

‘I Just Need to Get to Know You’:

A Foucauldian Genealogy of Health Care Assessments of Trans and Gender Diverse Youth

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Abstract

Despite the importance of transition related health care (TRHC) for many trans and gender diverse (trans) youth, there are many barriers to accessing this care, including assessment protocols that limit youth's autonomy. This research seeks to interrogate how and why current assessment practices in pediatric TRHC in Ontario have come to be. Drawing on the theories of (trans)normativity and governmentality, the project applied a Foucauldian discourse analysis to analyze interviews with five clinicians currently practicing in TRHC in Ontario. Analysis identified six sources which influenced clinicians' assessment practices: clinical guidelines, more experienced clinicians, other experience in pediatric care, evolving research and evidence, perspectives of youth and families, and external legal and social pressures. Additionally, analysis interrogated the evolution of mental health assessments from the realm of psychology and psychiatry to an embedded part of clinical care; the oft-repeated intention of clinicians to "get to know" youth; and the conditional decision-making authority, granted to some, but not all, trans youth. Findings discuss how these discourses obscure the ways in which power is enacted within the clinic. Finally, this project explores the implications of these findings for provider training, clinical practice, and theory. This research is put forward in the hope that, in the future, all trans and gender diverse children and youth will have access to the affirming TRHC that they need and deserve.

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Chapter 1 – Introduction

Access to vital transition related health care is fraught with challenges for trans and gender diverse (trans) youth (Gridley et al., 2016; Hastings et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). Common assessment practices delay and restrict access to care for many youth, despite evidence of the harm these practices cause (Gridley et al., 2016; Hastings et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). In this context, this study sought to understand the origins and evolution of current assessment practices in this field, and how individual clinicians learn to conduct assessments with trans youth. Reflecting a transformative research paradigm, the overarching goal of this project is to improve autonomy and access to care for trans youth.

For many trans youth, access to transition related health care (TRHC) is extremely important (Hastings et al., 2021). TRHC may include hormone blockers, which pause the effects of puberty, and hormones and transition related surgeries, which cause changes to individuals' primary or secondary sex characteristics (Hastings et al., 2021). Trans youth follow a variety of transition pathways and may seek to access some, all, or none of these options (Hastings et al., 2021).

Despite the importance of TRHC for many trans youth, existing research shows that young people experience many barriers to accessing the care that they need (Gridley et al., 2016; Hastings et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). Harmful assessment protocols that limit youth's autonomy to make decisions for themselves and their bodies are one significant barrier (Gridley et al., 2016; Hastings et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). Some research even describes current assessment practices at one Ontario clinic which includes invasive and unnecessary questions related to childhood gender expression,

sexual orientation, and masturbation (Seburn et al., 2019). These questions also bear a striking resemblance to assessment criteria implemented by clinicians working with trans adults in the mid-1900s to limit access to transition related surgeries (Benjamin, 1966). This is problematic, as these outdated criteria significantly restrict trans people's access to care that they need.

Some research has described the experiences of trans youth and their families accessing transition related health care (e.g., Gridley et al., 2016; Hastings et al., 2021; MacKinnon et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). However, a relatively small amount of research has addressed the experiences of clinicians who administer assessments (e.g., Dewey, 2015; MacKinnon et al., 2019, 2021; shuster, 2016, 2019), with even less research focusing on clinicians who conduct assessments of trans youth (e.g., MacKinnon et al., 2021; Pyne, 2018).

Most researchers who have interviewed trans health clinicians use grounded theory or institutional ethnography to understand clinicians' experiences of assessment processes (Dewey, 2015; MacKinnon et al., 2019; shuster, 2016). This research has suggested that clinicians learn to practice transition related care through reviewing standardized protocols, and interacting with patients (MacKinnon et al., 2019). Other findings show that some clinicians feel responsible for their clients' decisions about TRHC (Dewey, 2015; shuster, 2016) and may closely follow guidelines with the goal of preventing client regret (shuster, 2016) or risking liability (Dewey, 2015; shuster, 2016). Meanwhile, other clinicians feel more comfortable loosely interpreting guidelines to support their clients (shuster, 2016). Shuster (2019) suggests that many providers describe their practice as utilizing an informed consent process, while continuing to gatekeep access to TRHC. Gatekeeping, as commonly used in trans health scholarship, describes hierarchical assessment practices which restrict access to care by imposing excessive barriers to accessing TRHC and positioning clinicians as the ultimate decision maker or 'gatekeeper' to

determine if and when trans people should access TRHC (Ashley, 2019).

While these studies represent a significant contribution to the literature in this area, Pyne (2018) makes the distinction between “viewing talk as a resource” (p. 29), as in these grounded theory studies, which take participants experiences as truth, versus discourse analysis methodologies, which approach talk itself as the topic of study. The research outlined above provides useful insights into the perspectives of clinicians who conduct assessment practices of those seeking TRHC, however it does not always attend to the discourses which clinicians draw upon when describing their practice, or to how these practices may have come to be.

Pyne (2018) begins to address this gap, by conducting an interpretive repertoires discourse analysis of interviews with clinicians who work with trans youth. Pyne (2018) seeks to answer the question “what makes puberty suppression and early transition thinkable and possible” (p. 28). This research analyses the discourses present in clinicians talk about trans youth and finds that “the conditions of possibility that make early transition possible for some trans youth, are the same conditions that foreclose it for others” (p. 247), particularly autistic and racialized trans youth.

This existing research leaves many questions open about assessment practices for trans youth. Of particular note are the similarities between some current assessment practices of youth seeking TRHC (Seburn et al., 2019) and early gatekeeping assessments of the past (Benjamin, 1966). Situated in this context, this research conducts a Foucauldian discourse analysis to answer the question “how and why have current assessment practices in pediatric trans health care in Ontario come to be?”

Chapter 2 – Literature Review

Trans, nonbinary, and gender diverse (trans) youth are young people whose gender

identity does not align with the gender they were assigned at birth (Ontario Human Rights Commission, 2014). Trans youth may identify as male or female, or other gender identities outside of the gender binary, including labels such as nonbinary, genderqueer, agender, gender fluid, and others (Hastings et al., 2021). Young people may also hold culturally specific identities, including the label Two Spirit which “is popularly used by Indigenous people to identify a range of roles and identities which may span, and even complicate, distinctions between gender, sex, and sexuality” (Hunt, 2016, p. 5).

Many, though not all, trans youth seek to access TRHC, which may include hormone blockers, hormones, and/or transition-related surgeries (Hastings et al., 2021). Hormone blockers temporarily pause the effects of puberty, allowing youth more time to decide whether to continue puberty in the future by discontinuing hormone blockers or to take hormones, such as testosterone or estrogen, to develop a variety of secondary sex characteristics (Hastings et al., 2021). Some youth may also seek to access to some transition-related surgeries such as chest surgeries (Pullen Sansfaçon et al., 2019). For the purposes of this project, ‘youth’ includes young people under age 18, aligned with the common distinction between pediatric and adult TRHC in Ontario.

This literature review was undertaken with the aim of exploring the origins and current context of assessment practices for trans youth seeking to access TRHC. A search was conducted using the databases Nursing & Allied Health Premium, Public Health Database, Applied Social Sciences Index & Abstracts (ASSIA), Sociology Collection, and APA PsycInfo with various combinations of the search terms presented in the table below. Additional sources were retrieved through professional networks and relevant reference lists.

| Concept | Search Terms |
|-------------|---|
| health care | “Health care provider*”, doctor*, nurse*, “social worker*”, clinician*, |

| | |
|--------------------------------|--|
| providers | endocrinologist*, pediatrician* |
| Trans and gender diverse | Trans, Transgender, nonbinary, genderqueer, “Two Spirit”, “gender fluid”, “gender diverse”, “gender nonconforming”, “gender independent”, agender, transsexual, “gender creative” |
| Children and youth | Child, Youth, adolescent*, pediatric |
| Assessment | Assessment*, “readiness assessment*”, screening, diagnos* |
| Transition-related health care | “transition-related health care”, blocker*, “hormone blocker*”, “puberty blocker*”, “gender affirming health care”, “gender affirming care”, “transition related care”, hormone*, “hormone replacement therapy”, HRT, “transition related surger*”, “gender affirming surger*”, “sex reassignment surger*”, “top surger*”, “bottom surger*”, “lower surger*” |

This literature review will begin with a brief overview of the history of TRHC assessments for trans youth, followed by a summary of the current models of care used by clinicians in pediatric trans health, and a brief description of clinical guidelines which influence pediatric TRHC. It will then outline current key debates relating to assessments for trans youth and discuss trans youths’ own experiences of navigating assessments for TRHC. It will conclude with a review of past research which has explored the origins and implications of TRHC assessments, and the remaining gaps which my research will begin to address.

History of TRHC Assessments for Trans Youth

While gender diverse people have always existed, the mid-19th century was a time of significant development in Western medical transition for trans adults as some clinicians entered what they described as a “brave new frontier of untrodden medicine” (shuster, 2021, p. 24). In order to demonstrate their credibility, clinicians began to collaborate with therapists and institute strict criteria, including requirements related to normative gender expression, employment, and sexuality, to assess whether trans people would be accepted for TRHC (shuster, 2021).

Since the 1960s, clinical treatment has also focused on gender non-conforming children, beginning with clinics which aimed to change children’s gender expression to align with gender norms (Pyne, 2014). For many years, medical transition was not available to youth, because they

were assumed to be incompetent to make this decision and to have a high risk of regret (Delemarre-Van De Waal & Cohen-Kettenis, 2006). As a result, trans people were required to wait until adulthood to access any TRHC that was available (de Vries & Cohen-Kettenis, 2012).

Prior to the late 1990s, corrective models of care for trans youth, were most common. These models evolved into the biopsychosocial model, advocated by Dr. Ken Zucker, a psychologist clinician-scientist at the Centre for Addiction and Mental Health (CAMH) in Toronto (Zucker et al., 2012). Zucker conducted in depth assessments with the children and families he saw and suggested to parents and caregivers of young children that they could prevent their child from growing up to be trans by restricting their use of gender atypical toys (Zucker et al., 2012). Zucker published widely on his theories, clinical practices, and outcomes.

One of the major influences on Ken Zucker's work was Dr. Richard Green, an American psychiatrist who conducted research on 'feminine boys' at the UCLA Gender Identity Research Clinic in the 1970s and 80s (Lev, 2019). Green's research aimed to discover whether cross-gender behaviors in childhood correlated with adult homosexuality or transsexuality (Lev, 2019). Green also worked closely with Dr. Robert Stoller and Dr. George Rekers, who conducted behavioural therapies with the goal of preventing children from growing up to become trans adults (Lev, 2019). This work went on to inform the practices used at CAMH, based on the idea that behavioural interventions could prevent gender nonconforming children from growing up to be trans (Lev, 2019). After many years of criticism from trans communities and other professionals, Dr. Zucker was removed from CAMH in 2015 and it was announced that the clinic would be restructured (Lev, 2019).

Beginning in the late 1990s and early 2000s, clinicians in the Netherlands popularized the practice of prescribing hormone blockers to youth between the ages of 12 and 16 (de Vries &

Cohen-Kettenis, 2012), as they realized that requiring youth to undergo unwanted pubertal changes was detrimental to their wellbeing (Delemarre-Van De Waal & Cohen-Kettenis, 2006). In order to be eligible for hormone blockers, youth were required to undergo extensive assessments and to demonstrate that they “suffer[ed] from life-long gender dysphoria that had increased around puberty,” and were “psychologically stable... and supported in their environment” (Delemarre-Van De Waal & Cohen-Kettenis, 2006, p. 2).

As the first clinic to recommend transition-related medical intervention for youth, the Dutch team’s “wait-and-see” approach set the standard for the conceptualization and use of hormone blockers for trans and gender diverse youth. While they were extremely progressive for the time, the logic underpinning their wait-and-see approach to supporting trans children and youth was also based on extensive gatekeeping and producing normative adults who would not be visibly trans (Delemarre-Van De Waal & Cohen-Kettenis, 2006).

