

**Discussing Aspects of Medical Transition with the Parents of Young  
Transgender People: A Psychotherapist's Perspective**

**Damien W. Riggs**

College of Education, Psychology and Social Work

Flinders University

GPO Box 2100

Adelaide

South Australia 5001

[damien.riggs@flinders.edu.au](mailto:damien.riggs@flinders.edu.au)

## **Introduction**

The day before I came to write this chapter, I met for a third time with a mother and her transgender son. In previous appointments – which, as is typical of my practice, involved both the young person and their parents (as available) attending together – the mother had presented as highly supportive, as a strong advocate for her son, and as more than willing to challenge those around her in regards to ongoing issues such as the misgendering of her child. What was different about this appointment was that for part of the session I made the time to speak with the mother alone, without her son present. Previously, much of our discussion with her son present had involved talking about his desire to commence hormone therapy. As her son is under 18 years of age, he must have his parents' support, and they must petition the Family Court of Australia for permission to commence hormone therapy. His mother had previously presented a clear and reasonable argument for why she was not currently supporting an application to the Court, on the basis of the fact that two psychiatrists (also required in a petition to the Court) had not supported the young person's request.

When we spoke on our own the mother voiced a somewhat different narrative. The mother stated that the advice provided by the two psychiatrists made her question whether she should support her son to petition the Court for access to hormones, or whether he should just wait until he is 18. I suggested to her that a way to sort through the mixed messages she was receiving – on the one hand a message from the psychiatrists to wait, whilst on the other a strong message

from her son that he could not wait – might be to have an open conversation with her son about what dysphoria meant for him. This suggestion was based on the fact that I had previously had a conversation with her son in which he had expressed to me that he felt his parents didn't understand the extent of his dysphoria. In response to my suggestion that an open conversation about dysphoria might be useful the mother said "Well I know I don't really understand it. It's not okay with me". This statement was surprising, as it seemed to contradict her previous presentation as supportive and affirming of her son. We then spent some time unpacking this statement. What became clear was that for this particular mother, whilst she was okay with her child being transgender, and was indeed supportive and affirming of him, she wasn't okay with her own lack of understanding. She repeatedly stated that she felt she should be doing better: she should understand more, she should do more and she should be doing all of this quickly, and she should feel empowered to speak back to the psychiatrists. As such, dysphoria was not a problem in terms of how she viewed her child, but it was a problem for her – a problem because it made her feel inadequate as a parent.

I open this chapter with this particular example as I believe it clearly illustrates the challenges mental health clinicians face in working with parents of transgender young people in terms of supporting medical aspects of transition. What we must work with in many cases are the emotional responses of parents who, regardless of their rationalisations of the importance of supporting their child, might experience emotions that conflict with such rationalisations, and potentially conflict with a commitment to supporting their child. Furthermore,

this example is useful as it illustrates how the opinions of medical professionals (in this case psychiatrists) can decrease, rather than potentially increase, the support that parents display towards their transgender children, and that this can then become an issue for psychotherapists to engage with.

Taking up the points raised above, in this chapter I explore a number of key issues that I have witnessed in my own clinical practice as a psychotherapist working primarily with transgender young people aged between six and twenty and their parents. Specifically, I outline how I work directly with the parents of transgender young people, and the approaches I utilize that enable me to frame my clinical practice as centering young people's capacity for decision making, and their right to bodily self-determination. Such an approach at times requires countering the presumed inherent right of parents to control all aspects of their child's life, and for parents to instead consider ways of working in collaboration with their child to achieve the best outcomes both for the child and for the parent. This can involve encouraging parents to examine and consider their viewpoints and values (as outlined further in the chapter), but it can also involve helping young people to understand why their parents are not at present supporting certain aspects of their transition (such as commencing hormones before the age of 18), and to negotiate ways in which they might work towards that agenda either independently or with the assistance of their parents.

In this chapter I also provide a focus on some of the work I undertake jointly with young people and their parents, especially with regards to fertility, what lies ahead in terms of changes to their bodies, and how young people and their

parents may understand the broader social context that shapes the experiences of transgender. Whilst the focus of this book is primarily upon the experiences of parents, as I outlined in the example above and as a thread that runs throughout this chapter, it can be important for parents to understand – as much as is possible – what it means to experience dysphoria, and the specific issues that arise for young people. In other words, a focus on young people is not mutually exclusive of a focus on parents. Instead, a focus on working jointly with young people and their parents can assist parents in developing insights into what they may be failing to understand about their child, the challenges that their child faces, and to develop from that empathetic and informed responses.

