

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION**

DREW ADAMS, a minor, by and through
his next friend and mother, ERICA
ADAMS KASPER,

Plaintiff,

v.

THE SCHOOL BOARD OF ST. JOHNS
COUNTY, FLORIDA,

Defendant.

Case No. 3:17-cv-00739-TJC-JBT

**REQUEST FOR JUDICIAL NOTICE AND MEMORANDUM OF LAW AS TO
CLINICAL GUIDELINES, RESOLUTIONS, STANDARDS OF CARE, AND
STATEMENTS BY MAJOR MEDICAL AND MENTAL HEALTH
ORGANIZATIONS**

Pursuant to Federal Rule of Evidence 201, Plaintiff, Drew Adams, a minor, by and through his next friend and mother, Erica Adams Kasper (“Plaintiff”), and by and through their undersigned counsel, respectfully requests that this Court take judicial notice that the major medical and mental health organizations referenced herein have issued clinical guidelines, resolutions, standards of care, and statements supporting gender-affirming care for transgender people and gender dysphoria, including opposing policies that do not treat transgender people consistent with their identity. These official clinical guidelines, resolutions, standards of care, and statements are publicly available and readily verifiable on the websites of the respective organizations, as detailed below.

MEMORANDUM OF LAW

Federal Rule of Evidence 201 allows this Court to take judicial notice of adjudicative facts that cannot reasonably be disputed and are subject to ready proof. Specifically, “[t]he Court may judicially notice a fact that is not subject to reasonable dispute because it: (1) is generally known within the trial court’s territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned.” Fed. R. Evid. 201(b). Moreover, the Court is required to take judicial notice upon Plaintiff’s request where, as here, the Court “is supplied with the necessary information.” Fed. R. Evid. 201(c). All of these requirements are met here.

Courts within the Eleventh Circuit routinely take judicial notice of press releases such as these for the purpose of noting the existence of a press release’s message. *See First Global Corp. v. Mansiana Ocean Residences, LLC*, No. 09-21092, 2010 WL 2163756, at *3 n.3 (S.D. Fla. May 27, 2010) (“It is within the scope of Federal Rule of Evidence 201 for a court to take judicial notice of a press release, for the limited purpose of noting the existence of the press release’s message”) (citing *Shahar v. Bowers*, 120 F.3d 211, 214 n.5 (11th Cir. 1997)); *see also Richard Thorpe & Darrel Weisheit v. Walter Inv. Mgmt. Corp.*, 111 F. Supp. 3d 1336 (S.D. Fla. 2015) (taking judicial notice of, *inter alia*, organization’s press releases). What is more, courts in the Eleventh Circuit typically take judicial notice of press releases and other materials posted on a website where, as here, those materials exhibit conventional indicia of reliability. *See, e.g., R.S.B. Ventures, Inc. v. F.D.I.C.*, 514 F. App’x 853, 856 (11th Cir. 2013); *Mawulawde v. Bd. of Regents of Univ. Sys. of Georgia*, No. CV 105-099, 2007 WL 2460774 at *8 n.10 (S.D. Ga. 2007) (citing cases); *S.W. Georgia Fin. Corp. v. Colonial Am. Cas. & Sur.*

Co., No. CIV.A. 7:08-CV-55HL, 2009 WL 1410272 (M.D. Ga. 2009); *see also Elat v. Ngoubene*, 993 F. Supp. 2d 497, 516 (D. Md. 2014) (“tak[ing] judicial notice of the content of the website of the American Psychological Association pursuant to Fed. R. Evid. 201”).

In addition, courts may “take judicial notice of matters of science and common knowledge.” *Babish v. Sedgwick Claims Mgmt. Servs., Inc.*, No. 2:07-CV-1539, 2009 WL 563951, at *3 (W.D. Pa. Mar. 2, 2009). As such, courts routinely take judicial notice of medical diagnostic criteria, standards, and guidelines. *See, e.g., United States v. Long*, 562 F.3d 325, 335 (5th Cir. 2009) (“We take judicial notice of these as the DSM-IV’s authoritative nature makes the criteria ‘capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned.’ Fed. R. Evid. 201(b.)”); *United States v. Johnson*, 979 F.2d 396, 401 (6th Cir. 1992) (taking judicial notice of American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (“DSM”)); *United States v. Cantu*, 12 F.3d 1506, 1509 n.1 (9th Cir. 1993) (taking judicial notice of a condition listed in the DSM-IV); *Aldridge v. Thaler*, No. CIV.A. H-05-608, 2010 WL 1050335, at *29 (S.D. Tex. Mar. 17, 2010) (noting “[t]he Fifth Circuit has taken judicial notice of DSM-IV”); *Gough v. Metro. Life Ins. Co.*, No. 3:03-0158, 2003 WL 23411993, at *2 (M.D. Tenn. Nov. 21, 2003) (“The Court hereby takes judicial notice of the contents of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders Revised Text (4th Ed.2000) for purposes of adjudicating the parties’ cross Motions for Judgment on the Administrative Record.”).

Here, the standards of care and clinical guidelines are of such authoritative nature that they satisfy the criteria that they be “capable of accurate and ready determination by resort to

sources whose accuracy cannot reasonably be questioned.” Fed. R. Evid. 201(b). *See Doe by & through Doe v. Boyertown Area Sch. Dist.*, No. CV 17-1249, 2017 WL 3675418, at *37 (E.D. Pa. Aug. 25, 2017) (“There are accepted standards in the medical and mental health fields for treating gender dysphoria in adolescents, with these standards being documented in the Endocrine Society Guidelines and in the WPATH Standards of Care (currently in its seventh edition).”); *id.* (“The WPATH Standards of Care are widely used and accepted in the field by clinicians dealing with youth with gender identity issues.”); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal.) (“The World Professional Association for Transgender Health (“WPATH”) has developed Standards of Care for the Health of Transsexual, Transgender, and Gender–Nonconforming People (‘Standards of Care’), which are recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.”), *appeal dismissed and remanded*, 802 F.3d 1090 (9th Cir. 2015); *Glenn v. Brumby*, 724 F. Supp. 2d 1284, 1289 (N.D. Ga. 2010), *aff’d*, 663 F.3d 1312 (11th Cir. 2011) (“Based upon the record, there is sufficient evidence that statements of WPATH are accepted in the medical community.”).

Accordingly, pursuant to Federal Rule of Evidence 201, Plaintiff hereby requests that this Court take judicial notice that the major medical and mental health organizations listed below have issued clinical guidelines, resolutions, standards of care, and statements supporting gender-affirming care for transgender people and gender dysphoria, including opposing policies that do not treat transgender people consistent with their identity. In addition, Plaintiff requests that the Court take judicial notice of the contents of the clinical guidelines and standards of care listed below based on their indisputable authoritative nature.

- 1) The American Academy of Family Physicians, *American Academy of Family Physicians Reaffirms Antidiscrimination Policy with Vote on Transgender Equality*, (Sept. 20, 2016), <https://perma.cc/J7XS-6GFV> (last visited Nov. 28, 2017) (attached hereto as Exhibit 1).
- 2) American Family Therapy Academy, *Statement on Transgender Students* (Mar. 14, 2017), available at <https://perma.cc/YBH2-7WRE> (last visited Nov. 28, 2017) (attached hereto as Exhibit 2).
- 3) American Academy of Pediatrics, *Policy Statement: Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth* (2013), available at <https://perma.cc/XXW9-FW2V> (last visited Nov. 28, 2017) (attached hereto as Exhibit 3).
- 4) American Academy of Pediatrics, *Technical Report: Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth* (2013), available at <https://perma.cc/CJ5W-LUEU> (last visited Nov. 28, 2017) (attached hereto as Exhibit 4).
- 5) American College of Obstetricians and Gynecologists, *Health Care for Transgender Individuals* (Dec. 2011), available at <https://perma.cc/PM4G-R7R5> (last visited Nov. 28, 2017) (attached hereto as Exhibit 5).
- 6) American College of Physicians, Daniel, H., et al., *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 2 at 135-148

- (July 2015), available at <https://perma.cc/YAR2-DGRJ> (last visited Nov. 28, 2017) (attached hereto as Exhibit 6).
- 7) American Medical Association, *Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991* (2016), available at <https://perma.cc/4N67-N6YP> (last visited Nov. 28, 2017) (attached hereto as Exhibit 7).
 - 8) American Medical Association, *Removing Financial Barriers to Care for Transgender Patients H-185.950* (2016), available at <https://perma.cc/UYL8-4SLQ> (last visited Nov. 28, 2017) (attached hereto as Exhibit 8).
 - 9) American Medical Association, *Access to Basic Human Services for Transgender Individuals H-65.964* (2017), available at <https://perma.cc/RA33-4FFD> (last visited Nov. 28, 2017) (attached hereto as Exhibit 9).
 - 10) American Psychiatric Association, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (May 2012), available at <https://perma.cc/8DRZ-YV8W> (last visited Nov. 28, 2017) (attached hereto as Exhibit 10).
 - 11) American Psychiatric Association, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (May 2012), available at <https://perma.cc/UH8L-L9TG> (last visited Nov. 28, 2017) (attached hereto as Exhibit 11).
 - 12) American Psychological Association, *Transgender, Gender Identity, and Gender Expression Non-Discrimination* (Aug. 2008), available at <https://perma.cc/ER78-GZ9X> (last visited Nov. 28, 2017) (attached hereto as Exhibit 12).

- 13) American Psychological Association, *Report of the APA Task Force on Gender Identity & Gender Variance* (2009), available at <http://www.apa.org/pubs/info/reports/gender-identity.aspx> (last visited Nov. 28, 2017) (attached hereto as Exhibit 13).
- 14) American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 AMERICAN PSYCHOLOGIST 9 at 832-864 (Dec. 2015), available at <https://perma.cc/BRC5-LTAN> (last visited Nov. 28, 2017) (attached hereto as Exhibit 14).
- 15) American Psychological Association and National Association of School Psychologists, *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools*, (Feb. 2015), available at <http://www.apa.org/about/policy/orientation-diversity.aspx> (last visited Nov. 28, 2017) (attached hereto as Exhibit 15).
- 16) The Endocrine Society, *Position Statement: Transgender Health* (2017), available at <https://perma.cc/KX34-LXYU> (last visited Nov. 28, 2017) (attached hereto as Exhibit 16).
- 17) The Endocrine Society, Hembree, W., et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 11 at 3869-3903 (Nov. 2017) available at <https://perma.cc/PL9N-XR95> (last visited Nov. 28, 2017) (attached hereto as Exhibit 17).
- 18) National Association of Social Workers, *National Committee on Lesbian, Gay, Bisexual, and Transgender Issues: Position Statement* (May 2015), available at

- <https://perma.cc/9K5A-CX7B> (last visited Nov. 28, 2017) ((attached hereto as Exhibit 18).
- 19) National Association of Social Workers, *Policy Statement: Transgender and Gender Identity Issues* (Aug. 2008), available at <https://perma.cc/R86C-VKDK> (last visited Nov. 28, 2017) (attached hereto as Exhibit 19).
- 20) Pediatric Endocrine Society, Lopez, X., et al., *Statement on Gender-Affirmative Approach to Care from the Pediatric Endocrine Society Special Interest Group on Transgender Health*, 29 CURRENT OPINION ON PEDIATRICS 4 at 475-480 (Aug. 2017), available at <https://perma.cc/K8Z8-Y5YX> (last visited Nov. 28, 2017) (attached hereto as Exhibit 20).
- 21) Pediatric Endocrine Society, *PES Statement Promoting Safety of Transgender Youth* (Mar. 2017), available at <https://perma.cc/SU9J-N78Y> (last visited Nov. 28, 2017).
- 22) Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Oct. 2015), <https://perma.cc/NUD5-JEJX> (last visited Nov. 28, 2017) (attached hereto as Exhibit 22).
- 23) World Medical Association, *WMA Statement on Transgender People* (Oct. 2015), available at <https://perma.cc/YHA3-KWRL> (last visited Nov. 28, 2017) (attached hereto as Exhibit 23).
- 24) World Professional Association for Transgender Health, *Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the*

U.S.A. (Dec. 2016), available at <https://perma.cc/EE2X-SAWR> (last visited Nov. 28, 2017) (attached hereto as Exhibit 24).

25) World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version*, (2011) available at <https://perma.cc/L7SL-E3XG> (last visited Nov. 28, 2017) (attached hereto as Exhibit 25).

CONCLUSION

Wherefore, based on the foregoing, Plaintiff respectfully requests that this Court take judicial notice of the above adjudicative facts pursuant to Federal Rule of Evidence 201(b), as they are not subject to reasonable dispute.

CERTIFICATE OF CONFERENCE PURSUANT TO LOCAL RULE 3.01(g)

Pursuant to 3.01(g) of the Local Rules of the Middle District of Florida, the undersigned certifies that he has conferred with the attorneys representing Defendant regarding the relief requested in the motion. The parties were unable to reach a resolution and Defendant's counsel does not consent to the relief requested.

Dated this 29th of November, 2017

Respectfully submitted,

/s/ Omar Gonzalez-Pagan
Omar Gonzalez-Pagan
(admitted pro hac vice)
LAMBDA LEGAL DEFENSE
AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
Telephone: 212-809-8585
Facsimile: 212-809-0055
ogonzalez-pagan@lambdalegal.org

Kirsten Doolittle, Trial Counsel
Florida Bar No. 942391
THE LAW OFFICE OF KIRSTEN DOOLITTLE, P.A.
The Elks Building
207 North Laura Street, Ste. 240
Jacksonville, FL 32202
Telephone: 904-551-7775
Facsimile: 904-513-9254
kd@kdlawoffice.com

Tara L. Borelli (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308-1210
Telephone: 404-897-1880
Facsimile: 404-897-1884
tborelli@lambdalegal.org

Paul D. Castillo (*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE
AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, Texas 75219
Telephone: 214-219-8585
Facsimile: 214-219-4455
pcastillo@lambdalegal.org

Natalie Nardecchia
(*admitted pro hac vice*)
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010-3512
Tel. 213-382-7600 | Fax: 213-351-6050
nnardecchia@lambdalegal.org

Jennifer Altman
Florida Bar No: 881384
Markenzy Lapointe
Florida Bar No: 172601
Shani Rivaux
Florida Bar No: 42095
Aryeh Kaplan
Florida Bar No: 60558
PILLSBURY WINTHROP SHAW PITTMAN, LLP
600 Brickell Avenue Suite 3100
Miami, FL 33131
Telephone: 786-913-4900
Facsimile: 786-913-4901
jennifer.altman@pillsbury.com
markenzy.lapointe@pillsburylaw.com
shani.rivaux@pillsbury.com
aryeh.kaplan@pillsbury.com

Richard M. Segal (*admitted pro hac vice*)
Nathaniel R. Smith (*admitted pro hac vice*)
PILLSBURY WINTHROP SHAW PITTMAN LLP
501 W. Broadway, Suite 1100
San Diego, CA 92101
Telephone: 619-234-5000
Facsimile: 619-236-1995
richard.segal@pillsburylaw.com
nathaniel.smith@pillsburylaw.com

Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on November 29, 2017, the foregoing motion was filed electronically using the Court's ECF system, which will provide electronic notice to all counsel of record, including:

Terry J. Harmon (tharmon@sniffenlaw.com)
Robert J. Sniffen (rsniffen@sniffenlaw.com)
Michael P. Spellman (mspellman@sniffenlaw.com)
Lisa B. Fountain (lfountain@sniffenlaw.com)
Kevin Kostelnik (kkostelnik@sniffenlaw.com)
SNIFFEN & SPELLMAN, P.A.
123 North Monroe Street
Tallahassee, Florida 32301

Robert Christopher Barden (rcbarden@mac.com)
RC Barden & Associates
5193 Black Oaks Court North
Plymouth, MN 55446-2603

Attorneys for Defendant, The School Board of St. Johns County, Florida

/s/ Omar Gonzalez-Pagan

Omar Gonzalez-Pagan

(admitted pro hac vice)

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

120 Wall Street, 19th Floor

New York, New York 10005-3919

Tel.: 212-809-8585 | Fax: 212-809-0055

ogonzalez-pagan@lambdalegal.org

EXHIBIT 1



AAFP Reaffirms Antidiscrimination Policy with Vote on Transgender Equality

FOR IMMEDIATE RELEASE

Tuesday, Sept. 20, 2016

Contact:

Leslie Champlin

Senior Public Relations Strategist

American Academy of Family Physicians

(800) 274-2237, Ext. 5224

lchampli@aafp.org (<http://www.aafp.org/media-center/internal/mediacontacts/lchamplin.html>)

LEAWOOD, Kan. — The American Academy of Family Physicians today reaffirmed its policies against discrimination by approving a resolution that specifically opposes state and federal laws that compromise the safety and health of transgender people.

The action, which opposes laws prohibiting transgender people from using public facilities that match their identity, adds to the AAFP's long-standing policy against discrimination.

AAFP's [policy](http://www.aafp.org/about/policies/all/patient-discrimination.html) (<http://www.aafp.org/about/policies/all/patient-discrimination.html>) opposes "all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin."

However, delegates focused on access to public facilities as a result of recent legislation restricting transgender people's access to public accommodations. [Of 21 state bills dealing with transgender issues in 2015](http://www.hrc.org/resources/unprecedented-onslaught-of-state-legislation-targeting-transgender-american) (<http://www.hrc.org/resources/unprecedented-onslaught-of-state-legislation-targeting-transgender-american>), 17 -- or 81 percent -- restricted access to bathrooms, locker rooms or sports.

Delegates cited the psychological and physical fallout from laws that discriminate against transgender people. [Research](http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Gendered-Restrooms-and-Minority-Stress-June-2013.pdf) (<http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Gendered-Restrooms-and-Minority-Stress-June-2013.pdf>) has shown that the inability to use restroom facilities or avoiding restrooms can lead to dehydration, kidney infections and urinary tract infections.

"Although these issues can be divisive, clearly so-called bathroom bills are discriminatory, and the AAFP has longstanding policy against discrimination," said John Meigs, Jr., MD, president-elect of the AAFP.

###

Founded in 1947, the AAFP represents 129,000 physicians and medical students nationwide. It is the only medical society devoted solely to primary care.

Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care.

To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit www.aafp.org/media (<http://www.aafp.org/media>). For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, www.familydoctor.org (<http://www.familydoctor.org>).

AAFP Reaffirms Antidiscrimination Policy with Vote on Transgender Equality
<http://www.aafp.org/media-center/releases-statements/all/2016/transgender-equality.html>

Copyright © 2017 American Academy of Family Physicians. All rights reserved.
11400 Tomahawk Creek Parkway • Leawood, KS 66211-2680
800.274.2237 • 913.906.6000 • Fax: 913.906.6075 • aafp@aafp.org



EXHIBIT 2



STATEMENT ON TRANSGENDER STUDENTS

March 14, 2017

The American Family Therapy Academy (AFTA) stands in opposition to the recent executive order rescinding the protection of transgender students using bathrooms and locker rooms that correspond with their affirmed gender identity. Rescinding these protections puts transgender and gender non-conforming (TG/NC) children at risk for further harassment and discrimination. Seventy-five percent of transgender students report feeling unsafe at school and the discrimination they experience has led to a suicide attempt rate 42-46% higher than their cisgender peers. TG/NC students face significantly higher rates of harassment and discrimination than their lesbian and gay cisgender peers; not only by fellow students, but by adults charged with their care. This puts TG/NC students at increased risk for suicide, self-harm, risky behavior, school avoidance, and drug use. Federal protections are necessary to guarantee TG/NC students' civil rights within the school environment. They are vital to the health and safety of these students and their families.

AFTA supports transgender and gender non-conforming children and their families. No family should have to struggle with discrimination and harassment. We work to ensure a safety net for all families. We will work to reverse this executive order and to strongly voice our opposition.

AFTA Board of Directors



Kim Cox

Director of Operations of AFTA

Website: <http://www.afta.org>

November 2017
August 2017
July 2017
June 2017
March 2017
February 2017
January 2017
December 2016
October 2016
August 2016
July 2016
June 2016
March 2016
July 2015
June 2015
March 2015
January 2015
October 2014
August 2014
July 2014
June 2014
May 2014
April 2014
March 2014
February 2014
January 2014
December 2013
November 2013
October 2013
May 2012
March 2012
June 2004

Upcoming Events

There are no upcoming events at this time.

Site Map

[Home](#)

[Login](#)

[About AFTA](#)

[Letter from the President](#)

[History](#)

[Our Mission and Vision](#)

[Board of Directors](#)

[Past Presidents](#)

[Staff](#)

[Membership](#)

[Apply For Membership](#)

[Membership Criteria](#)

[Ethics Policy](#)

[Early Career Membership](#)

[Student Membership](#)

[AFTA Member Directory](#)

[Interest Groups](#)

[Committees](#)

[Awards](#)

[Members-Only Section](#)

[My Member Dashboard](#)

[Renew My Membership](#)

[Free Publications](#)

[Join an AFTA Committee](#)

[Join an Interest Group](#)

[AFTA Blog](#)

[Policies and Procedures](#)

[Helpful Links](#)

EXHIBIT 3



POLICY STATEMENT

Office-Based Care for Lesbian, Gay, Bisexual,
Transgender, and Questioning Youth

abstract

FREE

The American Academy of Pediatrics issued its last statement on homosexuality and adolescents in 2004. Although most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are quite resilient and emerge from adolescence as healthy adults, the effects of homophobia and heterosexism can contribute to health disparities in mental health with higher rates of depression and suicidal ideation, higher rates of substance abuse, and more sexually transmitted and HIV infections. Pediatricians should have offices that are teen friendly and welcoming to sexual minority youth. Obtaining a comprehensive, confidential, developmentally appropriate adolescent psychosocial history allows for the discovery of strengths and assets as well as risks. Referrals for mental health or substance abuse may be warranted. Sexually active LGBTQ youth should have sexually transmitted infection/HIV testing according to recommendations of the Sexually Transmitted Diseases Treatment Guidelines of the Centers for Disease Control and Prevention based on sexual behaviors. With appropriate assistance and care, sexual minority youth should live healthy, productive lives while transitioning through adolescence and young adulthood. *Pediatrics* 2013;132:198–203

INTRODUCTION

The American Academy of Pediatrics issued its first statement on sexual minority teenagers in 1983, with revisions in 1993 and 2004. Since the last report, research areas have rapidly expanded and hundreds of new publications have been produced about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, including an Institute of Medicine publication entitled “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.”¹ Being a member of this group of teenagers is not, in itself, a risk behavior and many sexual minority youth are quite resilient; sexual minority youth should not be considered abnormal. However, the presence of stigma from homophobia and heterosexism often leads to psychological distress, which may be accompanied by an increase in risk behaviors. Health disparities exist in mental health, substance abuse, and sexually transmitted infection (STI)/HIV. LGBTQ will be used whenever discussing studies and recommendations for all self-identified lesbian, gay, bisexual, transgender, or questioning youth. Many adolescents do not define themselves as a member of a sexual minority group but may have had same gender sexual

COMMITTEE ON ADOLESCENCE

KEY WORDS

sexual orientation, sexual identity, sexual behaviors, adolescents, sexual minority, homosexuality, gay, lesbian, bisexual, transgender

ABBREVIATIONS

CDC Centers for Disease Control and Prevention
HPV human papillomavirus
LGBTQ lesbian, gay, bisexual, transgender, and questioning
MSM men who have sex with men
STI sexually transmitted infection
WSW women who have sex with women

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2013.1282

doi:10.1542/peds.2013.1282

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2013 by the American Academy of Pediatrics

COMPANION PAPER: A companion to this article can be found on page e297, and online at www.pediatrics.org/cgi/doi/10.1542/peds.2013.1283.

behaviors (men who have sex with men [MSM] and women who have sex with women [WSW]). For this statement, the term “sexual minority” includes LGBTQ and MSM/WSW individuals.

DEFINITIONS

Typically, a young person’s sexual orientation emerges before or early in adolescence.^{2,3} Sexual orientation is referred to as “an individual’s pattern of physical and emotional arousal toward other persons.” Individuals who self identify as heterosexual are attracted to people of the opposite gender; homosexual individuals self identify as attracted to people of the same gender; bisexual teens report attraction to people of both genders. In common usage, self identified homosexual people are often referred to as “gay” if male, and “lesbian” if female.⁴ Many adolescents struggle with their sexual attractions and identity formation, and some may be referred to as “questioning.”² For other definitions, please see Table 1 in the accompanying technical report.

Gender identity and gender expression usually conform to anatomic sex for both homosexual and heterosexual teenagers.⁵ Gender dysphoria refers to the emotional distress of having a gender identity that is different from natal sex. Many young children with gender dysphoria will resolve their dysphoria by adolescence, but others will maintain it and desire transition to the opposite gender. These teenagers are “transgender.”^{6,7} Transgender people are often also identified by the natal gender and transition to the desired gender; MTF refers to males transitioning to females and FTM are females transitioning to males.^{1,5,7,9}

Many adolescents who self report as lesbian will still occasionally have sex with males, and many males who self report as gay may have sex with

females; behaviors do not equal identity.^{1,10} This range of sexuality may be reflected in the higher rate of teenage pregnancies experienced by WSW compared with their exclusively heterosexual peers.^{11,12}

HOMOPHOBIA, HETEROSEXISM, AND IDENTITY FORMATION

Homophobia and heterosexism may damage the emerging self image of an LGBTQ adolescent.^{13,15} Homophobia perceived by LGBTQ youth may lead to self destructive behaviors.¹⁶ Societal homophobia is reflected in the higher rates of bullying and violence suffered by sexual minority youth.¹⁷ With proper support and guidance, the majority of LGBTQ youth emerge as adults with sexual identities that are associated with little or no significant increase in risk behaviors compared with other youth. These resilient young adults lead happy, productive lives.^{18,19}

HEALTH DISPARITIES FOR SEXUAL MINORITY YOUTH

Stigmatization, ostracism, and parental rejection remain common. Resulting struggles with self image and self esteem put sexual minority youth at risk.^{11,20,21} Many sexual minority youth become homeless as a consequence of coming out to their families; sexual minority youth who are homeless may engage in riskier behaviors including survival sex.²²

Significant health disparities exist for sexual minority youth related to depression and suicidality, substance abuse, social anxiety, altered body image, and other mental health issues.^{1,13,17,23} Sexual minority youth suffer higher rates of depression and were more than twice as likely to have considered suicide.^{1,13,17,24,26} Protective factors against depression, suicidal ideation, and suicide attempts

included family connectedness, caring adults, and school safety.²⁷

Referral for “conversion” or “reparative therapy” is never indicated; therapy is not effective and may be harmful to LGBTQ individuals by increasing internalized stigma, distress, and depression.¹

When sexual minority teenagers “come out” and acknowledge their sexuality as adolescents, there are often significant repercussions, especially victimization.^{14,17,28} Even if not open about sexuality, 16% of MSM reported experiencing violence. Of adolescents who were open about their LGBTQ sexual orientation, 84% reported verbal harassment; 30% reported being punched, kicked, or injured; and 28% dropped out of school because of harassment.^{17,29} Sometimes it is simply the perception that an individual might be LGBTQ that may lead to bullying, harassment, violence, injury, and homicide.^{30,31}

Studies on the use of legal and illegal substances revealed significantly higher rates of tobacco, alcohol, marijuana, cocaine, ecstasy, methamphetamine, and heroin in sexual minority youth.^{1,17,32,33} Use of club drugs (eg, cocaine, methamphetamine, ecstasy, GHB [γ hydroxybutyric acid], ketamine, and LSD [lysergic acid diethylamide]) is especially concerning because of the association with unprotected sexual intercourse.³⁴

Health disparities exist in sexual health outcomes with respect to HIV/AIDS, other STIs, and teenage pregnancy among LGBTQ youth. Sexual minority youth were more likely than heterosexual youth to report having had intercourse, to have had intercourse before 13 years of age, and to have had intercourse with ≥4 people. Gay or lesbian youth were about half as likely as heterosexual youth to have used a condom at the last intercourse.²² During the past 15

years, reported rates of gonorrhea, chlamydia, and syphilis have trended downward for all adolescents, except for MSM.³⁵⁻³⁷ One particular disparity is in HIV infection. Data from the Centers for Disease Control and Prevention (CDC) show that HIV rates continue to increase among young MSM 13 to 24 years of age.³⁸

Information on sexual health disparities experienced by WSW is limited. High rates of STIs have been documented in lesbians and bisexual women with recent sexual contact with men, but there were also low but significant rates of STIs in exclusive WSW relationships. Viral infections, such as human papillomavirus (HPV) and herpes simplex virus infection, may be transmitted via exclusive female to female sexual contact.^{39,40}

LGBTQ youth are less likely to report the use of hormonal or barrier contraceptives at last sexual encounter when having sex with the opposite gender.²² Due to high rates of earlier sexual initiation, a greater number of partners, and less contraceptive use, WSW are at higher risk of teenage pregnancy than are teenagers who only have sex with the opposite gender.¹

HEALTH DISPARITIES FOR TRANSGENDER YOUTH

Challenges faced by such youth and the potential of family and societal disapproval increase the risk that transgender adolescents will experience mental health issues, substance abuse, and sexual risk taking behaviors. Transgender people face alarmingly high rates of verbal harassment and physical violence, including at home and at school.¹ Transgender youth face significant mental health issues as a consequence, including depression and suicidality, anxiety, body image distortion, substance abuse, and posttraumatic stress dis-

order. Supportive families can buffer an adolescent from these negative outcomes and promote positive health and well being.⁸

MTF transgender youth face even more sexual health disparities than other sexual minority youth, with very high rates of HIV and other STIs.⁴¹ There were higher rates of STIs and HIV in African American and Hispanic, compared with white, transgender individuals.^{42,43} Contributing factors included history of incarceration, homelessness, exchanging sex for resources, non consensual sex, and difficulty accessing health care. Many had injected liquid silicone in their lifetime, with some sharing needles for hormone or silicone injection. Transgender individuals who purchase or obtain transgender hormones on the street or from the Internet may cause significant health problems if used improperly, even if they are pure.²³

PROMOTING SEXUAL HEALTH FOR LGBTQ YOUTH

Pediatricians and their office staff should encourage teenagers to feel comfortable talking with them about their emerging sexual identities and concerns about their sexual activities. Care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about the teenager's sexual identity or behavior; doing so could expose the youth to harm.⁴⁴

Pediatricians' use of gender neutral terms can encourage teenagers to discuss any questions they have about their sexual behaviors or sexual orientation.¹⁹ Table 2 in the technical report offers suggestions for gender neutral questions.⁴⁵ Confidentiality must be emphasized.¹⁹

Teenagers who are abstinent should have their abstinence acknowledged and reinforced.¹⁹ If the adolescent notes that they have engaged in sex-

ual activity, 1 classic question is "Are you having sex with males, females, or both?"⁴⁶ Table 3 in the technical report offers some additional suggestions for asking about specific sexual behaviors.

STI/HIV TESTING AND PREVENTION

Recent guidelines from the CDC recommend assessing for STI risk including asking about the gender of all partners. Pediatricians should then make decisions about STI testing on the basis of the sexual behaviors identified by the sexual history.⁴⁷ Adolescents who have not engaged in high risk sex should be tested once per year. However, adolescents with multiple or anonymous partners, having unprotected intercourse, or having substance abuse issues should be tested at shorter intervals.⁴⁷ Specific STI screening recommendations for MSM are described in Table 4 in the technical report. Because of the increased incidence of anal cancer in HIV infected MSM, screening for anal cytologic abnormalities has been proposed.⁴⁸ Condoms should be encouraged for all insertive/receptive sexual activities.⁴⁷ WSW are at risk of acquiring bacterial, viral, and protozoan infections from current and previous partners, both male and female. STD treatment guidelines from the CDC recommend a frank discussion of sexual behavioral risk so that the physician can make decisions about which STI tests to perform. Additionally, because many WSW have also had sex with men, HPV vaccine and routine cervical cancer screening should be offered to women according to recommended guidelines. Condoms for sex toys and dental dam for oral vaginal contact should be emphasized.⁴⁷

The CDC recommends routine immunization of males and females 11 or 12 years of age with HPV 4; catch up

immunization is recommended for WSW and MSM through 26 years of age.^{47,49,50} HPV 2 has been approved for females 8 through 25 years of age.⁵¹

Because many teenagers who self identify as LGBTQ may have sexual encounters that may not be predicted by their orientation, conversation about highly effective birth control methods and emergency contraception is important.^{11,12}

TREATMENT OF TRANSGENDER YOUTH

See the technical report for additional details on the medical and surgical transition of transgender youth. Supportive counseling is paramount to assist the teenager with any dysphoria and to explore gender roles before altering the body. The therapy consists of potentially delaying puberty with gonadotropin releasing hormone analogs, then use of hormonal therapy, and finally surgery.⁵

ASSISTING PARENTS

Another critically important role of the pediatrician is to assist parents of sexual minority youth. Pediatricians should acknowledge the parents' feelings but should provide information and support for the adolescent who has disclosed. Parents' reactions and attitudes may adjust over time, and the pediatrician should check in regularly and offer support to the entire family. Please see Table 5 in the technical report for resources to assist sexual minority youth and their parents and families.

RECOMMENDATIONS

- Pediatricians' offices should be teen friendly and welcoming to all adolescents, regardless of sexual orientation and behavior; this includes training all office staff and ensuring that office forms do

not presume heterosexuality of patients (or parents).

- If a pediatrician does not feel competent to provide specialized care for sexual minority teenagers and their families, he or she has the responsibility to evaluate families and then refer for medically appropriate care.
- Pediatricians who provide care to sexual minority youth should follow prevention and screening guidelines as outlined in *Bright Futures*.¹⁹
- All adolescents should have a confidential adolescent psychosocial history. Verbal histories and/or written questionnaires should use a gender neutral approach. Screening and referral for depression, suicidality, other mood disorders, substance abuse, and eating disorders should be included.
- LGBTQ adolescents and MSM and WSW should have sexual behaviors and risks assessed and should be provided STI/HIV testing according to recommendations in the most recent sexually transmitted diseases treatment guidelines from the CDC.
- Contraception, including use of emergency contraceptives, should be offered to women regardless of their stated sexual orientation, and the importance of consistent condom/dental dam use should be discussed.
- Strengths, resources, and risks should be assessed, and targeted behavioral interventions should be implemented to allow the adolescent to maximize strengths and acknowledge and minimize risky behaviors.
- Pediatricians should be available to answer questions, to correct misinformation, and to provide the context that being LGBTQ is normal, just different.

- Transgender adolescents need to be supported and affirmed; they need education and referral for the process of transition and about avoiding the pitfalls of using treatments that were not prescribed by a licensed physician.
- Pediatricians should support parents in working through adjustment issues related to having a child who is LGBTQ while continuing to demonstrate love and support for their children.
- Pediatricians should support or create gay straight alliances at schools and support the development and enforcement of zero tolerance policies for homophobic teasing, bullying, harassment, and violence.
- Pediatricians should educate themselves about organizations that serve sexual minority youth and families in local communities and national organizations with information, support Web sites, and hotlines.

