A Qualitative Study of Genital Sex Reassignment in Transgendered Teens: Age of Consent and Assessment Process

Wallace Wong, Diversity Emotional Wellness Center, Canada

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Abstract
Currently, the WPATH guidelines recommend that a person be at the majority age in order to be considered a candidate for bottom surgery. In British Columbia, the majority is 19 years. However, in our clinical experience, there are youth between the ages of 16 to 19 that may benefit from having the surgery earlier. Some may say that waiting until 19 to have bottom surgery done is a "safe" practice, but we often ask ourselves if it is the best interest for our clients.

First of all, different provinces and countries have different standards on the "age of majority". Therefore, to consider a youth's readiness based only on the age of majority can be misleading. Perhaps it may be more accurate to reflect their readiness based on the youth's maturity, support systems, and consistency of their gender identity development. This paper used a focus group with nine different youths to generate themes regarding their experiences of having to wait for surgery. This paper will also examine how they perceive the risks and benefits for early surgery.

Keywords**:** Transgender, Youth, Surgery, SRS, Gender Reassignment Surgery, Age, Consent

Introduction

Treatment options for gender dysphoria

Presently, the guidelines outlined by the World Professional Association for Transgender Health (WPATH) in its Standards of Care for Health of Transsexual, Transgender, and Gender Nonconforming People (SOC; Coleman et al., 2011) are the most widely consulted for treatment of gender dysphoria. SOC describes sex reassignment surgery (SRS) as one important option to assist transgender individuals to achieve comfort with their identities and bodies (Coleman et al., 2011). WPATH notes that SRS also allows transgender individuals feel more comfortable in various settings where the body is more exposed, such as physician's office, swimming pools, health clubs, and in the presence of sex partners (Coleman et al., 2011). Consistent with this, past research have consistently demonstrated the benefits of SRS (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Garaffa, Christopher, & Ralph, 2010; Green & Fleming, 1990; Johansson, Sundbom, Höjerback, & Bodlund, 2010; Klein & Gorzalka, 2009; Krege et al. 2001; Pauly, 1981; Pfäfflin & Junge, 1998; Rehman et al., 1999; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). These studies collectively found improvement after SRS in patients' overall well-being, global functioning, psychosocial outcomes, cosmesis, sexual function, and gender dysphoria symptoms. While contrary evidence suggesting that SRS may be ineffective or harmful exists, these studies often are plagued by methodological flaws (Coleman et al., 2011).

Alternative physical interventions for gender dysphoria exist in the form of hormone therapy or gonadotropin-releasing hormone analogue, which unlike SRS, are fully or partially reversible. Generally, the age of consent for these hormone therapies is lower than that for SRS (Coleman et al., 2011). Consequently, SRS is typically the last, as well as the most deliberated; step in the treatment process for gender dysphoria. Unlike the significant body of research converging on the effectiveness of SRS, the efficaciousness of hormone treatments is less well established. Most research in this area unfortunately examines transgender individuals who have undergone hormone therapy in addition to SRS, instead of hormone therapy alone. Nonetheless, the available evidence points to favorable outcomes of hormonal treatment (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäffl in & Junge, 1998). While these alternate therapies involving hormone manipulation are promising, surgical modification of their primary and/or secondary sex characteristics for many transgender individuals is still necessary to relieve gender dysphoria (Hage & Karim, 2000).

Challenges in assessing for SRS readiness

Although many researchers would agree that SRS is an efficacious solution for gender dysphoria, they often disagree on *when* transgender individuals should receive SRS. Presently, there are no clear answers as to what age does gender identity become stable and what age is one considered mature enough to provide consent for SRS. Debate concerning transitioning in children and adolescents remains heated. Different theories give conflicting accounts of how gender is acquired and consolidates throughout development (Shechner, 2010).