Considering the chapter as a whole, and following the work of Lev (2004), I would suggest that my work as a clinician most often involves playing the role of the midwife. In other words, as clinicians supporting parents and young people through medical aspects of transition we are often bringing into being ways of thinking about bodies, relationships and the future that may not have previously been possible for young people and their families. In this sense, whilst my role in many ways is often directive, it is also always open to what comes into the room: the ways of being and thinking that young people bring with them, and the diverse range of responses that parents and other family members have to transgender young people.

## **Approaches for Working with Parents Directly**

When working with parents of transgender young people my approach explicitly involves three potentially competing approaches. The first, which I elaborate with parents on our first appointment, is that I adopt an affirmative approach in regards to transgender young people. This means that the young person's account of their gender and embodiment is what I take as the truth (which can include accepting that some young people experience a very real and powerful sense of dysphoria). Part of adopting an affirming approach means always utilizing young people's preferred names and pronouns, politely correcting misgendering if I witness it, and not engaging in conversations with parents that in any way undermine their child's sense of their gender identity.

The second approach that I take, specifically with regard to parents, involves making it clear that whilst part of my role is to listen to and attempt to validate their feelings of loss, their struggles, and their need to feel informed about their child's experiences and journey, this must always sit alongside (and indeed at times be preceded by) the needs of the child. I frame my explanation of this approach in terms of power differentials, and that in most contexts adult's rights are privileged over those of young people. This allows me to state to parents that I believe it is vitally important to try and create spaces where young people are empowered to make their needs known, and where appropriate for those needs to be met. Drawing attention to power imbalances, I find, can be useful even when working with the parents who are struggling the most, and who may be tempted to simply withdraw support for their child (including bringing them to

and paying for sessions with me). Amongst the people I have worked with, even for those who are struggling, there is still a commitment to equality and a desire not to be seen as perpetuating power imbalances (even if at times that is primarily a rhetorical rather than deeply felt position).

Finally, the third approach that informs my work with both parents and young people involves explicit acknowledgement of the fact that such work sits in a broader context where a diagnosis of gender dysphoria is at times needed, where the pathologisation of transgender people continues, and where not all clinicians adopt affirming approaches. What this means in practice is that I attempt to help parents understand that whilst I appreciate their own journeys, and acknowledge that often our appointments are shaped by systemic demands (such as for assessment and diagnosis), my primary focus is upon affirming young people and supporting their parents to do the same.

Of course an affirmative approach can usefully involve hearing and responding to the fears and concerns of parents. In order to support their children it is important for parents to be able to have honest and respectful conversations that might start with their fears and concerns, but which hold the potential to shift the way they understand the lives of transgender people. To achieve this my work is implicitly (and at times explicitly) framed with reference to the broader context of what Ansara and Hegarty (2014) refer to as 'cisgenderism': the ideology that delegitimizes people's own understandings of their bodies and genders. This framing allows me to both acknowledge the fears and concerns of parents, whilst respectfully challenging their fears and concerns by positioning

them as a product of cisgenderism. Centrally, such an approach involves affirming that an individual's experience of their gender identity is what is most important, not their assigned sex or what other people take to be their 'correct' gender identity.

One technique that I use to assist parents in thinking through any barriers they may be experiencing in supporting their child's transition is to ask them who they want their child to be in the future, how this differs from their child's own perceptions, and what it would mean if their child was not supported to live a life that is meaningful and true. This approach encourages parents to recognise that sometimes the values held by parents (which may be faith-based, or culturally and socially-determined) will differ from those held by children. Of course to a large degree this approach is counterintuitive to parenting for most people.

Parenting 101 typically involves stating that parents must determine clear boundaries for their children, should enforce those boundaries, and that such boundaries should be premised on the family's belief system. Such an approach, however, is prone to privilege those who hold the primary seat of power in the family (i.e., parents). An affirming approach in working with transgender young people requires that, at times, the balance of power must shift to the young person, in order for them to be able to voice and enact their needs in terms of their transition. In using the approach outlined above I aim to assist parents in considering what it might mean for their child if they do not support them – if they continue to privilege their own values over those of their child. This can involve drawing on research evidence documenting poor mental health outcomes amongst transgender people who experience family rejection (Koken,

Bimbi & Parsons, 2009), and it can also involve inviting discussions with parents in regards to what it would mean for their child to feel alienated by them, and to potentially leave home (either in the present or in the future). Most of the parents I work with, even those who are deeply struggling with their child's transition, would prefer that their child remained in their life.