LEAD AUTHOR

David A. Levine, MD

COMMITTEE ON ADOLESCENCE, 2012–2013

Paula K. Braverman, MD, Chairperson
 William P. Adelman, MD
 Cora C. Breuner, MD, MPH
 David A. Levine, MD
 Arik V. Marcell, MD, MPH
 Pamela J. Murray, MD, MPH
 Rebecca F. O'Brien, MD, MD

LIAISONS

Loretta E. Gavin, PhD, MPH *Centers for Disease Control and Prevention*
 Rachel J. Miller, MD *American College of Obstetricians and Gynecologists*
 Jorge L. Pinzon, MD *Canadian Pediatric Society*
 Benjamin Shain, MD, PhD *American Academy of Child and Adolescent Psychiatry*

STAFF

Karen S. Smith
 James Baumberger

REFERENCES

1. Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011
2. Spigarelli MG. Adolescent sexual orientation. *Adolesc Med State Art Rev*. 2007;18(3): 508-518, vii
3. Glover JA, Galliher RV, Lamere TG. Identity development and exploration among sexual minority adolescents: examination of a multidimensional model. *J Homosex*. 2009;56(1):77-101
4. Frankowski BL; American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. *Pediatrics*. 2004;113(6):1827-1832
5. World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Minneapolis, MN: World Professional Association for Transgender Health; 2011. Available at: www.wpath.org. Accessed June 11, 2012
6. Wallien MS, Cohen Kettenis PT. Psychosexual outcome of gender dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008; 47(12):1413-1423
7. Zucker K, Bradley S. Gender identity and psychosexual disorders. *Focus*. 2005;3(4): 598-617
8. Olson J, Forbes C, Belzer M. Management of the transgender adolescent. *Arch Pediatr Adolesc Med*. 2011;165(2):171-176
9. Hembree WC, Cohen Kettenis P, Delemarre van de Waal HA, et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94(9):3132-3154
10. Igartua K, Thombs BD, Burgos G, Montoro R. Concordance and discrepancy in sexual identity, attraction, and behavior among adolescents. *J Adolesc Health*. 2009;45(6): 602-608
11. Herrick AL, Matthews AK, Garofalo R. Health risk behaviors in an urban sample of young women who have sex with women. *J Lesbian Stud*. 2010;14(1):80-92
12. Goodenow C, Szalacha LA, Robin LE, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *Am J Public Health*. 2008;98(6):1051-1058
13. Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001-1014
14. Walls NE. Toward a multidimensional understanding of heterosexism: the changing nature of prejudice. *J Homosex*. 2008;55(1): 20-70
15. Chesir Teran D, Hughes D. Heterosexism in high school and victimization among lesbian, gay, bisexual, and questioning students. *J Youth Adolesc*. 2009;38(7):963-975
16. McDermott E, Roen K, Scourfield J. Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Cult Health Sex*. 2008;10(8):815-829
17. Kann L, Olsen EO, McManus T, et al; Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health risk behaviors among students in grades 9-12: youth risk behavior surveillance, selected sites, United States, 2001-2009. *MMWR Surveill Summ*. 2011;60(7):1-133
18. Saewyc EM, Homma Y, Skay CL, Bearinger LH, Resnick MD, Reis E. Protective factors in the lives of bisexual adolescents in North America. *Am J Public Health*. 2009;99(1): 110-117
19. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
20. Kipke MD, Kubicek K, Weiss G, et al. The health and health behaviors of young men who have sex with men. *J Adolesc Health*. 2007;40(4):342-350
21. Coker TR, Austin SB, Schuster MA. Health and healthcare for lesbian, gay, bisexual, and transgender youth: reducing disparities through research, education, and practice. *J Adolesc Health*. 2009;45(3):213-215
22. Physicians for Reproductive Choice and Health. *Gay, Lesbian, Bisexual, Transgender, and Questioning Youth*. 4th ed. New York, NY: The Adolescent Reproductive and Sexual Health Education Program; 2011. Available at: www.prch.org/arshep. Accessed June 13, 2012
23. Berg MB, Mimiaga MJ, Safren SA. Mental health concerns of gay and bisexual men seeking mental health services. *J Homosex*. 2008;54(3):293-306
24. Silenzio VM, Pena JB, Duberstein PR, Cerel J, Knox KL. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *Am J Public Health*. 2007;97(11): 2017-2019
25. Walls NE, Freedenthal S, Wisneski H. Suicidal ideation and attempts among sexual minority youths receiving social services. *Soc Work*. 2008;53(1):21-29
26. D'Augelli AR, Grossman AH, Salter NP, Vasey JJ, Starks MT, Sinclair KO. Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide Life Threat Behav*. 2005;35(6):646-660
27. Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39(5):662-668
28. Kelley TM, Robertson RA. Relational aggression and victimization in gay male relationships: the role of internalized homophobia. *Aggress Behav*. 2008;34(5):475-485
29. Consortium of Higher Education LGBT Resource Professionals. Press release. Syracuse, NY: Consortium of Higher Education LGBT Resource Professionals; October 4, 2004. Available at: www.lgbtcampus.org/about/news/2010/10/04/deaths. Accessed June 13, 2012
30. Lampinen TM, Chan K, Anema A, et al. Incidence of and risk factors for sexual orientation related physical assault among young men who have sex with men. *Am J Public Health*. 2008;98(6):1028-1035
31. Herek GM, Sims C. Sexual orientation and violence victimization: hate crimes and intimate partner violence among gay and bisexual men in the US. In: Wolitski RJ, Stall R, Valdiserri RO, eds. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the US*. New York, NY: Oxford University Press; 2008:35-71
32. D'Augelli AR. High tobacco use among lesbian, gay, and bisexual youth: mounting evidence about a hidden population's health risk behavior. *Arch Pediatr Adolesc Med*. 2004;158(4):309-310
33. Ridner SL, Frost K, Lajoie AS. Health information and risk behaviors among lesbian, gay, and bisexual college students. *J Am Acad Nurse Pract*. 2006;18(8):374-378
34. Parsons JT, Kelly BC, Weiser JD. Initiation into methamphetamine use for young gay and bisexual men. *Drug Alcohol Depend*. 2007;90(2-3):135-144
35. Benson PA, Hergenroeder AC. Bacterial sexually transmitted infections in gay, lesbian, and bisexual adolescents: medical and public health perspectives. *Semin Pediatr Infect Dis*. 2005;16(3):181-191

36. Kipke MD, Weiss G, Wong CF. Residential status as a risk factor for drug use and HIV risk among young men who have sex with men. *AIDS Behav*. 2007;11(suppl 6):56-69
37. Rudy ET, Shoptaw S, Lazzar M, Bolan RK, Tilekar SD, Kerndt PR. Methamphetamine use and other club drug use differ in relation to HIV status and risk behavior among gay and bisexual men. *Sex Transm Dis*. 2009;36(11):693-695
38. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001–2006. *MMWR Morb Mortal Wkly Rep*. 2008;57(25):681-686
39. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis*. 1981;8(2):75-76
40. Lindley LL, Barnett CL, Brandt HM, Hardin JW, Burcin M. STDs among sexually active female college students: does sexual orientation make a difference? *Perspect Sex Reprod Health*. 2008;40(4):212-217
41. Clements Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health*. 2001;91(6):915-921
42. Nuttbrock L, Hwahng S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*. 2009;52(3):417-421
43. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *J Adolesc Health*. 2006;38(3):230-236
44. Perrin E. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic; 2002
45. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64-90
46. Kaiser Permanente National Diversity Council. *A Provider's Handbook on Culturally Competent Care*. 2nd ed. Oakland, CA: Kaiser Foundation Health Plan Inc; 2004
47. Workowski KA, Berman SM; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR 12):1-110
48. Ho KS, Cranston RD. Anal cytology screening in HIV positive men who have sex with men: what's new and what's now? *Curr Opin Infect Dis*. 2010;23(1):21-25
49. Centers for Disease Control and Prevention. FDA licensure of quadrivalent human papillomavirus vaccine (HPV4, Gardasil) for use in males and guidance from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):630-632
50. Centers for Disease Control and Prevention. Recommendations on the use of quadrivalent human papillomavirus vaccine in males. Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR Morb Mortal Wkly Rep*. 2011;60(50):1705-1708
51. Centers for Disease Control and Prevention. FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):626-629

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132;198

DOI: 10.1542/peds.2013-1282 originally published online June 24, 2013;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/132/1/198
References	This article cites 43 articles, 1 of which you can access for free at: http://pediatrics.aappublications.org/content/132/1/198.full#ref-list-1
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Current Policy http://classic.pediatrics.aappublications.org/cgi/collection/current_policy Committee on Adolescence http://classic.pediatrics.aappublications.org/cgi/collection/committee_on_adolescence Adolescent Health/Medicine http://classic.pediatrics.aappublications.org/cgi/collection/adolescent_health:medicine_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: https://shop.aap.org/licensing-permissions/
Reprints	Information about ordering reprints can be found online: http://classic.pediatrics.aappublications.org/content/reprints

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since . Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: .

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132;198

DOI: 10.1542/peds.2013-1282 originally published online June 24, 2013;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/132/1/198>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since . Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: .

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



EXHIBIT 4



TECHNICAL REPORT

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine, MD, and the COMMITTEE ON ADOLESCENCE

KEY WORDS

sexual orientation, sexual identity, sexual behaviors, adolescents, sexual minority, homosexuality, gay, lesbian, bisexual, transgender

ABBREVIATIONS

CDC Centers for Disease Control and Prevention
FTM females transitioning to males
GnRH gonadotropin releasing hormone
HPV human papillomavirus
HSV herpes simplex virus
IOM Institute of Medicine
LGBTQ lesbian, gay, bisexual, transgender, and questioning
MSM men who have sex with men
MTF males transitioning to females
STI sexually transmitted infection
WSW women who have sex with women
YRBS Youth Risk Behavior Surveillance

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

www.pediatrics.org/cgi/doi/10.1542/peds.2013.1283

doi:10.1542/peds.2013.1283

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

(Continued on last page)

abstract

FREE

The American Academy of Pediatrics issued its last statement on homosexuality and adolescents in 2004. This technical report reflects the rapidly expanding medical and psychosocial literature about sexual minority youth. Pediatricians should be aware that some youth in their care may have concerns or questions about their sexual orientation or that of siblings, friends, parents, relatives, or others and should provide factual, current, nonjudgmental information in a confidential manner. Although most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are quite resilient and emerge from adolescence as healthy adults, the effects of homophobia and heterosexism can contribute to increased mental health issues for sexual minority youth. LGBTQ and MSM/WSW (men having sex with men and women having sex with women) adolescents, in comparison with heterosexual adolescents, have higher rates of depression and suicidal ideation, higher rates of substance abuse, and more risky sexual behaviors. Obtaining a comprehensive, confidential, developmentally appropriate adolescent psychosocial history allows for the discovery of strengths and assets as well as risks. Pediatricians should have offices that are teen friendly and welcoming to sexual minority youth. This includes having supportive, engaging office staff members who ensure that there are no barriers to care. For transgender youth, pediatricians should provide the opportunity to acknowledge and affirm their feelings of gender dysphoria and desires to transition to the opposite gender. Referral of transgender youth to a qualified mental health professional is critical to assist with the dysphoria, to educate them, and to assess their readiness for transition. With appropriate assistance and care, sexual minority youth should live healthy, productive lives while transitioning through adolescence and young adulthood. *Pediatrics* 2013;132:e297 e313

INTRODUCTION

The American Academy of Pediatrics issued its first statement on sexual minority teens in 1983, with revisions in 1993 and 2004. Since the last report, research areas have rapidly expanded and hundreds of new publications have been produced about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. In 2011, the Institute of Medicine (IOM) published "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding."¹

The comprehensive IOM publication includes a section on childhood and adolescence. This updated clinical report provides definitions and the best information available about the demographics of this group of adolescents. Being a member of this group of teens is not, in itself, a risk behavior; nor should sexual minority youth be considered abnormal. However, the presence of stigma reflected in the terms “homophobia” and “heterosexism” often leads to psychological distress, which may be accompanied by an increase in risk behaviors. “Homophobia” refers to an irrational fear and resulting hatred of homosexual individuals. “Heterosexism” is the societal expectation that heterosexuality is the expected norm and that, somehow, LGBTQ individuals are abnormal. Although limited, studies on the resilience of sexual minority youth will be discussed. Studies specifically focused on the disparities in the health of these teens in mental health, substance abuse, and sexuality will be presented, along with new research about emerging effective individual and community health strategies for reducing risks. Finally, issues in providing clinical care and modifying patient care approaches will be discussed.

Although most LGBTQ youth are quite resilient and emerge from adolescence relatively unscathed, the health disparities of this vulnerable population can be significant and often daunting for pediatricians or other health care providers who are assisting youth in their care. For this report, the term LGBTQ will be used whenever discussing studies and recommendations for all lesbian, gay, bisexual, transgender youth. Some of the studies discussed did not include questioning youth for these, the term LGBT (lesbian, gay, bisexual, and transgender) will be used. Because

many adolescents do not define themselves as a member of a sexual minority group, assisting teens who are men having sex with men (MSM) and women having sex with women (WSW) will also be discussed. Some of the studies in this clinical report reference self-identified LGBTQ individuals, and others reference only sexual behavior (MSM and WSW). For this report, the term “sexual minority” includes LGBTQ and MSM/WSW individuals.

DEFINITIONS

Adolescence is characterized as a time of rapid physical, emotional, and sexual change, during which sexual discovery, exploration, and experimentation are part of the process of incorporating sexuality into one's own identity. Adolescents solidify their gender identification and expression by observing the gender roles of their parents and adults, siblings, peers, and others. Typically, a young person's sexual orientation emerges before or early in adolescence.^{2,3} In the previous American Academy of Pediatrics clinical report on sexual minority youth published in June 2004, sexual orientation was referred to as “an individual's pattern of physical and emotional arousal toward other persons.” In strict definition, individuals who self-identify as heterosexual are attracted to people of the opposite gender; homosexual individuals self-identify as attracted to people of the same gender; bisexual teens report attraction to people of both genders.⁴ As noted in later sections, sexuality is much more complex than these classic definitions. Most self-identified gay and lesbian individuals have had sex with the opposite gender, and some continue to do so. Many heterosexuals have had sex with the same gender, yet self-identify as heterosexual.¹ In common usage, self-identified

homosexual people are often referred to as “gay” if male, and “lesbian” if female.⁴ Many adolescents struggle with their sexual attractions and identity formation, and some may be referred to as “questioning.”² Many individuals also resist definition; when reporting same gender sexual behavior, these individuals are referred to as MSM or WSW.¹

Gender identity and gender expression usually conform to anatomic and chromosomal sex or “natal” sex for both homosexual and heterosexual teens. Gender identity is knowledge of one's self as being male or female, whereas gender expression is an outward expression of being male or female. For transgender individuals, their gender or identity does not match their natal sex. Gender nonconforming (or variant) refers to people who do not follow other people's ideas about how they should act according to gender roles. They may or may not be distressed from the nonconformity.⁵ Gender dysphoria refers to dislike or distress about one's own gender and about the outward manifestations of gender (eg, hair style, clothing, sports, toys). Children often begin to express this dysphoria in the preschool period. Many young children with gender dysphoria will resolve their dysphoria by adolescence, but others will maintain it. It is difficult to predict, however, whether a young child with gender dysphoria will be transgender as a teenager or adult. Thus, it is best to help families to manage this uncertainty and make it clear in the family that all options remain acceptable and available as the child grows up.^{2,6}

Transgender people may be heterosexual, homosexual, or bisexual.⁷ Transgender people are often also identified by the natal gender and transition to the desired gender; MTF

refers to males transitioning to females and FTM are females transitioning to males. Transgender people may or may not desire to alter their body to match their perceived gender. When people have undergone hormonal and/or surgical alteration, they are often referred to as “trans sexual.” Gender dysphoria refers to the emotional distress of having a gender identity that is different from natal sex.^{1,5,7} In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, there was also a set of diagnostic criteria for “gender identity disorder,” but critics have noted that this “pathologizes” the issue for the patient. In the forthcoming *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, there will be continued diagnostic criteria for gender dysphoria, but “gender identity disorder” will probably be eliminated.^{8,9} “Transition” is defined as the process and time when a person goes from living as one gender to living as the other.^{7,10,11}

As a society, our culture assumes that individuals who self identify a sexual identity will have sexual behaviors that remain consistent with that identity. It is assumed that men or women who self identify as gay or lesbian will only have attractions to or sexual activity with the same gender. However, the paradigm of sexuality is much more complex, according to qualitative studies in sexual minority youth. Sexual attraction is a term that is easy for all youth to understand. In contrast, for a measure describing sexual orientation using the choices heterosexual, bisexual, gay/lesbian, or unsure, most teens preferred the answers “mostly heterosexual” and “mostly homosexual.”¹² This range of sexuality may be reflected in the surprising rate of teen pregnancies experienced by women who report having sex with women. WSW have reported lower rates of

contraceptive use than do women having sex with men.^{13,14}

Many adolescents who self report as lesbian will still occasionally have sex with males, and many males who self report as gay may have sex with females; thus, behaviors do not always equal identity.^{1,15} Some men who have sex with men (MSM) or women who have sex with women (WSW) actively resist being identified as gay or lesbian. And some individuals who are not yet sexually experienced already self identify as gay, lesbian, or bisexual.² Questioning adolescents struggle with sexuality issues more than others, and their sexual behaviors may be diverse. Studies examining how questioning adolescents resolve their inner struggles and reach a stable sexual identity are ongoing.¹⁶ Definitions are summarized in Table 1.

GENDER IDENTITY FORMATION

Awareness of gender identity happens very early in life. Between ages 1 and 2 years, children become conscious of physical differences between the 2 sexes. By age 3, children can identify themselves as a boy or a girl, and, by age 4, gender identity is stable. In middle

childhood, gender identification continues to become more firmly established, reflected in children’s interests in playing more exclusively with youngsters of their own gender and also in their interest in acting like, looking like, and having things like their same sex peers. Occasionally, a child may seem to display gender role confusion. More than just lacking an interest in what society defines as traditionally masculine activities, some boys actually tend to identify with females and/or feminine traits. Likewise, some girls identify more with males and/or masculine traits. Conflicted about their gender, they may come to dislike that part of themselves that is a boy or a girl.^{5,11,17} Many children resolve their dysphoria by the time they complete adolescence. Others will continue to feel dysphoria and may seek treatment to transition to the opposite gender.¹ The etiology of transgender is unknown and likely quite complex.¹⁰

HETEROSEXISM, HOMOPHOBIA, AND IDENTITY FORMATION

Although overt homophobia may damage the emerging self image of an LGBTQ adolescent, often, heterosexism

TABLE 1 Definitions

Term	Definition
Homophobia	An irrational fear and resulting hatred of homosexual individuals
Heterosexism	The societal expectation that heterosexuality is the expected normal
MSM	Men having sex with men
WSW	Women having sex with women
Gender identity	Knowledge of one’s self as male or female
Gender expression	Outward expression of being male or female
Gender nonconforming	Does not follow society’s ideas about how they should act according to gender roles
Natal sex	Chromosomal and anatomic gender
Transition	Process and time when a person goes from living as one gender to living as the other
MTF	Male transitioning to female
FTM	Female transitioning to male
Conversion or reparative therapy	Attempts to “convert” the individual to heterosexual
Survival sex	Engaging in sexual intercourse in exchange for shelter, food, or money; often includes high risk or unprotected sexuality

is more insidious and damaging. Homophobia refers to an irrational fear and resulting hatred of homosexuality and homosexual individuals. Pervasive in our culture, homophobia is institutionalized in stereotypes promoted in the media and in casual conversation.¹⁸ Heterosexism is the societal expectation that heterosexuality is the expected norm and that somehow LGBTQ teens are “abnormal.” Although it is often easy for the majority of sexual minority youth to hide their sexuality from family and friends, nondisclosure may ultimately be damaging to adolescents’ developing self image.^{19,20} Homophobia perceived by LGBTQ youth may lead to self destructive behaviors.²¹ Societal homophobia is reflected in the higher rates of bullying and violence suffered by sexual minority youth.²² Many sexuality education curricula taught in schools limit discussion to “abstinence only” until heterosexual marriage.” This expected standard may serve to further isolate and alienate many sexual minority youth and contributes to increased risks of personal violence, mental health issues, substance abuse, and risky sexual behaviors.^{19,23 25}

With proper support and guidance, the majority of LGBTQ youth emerge as adults with sexual identities that are associated with little or no significant increase in risk behaviors compared with other youth. These resilient young adults lead happy, productive lives.²⁶ Pediatricians have a role in helping teenagers sort through their feelings and behaviors. Young people need information about healthy, positive expressions of sexuality, and pediatricians should assist adolescents as they develop their identities and to avoid the consequences of unwanted pregnancy and sexually transmitted infections (STIs), regardless of sexual orientation.²⁷ Research suggests that LGBTQ youth really value these

opportunities for discussions with their pediatricians or primary health care providers.²⁸ The role of the pediatrician is further described in the section “Making the Office Teen Friendly for Sexual Minority Youth.”

There may be several barriers for pediatricians in working with LGBTQ youth. Until recently, there was not a focus on LGBTQ issues in medical education. The Association of American Medical Colleges has recently begun to develop additional resources for medical educators to use in implementing curricular reform on this topic.²⁹ The Joint Commission also recently published a comprehensive guidebook for hospital organizations.³⁰ Although confidentiality is recommended for all adolescents, there may be inadvertent breaches related to electronic health record access and insurers that send explanations of benefit information to parents.

Parental and other adult reactions to “coming out” vary, and often, adolescents and their families will also need support from their pediatrician during this process. Parents play a critical role in support of development for their sexual minority children. The IOM report noted that “parental support either partially or fully mediated associations related to suicidal thoughts, recent drug use, and depressive symptomatology.”³¹ Negative parental reactions were also associated with higher rates of risk behaviors.^{1,31} Parent support organizations, such as Parents, Families and Friends of Lesbians and Gays (www.pflag.org), can provide essential resources for parents.

NATIONAL STATISTICS

There are inherent difficulties in obtaining accurate data about sexual minority youth. Virtually all of the available information is self report data on survey instruments; sample

bias and general limitations of self reported data limit accuracy.³² Although some adolescents are comfortable enough to reveal their sexuality on these instruments, many may not trust that their information will truly be protected. It may take some time for an adolescent to come to an understanding of his/her sexual identity before it is possible to label or describe it or discuss it with others. Some of the best data about the number of gay or lesbian teenagers are state or city specific. Some states and communities have added questions to the Centers for Disease Control and Prevention’s (CDC’s) Youth Risk Behavior Surveillance (YRBS) System: at the time of this writing, Minnesota,³³ Vermont,³⁴ Massachusetts,³⁵ and New York City³⁶ have added these questions. More nationally representative data are found in the few recent national studies available.

In the 2006 2008 National Survey of Family Growth, 13.4% of females and 4.0% of males 15 to 24 years of age self reported that they had sex with someone of the same gender.³⁷ This number is much larger than those who would describe themselves as gay, lesbian, or bisexual. Among participants in the Growing Up Today Study, a US community based longitudinal cohort study in 9039 female and 7843 male children recruited at 9 to 14 years of age whose mothers were participating in the Nurses’ Health Study II, 16.3% of females and 8.7% of males reported a sexual orientation other than heterosexual.³⁸ In wave 1 of the National Longitudinal Study of Adolescent Health administered to students in grades 7 through 12, same gender relationships or attractions were reported in 7% of girls and 8.4% of boys.³⁹ Recently, the CDC combined data from several YRBS survey administrations studying behaviors among 9th through 12th grade sexual minority youth in the states that inquired about

sexual identity and the gender of sexual contacts. Seven states (Delaware, Maine, Massachusetts, Rhode Island, Vermont, Connecticut, and Wisconsin) and 6 large urban school districts (Boston, Chicago, Milwaukee, New York, San Diego, and San Francisco) elected to participate and used questions offered by the CDC. Across the 12 sites that assessed gender of sexual contacts, 53.5% reported having had sex with the opposite gender, 2.5% reported having had sex with the same gender, 3.3% reported having had sexual contact with both genders, and 40.5% reported having had no sexual contact.²²

Estimation of the prevalence of gender identity disorder and transgender youth is more difficult because of the lack of population based studies. The World Professional Association for Transgender Health published their seventh version of Standards of Care in 2011. Acknowledging the difficulty in obtaining true prevalence data, the World Professional Association for Transgender Health estimated prevalences of 1 in 11 900 to 1 in 45 000 for MTF youth and 1 in 30 400 to 1 in 200 000 for FTM youth.⁵ Because most studies have been performed in services providing transition care, population based studies are needed to capture the hidden populations not accessing such care.¹⁰

HEALTH DISPARITIES FOR GAY, LESBIAN, AND BISEXUAL YOUTH

Stigmatization, ostracism, and parental rejection remain common. Resulting struggles with self image and self esteem often put sexual minority youth at risk. Depression and other mental health issues may be manifest as these teens struggle with developing a stable self identity and family/community acceptance.^{13,40,41} As many as 25% to 40% of homeless youth may be LGBTQ or MSM/WSW, leading to

additional risk taking behaviors. Many sexual minority youth become homeless as a consequence of coming out to their families. After coming out or being discovered, many LGBTQ youth have been thrown out of their homes or mistreated, leading to runaway status and homelessness. Unfortunately, sexual minority youth who are homeless may engage in survival sex, leading to riskier behaviors and contributing to health disparities.⁴²

Mental Health Disparities

Significant health disparities exist for sexual minority youth related to depression and suicidality, substance abuse, social anxiety, altered body image, and other mental health issues.^{1,18,22,43} Data from the 2007 Washington, DC, administration of the YRBS survey revealed that 40% of sexual minority youth, compared with 26% of heterosexual youth, reported feeling sad or hopeless in the past 2 weeks. LGBTQ youth were more than twice as likely to have considered suicide in the past year (31% vs 14%).¹⁸ This increased risk has been extensively replicated in other studies and communities.^{1,22,44,45} Even for these teens, however, protective factors come into play. Data from the 2004 Minnesota Student Survey of 9th and 12th graders, in which 2255 respondents reported a same gender romantic or sexual experience, revealed that more than half of LGBTQ students had thought about suicide, and 37.4% had reported a suicide attempt. In this study, the factors that were significantly protective against suicidal ideation and attempts included family connectedness, caring adults, and school safety.⁴⁶ Another study found that suicide attempts among sexual minority youth were positively correlated with parental psychological abuse of the child, being considered gender atypical in childhood by parents, and parental efforts to discourage gender atypical

behavior.⁴⁷ Sexual minority teens who run away or are put out by their families after acknowledging their sexuality are often victimized, which leads to further mental health issues. Homeless LGBTQ teens are more likely than heterosexual teens to meet criteria for each of 4 mental disorders: major depressive disorder, posttraumatic stress disorder, substance abuse, and conduct disorder.⁴⁸

Social anxiety symptoms are experienced more often by LGBTQ adolescents. In a study in 100 young gay men in a 3 state area of the US East Coast, it was discovered that social anxiety predicted an increased probability of having engaged in unprotected anal intercourse in the previous 6 months.⁴⁹ Another study comparing 87 heterosexual and gay male undergraduates at the State University of New York at Stony Brook found that gay men reported greater fear of negative evaluation, greater social interaction anxiety, and lower self esteem than did heterosexual men.⁵⁰

Unfortunately, an additional barrier to care for LGBTQ (and other) adolescents may be a lack of mental health services in certain communities or mental health services that are not adolescent or sexual minority friendly. Services for adolescents in poverty may be even more limited.⁵¹ In no situation is a referral for conversion or reparative therapy indicated. An American Psychological Association task force to review peer reviewed studies on efforts to change sexual orientation concluded that conversion therapy is not effective and may be harmful to LGBT individuals by increasing internalized stigma, distress, and depression.¹

Bullying and Victimization

When sexual minority teens "come out" and acknowledge their sexuality as adolescents, there are often significant

repercussions, especially victimization.^{1,4,22,23,25} Even if not open about sexuality, 16% of MSM reported experiencing violence. Sometimes it is simply the perception that an individual might be LGBT that may lead to bullying, harassment, and violence.⁵² LGBTQ and MSM individuals report that the violence directed toward them is because of perceived sexual orientation or femininity.⁵³ When sexual minority youth are victimized, the physical assault may lead to death (homicide). Victimized LGBTQ, MSM, and WSW youth may experience increased mental health disorders including depression, sometimes leading to death by suicide. There is a strong association between victimization and suicidality among sexual minority adolescents recruited from gay youth community or university based organizations.⁵⁴

Bullying at school with resultant adolescent suicide has received increased national attention.⁵⁵ Of adolescents who are open about their LGBTQ sexual orientation, 84% reported verbal harassment; 30% reported being punched, kicked, or injured; and 28% dropped out of school because of harassment. The Consortium of Higher Education LGBT Resource Professions published a press release in October 2010 documenting the violence, injuries, and in some cases, deaths of LGBTQ adolescents.⁵⁶ The study of pooled CDC data from the 2001-2009 administrations of the YRBS survey to examine risk behaviors faced by sexual minority youth included questions on being victims of threats or violence. In the 9 communities that included relevant questions, sexual minority youth were more likely than heterosexual youth to be in a physical fight, to be injured in a fight, to be threatened on school grounds, and to stay home from school because of perceived risk of violence.²² Positive, supportive school environments, those with zero or at least low

tolerance for homophobic teasing, bullying, or abuse, were recently shown to be protective, with significantly lower rates of depression and suicidality for sexual minority youth.²⁵ Supporting the development of policies in school districts that limit teasing and bullying is an important role of the pediatrician. The US Department of Health and Human Services recently has increased antibullying efforts, and among other initiatives, has launched a new Web site, <http://www.StopBullying.gov>, which includes a specific section for sexual minority youth.⁵⁷

Unfortunately, schools are not the only source of homophobic/heterosexist bullying. Although less research has focused on nonschool settings, LGBT youth experience victimization in their homes, communities, and other institutions.¹ Even after the repeal of the "Don't ask, don't tell" policy, there continues to be victimization in the military.⁵⁸ Although many churches are offering education to their members about the issue of bullying in general, some churches continue to bully sexual minority youth.⁵⁹ "Cyberbullying," or bullying with electronic means (eg, Internet, texting), is rampant; 32% of all teens say they have been targeted in some form.⁶⁰ In 1 study, 52% of LGBT adolescents noted they had been cyberbullied in the past 30 days.⁶¹

Eating Disorders

Although 10% to 15% of all cases of eating disorders are in men, as many as 42% of young men affected may be gay or bisexual.⁶² Male sexual minority youth demonstrated more binge eating and purging than did male heterosexual youth.^{63,64} The IOM report acknowledged these findings but noted that they were from small studies and that additional research is necessary.¹ There also may be an association with eating disorders in transgender MTF individuals, but more research is necessary.⁶⁵

Substance Abuse

With the psychosocial and anxiety provoking stressors of homophobia and heterosexism, the enticement and escape of getting high may be addictive and can lead to increasing use of substances. The pooled YRBS study combining 2001-2009 data revealed significantly higher rates of current alcohol use in the past 30 days in self-identified sexual minority youth (bisexual, 55.6%; gay/lesbian, 47.5%; questioning, 35.1%; and heterosexual, 37.6%). For current use of marijuana, the rates were 36.8% among bisexual youth, 34.5% among gay/lesbian youth, 25.4% among questioning youth, and 21.8% among heterosexual youth. More striking differences were observed among youth for the following: (1) current cocaine use (gay/lesbian, 16.6%; bisexual, 11%; questioning, 11.4%; and heterosexual, 1.8%), (2) ever having used ecstasy (gay/lesbian, 22.9%; bisexual, 20.4%; questioning, 11.4%; and heterosexual, 4.6%), (3) ever having used heroin (gay/lesbian, 17.7%; bisexual, 9.6%; questioning, 13%; and heterosexual, 1.8%), and (4) ever having used methamphetamine (gay/lesbian, 21.5%; bisexual, 14.9%; questioning, 13.2%; and heterosexual, 3.4%).²² Because this study combined the data for MSM and WSW and included information only from the 7 states and 6 school districts that volunteered to ask more sexuality questions, the data may not be as nationally representative. Tobacco use is also overrepresented among gay and lesbian youth.^{1,66-69} Research into best practices to prevent and reduce tobacco use in sexual minority youth is underway.⁷⁰⁻⁷² The Young Men's Survey, from 1994 to 1998, was the first study that was considered to have a nationally representative sample of substance using young MSM. The sample was from 7 major cities, with young men 15 to 22 years of age. The primary objective

was to improve access to HIV testing in a high risk population. In the study, 93% had used alcohol, 71% had used marijuana, 31% had used cocaine, 28% had used methamphetamine, and 27% had used ecstasy.⁷³ A more recent study from 2007 attempted to assess the substance abuse rates for MSM 18 to 22 years of age in Los Angeles. Ninety percent of the sample reported use of alcohol (including 21% who had engaged in binge drinking), 64% reported use of marijuana, 23% reported use of cocaine, 20% reported use of methamphetamine, and 21% reported use of ecstasy. The comparison group used was the national sample from the 2006 Monitoring the Future Study (sexual minority and heterosexual youth combined), in which 75% reported alcohol use, 45% reported marijuana use, 8% reported cocaine use, 5% reported methamphetamine use, and 5% reported ecstasy use. Rates of crack cocaine and heroin use were low in both study groups.⁷⁴

Many studies have examined substance use by gay men, but fewer studies have explored WSW or lesbian youth's and young adults' substance use. WSW at a Midwestern university were 4.9 times more likely to smoke, 10.7 times more likely to drink, and 4.9 times as likely to smoke marijuana compared with women having sex with men.⁷⁵

Use of club drugs (eg, cocaine, methamphetamine, and ecstasy, along with GHB [γ hydroxybutyric acid], ketamine, and LSD [lysergic acid diethylamide] or "acid") is especially a health concern because of the association with other risk behaviors, including unprotected sexual intercourse. Initiation of young MSM into methamphetamine use seems to occur in social, not specifically sexual, settings, with users admitting to limited knowledge of its adverse effects and consequences.⁷⁶ Sexual minority youth who "party and play" (PNP) advertise

every day on Web sites that attract LGBTQ youth and young adults. When young men attend gay clubs and other gay oriented activities, their risk of alcohol and marijuana use increases. Interventions designed to address safety and responsible behaviors in these venues for young MSM need to be developed, implemented, and evaluated.⁷⁷

Sexual and Reproductive Health Disparities

Significant health disparities exist in sexual health outcomes with respect to HIV/AIDS, other STIs, and teen pregnancy among LGBTQ youth. As mentioned previously, sexual minority youth do not necessarily engage in sexual behaviors that are predicted by their orientation. In the CDC's pooled YRBS study, although 1.3% identified themselves as gay or lesbian, 2.5% reported having intercourse with the same gender only and 3.3% reported having sex with both genders.²²

Regarding sexual behavior, the YRBS pooled data study found that sexual minority youth were more likely than heterosexual youth to report having had intercourse, to have had intercourse before 13 years of age, and to have had intercourse with ≥ 4 people. Gay or lesbian youth were about half as likely as heterosexual youth (35.8% vs 65.5%) to have used a condom at the last intercourse.²² In a study in young gay men in college, even after adjusting for age, race, academic classification, and residence, gay men reported higher odds of inconsistent condom use, increased numbers of multiple partners in the past 30 days, and increased risk of illicit drug use than did their heterosexual peers.⁷⁸ Between 27% and 48% of young MSM have engaged in unprotected anal intercourse in the previous 6 months.⁴² Involvement in these behaviors may explain, in part, why during the past

15 years, reported rates of gonorrhea, chlamydia, and syphilis have trended downward for all adolescents, except for MSM.⁷⁹ Substance abusing gay or lesbian teens may also have more risky sexual behaviors, leading to higher rates of HIV seropositivity.^{80,81}

One particular disparity is in HIV infection. The IOM report notes that "the burden of HIV infection among young people falls disproportionately on young men under 25 who have sex with men, particularly those who belong to racial/ethnic minority groups."¹ Data from the CDC reveal that HIV rates continue to increase among young MSM 13 to 24 years of age. For all men, HIV rates between 2001 and 2006 increased by 9%, whereas rates for young MSM (13 to 24 years of age) increased by 12.4% and rates for young black MSM increased by 14.9%. In the age range of 13 to 24 years, MSM of all ethnicities accounted for 60% of the total HIV infections.⁸² Despite these alarming data, the IOM report noted that there has been no commensurate response to develop interventions to decrease this risk. The vast majority of published reports on HIV prevention programs focus on heterosexual adolescents and young adults.¹