Since this time, hormone blockers have become commonly available to some trans youth (Pyne, 2018), and some clinicians have shifted towards more affirming practices for youth TRHC (Hidalgo et al., 2013). Despite this, in depth assessments and stringent requirements remain common for youth seeking to access TRHC (Gridley et al., 2016; Pullen Sansfaçon et al., 2019; Seburn et al., 2019).

Current Models of Care

In recent years, an increased number of trans youth have been seeking TRHC at gender clinics in Canada and elsewhere (Bauer et al., 2021b). Research shows that many trans youth experience mental health challenges, including high rates of depression, anxiety, suicidality, and self-harm (Veale et al., 2017); however, those who are affirmed in their identities experience positive mental health outcomes similar to cisgender (non-trans) youth (Olson et al., 2016).

Youth also report that accessing the TRHC that they need positively impacts their mental health and well-being (Pullen Sansfaçon et al., 2019; Seburn et al., 2019).

Clinicians take a variety of approaches to TRHC for youth, which fall into three main models of care: the “corrective model,” the “wait-and-see model,” and the “gender-affirmative model” (Ashley, 2021). The corrective model aims to “help the child feel more comfortable in his or her [sic] own skin” (Zucker et al., 2012, p. 388), by reducing the persistence of gender dysphoria and discouraging children from becoming trans adults (Zucker et al., 2012). Many people consider this model a form of conversion therapy (Ashley, 2021), which has been associated with poor mental health outcomes in adulthood (Turban et al., 2020).

In contrast, the wait-and-see approach does not discourage youth from becoming trans adults; however, it does discourage young children from early social transition, based on the belief that they are likely to ‘desist’ or detransition and that this process would be harmful (de Vries & Cohen-Kettenis, 2012). For adolescents, this approach advocates for in-depth psychodiagnostic, psychiatric, social, and medical assessments, after which youth may be able to access hormone blockers, and later hormones and transition-related surgery (de Vries & Cohen-Kettenis, 2012).

Finally, in the gender-affirmative model, “pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth’s gender experience” (Rafferty et al., 2018, p. 4). This model is based on the principles that transgender identities and diverse gender expressions do not constitute a mental disorder; variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities; gender identity evolves as an interplay of biology, development, socialization, and culture; and if

a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child. (Rafferty et al., 2018, p. 4)

The gender-affirmative model is widely supported by experts, clinicians, professional guidelines, and trans youth themselves (eg. Ashley, 2021; Bauer et al., 2021b; Ehrensaft, 2012; Hidalgo et al., 2013; Pullen Sansfaçon et al., 2019; Rafferty et al., 2018; Seburn et al., 2019).

For adults, some clinicians are moving towards an informed consent model for access to TRHC (Schulz, 2018). Under this model, trans adults are able to make their own decisions about whether and when to access TRHC, rather than having their readiness assessed by a clinician (Schulz, 2018). Clinicians provide “information about risks, side effects, benefits, and possible consequences of undergoing [TRHC], and... obtain informed consent” (Schulz, 2018).

Recent research in British Columbia indicates that trans youth also demonstrate the capacity to give informed consent to hormone therapy (Clark & Virani, 2021). The authors advocate for informed consent models of care to be extended to trans youth who have the decisional capacity, arguing that this decision has the greatest impact on the youth themselves, rather than their family or clinicians, and that “denying access based on an arbitrary age of consent lacks ethical justification” (Clark & Virani, 2021, p. 162). Despite this, no literature indicates that an informed consent model of care is currently in use for youth in North America.

Clinical Guidelines and Best Practices

International clinician guidelines, including the World Professional Association of Transgender Health (WPATH) Standards of Care (SOC) and the Endocrine Society clinical guidelines aim to lay out current best practices for providing TRHC to trans children and youth. The WPATH SOC were developed by medical clinicians and mental health practitioners to establish shared criteria for assessing and treating trans and gender diverse people across the

world (Coleman et al., 2012). Currently, the guidelines for working with children and youth are informed by the corrective and wait-and-see models of care (Coleman et al., 2012). The SOC recommend that hormone blockers be prescribed to youth prior to HRT and that four criteria be met for youth to begin hormone blockers, including that their mental health is stable and that they have parental support (Coleman et al., 2012). Additionally, the SOC indicates that “[a]dolescents may be eligible to begin [HRT], preferably with parental consent” (Coleman et al., 2012, p. 20) but does not provide any details about the assessment process for initiating HRT.

The Endocrine Society guidelines were developed separately by clinicians, and similarly recommend that hormone blockers be prescribed to youth prior to initiating HRT. They also recommend that mental health providers be involved in diagnosing gender dysphoria and assessing youths’ capacity to consent to TRHC (Hembree et al., 2017).

While these guidelines make specific recommendations for the provision of TRHC to youth, research shows that when working with trans adults, only some providers follow them closely, while others are comfortable interpreting guidelines flexibly to put the needs of their patients first (shuster, 2016).

Key Debates in Assessments for Youth TRHC

Proponents of rigorous assessments for trans youth often cite the statistic that 80% of trans children do not identify as trans as adults (Temple Newhook et al., 2018a). This statistic is used to justify the need for assessments by asserting that they are a necessary tool to prevent children from transitioning and later realizing that they are cisgender, also referred to as “desisting” (Temple Newhook et al., 2018a). As noted by Temple Newhook et al. (2018a) and Ashley (2021), this statistic is often drawn from five follow up studies of trans and gender non-conforming children in Canada and the Netherlands, including the work of Ken Zucker at

CAMH in Ontario (i.e., Drummond et al., 2008; Singh, 2012; Steensma et al., 2011, 2013; Wallien & Cohen-Kettenis, 2008); however, these studies are methodologically flawed and have been the subject of significant critique (Ashley, 2021; Temple Newhook et al., 2018a, 2018b). For example, Temple Newhook et al. (2018a) note that many children included in these studies did not identify as trans at the time of the study, so it is unsurprising that many did not identify as trans in adulthood. Ashley (2021) points out that the clinic where two of these studies were conducted (Drummond et al., 2008; Singh, 2012) was later closed due to allegations that they practiced conversion therapy and, therefore, that their results may not provide an accurate representation of youth's identities.

Additionally, casting doubt on the accuracy of desistance claims, many other clinics who work with trans children have noted that the vast majority of children who they see continue to identify as trans adults (Conard et al., 2018). Some other young people have dynamic gender identities, they may detransition without regrets, and in some cases may retransition again (Turban & Keuroghlian, 2018).

Another recent argument used to promote assessments for youth seeking TRHC proposes a new concept labelled "Rapid Onset Gender Dysphoria" (RODG) (Littman, 2018). An online survey of parents suggests that RODG is a new kind of gender dysphoria that begins suddenly in youth, particularly those assigned female at birth, who experience mental health challenges and conflict with their parents and caregivers, and who are influenced by their peers to wrongly believe that they are trans (Littman, 2018). Littman frames RODG as dangerous, and advocates for more rigorous assessments aiming to prevent youth from accessing TRHC that they will regret.

Restar (2020) and Ashley (2020) critique Littman's methodology and findings. Firstly,

Littman makes claims about the identities and experiences of trans youth, however her data does not include youth's own perspectives (Ashley, 2020; Restar, 2020). Instead, survey respondents were all parents, specifically recruited from transantagonistic websites (Ashley, 2020; Restar, 2020) and Littman was open about the "social and peer contagion" premise of her research, which is likely to have influenced parents' participation and responses (Restar, 2020).

Additionally, Littman's language and approach to her research is pathologizing, describing trans identities as a disorder and an infectious disease, and ignoring the existing research on the needs and wellbeing of trans youth (Restar, 2020). As a result, Ashley (2020) describes Littman's study as an example of epistemological violence, because it ignores existing affirming explanations for the phenomena that RODG is purported to explain. For example, Littman points to the fact that many trans youth belong to friend groups with other trans young people as evidence of peer influence and "social contagion" (Littman, 2018). This makes little sense, as many trans youth seek out trans friends and support one another based on their shared experiences (Ashley, 2020).

Bauer, et al. (2021a) further refute the theory of RODG, based on their analysis of data from youth seeking care at 10 different Canadian gender clinics. This data showed that youth's experiences of depression, connection with online peer groups of other trans youth, parental support, and other factors which Littman suggests being correlated with RODG did not correlate with youth expressing more recent knowledge of their gender identity, as Littman hypothesized (Bauer, et al., 2021a). As a result, these findings do not support the phenomenon of RODG.

Finally, even if it were true that that majority of trans children cease to identify as trans later in life (Ashley, 2021), or that RODG is an accurate description for a subset of trans youth (Ashley, 2020) this would not justify preventing access to TRHC for youth (Pullen Sansfaçon et

al., 2022). Ashley (2021) demonstrates that delaying TRHC for trans youth is more harmful than detransition for cisgender youth, and that models of care which delay access to TRHC are harmful to youth who will later identify as cisgender, as well as those who will continue to identify as trans (Ashley, 2021).

Youth Experiences

Many trans people, including youth, experience significant barriers to accessing TRHC, including long wait times (Gridley et al., 2016; Pullen Sansfaçon et al., 2019; Seburn et al., 2019), harmful assessment processes (Frohard-Dourlent et al., 2020; Gridley et al., 2016; MacKinnon et al., 2020; Pullen Sansfaçon et al., 2019; Seburn et al., 2019), and restrictive protocols, that limit peoples' autonomy to make their own decisions (Frohard-Dourlent et al., 2020; Gridley et al., 2016; Hastings et al., 2021; MacKinnon et al., 2020; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). These barriers impact young people's mental health, including increased dysphoria (Seburn et al., 2019), anxiety, depression, and suicidality (Pullen Sansfaçon et al., 2019; Seburn et al., 2019).

Research on the assessment experiences of both trans youth and adults describes that people often feel pressured to prove their trans identity and readiness for TRHC to clinicians who have the power to approve or deny their access to care (Frohard-Dourlent et al., 2020; Gridley et al., 2016; Hastings et al., 2021; MacKinnon et al., 2020; Seburn et al., 2019). As a result, many people experience their TRHC assessments as gatekeeping (Frohard-Dourlent et al., 2020; Gridley et al., 2016; MacKinnon et al., 2020; Seburn et al., 2019).

Both trans youth and adults view many assessment questions, particularly those about gender identity (Frohard-Dourlent et al., 2020; Seburn et al., 2019), gender expression, and sexuality (Seburn et al., 2019) as unnecessary and invasive. Youth also express discomfort

discussing topics such as suicidality, depression, and their fears or concerns about TRHC with their clinicians (Pullen Sansfaçon et al., 2019). Notably, a community-based survey of trans youth and their parents and caregivers who accessed one gender clinic found that 70% of respondents were asked questions in their assessments “which made them uncomfortable or uneasy, or that they were confused by or did not know why they were being asked” (Seburn et al., 2019). As this statistic demonstrates, many youth have negative experiences of assessments, and describe that the questions they are asked are not aligned with their experiences.

For both youth and adults, assessments create particular barriers for nonbinary people, whose identities and transition goals may not fit within clinicians’ understandings of what it means to be trans and their transnormative expectations of TRHC (Frohard-Dourlent et al., 2020; Hastings et al., 2021; Pullen Sansfaçon et al., 2019; Seburn et al., 2019). Guidelines for TRHC are typically very binary, and nonbinary people may be denied care or experience other barriers because they are viewed as being “not trans enough” (Hastings et al., 2021; Seburn et al., 2019). As a result of these binary criteria, many nonbinary people do not seek care at all, or are not open about their transition goals with their health care providers (Hastings et al., 2021; Seburn et al., 2019). Some youth may also withhold their nonbinary identity from clinicians, presenting a binary trans identity instead to access care more easily (Pullen Sansfaçon et al., 2019; Seburn et al., 2019). One survey of trans youth who accessed a pediatric gender clinic found that more than 50% of nonbinary youth were not open about their nonbinary identity, due to past experiences of clinicians invalidating their identity or fears that their access to TRHC would be delayed (Seburn et al., 2019).

