Hepatitis C.

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. Adolescents who are considering hormone therapy should be informed of local service options. Appropriately screened peer mentors may be helpful in explaining what to expect from the hormone assessment process, and in providing

perspective about the temporary wait that is typically involved while the hormone assessment is completed. Expedited referrals to clinicians who can provide medical monitoring should be considered for the adolescent who has disclosed use of hormones without medical assistance.

Feminizing or masculinizing surgery. While sex reassignment surgery is typically not indicated prior to age 18 (de Vries et al., 2006), 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. Consumer education materials appropriate for older adolescents have recently been developed as part of the Trans Care Project (Simpson & Goldberg, 2006a; Simpson & Goldberg, 2006b).

Discussion about surgery should include information about costs and options for payment. In jurisdictions where private or public health insurance is an option, the eligibility criteria and process for application should be discussed. In many jurisdictions insurance explicitly excludes coverage for sex reassignment surgery, and adolescents should be made aware of this so they understand that they may not be able to obtain surgery at age 18. For adolescents in this situation, appropriately screened experienced peer mentors may be helpful in sharing information about ways to cope with not having access to needed 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 accep-

tance 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 circumstances 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 working in community settings. Careful communication is needed to ensure that transgender and gender-questioning adolescents have adequate ac-

cess 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 development of transgender adolescents. We hope this article helps non-specialists to feel more confident in working with this underserved population.

REFERENCES

- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR)* (4th Ed., Text Revision ed.). Washington, DC: Author.
- American Psychological Association (2002). *Developing adolescents: A reference for professionals*. Washington, DC: Author.
- Assistant Deputy Ministers’ Committee on Prostitution and the Sexual Exploitation of Youth (2000). *Sexual exploitation of youth in British Columbia* (Rep. No. C00-960303-4). Victoria, BC, Canada: BC Ministry of Health.
- Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is Gender Identity Disorder in children a mental disorder? *Sex Roles*, 43, 753-785.
- Bockting, W.O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality*, 17(3/4), 125-134.
- Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, 9(3/4), 35-82.
- Bradley, S. J., & Zucker, K. J. (1990). Gender identity disorder and psychosexual problems in children and adolescents. *Canadian Journal of Psychiatry*, 35, 477-486.
- Brown, M. L., & Rounsley, C. A. (1996). *True selves: Understanding transsexualism—For families, friends, coworkers, and helping professionals*. San Francisco, CA: Jossey-Bass.
- Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgendered youth. In G. P. Mallon (Ed.), *Social services with transgendered youth* (pp. 35-47). Binghamton, NY: Harrington Park Press.
- Cohen, L., de Ruiter, C., Ringelberg, H., & Cohen-Kettenis, P. T. (1997). Psychological functioning of