In terms of reconciling their own beliefs with their child's needs, I also utilize the above approach to encourage parents to reflect upon how their particular value-base may place them in conflict with their child's experience of their gender.

Often parents can elaborate very clear reasons why supporting a transgender child does not accord with their belief system. But when we discuss the fundamentals of those belief systems we often find that they primarily emphasise respect, support and caring familial relationships. Once we arrive at this point, I am able to discuss with parents who are struggling with their child's transition how their core values – of having caring and meaningful relationships with their child – can be best affirmed by supporting their child's transition.

Whilst some parents struggle to get to this point, moving beyond their personal beliefs to instead *acknowledge the primary value they place on their relationship with their child* can assist many parents to incorporate a supportive response into their belief systems, and for many people to become a strong advocate for their child and for transgender people more broadly.

Another part of my role in working with parents is to advise them as to what they can expect when they meet with medical professionals (including psychiatrists). In western nations we place considerable faith in medical

professionals – often our lives depend on this. This can result in us having unrealistic expectations of medical professionals, but it also can also lead to an unquestioning approach to the knowledge that medical professionals hold. When speaking with parents I often find it necessary to first outline what the role of a medical professional is. Many parents seem to expect that a medical professional will be a one-stop shop: they will diagnose, and prescribe, and treat, and listen, and care, and be a friend. Whilst on some occasions certain medical professionals may choose to be all of these things, I try to make it very clear to parents that medical professionals are there to do a specific job: to treat a specific physical or psychological issue through medication and/or surgery. This is their training.

Medical professionals are of course also trained in patient care in terms of listening and supporting. But this, I suggest to parents, is not their primary training, nor is it necessarily the best use of their (often very limited) time. In focusing on the diagnostic and treatment aspects of the work that medical professionals do, I attempt to prepare parents for the types of responses they are likely to receive. Many parents in the past have suggested to me that medical professionals are too 'clinical' (i.e., cold and distant). I now take the lead in raising this with parents, and suggest that this is appropriate – what we want from medical professionals is primarily for them to make a clinical assessment of our medical needs. The parents I work with report that understanding the role of medical professionals makes it easier to speak with them , and to maintain a focus on presenting issues and treatment plans in ways that are likely to be well received by medical professionals and thus achieve the intended outcome. Such an approach also can be useful in helping parents to understand the different

roles that a range of professionals can play. For example, a non-medical mental health professionals (e.g., a social worker or psychologist) might be actively involved in diagnosis, counseling and referral, whilst a psychiatrist might be more focused on prescription (in terms of hormone blockers or hormones).

Beyond the specific modes of engagement that parents can expect from medical professionals, I also speak with parents about the importance of educating themselves about their child's journey. Knowledge about medical responses to transgender people continues to rapidly evolve, and it is always possible that medical professionals may not be aware of the latest thinking on a specific aspect of medical transition for transgender young people. As part of my role as a clinician I spend a considerable amount of time ensuring that I am aware of ongoing changes in regards to medical responses to transgender people from across the world, so that I can share this information with parents and suggest to them how they might go about engaging with the information themselves.

For example, many young people I work with are in the process of being assessed for puberty blockers. In my role I often discuss with their parents the effects of blockers upon physical growth. Whilst many parents are keen to alleviate their child's dysphoria and fears of puberty beginning by commencing blockers as soon as possible, I discuss with parents the effects of commencing blockers too soon. For transgender boys, this can mean that physical growth is restricted (which is a concern, given most of the boys I work with want to be tall). For transgender girls, I raise the topic of possible future vaginoplasty, and speak about how this surgery is undertaken and that further growth of the penis

in the first stage of puberty might be important to ensure adequate skin for crafting a functional vagina. I do point out to parents that there are other ways that this can be done (taking skin from elsewhere for example), but that it is vitally important to keep in mind the rights of young people to a fulfilling intimate life in the future, and that skin from differing parts of the body are likely to produce different sensations that may not always be commensurate with those typically associated with intimacy.