Challenges navigating assessments are also exacerbated for trans people with complex mental health needs (MacKinnon et al., 2020). Assessment criteria typically require that any

complex mental health needs to be managed prior to accessing TRHC, despite the fact that TRHC often mitigates trans people's distress and improves mental health and wellbeing (MacKinnon et al., 2020). Discordantly, some trans youth feel that they are required to emphasize their distress related to their bodies and trans identities to demonstrate their need to access TRHC (Seburn et al., 2019), however, describing too much mental distress may jeopardized individuals' access to care because clinicians may determine they are incapable of providing informed consent (MacKinnon et al., 2020; Seburn et al., 2019).

As a result of negative experiences with assessments, many trans and gender diverse people withhold information or lie to their assessors to access the TRHC that they need (MacKinnon et al., 2020; Seburn et al., 2019). Some youth describe lying about their answers to uncomfortable questions or feeling "like [they] had to stretch [their] trans story to fit a stereotype" (Seburn et al., 2019, p. 16). MacKinnon et al. (2020) describe this as "the bullshit narrative" (p. 70) where trans people present their identity and experiences to fit the necessary criteria for approval and reduce the risk that their access to care will be denied or delayed.

There is also a significant gap in the research, which does not address the experiences of racialized trans youth accessing TRHC. The majority of research with trans youth does not mention race or does not include sufficient racialized participants to speak to the particular experiences of racialized trans youth (e.g., Pullen Sansfaçon et al., 2019; Seburn et al., 2019). Pyne (2018) addresses this gap and suggests that the same arguments commonly used to support access to TRHC for white trans youth simultaneously limit access to this care for racialized youth, noting a need for further research that would center racialized trans youths' experiences.

Research on TRHC Assessment Practices

This brief overview highlights the significant implications of assessment practices for

trans youth seeking to access TRHC. While debate over appropriate assessment protocols and criteria is ongoing among medical providers, gatekeeping practices, such as those outlined above, continue to harm trans youth. A small amount of research has explored the origins, and implications of TRHC assessments, some of which has focused on exploring the experiences of clinicians who administer assessments (e.g., Dewey, 2015; shuster, 2016, 2019). This research includes interviews with clinicians (Dewey, 2015; shuster, 2016, 2019) as well as observation at trans health conferences (shuster, 2019) and uses analysis based on grounded theory (Dewey, 2015), modified grounded theory (shuster, 2016) and inductive analysis (shuster, 2019). These projects find that providers feel responsible for their trans clients making good decisions about TRHC (Dewey, 2015; shuster, 2016) and may follow guidelines closely due to concerns about regret (shuster, 2016) and fear of liability (Dewey, 2015; shuster, 2016), while others feel comfortable bending guidelines to prioritize clients' needs (shuster, 2016). Finally, shuster (2019) also finds that many providers use the language of informed consent to describe their practice, but do not practice it in a meaningful way, and continue to perpetuate power imbalances and gatekeeping in their interactions with clients.

In other research about the implications of TRHC assessments, (MacKinnon et al., 2020) use institutional ethnography to interrogate how standardized assessment processes restrict access to TRHC in Canada, particularly for trans people with complex mental health needs. The authors drawn on the theory of transnormativity, which describes the “normalization of trans... identities through the adoption of cisgender institutions [such as conforming to normative gender roles] by trans persons” (Vipond, 2015, p. 24) to discuss the medical discourses shaped by trans health guidelines, particularly the discourse of the risks of transition regret (MacKinnon et al., 2020). They find that trans people seeking TRHC construct specific narratives or do other work

to demonstrate their readiness to access hormones or surgeries (MacKinnon et al., 2020).

Finally, Pyne (2018) uses interpretive repertoire discourse analysis to analyze how “puberty suppression and early gender transition [have] become thinkable futures for trans youth” (p. 27). Applying theoretical frameworks from “queer temporalities, sociological work on time and social power, queer and trans of colour critique, critical disability studies, critical autism studies, and transgender studies” Pyne (2018) finds that certain discourses make access to hormone blockers possible for some, mostly white, middle-class trans youth, while foreclosing these opportunities for others, particularly racialized and autistic trans youth (Pyne, 2018). Pyne (2018) argues that “puberty blockers... function as a ‘switchpoint’ moving privileged trans youth onto a track toward even greater privilege and widening the gap in life opportunities” (p. iv).

While much research focuses on trans adults, Pyne’s (2018) research was the only study that I found which conducted primary research to critically analyse current assessment practices used by clinicians with trans youth. Given the intense debate on the best practices for assessing, or not, trans youth’s readiness for TRHC, this represents a significant gap in the literature which demands further research. In addition, a community-based survey in Ottawa (Seburn et al., 2019) was the only research examining assessment practices currently in use in Canada.

Given these gaps, my research asked the question ‘how and why have current assessment practices in pediatric trans health care in Ontario come to be?’ This research used a Foucauldian discourse analysis and drew on interviews with clinicians in Ontario who conduct assessments with youth seeking to access TRHC, as well as publications by clinicians working in this field. It sought to understand what assessment practices are currently in use in Ontario, what sources clinicians draw on to inform the assessment practices they use, and how these practices have evolved over time.

Chapter 3 – Theory, Methodology, and Research Design

Theory

(Trans)normativity

Firstly, this project is informed by the theory of transnormativity (see Johnson, 2016; Vipond, 2015). Johnson (2016) defines transnormativity as “the specific ideological accountability structure to which transgender people’s presentations and experiences of gender are held accountable” (p. 466). Put differently, transnormativity describes how medicalized understandings of transness structure trans identities and narratives which dictate who is *trans enough* and thereby deserving of access to medical, social, and/or legal gender affirmation (Johnson, 2016, emphasis original). Assumptions that trans people must have known that they were trans since a young age and must urgently seek out a binary medical transition represent two examples of significant transnormative discourses (Johnson, 2016).

Both Johnson (2016) and Vipond (2015) apply transnormativity to TRHC settings, suggesting that transness is viewed as an illness to be treated through hormones and surgery, with an emphasis placed on the diagnosis of gender dysphoria. They also describe that access to TRHC is restricted for those who desire it, based on transnormative discourses, and that trans people are required to construct transnormative narratives of their identities in order to be granted access to care (Johnson, 2016; Vipond, 2015).

MacKinnon et al (2021) find that discourses of transnormativity in medicine lead clinicians to fear the possibility of their patients regretting transition or later detransitioning. Transnormative discourses construct these outcomes as “life-ending” (MacKinnon et al., 2021, p. 7), causing clinicians to tailor their assessment practices to reduce the perceived risk of malpractice lawsuits by hypothetical clients who regret medically transitioning. This discourse is

particularly noteworthy, as evidence shows that actual rates of transition regret and detransition are relatively low and rarely experienced as “life-ending” (MacKinnon et al., 2021).

Transnormativity highlights medicalized discourses of trans identity and describes the powerful effects of these discourses to organize, enable, and restrict access to medical and other types of gender affirmation for trans people. Its attention to both power and discourse makes it a helpful theory for use with Foucauldian discourse analysis. Transnormativity also emphasizes the medicalization of trans identities and the resulting implications for trans people who do or do not seek to medically transition, making it highly applicable to this study’s focus on assessments for youth seeking access to TRHC.

Johnson (2016) and Vipond (2015) both focus their descriptions of transnormativity on factors such as sexuality, gender expression, and desire to medically transition, which are used to legitimize or delegitimize people’s trans identities. Despite this, Velocci (2021) points out that fulfilling the necessary criteria to be legitimized as trans by medical diagnostic standards does not guarantee access to TRHC. Rather, Velocci (2021) suggests that clinicians’ concerns about the possibility of regret for reasons beyond one’s gender identity have also guided clinicians’ decision making about who should access medical interventions. In the 20th century, clinicians foresaw a plethora of potential causes of regret, including trans people experiencing discrimination because they were visibly trans, being disappointed because their expectations for medical transition outcomes were unrealistic, or being incompetent to make their own health care decisions (Velocci, 2021). Velocci (2021) suggests that these concerns influenced clinicians’ decisions about surgical approvals as much as, if not more so, than considerations related to patients’ gender identities.

Similarly, current guidelines dictate that in addition to assessing clients’ gender identity,

other considerations including mental health (MacKinnon et al., 2020), family support (Coleman et al., 2012), and stability of life circumstances (Coleman et al., 2012), should also factor into clinical decisions about whether and when trans people are able to access TRHC. Existing research also suggests that these guidelines are applied inequitably (Pyne, 2018). In fact, the same arguments which support access to TRHC for white non-disabled trans youth serve to limit this access for racialized and autistic trans youth (Pyne, 2018).

These factors are not included in past definitions of transnormativity, however Vipond (2015) also discusses normativity more broadly as “[depending] on a hierarchy of privilege and shame” (p. 23), which may include categorizations based on other vectors of power such as race, class, and ability. As a result, this project will take up the theory of *(trans)normativity* – extending the concept of transnormativity to address aspects of normativity beyond gender, including race, class, ability, and body size and shape. These factors are vital, as they also have powerful effects on legitimizing trans people’s identities and governing access to TRHC.

Governmentality

This project is also guided by Foucault’s theory of governmentality: a theory of power which describes “‘the conduct of conduct’, or the ‘power to act on the actions of others’” (Christie, 2006). Governmentality represents a shift towards indirect control, through “a melange of various apparatuses, institutions, modes of thinking, and associated classifications and practices” so that power is fluid and diffuse, rather than exerted through direct force (Marrone, 2013, p. 586). This is a poststructural conceptualization of power. In the context of TRHC, this control may be exerted in order to dynamically enforce (trans)normative discourses and explicates how clinicians and youth themselves may also participate in these discourses, allowing these theories to pair well together.

One key aspect of governmentality is “problematization” (Rose & Miller, 1992, p. 181) which Pyne (2014) describes as “the production of problems and the proliferation of experts to manage them” (p. 82). In other words, experts intervene in daily aspects of life, identifying new problems which demand their expertise. Li (2007) describes further that problematization may focus on particular groups identified by gender, race, age, location, or other factors, “each with characteristic deficiencies that serve as points of entry for corrective interventions” (p. 276).

According to Rose and Miller (1992), “[e]xperts have the capacity to generate what we term enclosures: relatively bounded locales or types of judgment within which their power and authority is concentrated, intensified, and defended” (p. 188). Pyne (2014) offers the example of early gender clinics as enclosures through which the “‘problem’ of childhood gender non-conformity... [was] produced” and where a variety of invasive technologies of surveillance and control were employed to ‘fix’ children’s gender nonconformity and prevent them from becoming trans adults (p. 83).

While, thankfully, these methods are no longer widely accepted in North American gender clinics, governmentality remains a useful framework for understanding the function of power within current gender clinics and other medical systems with which trans and gender diverse young people interact. Currently, childhood gender nonconformity itself is unlikely to be labelled as a problem by clinicians working directly with trans and gender diverse youth. Instead, other ‘problems’ like the potential for youth to detransition, or otherwise fail to follow transnormative life pathways, are frequently identified and used to justify the requirement for intensive pre-transition assessments and parental involvement in youth decision-making (MacKinnon et al., 2021).

As a result, while governmentality describes the production of new ‘problems’ to be managed by experts, (trans)normativity allows us to consider what issues are problematized in relation to TRHC for trans and gender diverse youth. Its attention to Foucauldian conceptions of power, and its relevance to (trans)normativity makes governmentality highly applicable to this study’s methodology of Foucauldian Discourse Analysis and its focus on power in clinician assessments of trans and gender diverse youth.

Onto-Epistemology

This project is anchored in Foucault’s position of skepticism regarding “claims about underlying structures or order, and of claims that there is an overarching trajectory to human history” (Bischoping & Gazso, 2016, p. 133). For example, one may claim that there is an overarching trajectory of assessments of trans youth, with care for youth becoming more equitable and accessible over time. This research approached this idea with skepticism by asking what assessment practices are currently in use and tracing their development over time to understand how they were produced.