In addition to theories of gender development, another important factor to consider in determining the appropriate age for SRS is that delays in SRS may mean delays in psychosocial development for children and adolescents with gender dysphoria. According to Erikson's Stages of Psychosocial Development, stage five, which pertains to the development of a stable and coherent sense of self that often includes gender identity, is expected to occur between the ages of thirteen to nineteen (Erikson, 1959). Transgender adolescents of this age range may have more difficulty with this stage of psychosocial development due to the incongruity between their gender identity and physical characteristics. Successful completion of this developmental stage may be too difficult for some until their gender dysphoria is alleviated through SRS. From this perspective, SRS should be performed sooner rather than later to avoid stunting of psychosocial development. Transgender youths have also been expressing interest in SRS at increasingly younger ages over the past decade, which should be no surprise when one takes into account that social transitioning and administration of hormones are occurring at earlier ages (Mildrod, 2014). On the other hand, lack of research exists on reliable ways to distinguish between youths with gender dysphoria that will persist into adulthood and those that will not (Wallien & Cohen-Kettenis, 2008). This knowledge deficit calls for making decisions about SRS readiness in a conservative manner given SRS's irreversible nature.

Current guidelines for SRS readiness assessment

Comprehensive and concrete guidelines for assessing SRS readiness still remain lacking. Although WPATH stipulates some specific criteria to be met before SRS is performed, in the same breath it emphasizes the significant variability inherent between patients and suggests a case-by-case decision-making process. However, WPATH is not clear on *how* to assess SRS readiness on a case-by-case basis. As a result, clinicians when assessing SRS readiness often default to one of WPATH's recommendations that SRS be performed after an individual has reached "age of majority in a given country" (Coleman et al., 2011). While this recommendation makes sense, the variability in age of majority across the globe makes age of majority seem like an arbitrary, rather than an empirically informed, threshold for SRS readiness. Age of majority is likely driven by a particular region's cultural attitudes, rather than empirical evidence on psychological development, and thus it alone is likely an imperfect and inefficient measure of eligibility for SRS. Figure 1 highlights the range of age of majority that exists between and within countries. In Canada, assessing for SRS readiness is further complicated by the Infants Act, which leaves adherence to age of majority to the clinician's discretion. Specifically, the Infants Act states that if a medical service provider has fully explained the nature and consequences of the medical service and has evaluated the service as being in the patient's best interests, an under-aged individual can receive the medical service after providing consent (Infant Act, R.S.B.C. 1996).

Should clinicians consider underage transgender youths for SRS or adhere strictly to the age of majority of their region? To our knowledge, no research has looked at the outcomes of performing SRS on underage individuals deemed psychologically ready. Even though SRS is not illegal to perform on underage individuals, health professionals often decline to share their experiences if they have been involved in such cases due to social disapproval (Mildrod, 2014).

Current study

Our goal for the present study was to gain better insight into the thorny issues of SRS readiness assessment and reliance on age of majority by examining the lived experiences and attitudes of underage transgender youths who were waiting to receive SRS. The present study used a qualitative design, which is ideal for studying rich and complex constructs instead of a quantitative approach, which tends to simplify human experiences. (Schwandt, 1994).

Methods and Participants

Participants were recruited through youth who have already attended a transgender youth group for six months or longer. The focus group consisted of nine transgendered teenagers under the age of nineteen, who were from British Columbia, Canada. The youngest participant was sixteen years old and the oldest was eighteen years old. Seven of them were Female-to-Male and two of them Male-to-Female. Participants in our focus group were at different stages of their transition. All participants were undergoing hormone therapy, ranging from eighteen to 30 months, but none had received the genital reassignment surgery. Four participants had been approved by physicians for chest reconstruction surgery. One participant had been approved for sex reassignment surgery. Participants had been under the care of the first author for three to eleven years. While all participants had familial support, two were under Continued Care Orders (CCO).

Procedure

In order to participate, participants had to be between the age 16 to 19 and have been on hormone therapy for at least six months or longer. Prior to participation, participants were informed of the study procedures and their right to decline or withdrawal from participation at any time. After parental and individual consent were obtained, Dr. Wallace Wong conducted a focus group with the participants, with the aid of three graduate students. The focus group lasted approximately two hours. Two recording pens were used to audiotape the discussion. Examples of questions that were posed to focus groups are as follows:

> Q1: At what age should a person be allowed to have bottom surgery. Please explain why.
> Q2: Does having to wait until you're 19 years old to have surgery affect your planning for the future? If so, how?
> Q3: If one wants to have bottom surgery before age of majority, how could we know if the youth is ready?
> Q4: Do you think you are ready to have bottom surgery even though you are not 19 yet today?