Information on sexual health disparities experienced by WSW is limited; until recently, little research was devoted to lesbian health and many, including physicians, incorrectly assumed that lesbians were at minimal risk of STIs.⁸³ As noted, many WSW have also had intercourse with men.¹ High rates of STIs have been documented in lesbians and bisexual women with recent sexual contact with men. Viral infections, such as human papillomavirus (HPV) and herpes simplex virus infection (HSV), may be transmitted via exclusive female to female sexual contact. In a study in bisexual and lesbian college women, 9% of those who had had sex with both men and women

reported that they had had an STI, but 2% of women who exclusively had sex with women also reported that they had had an STI.⁸⁴

LGBTQ youth are less likely to report use of hormonal or barrier contraceptives at last sexual encounter when having sex with the opposite gender. Young women who identified themselves as “unsure” of their sexual orientation were half as likely to report using contraception at last intercourse.⁴² Given the high rates of earlier sexual initiation, a greater number of partners, and less contraceptive use, WSW are at higher risk of teen pregnancy than are teens who only have sex with the opposite gender. In the 1999 Minnesota Adolescent Health Survey, lesbian and bisexual women, when compared with heterosexual youth, were found to be about as likely to have had vaginal intercourse (33% vs 29%) but had twice the rate of pregnancy (12% vs 6%) and were more likely to have had ≥ 2 pregnancies (23.5% vs. 9.8%). In a small study in 137 young women having sex with women (ages 16 to 24 years), 20% reported having had been pregnant.¹

WSW and MSM report high rates of physical and sexual abuse.^{85,86} In 1 study, the rate was 19% to 22%.⁸⁷ Consequences for sexual minority youth who have experienced physical or sexual abuse include higher rates of intimate partner violence as adults,⁸⁶ frequent drug use and higher risk sex,⁸⁸ and higher rates of HIV.⁸⁹ Homeless sexual minority youth are more likely to report histories of physical and sexual abuse and report engaging in risky sexual behaviors as survival strategies.⁴⁸ Childhood sexual abuse does not cause children to become LGBTQ.⁹⁰

Health Disparities for Transgender Youth

National data detailing the scope of medical, mental health, and substance

abuse issues for transgender youth are lacking. Like other sexual minority youth, self-identifying as transgender does not necessarily indicate the existence of other mental health issues.⁹¹ However, challenges faced by such youth and the potential of family and societal disapproval may increase the risk that transgender adolescents will experience mental health issues, substance abuse, and sexual risk taking behaviors.¹ Family rejection, peer rejection, harassment, trauma, abuse, legal problems, educational problems, and resulting poverty and homelessness are faced by transgender youth and adults. Transgender people face alarmingly high rates of verbal harassment and physical violence, including at home and at school.¹ Transgender youth face significant mental health issues as a consequence, including depression and suicidality, anxiety, body image distortion, substance abuse, and post-traumatic stress disorder. As with all teens, supportive families can buffer an adolescent from these negative outcomes and promote positive health and well being.¹⁰

MTF transgender youth face even more sexual health disparities than other sexual minority youth, with very high rates of HIV and other STIs. One study by the Department of Public Health in San Francisco revealed that HIV prevalence among MTF transgender individuals was 38% (the rate for FTM transgender individuals was much lower, at 2%). Risk factors for HIV infection among MTF transgender individuals in this study included African American race, attaining low education status, having a history of injection drug use, and reporting multiple sexual partners.⁹² Another study addressing racial disparity in MTF transgender individuals in New York revealed higher rates of STIs and HIV in African American and Hispanic, compared with white, individuals. The higher STI rates

in the study were associated with more lifetime partners, having engaged in commercial sex, unemployment, and injection drug use.⁹³ An HIV risk study examined 51 transgender MTF ethnic minority adolescents and young adults 16 to 25 years of age in Chicago and found that 22% were HIV positive. Contributing factors included history of incarceration (37%), homelessness (18%), exchanging sex for resources (59%), nonconsensual sex (52%), and difficulty accessing health care (41%). Among HIV positive MTF transgender individuals, 98% reported having had sex with men, including unprotected receptive anal intercourse (49%). The study also noted that 53% had had sex while under the influence of drugs or alcohol and 8% had used injection drugs. Twenty nine percent had injected liquid silicone (as part of their MTF transition) in their lifetime; 8% had shared needles for hormone or silicone injection, increasing HIV transmission risk. For transgender individuals who purchase or obtain transgenic hormones (estrogen or testosterone) on the street or from the Internet, there may be significant health problems if used improperly, even if they are pure.⁹⁴

THE RESILIENCE OF LGBTQ YOUTH

Even with the unique challenges faced by sexual minority youth, the majority grow up healthy and lead happy, productive lives. Research is now beginning to analyze the patterns of resilience in LGBTQ youth. A qualitative study in gay male youth 16 to 22 years of age noted that “general developmental dysfunction is not inevitable for gay adolescents, nor is identifiable personal or family pathology directly related to sexual identity.”⁹⁵ Similar to other studies in adolescents, another study found that family connectedness, school connectedness, and religious involvement were protective factors, leading to fewer risk behaviors.²⁶

Several studies have confirmed that a supportive family network, supportive teachers, and access to gay straight student alliances at school were all significantly protective.^{96,97}

HEALTH CARE FOR SEXUAL MINORITY YOUTH

Pediatricians have the responsibility to provide culturally effective care to help reduce health disparities. Such care should be individualized and meet the needs of the patient regardless of social, educational, or cultural background. This requires an understanding of a patient's ethnic group, neighborhood group, family identification, and religious affiliation.⁹⁸ Understanding sexual orientation, behavior, and gender identity is another part of this process.

Being gay, lesbian, bisexual, transgender, or questioning, is not a "problem" or "risk behavior" in itself. These teens, like all teens, should be individually assessed for challenges, vulnerabilities, strengths, and assets. Positive behaviors should be reinforced; teens can be engaged in targeted behavioral interventions to reduce existing risk behaviors. As noted in *Bright Futures*,²⁷ it is part of the responsibility of the pediatrician to help adolescents identify their strengths and build on their existing talents. Pediatricians and their office staff can encourage teenagers to feel comfortable to talk to them about their emerging sexual identity and concerns about their sexual activities. On the other hand, it is not the role of pediatricians to identify a young person as being gay, or lesbian, unless the teenager has chosen to discuss this. Care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about the teenager's sexual identity or behavior; doing so could expose the youth to harm.⁹⁸

Making the Office Teen-Friendly for Sexual Minority Youth

One of the challenges to health care is removing barriers to care and creating an environment welcoming all teens. Even LGBTQ youth who are open about their sexuality may not feel comfortable disclosing sexuality to their pediatrician. In a study in 131 sexual minority youth attending an empowerment conference, only 35% reported that their physician knew that they were lesbian, gay, or bisexual.⁹⁹ LGBTQ adolescents who are hiding their sexuality become quite adept at using gender neutral terms to describe their relationships and sexual behaviors. Pediatricians' use of gender neutral terms can encourage teenagers to discuss any questions they have about their sexual behaviors or sexual orientation.²⁷ Table 2 offers suggestions for gender neutral questions a pediatrician can use as components of the psychosocial interview.¹⁰⁰ Although pediatricians may use gender neutral items in obtaining histories, some teens may still choose not to disclose or may delay doing so until a subsequent visit.¹⁰¹

It is just as important that the pediatrician's office staff is nonjudgmental and welcoming. Internalized homophobia and heterosexism in the office setting may not be recognized by staff members but will inadvertently interfere with appropriate care. A nurse asking a teenage girl who is in a relationship with another woman about her boyfriend may be interpreted as nonaccepting of her relationship. This negative interaction may then hinder the health care provider's ability to form a trusting relationship.^{98,102} Likewise, intake forms and questionnaires should not assume heterosexuality. Another advantage of altering intake forms is to be welcoming to parents who are in same sex relationships. As for all adolescents, confidentiality

should be ensured. An environment that respects the confidentiality of each client is critical for a facility that provides care for MSM/WSW and LGBTQ youth. Confidentiality must be emphasized at all levels of the clinic staff; many offices and teen clinics have developed a clinic confidentiality policy statement that should be shared with the patient and his or her identified caregiver. Parents should not have access to protected information without the adolescent's consent.^{27,28} Current electronic health records may need to be modified to protect adolescents' confidentiality.

The office environment can be made welcoming for all teens by placing in the waiting room items such as brochures on a variety of adolescent topics, including sexual orientation, posters showing both same and opposite gender couples, and notices about support groups, if available in the region.¹⁰³ Brochures and information left in the privacy of the examination room may be more likely to be picked up by adolescent patients who are not open about their sexuality. If there are no local support groups, Web sites can be suggested so that the sexual minority adolescent does not feel isolated.⁴² Even a small "rainbow" button (often a symbol of acceptance of sexual minority individuals) or decal on an office bulletin board or door symbolizes openness and acceptance of diverse sexual orientation and will be appreciated by sexual minority teens and their parents.⁹⁸

Sexuality and Obtaining a Sexual History

For pediatricians to offer optimal clinical care, it is crucial to promote healthy sexuality, even if the teen is not sexually active. Creating an accepting environment will optimize opportunities to learn about a youth's sexual

behaviors. Teens who are abstinent should have their abstinence acknowledged and reinforced as a preferred method of prevention for both STIs and unwanted pregnancies.²⁷ If the adolescent notes that he or she has engaged in sexual activity, 1 classic question is “Are you having sex with males, females, or both?” For adolescents who are not yet sexually active, inquiring “Are you attracted to males, females, or both” will allow for discussions to prevent sexual risk behaviors. If the pediatrician gets an unusual response from the adolescent, a bridging statement such as “Many teenagers your age have sex with members of the opposite or the same sex” can facilitate communication.¹⁰¹ It may be difficult for some teenagers to answer these questions if they have not yet established trust in the pediatrician. Previous negative experiences in health care or in internalized shame as a result of societal homophobia/heterosexism may cause some teenagers to not disclose their sexual orientation or same gender sexual activity. Sexual minority adolescents also may not trust that their confidential information will truly be kept confidential from their parents/guardians or others. It has been shown that it is easier for some teens to reveal sensitive information (eg, sexual behavior and sexual orientation) before face to face visits with the pediatrician.¹⁰⁴ The most comfortable method is on a computer, and the next best is on a paper questionnaire.¹⁰⁵ Once a teen has acknowledged on a previsit form that he or she has a question about sexual activity or sexual identity, it is the responsibility of the pediatrician to introduce a conversation during the subsequent interview. Often, sexuality is disclosed at a future visit after the pediatrician has built a trusting relationship with the patient.

TABLE 2 Using Gender Neutral Terms in the Psychosocial History

Heterosexist Question	Instead Ask
“Do you have a girlfriend?”	“Are you dating anybody?” “Are you involved any romantic relationship?”
“What do you and your boyfriend do together?”	“What do the 2 of you do together?” “Tell me about your partner.”
“Are you and your girlfriend sexually active?”	“Are you having sex?” “Are the 2 of you in a sexual relationship?”

Sexual practices are not dissimilar for heterosexual and lesbian, gay, or bisexual or MSM/WSW teens. Many heterosexual youth engage in oral intercourse, and some engage in anal intercourse.¹⁰⁶ Table 3 offers some suggestions for asking about specific sexual behaviors.

Once sexual history is obtained, in the context of the remainder of the psychosocial history, then specific health promotion activities can be encouraged. Use of substances, depression, and other mental health disorders place youth at higher sexual risk because of lack of ability to make good decisions regarding use of condoms or contraception, and these issues should be addressed.¹⁰⁷ Using a strength and asset based approach and encouraging positive youth development is an effective way to reduce risks in all teenagers, including sexual minority youth.^{27,108} Frankowski et al’s¹⁰⁹ “Strength Based Interviewing” is a method that can be applied to all adolescents and young adults.

Pediatricians also may assist sexual minority youth in coming out to their parents/families on the patient’s own terms and timetable. This includes offering supportive suggestions and counseling and providing resources to assist the patient and family.⁴²

STI/HIV Testing and Prevention Recommendations for Sexual Minority Youth

Recent guidelines from the CDC recommend assessing for STI risk, which includes asking about the gender of all partners. Pediatricians should then

TABLE 3 Sexual History Questions About Sexual Behaviors

- Have you ever had sex? What have you done sexually with a partner?
- Have you ever had oral sex? Has a partner ever “gone down” on you or have you ever “gone down” on a partner?
- Have you ever had vaginal sex? Have you ever engaged in penile vaginal sex?
- Have you ever had anal sex? Did you put your penis in your partner’s anus or did your partner put his penis in your anus?
- *If there was any insertive or receptive sex:* Do you use condoms? What percentage of the time? What about last time?
- *If there was any oral genital contact:* Do you use dental dam or another barrier? What percentage of the time? What about last time?

make decisions about STI testing on the basis of the sexual behaviors identified by the sexual history.¹¹⁰ Similar to other populations of adolescents, if adolescents are having protected intercourse (monogamous relationship, using condoms 100% of the time and correctly, and no substance abuse involved), it is reasonable to test them once per year. However, adolescents with multiple or anonymous partners, having unprotected intercourse, or having substance abuse issues or any other risk factors should be tested at shorter intervals.¹¹⁰ Condoms should be promoted for all sexual activities that involve insertive or receptive intercourse. STI screening recommendations for MSM are described in Table 4.

A growing number of experts recommend testing for HSV (by serology) if infection status is unknown. Because of the increased incidence of anal cancer in HIV infected MSM, screening

for anal cytologic abnormalities has been proposed.^{110,111} An Atlanta study investigated cytologic screening results from HIV positive patients, and the authors found highly significant rates of anal dysplasia (47%).¹¹² However, evidence is limited concerning the natural history of anal intraepithelial neoplasia, the reliability of screening methods, and the safety and response to treatments.¹¹⁰ WSW are at risk of acquiring bacterial, viral, and protozoan infections from current and previous partners, both male and female. STD treatment guidelines from the CDC recommend a frank discussion of sexual identity and behavioral risk so that the physician can make decisions about which STI tests to perform. Digital vaginal and digital anal contact, especially with shared insertive devices, can transmit cervicovaginal secretions. Skin to skin or skin to mucosa transmission of HPV can occur. Additionally, because many WSW have also had sex with men, HPV vaccine and routine cervical cancer screening should be offered to women according to recommended guidelines. Limited data show inefficient transmission of HSV 2; however, the relatively frequent practice of orogenital sex may increase the risk of HSV 1. Bacterial vaginosis is common among women in general and even more so among WSW. Chlamydia and syphilis transmission may have been more common than previously thought; STD treatment guidelines from the CDC endorse targeted testing on the basis of sexual history. Reports by young women of sex with someone of the same gender should not deter pediatricians from screening them for STIs because of the possibility of a past history of sexual contact with male partners. Condoms should be promoted if using sex toys and dental dam should be promoted for any oral vaginal or oral anal contact.¹¹⁰

TABLE 4 Summary of Sexually Transmitted Diseases Screening Guidelines for MSM

- HIV serology, if HIV negative or not tested within the previous year
- Syphilis serology
- Test for urethral infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* using NAATs in men who have had insertive anal intercourse during the preceding year
- Test for rectal infection with *N gonorrhoeae* and *C trachomatis* in men who have had receptive anal intercourse during the preceding year, using either preferred NAATs (for laboratories that have met regulatory requirements for an off label procedure) or culture for *N gonorrhoeae* and enzyme immunoassay or direct fluorescent antibody assay for *C trachomatis*
- Test for pharyngeal infection with *N gonorrhoeae* in men who have acknowledged practicing receptive oral intercourse during the preceding year using NAATs (for those laboratories that have met regulatory requirements for an off label procedure) or culture; testing for *C trachomatis* pharyngeal infection is not recommended⁹⁸

NAAT, nucleic acid amplification test

In 2011, the CDC expanded its recommendations for the quadrivalent HPV vaccine (HPV 4 [Gardasil, Merck Sharp & Dohme Corp, Whitehouse Station, NJ]). The CDC recommends routine immunization of males and females 11 or 12 years of age with HPV 4, administered as a 3 dose series. The immunization series may be started as early as 9 years of age, and if not started at 11 or 12 years of age catch up immunization is recommended for females 12 through 26 years of age and males at 13 through 21 years of age. HPV 4 is recommended in males for the prevention of genital warts and precancerous/dysplastic lesions of the anus caused by the 4 strains in the vaccine (6, 11, 16, and 18). HPV 4 was noted to be 78% effective at preventing anal intraepithelial neoplasia from strains 16 and 18 in males. Ninety percent of all anal cancer is caused by HPV. For females, HPV 4 is recommended for prevention of genital warts and precancerous/dysplastic lesions of the cervix, vagina, vulva, and anus caused by the 4

strains contained in the vaccine. For MSM, the CDC recommends routine immunization through 26 years of age.^{110,113 115} Bivalent HPV vaccine (HPV 2 [Cervarix, GlaxoSmithKline, Middlesex, United Kingdom]) has been approved for the prevention of cervical cancer and precancerous/dysplastic lesions of the cervix caused by HPV types 16 and 18 in females 8 through 25 years of age and may be offered. There are no special recommendations for sexual minority adolescents and young adults.¹¹⁶

The 2010 STD treatment guidelines from the CDC also recommend that all MSM should be tested for hepatitis B by testing blood for hepatitis B surface antigen.¹¹⁰ This test may not need to be performed, however, if the pediatrician has clear evidence that the adolescent has received all doses of the hepatitis B vaccine. If not already immunized against hepatitis B or hepatitis A, all MSM should receive these vaccines. Hepatitis C testing should be conducted if the patient is a current or past drug user or if HIV infected.¹¹⁷

Because many teens who self identify as gay, lesbian, or bisexual may have sexual encounters that may not be predicted by their orientation, conversation about birth control is important.^{13,14} Emergency contraception should also be discussed. Emergency contraception is available over the counter if the patient is older than 17 years. A prescription may be required for a patient younger than 17 years; additional requirements vary by state.¹¹⁷

Treatment of Transgender Youth

In 2009, the Endocrine Society published “Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline.”¹¹ This was a refinement of the 2001 publication of The World Professional Association for Transgender Health’s Standards of

Care, which was updated in 2011.⁵ These documents integrate the best available evidence with clinical experience from experts in the field of assisting transgender patients with transition. The guidelines were further refined by Olson et al¹⁰ in a subsequent publication on the basis of clinical experiences with a large number of transgender patients in Los Angeles. These publications discuss the importance of psychological treatment approaches. The mental health professional is called on to accurately diagnose gender dysphoria and any comorbid conditions, to counsel about the range of treatment options, to ascertain readiness for hormone and surgical therapy, to make formal recommendations to medical and surgical colleagues as part of the team of care, to educate the patient and family, and to provide follow up. The skilled therapist will use affirming strategies: affirming the adolescent's sense of self, allowing for exploration of gender and self definition, and conveying the message that it is "entirely acceptable to be whoever you turn out to be." It is recommended that all transgender adolescents be involved in psychological therapy, even those who are functioning well, to ensure that they have the necessary support they need and a safe place to explore identities and consider the transitioning experience.^{5,10,11}

Classifications for the process of gender transition include reversible, partially reversible, and irreversible phases. Reversible transition includes the adoption of outward gender expression: wearing preferred clothing, adopting preferred hairstyles, and perhaps acquiring a new name. The use of gonadatropin releasing hormone (GnRH) analogs is also part of the reversible stage. The Endocrine Society guidelines state, "suppression of pubertal hormones starts when girls and boys first exhibit physical

changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively) but no earlier than Tanner stages 2-3." Suppression is similar to the treatment of precocious puberty. In general, it is recommended that transgender adolescents be maintained on suppressive GnRH analogs until they are emotionally and cognitively ready for cross gender sex hormones.^{10,11} The rationale for using GnRH analogs early (at sexual maturity rating 2) and then waiting to begin hormonal therapy is so that MTF adolescents experience desired outcomes. However, as noted from 1 large center treating transgender youth, they commonly present at older ages with pubertal development too far advanced for suppressive therapy. The average age of presentation at this center was 14.8 years, with an average sexual maturity rating of 4.1.¹¹⁸ Waiting too long may result in male voice pitch, laryngeal prominences, and facial hair pattern, which precludes the option of pubertal suppressive therapy.^{10,11,118}

The partially reversible treatment phase involves the use of cross gender hormone therapies. The Endocrine Society guidelines state that "pubertal development of the desired opposite gender be initiated at about the age of 16 years, using a gradually increasing dose schedule of cross sex steroids."¹¹ Olson's group follows these guidelines but may choose to provide therapy earlier after careful review of the risks and benefits with the youth and parents.¹⁰ It is recommended that cross gender hormone therapy begin after assessment of readiness by a medical professional, including a careful review of any hormone contraindications, and by the mental health professional who documents psychological readiness. For FTM patients, testosterone is used. For MTF patients, estrogen is used, sometimes in combination with

an androgen inhibitor, such as spironolactone.^{10,11,118}

Adolescents undergoing partially reversible cross gender hormone therapy should be monitored for progress in transition and for any potential medical complications. MTF patients started on estrogen might develop deep venous thrombosis, prolactinomas, hypertension, liver disease, and decreased libido and are at increased risk of breast cancer. Spironolactone can lead to hyperkalemia and decreased blood pressure. FTM patients receiving testosterone may develop hyperlipidemia, polycythemia, male pattern baldness, acne, and other significant side effects.^{10,11}

Irreversible therapy occurs during the surgical phase, with many different procedures now available to create a more masculine or feminine appearance. The Endocrine Society guidelines and the World Professional Association for Transgender Health's Standards of Care recommend deferring surgery until an individual is at least 18 years of age.^{5,11}

There are many barriers to transgender adolescents receiving desired medical therapies. It is difficult for transgender youth and their families to find comprehensive medical and mental health services. Pediatricians may not feel comfortable or knowledgeable enough to assist transition plans in transgender youth, in which case they should refer to another physician with experience or expertise around gender nonconformity. Most insurance companies do not pay for this care, and the use of GnRH analogs is quite expensive. Medical treatments are neither standardized nor approved by the Food and Drug Administration, although they are increasingly supported by medical literature.¹¹ Consent is another obstacle, and only Illinois' and West Virginia's state statutes can be interpreted favorably for transgender

adolescents to be able to consent for care.¹²⁰

Injectable medical grade silicone gel and oil have been used by physicians for soft tissue augmentation.¹²¹ Many transgender adolescents who do not have parental support or who are homeless have injected themselves or others with impure, nonmedical silicone, with significant health consequences. In the Chicago study in ethnic minority transgender youth, the authors found that 29% had injected silicone and 8% had shared needles, half of which were obtained on the street or via the Internet.⁹⁴ Injected industrial (nonmedical) silicones or medical silicones used incorrectly have been shown to cause multiorgan dysfunction,¹²² silicone pulmonary embolization,¹²³ and death.¹²⁴

ASSISTING PARENTS OF SEXUAL MINORITY YOUTH

Another critically important role of the pediatrician is to assist parents of sexual minority youth. Some parents have emotional reactions related to societal homophobia and may have extreme difficulty accepting their LGBT teens. Others mourn the loss of the image of the adolescent that they had before the disclosure. Pediatricians should acknowledge the parents' feelings but should provide information and support for the adolescent who has disclosed. Parents' reactions and attitudes may adjust over time and the pediatrician should check in regularly and offer support to the entire family. Organizations like Parents, Families and Friends of Lesbians and Gays (<http://www.pflag.org>) or Gay Family Support (<http://www.gayfamilysupport.com>) provide valuable resources for discussion. Lead with Love is another excellent resource that includes a film for viewing and discussion (<http://leadwithlovefilm.com>). For sexual minority youth who have been bullied or

victimized, the It Gets Better Project may assist parents and families (<http://www.itgetsbetter.org/>).

RESOURCES FOR SEXUAL MINORITY YOUTH

Pediatricians' knowledge about national and local resources to assist sexual minority youth is critical to provide LGBTQ patients and their families guidance and support as they progress through adolescence into young adulthood. Nonprofit organizations, such as the United Way in some communities, are a great place to start, as are adult LGBTQ and sexual health advocacy organizations. Table 5 provides selected Web sites of LGBTQ serving organizations and

resources for sexual minority youth, their families, and communities.

SUMMARY

Pediatricians and other health care providers already have many of the skills needed to provide culturally effective, developmentally appropriate care for sexual minority youth. LGBTQ teens/young adults and MSM/WSW are an underserved population, many of whom struggle with acceptance of their sexuality at the same time that they are managing the other rigors of adolescence. The adolescent psychosocial history will allow for discovery of any high risk behaviors, and targeted behavioral interventions may be developed with the adolescent.

TABLE 5 LGBTQ Support and Advocacy Organizations

-
- The Gay, Lesbian, and Straight Education Network mission is "Every student deserves a safe space" (<http://www.glsen.org>).
 - Parents, Families, and Friends of Lesbians and Gays (PFLAG) is a long standing support and advocacy organization (<http://community.pflag.org>).
 - The National Youth Advocacy Coalition (NYAC) is a social justice organization that advocates for and with young people who are lesbian, gay, bisexual, transgender, or questioning in an effort to end discrimination against these youth and to ensure their physical and emotional well being (<http://www.nyacyouth.org>).
 - The Trevor Project (<http://www.thetrevorproject.org>) operates the only nationwide, around the clock crisis and suicide prevention hotline for sexual minority youth (866 4 U TREVOR).
 - Youth Resource is a Web site created by and for LGBTQ young people. Sponsored by Advocates for Youth, Youth Resource takes a holistic approach to sexual health and exploring issues of concern to LGBTQ youth, by providing information and offering support on sexual and reproductive health issues through education and advocacy (<http://www.amplifyyourvoice.org/youthresource>).
 - For patients, communities, and health care professionals, the Gay and Lesbian Medical Association (<http://glma.org>) has referral and information resources.
 - TransKids Purple Rainbow is a foundation that advocates and organizes events on behalf of transgender children (<http://www.transkidspurpleinrainbow.org>).
 - The World Professional Association for Transgender Health, Inc (WPATH). Formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc, WPATH is a professional organization devoted to the understanding and treatment of gender identity disorders (<http://www.wpath.org>).
 - Transfamily provides support and education for transgender people, their families, friends, and significant others. The group is associated with PFLAG to bring awareness to school systems, through their principals and counselors, by offering literature, speakers, consultation, and support (<http://www.transfamily.org>).
 - Family Acceptance Project (Marian Wright Education Institute Resource for LGBTQ youth and families) (<http://familyproject.sfsu.edu>)
 - Other resources are available on the Adolescent Reproductive and Sexual Health Education Project Web site at the end of the presentations, "Gay, Lesbian, Bisexual, Transgender, and Questioning Youth" and "Caring for Transgender Adolescent Patients" found at <http://www.ph.org/ARSHEP>. These presentations are also outstanding for both self education and for use in training current and future medical professionals.
-

Referrals for mental health and substance abuse treatment may be warranted. Pediatricians have an obligation to ensure that sexual minority youth have access to a full range of appropriate health care services. As with all adolescents and young adults, sexual minority youth need honest answers and compassion in dealing with issues and questions around sexual orientation, identity, and sexual behaviors.

LEAD AUTHOR

David A. Levine, MD

COMMITTEE ON ADOLESCENCE, 2012–2013

Paula K. Braverman, MD, Chairperson
William P. Adelman, MD
Cora C. Breuner, MD, MPH
David A. Levine, MD
Arik V. Marcell, MD, MPH
Pamela J. Murray, MD, MPH
Rebecca F. O'Brien, MD, MD

LIAISONS

Loretta E. Gavin, PhD, MPH *Centers for Disease Control and Prevention*
Rachel J. Miller, MD *American College of Obstetricians and Gynecologists*
Jorge L. Pinzon, MD *Canadian Pediatric Society*
Benjamin Shain, MD, PhD *American Academy of Child and Adolescent Psychiatry*

STAFF

Karen S. Smith
James Baumberger

REFERENCES

- Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011
- Spigarelli MG. Adolescent sexual orientation. *Adolesc Med State Art Rev*. 2007;18(3):508–518, vii
- Glover JA, Galliher RV, Lamere TG. Identity development and exploration among sexual minority adolescents: examination of a multidimensional model. *J Homosex*. 2009;56(1):77–101
- Frankowski BL; American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. *Pediatrics*. 2004;113(6):1827–1832
- World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Minneapolis, MN: World Professional Association for Transgender Health; 2011. Available at: www.wpath.org. Accessed June 11, 2012
- Wallien MS, Cohen Kettner PT. Psychosexual outcome of gender dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008;47(12):1413–1423
- Zucker K, Bradley S. Gender identity and psychosexual disorders. *J Lifelong Learn Psychiatry*. 2005;3(4):598–617
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, text revision. Washington, DC: American Psychiatric Association; 2000
- Sexual and Gender Disorders Work Group for American Psychiatric Association DSM 5 Development. 2011. Available at: www.dsm5.org/ProposedRevision/Pages/GenderDysphoria.aspx. Accessed June 11, 2012
- Olson J, Forbes C, Belzer M. Management of the transgender adolescent. *Arch Pediatr Adolesc Med*. 2011;165(2):171–176
- Hembree WC, Cohen Kettner P, Delemarre van de Waal HA, et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94(9):3132–3154
- Austin SB, Conron K, Patel A, Freedner N. Making sense of sexual orientation measures: findings from a cognitive processing study with adolescents on health survey questions. *J LGBT Health Res*. 2007;3(1):55–65
- Herrick AL, Matthews AK, Garofalo R. Health risk behaviors in an urban sample of young women who have sex with women. *J Lesbian Stud*. 2010;14(1):80–92
- Goodenow C, Szalacha LA, Robin LE, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *Am J Public Health*. 2008;98(6):1051–1058
- Igartua K, Thombs BD, Burgos G, Montoro R. Concordance and discrepancy in sexual identity, attraction, and behavior among adolescents. *J Adolesc Health*. 2009;45(6):602–608
- Wilson BD, Harper GW, Hidalgo MA, Jamil OB, Torres RS, Fernandez MI; Adolescent Medicine Trials Network for HIV/AIDS Interventions. Negotiating dominant masculinity ideology: strategies used by gay, bisexual and questioning male adolescents. *Am J Community Psychol*. 2010;45(1–2):169–185
- American Academy of Pediatrics. Gender identity and gender confusion in children. Elk Grove Village, IL: American Academy of Pediatrics; 2010. Available at: www.healthychildren.org/English/ages_stages/gradeschool/Pages/GenderIdentityandGenderConfusionInChildren.aspx. Accessed June 11, 2012
- Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001–1014
- Walls NE. Toward a multidimensional understanding of heterosexism: the changing nature of prejudice. *J Homosex*. 2008;55(1):20–70
- Chesir Teran D, Hughes D. Heterosexism in high school and victimization among lesbian, gay, bisexual, and questioning students. *J Youth Adolesc*. 2009;38(7):963–975
- McDermott E, Roen K, Scourfield J. Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Cult Health Sex*. 2008;10(8):815–829
- Kann L, Olsen EO, McManus T, et al; Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health risk behaviors among students in grades 9–12 youth risk behavior surveillance, selected sites, United States, 2001–2009. *MMWR Surveill Summ*. 2011;60(7):1–133
- Kelley TM, Robertson RA. Relational aggression and victimization in gay male relationships: the role of internalized homophobia. *Aggress Behav*. 2008;34(5):475–485
- Friedman MS, Marshal MP, Stall R, Cheong J, Wright ER. Gay-related development, early abuse and adult health outcomes among gay males. *AIDS Behav*. 2008;12(6):891–902
- Birkett M, Espelage DL, Koenig B. LGBT and questioning students in schools: the

- moderating effects of homophobic bullying and school climate on negative outcomes. *J Youth Adolesc.* 2009;38(7):989-1000
26. Saewyc EM, Honna Y, Skay CL, Bearinger LH, Resnick MD, Reis E. Protective factors in the lives of bisexual adolescents in North America. *Am J Public Health.* 2009;99(1):110-117
27. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
28. Hoffman ND, Freeman K, Swann S. Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *J Adolesc Health.* 2009;45(3):222-229
29. American Association of Medical Colleges. Diversity policy and programs: who we are, what we do, where we're going. Washington, DC: American Association of Medical Colleges; 2011. Available at: https://www.aamc.org/download/266998/data/dpp_briefing_book_2011.pdf. Accessed June 11, 2012
30. The Joint Commission. Advancing effective communication, cultural competence, and patient and family centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: a field guide. Oakbrook Terrace, IL: 2011. Available at: www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf. Accessed June 11, 2012
31. Bouris A, Guilamo Ramos V, Pickard A, et al. A systematic review of parental influences on the health and well being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda. *J Prim Prev.* 2010;31(5-6):273-309
32. Bauhoff S. Systematic self-report bias in health data: impact on estimating cross-sectional and treatment effects. *Health Serv Outcomes Res Methodol.* 2011;11(1-2):44-53
33. Anfinson A, ed. 2007 Minnesota Student Survey statewide tables. Minnesota Student Survey Interagency Team. Roseville, MN: Minnesota Department of Education; 2007. Available at: <http://education.state.mn.us/mdeprod/idcplg?IdcService=GETFILE&RevisionSelectionMethod=latestReleased&Rendition=primary&dDocName=042114>. Accessed June 11, 2012
34. Moffat S, Cate R. *The 2007 Vermont Youth Risk Behavior Survey.* Burlington, VT: Vermont Department of Health, Division of Health Surveillance; 2007
35. Massachusetts Department of Elementary and Secondary Education, Massachusetts Department of Public Health. Massachusetts high school students and sexual orientation: results of the 2007 Youth Risk Behavior Survey. Malden, MA: Massachusetts Department of Elementary and Secondary Education; 2008. Available at: www.mass.gov/cgly/yrebs07.pdf. Accessed June 13, 2012
36. Pathela P, Schilling JA. Sexual behaviors and sexual violence: adolescents with opposite, same, or both sex partners. *Pediatrics.* 2010;126(5):879-886
37. Chandra A, Mosher WD, Copen C, Sionean C. Sexual behavior, sexual attraction, and sexual identity in the United States: data from the 2006-2008 National Survey of Family Growth. *Natl Health Stat Rep.* 2011; Mar 3(36):1-36
38. Corliss HL, Rosario M, Wypij D, Fisher LB, Austin SB. Sexual orientation disparities in longitudinal alcohol use patterns among adolescents: findings from the Growing Up Today Study. *Arch Pediatr Adolesc Med.* 2008;162(11):1071-1078
39. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a national study. *Am J Public Health.* 2001;91(8):1276-1281
40. Kipke MD, Kubicek K, Weiss G, et al. The health and health behaviors of young men who have sex with men. *J Adolesc Health.* 2007;40(4):342-350
41. Coker TR, Austin SB, Schuster MA. Health and healthcare for lesbian, gay, bisexual, and transgender youth: reducing disparities through research, education, and practice. *J Adolesc Health.* 2009;45(3):213-215
42. Physicians for Reproductive Choice and Health. Gay, lesbian, bisexual, transgender, and questioning youth. 4th ed. New York, NY: The Adolescent Reproductive and Sexual Health Education Program; 2011. Available at: www.prch.org/arshep. Accessed June 13, 2012
43. Berg MB, Mimiaga MJ, Safren SA. Mental health concerns of gay and bisexual men seeking mental health services. *J Homosex.* 2008;54(3):293-306
44. Silenzio VM, Pena JB, Duberstein PR, Cerel J, Knox KL. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *Am J Public Health.* 2007;97(11):2017-2019
45. Walls NE, Freedenthal S, Wisneski H. Suicidal ideation and attempts among sexual minority youths receiving social services. *Soc Work.* 2008;53(1):21-29
46. Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health.* 2006;39(5):662-668
47. D'Augelli AR, Grossman AH, Salter NP, Vasey JJ, Starks MT, Sinclair KO. Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide Life Threat Behav.* 2005;35(6):646-660
48. Whitbeck LB, Chen X, Hoyt DR, Tyler KA, Johnson KD. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and run away adolescents. *J Sex Res.* 2004;41(4):329-342
49. Hart TA, Heimberg RG. Social anxiety as a risk factor for unprotected intercourse among gay and bisexual male youth. *AIDS Behav.* 2005;9(4):505-512
50. Pachankis JE, Goldfried MR. Social anxiety in young gay men. *J Anxiety Disord.* 2006;20(8):996-1015
51. Schwartz SW. Adolescent mental health in the United States. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University; 2009. Available at: http://nccp.org/publications/pdf/text_878.pdf. Accessed June 13, 2012
52. Lampinen TM, Chan K, Anema A, et al. Incidence of and risk factors for sexual orientation related physical assault among young men who have sex with men. *Am J Public Health.* 2008;98(6):1028-1035
53. Herek GM, Sims C. Sexual orientation and violence victimization: hate crimes and intimate partner violence among gay and bisexual men in the US. In: Wolitski RJ, Stall R, Valdiserri RO, eds. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the US.* New York, NY: Oxford University Press; 2008:35-71
54. Friedman MS, Koeske GF, Silvestre AJ, Korr WS, Sites EW. The impact of gender role nonconforming behavior, bullying, and social support on suicidality among gay male youth. *J Adolesc Health.* 2006;38(5):621-623
55. Cloud J. Bullied to death. *Time.* 2010;176(16):60-63
56. Consortium of Higher Education LGBT Resource Professionals. Press release. Syracuse, NY: Consortium of Higher Education LGBT Resource Professionals; October 4, 2004. Available at: www.lgbtampus.org/about/news/2010_10_04_deaths. Accessed June 13, 2012
57. US Department of Health and Human Services. stopbullying.org Web site. Available at: www.stopbullying.gov. Accessed June 13, 2012
58. Burks DJ. Lesbian, gay, and bisexual victimization in the military: an unintended