Despite this, this research also deviated somewhat from traditional Foucauldian discourse analysis in terms of onto-epistemological approach. Foucault believed that all knowledge was subjective and rejected the idea that there could be any universal truth (Bischoping & Gazso, 2016). This position has been critiqued by feminist scholars as it “appears to reject the possibility of an emancipatory truth, and a feminist standpoint from which to know, to critique, to resist, and to effect change” (Nancy Hartsock, 1990 in Bischoping & Gazso, 2016). This research began from a gender affirming approach, which is grounded in affirming the voices of trans youth, while approaching the views of cisgender people about trans youth with skepticism. This research took the position that embodied knowledge of people about their own experiences

carries greater weight compared to knowledge of people, including medical professionals, about experiences that are not their own. As a result, this research took a feminist standpoint, which “allies Foucault with embodied knowledge” (Bischoping & Gazso, 2016, p. 134) to position this research with trans youth and to propose change to current assessment practices.

Methodology

This project applied a feminist standpoint Foucauldian discourse analysis to understand the current context of assessment practices used in pediatric trans health care in Ontario.

Bischoping and Gazso (2016) describe discourse analysis as “a strategy for understanding how we come to construct as coherent something that is contingent, messy, and haphazard” (p. 133).

This is highly applicable to assessment practices in pediatric trans health which are applied by clinicians in many different and contradictory ways (eg. de Vries & Cohen-Kettenis, 2012; Hidalgo et al., 2013; Zucker et al., 2012). Additionally, assessment practices often do not align with trans youth and their parents and caregivers’ own understandings of themselves and their needs (Gridley et al., 2016; Seburn et al., 2019). Thus, this project aimed to explicate the discourses present in clinicians’ talk about youth TRHC assessments, and to understand how these assessment practices have evolved over time and come to be.

Foucault defines discourse as “the site of struggle within which truth emerges [or] the social conditions that determine how certain statements acquire the status of truth and knowledge” (Macias, 2015, p. 228). Within this definition of discourse, Foucault includes language, text, and talk, as well as “statements and systems of statements that are power-laden, persuasive, employed strategically, and part of social practices, interactions, behaviors, and ways of being” (Bischoping & Gazso, 2016, p. 131).

This project focused on the systems of statements which produce varied understandings

of appropriate assessment practices for trans youth. Here, discourses are analyzed to expose contradictory perspectives among pediatric clinicians, and the current context of pediatric trans health assessments. Some of the common and sometimes contradictory discourses used to describe assessment practices with trans and gender diverse children and youth within existing literature include the discourse of ‘desistance’: that children are likely to stop identifying as trans by adulthood (Drummond et al., 2008; Singh, 2012; Steensma et al., 2011, 2013; Wallien & Cohen-Kettenis, 2008); that the growing number of youth seeking TRHC in recent years is the result of cisgender youth being led by peer influence to believe, mistakenly, that they are trans (Littman, 2018); and that affirming youth’s identities is important and necessary to avoid negative mental health outcomes, including suicide (Olson et al., 2016). Slothouber (2020) identifies that the first two of these discourses appear frequently in media articles referencing detransition, demonstrating the mainstream prevalence and moral panic surrounding these discourses. Each of these discourses and/or many others may also be leveraged by clinicians when describing their assessment practices and their approach to TRHC with youth. This project sought to identify the discourses at work in clinicians’ talk about their assessment practices and, further, to understand how those discourses came to be employed in these ways and understood as meaningful.

Foucauldian discourse analysis aims to “understand and map how power works to produce what we have come to accept as truth, and how these processes ... [marginalize] *other* truths and *other* subjects” (Macias, 2015, p. 239, emphasis original). For example, what truths about trans youth and TRHC do clinicians employ in their talk about assessment practices of trans youth, and which truths are left out? How and why has this come to be?

Macias suggests that Foucauldian discourse analysis aligns well with emancipatory

research, because “by uncovering how truth and social conditions become, we have to accept that *they do not have to be the way they are*” (Macias, 2015, p. 238, emphasis original). As such, it is the hope that understanding the origins and discursive production of current assessment practices will help to uncover how these practices “*do not have to be the way they are*” (Macias, 2015, p. 238, emphasis original). One tool for achieving this aim through Foucauldian discourse analysis is genealogy. Genealogy approaches statements presented as truth with skepticism, and follows historical, discursive traces to understand how these statements of have come to be accepted as truth and what else is left out (Bischoping & Gazso, 2016; Macias, 2015). This project employed a genealogical analysis of assessment practices used in pediatric TRHC to understand their history, how they have come to be accepted as truth, and how clinicians learn and enact them.

Sampling, Recruitment and Data Collection Methods

Eligible participants were: (1) a registered physician, nurse practitioner, social worker, psychologist, psychiatrist, or similar; (2) currently working in Ontario; (3) currently working with trans and gender diverse youth, up to age 17, who are considering or seeking access to hormone blockers, hormones, and/or transition related surgeries and; (4) those who have clinical authority in their practice to recommend youth for hormone blockers, hormones, and/or transition related surgeries.

Initial participant recruitment was conducted via direct email communication to the researcher’s existing professional contacts. Additional recruitment was conducted via snowball sampling until a sample size of 5 participants was reached. Potential participants were sent a form email including information about the research project (Appendix A). If participants expressed interest in participating, a follow up email was sent containing additional information and a written informed consent document (Appendix B) for them to review prior to agreeing to

participate.

Data were collected via one-on-one semi-structured interviews which were conducted and recorded on zoom. Interview questions inquired about participants' introduction to working with trans youth; their current practices for assessing trans youth; and how they determine if or when youth should begin hormone blockers, be prescribed hormones, or be referred for transition related surgery. Participants were also asked about how they learned to conduct these assessments and if or how their practice had evolved over their career (Appendix C).

Interviews took approximately one hour, and each interview was transcribed verbatim.

Drawing on the six stages of basic Foucauldian discourse analysis suggested by Willig (2013), codes were constructed with the goal of identifying and elucidating (1) discursive constructions and discourses within clinicians' talk, (2) what these discourses achieve or aim to achieve, (3) the discursive positions and subjectivities that these discourses constitute, and (4) how these discourses support current practices of assessments of trans youth. For example, in step one, coding could identify that participants draw on the discourse that trans people must have always known they are trans, which is commonly employed within (trans)normativity. Step two could then find that this discourse has the effect of validating some trans people's identities, while casting doubt on the validity of others' identities. Step three could illuminate how this effect serves to constitute the discursive subjectivities of expert clinicians and untrustworthy patients. Finally, in step four the research could show how this discursive work supports the need for detailed assessments and gatekeeping, which many trans youth currently experience.

Drawing on the more in depth 20 step analysis proposed by Parker (1992), analysis also aimed to (1) identify competing discourses that are present in clinicians' talk, (2) describe how these competing discourses contradict each other and/or overlap, and (3) show how discourses

reinforce and/or subvert institutions and empower and/or oppress people and communities.

In the final stage, this project extended analysis to existing publications and clinical guidelines referenced directly or indirectly by interview participants. This stage of analysis took a genealogical approach to trace evidence of discourses which appear in both clinicians' talk and existing publications or guidelines. Through the process, this research aimed to begin to theorize about the origins of the discourses clinicians draw on and how they have evolved or remained consistent over time (Parker, 1992).

Ethical Considerations

In addition to the ethical considerations of informed consent, confidentiality, and mitigating risks for research participants, this project also considered the wellbeing of the researcher, and the goal of justice-doing (Clark, 2017; Pyne, 2018). The principle of justice-doing requires attention to the impacts of this work on trans youth as indirect subjects and beneficiaries, although no trans youth are directly involved in this research.

Prior to agreeing to participate in an interview, participants were sent a written informed consent document via email for them to review. Participants were then asked at the start of each interview to give verbal consent to participate and for the interview to be recorded. After the interview, participants were able to withdraw their consent to participate and request to have their interview data deleted up until data analysis began.

To mitigate risks to confidentiality, interviews took place individually over a secure video conferencing platform. Interview recordings and transcripts were deidentified and stored using password protected storage and interview recordings were deleted. Additionally, all identifying information was removed in all reports, including individual participants' roles, titles, geographic locations within Ontario, and any descriptive characteristics. Findings use gender

neutral language for all participants (Barbour, 2014).

Other risks to participants include the possibility of experiencing distress related to answering questions about their current and former practice with trans youth, and the possibility that research findings may negatively portray participants and their work with trans youth. To mitigate these risks, participants had the option to skip any questions they did not wish to answer. Additionally, all findings were anonymized, and care was taken to present research findings which acknowledge the importance of work that participants do to support trans youth, as well as opportunities for improvements in the field to best meet the needs of trans youth. While participants did not benefit from participating in the research directly, they contributed to the goals of the research which aims to support clinicians to best meet the needs of trans youth.

As clinicians are not a vulnerable research population (Pyne, 2018) this research also aims to support the wellbeing of trans youth, whose voices are less represented in academic and clinical contexts. As such, the research findings attend to the goal of supporting improved care for trans youth seeking TRHC. The process of data analysis and reporting was also guided by reflexivity on the part of the researcher. As a trans young person myself, and as someone who has worked with trans youth and their families for many years, I am attentive to the influence that my positionality has on this research. As a white, able-bodied, transmasculine person, I am also attentive to the ways in which these privileges may lead me to overlook experiences of racialized, disabled, or transfeminine youth. Guided by the goal of justice-doing, I sought to center the experiences of marginalized trans youth in this work and attend to the particular ways that discourses of whiteness and ability influence clinical care decisions.

Lastly, this project considered ethical questions related to the impact of research on the researcher (Barbour, 2014). As a young trans person myself, interviewing clinicians about their

work with trans youth required me to navigate complex power dynamics, and this work was very emotionally draining. During interviews, and while reviewing existing research, I also encountered, and analyzed in depth, transphobic and sanist medical care and cissexist arguments about trans people and our health care. I managed this work, and the emotional impact it had on me, by building in time to rest and care for myself, and by connecting with and seeking support from colleagues and members of my communities.