After each question was posed, participants were given the option to respond. Appropriate follow-up questions were introduced based on the group discussion, which usually elicited participants to elaborate on their answers, provide additional details, and clarify subject matter. We used a qualitative approach to analyze the data gathered from the focus group as qualitative research allows a holistic and in-depth understanding of human experiences and behaviors.

Data Analysis

Interview transcripts

The focus group was audiotaped and transcribed. Constant comparison method was used to analyze the interview transcript. Prior to reading the transcripts, researchers familiarized themselves with the primary objective of the study: to better understand attitudes of transgendered adolescents towards the use of age of majority as a criterion for SRS readiness and the assessment process overall. Then, the researchers independently read over the focus group interview transcripts for the first time, without attempting to write down any themes. In the second round, each researcher independently recorded the unique and important impressions in the margins of the text. During the third reading, researchers re-read the transcripts and extracted all the re-occurring possible themes that appeared in the focus group discussion. Then, researchers reviewed and discussed all the possible themes together until they agreed on the major themes. There were a total of nine themes extracted from the transcripts. Finally, researchers identified the passages that supported each theme and highlighted them using different colors on a separate word document.

Results

Our focus group consisted of nine transgendered adolescents under the age of 19. None had undergone SRS. Two major categories of themes emerged, with one pertaining to the SRS readiness assessment process and the other pertaining to the effects of waiting for SRS due to age. Related to the first category, the following themes emerged from the focus group discussions: (1) instead of using age of majority as a threshold, SRS readiness should be determined on a case-by-case basis, (2) sixteen is an acceptable minimum age for undergoing SRS, and (3) the comprehensiveness of the assessment process is both beneficial and detrimental. Related to the second thematic category of effects of being denied surgery due to age, the following themes were extracted: (1) effects on emotional well-being, (2) effects on planning for the future, and (3) effects on interpersonal relationships.

Themes Associated with the Assessment Process

Case-by-case basis

One major theme that arose from the focus group discussion was a preference for a case-by-case assessment process, which was agreed on unanimously. Participants believed this to be a superior method to strict reliance on age of majority as a gatekeeper. Age instead should be considered as one of many variables in determining readiness for SRS. One participant stated:

> *Not everyone matures at the exact same age and grows at the exact same age so, like if you, like study a person, know that they, they're done their growing, you know that they're ready for this, then age isn't really that much of a factor. (M, FtM)*

The focus group also believed that psychologists performing the assessment should use their knowledge and clinical experience to establish the psychological maturity and readiness of a youth for SRS. Related to this, another participant stated, "Case-

by-case would be best because then not only are….your psychologists know exactly where you are, and how mature or ready you are for surgery."(N, MtF)

Sixteen as an acceptable minimum age

When asked if a minimum age for SRS should be set at all or abolished completely, eight of nine youths advocated for retaining a minimum age that is lowered from nineteen, as currently stipulated by the province of British Columbia in Canada, to sixteen. These youths conveyed that they arrived at the age of sixteen as they believe most youths would be psychologically and physically mature enough to undergo SRS at that age. One participant stated,

> *"I'm thinking like sixteen, cause….you've gone through puberty, most likely, and then, like… you would know if that's really how you felt."(J, FtM).*

The remaining youth suggested a minimum age of seventeen based on his personal experience of puberty and physical maturation:

> *If someone gets it at a really young age, what happens when their body starts to grow? Right, you also have to think about that, I mean, you would get so many, so much scarring and everything, that at the point when you… I would say seventeen is a good age, only because, not just because its in the middle but because a lot of people have stopped having their growth spurts by then, right, at thirteen, like, I didn't get my growth, my first growth spurt until I was fifteen, right. So, imagine if I had bottom surgery then, you know, I would've, something would've torn or like, something would've malfunctioned and that's not good…" (E, FtM)*

Comprehensiveness of the assessment process

A third theme that arose from the focus group was that the comprehensiveness of the assessment process is often a double-edged sword. All of the youths agreed that a comprehensive SRS assessment process is helpful for screening out false positives but may also be an obstacle for those who are truly ready for SRS. One participant stated:

> *"There's steps that you have to go through. Like if, you're getting hormone therapy first, and you have to do that first, which takes a while and you have to be on it for a set number of time. So while the person's, you know, getting their real life experience and then like, being on hormones actually passing as the gender that they want to be perceived as. Like, they'll know….that takes a really long time…. there's like lots of like, safety nets to prevent like, accidental surgery." (T, FtM).*