As such, at the same time as emphasising the need for parents to be apprised of current knowledge about medical responses to transgender people, I also emphasise to parents the importance of having faith that medical practitioners know their job. Whilst there are certainly instances where some medical professionals untrained in working with transgender young people may not be aware of the correct medical pathways to follow, generally speaking it is the case that those who specialize in the area are knowledgeable and skilled. Part of my work, then, involves knowing which specialists are available, and referring clients to them. When giving such referrals I emphasise that whilst I know how stressful the process may be for both parents and their children, and whilst some parents may wish medical intervention to happen sooner rather than later to alleviate their child's distress, I nonetheless emphasise that specialist medical professionals are highly trained in knowing when to prescribe hormone blockers, for example. Encouraging parents to have faith in the skills of their child's administering medical professionals is thus an important part of the work that I do. Sometimes this can involve playing a mediating role between clients and medical professionals, so that I interpret for clients the likely intentions and

reasoning behind decisions made by medical professionals. In reverse, I often consult with medical professionals by providing summaries of the complex family dynamics I have witnessed when working with a particular family, so that the medical professional is apprised of the factors that might influence a demand for particular medical responses.

### **Approaches for Working Jointly with Parents and Children**

All of the the young people I work with display a keen desire to know as much as possible about what lies ahead for them. Many young people I work with come to see me with a relatively normative understanding of their transgender body and identity. Gleaned from the media, from websites and from their parents, there is often a strong narrative of 'the wrong body', of 'wanting to change' and of 'feeling different'. Some of the young people I work with report a strong sense of dysphoria, whilst others do not. Part of my approach to working with young people and their parents, as outlined above, is to affirm their sense of self as it currently stands. So this might well involve talking about dysphoria, or a sense of being in the wrong body, or a desire to change, or the experience of feeling different. Gradually, I also introduce conversations about the diversity of all bodies. These conversations are often based on academic research that has examined the experiences of transgender adults in terms of intimacy and embodiment. For example, such research (Doorduyn & Van Berlo, 2014) has repeatedly indicated that for many transgender people intimate interactions with cisgender people help them to see that bodily discomfort, bodily dissatisfaction and many differing bodily configurations are the norm for all

people. Importantly, this is not to discount the specific experiences of transgender people living in a context of cisgenderism, where it is presumed that nataly-assigned sex will normatively accord with gender identity. Rather, it is to open up a range of ways to think about identity and embodiment.

This approach to opening up new conversations is, I find, important for working with young people, and is an important thing for parents to understand, specifically with regard to how they respond to their child's potential sense of dysphoria, which can often increase with age. Talking about embodiment is vitally important from a young age as in almost all cases a sense of being in the wrong body cannot be addressed medically for very young people. For many of the young people I work with, the feeling of eternal waiting can lead to anxieties over their bodies that in some instances become generalized. To address this I take two approaches. The first is to talk in very concrete terms about bodies, but to use terms that are to a degree degendered (or we might want to think of them as regendered). Again, academic research that has examined the experiences of transgender adults in regards to their understandings of their bodies suggests that many transgender adults renegotiate the normative meanings ascribed to particular body parts. Thus some transgender men will be comfortable with receptive vaginal intercourse when they understand their vagina as a 'bonus hole' or as a term other than 'vagina' (Schleifer, 2006). Similarly, some transgender men refer to the clitoris as a little guy, penis, or dickclit amongst other terms (Edelmann & Zimman, 2014). Research also suggests that some transgender women who have not yet had, or who have decided not to have, vaginoplasty regender the penis so that it signifies femininity (Bolin, 1988).

Given my approach – which centres young people’s right to bodily autonomy and intimacy into the future – I believe it important to talk about bodies in ways that open them up to reinscription. This, I have found, is an important counter to some of the fears and anxieties that young people have about their bodies, and certainly can be a useful task for parents to engage with in terms of how they talk about bodies and identity within the family across all individuals.