- consequence of "Don't Ask, Don't Tell"? *Am Psychol.* 2011;66(7):604 613
59. Hand K. United States: Mormon apostle bullies gay youth. *Green Left Weekly.* Octo 10, 2010. Available at: www.greenleft.org.au/node/45676. Accessed June 13, 2012
 60. Parents, Families and Friends of Lesbians and Gays. Seven: cyber bullying. Available at: <http://community.pflag.org/page.aspx?pid=1025>. Accessed June 13, 2012
 61. Blumenfeld WJ, Cooper RM. LGBT and allied youth responses to cyberbullying: policy implications. *Int J Crit Pedagogy.* 2010;3(1):114 133
 62. Russell CJ, Keel PK. Homosexuality as a specific risk factor for eating disorders in men. *Int J Eat Disord.* 2002;31(3):300 306
 63. Austin SB, Ziyadeh NJ, Corliss HL, et al. Sexual orientation disparities in purging and binge eating from early to late adolescence. *J Adolesc Health.* 2009;45(3):238 245
 64. Feldman MB, Meyer IH. Childhood abuse and eating disorders in gay and bisexual men. *Int J Eat Disord.* 2007;40(5):418 423
 65. Hepp U, Milos G. Gender identity disorder and eating disorders. *Int J Eat Disord.* 2002;32(4):473 478
 66. D'Augelli AR. High tobacco use among lesbian, gay, and bisexual youth: mounting evidence about a hidden population's health risk behavior. *Arch Pediatr Adolesc Med.* 2004;158(4):309 310
 67. Remafedi G, Jurek AM, Oakes JM. Sexual identity and tobacco use in a venue based sample of adolescents and young adults. *Am J Prev Med.* 2008;35(6 suppl):S463 S470
 68. Lee JG, Griffin GK, Melvin CL. Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tob Control.* 2009;18(4):275 282
 69. Ortiz Hernández L, Tello BL, Valdés J. The association of sexual orientation with self rated health, and cigarette and alcohol use in Mexican adolescents and youths. *Soc Sci Med.* 2009;69(1):85 93
 70. Remafedi G, Carol H. Preventing tobacco use among lesbian, gay, bisexual, and transgender youths. *Nicotine Tob Res.* 2005;7(2):249 256
 71. Remafedi G. Lesbian, gay, bisexual, and transgender youths: who smokes, and why? *Nicotine Tob Res.* 2007;9(suppl 1):S65 S71
 72. Schwappach DL. Queer quit: gay smokers' perspectives on a culturally specific smoking cessation service. *Health Expect.* 2009;12(4):383 395
 73. Valleroy LA, MacKellar DA, Karon JM, et al; Young Men's Survey Study Group. HIV prevalence and associated risks in young men who have sex with men. *JAMA.* 2000;284(2):198 204
 74. Kipke MD, Weiss G, Ramirez M, et al. Club drug use in Los Angeles among young men who have sex with men. *Subst Use Misuse.* 2007;42(11):1723 1743
 75. Ridner SL, Frost K, Lajoie AS. Health in formation and risk behaviors among lesbian, gay, and bisexual college students. *J Am Acad Nurse Pract.* 2006;18(8):374 378
 76. Parsons JT, Kelly BC, Weiser JD. Initiation into methamphetamine use for young gay and bisexual men. *Drug Alcohol Depend.* 2007;90(2 3):135 144
 77. Rosario M, Schrimshaw EW, Hunter J. Predictors of substance abuse over time among gay, lesbian, and bisexual youths: an examination of three hypotheses. *Ad dict Behav.* 2004;29(8):1623 1631
 78. Rhodes SD, McCoy T, Hergenrather KC, Omlil MR, Durant RH. Exploring the health behavior disparities of gay men in the United States: comparing gay male university students to their heterosexual peers. *J LGBT Health Res.* 2007;3(1):15 23
 79. Benson PA, Hergenroeder AC. Bacterial sexually transmitted infections in gay, lesbian, and bisexual adolescents: medical and public health perspectives. *Semin Pediatr Infect Dis.* 2005;16(3):181 191
 80. Kipke MD, Weiss G, Wong CF. Residential status as a risk factor for drug use and HIV risk among young men who have sex with men. *AIDS Behav.* 2007;11(6 suppl):56 69
 81. Rudy ET, Shoptaw S, Lazzar M, Bolan RK, Tilekar SD, Kerndt PR. Methamphetamine use and other club drug use differ in relation to HIV status and risk behavior among gay and bisexual men. *Sex Transm Dis.* 2009;36(11):693 695
 82. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses among men who have sex with men 33 states, 2001 2006. *MMWR Morb Mortal Wkly Rep.* 2008;57(25):681 686
 83. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis.* 1981;8(2):75 76
 84. Lindley LL, Barnett CL, Brandt HM, Hardin JW, Burcin M. STDs among sexually active female college students: does sexual orientation make a difference? *Perspect Sex Reprod Health.* 2008;40(4):212 217
 85. Stoddard JP, Dibble SL, Fineman N. Sexual and physical abuse: a comparison between lesbians and their heterosexual sisters. *J Homosex.* 2009;56(4):407 420
 86. Welles SL, Corbin TJ, Rich JA, Reed E, Raj A. Intimate partner violence among men having sex with men, women, or both: early life sexual and physical abuse as antecedents. *J Community Health.* 2011;36(3):477 485
 87. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual intercourse, abuse and pregnancy among adolescent women: does sexual orientation make a difference? *Fam Plann Perspect.* 1999;31(3):127 131
 88. Arreola S, Neilands T, Pollack L, Paul J, Catania J. Childhood sexual experiences and adult health sequelae among gay and bisexual men: defining childhood sexual abuse. *J Sex Res.* 2008;45(3):246 252
 89. Mimiaga MJ, Noonan E, Donnell D, et al. Childhood sexual abuse is highly associated with HIV risk taking behavior and infection among MSM in the EXPLORE Study. *J Acquir Immune Defic Syndr.* 2009;51(3):340 348
 90. Perrin E. *Sexual Orientation in Child and Adolescent Health Care.* New York, NY: Kluwer Academic; 2002
 91. American Psychological Association. *Task Force on Gender Identity and Gender Variance. Report of the Task Force on Gender Identity and Gender Variance.* Washington, DC: American Psychological Association; 2009
 92. Clements Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health.* 2001;91(6):915 921
 93. Nuttbrock L, Hwang S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male to female transgender persons. *J Acquir Immune Defic Syndr.* 2009;52(3):417 421
 94. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at risk: exploring the lives and HIV risk of ethnic minority male to female transgender youth. *J Adolesc Health.* 2006;38(3):230 236
 95. Eccles TA, Sayegh MA, Fortenberry JD, Zimet GD. More normal than not: a qualitative assessment of the developmental experiences of gay male youth. *J Adolesc Health.* 2004;35(5):425.e11 425.e18
 96. Cohn TJ, Hastings SL. Resilience among rural lesbian youth. *J Lesbian Stud.* 2010;14(1):71 79
 97. Russell ST, Muraco A, Subramaniam A, Laub C. Youth empowerment and high school gay straight alliances. *J Youth Adolesc.* 2009;38(7):891 903
 98. Satcher D. The Surgeon General's call to action to promote sexual health and

- responsible sexual behavior. Washington, DC: US Department of Health and Human Services; 2001. Available at: www.surgeongeneral.gov/library/sexualhealth/index.html. Accessed June 13, 2012
99. Meckler GD, Elliott MN, Kanouse DE, Beals KP, Schuster MA. Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Arch Pediatr Adolesc Med*. 2006;160(12):1248-1254
100. Levine DA. Office based care for gay, lesbian, bisexual, and questioning youth. *Adolesc Med State Art Rev*. 2009;20(1):223-242, xi-xii
101. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64-90
102. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual minority health: what do we know and where do we need to go? *Am J Public Health*. 2008;98(6):989-995
103. Canadian Paediatric Society, Adolescent Health Committee. Adolescent sexual orientation. *Paediatr Child Health (Oxford)*. 2008;13(7):619-623
104. Moyer C. LGBT patients: reluctant and underserved. *Am Med News*. Sept 5 2011. Available at: www.ama-assn.org/amednews/2011/09/05/prsa0905.htm. Accessed June 13, 2012
105. Gutiérrez JP, Torres Pereda P. Acceptability and reliability of an adolescent risk behavior questionnaire administered with audio and computer support. *Rev Panam Salud Publica*. 2009;25(5):418-422
106. Kaiser Permanente National Diversity Council. *A Provider's Handbook on Culturally Competent Care*. 2nd ed. Oakland, CA: Kaiser Foundation Health Plan Inc; 2004
107. Rosario M, Schrimshaw EW, Hunter J. A model of sexual risk behaviors among young gay and bisexual men: longitudinal associations of mental health, substance abuse, sexual abuse, and the coming out process. *AIDS Educ Prev*. 2006;18(5):444-460
108. Duncan PM, Garcia AC, Frankowski BL, et al. Inspiring healthy adolescent choices: a rationale for and guide to strength promotion in primary care. *J Adolesc Health*. 2007;41(6):525-535
109. Frankowski BL, Leader IC, Duncan PM. Strength based interviewing. *Adolesc Med State Art Rev*. 2009;20(1):22-40, vii-xiii
110. Workowski KA, Berman SM; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR12):1-110
111. Ho KS, Cranston RD. Anal cytology screening in HIV positive men who have sex with men: what's new and what's now? *Curr Opin Infect Dis*. 2010;23(1):21-25
112. Bakotic WL, Willis D, Birdsong G, Tadros TS. Anal cytology in an HIV positive population: a retrospective analysis. *Acta Cytol*. 2005;49(2):163-168
113. US Food and Drug Administration. FDA: Gardasil approved to prevent anal cancer [news release]. Silver Spring, MD: US Food and Drug Administration; December 22, 2010
114. Centers for Disease Control and Prevention. FDA licensure of quadrivalent human papillomavirus vaccine (HPV4, Gardasil) for use in males and guidance from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):630-632
115. Centers for Disease Control and Prevention. Recommendations on the use of quadrivalent human papillomavirus vaccine in males. Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR Morb Mortal Wkly Rep*. 2011;60(50):1705-1708
116. Centers for Disease Control and Prevention. FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010;59(20):626-629
117. Blythe MJ, Diaz A; American Academy of Pediatrics Committee on Adolescence. Contraception and adolescents. *Pediatrics*. 2007;120(5):1135-1148
118. Spack NP, Edwards Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;129(3):418-425
119. Ashbee O, Goldberg J. Trans care gender transition: hormones: a guide for MTFs. Vancouver, British Columbia, Canada: Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition; 2006. Available at: <http://transhealth.vch.ca/resources/library/tcpdocs/consumer/hormonesMTF.pdf>. Accessed June 13, 2012
120. Carroll M. Transgender youth, adolescent decision making, and Roper v. Simmons. *UCLA Law Rev*. 2009;56(3-4):725-753
121. Chasan PE. The history of injectable silicone fluids for soft tissue augmentation. *Plast Reconstr Surg*. 2007;120(7):2034-2040, discussion 2041-2043
122. Clark RF, Cantrell FL, Pacal A, Chen W, Betten DP. Subcutaneous silicone injection leading to multi system organ failure. *Clin Toxicol (Phila)*. 2008;46(9):834-837
123. Schmid A, Tzur A, Leshko L, Krieger BP. Silicone embolism syndrome: a case report, review of the literature, and comparison with fat embolism syndrome. *Chest*. 2005;127(6):2276-2281
124. Rosioreanu A, Brusca Augello GT, Ahmed QA, Katz DS. CT visualization of silicone related pneumonitis in a transsexual man. *AJR Am J Roentgenol*. 2004;183(1):248-249

(Continued from first page)

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2013 by the American Academy of Pediatrics

COMPANION PAPER: A companion to this article can be found on page 198, and online at www.pediatrics.org/cgi/doi/10.1542/peds.2013.1282.

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine and the COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132:e297

DOI: 10.1542/peds.2013-1283 originally published online June 24, 2013;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/132/1/e297
References	This article cites 96 articles, 5 of which you can access for free at: http://pediatrics.aappublications.org/content/132/1/e297_full#ref-list-1
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Current Policy http://classic.pediatrics.aappublications.org/cgi/collection/current_policy Committee on Adolescence http://classic.pediatrics.aappublications.org/cgi/collection/committee_on_adolescence Administration/Practice Management http://classic.pediatrics.aappublications.org/cgi/collection/administration:practice_management_sub Professionalism http://classic.pediatrics.aappublications.org/cgi/collection/professionalism_sub Quality Improvement http://classic.pediatrics.aappublications.org/cgi/collection/quality_improvement_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: https://shop.aap.org/licensing-permissions/
Reprints	Information about ordering reprints can be found online: http://classic.pediatrics.aappublications.org/content/reprints

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since . Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: .

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

David A. Levine and the COMMITTEE ON ADOLESCENCE

Pediatrics 2013;132:e297

DOI: 10.1542/peds.2013-1283 originally published online June 24, 2013;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/132/1/e297>

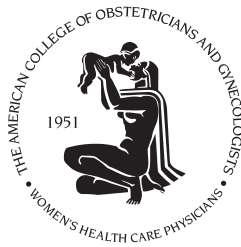
Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since . Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: .

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



EXHIBIT 5



The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

COMMITTEE OPINION

Number 512 • December 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Health Care for Transgender Individuals

ABSTRACT: Transgender individuals face harassment, discrimination, and rejection within our society. Lack of awareness, knowledge, and sensitivity in health care communities eventually leads to inadequate access to, underutilization of, and disparities within the health care system for this population. Although the care for these patients is often managed by a specialty team, obstetrician–gynecologists should be prepared to assist or refer transgender individuals with routine treatment and screening as well as hormonal and surgical therapies. The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder.

The Spectrum of Transgender Identity

Transgender is a broad term used for people whose gender identity or gender expression differs from their assigned sex at birth (Box 1) (1). However, there is no universally accepted definition of the word “transgender” because of the lack of agreement regarding what groups of people are considered “transgender.” In addition, definitions often vary by geographic region and by individual (2). The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, considers transgender individuals to be individuals with a disturbance in sexual or gender identity. Any combination of sexual and gender identity is possible for transgender individuals (Box 2). The diagnosis of gender identity disorder is only established for individuals with clinically significant distress and functional impairment caused by the persistent discomfort with one's assigned sex and primary and secondary sex characteristics. If untreated, gender identity disorder can result in psychologic dysfunction, depression, suicidal ideation, and even death (3).

Prevalence rates of transgender populations are not clearly established; however, studies suggest that transgender individuals constitute a small but substantial population (4). Additional research is needed among this population as outlined by the Institute of Medicine Report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2).

The social and economic marginalization of transgender individuals is widespread. Harassment, discrim-

ination, and rejection occur frequently within an individual's own family and affect educational, employment, and housing opportunities.

Transgender individuals, particularly young transgender individuals, are disproportionately represented in the homeless population (5). Once homeless, individuals may be denied access to shelters because of their gender or are placed in inappropriate housing. Subsequently, many homeless transgender individuals turn to survival sex (the exchange of sex for food, clothing, shelter, or other basic needs), which increases the risk of exposure to sexually transmitted infections and becoming victims of violence (6). In one small study, 35% of male-to-female transgender individuals tested positive for human immunodeficiency virus (HIV), 20% were homeless, and 37% reported physical abuse (7).

Barriers to Health Care

Within the medical community, transgender individuals face significant barriers to health care. This includes the failure of most health insurance plans to cover the cost of mental health services, cross-sex hormone therapy, or gender affirmation surgery. This barrier exists despite evidence that such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment (8). With medical and psychiatric care that affirms transgender identity, the transgender individual can lead an enhanced, functional life (9).

Box 1. Transgender Definitions

Transsexual—an individual who strongly identifies with the other sex and seeks hormones or gender-affirmation surgery or both to feminize or masculinize the body; may live full-time in the crossgender role.*

Crossdresser—an individual who dresses in the clothing of the opposite sex for reasons that include a need to express femininity or masculinity, artistic expression, performance, or erotic pleasure, but do not identify as that gender. The term “transvestite” was previously used to describe a crossdresser, but it is now considered pejorative and should not be used.†

Bigendered—individuals who identify as both or alternatively male and female, as no gender, or as a gender outside the male or female binary.†

Intersex—individuals with a set of congenital variations of the reproductive system that are not considered typical for either male or female. This includes newborns with ambiguous genitalia, a condition that affects 1 in 2,000 newborns in the United States each year.‡

Female-to-male—refers to someone who was identified as female at birth but who identifies and portrays his gender as male. This term is often used after the individual has taken some steps to express his gender as male, or after medically transitioning through hormones or surgery. Also known as FTM or transman.†

Male-to-female—refers to someone who was identified as male at birth but who identifies and portrays her gender as female. This term is often used after the individual has taken some steps to express her gender as female, or after medically transitioning through hormones or surgery. Also known as MTF or transwoman.†

*The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. Washington, DC: National Academies Press; 2011. Available at: http://www.nap.edu/openbook.php?record_id=13128&page=R1. Retrieved August 8, 2011.

† Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010. Available at: http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Retrieved July 22, 2011.

‡ Dreger AD. “Ambiguous sex”--or ambivalent medicine? Ethical issues in the treatment of intersexuality. *Hastings Cent Rep* 1998; 28:24–35.

Box 2. Sexual Identity and Gender Identity Definitions

Sex—designation of a person at birth as male or female based on anatomy and biology.*

Gender identity—a person’s innate identification as a man, woman, or something else that may or may not correspond to the person’s external body or assigned sex at birth.*

Gender expression—how individuals present themselves socially, including clothing, hairstyle, jewelry, and physical characteristics, including speech and mannerisms. This may not be the same gender in all settings.*

Sexual orientation—a person’s physical, romantic, emotional, and/or spiritual attraction to individuals of the same (lesbian or gay), different (heterosexual), or both (bisexual) biologic sexes. Sexual orientation does not define the real-life sexual practices and behaviors of an individual.*

Sexual behavior—the sexual encounters and behaviors of the individual. This is likely to be the most important factor in assessing the risk of sexually transmitted infections. Sexual behavior differs from sexual orientation; for example, not all individuals who engage in same-sex behaviors view themselves as gay, lesbian, or bisexual.

Legal sex—sex as stated on legal identifications, forms, and documents. Transgender individuals may adopt a second name other than their legal name with which they may prefer to be addressed. Transgender persons should be asked for their preferred name, even if it differs from their legal name and sex. State regulations vary and it may be difficult or impossible for a transgender individual to meet that state’s requirements to change their legal sex.†

*Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010. Available at: http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Retrieved July 22, 2011.

† This is a significant issue for transgender individuals. Some states have adopted progressive laws that do not require gender-affirmation surgery or an original birth certificate; instead, these laws allow individuals to change their legal sex with a letter from their health care providers stating that the individuals live their lives as this gender. See the National Center for Transgender Equality (www.transequality.org) and the Transgender Law and Policy Institute (www.transgenderlaw.org) for more information, including descriptions of state laws.

The consequences of inadequate treatment are staggering. Fifty-four percent of transgender youth have attempted suicide and 21% resort to self-mutilation. More than 50% of persons identified as transgender have used injected hormones that were obtained illegally or used outside of conventional medical settings. Additionally, such individuals frequently resort to the illegal and dangerous use of self-administered silicone injections to

spur masculine or feminine physiologic changes (5). The American College of Obstetricians and Gynecologists, therefore, urges public and private health insurance plans to cover the treatment of gender identity disorder.

Caring for Transgender Individuals

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals for routine treatment

and screening as well as hormonal and surgical therapies. Basic preventive services, like sexually transmitted infection testing and cancer screening, can be provided without specific expertise in transgender care. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients (see Resources). Physical and emotional issues for transgender individuals and the effects of aging, as in all other individuals, affect the health status of this population and should be addressed. Health care providers who are morally opposed to providing care to this population should refer them elsewhere for care. For more information, a resource guide on health care for transgender individuals is available at www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=5825.

Creating a Welcoming Environment

Health care providers' discomfort when treating transgender individuals may alienate patients and result in lower quality or inappropriate care as well as deter them from seeking future medical care (10). Excellent resources exist to facilitate the provision of culturally competent care for transgender patients (10). Adding a "transgender" option to check boxes on patient visit records can help to better capture information about transgender patients, and could be a sign of acceptance to that person (10). Questions should be framed in ways that do not make assumptions about gender identity, sexual orientation, or behavior. It is more appropriate for clinicians to ask their patients which terms they prefer (1). Language should be inclusive, allowing the patient to decide when and what to disclose. The adoption and posting of a nondiscrimination policy can also signal health care providers and patients alike that all persons will be treated with dignity and respect. Assurance of confidentiality can allow for a more open discussion, and confidentiality must be ensured if a patient is being referred to a different health care provider. Training staff to increase their knowledge and sensitivity toward transgender patients will also help facilitate a positive experience for the patient (10). It is important to prepare now to treat a future transgender patient. Additional guidelines for creating a welcoming office environment for transgender patients have been developed by the Gay and Lesbian Medical Association and can be found at http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf.

Gender Transition: World Professional Association for Transgender Health Guidelines

The World Professional Association for Transgender Health is a multidisciplinary professional society representing the specialties of medicine, psychology, social

sciences, and law. Their published clinical guidelines about the psychiatric, psychologic, medical, and surgical management of gender identity disorders are widely used by specialists in transgender health care (11), but are not universally accepted by all members of the transgender health community because critics consider them to be overly restrictive and inflexible.

The World Professional Association for Transgender Health guidelines describe the transition from one gender to another in three stages: 1) living in the gender role consistent with gender identity; 2) the use of cross-sex hormone therapy after living in the new gender role for at least 3 months; 3) gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months. Additional clinical guidelines have been published by the Endocrine Society (12).

Female-to-Male Transgender Individuals

Hormones

Methyltestosterone injections every 2 weeks are usually sufficient to suppress menses and induce masculine secondary sex characteristics (13). Before receiving androgen therapy, patients should be screened for medical contraindications and have periodic laboratory testing, including hemoglobin and hematocrit to evaluate for polycythemia, liver function tests, and serum testosterone level assessments (goal is a mid normal male range of 500 microgram/dL), while receiving the treatment.

Surgery

Hysterectomy, with or without salpingo-oophorectomy, is commonly part of the surgical process. An obstetrician-gynecologist who has no specialized expertise in transgender care may be asked to perform this surgery, and also may be consulted for routine reasons such as dysfunctional bleeding or pelvic pain. Reconstructive surgery should be performed by a urologist, gynecologist, plastic surgeon, or general surgeon who has specialized competence and training in this field.

Screening

Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred. For patients using androgen therapy who have not had a complete hysterectomy, there may be an increased risk of endometrial cancer and ovarian cancer (13).

Male-to-Female Transgender Individuals

Hormones

Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications. After surgery, doses of estradiol, 2–4 mg/d, or conjugated equine estrogen, 2.5 mg/d, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Nonoral therapy

also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma (13).

Surgery

Surgery usually involves penile and testicular excision and the creation of a neovagina (14). Reported complications of surgery include vaginal and urethral stenosis, fistula formation, problems with remnants of erectile tissue, and pain. Vaginal dilation of the neovagina is required to maintain patency. Other surgical procedures that may be performed include breast implants and nongenital surgery, such as facial feminization surgery.

Screening

Age-appropriate screening for breast and prostate cancer is appropriate for male-to-female transgender patients. Opinion varies regarding the need for Pap testing in this population. In patients who have a neocervix created from the glans penis, routine cytologic examination of the neocervix may be indicated (15). The glans are more prone to cancerous changes than the skin of the penile shaft, and intraepithelial neoplasia of the glans is more likely to progress to invasive carcinoma than is intraepithelial neoplasia of other penile skin (14).

Conclusion

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals. Physicians are urged to eliminate barriers to access to care for this population through their own individual efforts. An important step is to identify the sexual orientation and gender identity status of all patients as a routine part of clinical encounters and recognize that many transgender individuals may not identify themselves. The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care.

Resources

Select clinics with expertise in treating transgender individuals:

Fenway Community Health
www.fenwayhealth.org

University of Minnesota, Center for Sexual Health
www.phs.umn.edu/clinic/home.html

Callen-Lorde Community Health Center
www.callen-lorde.org

Tom Waddell Health Center
www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/
TransgenderHlthCtr.asp

References

1. Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010. Available at: http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Retrieved July 22, 2011.
2. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. Washington, DC: National Academies Press; 2011. Available at: http://www.nap.edu/openbook.php?record_id=13128&page=R1. Retrieved August 8, 2011.
3. American Psychiatric Association. Gender identity disorder. In: Diagnostic and statistical manual of mental disorders. 4th ed. text revision. Washington, DC: APA; 2000. p. 576–82.
4. Olyslager F, Conway L. On the calculation of the prevalence of transsexualism. Paper presented at the WPATH 20th International Symposium, Chicago, Illinois, September 5–8, 2007. Available at: <http://ai.eecs.umich.edu/people/conway/TS/Prevalence/Reports/Prevalence%20of%20Transsexualism.pdf>. Retrieved July 12, 2011.
5. Ray N. Lesbian, gay, bisexual and transgender youth: an epidemic of homelessness. New York (NY): National Gay and Lesbian Task Force Policy Institute; National Coalition for the Homeless; 2006. Available at: <http://www.the-taskforce.org/downloads/HomelessYouth.pdf>. Retrieved July 22, 2011.
6. Crossing to safety: transgender health and homelessness. Health Care for the Homeless Clinicians' Network. Healing Hands 2002;6(4):1–2. Available at: <http://www.nhchc.org/Network/HealingHands/2002/June2002HealingHands.pdf>. Retrieved July 22, 2011.
7. San Francisco Department of Public Health. The Transgender Community Health Project: descriptive results. San Francisco (CA): SFDPH; 1999. Available at: <http://hivinsite.ucsf.edu/InSite?page=cftg-02-02>. Retrieved July 22, 2011.
8. National Coalition for LGBT Health. An overview of U.S. trans health priorities: a report by the Eliminating Disparities Working Group. Washington, DC: National Coalition for LGBT Health; 2004. Available at: <http://transequality.org/PDFs/HealthPriorities.pdf>. Retrieved July 22, 2011.
9. American Medical Association. Patient-physician relationship: respect for law and human rights. In: Code of medical ethics of the American Medical Association: current opinions with annotations. 2010–2011 ed. Chicago (IL): AMA; 2010. p. 349–51.
10. Gay and Lesbian Medical Association. Guidelines for care of lesbian, gay, bisexual, and transgender patients. Washington, DC: GLMA; 2006. Available at: http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf. Retrieved July 22, 2011.
11. World Professional Association for Transgender Health. The Harry Benjamin International Gender Dysphoria Association's standards of care for gender identity dis-

- orders. 6th version. Minneapolis (MN): WPATH; 2001. Available at: <http://www.wpath.org/documents2/socv6.pdf>. Retrieved July 22, 2011.
12. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2009;94:3132–54.
 13. Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. *J Clin Endocrinol Metab* 2003;88:3467–73.
 14. Lawrence AA. Vaginal neoplasia in a male-to-female transsexual: case report, review of the literature, and recommendations for cytological screening. *Int J Transgender* 2001;5(1). Available at: http://www.wpath.org/journal/www.iiav.nl/eazines/web/IJT/97-03/numbers/symposion/ijtv05no01_01.htm. Retrieved July 22, 2011.
 15. Feldman JL, Goldberg J. Transgender primary medical care: suggested guidelines for clinicians in British Columbia. Vancouver (BC): Transgender Health Program; 2006. Available at: <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf>. Retrieved July 22, 2011.

Copyright December 2011 by the American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, posted on the Internet, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Requests for authorization to make photocopies should be directed to: Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400.

ISSN 1074-861X

Health care for transgender individuals. Committee Opinion No. 512. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;118:1454–8.

EXHIBIT 6

Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians

Hilary Daniel, BS, and Renee Butkus, BA, for the Health and Public Policy Committee of the American College of Physicians*

In this position paper, the American College of Physicians examines the health disparities experienced by the lesbian, gay, bisexual, and transgender (LGBT) community and makes a series of recommendations to achieve equity for LGBT individuals in the health care system. These recommendations include enhancing physician understanding of how to provide culturally and clinically competent care for LGBT individuals, addressing environ-

mental and social factors that can affect their mental and physical well-being, and supporting further research into understanding their unique health needs.

Ann Intern Med. 2015;163:135-137. doi:10.7326/M14-2482 www.annals.org

For author affiliations, see end of text.

This article was published online first at www.annals.org on 12 May 2015.

The lesbian, gay, bisexual, and transgender (LGBT) community is diverse, comprising persons from various races, ethnicities, and socioeconomic backgrounds; however, LGBT persons face a common set of challenges within the health care system. These challenges range from access to health care coverage and culturally competent care to state and federal policies that reinforce social stigma, marginalization, or discrimination. Recent years have brought about reliable data collection, research, and a greater understanding of the health care needs of the LGBT community and the challenges they face in accessing care. Although great strides have been taken in reducing health disparities in the LGBT community, much more needs to be done to achieve equity for LGBT persons in the health care system.

Although members of the LGBT community face similar health concerns as the general population, certain disparities are reported at a higher rate among LGBT persons than the heterosexual population (1). These disparities experienced by LGBT persons may be compounded if they are also part of a racial or ethnic minority (1). Of note, LGBT persons are more likely to identify themselves as being in poor health than heterosexual individuals, and different segments of the LGBT population have individual health risks and needs. For example, gay and bisexual men are at increased risk for certain sexually transmitted infections and account for more than half of all persons living with HIV or AIDS in the United States (1); lesbian women are less likely to have mammography or Papanicolaou test screening for cancer (2); lesbian and bisexual women are more likely to be overweight or obese (3); and lesbian, gay, and bisexual persons are more likely to become disabled at a younger age than heterosexual individuals (4).

Various state or federal laws may affect the quality of life of LGBT persons and can affect their physical and mental health. Same-sex marriage bans may cause psychological distress (5), prohibitive hospital visitation policies may prevent a same-sex parent from seeing a minor while the child is ill or participating in medical decision making for the child, and exclusions on trans-

gender health care in private and public health plans may cause a transgender patient to seek treatment options through illegal channels (6). These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse (7).

Addressing these disparities will require changes in the way LGBT persons and their families are regarded in society and by the health care system. Policies that are discriminatory toward the LGBT community, or are no longer supported by empirical research, continue to reinforce the environmental and social factors that can affect the mental and physical well-being of LGBT persons. The American College of Physicians (ACP) has a long-standing commitment to improving the health of all Americans and opposes any form of discrimination in the delivery of health care services. ACP is dedicated to eliminating disparities in the quality of or access to health care and is committed to working toward fully understanding the unique needs of the LGBT community and eliminating health disparities for LGBT persons.

This Executive Summary provides a synopsis of the full position paper, which is available in **Appendix** (available at www.annals.org).

METHODS

The ACP Health and Public Policy Committee, which is charged with addressing issues affecting the

See also:

Related article	99
Celebrating the ACP Centennial: From the <i>Annals</i> Archive	140
Editorial comment	143

Web-Only
CME quiz

health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed numerous studies, reports, and surveys on LGBT health care and related health policy. The committee also reviewed information on how state and federal policies may affect the physical and mental health of the LGBT population. Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 27 April 2015.

ACP POSITION STATEMENTS AND RECOMMENDATIONS

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (Appendix).

A glossary of LGBT terminology used throughout this paper can be found at <https://lgbt.ucsf.edu/glossary-terms>.

1. *The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.*

2. *The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.*

3. *The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.*

4. *The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.*

5. *The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to*

ongoing stigma and discrimination for LGBT persons and their families.

6. *The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.*

7. *Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.*

8. *The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.*

9. *The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.*

CONCLUSION

The ACP recognizes that reducing health disparities in the LGBT population will take concerted efforts not only by those in the medical community but also from society as a whole. Training future physicians to be culturally and clinically competent in LGBT health care, working with practicing physicians to increase their understanding of the LGBT population and their health needs, advocating for practical health policies supported by empirical research, and working to eliminate laws that discriminate against the LGBT community and their families are all important steps to reducing and ultimately eliminating the health disparities experienced by the LGBT community.

Note Added in Proof: On 12 May 2015, the U.S. Food and Drug Administration released the document "Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products: Draft Guidance for Industry." The proposed recommendations would replace the lifetime ban on blood donation by men who have sex with men with a 12-month deferral period from most recent sexual contact.

From the American College of Physicians, Washington, DC.

Disclaimer: The authors of this article are responsible for its contents, including any clinical or treatment recommendations.

* This paper, written by Hilary Daniel, BS, and Renee Butkus, BA, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee from initiation of the project until its approval and authored this position paper are Thomas G. Tape, MD (*Chair*); Douglas M. DeLong, MD (*Vice-Chair*); Micah W. Beachy, DO; Sue S. Bornstein, MD; James F. Bush, MD; Tracey Henry, MD; Gregory A. Hood, MD; Gregory C. Kane, MD; Robert H. Lohr, MD; Ashley Minaei; Darilyn V. Moyer, MD; and Shakaib U. Rehman, MD. Approved by the ACP Board of Regents on 27 April 2015.

Acknowledgment: Additional contributions provided by Jorge Ramallo, MD.

Financial Support: Financial support for the development of this guideline comes exclusively from the ACP operating budget.

Disclosures: Dr. Moyer is the elected Chair of the ACP Board of Governors. Authors not named here have disclosed no conflicts of interest. Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M14-2482.