Themes Associated with the Impact of Waiting for Surgery

Effects on emotional well-being

All participants expressed experiencing poorer self-image, fear for safety, and depressed mood associated with not having body parts consistent with their affirmed gender while waiting for SRS. Participants often described feeling inadequate, inferior, and awkward. Almost all participants listed physical activities, such as playing sports, swimming, and going to the gym, as one type of situations where not

having the 'right' body parts leads to significant fear. For example, one participant noted:

> *I do not feel comfortable going to the gym and working out, even though I would love like, in my brain, I'm like yeah, you know if I go to the gym and I work out, I'll like, loose some weight and get some abs and I'll feel like, more comfortable in my body. But because….I don't have… the right… like, cuz I don't have a flat chest, you know I don't have a bulge in my pants. Like, I feel scared out of my mind to go the gym (D, FtM)*

Tyler, another female-to-male participant, described her feelings and concerns related to swimming:

> *Whenever I'm at a pool, or whenever I'm like, in my sweater and a t-shirt, because I don't feel comfortable just wearing a t-shirt, and I see some lucky guy just walking around with his shirt off, when its thirty two degree in the summer, it makes you feel really envious, and really jealous. And it's a huge safety thing for the washrooms too. Like, Whenever I can I'll use like, a family bathroom or like, a handicap bathroom because, I am afraid of a guy finding out that, wait a second you don't have a dick, and then getting raped. It's a really big safety issue for me. And it terrifies me, like, all the time, that just randomly even like, walking home, waiting for the bus at Surrey central like, its a huge safety issue. (T, FtM)*

Many participants echoed Tyler's description of going swimming as a transgendered youth that has not undergone SRS. They described avoidance of the swimming pool and beach due to their inability to "pass" while wearing bathing suits that are consistent with their affirmed gender.

According to all of the participants, waiting for SRS also has a significant negative impact on their mood. One participant noted,

> *"They shouldn't make us wait longer because it's depressing, and to see somebody have the parts that you don't have….and they shouldn't also make you wait because it's like, wasting your life" (Justin, FtM)*.

Several participants believed that waiting for SRS leads to depressed mood because not having body parts consistent of one's affirmed gender creates psychological distress and puts limits on one's functioning. As one youth summarized:

> *Not feeling comfortable in your own body, it prevents you from doing everything. I mean like, it prevents you from going outdoors. It prevents you from experiencing real life. It prevents you from feeling comfortable with yourself. I mean, if you can't feel comfortable with yourself, how can you love yourself, how can you love other people, how can you actually fulfill life to the fullest. (T, FtM)*

Effects on future planning

Throughout the focus group discussion, participants emphasized that having to wait for surgery has led them to postpone making plans for the future, ranging from more

minor plans like travelling to significant ones like academic and career pursuits. One participant described her travel plans being delayed until after surgery:

> *I haven't been able to plan any of my travelling for like, after I'm 19….I wanted to go on a vacation over to Germany with my mom, and hopefully travel around Europe, but I cannot even do that without my passport. And because I look male and I don't look like the female that's on um… my passport. I can't legally travel.. (E, FtM)*

With regards to their academic aspirations, almost all participants reported that they plan to defer post-secondary studies until after SRS. Participants cited two main reasons for this: their anticipation that SRS would be a substantial disruption to their studies and their preference to finish transitioning prior to meeting new peers. For example, one participant described:

> *As of right now I graduate when I am 17 so, earlier than most people. Umm… and after I graduate, I pretty much sit at home and work because I won't be going to university until I have surgery. Um… because it's a lot of money for university and I don't want to pay for like, a semester or a year and then all of a sudden be like, k, you can get surgery early….When it was completely pointless since I have to like, drop out now, and um you don't get the money back… And then just like, having to recover and everything, and then going back, then the people that were in like, your grade or class have moved up and then you're back at the bottom (N, MtF).*

Furthermore, several participants emphasized that their inability to undergo SRS until they are nineteen years old is a major obstacle in their occupational aspirations. For example, one participant stated:

> *I do want to be an RCMP officer, I do have to wait till nineteen to register anyway, but the thing is, I mean I would like to register when I, when I do have my surgery and I…and when I do, when I do recover from my surgery which means, it probably takes me off, maybe a couple years off. So that means I've got to wait longer now. (T, FtM)*