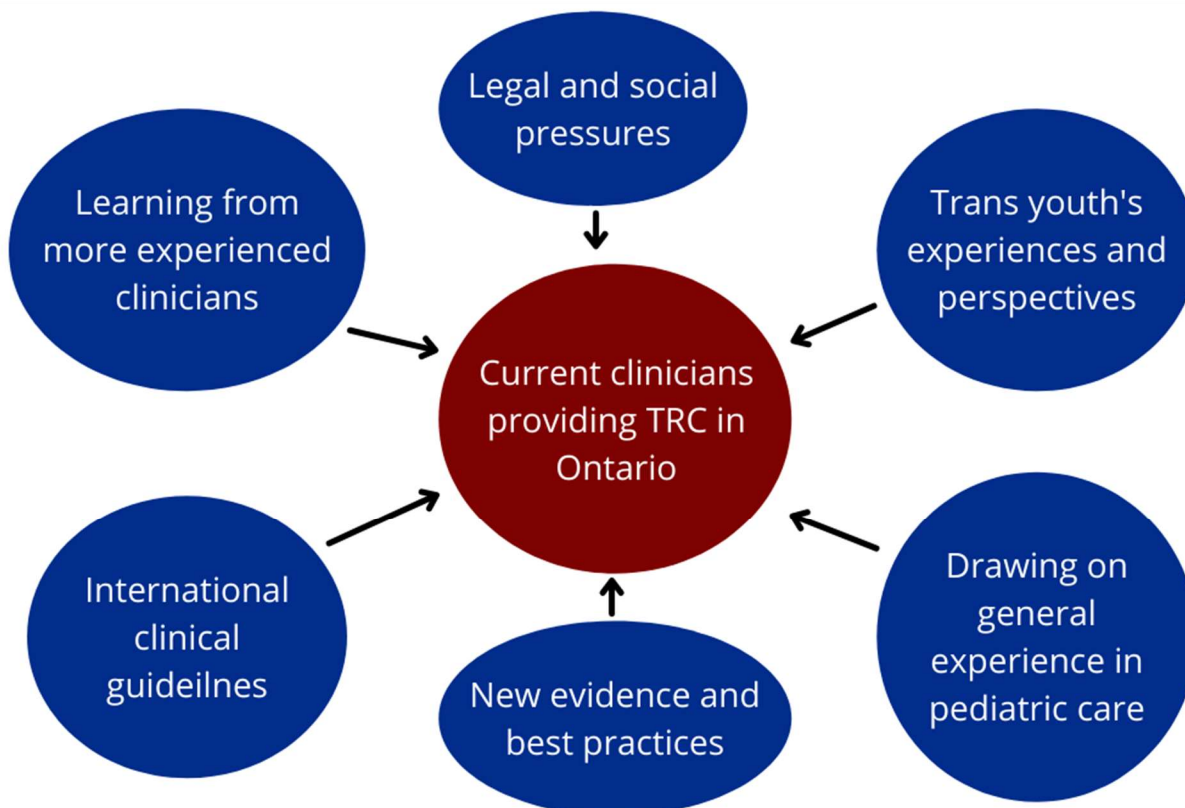
Chapter 4 – Findings

This project employed a genealogical analysis of assessment practices used in pediatric TRHC to understand their history, how they have come to be accepted as truth, and how clinicians learn and enact them. To answer these questions, I will first elucidate how clinicians learn to work with trans youth and administer pediatric TRHC, and what sources of information influence their current practices. Secondly, I will discuss some of the key themes that arose from clinicians' descriptions of their current practices and explore how these practices highlight the contradictions and complexities of the operation of power within pediatric TRHC settings, how these practices may have evolved over time, and how they impact trans and gender diverse children and youth.

Influences on Assessment Practices

Each of the participants described how they first learned about trans identities and providing TRHC and how they continue to learn while doing this work. Participants described six key sources through which they learned about providing TRHC: clinical guidelines, learning from more experienced clinicians, drawing on other experience in pediatric health care, following evolving research and evidence, the experiences and perspectives of the youth and families they work with, and external legal and social pressures.

Influences on Pediatric Trans Care in Ontario



In addition to their initial education on providing TRHC, many of the participants also described engaging in ongoing learning by keeping up to date with current research, reading about issues of importance to trans communities, and attending conferences to learn about what others in the field are doing. For example, one participant expressed the importance of paying attention to current issues in the trans community, because of their impact on the work they do:

[W]e'll see some... documentary... or, you know, we might go... watch a video about billboard Chris [a transphobic parent who has featured prominently in media protesting TRHC for youth] or whoever it is.... I mean we pay attention to all this stuff I think you have to. (Interview 3)

Clinical Guidelines

Many participants identified the World Professional Association of Transgender Health (WPATH) Standards of Care (SOC) and the Endocrine Society clinical guidelines as sources that

influence their practice. Previous versions of these guidelines also informed the work of other clinicians across North America who, in turn, helped guide the early practices of Ontario clinics.

While these guidelines were often mentioned by participants, they did not necessarily follow them precisely, and often viewed them as a guide to use when they were helpful. For example, one clinician described that different staff at their clinic disagree about how closely to follow the guidelines. They said,

[s]ome endocrinologists... are very comfortable prescribing hormones if... we've known the youth for a bit, and [other requirements are met]... [T]wo of us [on our team] will do that and but the third will not. [They] used to. [They] went on [leave] and... had a change of heart and said no, no we're doing things wrong. We're not following WPATH guidelines. We need to have a psychology assessment... for everybody. (Interview 1)

As this quote alludes to, there was wide variation in clinicians' practice. Many clinicians flexibly interpreted the guidelines, which some described as not accurately reflecting the best practice for care. Participants also described the perspectives of some colleagues who followed the guidelines more closely, out of a concern that if they did not, they would not be doing their due diligence as clinicians.

Learning From Experienced Clinicians

Each of the participants described learning about TRHC and developing their practices based on knowledge shared with them by clinicians who had more experience in this area. For example, one clinician who works in a centralized clinic described learning from their colleagues who had established the clinic and gained experience working with trans and gender diverse youth. Another clinician works outside of a centralized clinic, prescribing Lupron and referring families to their local gender clinic if/when they are interested in accessing HRT. This clinician described learning from the clinicians in their partner clinic as well as attending training by Rainbow Health Ontario.

The other three participants I spoke with were among the leaders of youth TRHC in Ontario. They work in clinics which offer hormone blockers, hormones, and referrals for transition related surgery, as well as assistance accessing other supports. Each of these clinicians had been inexperienced with working with trans youth or providing TRHC and had sought the expertise of more experienced practitioners who were already working in similar clinics elsewhere in North America.

Each of the participants also described taking an active role in training current residents and new clinicians who are interested in working with trans children and youth. These residents learn through formal rotations in adolescent medicine or endocrinology where they have an opportunity to shadow and work in gender clinics as part of their formal medical education.

Dr. Ken Zucker and the Centre for Addiction and Mental Health (CAMH). Dr. Ken Zucker was an early practitioner in the field of pediatric TRHC in Ontario, however his work has been widely critiqued due to his research and practice of the biopsychosocial model of care, which is considered by many to be a form of corrective therapy (Ashley, 2021; Lev, 2019). Zucker was particularly influential in training many medical providers and in initiating the creation of medical clinics at multiple sites in Ontario. One clinician I interviewed told me,

To be honest, you know the push for us to start [the clinic] frankly came from Ken Zucker... [H]e came to me... and said you know... when we... have patients who we think should start on hormones there's nowhere to send them... [A] lot of people don't believe that but it's true (Interview 3).

This participant indicated that Zucker continued to advocate for the creation of this clinic, however the clinic they created did not follow the biopsychosocial model set out by CAMH. As another clinician from the clinic described “right around the time all that stuff was going down with CAMH [getting shut down]... we were really trying to stay apolitical and not get caught up into that” (Interview 5).

Despite Dr. Zucker's influence on pediatric trans care in Ontario, his work was not received without critique. A clinician working at another clinic described a training they attended by Dr. Zucker which prompted them to start working with trans youth for a different reason:

[W]e were trained in a national meeting. Believe it or not, we had Ken Zucker come and speak... and told us how with talk therapy, he could make these kids normal And I thought 'this is horrific'.... I looked at this and I thought well, I know how to block hormones and know how to replace them.... I tried to find somebody who did this [but]... [m]y colleagues said 'oh no, we don't do that or if we do get a referral we refer to Ken Zucker, at CAMH'. I thought, 'no, no, no, no'. (Interview 1)

This clinician describes their introduction to Dr. Zucker's work which prompted them to begin working with trans and gender diverse youth so that they could provide another option for children and families, outside of Dr. Zucker's practice, which they viewed as unethical.

Hospital-Based Gender Clinics. Many participants who were leaders in TRHC in Ontario also described developing their initial practice based on the work of hospital-based gender clinics across North America. One of these clinics is the BC Children's Hospital (BCCH), which is one of the first dedicated clinics offering TRHC to youth in North America. The BCCH was progressive for the time of its inception, facilitating greatly increased access to care for trans youth (Khatchadourian et al., 2014). As of 2011, the clinic continued to involve in-depth mental health evaluations, with youth requiring an evaluation from a psychologist or psychiatrist external to the clinic prior to the initiation of hormone therapy (Khatchadourian et al., 2014). In some cases, youth were also denied care for a variety of reasons, including heavy smoking, an eating disorder, and depression (Khatchadourian et al., 2014).

Conversely, youth in the BCCH were given some choices to make decisions about their own care. For example, in Ontario today, interview participants described that it is a requirement for all youth to take hormone blockers prior to initiating hormones. However, the BCCH gave youth a choice between starting hormones blockers or waiting to begin HRT without initial

puberty suppression (Khatchadourian et al., 2014).

Participants also described consulting with other clinics located in the United States, including The Boston Children's Hospital Gender Multispecialty Service (GeMS, formerly the Gender Management Service) which was the first dedicated pediatric medical clinic for trans youth in the United States, founded in 2007 (Tishelman et al., 2015). The GeMS clinic, led by Dr. Norman Spack was very affirming of trans youth for this time, and advocated for youth to access care at younger ages and without the excessive pathologization and strict gatekeeping common of many psychiatrists at the time (Spack, 2009). At the same time, the GeMS clinic initially followed the Dutch protocol's "wait and see" approach in utilizing rigorous mental health assessments and taking a very binary approach to care (Spack, 2009). For example, Dr. Spack advocated for early access to hormone blockers based on the goal of protecting children from becoming visibly trans adults and helping them "look normal" (Spack, 2009, p. 317).

Today, several American clinics work together through the Trans Youth Research Network, a national study of longitudinal outcomes for children and youth accessing TRHC. These clinics are known for their development and advocacy of the Gender Affirming Care Model, which members of many teams have published together in support of (Hidalgo et al., 2013), and which informs the current work of many clinicians in Ontario.

General Pediatric Health Care Experience.

In addition to the learning that clinicians gained from more experienced colleagues in the field of pediatric TRHC, clinicians also drew on their own knowledge of pediatric health care in general. For example, as one clinician put it, "I knew how to prescribe blockers already, because [I dealt with] precocious puberty for decades.... So it's... exactly the same, in terms of the medical part of it" (Interview 1). This clinician describes drawing on their existing knowledge of

the medical aspects of prescribing hormone blockers to guide their work with trans youth. Despite this, in other ways this clinician experiences providing TRHC very differently from other types of care: “[H]ow did I learn? It's just... I know how hormones work. But trans care is so much more than that” (Interview 1).

This clinician’s description of trans care as “so much more” than just hormones may echo what Stef Shuster (2021) terms “trans exceptionalism... [that] providers... have a difficult time importing evidence and their experiences from other areas of medicine into their decision-making and interactions with trans patients” (p. 5). While this clinician’s quotes challenge this idea in some ways, as they confidently apply their knowledge of hormones to working with trans youth, they describe the other aspects of care for trans patients as being much more complex compared to their other work.

Another participant described the conversations they have with youth in the clinic about mental health and dating safety by saying “to be honest, none of these things are any different for the transgender clinic [sic] than they are for any of the other clinics that we run” (Interview 3). This clinician also draws on their other areas of care to inform their practice with trans youth, indicating that the conversations they have with youth represent their overall philosophy to provide holistic care, rather than a specific assessment for trans and gender diverse youth.

Trans Youth Perspectives

Many participants named the perspectives of trans youth themselves as an influence on their practice. For example, one clinician described changing their practices to stop conducting physical exams, based on feedback about youth experiences:

Yeah, I used to do [physical exams to measure puberty stage]..., and it certainly caused dysphoria. And then... I said you know, we... don't need to do an exam to know [if someone is in puberty]. So I stopped doing... [them c]ompletely.... [T]hat feels really good because I know for the youth this is really distressing. (Interview 1)

This participant describes taking seriously the experiences and perspectives of the youth they work with, and the impact on their clinical practice. This is significant, given that trans and gender diverse people have historically been excluded from decisions about the care they need.

New Evidence and Evolving Best Practices

Participants also describe evolving evidence and best practices as another influence on their assessment practices. One participant gave an example of this, describing their observations of the evolving best practices for prescribing Lupron. They stated,

[T]here previously seemed to be [a best practice of] quite a medical like ‘Let's do blood work on everybody. Let's do... investigations. Let's sort of treat this as a medical workup’. And now, [there is] a move towards, you know, if it's a healthy little person, why are we doing that? (Interview 4)

This clinician describes their perception of the shifts in evidence and best practices surrounding blood work and medical screening prior to initiating hormone blockers, based on previous work with trans youth that found them to be unnecessary.