- adolescent transsexuals: Personality and psychopathology. *Journal of Clinical Psychology*, 53, 187-196.
- Cohen-Kettenis, P. T., & Van Goozen, S. H. M. (1997). Sex reassignment of adolescent transsexuals: a follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 263-271.
- Currah, P., & Minter, S. (2000). *Transgender equality: A handbook for activists and policymakers*. New York, NY: National Gay and Lesbian Task Force and The National Center for Lesbian Rights.
- Dahl, M., Feldman, J., Goldberg, J. M., & Jaber, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism*, 9(3/4), 111-134.
- de Castell, S., & Jenson, J. (2002). *No place like home: Final research report on the Pridehouse Project*. Burnaby, BC, Canada: Simon Fraser University.
- de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarvan de Waal, H. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism*, 9(3/4), 83-94.
- Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., Bowen, D. J., Bradford, J., Rothblum, E., White, J., Dunn, P., Lawrence, A., Wolfe, D., & Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association*, 4, 102-151.
- Di Ceglie, D., Freedman, D., McPherson, S., & Richardson, P. (2002). Children and adolescents referred to a specialist gender identity development service: Clinical features and demographic characteristics. *International Journal of Transgenderism*, 6. Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no01_01.htm
- Dimensions (2000a). *Dimensions treatment guidelines for FTM Transition*. Retrieved January 1, 2005, from <http://tghealth-critiques.tripod.com/protoc2.htm>
- Dimensions (2000b). *Dimensions treatment guidelines for MTF transition*. Retrieved January 1, 2005, from <http://tghealth-critiques.tripod.com/protoc1.htm>
- Ellis, K. M., & Eriksen, K. (2002). Transsexual and transgenderist experiences and treatment options. *The Family Journal: Counseling and Therapy for Couples & Families*, 10, 289-299.
- Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy*, 7, 1-12.
- Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the U.S., Canada, and Mexico*. Philadelphia, PA: University of Pennsylvania.
- Feldman, J., & Goldberg, J. M. (2006). Transgender primary medical care. *International Journal of Transgenderism*, 9(3/4), 3-34.
- findlay, b., Laframboise, S., Brady, D., Burnham, C. W. G., & Skolney-Elverson, S. R. (1996). *Finding our place: The transgendered law reform project*. Vancouver, BC, Canada: High Risk Project Society.
- Fontaine, J. H., & Hammond, N. L. (1996). Counseling issues with gay and lesbian adolescents. *Adolescence*, 31, 817-830.
- Goldberg, J. M., & White, C. (2004). Expanding our understanding of gendered violence: Violence against trans people and loved ones. *Aware: The Newsletter of the BC Institute Against Family Violence*, 11, 21-25.
- Goldenring, J. M., & Rosen, D. S. (2004). Getting into adolescent heads: An essential update. *Contemporary Pediatrics*, 21, 64-90.
- Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2005). Gender identity disorders in childhood and adolescence: A critical inquiry. *Journal of Psychology & Human Sexuality*, 17(3/4), 7-34.
- Hope-Mason, T., Conners, M. M., & Kammerer, C. A. (1995). *Transgender and HIV risks: Needs assessment*. Boston, MA: Department of Public Health, HIV/AIDS Bureau.
- Kagan, S., & Melrose, C. (2003). The SCOFF questionnaire was less sensitive but more specific than the ESP for detecting eating disorders. *Evidence-Based Nursing*, 6, 118.
- Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, 30, 19-26.
- Klein, R. (1999). Group work practice with transgendered male to female sex workers. In G. P. Mallon (Ed.), *Social services with transgendered youth* (pp. 95-109). Binghamton, NY: The Haworth Press, Inc.
- Kosciw, J. G., & Cullen, M. K. (2001). *The GLSEN 2001 National School Climate Survey: The school-related experiences of our nation's lesbian, gay, bisexual and transgender youth*. New York, NY: Gay, Lesbian and Straight Education Network.
- Langer, S. J., & Martin, J. I. (2004). How dresses can make you mentally ill: Examining Gender Identity Disorder in children. *Child and Adolescent Social Work Journal*, 21, 5-23.
- Leichtentritt, R. D., & Arad, B. D. (2004). Adolescent and young adult male-to-female transsexuals: Pathways to prostitution. *British Journal of Social Work*, 34, 349-374.
- Lerner, R. M. (2002). *Adolescence: Development, diversity, context, and application*. Upper Saddle River, NJ: Prentice-Hall.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: The Haworth Clinical Practice Press.
- Lindgren, T. W., & Pauly, I. B. (1975). A body image scale for evaluating transsexuals. *Archives of Sexual Behavior*, 4, 639-656.
- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42, 89-101.