Difficulty with relationships

All participants agreed that waiting for SRS has hindered the growth of various interpersonal relationships. Related to this, one participant expressed

> *"It's really hard to do all that when you don't have the right body. And… it is hard to find someone who will accept you fully" (B, FtM).*

Majority of participants described that waiting for SRS has interfered with romantic and sexual relationships. As participant stated,

> *"I think people will be more accepting to be, ah… to be romantic with a transgendered person if they had that body part down there. And you'd feel more comfortable to have sex and be more intimate, and love yourself more if you have that body part" (T, MtF).*

Another participant noted:

> *It makes me question who I could actually have an intimate relationship with. Um… like if you're a straight guy, you look for straight woman. If you're a lesbian, you look for other lesbians. If you are gay man you look for other gay men. But when you're trans it's like, who can I even, you know like… either they're not going to be interested in me or… or they're going to lose interest when I start transitioning. Or… like I just, I don't even know… what I'm supposed to be looking for. I don't know that maybe makes no sense at all. But it just, it feels like I can't start a relationship with anybody because there's always going to be, some problem caused by either, transition, or surgery, or not having surgery. (K, MtF)*

In addition to romantic and sexual relationships, majority of participants also spoke about the detrimental impact of waiting for SRS on their peer relationships and friendships. All youths expressed their need to keep some distance between themselves and their peers, due to their lacking the physical characteristics consistent with their affirmed gender. Moreover, many participants expressed worries about fitting in with peers and difficulties with making friends. One female-to-male participant pointed out:

> *Whenever I'm around other guys, I feel intimidated by them and less than them, and it is hard for me to make guy friends, because I feel like…I don't fully fit in with them, because they have everything that I want. And like if they like, you know, wanna go hangout, I mean, I have to worry if you know, if they're just gonna like, if they wanna go skinny dipping or something you know… you have to worry about that, and just that…you don't feel fully comfortable around your friends and stuff. (T, MtF)*

Discussion

Limited research has focused on the assessment process of SRS readiness for transgendered adolescents. The aim of our study was to better understand attitudes of transgendered adolescents towards the use of age of majority as a criterion for SRS readiness and the assessment process overall. Thematic content analyses of our focus group transcript revealed two categories of themes in the discussion: attitudes toward the current assessment process and the effects of waiting for SRS.

Attitudes toward current assessment process

With respect to attitudes toward the current assessment process, three themes emerged from our analyses: (1) readiness should be determined on a case-by-case basis, (2) sixteen is an acceptable minimum age for undergoing SRS, and (3) the comprehensiveness of the assessment process is both beneficial and detrimental.

Participant's suggestion for case-by-case determination of SRS readiness is consistent with the guidelines stipulated by the World Professional Association for Transgendered Health (WPATH) (Coleman, 2014). Most youths in the focus group

agreed that individuals psychologically and physically mature at different rates and therefore may be ready for SRS at different ages.

It is interesting to contrast SRS with elective plastic surgery in youths. The rate for elective plastic surgery, such as rhinoplasty and chin augumentation, in youths has steadily risen over the past ten years (McGrath & Murkeji, 2000). Many of these youths undergo such surgeries under the under the age of nineteen. Prior to undergoing plastic surgery, surgeons would determine on a case-by-case basis, with age being one factor to consider, whether a particular patient is psychologically mature enough to give informed consent. It may be useful for clinicians assessing for SRS readiness to open a dialogue with those involved in performing elective plastic surgery for youths to gain a better understanding of their assessment procedures. Perhaps with a more detailed assessment protocol in place, clinicians may be more comfortable with assessing whether underage individuals are eligible for SRS, instead of refusing SRS based solely on age. The eligible adolescents will likely benefit from undergoing SRS at an earlier time given what we found in this study with respect to the negative effects of waiting for SRS.

Another theme apparent from the focus group discussion is to lower the age of majority to sixteen. The main justification that participants gave for this is that they believe at the age of sixteen, youths are physically developed enough to undergo surgery and are psychologically mature enough to consent to surgery. It appears that the participants would like to establish a new age of majority that reflects physical and psychological development, rather than cultural guidelines.