The second approach I take, as already indicated above, is to speak with young people about their bodies and identities in ways that locate them in a wider social context. Sometimes this means we talk about how unrealistic and unfair stereotypes and norms are when it comes to bodies. I might use my own body or their parents’ bodies as a reference point to discuss the expectations we experience and the differences between us. For example, I might comment on how gaining weight or ageing has changed the shape of my body, and that whilst this can be challenging, it doesn’t change my gender identity. Parents will often then share similar stories to further demonstrate the impact of body norms upon us all. Beyond this focus upon specific bodies known to the young person, we might also discuss how they come to have knowledge about bodies and gender, and what types of beliefs and assumptions inform them. Importantly, as noted above, this is not to discount many transgender people’s experiences of dysphoria, nor to promote a liberal narrative of ‘we are all the same’. Instead, the intention is to discuss the broader social forces that shape how we understand our bodies and our selves. This can be empowering for young people to understand that there are other ways of thinking about their lives and

experiences, and parents can play an important role in affirming the diversity of bodily experiences.

An example of this focus on all bodies as diverse comes from my work with a young transgender girl. When we first met she reported a significant fear that she would grow up and be hairy like her father. At the time she had fine hair on her legs, and had developed a behavior that involved pulling at the hair in order to remove it. She reported the perception that her mother had hairless legs and that this was a key signifier (along with breasts) of what it means to be female. Over a number of sessions her parents and I were able to discuss the normative expectations that are placed on women in our society, which involved her mother disclosing that she shaves her legs, that not all women do so, and that not all men are hirsute. Her mother also disclosed the challenges in having (for her particularly large) breasts, and that whilst she could understand the meaning of having them in terms of femininity, she could also provide many examples of female family members who did not have such well developed breasts.

These conversations were not intended to discount the young person's sense of dysphoria nor to delegitimize her desires. Rather, they were intended to facilitate an understanding of the diversity of bodies, that the expectations we have of bodies marked as female or male are normative, and that to a degree she can have control over the outcomes for her body. This involved frank conversations between the parents, the young person, and myself about the effects of first puberty blockers and then hormone therapy. Speaking honestly with her about what hormones do to bodies – primarily in non-gendered ways

(i.e., testosterone can produce or inhibit hair growth, estrogen can change result in the growth of breasts, but without discussing these hormones as male or female) – assisted her to both understand the possibilities that lie ahead, but also to understand that hormones have differential effects for all people including having limited effects for some people or indeed deleterious effects (such as emotional deregulation, hair loss or excessive hair growth, acne, etc).

In terms of medical professionals, much of the work I do with young people takes the form of coaching, and this is most often done in conjunction with parents as described above. Importantly, my intention in doing so is not to ‘train’ young people in how to get what they want from medical professionals. At the same time, however, and drawing on academic research that has examined transgender adult’s experiences of engaging with medical professionals (Speer & Parsons, 2006), it is important to acknowledge that in many instances a relatively normative narrative is expected of transgender people by medical professionals. This narrative is shaped by diagnostic requirements and current understandings about medical responses to transgender people. Talking with young people and their parents in this context requires a clear acknowledgement that there is a system with which they must negotiate, that a range of differing rules drive the system, and that those rules are determined by social norms and beliefs about transgender people. This type of conversation is important, I believe, as it can assist young people and their parents in developing the critical thinking skills that can result in them understanding the systems that often govern them, to refuse their pathologising effects, but to nonetheless negotiate the outcomes they desire. Speaking honestly with young people and their

parents about the diagnosis of gender dysphoria, for example, is something I have found to be an important and empowering conversation.

Another conversation that I have with young people and their parents as they approach the time when they will commence hormone blockers is the topic of fertility. Understandably, for most young people the idea of having children may be one they have given little thought to. For some transgender young people I work with this is true. For other transgender young people, the topic of fertility and having children is a source of significant distress. For some transgender boys, the idea of a pregnancy is a normative gendered expectation that further triggers feelings of dysphoria. Conversely, for some transgender girls the idea of not being able to carry a child is a source of distress. For yet other transgender young people, they have already developed a very clear narrative of how they might have children in the future, including preserving their own genetic materials (through sperm or ovum storage if they have already commenced the puberty associated with their natal assigned sex) or adopting or fostering children. As with any topic, the question of fertility and children is very much shaped by the information that young people are exposed to in their family, education, and broader community. Often I find that parents avoid the topic of fertility in the presence of their children. For some this may be because they find it uncomfortable, for others because they fear triggering their child's experience of dysphoria, and for others they may consider it inappropriate to talk with a young person about their body in terms of future reproductive desires.