Legal and Social Pressures

Finally, several participants described the impacts of external social and legal pressures on their clinical practices. In particular clinicians highlighted the current political climate of heightened transphobia which impacts the youth and families they work with, as well as clinicians themselves. For instance, one participant described how these messages have impacted them and their colleagues:

You know we second guess ourselves sometimes, right. When you've got all these people saying, ‘it's wrong it's wrong it's wrong’. And we're like, well, is it? You know like... there's some pause there. (Interview 5)

This clinician describes that the increase in transphobic rhetoric has also impacted the comfort of affirming practitioners to provide TRHC. Despite this ongoing rhetoric, this clinician and their colleagues remain committed to supporting trans and gender diverse youth. They go on to say,

But then we see all the positive outcomes and all the things that are working for these young people... and all the little thank you messages that you know 'you saved my life' and you know 'I couldn't have done this without you' kind of comments. (Interview 5)

The current climate of heightened transphobia and legal bans on transition related care for children and youth were a consistent undercurrent throughout my conversations with clinicians. Despite practicing in a jurisdiction that has not been directly impacted by these legal bans, clinicians were extremely concerned about this trend, as well as the general rise in transphobic media which significantly impacts the youth and families they work with.

Current Practices and Their Evolution

In addition to discussing the sources of clinicians' learning about TRHC, participants also described their current practices for working with youth and their families seeking to access TRHC. The following section discusses some of the key themes that arose, and that demonstrate the contradictions and complexities of the operation of power in clinical encounters, through the theoretical lenses of governmentality and (trans)normativity. This concept of 'encounters' draws on the work of Kuwee Kumsa (2007) who describes encounters as a way of focusing on the interaction between people that "mak[es] visible the relationality of oppression" (p. 95).

Mental Health Assessments

All of the clinicians who I interviewed emphasized that their clinics did not involve the support of dedicated mental health practitioners. As one clinician put it, "[W]e're a model which did not include, by intention, psychology or mental health work as a requirement.... [W]e said no, it's just not a mental health disorder" (Interview 1). As this participant alluded to, clinicians viewed the requirement of a dedicated mental health practitioner seeing youth before accessing TRHC, as a barrier that further pathologizes trans identities.

Still, clinicians did not advocate for doing away with mental health assessments

altogether. Instead, participants indicated that they or their colleagues conducted mental health assessments themselves as a routine part of the care they provide. One adolescent medicine physician stated, “We don't have mental health, like a psychologist or psychiatrist that meets with young people. Some other programs you have to see one of those people before, but adolescent medicine is considered... as sort of mental health practitioners” (Interview 2). As this quote describes, each of the clinicians I spoke with continue to conduct mental health assessments within their clinics, often as part of the role of an adolescent medicine specialist.

These anecdotes represent a shift away from mental health evaluations conducted by a designated mental health practitioner, as in the other models which many clinicians learned from. Instead, mental health assessments are conducted within the clinic, by a medical practitioner, based on youths’ perspectives that the involvement of psychologists or psychiatrists further pathologizes trans identities.

Participants described the mental health evaluations that they conducted as having two roles. Firstly, as one clinician put it bluntly, “You're really trying to sort out, is there someone who's so troubled that... at this point, they're not ready to make decisions?” (Interview 3). Another participant echoed a similar sentiment, stating, “I just don't want a really anxious kid to sort of be perceived as having gender dysphoria where actually, it's anxiety related to something else” (Interview 4). As these clinicians suggest, one reason clinicians conduct mental health assessments with youth seeking TRHC is to assess their decision-making capacity and attempt to verify that they are truly trans and not suffering from an unrelated mental health issue.

Some clinicians indicated that youths’ mental health needs must be ‘stable’ before initiating care – a reference to the current WPATH SOC. As one participant put it,

[W]e’ve had some kids that [say] ‘If you don't give me [testosterone] I'm going to kill myself.’ I'm like, okay, well, that concerns me that you might not be ready. So, let’s have

a conversation about this and what other supports do you need to make those decisions.
(Interview 5)

This clinician indicates they would not move forward with prescribing hormones to clients who are suicidal and who express that accessing hormones would fix their suicidality, as they do not perceive these clients to be ready move forward with TRHC.

These ideas, that mental health assessments are necessary in order to ensure that trans youth are really trans, that they are ‘stable’ enough to begin TRHC, and that they are able to give informed consent, draw on recognizable discourses about trans identity and mental health. Firstly, this draws on the current WPATH standards of care which state that prior to beginning hormone blockers “[a]ny coexisting psychological, medical, or social problems... have been addressed, such that the adolescent’s situation and functioning are stable enough to start treatment” (Coleman et al., 2012, p. 19). Additionally, these anecdotes support the idea that youth who identify as trans may actually be experiencing a mental health condition causing them to mistakenly believe that they are trans. This idea has been frequently cited by proponents of the corrective model as a caution regarding affirmative care for trans youth (Zucker et al., 2012), however participants also noted that they did not support applications of mental health assessments, which restricted access to care for youth with mental health diagnoses, perceiving them as pathologizing. Clinicians did not provide a clear consensus regarding the appropriate ‘level’ of mental health assessment which should be required for youth seeking THRC.

Secondly, clinicians describe conducting mental health assessments to determine any other support needs that young people may have, and to provide concurrent support or referrals while initiating TRHC. For example, one participant described,

If there's anxiety or depression underlying, that's really what I'm sort of trying to screen for.... To essentially treat both... [it] wouldn't delay blockers or support for gender stuff but just to sort of say, ‘Do I need more? Do we need to involve somebody else or do we

need to start looking at treatment options for anxiety and depression as well as other stuff?’ (Interview 4)

As this example indicates, many clinicians reiterated that having a mental health diagnosis or requiring mental health support did not prohibit them from accessing TRHC. Participants describe this approach to mental health assessments as drawing on their general experience of adolescent medicine, where they routinely conduct mental health assessments with the youth they see. Despite this, it is not clear from participants accounts whether their routine mental health assessments in other areas of care play the same dual role of assessment in addition to offering support. This may present challenges to providing meaningful care, as youth may need to downplay their distress in order to avoid being seen as too ‘unstable’ to access care, thus not receiving the supports that they need (MacKinnon et al., 2020; Seburn et al., 2019).

These framings of mental health assessments also demonstrate the workings of governmentality and (trans)normativity. Current assessment practices within clinics are described as a departure from the pathologizing model used in other times and places, where mental health assessments are required in order for youth to access TRHC. At the same time, mental health assessments continue to be used, now in the context of a medical evaluation. This does not necessarily represent a shift away from gatekeeping and exertions of power by clinicians. Rather, this is a shift towards a new form of control which is less overt, but still present, despite some clinicians attempts to minimize it, as is characteristic of governmentality.

These anecdotes also highlight a specific focus within clinical care on the mental health of trans young people. Participants described the requirement that one’s mental health must be ‘stable’ enough prior to initiating TRHC, or that if this is not the case, other interventions may be needed to support a young person’s mental health.

While mental health supports are an extremely important resource for those who desire

them, these requirements are also an example of (trans)normative problematization. For trans youth whose mental health is not deemed to be ‘stable,’ such as youth who express suicidal ideation due to lack of access to care, their experiences of mental health are problematized – leading to additional referrals to additional experts, until they are deemed ready to access care. This also draws on a familiar discourse of (trans)normativity, as sanist mental health screening requirements are a common way in which trans people’s identities are legitimized or delegitimized when seeking to access TRHC.

“Getting to Know” Youth

Participants frequently described their assessment process as “getting to know” the youth in order to determine when they should begin TRHC. As one participant shared, “[w]e kind of decided early on that we... weren't going to start... medications on our first visits. We were going to, you know, have time to *get to know people* and who they were and what their goals were” (Interview 3, emphasis added). Another clinician said, “While we're affirming and non-directive, we're also kind of careful and cautious because we also, as healthcare professionals, you know we're under the mantra of do no harm and we also really need to *get to know somebody* before we're going to prescribe a medication” (Interview 2, emphasis added).

In these examples, clinicians position “getting to know” youth as part of avoiding harm to the people they work with. Another clinician described some of the questions they ask youth at their initial meeting, which they frame as aiming to “get to know” the youth they are seeing:

I say so when... you were in kindergarten, what do you remember about your gender and how you felt about it? You know, your behaviors,... the way you acted, the way you felt, and the things that you did.... And I say, What about grade one to three? ...This goes very slowly [through each grade]. (Interview 1)

In addition to these questions about childhood gender expression, this clinician also described questions about bathroom use, including asking, “When you pee, are you sitting or

standing?” (Interview 1). This clinician reiterated that there are “no wrong answers” and that their questions were intended to “get to know youth” and not to approve or deny care (Interview 1). Despite this, these questions relate to common transnormative discourses which posit that, in order for their identities to be authentic, trans and gender diverse youth must have expressed their gender nonconformity from a young age, and experience significant genital dysphoria. These questions are also highly subject to recall bias given they are covering timelines of over ten years.

While it is certainly helpful for clinicians to get to know the youth they work with, this oft-repeated phrase of “getting to know youth” also appears in some instances to stand in for decisions which are made subjectively, based on clinician’s individual judgement, which is likely to be influenced by a variety of factors, including cis- and (trans)normative biases. Notably, these questions about childhood gender expression and bathroom use draw on similar rhetoric to the discredited theory of RODG, which suggests that a new cohort of youth are being mistakenly led to believe that they are trans, when they had not previously exhibited any childhood gender nonconformity (Littman, 2018). Despite this, earlier research indicated that similar questions were frequently asked at one gender clinic in Ontario prior to the publication of Littman’s RODG study (Seburn et al., 2019), and many participants specifically denounced Littman’s work and described their efforts to push back against the concept of RODG. None of the clinicians I spoke with supported the concept of RODG, however these questions appear to draw on related discourses, nonetheless.

In early literature describing assessment practices with trans and gender diverse youth, protocols stated clearly that only certain young people were approved to access hormone blockers or HRT, while others were turned away if they did not meet the requisite criteria

(Delemarre-Van De Waal & Cohen-Kettenis, 2006). While this is no longer the case, framing decisions about when youth can access TRHC as being based on “getting to know” youth obscures the ways in which clinicians exercise power to approve or deny young people’s requests for TRHC and the subjective nature of these decisions. This phrasing represents a shift away from overt gatekeeping towards indirect exertions of power, as is characteristic of governmentality.

Conditional Decision-Making Authority

Related to the rhetoric of “getting to know youth”, the shift away from overt forms of power and control (such as denying care to youth who do not meet strict criteria) to less direct and more diffuse exertions of power are also exemplified by participants’ descriptions of their decision-making processes, which were often vague or contradictory. For example, one participant described their decision-making process for offering HRT, stating that “ultimately it can be the teen's decision” (Interview 2). This statement draws on the discourse of informed consent – positioning the youth as the ultimate decision maker in regard to their care. In contrast, the same clinician also described their uncertainty in assessing youth who they view as more ‘complex’:

I think there are young people for whom we struggle a little bit when there is a lot of complexity going on for them where you know they've got significant mental health issues, where their, their families are really insistent that... they don't think that they are transgender. (Interview 2)

This participant points specifically to youth with mental health needs, as well as those with unsupportive families, as the clients who they struggle the most with deciding whether or not to move forward with TRHC. This quote positions clinicians as the decision makers who will determine whether or when youth should begin TRHC, contradicting this participant’s earlier statement that the decision ultimately belongs to the youth. This contradiction obscures the

exertion of power in the clinic, as youth are told that they hold the decision-making power – while they may not be free to exert this power if clinicians do not agree with their decision. This represents another example of governmentality, as the exertion of power between clinicians and youth has become diffused, with youth having the power to make decisions for themselves in some instances, while in others, clinicians continue to hold this authority.

This diffusion of power also represents another example of (trans)normative problematization, as some youth, but not others, are granted the authority to make decisions about their own care. Mental health needs and unsupportive parents or guardians are named specifically as problems influencing clinicians to consider denying access to care. Other factors, such as race, are not named at all, however many participants suggested that the racialized youth they worked with were less likely to have supportive parents or caregivers, drawing on common racist discourses that homophobia and transphobia are more prevalent in, and are a failing of, racialized communities (Westcott, 2018). Due to this perception of racialized parents as less supportive, racialized youth may also be more likely to have their access to care restricted.