Requests for Single Reprints: Hilary Daniel, BS, American College of Physicians, 25 Massachusetts Avenue NW, Suite 700, Washington, DC 2001; e-mail, HDaniel@mail.acponline.org.

Current author addresses and author contributions are available at www.annals.org.

References

1. Ranji U, Beamesderfer A, Kates J, Salganicoff A. Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. Menlo Park, CA: Kaiser Family Foundation;

2014. Accessed at <http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-health-challenges> on 10 December 2014.

2. Buchmueller T, Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *Am J Public Health*. 2010;100:489-95. [PMID: 20075319] doi:10.2105/AJPH.2009.160804

3. Ard KL, Makadon HJ. Improving the health care of lesbian, gay, bisexual and transgender people: understanding and eliminating health disparities. Boston: The Fenway Institute; 2012. Accessed at www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBTHealtharticle_v3_07-09-12.pdf on 11 February 2015.

4. Fredriksen-Goldsen KI, Kim HJ, Barkan SE. Disability among lesbian, gay, and bisexual adults: disparities in prevalence and risk. *Am J Public Health*. 2012;102:e16-21. [PMID: 22095356] doi:10.2105/AJPH.2011.300379

5. Wight RG, Leblanc AJ, Lee Badgett MV. Same-sex legal marriage and psychological well-being: findings from the California Health Interview Survey. *Am J Public Health*. 2013;103:339-46. [PMID: 23237155] doi:10.2105/AJPH.2012.301113

6. Committee on Health Care for Underserved Women. Committee Opinion no. 512: health care for transgender individuals. *Obstet Gynecol*. 2011;118:1454-8. [PMID: 22105293] doi:10.1097/AOG.0b013e31823ed1c1

7. U.S. Department of Health and Human Services. Healthy people 2020: lesbian, gay, bisexual, and transgender health. Accessed at www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health on 10 December 2014.

ANNALS BACK FILES

The *Annals* Back Files collection, encompassing the full text of articles from 1927 to 1992, is available at www.annals.org. Features include:

Fully searchable, high-resolution PDFs

Fully searchable HTML pages displaying the article citation, abstract, and references

Annals of Internal Medicine

Current Author Addresses: Ms. Daniel and Ms. Butkus: American College of Physicians, 25 Massachusetts Avenue NW, Suite 700, Washington, DC 2001.

Author Contributions: Conception and design: S.S. Bornstein, R. Butkus, H. Daniel, D. DeLong, A.A. Minaei.

Analysis and interpretation of the data: J.F. Bush, H. Daniel, T.L. Henry, A.A. Minaei.

Drafting of the article: M. Beachy, R. Butkus, H. Daniel, D. DeLong.

Critical revision for important intellectual content: R. Butkus, H. Daniel, D. DeLong, R.H. Lohr, A.A. Minaei, S.U. Rehman, T.G. Tape.

Final approval of the article: M. Beachy, R. Butkus, D. DeLong, G.A. Hood, R.H. Lohr, A.A. Minaei, D.V. Moyer, S.U. Rehman, T.G. Tape.

Administrative, technical, or logistic support: T.L. Henry, G.A. Hood.

Collection and assembly of data: H. Daniel.

APPENDIX: LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH DISPARITIES: A POLICY POSITION PAPER FROM THE AMERICAN COLLEGE OF PHYSICIANS

Understanding the LGBT Community

The LGBT community is a highly diverse and multifaceted group of persons encompassing all cultures, ethnicities, and walks of life. Under the LGBT umbrella, each individual group faces unique cultural and health-related needs but shares common challenges, such as social stigma, discrimination, and disparities in health care, that unite them.

Research into LGBT health has been expanding as the community has become more visible and outspoken about engaging the health care system in developing a knowledge base on the distinctive challenges and health disparities they face. However, gaps in the medical community's understanding of the overall makeup of the LGBT community and the environmental and social factors that may influence the needs of those persons present an obstacle to addressing challenges in a meaningful way. In 2011, the Institute of Medicine issued a report outlining a research agenda targeting several areas that could affect how the health care system approaches LGBT health, including demographics, social influences, disparities and inequalities, intervention that includes increasing access to care and addressing physical or mental conditions, and transgender-specific needs. The report also recommended the inclusion of the LGBT community in national health surveys and emphasized a need for scientific rigor and a respectful environment when gathering data (8).

One important obstacle to identifying health issues within the LGBT population is a lack of reliable data and the exclusion of sexual and gender minorities' identifi-

cation on federal health surveys. Recent efforts have been made to gather population data on persons who identify as lesbian, gay, bisexual, or transgender and those who identify as being in a same-sex marriage or partnership. For the first time in 2010, the U.S. Census Bureau did not change the data reporting the number of same-sex couples that identified as being married. Before that, the 2000 U.S. Census changed the relationship status of same-sex partners identifying as being the spouse of the head of household to an "unmarried partner" because there were no states in which same-sex marriage was legal. In the 1990 U.S. Census, if a same-sex couple identified themselves as married, the sex of 1 of the respondents was automatically changed to the opposite sex and the couple was enumerated as an opposite-sex married couple (9). The Patient Protection and Affordable Care Act allows the Department of Health and Human Services (HHS) to collect "additional demographic data to further improve our understanding of health disparities," and in 2013, the National Health Interview Survey—an annual study of health care access, use, and behaviors—included sexual orientation as part of its data collection system (10). Recent estimates put the number of persons who identify as lesbian, gay, bisexual, or transgender at more than 9 million or approximately 3.4% of the U.S. population, which some analysts believe may be an underestimate (1). Individuals who may have same-sex attractions or experiences but do not self-identify as LGBT may still fall into the category of sexual minorities and face health disparities associated with LGBT persons.

Access to Care in the LGBT Population

The LGBT community has often been overlooked when discussing health care disparities and continues to face barriers to equitable care. Barriers to care are multidimensional and include stigma and discrimination, poverty, lack of education, racial or ethnic minority status, and other psychological health determinants (11). Studies show that persons who identify as LGBT have greater economic disadvantages and are more vulnerable to poverty than those who do not. Using available information from national surveys, the Williams Institute reports higher overall poverty rates for persons identifying under the LGBT umbrella than heterosexual persons and higher rates of poverty in same-sex couples than heterosexual couples (7.6% vs. 5.7%) (12).

Research shows that LGBT adults and their children are more likely to be uninsured by public or private insurance and that they and their family members continue to face difficulties in gaining access to care and face a higher risk for health disparities than the general population (2). Most Americans gain health insurance coverage through their employer; data are limited but suggest LGBT persons face higher unemployment rates

than non-LGBT persons. A 2009 survey in California found a 14% unemployment rate among LGBT adult workers compared with 10% among non-LGBT adults (13).

The Affordable Care Act sought to increase access to care for low-income Americans by expanding Medicaid programs to all persons at or below 133% of the federal poverty level, providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state marketplace exchanges, and including non-discrimination protections in health plans sold on the exchanges. Although estimates suggested that the number of uninsured LGBT persons would be reduced as a result of Medicaid expansion, only about half of states have chosen to expand their Medicaid programs, which greatly diminishes its effect. This increases the number of LGBT persons who may fall into what has been dubbed the "coverage gap," in which persons may earn too much to qualify for their state's Medicaid program but too little to qualify for subsidies (14).

Transgender individuals face additional challenges in gaining access to care. Not only are they more likely to be uninsured than the general population, they are more likely to be uninsured than lesbian, gay, or bisexual persons (1). They also face high out-of-pocket costs for transgender-specific medical care if they lack insurance or their insurance coverage does not cover transgender health care. According to the American Congress of Obstetricians and Gynecologists, transgender youth who receive inadequate treatment are at an increased risk for engaging in self-mutilation or using illicit venues to obtain certain treatments; research shows more than 50% of persons who identify as transgender have obtained injected hormones through illegal means or outside of the traditional medical setting (6).

Mental and Physical Health Disparities

Existing research into the health of the LGBT population has found some health disparities that disproportionately affect the LGBT population. In 2000, the first federally funded research study on the health of LGBT persons assessed 5 major areas of concern for lesbian, gay, and bisexual persons (the report noted that transgender health concerns warranted an independent evaluation): cancer, family planning, HIV and AIDS, immunization and infectious diseases, and mental health (15). Research has shown that lesbian women are less likely to get preventive cancer screenings; lesbian and bisexual women are more likely to be overweight or obese (16); gay men are at higher risk for HIV and other sexually transmitted infections; and LGBT populations have the highest rates of tobacco, alcohol, and other drug use (17). Lesbian, gay, and bisexual persons are approximately 2.5 times more likely to

have a mental health disorder than heterosexual men and women (18).

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons (19). A 2011 survey of transgender or gender-nonconforming persons found that 41% reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (20).

Positions

1. *The American College of Physicians recommends that gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies. The College encourages medical schools, hospitals, physicians' offices, and other medical facilities to adopt gender identity as part of their nondiscrimination and antiharassment policies.*

Nondiscrimination policies are in place to prevent employment discrimination or harassment based on race, color, national or ethnic origin, age, religion, sex, disability, genetics, or other characteristics protected under federal, state, or local law (21). However, state law varies considerably on the inclusion of sexual orientation and gender identity in nondiscrimination policies and some policies based on sexual orientation alone may not include gender identity. Eighteen states have employment nondiscrimination or equal employment opportunity statutes that cover both gender identity and sexual orientation, and an additional 3 states have nondiscrimination statutes that cover sexual orientation only (22). The Human Rights Campaign, an LGBT rights organization, estimated that as a result of these assorted laws, 3 of 5 U.S. citizens live in an area that does not provide protection for gender identity or sexual orientation (23).

Sexual orientation and gender identity are inherently different and should be considered as such when assessing whether nondiscrimination or harassment policies provide protection to all members of the LGBT community. According to the Institute of Medicine, "sexual orientation" refers to a person's enduring pattern of or disposition to have sexual or romantic desires for, and relationships with, persons of the same sex or both sexes (8). "Gender identity" refers to a person's basic sense of being a man or boy, a woman or girl, or another gender. Gender identity may or may not correspond to a person's anatomical sex assigned at birth. The term "transgender" is now widely used to refer to a diverse group of persons who depart significantly from traditional gender norms (24). Persons who have a "marked difference" between their anatomical sex at birth and their expressed or experienced gender may

be diagnosed with gender dysphoria, which is a diagnosis under the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (25).

Evidence shows that individuals with gender identity variants face increased discrimination, threats of violence, and stigma. The National Gay and Lesbian Task Force and the National Center for Transgender Equality conducted a national survey of transgender and gender-nonidentifying persons and found high rates of harassment (78%), physical assault (35%), and sexual violence (12%) (20). More than 90% of survey participants reported harassment or discrimination in the workplace, and they experience double the rate of unemployment than the general population (20). Therefore, LGBT persons are more likely to lose their job or not be hired (26).

Employers have the option to include gender identity as part of their company's nondiscrimination or antiharassment policies even if their state does not, and many companies have chosen to include comprehensive protections policies. To reduce the potential for discrimination, harassment, and physical and emotional harm toward persons who are not covered by current protections, the medical community should include both sexual orientation and gender identity as part of any comprehensive nondiscrimination or antiharassment policy.

2. *The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.*

The LGBT community is at increased risk for physical and emotional harm resulting from discrimination or harassment, and transgender persons may face greater inequalities in the health care system than the general population. Of note, 19% of transgender persons lack any type of health insurance (20). A handful of states have laws about insurance coverage for transgender health care, such as hormone replacement therapy or sexual reassignment surgery, which may be considered medically necessary as part of the patient's care. Eight states and the District of Columbia have prohibitions on insurance exclusion of treatments for sex reassignment surgery (27).

The World Professional Association for Transgender Health has developed health care standards for transgender persons who have been diagnosed with gender dysphoria. The standards emphasize treatments that will achieve "lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment" and may or may not include modification to a person's gender expression or how this individual appears or presents physically to others (28). Research shows that

when transgender persons receive individual, medically appropriate care, they have improved mental health, reduction in suicide rates, and lower health care costs overall because of fewer mental health-related and substance abuse-related costs (29). However, not all health plans cover all services associated with transgender health or consider such services medically necessary; some plans may issue blanket exclusions on transgender health care, not cover certain services for a transgender person as they would for nontransgender persons, or only cover the cost of gender reassignment surgery if certain conditions are met. For example, an insurance company may cover posthysterectomy estrogenic hormone replacement therapy for biological women but will not cover a similar type of hormone therapy for a postoperative male-to-female transgender patient. Many professional medical organizations, including the American Medical Association, American Psychological Association, American Psychiatric Association, American Congress of Obstetricians and Gynecologists, and American Academy of Family Physicians, consider gender transition-related medical services medically necessary (30).

The decision to institute a hormone therapy regimen or pursue sexual reassignment surgery for transgender individuals is not taken lightly. Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs. Throughout the course of treatment, patients and their physicians or health care team should discuss available options and the evidence base for those treatments in which such evidence exists. It is especially important that transgender patients whose health care team has determined that treatment should include cross-sex hormone therapy or sexual reassignment surgery and postoperative hormone therapy be well-informed about the potential health risks associated with the long-term use of some hormonal replacement therapies before treatment.

Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive. The most extensive and expensive sexual reassignment surgeries may cost tens of thousands of dollars; this does not include associated costs, such as counseling, hormone replacement therapy, copays, or aftercare. The high costs of treatment can result in persons who cannot access the type of care they need, which can increase their levels of stress and discomfort and lead to more serious health conditions. In 2014, the HHS lifted the blanket ban on Medicare coverage for gender reassignment surgery (31) and the federal government announced it would no longer prohibit health plans offered on the Federal Employees Health Benefits Program from offering gender reassignment

as part of the plan (27). Transgender health advocates are hopeful this will result in wider coverage for transgender care in private health plans.

The cost of including transgender health care in employee health benefits plans is minimal and is unlikely to raise costs significantly, if at all. A survey of employers offering transition-related health care in their health benefit plans found that two thirds of employers that provided information on actual costs of employee utilization of transition-related coverage reported 0 costs (32). This is the result of a very small portion of the population identifying as transgender and a smaller portion of that group having the most expensive type of gender reassignment surgery as part of their treatment. An analysis of the utilization of transgender health services over 6 years after transgender discrimination was prohibited in one California health plan found a utilization rate of 0.062 per 1000 covered persons (33). The inclusion of transgender-related health care services within a health plan may also result in an overall reduction of health care costs over time because patients are less likely to engage in self-destructive behaviors, such alcohol or substance abuse.

3. *The definition of "family" should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship.*

The term "family" as it is seen in society is changing and no longer means married heterosexual parents with children. An analysis shows only 22% of families fall into this category (34). Stepparents, single parents, grandparents, same-sex couples, or foster or adoptive parents all make up the changing face of U.S. families. Across the country, LGBT persons are raising children, and demographic data shows that 110 000 same-sex couples are raising as many as 170 000 biological, adopted, or foster children and 37% of LGBT adults have had a child (35). This modern concept of family is no longer dependent on parental status and does not only include adult heads of household with minor children. Same-sex couples and different-sex couples who do not have children may nevertheless have persons in their lives that they consider family.

Despite research that shows a growing trend toward acceptance of LGBT individuals and families (36), there is no widely used standard definition of family inclusive of the diverse nature of the family structure and definitions vary widely: They can differ from state to state, within the Internal Revenue Service for tax purposes, by employers to determine eligibility for health plans, and by hospitals for the purposes of visitation or medical decision making. If LGBT spouses or partners are not legally considered a family member, they are at risk for reduced access to health care and restrictions on caregiving and decision making; further, they are at

increased risk for health disparities, and their children may not be eligible for health coverage (34). Therefore, LGBT persons and families may already be at a financial disadvantage, with single LGBT parents 3 times more likely to live near the poverty line than their non-LGBT counterparts and LGBT families twice as likely to live near the poverty threshold (35). These financial disadvantages can translate into lack of access to medical care and poorer health outcomes similar to those experienced by non-LGBT persons and their families who are uninsured or underinsured, in addition to the health disparities that are already reported among the LGBT community.

The Human Rights Campaign's definition of family for health care organizations, developed with multi-stakeholder input, is inclusive of same- and different-sex married couples and families and is an example of a broad, comprehensive definition of family that includes a person's biological, legal, and chosen family:

Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. (37)

A definition of family inclusive of all types of families, including the LGBT population, is not only fundamental to reducing the disparities and inequalities that exist within the health care system, but also important for the equal treatment of LGBT patients and their visitors in the hospital setting. Countless accounts show loved ones being denied the right to visit; assist in the medical decision-making process for their partner, minor, or child; or be updated on the condition of a patient because hospital visitation policy broadly prohibits those who are not recognized family members from access to the patient. These policies are discriminatory against LGBT patients, their visitors, and the millions of others who are considered family, such as friends, neighbors, or nonrelative caregivers who can offer support to the patient.

4. *The American College of Physicians encourages all hospitals and medical facilities to allow all patients to determine who may visit and who may act on their behalf during their stay, regardless of their sexual orientation, gender identity, or marital status, and ensure visitation policies are consistent with the Centers for Medicare & Medicaid Services Conditions of Participation and The Joint Commission standards for Medicare-funded hospitals and critical-access hospitals.*

When persons or their loved ones need emergency care or extended inpatient stays in the hospital,

they do not often immediately think about access to visitors or hospital visitation policies, the ability to assist in medical decision making, or their legal rights as patients or visitors. Hospital visitation policies are not always clear or consistent about who can visit or make medical decisions for a patient if they become incapacitated or cannot do so themselves. The absence or limited access of loved ones can cause uncertainty and anxiety for the patient. In contrast, the involvement of family and outside support systems can improve health outcomes, such as management of chronic illness and continuity of care (38).

A highly publicized incident of LGBT families facing discrimination and being denied hospital visitation occurred in Florida in 2007. A woman on vacation with her family had an aneurysm and was taken to the hospital. Her same-sex partner and their children were denied the right to see her or receive updates on her condition, and she eventually slipped into a coma and died (39). In response to this incident, President Obama issued a presidential memorandum recommending that the HHS review and update hospital visitation policies for hospitals participating in Medicare or Medicaid and critical-access hospitals to prohibit discrimination based on such factors as sexual orientation or gender identity (40).

Throughout the rulemaking process, the HHS revised the Medicare Conditions of Participation to require that all hospitals explain to all patients their right to choose who may visit during an inpatient stay, including same-sex spouses, domestic partners, and other visitors, and the patients' right to choose a person to act on their behalf. The Joint Commission, the nation's largest organization for hospital accreditation, also updated its standards to include equal visitation for LGBT patients and visitors (41). As a result of these updated policies, most hospitals and long-term care facilities are required to allow equal visitation for LGBT persons and their families.

The presidential memorandum also recommended that the HHS instruct hospitals to disclose to their patients that patients have a right to designate a representative to make medical decisions on their behalf if they cannot make those decisions themselves. The revised Conditions of Participation emphasized that hospitals "should give deference to patients' wishes about their representatives, whether expressed in writing, orally, or through other evidence, unless prohibited by state law" (42). With piecemeal regulations and policies governing the legal rights of LGBT persons and their families, some same-sex spouses or domestic partners choose to prepare advance directives, such as durable powers of attorney and health care proxies, in an effort to ensure their access to family members and their ability to exert their right to medical decision making if necessary.

5. The American College of Physicians supports civil marriage rights for same-sex couples. The denial of such rights can have a negative impact on the physical and mental health of these persons and contribute to ongoing stigma and discrimination for LGBT persons and their families.

The health and financial benefits of marriage for different-sex couples are widely reported, and contemporary research supports similar benefits in same-sex marriage. On the other hand, denial of marriage rights for LGBT persons may lead to mental and physical health problems. Health benefits associated with same-sex marriage result from improved psychological health and a reinforced social environment with community support (43). Research suggests that being in a legally recognized same-sex marriage diminishes mental health differentials between LGBT and heterosexual persons (5). A comparison study on the utilization of public health services by gay and bisexual men before and after Massachusetts legalized same-sex marriage found a reduction in the number of visits for health problems and mental health services. The study noted a 13% reduction in visits overall after the legalization of same-sex marriage (44).

In contrast, denial of such rights can result in ongoing physical and psychological health issues. Thus, LGBT persons encountering negative societal attitudes and discrimination often internalize stressors and have poor health unseen to those around them; further, these stressors can lead to self-destructive behaviors (43). A study of LGBT individuals living in states with a same-sex marriage ban found increases in general anxiety, mood disorders, and alcohol abuse (45). The denial of marriage rights to LGBT persons has also been found to reinforce stigmas of the LGBT population that may undermine health and social factors, which can affect young adults (46). The American Medical Association's broad policy supporting civil rights for LGBT persons acknowledges that denial of civil marriage rights can be harmful to LGBT persons and their families and contribute to ongoing health disparities (47).

Since 2003, the overall support for marriage equality has increased. The shift in attitudes toward acceptance of same-sex marriage has broad positive implications for the future of U.S. civil marriage rights. A 2013 survey by the Pew Research Center revealed that nearly half of U.S. adults expressed support for same-sex marriage. Of note, millennials (those born after 1980) showed the highest rate of support for same-sex marriage rights at 70%. Not only has overall opinion changed, but individually, 1 in 7 respondents reported they had changed their minds from opposing to supporting same-sex marriage. The Pew survey found that 32% of respondents changed their mind because they knew someone who identified as lesbian or gay (36).

The legal landscape is also shifting in favor of inclusive civil marriage rights for same-sex couples. The American Bar Association has adopted a resolution recognizing “that lesbian, gay, bisexual and transgender (LGBT) persons have a human right to be free from discrimination, threats and violence based on their LGBT status and condemns all laws, regulations and rules or practices that discriminate on the basis that an individual is [an] LGBT person” (48). In June 2013, the U.S. Supreme Court struck down a provision of the Defense of Marriage Act that defined marriage as a “union between a man and a woman.” The decision allowed legally married same-sex couples to have the same federal benefits offered to heterosexual couples (49). Currently more than half of the states and the District of Columbia allow same-sex marriage, and several states have rulings in favor of same-sex marriage that are stayed pending legal appeals (50). In April 2015, the Supreme Court heard oral arguments in a case involving same-sex marriage bans in Michigan, Ohio, Kentucky, and Tennessee; this will ultimately determine the constitutionality of same-sex marriage bans, including whether states would be required to recognize same-sex marriages performed legally out of state (51).

6. *The American College of Physicians supports data collection and research into understanding the demographics of the LGBT population, potential causes of LGBT health disparities, and best practices in reducing these disparities.*

Previous efforts to understand the LGBT population by including sexual orientation or gender identity in health surveys and data collection are a good first step, but there is a long way to go to understand the unique health needs of all members of the LGBT community. Understanding the demographics of the persons who make up this community is a key first step to understanding how environmental and social determinants may contribute to the health disparities they face. Overwhelming evidence shows that racial and ethnic minorities experience greater health disparities than the general population. In 2010, ACP published an updated position paper on racial and ethnic disparities in health care, which identified various statistics on health disparities in racial and ethnic minority groups, such as higher levels of uninsured Hispanics than white persons (34% vs. 13%) and lower rates of medication adherence in minority Medicare beneficiaries diagnosed with dementia (52). Persons who are part of both the LGBT community and a racial or ethnic minority group may face the highest levels of disparities. For example, data show that 30% of African American adults who identify as lesbian, gay, or bisexual are likely to delay getting a prescription compared with 19% of African American heterosexual adults (26).

Transgender persons may also face certain increased risk factors that can affect their health that are

not included when discussing the LGBT population as a whole, which creates research gaps with the LGBT community. A survey study of transgender persons shows elevated reports of harassment, physical assault, and sexual violence (20). In addition, transgender persons are more likely to face discrimination in education, employment, housing, and public accommodations than other sexual, racial, or ethnic minority groups. The lack of and unfamiliarity with research focused on the physical health issues of transgender persons, such as hormone replacement therapy and cancer risk, limit the understanding or development of best practices that could reduce the disparities felt by this population. The dearth of such research is detrimental to physicians' understanding of issues unique to transgender patients and reduces their ability to care for these patients.

Data that have been gathered in the relatively short time since the inclusion of sexual orientation, gender identity, and same-sex marital status have revealed information that can be used to create tailored plans to decrease health disparities in the LGBT community. For example, in 2009 the California Health Interview Survey collected information on certain health indicators and included sexual orientation along with racial and minority status. The survey found a higher rate of uninsured lesbian, gay, or bisexual Latino adults in the state than their African American counterparts (36% vs. 14%) (20).

In addition to obtaining information from population surveys, including gender identity and sexual orientation as a component of a patient's medical record (paper or electronic) may help a physician to better understand an LGBT patient's needs and provide more comprehensive care. This can be particularly useful in the care of transgender persons, whose gender identity and gender expression may differ from their sex assigned at birth and are not in line with the standard sex template on many forms. Including this information—especially in electronic health records that can standardize information, such as anatomy present and the preferred name/pronoun—can create a more comfortable experience for the patient and keep the physician up to date on the patient's transition history, if applicable (53). If a physician uses paper medical records, the patient's chart should be flagged using an indicator, such as a sticker, to alert staff to use the preferred name and pronoun of the patient (54).

7. *Medical schools, residency programs, and continuing medical education programs should incorporate LGBT health issues into their curricula. The College supports programs that would help recruit LGBT persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians.*

Establishing understanding, trust, and communication between a physician and a patient is key to an

ongoing and beneficial physician-patient relationship. However, reported instances of physician bias or denial of care to LGBT patients may influence patients to withhold information on their sexual orientation, gender identity, or medical conditions that could help the physician have a better understanding of the potential health needs of their patients. Physicians can play an integral role in helping an LGBT patient navigate through the medical system by providing respectful, culturally, and clinically competent care that underscores the overall health of the patient. In an article published in *The New England Journal of Medicine*, Makadon noted how physicians can create a welcoming and inclusive environment to LGBT patients:

[G]uidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be experts on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary. (55)

Providing clinically and culturally competent care for transgender persons in the primary care setting may present a challenge to physicians who are not knowledgeable about transgender health. Transgender persons have reported encounters with physicians who are unaware of how to approach treatment of a transgender person, and half of transgender patients reported having to "teach" their physician about transgender health (20). The National Transgender Survey found that 19% of participants had been denied medical care because of their transgender status (20). Resources for physicians on how to approach the treatment of transgender patients should emphasize respecting the patient's gender identity while providing prevention, treatment, and screening to the anatomy that is present (56).

To better understand the unique health needs of the LGBT community, physicians and medical professionals must develop a knowledge base in cultural and clinical competency and understand the factors that affect LGBT health; this should begin in the medical school setting and continue during practice. Assessment of LGBT-related content at medical schools found a median of 5 hours spent on LGBT-related issues over the course of the curriculum (57). Exposure to members of the LGBT population in medical school has been shown to increase the likelihood that a physician will take a more comprehensive patient history, have a better understanding of LGBT health issues, and have a

more positive attitude toward LGBT patients (58). Studies show that undergraduate students pursuing a career in medicine are receptive to incorporating LGBT-related issues into their education and agree that it applies to their future work (59). The College recognizes the importance of incorporating LGBT health into the medical school curriculum and publishes a comprehensive medical textbook on LGBT health, *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition* (60).

In November 2014, the Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development released a comprehensive report recommending strategies on how to implement changes in academic medical institutions to better address the needs of LGBT patients; further, the committee identified challenges and barriers to carrying out these changes. The report recognizes 3 methods of integrating LGBT health into the medical school curricula: full curriculum revision, the addition of a required class, or LGBT health study as a part of elective materials. The report also identifies barriers to curricular changes, including but not limited to a lack of material that has been shown to be effective, reluctance of faculty and staff to teach the new material, and a shortage of institutional time that would permit teachers to participate in continuing education on the topic (61).

For some LGBT persons interested in pursuing careers in medicine, there continues to be an underlying concern that their sexual orientation or gender identity may affect their selection into a medical school or residency program and acceptance by their peers. In 2012, Dr. Mark Schuster published his personal story about being gay in medicine starting in the 1980s when he entered medical school, through residency, and into practice. In his article, he spoke of a former attending physician he worked under who acted as an advisor and had indicated he would offer him a recommendation for residency, only to find this physician later renege on that offer after Dr. Schuster shared that he was gay (62). Little research has been done on the recruitment of LGBT physicians into the practice of medicine or how disclosing sexual orientation may affect training. One survey measuring the perceptions and attitudes toward sexual orientation during training found that 30% of respondents did not reveal their sexual orientation when applying for residency positions for fear of rejection (63).

Academic medical institutions can make efforts to create a welcoming and inclusive environment for students and faculty. The University of California, San Francisco, LGBT Resource Center developed a checklist for medical schools to assess LGBT curriculum, admissions, and the working environment within their institution. The checklist includes inclusive application procedures,

measurement of retention of LGBT students, and efforts and resources dedicated to student well-being (64). In a 2013 white paper, the Gay and Lesbian Medical Association made several recommendations to support an LGBT-inclusive climate at health professional schools in such areas as institutional equality, transgender services and support, diversity initiatives, admissions, staff and faculty recruitment and retention, staff and faculty training, and other areas that underscore simple yet thoughtful ways to create an accepting environment for LGBT students, faculty, and employees (65). Tools such as these can assist in recruiting and retaining LGBT physicians.

8. *The College opposes the use of "conversion," "reorientation," or "reparative" therapy for the treatment of LGBT persons.*

Since 1973, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* has not considered homosexuality an illness (66). All major medical and mental health organizations do not consider homosexuality as an illness but as a variation of human sexuality, and they denounce the practice of reparative therapy for treatment of LGBT persons (67). The core basis for "conversion," "reorientation," or "reparative" therapy, which is generally defined as therapy aiming at changing the sexual orientation of lesbian women and gay men, is mostly based on religious or moral objections to homosexuality or the belief that a homosexual person can be "cured" of their presumed illness.

In 2007, the American Psychological Association conducted a literature review of 83 studies on the efficacy of efforts to change sexual orientation. It found serious flaws in the research methods of most of the studies and identified only 1 study that met research standards for establishing safety or efficacy of conversion therapy and also compared persons who received a treatment with those who did not. In that study, intervention had no effect on the rates of same-sex behavior, so it is widely believed that there is no scientific evidence to support the use of reparative therapy (68). The Pan American Health Organization, the regional office for the Americas of the larger World Health Organization, also supports the position that there is no medical basis for reparative therapy and that the practice may pose a threat to the overall health and well-being of an individual (69). Dr. Robert Spitzer, the author of a 2003 research study often cited by supporters of the reparative therapy movement to purport that persons may choose to change their sexual orientation, has denounced the research as flawed and apologized to the LGBT community in a letter for misinterpretations or misrepresentations that arose from the study (70).

Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the prac-

tice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons. Research done at San Francisco State University on the effect of familial attitudes and acceptance found that LGBT youth who were rejected by their families because of their identity were more likely than their LGBT peers who were not rejected or only mildly rejected by their families to attempt suicide, report high levels of depression, use illegal drugs, or be at risk for HIV and sexually transmitted illnesses (71). The American Psychological Association literature review found that reparative therapy is associated with the loss of sexual feeling, depression, anxiety, and suicidality (68).

States have delved into the debate over the use of reparative therapy for minor children given the potential for harm. California; New Jersey; and Washington, DC, have enacted laws banning the practice. Several other state legislatures, such as those in Washington state, Massachusetts, New York, and Oregon, have introduced or passed legislation through one chamber but failed to pass the bill into law (72). The New Jersey law was challenged on the grounds that the ban limited the free speech of mental health professionals, but the law was upheld by the Third U.S. Circuit Court of Appeals (73). In May 2015, the U.S. Supreme Court declined to hear a challenge to the law (74).

9. *The American College of Physicians supports continued reviews of blood donation deferral policies for men who have sex with men. The College supports evidence-based deferral policies that take into account a comprehensive assessment of the risk level of all individuals seeking to donate, which may result in varying deferral periods or a lengthened or permanent deferral on blood donation.*

Persons who are considered at increased or possible risk for certain infectious diseases, such as intravenous drug users, recipients of animal organs or tissues, and those who have traveled or lived abroad in certain countries, are prohibited by the U.S. Food and Drug Administration from donating blood (75). Since the early 1980s, the policy has also included men who have sex with men (MSM) since 1977. This lifetime deferral of blood donation for MSM was instituted during a time when the incidence of HIV and AIDS increased to epidemic levels in the United States, and the disease and how it was transmitted were largely misunderstood by the scientific community. In the following years, concerted efforts by the medical community, patient advocates, and government officials and agencies resulted in advancements in blood screening technology and treatments for the virus. However, during that time of uncertainty, policies were implemented to balance the risk for contaminating the blood supply with what was known about the transmissibility of the disease.

Several medical organizations support deferral policy reform based on available scientific evidence and

testing capabilities. The American Medical Association policy on blood donor criteria supports, "the use of rational, scientifically based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk" (76). The American Association of Blood Banks, America's Blood Centers, and the American Red Cross have long advocated for a modification to deferral criteria to be "made comparable with criteria for other groups at increased risk for sexual transmission of transfusion-transmitted infections" and recommend a 12-month deferral for men who have had sex with another man since 1977, which is in line with deferral criteria for others who have exhibited high-risk behavior (77). The eligibility standards and policies on the donation of tissues or tissue products (5-year deferral since last sexual contact) (78) and vascular organs (risk assessed individually, disclosed to transplant team, and consent required) (79) by MSM also reflect a measured assessment of disease transmission risk to donor recipients.

Many countries, including the United Kingdom, Canada, Finland, Australia, and New Zealand, have successfully instituted deferral periods ranging from 12 months to 5 years in lieu of a lifetime ban on blood donation by MSM without measurable increased risk to the blood supply. A study of the risk of blood donations from MSM after the implementation of shorter deferral periods in England and Wales 12 months after their last sexual encounter found only a marginal increase in the risk for transfusion-transmitted HIV (80). Australia changed the deferral policy for MSM from 5 years to 12 months over 1996 to 2000. A study that compared the prevalence of HIV among blood donors from the 5-year deferral period compared with the 12-month deferral period found no evidence that the 12-month period increased risk for HIV in recipients (81).

In late 2014, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted in favor of recommending a 1-year deferral policy for MSM and increased surveillance of the blood supply. The U.S. Food and Drug Administration announced it would be updating its policy on blood donation from MSM after considering recommendations made by the HHS, reviews of available scientific evidence, and recommendations from its own Blood Products Advisory Committee. The policy about indefinite deferral on blood donation from MSM is being updated to a 1-year deferral period from the last sexual contact, and the U.S. Food and Drug Administration will issue draft guidance on the policy change in 2015. In addition, the agency announced it has already taken steps to implement a national blood surveillance system to monitor what, if any, effects the new policy has on the nation's blood supply (82). Lifting the lifetime ban on blood donation by MSM is an important first step toward creating equity among those wishing to donate blood. The U.S.

Food and Drug Administration should continue to monitor the effects of a 1-year deferral and update its policy as information and data are gathered through surveillance to make further strides toward policies that assess donor eligibility on the basis of scientific data and individual risk factors, such as the length of time since a high-risk behavior has occurred, type of sex that occurred, number of partners during a period of time, or a combination of factors (83).