In order to open up a space for conversations about fertility at the same time as managing the potential discomfort of parents, sometimes I engage in 'ventriloquising' the thoughts and feelings of parents for children: voicing the thoughts and concerns that parents might have that they are struggling to express. Before doing this I first always check in with parents about what they think and feel about a specific topic related to their child's body, and often parents request that I speak with their child on their behalf about topics that they are struggling to broach. The conversations that result are thus typically led by me, and involve me raising a thought or concern on behalf of the parents, and discussing the specific topic with the young person with their parents present. Sometimes the parents will join in the conversation and often the young person will look to their parents to see how they are responding, but typically these are very productive conversations that are both serious and light-hearted. Often the legacy of these conversations is felt for many sessions, where parents report feeling happier knowing that the topic has been broached, and young people often return many sessions later wanting to talk more about the topic. And of course this approach can usefully open up the possibility for parents to themselves talk with their child about issues that concern them, rather than requiring me to do so on their behalf.

## **Conclusions**

To return to the case example that opened this chapter, it is important to acknowledge that at differing points in the journey through a young person's transition some, if not many, parents will struggle. This may be for many

differing reasons. Some parents may feel they are not doing enough – as was the case for the mother described earlier – whilst other parents may view being transgender as an illness or a phase. Some parents may get the message that supporting their child is wrong, and sometimes this message may come from medical professionals, as was the case in the example with which I opened this chapter. In cases such as this, parents may be very supportive of their transgender child, but may also need support themselves in weighing up the range of options and opinions they are likely faced with. They may also need mental health clinicians to play an advocacy or mediating role to open up conversations with medical professionals about the best course of action to take. Regardless of any individual parent's experience, however, if our starting place as clinicians is an affirming response to young people, then it is possible to negotiate modes of engagement that both allow parents to speak about their emotional responses and support needs, whilst centering the importance of affirming young people in their gender transition.

As I have outlined throughout this chapter, engaging with parents and young people in regards to the medical aspects of transitioning often requires honest and frank conversations, but it is vitally important that these conversations are framed with explicit reference to the broader context of cisgenderism and the most common responses from medical professionals towards transgender people. For me, preparing transgender young people and their parents both for the challenges and joys of the journey ahead is important: to do otherwise would be disingenuous. Whilst my aim is never to provide either young people or their parents with a 'script' for using when they see a medical professional, I am

nonetheless convinced of the importance of priming young people and their parents with information about what to expect, how to negotiate the expectations placed upon them in the most straightforward way, and how to respond to moments when they feel marginalized by the demands of the medical system.

In my practice I have at times acknowledged to parents that it might be easier if we lived in a world where gender binaries were not dominant. However, I always make this statement with caution and clarity. My purpose in making the statement is never to deny the experiences of transgender young people, nor is it to set them up as dupes of a gender binary. Rather, my goal is always to shift the focus away from them as the source of difference, and instead to work with parents to develop critical thinking skills to reflect upon how difference is produced by particular modes of classification. Whilst such a focus does not bring an end to their struggles nor their child's feelings of difference or dysphoria, it can help to enable an outward focus that, I believe, will be an asset to both parents and young people into the future in terms of how people throughout their lives respond to transgender people.

## **References**

Ansara, Y.G., & Hegarty, P. (2014). Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research. *Feminism and Psychology, 24*, 259-270.

Bolin, A. (1988). *In search of Eve: Transsexual rites of passage*. London: Bergin & Garvey.

Doorduyn, T., & Van Berlo, W. (2014). Trans People's Experience of Sexuality in the Netherlands: A Pilot Study. *Journal of homosexuality*, 61(5), 654-672.

Edelman, E. A., & Zimman, L. (2014). Boycunts and Bonus Holes: Trans Men's Bodies, Neoliberalism, and the Sexual Productivity of Genitals. *Journal of homosexuality*, 61(5), 673-690.

Koken, J. A., Bimbi, D. S., & Parsons, J. T. (2009). Experiences of familial acceptance–rejection among transwomen of color. *Journal of Family Psychology*, 23(6), 853.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Routledge.

Schleifer, D. (2006). Make me feel mighty real: Gay female-to-male transgenderists negotiating sex, gender, and sexuality. *Sexualities*, 9(1), 57-75.

Speer, S. A., & Parsons, C. (2006). Gatekeeping gender: Some features of the use of hypothetical questions in the psychiatric assessment of transsexual patients. *Discourse & Society*, 17(6), 785-812.