This contradiction regarding who holds the ultimate authority to determine when youth access TRHC appears to stem from the same contradictions contained within best practice models of care for working with trans youth. Following perspectives of trans youth themselves, as well as the gender affirming care model, providers employ some of the language and rhetoric of informed consent to state that youth are supported to make informed decisions for themselves about the care they would like. Conversely, assessment practices also draw on existing guidelines and older clinical practices which reinforce the need for clinicians to assess youth and determine whether or not they should access TRHC, based on factors such as mental health and family support (Coleman et al., 2012). This contradiction aligns with research on health care

practice with trans adults, which finds that many providers use the language of informed consent to describe their practice, but do not practice it in a meaningful way, and continue to perpetuate power imbalances and gatekeeping in their interactions with clients (shuster, 2019).

Chapter 5 – Discussion and Conclusion

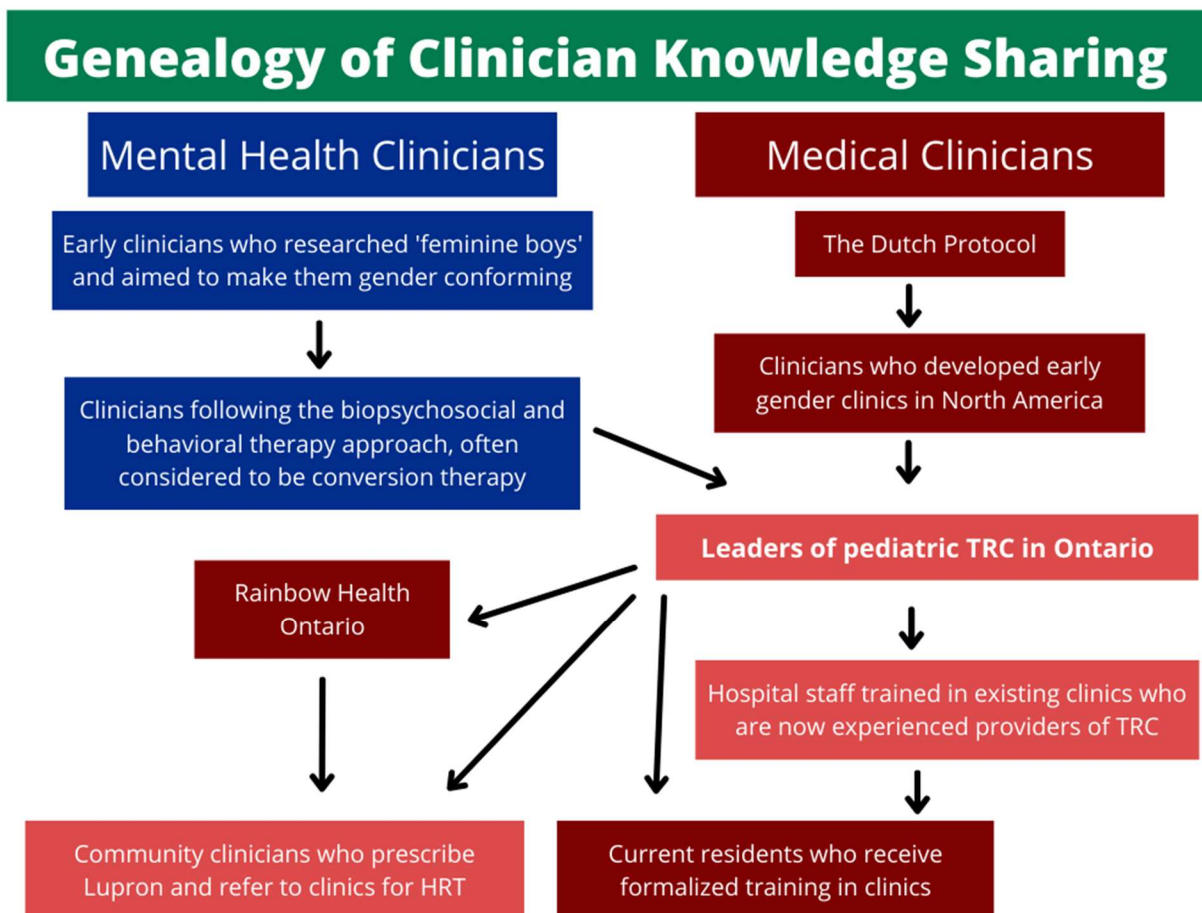
The clinicians I interviewed are doing vital work to support trans and gender diverse youth and their families. Over the past few years, laws have been proposed and enacted in many jurisdictions that restrict the rights and access to affirming care for trans and gender diverse young people (Bell v. Tavistock, 2020; Goodman, 2022). During this time, these clinicians are on the front lines, advocating for greater access to more affirming care for the children, youth, and families they work with.

This project has aimed to document this work and the many ways in which clinicians working in pediatric trans health have learned, implemented, and adjusted their practices over time. This analysis also sought to understand the ways in which current assessment practices continue to marginalize trans youth, and present opportunities to make seeking pediatric TRHC in Ontario a more affirming experience for young people. There is always more work to be done, and through my conversations with participants, I was heartened by their openness and dedication to continually evolve and shift their practice with the goal of providing the best support possible to the young people they work with.

Implications for Provider Training and Education

Understanding how clinicians learn about TRHC, and how this knowledge is shared between experienced and newer practitioners has important implications for training and education of health care providers in the field of pediatric TRHC. In particular, participant interviews, along with additional genealogical research illuminated the historical and current

pathways through which clinicians have passed on knowledge and best practices in pediatric trans care to one another over time. These pathways are represented in the chart below, with the pink boxes representing categories of clinicians who participated in this project.



As this chart makes clear, a small number of leaders in the field of pediatric TRHC in Ontario are largely responsible for the work of fostering medical support for trans youth across the province. These clinicians have learned over many years from those who provided earlier support to trans youth across North America and in Europe. These clinicians are also responsible for training the majority of providers who have more recently begun to provide pediatric TRHC both in hospital clinics and community settings.

As a result, these clinicians are well connected to other experienced providers, as well as to those who are new to working with trans youth, or who are interested in learning more. They hold significant power and influence to be able to advocate for the most affirming approaches to pediatric TRHC in Ontario

Participant interviews also illuminated two important areas for ongoing provider education to attend to. Firstly, it is notable that many dated and harmful discourses arose in clinicians' talk, even when they described their intentions to practice from an affirming approach. For example, clinicians made reference to the idea that youth seeking TRHC may in fact be experiencing a mental health condition causing them to mistakenly believe that they are trans, and asked questions about youth's childhood gender expression and whether they sit or stand to pee, which bring to mind ideas about ROGD and common mid-20th century transnormative expectations that there is a right or wrong way to be trans.

At other times clinicians also drew on their knowledge of the historical context of TRHC and common (trans)normative discourses to work towards more affirming care. For example, clinicians described avoiding mandating psychological assessments, as they understood this to reinforce the harmful discourse that being trans is a mental illness, and that these requirements are viewed as pathologizing by many trans youth.

Ongoing provider education that addresses the historical context of TRHC and these common (trans)normative discourses may support clinicians to further interrogate their practice and the ways that they may intentionally or unintentionally reinforce and/or subvert these discourses. Particularly as many new clinicians learn to provide TRHC, it is important that the knowledge and understanding of trans communities' fraught relationships with medical establishments not be lost or overlooked.

The pathways through which clinical knowledge of pediatric TRHC has been passed on also demonstrate that much of the knowledge that clinicians practicing today have drawn on has evolved from early practices, such as the wait-and-see approach, which are not aligned with current principles of gender affirming care. As a result, understanding this historical evolution may support clinicians to continue to interrogate their current practices, understand their origins, and determine what practices are useful and affirming, and what practices have been common over time but may not be in support of more affirming care.

Additionally, these findings describe disagreement among clinicians about how closely to conform to published guidelines, such as the WPATH SOC. These findings are echoed by Shuster (2016) who describes that some providers follow guidelines more closely due to concerns about transition regret or liability, while others are more comfortable interpreting guidelines flexibly to put the needs of their patients first. Including context about the history and evolution of these guidelines in provider education may also help to provide clinicians with a more fulsome picture, which challenges the supremacy and evidence-informed status of these guidelines. This is particularly timely now, as an updated version of the WPATH SOC are scheduled for release this year, which are likely to recommend significantly stricter and less affirming assessment guidelines for clinicians working with youth (WPATH, 2021), which, if enacted, may present serious additional barriers to youth seeking to access TRHC.

Finally, participants described the challenges of doing their work in isolation and the importance of having access to a supportive community of practice, not only as they learn, but also as they continue to work with trans and gender diverse youth. In particular, participants described the uncertainty that comes with working in a field that is heavily targeted by right wing

legislation and transphobic media coverage, which influences the perceptions of their colleagues as well as the families they work with.

Establishing ongoing communities of support for practitioners who are new to providing pediatric TRHC may be another way to support clinicians to provide the most affirming care possible, and to resist the doubt that comes with the ongoing attacks against their work.

Implications for Assessment Practices

These findings also have important implications for clinicians currently conducting assessments of youth seeking TRHC. Most importantly, these results illuminate the contradictions that are common within the work towards affirming care for trans youth. For example, clinicians' discussion of 'getting to know youth' and lack of clarity about who holds the ultimate decision-making authority about whether and when youth receive TRHC suggests that youth who are seeking this care may also encounter these contradictions.

Many trans people describe their experiences seeking TRHC as a test, in which they are attempting to say the right things to gain access to the care that they need, even if this does not accurately represent their experiences (MacKinnon et al., 2020; Seburn et al., 2019). While clinicians aim to remedy this by seeking to provide affirming care, these contradictions and inconsistencies regarding who holds decision making power in these encounters may inadvertently continue to send the message to trans youth that it is not safe to share all aspects of their experiences with the clinicians who support them.

This fact is concerning as youth who do not share their stories in the ways that are expected of them and deemed to be accurate accounts of trans identity face further barriers to care. In particular, prior research shows that this disproportionately impacts autistic youth, who may not tell their gender stories in ways that are intelligible to clinicians (Pyne, 2018).

Additionally, if trans youth do not feel comfortable sharing all aspects of their experiences with the clinicians who support them, this may also make it more challenging for youth to get connected with other supports, including mental health resources, that may be helpful to them.

Some participants described building trust with the youth they work with by affirming that anything shared in their appointments was confidential, and clarifying that the goal of the questions they asked was not to prove that they are trans. One clinician also described how they pay particular attention to difference in youth's communication style and comfort sharing their experiences with clinicians, as one way in which they work to mitigate these barriers.

Building upon these practices, it is recommended that clinicians establish clear guidelines regarding who holds the authority to make decisions about a young person's access to care, and in what situations, if any, this care may be restricted. Sharing, and following through on, these clear expectations with youth who are seeking TRHC may empower youth to know their rights, build trusting relationships with their clinicians, and to make more informed decisions about what information they wish to share with the clinicians who support them.

Implications for Theory

Lastly, these findings make contributions to theory, by introducing the concept of (trans)normativity, as well as its use with Foucauldian theories of power. The existing concept of transnormativity describes how medicalized understandings of transness structure trans identities and narratives which dictate who is *trans enough* and thereby deserving of access to medical, social, and/or legal gender affirmation (Johnson, 2016, emphasis original).

(Trans)normativity extends this idea to include other aspects of normativity, including expectations about mental health and family support, which relate to common requirements for access to TRHC for youth.

This use of (trans)normativity draws attention to the ways in which aspects of identity and experience which appear separate from gender, including race, class, and ability, continue to inequitably impact trans and gender diverse young people's access to TRHC. By analyzing (trans)normativity alongside governmentality, this work has also emphasized how (trans)normative discourses influence power relations between clinicians and trans youth and their families. This emphasis makes contributions to the theoretical literature and may also be supportive for clinicians seeking to further understand and address the workings of power in their clinical encounters.