Web-Only References

8. Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Pr; 2011.
9. U.S. Census Bureau, Fertility and Family Statistics Branch. Frequently asked questions about same-sex households. Accessed at www.census.gov/hhes/samesex/files/SScplfactsheet_final.pdf on 10 December 2014.
10. Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS. Sexual orientation and health among U.S. adults: national health interview survey, 2013. *Natl Health Stat Report*. 2014;1-10. [PMID: 25025690]
11. Dilley JA, Simmons KW, Boysun MJ, Pizacani BA, Stark MJ. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest. *Am J Public Health*. 2010;100:460-7. [PMID: 19696397] doi:10.2105/AJPH.2007.130336
12. Lee Badgett MV, Durso LE, Schneebaum A. New patterns of poverty in the lesbian, gay, and bisexual community. Los Angeles: The Williams Institute; 2013. Accessed at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf> on 10 December 2014.
13. A broken bargain: discrimination, fewer benefits and more taxes for LGBT workers: condensed version. Denver: Movement Advancement Project; 2013. Accessed at www.lgbtmap.org/file/a-broken-bargain-condensed-version.pdf on 10 December 2014.
14. Kates J, Ranji U. Health care access and coverage for the lesbian, gay, bisexual, and transgender (LGBT) community in the United States: opportunities and challenges in a new era. Oakland, CA: Kaiser Family Foundation; 2014. Accessed at <http://kff.org/disparities-policy/perspective/health-care-access-and-coverage-for-the-lesbian-gay-bisexual-and-transgender-lgbt-community-in-the-united-states-opportunities-and-challenges-in-a-new-era> on 10 December 2014.
15. Dean L, Meyer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al. Lesbian, gay, bisexual, and transgender health: findings and concerns. *Journal of the Gay and Lesbian Medical Association*. 2000; 4:101-51. Accessed at www.felgltb.org/rs/334/d112d6ad-54ec-438b-9358-4483f9e98868/91f/filename/2000-dean-l-lgbt-health-findings-and-concerns.pdf on 11 February 2015.
16. Brown JP, Tracy JK. Lesbians and cancer: an overlooked health disparity. *Cancer Causes Control*. 2008;19:1009-20. [PMID: 18551371] doi:10.1007/s10552-008-9176-z
17. U.S. Department of Health and Human Services. Healthy people 2020: lesbian, gay, bisexual, and transgender health: understanding LGBT health. Accessed at www.healthypeople.gov/2020/topics-objectives/2020/overview.aspx?topicid=25#eleven on 10 December 2014.
18. National Alliance on Mental Illness. Mental health issues among gay, lesbian, bisexual, and transgender (GLBT) people. Arlington, VA: National Alliance on Mental Illness Multicultural Action Center; 2007. Accessed at www.nami.org/Content/ContentGroups/Multicultural_Support1/Fact_Sheets1/GLBT_Mental_Health_07.pdf on 10 December 2014.
19. Reisner SL, White JM, Bradford JB, Mimiaga MJ. Transgender health disparities: comparing full cohort and nested matched-pair study designs in a community health center. *LGBT Health*. 2014;1: 177-184. [PMID: 25379511]

20. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: a report of the national transgender discrimination survey. Accessed at www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf on 10 December 2014.
21. U.S. Equal Employment Opportunity Commission. What you should know about EEOC and the enforcement protections for LGBT workers. Washington, DC: U.S. Equal Employment Opportunity Commission; 2014. Accessed at www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm on 10 December 2014.
22. American Civil Liberties Union. Non-discrimination laws: state by state information—map. New York: American Civil Liberties Union; 2014. Accessed at www.aclu.org/maps/non-discrimination-laws-state-state-information-map on 10 December 2014.
23. Human Rights Campaign. Resources: workplace discrimination laws and policies. Washington, DC: Human Rights Campaign; 2014. Accessed at www.hrc.org/resources/entry/Workplace-Discrimination-Policies-Laws-and-Legislation on 10 December 2014.
24. Bockting WO. From construction to context: gender through the eyes of the transgendered. SIECUS Report 28: 3-7.
25. American Psychiatric Association. Gender dysphoria. Arlington, VA: American Psychiatric Publishing; 2013. Accessed at www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf on 10 December 2014.
26. Krehely J. How to close the LGBT health disparities gap: disparities by race and ethnicity. Washington, DC: Center for American Progress; 2009. Accessed at http://cancer-network.org/media/pdf/lgbt_health_disparities_gap_race.pdf on 11 February 2015.
27. Millman J. One health insurer just took the feds' offer to end transgender discrimination. Who else will follow? The Washington Post. 31 October 2014. Accessed at www.washingtonpost.com/blogs/wonkblog/wp/2014/10/31/one-health-insurer-just-took-the-feds-offer-to-end-transgender-discrimination-who-else-will-follow on 10 December 2014.
28. Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. International Journal of Transgenderism. 2011;13:165-232. Accessed at www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf on 11 February 2015.
29. National Center for Transgender Equality, National Gay and Lesbian Task Force. National transgender discrimination survey report on health and health care. Washington, DC: National Center for Transgender Equality; 2010. Accessed at www.thetaskforce.org/static_html/downloads/reports/reports/ntds_report_on_health.pdf on 1 May 2015.
30. Cray A, Baker K. FAQ: health insurance needs for transgender Americans. Washington, DC: Center for American Progress; 2012. Accessed at <http://cdn.americanprogress.org/wp-content/uploads/2012/10/TransgenderHealth.pdf> on 10 December 2014.
31. Cha AE. Ban lifted on Medicare coverage for sex change surgery. The Washington Post. 30 May 2014. Accessed at www.washingtonpost.com/national/health-science/ban-lifted-on-medicare-coverage-for-sex-change-surgery/2014/05/30/28bcd122-e818-11e3-a86b-362fd5443d19_story.html on 10 December 2014.
32. Herman JL. Costs and benefits of providing transition-related health care coverage in employee health benefits plans: findings from a survey of employers. Los Angeles: The Williams Institute; 2013. Accessed at <https://escholarship.org/uc/item/5z38157s> on 11 February 2015.
33. State of California Department of Insurance. Economic impact assessment: gender nondiscrimination in health insurance. Los Angeles: California Department of Insurance; 2012. Accessed at <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf> on 10 December 2014.
34. Movement Advancement Project, Family Equality Council, Center for American Progress. All children matter: how legal and social inequalities hurt LGBT families: condensed version. Denver: Movement Advancement Project; 2011. Accessed at www.lgbtmap.org/file/all-children-matter-condensed-report.pdf on 11 February 2015.
35. Gates GJ. LGBT parenting in the United States. Los Angeles: The Williams Institute; 2013. Accessed at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Parenting.pdf> on 10 December 2014.
36. Pew Research Center. Growing support for gay marriage: changed minds and changing demographics. Washington, DC: Pew Research Center; 2013. Accessed at www.people-press.org/2013/03/20/growing-support-for-gay-marriage-changed-minds-and-changing-demographics on 10 December 2014.
37. The Human Rights Campaign. LGBT-inclusive definitions of family. Washington, DC: Human Rights Campaign; 2014. Accessed at www.hrc.org/resources/entry/lgbt-inclusive-definitions-of-family on 10 December 2014.
38. Institute for Patient and Family-Centered Care. Changing hospital "visiting" policies and practices: supporting family presence and participation. Bethesda, MD: Institute for Patient and Family-Centered Care; 2010. Accessed at www.ipfcc.org/visiting.pdf on 10 December 2014.
39. Riou G. Hospital visitation and medical decision making for same-sex couples. Washington, DC: Center for American Progress; 2014. Accessed at www.americanprogress.org/issues/lgbt/news/2014/04/15/88015/hospital-visitation-and-medical-decision-making-for-same-sex-couples on 10 December 2014.
40. Obama B. Presidential memorandum: Hospital visitation. 15 April 2010. Accessed at www.whitehouse.gov/the-press-office/2010/04/15/presidential-memorandum-hospital-visitation on 10 December 2014.
41. The Joint Commission. New and Revised Hospital EPs to Improve Patient-Provider Communication. Approved: New and revised hospital EPs to improve patient-provider communication. Jt Comm Perspect. 2010;30:5-6. [PMID: 20108789]
42. Centers for Medicare & Medicaid Services. Medicare steps up enforcement of equal visitation and representation rights in hospitals. 8 September 2011. Accessed at www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2011-Press-releases-items/2011-09-08.html on 10 December 2014.
43. Buffie WC. Public health implications of same-sex marriage. Am J Public Health. 2011;101:986-90. [PMID: 21493934] doi:10.2105/AJPH 2010.300112
44. Hatzenbuehler ML, O'Cleirigh C, Grasso C, Mayer K, Safren S, Bradford J. Effect of same-sex marriage laws on health care use and expenditures in sexual minority men: a quasi-natural experiment. Am J Public Health. 2012;102:285-91. [PMID: 22390442] doi:10.2105/AJPH.2011.300382
45. Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. Am J Public Health. 2010;100:452-9. [PMID: 20075314] doi:10.2105/AJPH 2009.168815
46. Herdt G, Kertzner R. I do, but I can't: the impact of marriage denial on the mental health and sexual citizenship of lesbian and gay men in the United States. Sex Res Soc Pol. 2006;3:33-49.
47. American Medical Association. AMA policies on LGBT issues: general policies. Accessed at www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbtc-advisory-committee/ama-policy-regarding-sexual-orientation.page? on 10 December 2014.
48. American Bar Association. Resolution 114B. Accessed at www.americanbar.org/content/dam/aba/images/abanews/2014am_hodres/114b.pdf on 10 December 2014.
49. Schwartz J. United States v. Windsor: between the lines of the defense of marriage act opinion. The New York Times. 26 June 2013. Accessed at www.nytimes.com/interactive/2013/06/26/us/annotated-supreme-court-decision-on-doma.html?_r=0 on 10 December 2014.
50. Freedom to Marry. States. Accessed at www.freedomtomarry.org/states on 10 December 2014.

51. The Supreme Court. Certiorari granted. 16 January 2015. Accessed at www.supremecourt.gov/orders/courtorders/011615zr_f2q3.pdf on 23 January 2015.
52. American College of Physicians. Racial and ethnic disparities in health care, updated 2010. Philadelphia: American College of Physicians; 2010. Accessed at www.acponline.org/advocacy/current_policy_papers/assets/racial_disparities.pdf on 11 February 2015.
53. Deutsch MB, Green J, Keatley J, Mayer G, Hastings J, Hall AM; World Professional Association for Transgender Health EMR Working Group. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. *J Am Med Inform Assoc*. 2013;20:700-3. [PMID: 23631835] doi:10.1136/amiajnl-2012-001472
54. National LGBT Health Education Center. Affirmative care for transgender and gender non-conforming people: best practices for front-line health care staff. Accessed at www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf on 10 December 2014.
55. Makadon HJ. Improving health care for the lesbian and gay communities. *N Engl J Med*. 2006;354:895-7. [PMID: 16510743]
56. Center of Excellence for Transgender Health; University of California, San Francisco. Transgender patients. Accessed at <http://transhealth.ucsf.edu/trans?page=protocol-patients> on 10 December 2014.
57. Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306:971-7. [PMID: 21900137] doi:10.1001/jama.2011.1255
58. Sanchez NF, Rabatin J, Sanchez JP, Hubbard S, Kalet A. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Fam Med*. 2006;38:21-7. [PMID: 16378255]
59. Sequeira GM, Chakraborti C, Panunti BA. Integrating lesbian, gay, bisexual, and transgender (LGBT) content into undergraduate medical school curricula: a qualitative study. *Ochsner J*. 2012;12:379-82. [PMID: 23267268]
60. Makadon HJ, Mayer KH, Potter J, Goldhammer H. The Fenway Guide to LGBT Health. 2nd ed. Philadelphia: American College of Physicians; 2015. Accessed at www.acponline.org/newsroom/fenway_guide_book.htm on 5 May 2015.
61. Association of American Medical Colleges. Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD. Washington, DC: Association of American Medical Colleges; 2014. Accessed at http://lgbt.ucsf.edu/sites/lgbt.ucsf.edu/files/wysiwyg/AAMC_LGBT-DSD%20Report%202014.pdf on 11 February 2015.
62. Schuster MA. On being gay in medicine. *Acad Pediatr*. 2012;12:75-8. [PMID: 22424395] doi:10.1016/j.acap.2012.01.005
63. Lee KP, Kelz RR, Dubé B, Morris JB. Attitude and perceptions of the other underrepresented minority in surgery. *J Surg Educ*. 2014;71:e47-52. [PMID: 24974336] doi:10.1016/j.jsurg.2014.05.008
64. University of San Francisco LGBT Center. LGBT concerns in medical education: a tool for institutional self-assessment. Accessed at http://geiselmed.dartmouth.edu/students/diversity/qmd/medical_education.pdf on 10 December 2014.
65. Snowdon S. Recommendations for enhancing the climate for LGBT students and employees in health professional schools: a GLMA white paper. Accessed at http://gme.wustl.edu/About_the_GME_Consortium/Educational%20Resources/Recommendations%20for%20Enhancing%20LGBT%20Climate%20in%20Health%20Professional%20Schools.pdf on 11 February 2015.
66. American Psychiatric Association. LGBT-sexual orientation. Accessed at www.psychiatry.org/lgbt-sexual-orientation on 10 December 2014.
67. American Psychological Association. Just the facts about sexual orientation & youth: a primer for principals, educators, & school personnel: efforts to change sexual orientation through therapy. Accessed at www.apa.org/pi/lgbt/resources/just-the-facts.aspx on 10 December 2014.
68. American Psychological Association Task Force. Report of the American Psychological Association Task Force on appropriate therapeutic responses to sexual orientation. Washington, DC: American Psychological Association; 2009. Accessed at www.apa.org/pi/lgbt/resources/therapeutic-response.pdf on 11 February 2015.
69. Pan American Health Organization. "Cures" for an illness that does not exist. Accessed at www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=17703 on 10 December 2014.
70. Spitzer RL. Spitzer reassesses his 2003 study of reparative therapy of homosexuality [Letter]. *Arch Sex Behav*. 2012;41:757. [PMID: 22622659] doi:10.1007/s10508-012-9966-y
71. Ryan C. Supportive families, healthy children: helping families with lesbian, gay, bisexual & transgender children. San Francisco: Family Acceptance Project, San Francisco State Univ; 2009. Accessed at http://cchealth.org/topics/lgbtq/pdf/supportive_families.pdf on 10 December 2014.
72. Hartmann, M. Where the states stand in the fight to ban gay conversion therapy. Accessed at <http://nymag.com/daily/intelligencer/2015/04/where-the-states-stand-on-gay-conversion-therapy.html> on 5 May 2015.
73. United States Court of Appeals for the Third Circuit. No. 13-4429. Accessed at www2.ca3.uscourts.gov/opinarch/134429p.pdf on 10 December 2014.
74. Hurley L. U.S. top court rejects challenge to New Jersey 'gay conversion therapy' ban. Accessed at www.reuters.com/article/2015/05/04/us-usa-court-gays-idUSKBN0NP17L20150504 on 5 May 2015.
75. U.S. Food and Drug Administration. Blood donations from men who have sex with other men questions and answers. Accessed at www.fda.gov/biologicsbloodvaccines/bloodbloodproducts/questionsaboutblood/ucm108186.htm on 10 December 2014.
76. American Medical Association. Policy H-50.973: blood donor referral criteria. In: AMA policies on LGBT issues. Accessed at www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbtt-advisory-committee/ama-policy-regarding-sexual-orientation.page on 10 December 2014.
77. American Association of Blood Banks. Joint statement before ACBSA on donor deferral for men who have had sex with another man (MSM). 15 June 2010. Accessed at www.aabb.org/advocacy/statements/Pages/statement061510.aspx on 10 December 2014.
78. U.S. Food and Drug Administration. Guidance for industry: eligibility determination for donors of human cells, tissues, and cellular and tissue-based products: IV. donor screening (§ 1271.75). Accessed at www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Guidances/Tissue/ucm073964.htm#DONORSCREENING1271.75 on 5 May 2015.
79. Cray A. Discriminatory donor policies substitute stereotypes for science. Washington, DC: Center for American Progress; 2012. Accessed at www.americanprogress.org/issues/lgbt/news/2012/09/11/37294/discriminatory-donor-policies-substitute-stereotypes-for-science on 10 December 2014.
80. Davison KL, Conti S, Brailsford SR. The risk of transfusion-transmitted HIV from blood donations of men who have sex with men, 12 months after last sex with a man: 2005-2007 estimates from England and Wales. *Vox Sang*. 2013;105:85-8. [PMID: 23398193] doi:10.1111/vox.12024
81. Seed CR, Kiely P, Law M, Keller AJ. No evidence of a significantly increased risk of transfusion-transmitted human immunodeficiency virus infection in Australia subsequent to implementing a 12-month deferral for men who have had sex with men. *Transfusion*. 2010;50:2722-30. [PMID: 20663106] doi:10.1111/j.1537-2995.2010.02793.x
82. Hamburg MA. FDA Commissioner Margaret A. Hamburg's statement on FDA's blood donor deferral policy for men who have sex with men. 23 December 2014. Accessed at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm427843.htm on 19 January 2015.
83. Flanagan P. How should we assess risk behaviour when determining donor deferral? Reflections on the MSM deferral. *Biologicals*. 2012;40:173-5. [PMID: 22071002] doi:10.1016/j.biologicals.2011.10.009

EXHIBIT 7

Health Care Delivery

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

Topic: Health Care Delivery **Policy Subtopic:** NA

Meeting Type: Annual **Year Last Modified:** 2016

Action: Modified **Type:** Health Policies

Council & Committees: NA



1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and **transgender** (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.

Policy Timeline

EXHIBIT 8

Health Insurance

Removing Financial Barriers to Care for Transgender Patients H-185.950

Topic: Health Insurance **Policy Subtopic:** Benefits and Coverage

Meeting Type: Annual **Year Last Modified:** 2016

Action: Modified **Type:** Health Policies

Council & Committees: NA



Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Policy Timeline

Res. 122 A-08 Modified: Res. 05, A-16

EXHIBIT 9

Civil and Human Rights

Access to Basic Human Services for Transgender Individuals H-65.964

Topic: Civil and Human Rights **Policy Subtopic:** NA

Meeting Type: Annual **Year Last Modified:** 2017

Action: NA **Type:** Health Policies

Council & Committees: NA



Our AMA: (1) opposes policies preventing **transgender** individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for **transgender** individuals according to one's gender identity.

Policy Timeline

Res. 010, A-17

EXHIBIT 10

Position Statement on Discrimination Against Transgender and Gender Variant Individuals

Approved by the Board of Trustees, July 2012

Approved by the Assembly, May 2012

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

Issue: Being transgender gender or variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression. As a result, transgender and gender variant persons face challenges in their marriage, adoption and parenting rights, are regularly discharged from uniformed services or are rejected from enlisting due to their gender identity, and have difficulty revising government identity documents. Incarcerated transgender and gender variant persons suffer risks to their personal safety and lack of access to comprehensive healthcare. Further, transgender and gender variant individuals may be inappropriately assigned space in gender-segregated facilities such as inpatient psychiatric units and residential treatment programs. Transgender and gender variant people are frequently harassed and discriminated against when seeking housing or applying to jobs or schools and are often victims of violent hate crimes.

The APA declares in its vision statement that it is, "the voice and conscience of modern psychiatry." Thus, this position statement is relevant to the APA because discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals. In addition, APA's values include "advocacy for patients." Speaking out firmly and professionally against discrimination and lack of equal civil rights is a critical advocacy role that the APA is uniquely positioned to take.

APA Position:

Therefore, the American Psychiatric Association:

- 1. Supports laws that protect the civil rights of transgender and gender variant individuals**
- 2. Urges the repeal of laws and policies that discriminate against transgender and gender variant individuals.**
- 3. Opposes all public and private discrimination against transgender and gender variant individuals in such areas as health care, employment, housing, public accommodation, education, and licensing.**
- 4. Declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons.**

Authors: Jack Drescher, M.D., Ellen Haller, M.D., APA Caucus of Lesbian, Gay and Bisexual Psychiatrists.

Background to the Position Statement

In 1973, the American Psychiatric Association removed the diagnosis of homosexuality from the DSM-II (1, 2) and issued a position statement of support of gay and lesbian civil rights (3). In subsequent years, APA continued to expand its public positions regarding gay and lesbian civil rights. In 1990, APA issued a statement opposing “exclusion and dismissal from the armed services on the basis of sexual orientation” (4). In 1992, APA called on “all international health organizations, psychiatric organizations, and individual psychiatrists in other countries to urge the repeal in their own countries of legislation that penalizes homosexual acts by consenting adults in private” (5).

In 2000, following Vermont’s passage of civil union laws, APA endorsed “the legal recognition of same-sex unions and their associated legal rights, benefits and responsibilities” (6). In 2002, APA approved a position statement supporting “initiatives which allow same-sex couples to adopt and co-parent children and supports all the associated legal rights, benefits, and responsibilities which arise from such initiatives” (7).

In 2005, after Massachusetts’ 2004 legalization of marriage equality, APA issued a statement supporting “the legal recognition of same-sex civil marriage with all rights, benefits and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities” (8).

In contrast to its strong affirmation of lesbian and gay civil rights since the 1973 decision to remove homosexuality from the DSM, APA has not issued position statements in support of transgender civil rights. The APA Committee on Gay, Lesbian, and Bisexual Issues often functioned as the default clearinghouse for queries to the APA about trans issues.

Gender variant and transgender individuals must cope with multiple unique challenges. They face significant discrimination, prejudice and hatred and the potential for victimization from violent hate crimes (9). In the workplace, bias may impact transgender people as part of the application process or during their employment precipitated by the individual coming out as transgender (either on their own or by being “outed” by others), or transitioning while an employee. These individuals also need to navigate numerous expensive and complex legal issues such as changing their identity documents including, in part, their social security, driver’s license, and passport (10). They often experience discrimination when accessing non-gender transition-related health care and are denied numerous basic civil rights and protections (11). Gender variant and transgender people have no federal protection against discrimination on the basis of their gender identity or expression in public accommodations, housing, credit, education, or federally-funded programs.

The mental health of gender variant and transgender people is hypothesized to be adversely impacted by discrimination and stigma. For example, gender-based discrimination and victimization were found to be independently associated with attempted suicide in a population of transgender individuals, 32% of whom had histories of trying to kill themselves (12). And, in the largest survey to date of gender variant and transgender people with an N of 6,450, 41% reported attempting suicide (13).

Other organizations, including the American Medical Association and the American Psychological Association, have endorsed strong policy statements deploring the discrimination experienced by gender variant and transgender individuals and calling for laws to protect their civil rights (14, 15).

References

1. Bayer, R. (1981). *Homosexuality and American psychiatry: The politics of diagnosis*. New York: Basic Books.
2. Drescher, J., & Merlino, J. P. (Eds.). (2007). *American psychiatry and homosexuality: An oral history*. New York: Harrington Park Press.
3. American Psychiatric Association: Position statement on homosexuality and civil rights, December 1973 (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
4. American Psychiatric Association: Position statement on homosexuality and the armed services, December 1990 (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
5. American Psychiatric Association: Position statement on homosexuality, December 1992; Reaffirmed July 2011 (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
6. American Psychiatric Association: Position Statement on Same Sex Unions, December 2004 (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
7. American Psychiatric Association: Position Statement on Adoption and Co-parenting of Children by Same-sex Couples, November (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
8. American Psychiatric Association: Position Statement on Support of Legal Recognition of Same-Sex Civil Marriage, July 2005 (<http://www.psychiatry.org/advocacy--newsroom/position-statements>)
9. National Gay and Lesbian Task Force. *Injustice at Every Turn: A report of the National Transgender Discrimination Survey*. Accessed on May 16, 2011, from: http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf
10. Transgender Law Center. *The State of Transgender California Report*. Accessed on May 16, 2011, from: http://www.transgenderlawcenter.org/pdf/StateTransCA_report_2009Print.pdf
11. National Transgender Discrimination Survey Report on health and health care, Accessed online May 16, 2011, from: http://www.thetaskforce.org/downloads/reports/reports/ntds_report_on_health.pdf
12. Clements-Nolle K, Marx R, Katz M (2006): Attempted Suicide Among Transgender Persons, *Journal of Homosexuality*, 51:3, 53-69 http://dx.doi.org/10.1300/J082v51n03_04
13. Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011. http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf
14. American Medical Association policies: Continued Support of Human Rights and Freedom, Nondiscrimination Policy, and Civil Rights Restoration. Accessed online May 16, 2011, from: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbl-advisory-committee/ama-policy-regarding-sexual-orientation.page?>
15. American Psychological Association. *APA Policy Statement: Transgender, Gender Identity & Gender Expression Non-Discrimination*. Accessed online May 16, 2011, from: <http://www.apa.org/about/governance/council/policy/transgender.aspx>

EXHIBIT 11

Position Statement on Access to Care for Transgender and Gender Variant Individuals

Approved by the Board of Trustees, July 2012

Approved by the Assembly, May 2012

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

Issue: Significant and long-standing medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to assist gender variant individuals seeking transition. However, private and public insurers often do not offer, or may specifically exclude, coverage for medically necessary treatments for gender transition. Access to medical care (both medical and surgical) positively impacts the mental health of transgender and gender variant individuals.

The APA's vision statement includes the phrase: "Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment," yet currently, transgender and gender variant individuals frequently lack available and accessible treatment. In addition, APA's values include the following points:

- best standards of clinical practice
- patient-focused treatment decisions
- scientifically established principles of treatment
- advocacy for patients

Transgender and gender variant individuals currently lack access to the best standards of clinical practice, frequently do not have the opportunity to pursue patient-focused treatment decisions, do not receive scientifically established treatment and could benefit significantly from APA's advocacy.

APA Position:

Therefore, the American Psychiatric Association:

1. **Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments.**
2. **Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.**
3. **Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.**

Authors: Jack Drescher, M.D., Ellen Haller, M.D., APA Caucus of Lesbian, Gay and Bisexual Psychiatrists.

Background to the Position Statement

Transgender and gender variant people are frequently denied medical, surgical and psychiatric care related to gender transition despite significant evidence that appropriately evaluated individuals benefit from such care. It is often asserted that the DSM (and ICD) diagnoses provide the only pathways to insurance reimbursement for transgender individuals seeking medical assistance. However, to date, the APA has issued no treatment guidelines for gender identity disorder (GID) in either children or adults. This omission is in contrast to an increasing proliferation of APA practice guidelines for other DSM diagnoses (1).

The absence of a formal APA opinion about treatment of a diagnosis of its own creation has contributed to an ongoing problem of many health care insurers and other third party payers claiming that hormonal treatment and sex reassignment surgery (SRS) are “experimental treatments,” “elective treatments,” or “not medically necessary,” and, therefore, not reimbursable or covered under most insurance plans. The lack of consistency in how a transgender condition is defined by some institutions further marginalizes these individuals based on their subjective, surgical and hormonal status (2). In addition, treatment is not always accessible to wards of governmental agencies, such as transgender and gender variant individuals in foster care and prison systems. In other words, the presence of the GID diagnosis in the DSM has not served its intended purpose of creating greater access to care--one of the major arguments for diagnostic retention (1).

Lack of access to care adversely impacts the mental health of transgender and gender variant people, and both hormonal and surgical treatment have been shown to be efficacious in these individuals (3-7). Practice guidelines have been developed based on peer-reviewed scientific studies and are published and available for clinicians to access (3, 8, 9). The American Medical Association and the American Psychological Association both have position statements stating the critical importance of access to care for transgender and gender variant individuals (10, 11).

REFERENCES

1. Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual (DSM).” *Archives of Sexual Behavior*, 39, 427–460.
2. Rosenblum, Darren, "Trapped" in Sing Sing: Transgendered Prisoners Caught in the Gender Binarism" (2000). Pace Law Faculty Publications. Paper 207
3. World Professional Association for Transgender Health (WPATH) Standards of Care. Accessed online May 16, 2011, from: http://www.wpath.org/publications_standards.cfm
4. IOM (Institute of Medicine), 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academics Press. Accessed online May 16, 2011, from: <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>
5. De Cuyper G, TSjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebcke, P., Monstrey, S., Vansteenwegen A., & Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior*, 34(6), 679-690.
6. Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, 15(9), 1447-1457.
7. Smith Yolanda L S; Van Goozen Stephanie H M; Kuiper Abraham J; Cohen-Kettenis Peggy T. (2005). Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*; 35(1):89-99.
8. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ, III, Spack NP, Tangpricha V, Montori VM: Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2009; 94:3132-3154
9. UCSF Center of Excellence for Transgender Health Primary Care Protocol for Transgender Patient Care. Accessed online May 16, 2011, from: <http://transhealth.ucsf.edu/trans?page=protocol-00-00>
10. American Medical Association. Removing Financial Barriers to Care for Transgender Patients. Accessed online May 16, 2011, from: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-advocacy-committee/ama-policy-regarding-sexual-orientation.page?>
11. American Psychological Association. APA Policy Statement: Transgender, Gender Identity & Gender Expression Non-Discrimination. Accessed online May 16, 2011, from: <http://www.apa.org/about/governance/council/policy/transgender.aspx>

EXHIBIT 12



Transgender, Gender Identity, and Gender Expression Non-Discrimination

RESOLUTION

WHEREAS transgender and gender variant people frequently experience prejudice and discrimination and psychologists can, through their professional actions, address these problems at both an individual and a societal level; and

WHEREAS the American Psychological Association (APA) opposes prejudice and discrimination based on demographic characteristics including gender identity, as reflected in policies including the Hate Crimes Resolution (Paige, 2005), the Resolution on Prejudice Stereotypes and Discrimination (Paige, 2007), APA Bylaws (Article III, Section 2), the Ethical Principles of Psychologists and Code of Conduct (APA 2002, Standard 3.01 and Principle E); and

WHEREAS transgender and other gender variant people benefit from treatment with therapists with specialized knowledge of their issues (Lurie, 2005; Rachlin, 2002), and that the Ethical Principles of Psychologists and Code of Conduct states that when scientific or professional knowledge...is essential for the effective implementation of their services or research, psychologists have or obtain the training...necessary to ensure the competence of their services" (APA, 2002, 2.01b); and

WHEREAS discrimination and prejudice against people based on their actual or perceived gender identity or expression detrimentally affect psychological, physical, social, and economic well-being (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Resolution on Prejudice Stereotypes and Discrimination, in Paige, 2007; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005); and

WHEREAS transgender people may be denied basic non-gender transition related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005); and

WHEREAS gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005); and

WHEREAS gender variant and transgender people may be denied basic civil rights and protections (Minter, 2003; Spade, 2003) including: the right to civil marriage which confers a social status and important legal benefits, rights, and privileges (Paige, 2005); the right to obtain appropriate identity documents that are consistent with a post-transition identity; and the right to fair and safe and harassment-free institutional environments such as care facilities, treatment centers, shelters, housing, schools, prisons and juvenile justice programs; and

WHEREAS transgender and gender variant people experience a disproportionate rate of homelessness (Kammerer et al., 2001), unemployment (APA, 2007), and job discrimination (Herbst et al., 2007), disproportionately report income below the poverty line (APA, 2007), and experience other financial disadvantages (Lev, 2004); and

WHEREAS transgender and gender variant people may be at increased risk in institutional environments and facilities

Adopted by
the American
Psychological
Association Council
of Representatives

on August, 2008.

For more information, please see www.apa.org/pi/lgbt.

PLEASE CITE AS:

Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, 64, 372–453. doi:10.1037/a0015932

for harassment, physical and sexual assault (Edney, 2004; Minter, 2003; Petersen et al., 1996; Witten & Eyler, 2007) and inadequate medical care including denial of gender transition treatments such as hormone therapy (Edney, 2004; Petersen et al., 1996; Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005); and

WHEREAS many gender variant and transgender children and youth face harassment and violence in school environments, foster care, residential treatment centers, homeless centers, and juvenile justice programs (D'Augelli, Grossman, & Starks, 2006; Gay Lesbian and Straight Education Network, 2003; Grossman, D'Augelli, & Slater, 2006); and

WHEREAS psychologists are in a position to influence policies and practices in institutional settings, particularly regarding the implementation of the Standards of Care published by the World Professional Association of Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association) which recommend the continuation of gender transition treatments and especially hormone therapy during incarceration (Meyer et al., 2001); and

WHEREAS psychological research has the potential to inform treatment, service provision, civil rights, and approaches to promoting the well-being of transgender and gender variant people; and

WHEREAS APA has a history of successful collaboration with other organizations to meet the needs of particular populations, and organizations outside of APA have useful resources for addressing the needs of transgender and gender variant people;

THEREFORE BE IT RESOLVED that APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

BE IT FURTHER RESOLVED that APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

BE IT FURTHER RESOLVED that APA supports full access to employment, housing, and education regardless of gender identity and expression;

BE IT FURTHER RESOLVED that APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals;

BE IT FURTHER RESOLVED that APA encourages legal and social recognition of transgender individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression which do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

BE IT FURTHER RESOLVED that APA supports access to civil marriage and all its attendant benefits, rights, privileges, and responsibilities, regardless of gender identity or expression;

BE IT FURTHER RESOLVED that APA supports efforts to provide fair and safe environments for gender variant and transgender people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

BE IT FURTHER RESOLVED that APA supports efforts to provide safe and secure educational environments, at all levels of education, as well as foster care environments and juvenile justice programs, that promote an understanding and acceptance of self and in which all youths, including youth of all gender identities and expressions, may be free from discrimination, harassment, violence, and abuse;

BE IT FURTHER RESOLVED that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals;

BE IT FURTHER RESOLVED that APA recognizes the efficacy, benefit, and necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

BE IT FURTHER RESOLVED that APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender transition therapies;

BE IT FURTHER RESOLVED that APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender;

BE IT FURTHER RESOLVED that APA supports the funding of basic and applied research concerning gender expression and gender identity;

BE IT FURTHER RESOLVED that APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development, and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals regardless of gender identity or gender expression;

BE IT FURTHER RESOLVED that APA supports cooperation with other organizations in efforts to accomplish these ends.

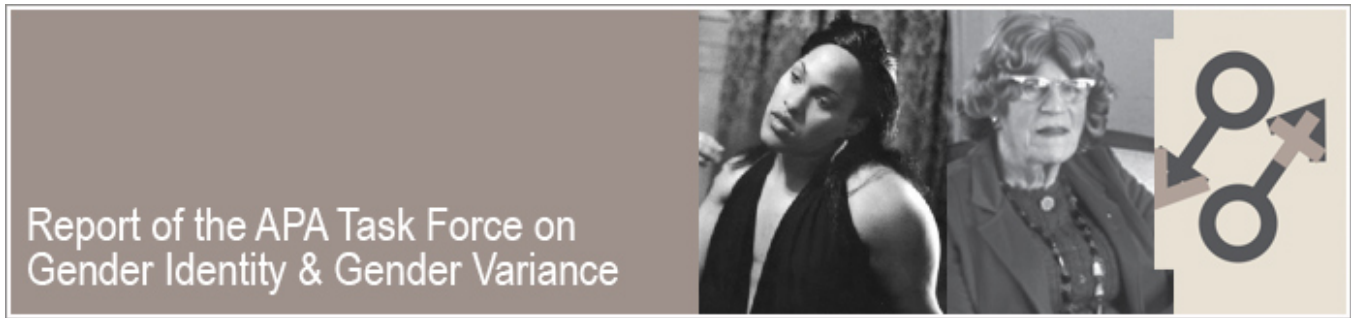
REFERENCES

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, *57*, 1060–1073. doi:10.1037/0003-066X.57.12.1060
- American Psychological Association. (2006). *Bylaws of the American Psychological Association*. Retrieved from <http://www.apa.org/about/governance/bylaws/index.aspx>
- American Psychological Association. (2007). *Report of the APA Task Force on Socioeconomic Status*. Washington, DC: Author.
- Bockting, W. O., & Fung, L. C. T. (2005). Genital reconstruction and gender identity disorders. In D. Sarwer, T. Pruzinsky, T. Cash, J. Persing, R. Goldwyn, & L. Whitaker (Eds.), *Psychological aspects of reconstructive and cosmetic plastic surgery: Clinical, empirical, and ethical perspectives* (pp. 207–229). Philadelphia, PA: Lippincott, Williams, & Wilkins.
- Bockting, W. O., Huang, C., Ding, H., Robinson, B., & Rosser, B. R. S. (2005). Are transgender persons at higher risk for HIV than other sexual minorities? A comparison of HIV prevalence and risks. *International Journal of Transgenderism*, *8*(2/3), 123–131.
- Clements-Nolle, K. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, *51*(3), 53–69. doi:10.1300/J082v51n03_04
- Coan, D. L., Schraner, W., & Packer, T. (2005). The role of male sex partners in HIV infection among male-to-female transgendered individuals. *International Journal of Transgenderism*, *8*(2/3), 21–30.
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, *21*, 1462–1482.
- De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., Monstrey, S., Vansteenwegen, A., & Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior*, *34*, 679–690. doi:10.1007/s10508-005-7926-5
- Edney, R. (2004). To keep me safe from harm? Transgender prisoners and the experience of imprisonment. *Deakin Law Review*, *9*, 327–338.
- Gay, Lesbian and Straight Education Network. (2004). *2003 National School Climate Survey: The school related experiences of our nation's lesbian, gay, bisexual and transgender youth*. New York, NY: Author.
- GLBT Health Access Project. (2000). *Access to healthcare for transgendered persons in greater Boston*. Boston, MA: J. S. I. Research and Training Institute, Inc.
- Grossman, A. H., D'Augelli, A. R., & Slater, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies*, *2*, 71–92. doi:10.1300/J461v02n01_04
- Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepas, N. (2007). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior*, *12*, 1–17. doi:10.1007/S10461-007-92993.
- Kammerer, N., Mason, T., Connors, M., & Durkee, R. (2001). Transgender health and social service needs in the context of HIV risk. In W. Bockting & S. Kirk (Eds.), *Transgender and HIV: Risks prevention and care* (pp. 39–57). Binghamton, NY: Haworth Press.