The last theme extracted from the focus group discussion was related to the comprehensiveness of the assessment process for SRS readiness. Participants viewed it as a double-edged sword that yields clear benefits and disadvantages for patients. Given that our assessments typically require multiple sessions over the span of months and involve a variety of tasks, such as paper-pencil questionnaires, clinical interview and gathering parent report, we anticipated the youths to express dissatisfaction with how painstaking the current assessment process is. However, we were surprised that participants recognized the utility of a detailed and prolonged assessment. Contradictory to stereotypes of adolescents being impulsive and short-sighted, transgender youths seem to appreciate why SRS readiness assessment are comprehensive and time-consuming.

Effects of Waiting for Surgery

The focus group discussion was as much about the SRS readiness assessment process as the effects of waiting for SRS, which can be grouped into those on emotional well-being, future planning and interpersonal relationships. These three themes regarding the effects of waiting for SRS are consistent with the current literature on the effects of gender dysphoria. For example, Cohen-Kettinis, Steensma, and De Vries (2011) concluded that transgender youths are more likely to develop depression, suicidality, anxiety, oppositional defiant disorders, school truancy and social withdrawal.

From the discussion, there appears to be a tendency to postpone life until SRS is completed. Participants spoke out about delaying travel plans, post-secondary education and romantic relationships until they undergo SRS. Through the lens of

Erikson's Stages of Psychosocial Development, it appears that these youths are purposefully stunting themselves as the various developmental stages until they have the physical characteristics consistent with their affirmed gender. This is worrisome given that successful resolution of these stages in a timely manner are associated with better psychological outcomes.

Limitations of the Study

In this study, participants consisted of transgender youths who were under our care, had basic level of familial support, and under the age of nineteen. Thus, the generalizability of our results to transgender youths who are not accessing health care services, supported by family or younger than nineteen years old is unknown. It is also possible that if the focus groups were conducted at countries where the age of majority is not nineteen, the results may have been different. Lastly, the groups were led by Dr. Wallace Wong, who was involved in the care of all of the participants. Having their psychologist as the group facilitator may have biased the responses of the participants.

Implications of this Study

Although this study has limitations, we believe that it can inform how the assessment process for SRS readiness may be improved. First, assessments should be conducted on a case-by-case basis rather than heavily relying on age of majority. Perhaps, a better indicator of SRS readiness is number of years living in congruence with the affirmed gender. It may be worthwhile to designate, based on empirical evidence, a specific number of years one has to live as his or her affirmed gender to bypass the age of majority and undergo SRS at a younger age. In addition, it may be worthwhile to agree on an age of majority for SRS across the globe that reflects what is known about developmental psychology. Lastly, given that waiting for SRS may lead a host of negative consequences, clinicians should carefully weigh the risks of delaying SRS when they assess for readiness.

Future Directions

More research efforts should be directed towards investigating and delineating the best practice for assessing SRS readiness. Furthermore, qualitative and quantitative studies examining the outcomes of those receiving SRS before and after reaching age of majority would illuminate the utility of strict adherence to age. Finally, conducting focus groups with populations other than underage transgender youths, such as health professionals involved in the care of transgender individuals, parents of transgender children, transgender adults that have completed SRS, will shed more light on how to improve the SRS readiness assessment process to best serve the transgender population.

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Contact email: Wallace.wong@gov.bc.ca

Figure 1. The age of majority, which is one of the eligibility criteria for genital sex reassignment surgery according to WPATH's Standards of Care Version 7, varies regionally

Region	Age
Germany	No Clear Minimum Age Stated
Netherlands	No Clear Minimum Age Stated
UK	18
Canada- British Columbia	19
Canada- Quebec	18
Canada- Ontario	18
Spain	18
Belgium	18
Norway	18
Sweden	18
Denmark	21
Finland	20
Turkey	No Clear Minimum Age Stated
Ukraine	25
US	18
Argentina	18

Appendix A- The criteria for genital sex reassignment surgery eligibility according to WPATH's Standards of Care Version 7

Criteria for hysterectomy and salpingo-oophorectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well-documented gender dysphoria;16

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled.

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Appendix B- Canada's Infant Act: Consent of infant to medical treatment

(1) In this section:
"health care" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care;
"health care provider" includes a person licensed, certified or registered in British Columbia to provide health care.

(2) Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.

(3) A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care
(a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.