Limitations

Given the short timeline for the research project, these findings have several important limitations. This project included a small sample size of only five participants working at three different sites across Ontario. These participants reached out to me in response to information that was shared throughout my existing networks. Many participants were also familiar with my previous work, including critiques of pathologizing assessment practices currently in use in Ontario (i.e., Seburn et al., 2019). As a result, all of the clinicians who reached out are already working hard to practice from a gender affirming approach and resist the pathologization the trans youth they work. Based on what participants shared about their colleagues and the other clinicians in the networks, it is clear that they do not represent the full range of perspectives and approaches to care currently in use in Ontario.

In addition to these limitations, all participants were white and cisgender. While this is likely representative of many clinicians working in pediatric TRHC, these findings may not accurately represent the perspectives of racialized, Indigenous, trans or gender diverse clinicians.

Lastly, due to the small scope of this project, this data only reflects the perspectives and accounts of clinicians, and not those of the youth and families they work with. As a result, clinicians own accounts of their assessment practices may not mirror the experiences of the youth who they see. Future research would benefit from including the perspectives of trans youth themselves in order to understand the similarities and differences in how clinicians and trans youth understand and experiences assessment practices and clinical encounters in the context of pediatric TRHC.

How This Research Should Be Used

Finally, I would like to conclude with a brief note on the intentions of this research and how I hope it will be used. This project presents critiques of current practices in use in pediatric TRHC in Ontario and comes at a time when reactionary ideologies and legislation are questioning and restricting any access to TRHC for children and youth. The critiques put forward in this paper should not be conflated with these ideologies. Rather, these findings reflect a need for more access to care for trans youth – not less.

Similarly, clinicians working in the field of pediatric TRHC at this time are being challenged from many directions. They are facing backlash against their work from legal challenges in many jurisdictions, transphobic news coverage questioning their ethics, and concerned parents who are hearing about the ‘dangers’ of TRHC from online news.

At the same time, these clinicians are doing their best to provide affirming care to the youth they support and ensure that youth are able to access the care that they need. This research does not intend to pile on further to the criticisms against affirming clinicians. Rather, I hope that these findings will challenge the systems of power which restrict access to affirming care for trans youth, and support clinicians to further reflect on the historical context of their work and

the ways in which power is enacted in everyday encounters regardless of our best intentions. Ultimately, my hope is that this work supports trans communities and clinicians to provide the best possible support to the trans and gender diverse youth who seek to access TRHC, which many youth desperately need and deserve.

Conclusion

This project has conducted a Foucauldian discourse analysis of clinician perspectives on pediatric transition related health care, with insights based on the theories of (trans)normativity and governmentality. In doing so, I have sought to answer the question ‘how and why have current assessment practices in pediatric trans health care in Ontario come to be?’

Through interviews with clinicians currently working in the field of pediatric TRHC, I have begun to trace the historical evolution of pediatric TRHC assessments in Ontario, by understanding where clinicians learn about TRHC, and what factors influence the evolution of the practices over time. In addition, I have discussed the evolution of mental health assessments from the realm of psychology and psychiatry practice to an embedded part of clinical care; the oft-repeated intention of clinicians to “get to know” youth, which obscures the subjective nature of clinical decision making in pediatric TRHC; and the conditional decision making authority which is granted to some, but not all, trans youth, and which obscures the ways in which power acts and is enacted within the clinic. These three key themes arose from clinicians’ descriptions of their current assessment practices. They highlight the contradictions and complexities of the operation of power within pediatric TRHC settings and the (trans)normative problematization of some aspects of trans youth’s experiences, including mental health needs, and unsupportive families.

Finally, I have discussed the implications of this work for clinician training and education and clinical assessments of youth seeking TRHC and made recommendations for some shifts towards more affirming practice. I have suggested that provider education include more explicit description of the historical context of TRHC and common (trans)normative discourses which clinicians are likely to encounter. I have also recommended that clinicians conducting assessments provide clear and comprehensive information about the requirements to access TRHC and who holds the authority to make these decisions when youth first enter their care. Lastly, I have discussed the theoretical contributions of this work, including the introduction of the concept of (trans)normativity, as an extension of transnormativity, which considers the influence of other aspects of trans peoples experiences, apart from gender, which also impact their access to TRHC.

It is my hope that this work will add to the voices of many trans and gender diverse scholars, community organizers, and advocates, whose work has led us to this point and continues to carry us forward. My hope is that in the future, all trans and gender diverse children and youth will have access to the affirming transition related health care that they need and deserve.

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Appendix A: Recruitment Materials

Hello [NAME],

I hope this email finds you well. I am reaching out to you to invite you to participate in a research interview for a study I am conducting in connection with my Master of Social Work at York University.

The title of my project is “Clinician Perspectives on Assessments of Trans and Gender Diverse Youth.” The project aims to understand how clinicians learn to conduct assessments with trans youth, and how assessment practices evolve over time.

I am commencing an interview-based study of clinicians who conduct assessments for hormone blockers, hormones, and/or transition related surgeries with trans and gender diverse youth in Ontario. You are being invited to participate on the basis of your professional expertise in the area of youth transition-related care.

Participating in this project involves one anonymous 60-minute research interview conducted over Zoom. Interviews will take place in January or February.

If you are interested in participating or if you would like more information about this project, I will follow up with the informed consent form. I also invite you to share this email with anyone else on your team who may be interested.

Others on your team are eligible to participate in an interview if they:

- Hold a professional title as a physician, nurse practitioner, social worker, psychologist, psychiatrist, or similar;
- Currently work in Ontario;
- Currently work with trans and gender diverse youth, up to age 17, who are considering or seeking hormone blockers, hormones, and/or transition related surgeries and;
- Have clinical authority in their practice to recommend youth for hormone blockers, hormones, and/or transition related surgeries.

Thank you for your time,

Kaeden Seburn

MSW Student, School of Social Work, York University

Appendix B: Informed Consent Form

Please read this document before deciding to participate in this study. The researcher will answer any questions you have, and you will be asked to give verbal consent to participate before your interview.

Study Title: Clinician Perspectives on Assessments of Trans and Gender Diverse Youth

Study Purpose: The project aims to identify how clinicians understand transition-related assessments, how they learn to conduct assessments with youth seeking transition related health care, and how assessment practices evolve over time. Approximately 5-20 clinician-participants will be engaged for this research study. Participants are eligible if they hold a professional title as a physician, nurse practitioner, social worker, psychologist, psychiatrist, or similar; currently work in Ontario with trans and gender diverse youth, up to age 17, who are considering or seeking hormone blockers, hormones, and/or transition related surgeries.; and have clinical authority in their practice to recommend youth for hormone blockers, hormones, and/or transition related surgeries.

Knowledge dissemination: Findings may be reported in a Major Research Project report, conference presentations, academic publications, and/or community reports for lay audiences.

Procedures: You are being asked to participate in an audio-recorded Zoom interview lasting up to one hour. In the interview, you will be asked questions regarding your work with trans youth; how you determine if or when youth should begin hormone blockers, or hormones, or be referred for transition related surgery; and if or how your practice has evolved over time.

Potential Risks of Participating: Some interview questions may make you uncomfortable or you may not wish to answer. All questions are optional, and you are free to skip any questions or to stop the interview at any time.

Potential Benefits of Participating: There are no direct benefits to you from participating in this study. By participating you will contribute to the goals of this research which aims to support clinicians to best meet the needs of trans youth.

Confidentiality: Confidentiality will be provided to the fullest extent possible by law.

This study will use Zoom to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP address or other information which could link your participant to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact Kaeden Seburn at kseburn@yorku.ca for further information.

Interviews will be transcribed and de-identified. Audio recordings will be deleted after transcription and deidentified transcripts from your interview will be stored. Recordings will be

saved in a password protected file to research's local computer. When study findings are shared, no identifying information will be associated with your responses. Demographic information may be presented for participants as a group. For instance, findings may state: "Participants held professional titles including pediatrician, nurse practitioner, and social worker".

Voluntary participation: Your participation in this study is completely voluntary. There is no penalty for not participating. You may also refuse to answer any questions asked.

Right to withdraw from the study: You have the right to withdraw from the study at any time without consequence. You will be able to withdraw from the study and have any interview data deleted up until data analysis begins. To withdraw, please contact Kaeden Seburn at kseburn@yorku.ca.

If you have questions about the study, please contact Kaeden Seburn at kseburn@yorku.ca or the student's PRP supervisor, Dr. Kinnon MacKinnon at kinnonmk@yorku.ca

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Agreement: I have read the procedure described above and I understand the nature of this project. I voluntarily agree to participate in this study by Kaeden Seburn of York University. I consent to the audio recording of my interview. I am not waiving any of my legal rights by consenting to participation.

Appendix C: Verbal Consent and Interview Guide

Participant # _____ Date _____

Verbal Informed Consent Script

Thank you for your interest in participating in this interview. Did you have a chance to read the consent form? What questions about the study and/or your involvement can I answer for you?

discussion about study objectives, participant role and rights, withdrawal of data procedures

Begin Audio Recording on Zoom

If you don't have any more questions about participating, do you consent to participating in the study? If yes, please state:

I _____ (name) _____ understand the nature of this project and I provide my verbal informed consent to participate in this study by Kaeden Seburn of York University. I am not waiving any of my legal rights by consenting to participation.

Do you consent to being audio recorded? State: "I consent to the audio-recording of my interview." Yes or No. Response: _____

If yes: Great. You are enrolled in the study. We can start the interview now.

If no: Thank you for your time. I can't proceed with the interview, and I will turn off the recorder now.

Interview Questions

1. How did you first start working with trans and gender diverse children and youth?
2. How did you learn to make decisions about when youth should begin medical transition?
 - a. Did you learn from someone / somewhere?
 - i. How is your practice the same or different from theirs? Why?
3. Has your decision-making process changed or evolved since you first started referring youth for transition related health care?
 - a. In what ways has it evolved or stayed the same?
 - b. What might lead to changes in your practice?
 - c. Can you tell me about a time when your practice evolved or changed in some way?
4. As of right now, how would you describe your overall approach to working with trans children, youth, and families?
 - a. What does this approach [eg. gender affirming care, client-centered care, etc] mean to you?

5. In the clinic where you work now, what does a typical care pathway look like for a new patient?
 - a. For example, who would they meet with first?
 - b. Is this different depending on the age of the child or youth?
 - c. Are there other factors that influence this process?
6. As of right now, how do you decide whether or when to refer a youth to start hormone blockers or hormones, or for transition related surgeries?
 - a. What questions would you ask a youth to make this decision?
 - b. How would you work with a youth who you do not feel is ready to access hormone blockers, hormones, or transition related surgery?
7. Many clinics are seeing an increase in youth seeking out transition related care over the past few years. Is that the case in your clinic?
 - a. What are your thoughts about this?
 - b. Has this led to any changes in your practice, in terms of referral pathways in your clinic?
 - c. To your knowledge, has this trend impacted your assessment process?
 - d. What are your thoughts about changing demographics of referrals for trans youth?
 - e. In your experience, is there a “new cohort” of primarily AFAB trans/nonbinary youth? (eg, that there is a “new cohort” of primarily AFAB trans/nonbinary youth)
 - f. Do ideas about this “new cohort” impact your assessment practices with AFAB youth in particular? Or youth more generally?

Before we wrap up, I’m going to ask you a few demographic questions. This is helpful to contextualize your responses, and the overall demographics of participants. All of the questions are optional, and you can respond “pass” to any questions you would prefer not to answer.

1. What is your professional title?
2. How long have you held this professional title?
3. What is your current role?
4. How long have you worked in this role?
5. What is your age?
6. What is your racial or ethnic identity?
7. What is your sexual orientation?
8. What is your gender identity?
9. Do you identify as Two Spirit, trans, nonbinary, or gender diverse?

Certificate of Completion

This document certifies that

Kaeden Seburn

*has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)*

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Date of Issue: 19 October, 2021