Transgender, Gender Identity, and Gender Expression Non-Discrimination

- Kenagy, G. P. (2005). The health and social service needs of transgender people in Philadelphia. *International Journal of Transgenderism*, 8(2/3), 49–56.
- Kenagy, G. P., & Bostwick, W. B. (2005). Health and social service needs of transgender people in Chicago. *International Journal of Transgenderism*, 8(2/3), 57–66.
- Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: A study of 141 Dutch transsexuals. *Archives of Sexual Behavior*, 17, 439–457. doi:10.1007/BF01542484
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Press.
- Lundstrom, B., Pauly, I., & Walinder, J. (1984). Outcome of sex reassignment surgery. *Acta Psychiatrica Scandinavica*, 70, 289–294. doi:10.1111/j.1600-0447.1984.tb01211.x
- Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism*, 8(2/3), 93–112.
- Meyer, W., III, Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., et al. (2001). The standards of care for gender identity disorders, sixth version. *International Journal of Transgenderism*, 5(1). Retrieved from <http://www.wpath.org/journal/www.iiav.nl/eazines/web/IJT/97-03/numbers/symposium/index-2.htm>
- Minter, S. (2003). *Representing transsexual clients: Selected legal issues*. Retrieved from <http://www.transgenderlaw.org/resources/translaw.htm>
- Nemoto, T., Operario, D., & Keatley, J. (2005). Health and social services for male-to-female transgender persons of color in San Francisco. *International Journal of Transgenderism*, 8(2/3), 5–20.
- Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, 15, 1447–1457.
- Paige, R. U. (2005). Proceedings of the American Psychological Association for the Legislative Year 2004: Minutes of the Annual Meeting of the Council of Representatives. *American Psychologist*, 60, 436–511. doi:10.1037/0003-066X.60.5.436
- Paige, R. U. (2007). Proceedings of the American Psychological Association for the legislative year 2006. Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, 62, 400–490. doi:10.1037/0003-066X.62.5.400
- Petersen, M., Stephens, J., Dickey, R., & Lewis, W. (1996). Transsexuals within the prison system: An international survey of correctional services policies. *Behavioral Sciences and the Law*, 14, 219, 221–222. doi:10.1002/(SICI)1099-0798(199621)14:2<219::AID-BSL234>3.3.CO;2-E
- Pfafflin, F., & Junge, A. (1998). *Sex reassignment—Thirty years of international follow-up studies: SRS: A comprehensive review, 1961–1991*. Dusseldorf, Germany: Symposium Publishing.
- Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism*, 6(1).
- Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfaction of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior*, 28, 71–89. doi:10.1023/A:1018745706354
- Risser, J. M. H., Shelton, A., McCurdy, S., Atkinson, J., Padgett, P., Useche, B., et al. (2005). Sex, drugs, violence, and HIV status among male-to-female transgender persons in Houston, Texas. *International Journal of Transgenderism*, 8(2/3), 67–74.
- Rodriguez-Madera, S., & Toro-Alfonso, J. (2005). Gender as an obstacle in HIV/AIDS prevention: Considerations for the development of HIV/AIDS prevention efforts for male-to-female transgenders. *International Journal of Transgenderism*, 8(2/3), 113–122.
- Ross, M.W., & Need, J. A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: A follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior*, 18, 145–153. doi:10.1007/BF01543120
- Spade, D. (2003). Resisting medicine, re/modeling gender. *Berkeley Women's Law Journal*, 18(15), 15–37.
- Sperber, J., Landers, S., & Lawrence, S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. *International Journal of Transgenderism*, 8(2/3), 75–92.
- Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*, 35, 89–99. doi:10.1017/S0033291704002776
- Van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology*, 47, 337–342. doi:10.1046/j.1365-2265.1997.2601068.x
- Witten, T. M., & Eyler, A. E. (2007). Transgender aging and the care of the elderly transgendered patient. In R. Ettner, S. Monstrey, & A. E. Eyler (Eds.), *Principles of Transgender Medicine and Surgery* (pp. 343–372). New York, NY: Haworth Press.
- Xavier, J. M., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism*, 8(2/3), 31–48.

EXHIBIT 13



Introduction

Download report

[\(/pi/gbt/resources/policy/gender-identity-report.pdf\)](#) (PDF, 1MB)

In recent years, transgender people have increasingly been willing to identify themselves openly. Public awareness of transgender issues has increased dramatically, in part because of an increasing number of books, motion pictures and television programs featuring transgender characters and addressing transgender issues. As a result, not only transgender people themselves but also their families and friends, employers, schools and government agencies are increasingly turning to psychologists for help in addressing these issues on individual and community levels. At the same time, changes in service delivery systems related to transgender issues have resulted in transsexuals and other people with gender identity concerns more frequently turning to community mental health professionals for assessment and treatment.

Consequently, it has become increasingly likely that psychologists will encounter people needing assistance with gender identity concerns. This trend underscores the need for psychologists to acquire greater knowledge and competence in addressing transgender issues.

In February 2005, the Council of Representatives of the American Psychological Association (APA) authorized the appointment of a Task Force on Gender Identity and Gender Variance. The task force was charged with the following:

Review extant APA policies regarding these issues and affected populations and recommend any indicated changes.

Develop recommendations for education, training, and further research into these topics.

Propose how APA can best meet the needs of psychologists and students who identify as transgender or gender variant.

Recommend appropriate collaboration with other professional organizations concerning these issues.

► **Policy Recommendations**

The task force reviewed APA policy documents, including bylaws, association rules, policies and procedures, the Ethical Principles of Psychologists and Code of Conduct (APA, 2002), practice guidelines, criteria for continuing education content and sponsorship, resolutions, and the Guidelines and Principles for Accreditation of Programs in Professional Psychology (APA Committee on Accreditation, 2006). On the basis of this review, the task force made specific policy recommendations in a number of areas.

They proposed, among other things, the development of practice guidelines for transgender and gender variant clients. Although there may not be sufficient research concerning many transgender issues to develop empirically based guidelines related to all important areas of practice, the task force agreed that there was adequate research concerning discrimination and stereotyping to support the development of clinical guidelines addressing these issues specifically.

The task force noted that APA is in a position to advocate on behalf of transgender people in the same way it advocates on behalf of many other disadvantaged groups: through activities such as lobbying and filing amicus briefs. Specific policy areas that would appropriately be a focus of such advocacy include access to transition-related health care, appropriate placement and treatment within sex-segregated facilities, and access to appropriate legal documents.

► **Education and Training Recommendations**

APA sponsors a variety of education and training activities and services for members, including hosting conventions, providing continuing education opportunities, publishing books and journals, and accrediting training sites. To meet its public education mandate, APA also publishes brochures, reports, periodicals, and Internet materials designed for laypersons. Accordingly, we believe that APA is well positioned to address the educational needs of its members and the general public regarding issues of transgender and gender variance.

To address the needs of psychologists, students, and interested members of the public, we outlined three levels of information, including specific products that should be available at these levels:

- Basic information on transgender issues would be readily available to all psychologists and students of psychology as an element of cultural competence and would also be available to interested members of the public.
- Intermediate-level information concerning transgender issues is important for psychologists who work with transgender clients and for interested members of the public; such information would address clinical presentations, prevalence, etiology, life span

development, assessment and treatment, comorbidity, and aspects of cultural competency.

- Advanced or specialized information concerning transgender issues would include a more in-depth consideration of the topics listed under intermediate-level resources; this information would be most relevant to clinicians working intensively with transgender clients and to students with particular interests in transgender issues.

In support of these aims, the task force created an educational brochure concerning transgender issues (</topics/gbt/transgender.aspx>), intended for APA members and the general public.

▶ **Meeting the Needs of Transgender Psychologists and Students**

The task force surveyed transgender psychologists and students and identified several broad categories of needs related to their status as transgender persons. These included more education, training, and research devoted to transgender issues; greater protection from discrimination; greater acceptance, mentoring, advocacy, and demonstration of ally status by colleagues; and increased recognition that transgender persons are experts regarding their own issues.

We identified a variety of specific needs related to educational and workplace settings. These included promotion of education regarding transgender issues in accredited training programs and internships sites; access to facilities that are typically segregated by sex, such as restrooms; confidential document management that reflects the individual's gender identity; and access to appropriate medical care and health insurance.

Within APA itself, specific needs included collection of demographic information regarding transgender status in relevant surveys of APA members; review of existing APA employment policies to ensure that they support equal employment opportunities for transgender people; and review of health insurance programs offered to APA members to ensure that they include transgender-related health care.

▶ **Recommendation for Collaboration With Other Organizations**

The task force identified six professional organizations with substantial expertise in transgender issues and with which APA should consider collaboration:

HBIGDA, now known as The World Association for Transgender Health (<http://www.wpath.org/>),

The Society for the Scientific Study of Sexuality (<http://www.sexscience.org/>),

The Council on Sexual Orientation and Gender Expression of the Council on Social Work Education (<http://www.cswe.org/cms/15548.aspx>) ,

The American Psychiatric Association (<http://www.psych.org/default.aspx>) ,

The International Association for Social Work Research and

The American Public Health Association (<http://www.apha.org/>) .

They also identified several other professional organizations and community-based organizations that have an interest in these issues and that could be considered for collaboration.

► **Task Force members**

Members

Margaret S. Schneider, PhD, Chair

Walter O. Bockting, PhD

Randall D. Ehrbar, PsyD

Anne A. Lawrence, MD, PhD

Katherine Rachlin, PhD

Kenneth J. Zucker, PhD

APA Public Interest Directorate Staff

Clinton W. Anderson, Director, Lesbian, Gay, Bisexual, and Transgender Concerns Office

Charlene DeLong, Administrative Coordinator

Find this article at:

<http://www.apa.org/pubs/info/reports/gender-identity.aspx>

EXHIBIT 14

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

American Psychological Association

Transgender and gender nonconforming¹ (TGNC) people are those who have a gender identity that is not fully aligned with their sex assigned at birth. The existence of TGNC people has been documented in a range of historical cultures (Coleman, Colgan, & Gooren, 1992; Feinberg, 1996; Miller & Nichols, 2012; Schmidt, 2003). Current population estimates of TGNC people have ranged from 0.17 to 1,333 per 100,000 (Meier & Labuski, 2013). The Massachusetts Behavioral Risk Factor Surveillance Survey found 0.5% of the adult population aged 18 to 64 years identified as TGNC between 2009 and 2011 (Conron, Scott, Stowell, & Landers, 2012). However, population estimates likely underreport the true number of TGNC people, given difficulties in collecting comprehensive demographic information about this group (Meier & Labuski, 2013). Within the last two decades, there has been a significant increase in research about TGNC people. This increase in knowledge, informed by the TGNC community, has resulted in the development of progressively more trans-affirmative practice across the multiple health disciplines involved in the care of TGNC people (Bockting, Knudson, & Goldberg, 2006; Coleman et al., 2012). Research has documented the extensive experiences of stigma and discrimination reported by TGNC people (Grant et al., 2011) and the mental health consequences of these experiences across the life span (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), including increased rates of depression (Fredriksen-Goldsen et al., 2014) and suicidality (Clements-Nolle, Marx, & Katz, 2006). TGNC people's lack of access to trans-affirmative mental and physical health care is a common barrier (Fredriksen-Goldsen et al., 2014; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman & D'Augelli, 2006), with TGNC people sometimes being denied care because of their gender identity (Xavier et al., 2012).

In 2009, the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (TFGIGV) survey found that less than 30% of psychologist and graduate student participants reported familiarity with issues that TGNC people experience (APA TFGIGV, 2009). Psychologists and other mental health professionals who have limited training and experience in TGNC-affirmative care may cause harm to TGNC people (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012). The significant level of societal stigma and discrimination that TGNC people face, the associated mental health consequences, and psychologists' lack of familiarity with trans-affirmative care led the APA Task Force to recommend that psycho-

logical practice guidelines be developed to help psychologists maximize the effectiveness of services offered and avoid harm when working with TGNC people and their families.

Purpose

The purpose of the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (hereafter *Guidelines*) is to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people. Trans-affirmative practice is the provision

The American Psychological Association's (APA's) Task Force on Guidelines for Psychological Practice with Transgender and Gender Nonconforming People developed these guidelines. Lore M. Dickey, Louisiana Tech University, and Anneliese A. Singh, The University of Georgia, served as chairs of the Task Force. The members of the Task Force included Walter O. Bockting, Columbia University; Sand Chang, Independent Practice; Kelly Ducheny, Howard Brown Health Center; Laura Edwards-Leeper, Pacific University; Randall D. Ehrbar, Whitman Walker Health Center; Max Fuentes Fuhmann, Independent Practice; Michael L. Hendricks, Washington Psychological Center, P.C.; and Ellen Magalhaes, Center for Psychological Studies at Nova Southeastern University and California School of Professional Psychology at Alliant International University.

The Task Force is grateful to BT, Robin Buhrke, Jenn Burleton, Theo Burnes, Loree Cook-Daniels, Ed Delgado-Romero, Maddie Deutsch, Michelle Emerick, Terry S. Gock, Kristin Hancock, Razia Kosi, Kimberly Lux, Shawn MacDonald, Pat Magee, Tracee McDaniel, Edgardo Menvielle, Parrish Paul, Jamie Roberts, Louise Silverstein, Mary Alice Silverman, Holiday Simmons, Michael C. Smith, Cullen Sprague, David Whitcomb, and Milo Wilson for their assistance in providing important input and feedback on drafts of the guidelines. The Task Force is especially grateful to Clinton Anderson, Director, and Ron Schlittler, Program Coordinator, of APA's Office on LGBT Concerns, who adeptly assisted and provided counsel to the Task Force throughout this project. The Task Force would also like to thank liaisons from the APA Committee on Professional Practice and Standards (COPPS), April Harris-Britt and Scott Hunter, and their staff support, Mary Hardiman. Additionally, members of the Task Force would like to thank the staff at the Phillip Rush Center and Agnes Scott College Counseling Center in Atlanta, Georgia, who served as hosts for face-to-face meetings.

This document will expire as APA policy in 2022. After this date, users should contact the APA Public Interest Directorate to determine whether the guidelines in this document remain in effect as APA policy.

Correspondence concerning this article should be addressed to the Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002.

¹ For the purposes of these guidelines, we use the term *transgender and gender nonconforming* (TGNC). We intend for the term to be as broadly inclusive as possible, and recognize that some TGNC people do not ascribe to these terms. Readers are referred to [Appendix A](#) for a listing of terms that include various TGNC identity labels.

of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people (Korell & Lorah, 2007). The *Guidelines* are an introductory resource for psychologists who will encounter TGNC people in their practice, but can also be useful for psychologists with expertise in this area of practice to improve the care already offered to TGNC people. The *Guidelines* include a set of definitions for readers who may be less familiar with language used when discussing gender identity and TGNC populations (see Appendix A). Distinct from TGNC, the term “cisgender” is used to refer to people whose sex assigned at birth is aligned with their gender identity (E. R. Green, 2006; Serano, 2006).

Given the added complexity of working with TGNC and gender-questioning youth² and the limitations of the available research, the *Guidelines* focus primarily, though not exclusively, on TGNC adults. Future revisions of the *Guidelines* will deepen a focus on TGNC and gender-questioning children and adolescents. The *Guidelines* address the strengths of TGNC people, the challenges they face, ethical and legal issues, life span considerations, research, education, training, and health care. Because issues of gender identity are often conflated with issues of gender expression or sexual orientation, psychological practice with the TGNC population warrants the acquisition of specific knowledge about concerns unique to TGNC people that are not addressed by other practice guidelines (APA, 2012). It is important to note that these *Guidelines* are not intended to address some of the conflicts that cisgender people may experience due to societal expectations regarding gender roles (Butler, 1990), nor are they intended to address intersex people (Dreger, 1999; Preves, 2003).

Documentation of Need

In 2005, the APA Council of Representatives authorized the creation of the Task Force on Gender Identity and Gender Variance (TFGIGV), charging the Task Force to review APA policies related to TGNC people and to offer recommendations for APA to best meet the needs of TGNC people (APA TFGIGV, 2009). In 2009, the APA Council of Representatives adopted the Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination, which calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment; encourages psychologists to take a leadership role in working against discrimination; supports the provision of adequate and necessary mental and medical health care; recognizes the efficacy, benefit, and medical necessity of gender transition; supports access to appropriate treatment in institutional settings; and supports the creation of educational resources for all psychologists (Anton, 2009). In 2009, in an extensive report on the current state of psychological practice with TGNC people, the TFGIGV determined that there was sufficient knowledge and expertise in the field to warrant the development of practice guidelines for TGNC populations (APA TFGIGV, 2009). The report identified that TGNC people constituted a population with

unique needs and that the creation of practice guidelines would be a valuable resource for the field (APA TFGIGV, 2009). Psychologists’ relative lack of knowledge about TGNC people and trans-affirmative care, the level of societal stigma and discrimination that TGNC people face, and the significant mental health consequences that TGNC people experience as a result offer a compelling need for psychological practice guidelines for this population.

Users

The intended audience for these *Guidelines* includes psychologists who provide clinical care, conduct research, or provide education or training. Given that gender identity issues can arise at any stage in a TGNC person’s life (Lev, 2004), clinicians can encounter a TGNC person in practice or have a client’s presenting problem evolve into an issue related to gender identity and gender expression. Researchers, educators, and trainers will benefit from use of these *Guidelines* to inform their work, even when not specifically focused on TGNC populations. Psychologists who focus on TGNC populations in their clinical practice, research, or educational and training activities will also benefit from the use of these *Guidelines*.

Distinction Between Standards and Guidelines

When using these *Guidelines*, psychologists should be aware that APA has made an important distinction between *standards* and *guidelines* (Reed, McLaughlin, & Newman, 2002). Standards are mandates to which all psychologists must adhere (e.g., the *Ethical Principles of Psychologists and Code of Conduct*; APA, 2010), whereas guidelines are aspirational. Psychologists are encouraged to use these *Guidelines* in tandem with the *Ethical Principles of Psychologists and Code of Conduct*, and should be aware that state and federal laws may override these *Guidelines* (APA, 2010).

In addition, these *Guidelines* refer to psychological practice (e.g., clinical work, consultation, education, research, and training) rather than treatment. Practice guidelines are practitioner-focused and provide guidance for professionals regarding “conduct and the issues to be considered in particular areas of clinical practice” (Reed et al., 2002, p. 1044). Treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition (Reed et al., 2002). The current *Guidelines* are intended to complement treatment guidelines for TGNC people seeking mental health services, such as those set forth by the World Professional Association for Transgender Health Standards of Care (Coleman et al., 2012) and the Endocrine Society (Hembree et al., 2009).

² For the purposes of these guidelines, “youth” refers to both children and adolescents under the age of 18.

Compatibility

These *Guidelines* are consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010), the *Standards of Accreditation for Health Service Psychology* (APA, 2015), the APA TFGIGV (2009) report, and the APA Council of Representatives Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination (Anton, 2009).

Practice Guidelines Development Process

To address one of the recommendations of the APA TFGIGV (2009), the APA Committee on Sexual Orientation and Gender Diversity (CSOGD; then the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns) and Division 44 (the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues) initiated a joint Task Force on Psychological Practice Guidelines with Transgender and Gender Nonconforming People in 2011. Task Force members were selected through an application and review process conducted by the leadership of CSOGD and Division 44. The Task Force included 10 members who had substantial psychological practice expertise with TGNC people. Of the 10 task force members, five individuals identified as TGNC with a range of gender identities and five identified as cisgender. In terms of race/ethnicity, six of the task force members identified as White and four identified as people of color (one Indian American, one Chinese American, one Latina American, and one mixed race).

The Task Force conducted a comprehensive review of the extant scholarship, identified content most pertinent to the practice of psychology with TGNC people, and evaluated the level of evidence to support guidance within each guideline. To ensure the accuracy and comprehensiveness of these *Guidelines*, Task Force members met with TGNC community members and groups and consulted with subject matter experts within and outside of psychology. When the Task Force discovered a lack of professional consensus, every effort was made to include divergent opinions in the field relevant to that issue. When this occurred, the Task Force described the various approaches documented in the literature. Additionally, these *Guidelines* were informed by comments received at multiple presentations held at professional conferences and comments obtained through two cycles of open public comment on earlier *Guideline* drafts.

This document contains 16 guidelines for TGNC psychological practice. Each guideline includes a Rationale section, which reviews relevant scholarship supporting the need for the guideline, and an Application section, which describes how the particular guideline may be applied in psychological practice. The *Guidelines* are organized into five clusters: (a) foundational knowledge and awareness; (b) stigma, discrimination, and barriers to care; (c) life span development; (d) assessment, therapy, and intervention; and (e) research, education, and training.

Funding for this project was provided by Division 44 (Society for the Psychological Study of LGBT Issues); the

APA Office on Lesbian, Gay, Bisexual, and Transgender (LGBT) Concerns; a grant from the Committee on Division/APA Relations (CODAPAR); and donations from Randall Ehrbar and Pamela St. Amand. Some members of the Task Force have received compensation through presentations (e.g., honoraria) or royalties (e.g., book contracts) based in part on information contained in these *Guidelines*.

Selection of Evidence

Although the number of publications on the topic of TGNC-affirmative practice has been increasing, this is still an emerging area of scholarly literature and research. When possible, the Task Force relied on peer-reviewed publications, but books, chapters, and reports that do not typically receive a high level of peer review have also been cited when appropriate. These sources are from a diverse range of fields addressing mental health, including psychology, counseling, social work, and psychiatry. Some studies of TGNC people utilize small sample sizes, which limits the generalizability of results. Few studies of TGNC people utilize probability samples or randomized control groups (e.g., Conron et al., 2012; Dhejne et al., 2011). As a result, the Task Force relied primarily on studies using convenience samples, which limits the generalizability of results to the population as a whole, but can be adequate for describing issues and situations that arise within the population.

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.

Rationale. Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender (Betha & McCollum, 2013; Institute of Medicine [IOM], 2011). In many cultures and religious traditions, gender has been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman (Benjamin, 1966; Mollenkott, 2001; Tanis, 2003). These mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth (Betha & McCollum, 2013). For TGNC people, gender identity differs from sex assigned at birth to varying degrees, and may be experienced and expressed outside of the gender binary (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Gender as a nonbinary construct has been described and studied for decades (Benjamin, 1966; Herdt, 1994; Kulick, 1998). There is historical evidence of recognition, societal acceptance, and sometimes reverence of diversity in gender identity and gender expression in several different cultures (Coleman et al., 1992; Feinberg, 1996; Miller

& Nichols, 2012; Schmidt, 2003). Many cultures in which gender nonconforming persons and groups were visible were diminished by westernization, colonialism, and systemic inequity (Nanda, 1999). In the 20th century, TGNC expression became medicalized (Hirschfeld, 1910/1991), and medical interventions to treat discordance between a person's sex assigned at birth, secondary sex characteristics, and gender identity became available (Meyerowitz, 2002).

As early as the 1950s, research found variability in how an individual described their³ gender, with some participants reporting a gender identity different from the culturally defined, mutually exclusive categories of "man" or "woman" (Benjamin, 1966). In several recent large online studies of the TGNC population in the United States, 30% to 40% of participants identified their gender identity as other than man or woman (Harrison et al., 2012; Kuper et al., 2012). Although some studies have cultivated a broader understanding of gender (Conron, Scout, & Austin, 2008), the majority of research has required a forced choice between man and woman, thus failing to represent or depict those with different gender identities (IOM, 2011). Research over the last two decades has demonstrated the existence of a wide spectrum of gender identity and gender expression (Bockting, 2008; Harrison et al., 2012; Kuper et al., 2012), which includes people who identify as either man or woman, neither man nor woman, a blend of man and woman, or a unique gender identity. A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological (Coleman et al., 2012). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth, as well as societal stigma and discrimination (Coleman et al., 2012).

Between the late 1960s and the early 1990s, health care to alleviate gender dysphoria largely reinforced a binary conceptualization of gender (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). At that time, it was considered an ideal outcome for TGNC people to conform to an identity that aligned with either sex assigned at birth or, if not possible, with the "opposite" sex, with a heavy emphasis on blending into the cisgender population or "passing" (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). Variance from these options could raise concern for health care providers about a TGNC person's ability to transition successfully. These concerns could act as a barrier to accessing surgery or hormone therapy because medical and mental health care provider endorsement was required before surgery or hormones could be accessed (Berger et al., 1979). Largely because of self-advocacy of TGNC individuals and communities in the 1990s, combined with advances in research and models of trans-affirmative care, there is greater recognition and acknowledgment of a spectrum of gender diversity and corresponding individualized, TGNC-specific health care (Bockting et al., 2006; Coleman et al., 2012).

Application. A nonbinary understanding of gender is fundamental to the provision of affirmative care for TGNC people. Psychologists are encouraged to adapt or

modify their understanding of gender, broadening the range of variation viewed as healthy and normative. By understanding the spectrum of gender identities and gender expressions that exist, and that a person's gender identity may not be in full alignment with sex assigned at birth, psychologists can increase their capacity to assist TGNC people, their families, and their communities (Lev, 2004). Respecting and supporting TGNC people in authentically articulating their gender identity and gender expression, as well as their lived experience, can improve TGNC people's health, well-being, and quality of life (Witten, 2003).

Some TGNC people may have limited access to visible, positive TGNC role models. As a result, many TGNC people are isolated and must cope with the stigma of gender nonconformity without guidance or support, worsening the negative effect of stigma on mental health (Fredriksen-Goldsen et al., 2014; Singh, Hays, & Watson, 2011). Psychologists may assist TGNC people in challenging gender norms and stereotypes, and in exploring their unique gender identity and gender expression. TGNC people, partners, families, friends, and communities can benefit from education about the healthy variation of gender identity and gender expression, and the incorrect assumption that gender identity automatically aligns with sex assigned at birth.

Psychologists may model an acceptance of ambiguity as TGNC people develop and explore aspects of their gender, especially in childhood and adolescence. A non-judgmental stance toward gender nonconformity can help to counteract the pervasive stigma faced by many TGNC people and provide a safe environment to explore gender identity and make informed decisions about gender expression.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Rationale. The constructs of gender identity and sexual orientation are theoretically and clinically distinct, even though professionals and nonprofessionals frequently conflate them. Although some research suggests a potential link in the development of gender identity and sexual orientation, the mechanisms of such a relationship are unknown (Adelson & American Academy of Child and Adolescent Psychiatry [AACAP] Committee on Quality Issues [CQI], 2012; APA TFGIGV, 2009; A. H. Devor, 2004; Drescher & Byne, 2013). *Sexual orientation* is defined as a person's sexual and/or emotional attraction to another person (Shively & De Cecco, 1977), compared with *gender identity*, which is defined by a person's felt, inherent sense of gender. For most people, gender identity develops earlier than sexual orientation. Gender identity is often established in young toddlerhood (Adelson & AACAP CQI, 2012; Kohlberg, 1966), compared with aware-

³ The third person plural pronouns "they," "them," and "their" in some instances function in these guidelines as third-person singular pronouns to model a common technique used to avoid the use of gendered pronouns when speaking to or about TGNC people.

ness of same-sex attraction, which often emerges in early adolescence (Adelson & AACAP CQI, 2012; D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Ryan, 2009; Savin-Williams & Diamond, 2000). Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood. The developmental pathway of gender identity typically includes a progression through multiple stages of awareness, exploration, expression, and identity integration (Bockting & Coleman, 2007; A. H. Devor, 2004; Vanderburgh, 2007). Similarly, a person's sexual orientation may progress through multiple stages of awareness, exploration, and identity through adolescence and into adulthood (Bilodeau & Renn, 2005). Just as some people experience their sexual orientation as being fluid or variable (L. M. Diamond, 2013), some people also experience their gender identity as fluid (Lev, 2004).

The experience of questioning one's gender can create significant confusion for some TGNC people, especially for those who are unfamiliar with the range of gender identities that exist. To explain any discordance they may experience between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, and/or gender role nonconformity and gender identity, some TGNC people may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009). Focusing solely on sexual orientation as the cause for discordance may obscure awareness of a TGNC identity. It can be very important to include sexual orientation and gender identity in the process of identity exploration as well as in the associated decisions about which options will work best for any particular person. In addition, many TGNC adults have disguised or rejected their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimize their fear of difference (Bockting & Coleman, 2007; Byne et al., 2012).

Because gender and patterns of attraction are used to identify a person's sexual orientation, the articulation of sexual orientation is made more complex when sex assigned at birth is not aligned with gender identity. A person's sexual orientation identity cannot be determined by simply examining external appearance or behavior, but must incorporate a person's identity and self-identification (Broido, 2000).

Application. Psychologists may assist people in differentiating gender identity and sexual orientation. As clients become aware of previously hidden or constrained aspects of their gender identity or sexuality, psychologists may provide acceptance, support, and understanding without making assumptions or imposing a specific sexual orientation or gender identity outcome (APA TFIGIV, 2009). Because of their roles in assessment, treatment, and prevention, psychologists are in a unique position to help TGNC people better understand and integrate the various aspects of their identities. Psychologists may assist TGNC people by introducing and normalizing differences in gender identity and expression. As a TGNC person finds a

comfortable way to actualize and express their gender identity, psychologists may notice that previously incongruent aspects of their sexual orientation may become more salient, better integrated, or increasingly egosyntonic (Bockting et al., 2009; H. Devor, 1993; Schleifer, 2006). This process may allow TGNC people the comfort and opportunity to explore attractions or aspects of their sexual orientation that previously had been repressed, hidden, or in conflict with their identity. TGNC people may experience a renewed exploration of their sexual orientation, a widened spectrum of attraction, or a shift in how they identify their sexual orientation in the context of a developing TGNC identity (Coleman, Bockting, & Gooren, 1993; Meier, Pardo, Labuski, & Babcock, 2013; Samons, 2008).

Psychologists may need to provide TGNC people with information about TGNC identities, offering language to describe the discordance and confusion TGNC people may be experiencing. To facilitate TGNC people's learning, psychologists may introduce some of the narratives written by TGNC people that reflect a range of outcomes and developmental processes in exploring and affirming gender identity (e.g., Bornstein & Bergman, 2010; Boylan, 2013; J. Green, 2004; Krieger, 2011; Lawrence, 2014). These resources may potentially aid TGNC people in distinguishing between issues of sexual orientation and gender identity and in locating themselves on the gender spectrum. Psychologists may also educate families and broader community systems (e.g., schools, medical systems) to better understand how gender identity and sexual orientation are different but related; this may be particularly useful when working with youth (Singh & Burnes, 2009; Whitman, 2013). Because gender identity and sexual orientation are often conflated, even by professionals, psychologists are encouraged to carefully examine resources that claim to provide affirmative services for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, and to confirm which are knowledgeable about and inclusive of the needs of TGNC people before offering referrals or recommendations to TGNC people and their families.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Rationale. Gender identity and gender expression may have profound intersections with other aspects of identity (Collins, 2000; Warner, 2008). These aspects may include, but are not limited to, race/ethnicity, age, education, socioeconomic status, immigration status, occupation, disability status, HIV status, sexual orientation, relational status, and religion and/or spiritual affiliation. Whereas some of these aspects of identity may afford privilege, others may create stigma and hinder empowerment (Burnes & Chen, 2012; K. M. de Vries, 2015). In addition, TGNC people who transition may not be prepared for changes in privilege or societal treatment based on gender identity and gender expression. To illustrate, an African American trans man may gain male privilege, but may face racism and

societal stigma particular to African American men. An Asian American/Pacific Islander trans woman may experience the benefit of being perceived as a cisgender woman, but may also experience sexism, misogyny, and objectification particular to Asian American/Pacific Islander cisgender women.

The intersection of multiple identities within TGNC people's lives is complex and may obstruct or facilitate access to necessary support (A. Daley, Solomon, Newman, & Mishna, 2008). TGNC people with less privilege and/or multiple oppressed identities may experience greater stress and restricted access to resources. They may also develop resilience and strength in coping with disadvantages, or may locate community-based resources available to specific groups (e.g., for people living with HIV; Singh et al., 2011). Gender identity affirmation may conflict with religious beliefs or traditions (Bocking & Cesaretti, 2001). Finding an affirmative expression of their religious and spiritual beliefs and traditions, including positive relationships with religious leaders, can be an important resource for TGNC people (Glaser, 2008; Porter, Ronneberg, & Witten, 2013; Xavier, 2000).

Application. In practice, psychologists strive to recognize the salient multiple and intersecting identities of TGNC people that influence coping, discrimination, and resilience (Burnes & Chen, 2012). Improved rapport and therapeutic alliance are likely to develop when psychologists avoid overemphasizing gender identity and gender expression when not directly relevant to TGNC people's needs and concerns. Even when gender identity is the main focus of care, psychologists are encouraged to understand that a TGNC person's experience of gender may also be shaped by other important aspects of identity (e.g., age, race/ethnicity, sexual orientation), and that the salience of different aspects of identity may evolve as the person continues psychosocial development across the life span, regardless of whether they complete a social or medical transition.

At times, a TGNC person's intersection of identities may result in conflict, such as a person's struggle to integrate gender identity with religious and/or spiritual upbringing and beliefs (Kidd & Witten, 2008; Levy & Lo, 2013; Rodriguez & Follins, 2012). Psychologists may aid TGNC people in understanding and integrating identities that may be differently privileged within systems of power and systemic inequity (Burnes & Chen, 2012). Psychologists may also highlight and strengthen the development of TGNC people's competencies and resilience as they learn to manage the intersection of stigmatized identities (Singh, 2012).