- Menvielle, E. J. (1998). Gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37, 243-244.
- Menvielle, E. J. & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1010-1013.
- Meyer, W. J., III, Bockting, W. O., Cohen-Kettenis, P. T., Coleman, E., Di Ceglie, D., Devor, H., Gooren, L., Hage, J. J., Kirk, S., Kuiper, B., Laub, D., Lawrence, A., Menard, Y., Monstrey, S., Patton, J., Schaefer, L., Webb, A., & Wheeler, C. C. (2001). *The standards of care for Gender Identity Disorders* (6th ed.). Minneapolis, MN: Harry Benjamin International Gender Dysphoria Association.
- Minter, S. (1999). Diagnosis and treatment of gender identity disorder in children. In M. Rottnek (Ed.), *Sissies and tomboys: Gender nonconformity and homosexual childhood* (pp. 9-33). New York: New York University Press.
- Moore, S. M. (2002). Diagnosis for a straight planet: A critique of gender identity disorder for children and adolescents in the *DSM-IV*. *Dissertation Abstracts International*, 63(4B), 2066. (University Microfilms No. AAI3051898)
- Nemoto, T., Operario, D., Keatley, J., & Villegas, D. (2004). Social context of HIV risk behaviours among male-to-female transgenders of colour. *AIDS Care*, 16, 724-735.
- Newman, L. K. (2002). Sex, gender and culture: Issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology & Psychiatry*, 7, 352-359.
- Odo, C., & Hawelu, A. (2001). Eo na Mahu o Hawai'i: the extraordinary health needs of Hawai'i's Mahu. *Pacific Health Dialog*, 8, 327-334.
- Pazos, S. (1999). Practice with female-to-male transgendered youth. In G. P. Mallon (Ed.), *Social services with transgendered youth* (pp. 65-82). Binghamton, NY: The Haworth Press, Inc.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.
- Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *International Journal of Transgenderism*, 6. Retrieved January 1, 2005, from http://www.symposion.com/ijt/ijtvo06no02_04.htm
- Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 619-621.
- Simpson, A. J., & Goldberg, J. M. (2006). *Surgery: A guide for FTMs*. Vancouver, BC, Canada: Vancouver Coastal Health Authority.
- Simpson, A. J., & Goldberg, J. M. (2006). *Surgery: A guide for MTFs*. Vancouver, BC, Canada: Vancouver Coastal Health Authority.
- Smith, Y. L. S., Cohen, L., & Cohen-Kettenis, P. T. (2002). Postoperative psychological functioning of adolescent transsexuals: A Rorschach study. *Archives of Sexual Behavior*, 31, 255-261.
- Smith, Y. L. S., Van Goozen, S. H. M., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 472-481.
- Social Services and Community Safety Division - Justice Institute of British Columbia (2002). *Commercial sexual exploitation: Innovative ideas for working with children and youth*. New Westminster, BC, Canada: Justice Institute of British Columbia.
- Tonkin, R. S. (2002). *Accenting the positive: A developmental framework for reducing risk and promoting positive outcomes among BC youth*. Vancouver, BC, Canada: McCreary Centre Society.
- Tubman, M., & Bramly, L. (1998). *Out from the Shadows: International Summit of Sexually Exploited Youth—Final summit report*. Ottawa, ONT, Canada: Save the Children.
- White Holman, C., & Goldberg, J. (2006). Social and medical transgender case advocacy. *International Journal of Transgenderism*, 9(3/4), 197-217.
- Wilson, I., Griffin, C., & Wren, B. (2002). The validity of the diagnosis of gender identity disorder (child and adolescent criteria). *Clinical Child Psychology & Psychiatry*, 7, 335-351.
- Worth, H. (2000). Up on K Road on Saturday night: Sex, gender and sex work in Auckland. *Venereology: Interdisciplinary, International Journal of Sexual Health*, 13, 15-24.
- Wyss, S. E. (2004). 'This was my hell': The violence experienced by gender non-conforming youth in US high schools. *International Journal of Qualitative Studies in Education*, 17, 709-730.
- Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America*, 13, 551-568.
- Zucker, K. J., Deogracias, J. J., Johnson, L. L., Meyer-Bahlburg, H. F., Kessler, S. J., & Schober, J. M. (2005). *The Gender Identity Questionnaire for Adults and the Recalled Childhood Gender Questionnaire-Revised: Final analyses*. Poster presentation, Meeting of the International Academy of Sex Research, Ottawa, ONT, Canada.

Copyright of International Journal of Transgenderism is the property of Haworth Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.