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

Rationale. Psychologists, like other members of society, come to their personal understanding and acceptance of different aspects of human diversity through a

process of socialization. Psychologists' cultural biases, as well as the cultural differences between psychologists and their clients, have a clinical impact (Israel, Gorcheva, Burnes, & Walther, 2008; Vasquez, 2007). The assumptions, biases, and attitudes psychologists hold regarding TGNC people and gender identity and/or gender expression can affect the quality of services psychologists provide and their ability to develop an effective therapeutic alliance (Bess & Stabb, 2009; Rachlin, 2002). In addition, a lack of knowledge or training in providing affirmative care to TGNC people can limit a psychologist's effectiveness and perpetuate barriers to care (Bess & Stabb, 2009; Rachlin, 2002). Psychologists experienced with lesbian, gay, or bisexual (LGB) people may not be familiar with the unique needs of TGNC people (Israel, 2005; Israel et al., 2008). In community surveys, TGNC people have reported that many mental health care providers lack basic knowledge and skills relevant to care of TGNC people (Bradford, Xavier, Hendricks, Rives, & Honnold, 2007; Xavier, Bobbin, Singer, & Budd, 2005) and receive little training to prepare them to work with TGNC people (APA TFGIGV, 2009; Lurie, 2005). The National Transgender Discrimination Survey (Grant et al., 2011) reported that 50% of TGNC respondents shared that they had to educate their health care providers about TGNC care, 28% postponed seeking medical care due to antitrans bias, and 19% were refused care due to discrimination.

The APA ethics code (APA, 2010) specifies that psychologists practice in areas only within the boundaries of their competence (Standard 2.01), participate in proactive and consistent ways to enhance their competence (Standard 2.03), and base their work upon established scientific and professional knowledge (Standard 2.04). Competence in working with TGNC people can be developed through a range of activities, such as education, training, supervised experience, consultation, study, or professional experience.

Application. Psychologists may engage in practice with TGNC people in various ways; therefore, the depth and level of knowledge and competence required by a psychologist depends on the type and complexity of service offered to TGNC people. Services that psychologists provide to TGNC people require a basic understanding of the population and its needs, as well as the ability to respectfully interact in a trans-affirmative manner (L. Carroll, 2010).

APA emphasizes the use of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). Given how easily assumptions or stereotypes could influence treatment, evidence-based practice may be especially relevant to psychological practice with TGNC people. Until evidence-based practices are developed specifically for TGNC people, psychologists are encouraged to utilize existing evidence-based practices in the care they provide. APA also promotes collaboration with clients concerning clinical decisions, including issues related to costs, potential benefits, and the existing options and resources related to treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). TGNC people could benefit from such collaboration and active engagement in decision

making, given the historical disenfranchisement and disempowerment of TGNC people in health care.

In an effort to develop competence in working with TGNC people, psychologists are encouraged to examine their personal beliefs regarding gender and sexuality, gender stereotypes, and TGNC identities, in addition to identifying gaps in their own knowledge, understanding, and acceptance (American Counseling Association [ACA], 2010). This examination may include exploring one's own gender identity and gendered experiences related to privilege, power, or marginalization, as well as seeking consultation and training with psychologists who have expertise in working with TGNC people and communities.

Psychologists are further encouraged to develop competence in working with TGNC people and their families by seeking up-to-date basic knowledge and understanding of gender identity and expression, and learning how to interact with TGNC people and their families respectfully and without judgment. Competence in working with TGNC people may be achieved and maintained in formal and informal ways, ranging from exposure in the curriculum of training programs for future psychologists and continuing education at professional conferences, to affirmative involvement as allies in the TGNC community. Beyond acquiring general competence, psychologists who choose to specialize in working with TGNC people presenting with gender-identity-related concerns are strongly encouraged to obtain advanced training, consultation, and professional experience (ACA, 2010; Coleman et al., 2012).

Psychologists may gain knowledge about the TGNC community and become more familiar with the complex social issues that affect the lives of TGNC people through first-hand experiences (e.g., attending community meetings and conferences, reading narratives written by TGNC people). If psychologists have not yet developed competence in working with TGNC people, it is recommended that they refer TGNC people to other psychologists or providers who are knowledgeable and able to provide trans-affirmative care.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Rationale. Many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Bazargan & Galvan, 2012; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011). Discrimination can include assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression (Na-

dal, Rivera, & Corpus, 2010; Nadal, Skolnik, & Wong, 2012). Discrimination may also include refusing access to housing or employment or extreme acts of violence (e.g., sexual assault, murder). TGNC people who hold multiple marginalized identities are more vulnerable to discrimination and violence. TGNC women and people of color disproportionately experience severe forms of violence and discrimination, including police violence, and are less likely to receive help from law enforcement (Edelman, 2011; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011).

TGNC people are at risk of experiencing antitrans prejudice and discrimination in educational settings. In a national representative sample of 7,898 LGBT youth in K-12 settings, 55.2% of participants reported verbal harassment, 22.7% reported physical harassment, and 11.4% reported physical assault based on their gender expression (Kosciw, Greytak, Palmer, & Boesen, 2014). In a national community survey of TGNC adults, 15% reported prematurely leaving educational settings ranging from kindergarten through college as a result of harassment (Grant et al., 2011). Many schools do not include gender identity and gender expression in their school nondiscrimination policies; this leaves TGNC youth without needed protections from bullying and aggression in schools (Singh & Jackson, 2012). TGNC youth in rural settings may be even more vulnerable to bullying and hostility in their school environments due to antitrans prejudice (Kosciw et al., 2014).

Inequities in educational settings and other forms of TGNC-related discrimination may contribute to the significant economic disparities TGNC people have reported. Grant and colleagues (2011) found that TGNC people were four times more likely to have a household income of less than \$10,000 compared with cisgender people, and almost half of a sample of TGNC older adults reported a household income at or below 200% of poverty (Fredriksen-Goldsen et al., 2014). TGNC people often face workplace discrimination both when seeking and maintaining employment (Brewster, Velez, Mennicke, & Tebbe, 2014; Dispenza et al., 2012; Mizock & Mueser, 2014). In a nonrepresentative national study of TGNC people, 90% reported having "directly experienced harassment or mistreatment at work and felt forced to take protective actions that negatively impacted their careers or their well-being, such as hiding who they were to avoid workplace repercussions" (Grant et al., 2011, p. 56). In addition, 78% of respondents reported experiencing some kind of direct mistreatment or discrimination at work (Grant et al., 2011). Employment discrimination may be related to stigma based on a TGNC person's appearance, discrepancies in identity documentation, or being unable to provide job references linked to that person's pretransition name or gender presentation (Bender-Baird, 2011).

Issues of employment discrimination and workplace harassment are particularly salient for TGNC military personnel and veterans. Currently, TGNC people cannot serve openly in the U.S. military. Military regulations cite "transsexualism" as a medical exclusion from service (Department of Defense, 2011; Elders & Steinman, 2014). When

enlisted, TGNC military personnel are faced with very difficult decisions related to coming out, transition, and seeking appropriate medical and mental health care, which may significantly impact or end their military careers. Not surprisingly, research documents very high rates of suicidal ideation and behavior among TGNC military and veteran populations (Blosnich et al., 2013; Matarazzo et al., 2014). Being open about their TGNC identity with health care providers can carry risk for TGNC military personnel (Out-Serve-Servicemembers Legal Defense Network, n.d.). Barriers to accessing health care noted by TGNC veterans include viewing the VA health care system as an extension of the military, perceiving the VA as an unwelcoming environment, and fearing providers' negative reactions to their identity (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd, Mizock, Maguen, & Green, 2012). A recent study shows 28% of LGBT veterans perceived their VA as welcoming and one third as unwelcoming (Sherman et al., 2014). Multiple initiatives are underway throughout the VA system to improve the quality and sensitivity of services to LGBT veterans.

Given widespread workplace discrimination and possible dismissal following transition, TGNC people may engage in sex work or survival sex (e.g., trading sex for food), or sell drugs to generate income (Grant et al., 2011; Hwang & Nuttbrock, 2007; Operario, Soma, & Underhill, 2008; Stanley, 2011). This increases the potential for negative interactions with the legal system, such as harassment by the police, bribery, extortion, and arrest (Edelman, 2011; Testa et al., 2012), as well as increased likelihood of mental health symptoms and greater health risks, such as higher incidence of sexually transmitted infections, including HIV (Nemoto, Operario, Keatley, & Villegas, 2004).

Incarcerated TGNC people report harassment, isolation, forced sex, and physical assault, both by prison personnel and other inmates (American Civil Liberties Union National Prison Project, 2005; Brotheim, 2013; C. Daley, 2005). In sex-segregated facilities, TGNC people may be subjected to involuntary solitary confinement (also called "administrative segregation"), which can lead to severe negative mental and physical health consequences and may block access to services (Gallagher, 2014; National Center for Transgender Equality, 2012). Another area of concern is for TGNC immigrants and refugees. TGNC people in detention centers may not be granted access to necessary care and experience significant rates of assault and violence in these facilities (Gruberg, 2013). TGNC people may seek asylum in the United States to escape danger as a direct result of lack of protections in their country of origin (APA Presidential Task Force on Immigration, 2012; Cerezo, Morales, Quintero, & Rothman, 2014; Morales, 2013).

TGNC people have difficulty accessing necessary health care (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012) and often feel unsafe sharing their gender identity or their experiences of antitrans prejudice and discrimination due to historical and current discrimination from health care providers (Grant et al., 2011; Lurie, 2005; Singh & McKleroy, 2011). Even when TGNC people have health insurance, plans may explicitly exclude coverage

related to gender transition (e.g., hormone therapy, surgery). TGNC people may also have difficulty accessing trans-affirmative primary health care if coverage for procedures is denied based on gender. For example, trans men may be excluded from necessary gynecological care based on the assumption that men do not need these services. These barriers often lead to a lack of preventive health care for TGNC people (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012). Although the landscape is beginning to change with the recent revision of Medicare policy (National Center for Transgender Equality, 2014) and changes to state laws (Transgender Law Center, n.d.), many TGNC people are still likely to have little to no access to TGNC-related health care as a result of the exclusions in their insurance.

Application. Awareness of and sensitivity to the effects of antitrans prejudice and discrimination can assist psychologists in assessing, treating, and advocating for their TGNC clients. When a TGNC person faces discrimination based on gender identity or gender expression, psychologists may facilitate emotional processing of these experiences and work with the person to identify supportive resources and possible courses of action. Specific needs of TGNC people might vary from developing self-advocacy strategies, to navigating public spaces, to seeking legal recourse for harassment and discrimination in social services and other systems. Additionally, TGNC people who have been traumatized by physical or emotional violence may need therapeutic support.

Psychologists may be able to assist TGNC people in accessing relevant social service systems. For example, psychologists may be able to assist in identifying health care providers and housing resources that are affirming and affordable, or locating affirming religious and spiritual communities (Glaser, 2008; Porter et al., 2013). Psychologists may also assist in furnishing documentation or official correspondence that affirms gender identity for the purpose of accessing appropriate public accommodations, such as bathroom use or housing (Lev, 2009; W. J. Meyer, 2009).

Additionally, psychologists may identify appropriate resources, information, and services to help TGNC people in addressing workplace discrimination, including strategies during a social and/or medical transition for identity disclosure at work. For those who are seeking employment, psychologists may help strategize about how and whether to share information about gender history. Psychologists may also work with employers to develop supportive policies for workplace gender transition or to develop training to help employees adjust to the transition of a coworker.

For TGNC military and veteran populations, psychologists may help to address the emotional impact of navigating TGNC identity development in the military system. Psychologists are encouraged to be aware that issues of confidentiality may be particularly sensitive with active duty or reserve status service members, as the consequences of being identified as TGNC may prevent the client's disclosure of gender identity in treatment.

In educational settings, psychologists may advocate for TGNC youth on a number of levels (APA & National

Association of School Psychologists, 2014; Boulder Valley School District, 2012). Psychologists may consult with administrators, teachers, and school counselors to provide resources and trainings on antitrans prejudice and developing safer school environments for TGNC students (Singh & Burnes, 2009). Peer support from other TGNC people has been shown to buffer the negative effect of stigma on mental health (Bockting et al., 2013). As such, psychologists may consider and develop peer-based interventions to facilitate greater understanding and respectful treatment of TGNC youth by cisgender peers (Case & Meier, 2014). Psychologists may work with TGNC youth and their families to identify relevant resources, such as school policies that protect gender identity and gender expression (APA & National Association of School Psychologists, 2014; Gonzalez & McNulty, 2010), referrals to TGNC-affirmative organizations, and online resources, which may be especially helpful for TGNC youth in rural settings.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Rationale. Antitrans prejudice and the adherence of mainstream society to the gender binary adversely affect TGNC people within their families, schools, health care, legal systems, workplaces, religious traditions, and communities (American Civil Liberties Union National Prison Project, 2005; Bradford et al., 2013; Brewster et al., 2014; Levy & Lo, 2013; McGuire, Anderson, & Toomey, 2010). TGNC people face challenges accessing gender-inclusive restrooms, which may result in discomfort when being forced to use a men's or women's restroom (Transgender Law Center, 2005). In addition to the emotional distress the forced binary choice that public restrooms may create for some, TGNC people are frequently concerned with others' reactions to their presence in public restrooms, including potential discrimination, harassment, and violence (Herman, 2013).

Many TGNC people may be distrustful of care providers due to previous experiences of being pathologized (Benson, 2013). Experiences of discrimination and prejudice with health care providers may be complicated by power differentials within the therapeutic relationship that may greatly affect or complicate the care that TGNC people experience. TGNC people have routinely been asked to obtain an endorsement letter from a psychologist attesting to the stability of their gender identity as a prerequisite to access an endocrinologist, surgeon, or legal institution (e.g., driver's license bureau; Lev, 2009). The need for such required documentation from a psychologist may influence rapport, resulting in TGNC people fearing prejudicial treatment in which this documentation is withheld or delayed by the treating provider (Bouman et al., 2014). Whether a TGNC person has personally experienced interactions with providers as disempowering or has learned from community members to expect such a dynamic, psychologists are encouraged to be prepared for TGNC people to be very cautious when entering into a therapeutic rela-

tionship. When TGNC people feel validated and empowered within the environment in which a psychologist practices, the therapeutic relationship will benefit and the person may be more willing to explore their authentic selves and share uncertainties and ambiguities that are a common part of TGNC identity development.

Application. Because many TGNC people experience antitrans prejudice or discrimination, psychologists are encouraged to ensure that their work settings are welcoming and respectful of TGNC people, and to be mindful of what TGNC people may perceive as unwelcoming. To do so, psychologists may educate themselves about the many ways that cisgender privilege and antitrans prejudice may be expressed. Psychologists may also have specific conversations with TGNC people about their experiences of the mental health system and implement feedback to foster TGNC-affirmative environments. As a result, when TGNC people access various treatment settings and public spaces, they may experience less harm, disempowerment, or pathologization, and thus will be more likely to avail themselves of resources and support.

Psychologists are encouraged to be proactive in considering how overt or subtle cues in their workplaces and other environments may affect the comfort and safety of TGNC people. To increase the comfort of TGNC people, psychologists are encouraged to display TGNC-affirmative resources in waiting areas and to avoid the display of items that reflect antitrans attitudes (Lev, 2009). Psychologists are encouraged to examine how their language (e.g., use of incorrect pronouns and names) may reinforce the gender binary in overt or subtle and unintentional ways (Smith, Shin, & Officer, 2012). It may be helpful for psychologists to provide training for support staff on how to respectfully interact with TGNC people. A psychologist may consider making changes to paperwork, forms, or outreach materials to ensure that these materials are more inclusive of TGNC people (Spade, 2011b). For example, demographic questionnaires can communicate respect through the use of inclusive language and the inclusion of a range of gender identities. In addition, psychologists may also work within their institutions to advocate for restrooms that are inclusive and accessible for people of all gender identities and/or gender expressions.

When working with TGNC people in a variety of care and institutional settings (e.g., inpatient medical and psychiatric hospitals, substance abuse treatment settings, nursing homes, foster care, religious communities, military and VA health care settings, and prisons), psychologists may become liaisons and advocates for TGNC people's mental health needs and for respectful treatment that addresses their gender identity in an affirming manner. In playing this role, psychologists may find guidance and best practices that have been published for particular institutional contexts to be helpful (e.g., Department of Veterans Affairs, Veterans' Health Administration, 2013; Glezer, McNeil, & Binder, 2013; Merksamer, 2011).

Guideline 7: Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

Rationale. The lack of public policy that addresses the needs of TGNC people creates significant hardships for them (Taylor, 2007). Although there have been major advances in legal protections for TGNC people in recent years (Buzuvis, 2013; Harvard Law Review Association, 2013), many TGNC people are still not afforded protections from discrimination on the basis of gender identity or expression (National LGBTQ Task Force, 2013; Taylor, 2007). For instance, in many states, TGNC people do not have employment or housing protections and may be fired or lose their housing based on their gender identity. Many policies that protect the rights of cisgender people, including LGB people, do not protect the rights of TGNC people (Currah, & Minter, 2000; Spade, 2011a).

TGNC people can experience challenges obtaining gender-affirming identity documentation (e.g., birth certificate, passport, social security card, driver's license). For TGNC people experiencing poverty or economic hardship, requirements for obtaining this documentation may be impossible to meet, in part due to the difficulty of securing employment without identity documentation that aligns with their gender identity and gender expression (Sheridan, 2009). Additionally, systemic barriers related to binary gender identification systems prevent some TGNC people from changing their documents, including those who are incarcerated, undocumented immigrants, and people who live in jurisdictions that explicitly forbid such changes (Spade, 2006). Documentation requirements can also assume a universal TGNC experience that marginalizes some TGNC people, especially those who do not undergo a medical transition. This may affect a TGNC person's social and psychological well-being and interfere with accessing employment, education, housing and shelter, health care, public benefits, and basic life management resources (e.g., opening a bank account).

Application. Psychologists are encouraged to inform public policy to reduce negative systemic impact on TGNC people and to promote positive social change. Psychologists are encouraged to identify and improve systems that permit violence; educational, employment, and housing discrimination; lack of access to health care; unequal access to other vital resources; and other instances of systemic inequity that TGNC people experience (ACA, 2010). Many TGNC people experience stressors from constant barriers, inequitable treatment, and forced release of sensitive and private information about their bodies and their lives (Hendricks & Testa, 2012). To obtain proper identity documentation, TGNC people may be required to provide court orders, proof of having had surgery, and documentation of psychotherapy or a psychiatric diagnosis. Psychologists may assist TGNC people by normalizing their reactions of fatigue and traumatization while interacting with legal systems and requirements; TGNC people may also benefit from guidance about alternate avenues of

recourse, self-advocacy, or appeal. When TGNC people feel that it is unsafe to advocate for themselves, psychologists may work with their clients to access appropriate resources in the community.

Psychologists are encouraged to be sensitive to the challenges of attaining gender-affirming identity documentation and how the receipt or denial of such documentation may affect social and psychological well-being, the person's ability to obtain education and employment, find safe housing, access public benefits, obtain student loans, and access health insurance. It may be of significant assistance for psychologists to understand and offer information about the process of a legal name change, gender marker change on identification, or the process for accessing other gender-affirming documents. Psychologists may consult the National Center for Transgender Equality, the Sylvia Rivera Law Project, or the Transgender Law Center for additional information on identity documentation for TGNC people.

Psychologists may choose to become involved with an organization that seeks to revise law and public policy to better protect the rights and dignities of TGNC people. Psychologists may participate at the local, state, or national level to support TGNC-affirmative health care accessibility, human rights in sex-segregated facilities, or policy change regarding gender-affirming identity documentation. Psychologists working in institutional settings may also expand their roles to work as collaborative advocates for TGNC people (Gonzalez & McNulty, 2010). Psychologists are encouraged to provide written affirmations supporting TGNC people and their gender identity so that they may access necessary services (e.g., hormone therapy).

Life Span Development

Guideline 8. Psychologists working with gender-questioning⁴ and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.

Rationale. Many children develop stability (constancy across time) in their gender identity between Ages 3 to 4 (Kohlberg, 1966), although gender consistency (recognition that gender remains the same across situations) often does not occur until Ages 4 to 7 (Siegal & Robinson, 1987). Children who demonstrate gender nonconformity in preschool and early elementary years may not follow this trajectory (Zucker & Bradley, 1995). Existing research suggests that between 12% and 50% of children diagnosed with gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley,

⁴ Gender-questioning youth are differentiated from TGNC youth in this section of the guidelines. Gender-questioning youth may be questioning or exploring their gender identity but have not yet developed a TGNC identity. As such, they may not be eligible for some services that would be offered to TGNC youth. Gender-questioning youth are included here because gender questioning may lead to a TGNC identity.

Peterson-Badaali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). However, several research studies categorized 30% to 62% of youth who did not return to the clinic for medical intervention after initial assessment, and whose gender identity may be unknown, as “desisters” who no longer identified with a gender different than sex assigned at birth (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008a). As a result, this research runs a strong risk of inflating estimates of the number of youth who do not persist with a TGNC identity. Research has suggested that children who identify more intensely with a gender different than sex assigned at birth are more likely to persist in this gender identification into adolescence (Steensma et al., 2013), and that when gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term TGNC identification increases (A. L. de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008b). Gender-questioning children who do not persist may be more likely to later identify as gay or lesbian than non-gender-questioning children (Bailey & Zucker, 1995; Drescher, 2014; Wallien & Cohen-Kettenis, 2008).

A clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature. Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children. Lack of consensus about the preferred approach to treatment may be due in part to divergent ideas regarding what constitutes optimal treatment outcomes for TGNC and gender-questioning youth (Hembree et al., 2009). Two distinct approaches exist to address gender identity concerns in children (Hill, Menvielle, Sica, & Johnson, 2010; Wallace & Russell, 2013), with some authors subdividing one of the approaches to suggest three (Byne et al., 2012; Drescher, 2014; Stein, 2012).

One approach encourages an affirmation and acceptance of children’s expressed gender identity. This may include assisting children to socially transition and to begin medical transition when their bodies have physically developed, or allowing a child’s gender identity to unfold without expectation of a specific outcome (A. L. de Vries & Cohen-Kettenis, 2012; Edwards-Leeper & Spack, 2012; Ehrensaft, 2012; Hidalgo et al., 2013; Tishelman et al., 2015). Clinicians using this approach believe that an open exploration and affirmation will assist children to develop coping strategies and emotional tools to integrate a positive TGNC identity should gender questioning persist (Edwards-Leeper & Spack, 2012).

In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. This includes endorsing and supporting behaviors and attitudes that align with the child’s sex assigned at birth prior to the onset of puberty (Zucker, 2008a; Zucker, Wood, Singh, & Bradley, 2012). Clinicians using

this approach believe that undergoing multiple medical interventions and living as a TGNC person in a world that stigmatizes gender nonconformity is a less desirable outcome than one in which children may be assisted to happily align with their sex assigned at birth (Zucker et al., 2012). Consensus does not exist regarding whether this approach may provide benefit (Zucker, 2008a; Zucker et al., 2012) or may cause harm or lead to psychosocial adversities (Hill et al., 2010; Pyne, 2014; Travers et al., 2012; Wallace & Russell, 2013). When addressing psychological interventions for children and adolescents, the World Professional Association for Transgender Health Standards of Care identify interventions “aimed at trying to change gender identity and expression to become more congruent with sex assigned at birth” as unethical (Coleman et al., 2012, p. 175). It is hoped that future research will offer improved guidance in this area of practice (Adelson & AACAP CQI, 2012; Malpas, 2011).

Much greater consensus exists regarding practice with adolescents. Adolescents presenting with gender identity concerns bring their own set of unique challenges. This may include having a late-onset (i.e., postpubertal) presentation of gender nonconforming identification, with no history of gender role nonconformity or gender questioning in childhood (Edwards-Leeper & Spack, 2012). Complicating their clinical presentation, many gender-questioning adolescents also present with co-occurring psychological concerns, such as suicidal ideation, self-injurious behaviors (Liu & Mustanski, 2012; Mustanski, Garofalo, & Emerson, 2010), drug and alcohol use (Garofalo et al., 2006), and autism spectrum disorders (A. L. de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Jones et al., 2012). Additionally, adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would benefit and to which they feel entitled (Angello, 2013; Edwards-Leeper & Spack, 2012). This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery.

Nonetheless, there is greater consensus that treatment approaches for adolescents affirm an adolescents’ gender identity (Coleman et al., 2012). Treatment options for adolescents extend beyond social approaches to include medical approaches. One particular medical intervention involves the use of puberty-suppressing medication or “blockers” (GnRH analogue), which is a reversible medical intervention used to delay puberty for appropriately screened adolescents with gender dysphoria (Coleman et al., 2012; A. L. C. de Vries et al., 2014; Edwards-Leeper, & Spack, 2012). Because of their age, other medical interventions may also become available to adolescents, and psychologists are frequently consulted to provide an assessment of whether such procedures would be advisable (Coleman et al., 2012).

Application. Psychologists working with TGNC and gender-questioning youth are encouraged to regularly review the most current literature in this area, recognizing the limited available research regarding the potential benefits and risks of different treatment approaches for children and for adolescents. Psychologists are encouraged to offer parents and guardians clear information about available treatment approaches, regardless of the specific approach chosen by the psychologist. Psychologists are encouraged to provide psychological service to TGNC and gender-questioning children and adolescents that draws from empirically validated literature when available, recognizing the influence psychologists' values and beliefs may have on the treatment approaches they select (Ehrbar & Gorton, 2010). Psychologists are also encouraged to remain aware that what one youth and/or parent may be seeking in a therapeutic relationship may not coincide with a clinician's approach (Brill & Pepper, 2008). In cases in which a youth and/or parent identify different preferred treatment outcomes than a clinician, it may not be clinically appropriate for the clinician to continue working with the youth and family, and alternative options, including referral, might be considered. Psychologists may also find themselves navigating family systems in which youth and their caregivers are seeking different treatment outcomes (Edwards-Leeper & Spack, 2012). Psychologists are encouraged to carefully reflect on their personal values and beliefs about gender identity development in conjunction with the available research, and to keep the best interest of the child or adolescent at the forefront of their clinical decisions at all times.

Because gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification (Ehrensaft, 2012). Additionally, psychologists may provide parents with information about possible long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists (Edwards-Leeper & Spack, 2012).

When working with adolescents, psychologists are encouraged to recognize that some TGNC adolescents will not have a strong history of childhood gender role nonconformity or gender dysphoria either by self-report or family observation (Edwards-Leeper & Spack, 2012). Some of these adolescents may have withheld their feelings of gender nonconformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as TGNC. Parents of these adolescents may need additional assistance in understanding and supporting their youth, given that late-onset gender dysphoria and TGNC identification may come as a significant surprise. Moving more slowly and cautiously in these cases is often advisable (Edwards-Leeper & Spack, 2012). Given the possibility of adolescents' intense focus on immediate desires and strong reactions to perceived delays or barriers, psychologists are encouraged to validate these concerns and the desire to move through the process

quickly while also remaining thoughtful and deliberate in treatment. Adolescents and their families may need support in tolerating ambiguity and uncertainty with regard to gender identity and its development (Brill & Pepper, 2008). It is encouraged that care should be taken not to foreclose this process.

For adolescents who exhibit a long history of gender nonconformity, psychologists may inform parents that the adolescent's self-affirmed gender identity is most likely stable (A. L. de Vries et al., 2011). The clinical needs of these adolescents may be different than those who are in the initial phases of exploring or questioning their gender identity. Psychologists are encouraged to complete a comprehensive evaluation and ensure the adolescent's and family's readiness to progress while also avoiding unnecessary delay for those who are ready to move forward.

Psychologists working with TGNC and gender-questioning youth are encouraged to become familiar with medical treatment options for adolescents (e.g., puberty-suppressing medication, hormone therapy) and work collaboratively with medical providers to provide appropriate care to clients. Because the ongoing involvement of a knowledgeable mental health provider is encouraged due to the psychosocial implications, and is often also a required part of the medical treatment regimen that may be offered to TGNC adolescents (Coleman et al., 2012; Hembree et al., 2009), psychologists often play an essential role in assisting in this process.

Psychologists may encourage parents and caregivers to involve youth in developmentally appropriate decision making about their education, health care, and peer networks, as these relate to children's and adolescents' gender identity and gender expression (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Psychologists are also encouraged to educate themselves about the advantages and disadvantages of social transition during childhood and adolescence, and to discuss these factors with both their young clients and clients' parents. Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth (Wallien, & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Psychologists are encouraged to acknowledge and explore the fear and burden of responsibility that parents and caregivers may feel as they make decisions about the health of their child or adolescent (Grossman, D'Augelli, Howell, & Hubbard, 2006). Parents and caregivers may benefit from a supportive environment to discuss feelings of isolation, explore loss and grief they may experience, vent anger and frustration at systems that disrespect or discriminate against them and their youth, and learn how to communicate with others about their child's or adolescent's gender identity or gender expression (Brill & Pepper, 2008).

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Rationale. Little research has been conducted about TGNC elders, leaving much to be discovered about this life stage for TGNC people (Auldridge, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012). Socialization into gender role behaviors and expectations based on sex assigned at birth, as well as the extent to which TGNC people adhere to these societal standards, is influenced by the chronological age at which a person self-identifies as TGNC, the age at which a person comes out or socially and/or medically transitions (Birren & Schaie, 2006; Bockting & Coleman, 2007; Cavanaugh & Blanchard-Fields, 2010; Nuttbrock et al., 2010; Wahl, Iwarsson, & Oswald, 2012), and a person's generational cohort (e.g., 1950 vs. 2010; Fredriksen-Goldsen et al., 2011).

Even decades after a medical or social transition, TGNC elders may still subscribe to the predominant gender role expectations that existed at the time of their transition (Knochel, Croghan, Moore, & Quam, 2011). Prior to the 1980s, TGNC people who transitioned were strongly encouraged by providers to pass in society as cisgender and heterosexual and to avoid associating with other TGNC people (Benjamin, 1966; R. Green & Money, 1969; Hastings, 1974; Hastings & Markland, 1978). Even TGNC elders who were comfortable telling others about their TGNC identity when they were younger may choose not to reveal their identity at a later stage of life (Ekins & King, 2005; Ippolito & Witten, 2014). Elders' unwillingness to disclose their TGNC identity can result from feelings of physical vulnerability or increased reliance on others who may discriminate against them or treat them poorly as a result of their gender identity (Bockting & Coleman, 2007), especially if the elder resides in an institutionalized setting (i.e., nursing home, assisted living facility) and relies on others for many daily needs (Auldridge et al., 2012). TGNC elders are also at a heightened risk for depression, suicidal ideation, and loneliness compared with LGB elders (Auldridge et al., 2012; Fredriksen-Goldsen et al., 2011).

A Transgender Law Center survey found that TGNC and LGB elders had less financial well-being than their younger cohorts, despite having a higher than average educational level for their age group compared with the general population (Hartzell, Frazer, Wertz, & Davis, 2009). Survey research has also revealed that TGNC elders experience underemployment and gaps in employment, often due to discrimination (Auldridge et al., 2012; Beemyn & Rankin, 2011; Factor & Rothblum, 2007). In the past, some TGNC people with established careers may have been encouraged by service providers to find new careers or jobs to avoid undergoing a gender transition at work or being identified as TGNC, potentially leading to a significant loss of income and occupational identity (Cook-Daniels, 2006). Obstacles to employment can increase economic disparities that result in increased needs for supportive housing and other social services (National Center for

Transgender Equality, 2012; Services and Advocacy for GLBT Elders & National Center for Transgender Equality, 2012).

TGNC elders may face obstacles to seeking or accessing resources that support their physical, financial, or emotional well-being. For instance, they may be concerned about applying for social security benefits, fearing that their TGNC identity may become known (Hartzell et al., 2009). A TGNC elder may avoid medical care, increasing the likelihood of later needing a higher level of medical care (e.g., home-based care, assisted living, or nursing home) than their same-age cisgender peers (Hartzell et al., 2009; Ippolito & Witten, 2014; Mikalson et al., 2012). Nursing homes and assisted living facilities are rarely sensitive to the unique medical needs of TGNC elders (National Senior Citizens Law Center, 2011). Some TGNC individuals who enter congregate housing, assisted living, or long-term care settings may feel the need to reverse their transition to align with sex assigned at birth to avoid discrimination and persecution by other residents and staff (Ippolito & Witten, 2014).

Older age may both facilitate and complicate medical treatment related to gender transition. TGNC people who begin hormone therapy later in life may have a smoother transition due to waning hormone levels that are a natural part of aging (Witten & Eyler, 2012). Age may also influence the decisions TGNC elders make regarding sex-affirmation surgeries, especially if physical conditions exist that could significantly increase risks associated with surgery or recovery.

Much has been written about the resilience of elders who have endured trauma (Fuhrmann & Shevlowitz, 2006; Hardy, Concato, & Gill, 2004; Mlinac, Sheeran, Blissmer, Lees, & Martins, 2011; Rodin & Stewart, 2012). Although some TGNC elders have experienced significant psychological trauma related to their gender identity, some also have developed resilience and effective ways of coping with adversity (Fruhauf & Orel, 2015). Despite the limited availability of LGBTQ-affirmative religious organizations in many local communities, TGNC elders make greater use of these resources than their cisgender peers (Porter et al., 2013).

Application. Psychologists are encouraged to seek information about the biopsychosocial needs of TGNC elders to inform case conceptualization and treatment planning to address psychological, social, and medical concerns. Many TGNC elders are socially isolated. Isolation can occur as a result of a loss of social networks through death or through disclosure of a TGNC identity. Psychologists may assist TGNC elders in establishing new social networks that support and value their TGNC identity, while also working to strengthen existing family and friend networks after a TGNC identity has been disclosed. TGNC elders may find special value in relationships with others in their generational cohort or those who may have similar coming-out experiences. Psychologists may encourage TGNC elders to identify ways they can mentor and improve the resilience of younger TGNC generations, creating a sense of generativity (Erikson, 1968) and contribu-

tion while building new supportive relationships. Psychologists working with TGNC elders may help them recognize the sources of their resilience and encourage them to connect with and be active in their communities (Fuhrmann & Craffey, 2014).

For TGNC elders who have chosen not to disclose their gender identity, psychologists may provide support to address shame, guilt, or internalized antitrans prejudice, and validate each person's freedom to choose their pattern of disclosure. Clinicians may also provide validation and empathy when TGNC elders have chosen a model of transition that avoids any disclosure of gender identity and is heavily focused on passing as cisgender.

TGNC elders who choose to undergo a medical or social transition in older adulthood may experience antitrans prejudice from people who question the value of transition at an older age or who believe that these elders are not truly invested in their transition or in a TGNC identity given the length of time they have waited (Auldridge et al., 2012). Some TGNC elders may also grieve lost time and missed opportunities. Psychologists may validate elders' choices to come out, transition, or evolve their gender identity or gender expression at any age, recognizing that such choices may have been much less accessible or viable at earlier stages of TGNC elders' lives.

Psychologists may assist congregate housing, assisted living, or long-term care settings to best meet TGNC elders' needs through respectful communication and affirmation of each person's gender identity and gender expression. Psychologists may work with TGNC people in hospice care systems to develop an end-of-life plan that respects the person's wishes about disclosure of gender identity during and after death.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Rationale. TGNC people may seek assistance from psychologists in addressing gender-related concerns, other mental health issues, or both. Mental health problems experienced by a TGNC person may or may not be related to that person's gender identity and/or may complicate assessment and intervention of gender-related concerns. In some cases, there may not be a relationship between a person's gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, having a TGNC identity may lead or contribute to a co-occurring mental health condition, either directly by way of gender dysphoria, or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; I. H. Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one's gender; Baltieri & De

Andrade, 2009; Hepp, Kraemer, Schnyder, Miller, & Designore, 2004).

Regardless of the presence or absence of an etiological link, gender identity may affect how a TGNC person experiences a co-occurring mental health condition, and/or a co-occurring mental health condition may complicate the person's gender expression or gender identity. For example, an eating disorder may be influenced by a TGNC person's gender expression (e.g., rigid eating patterns used to manage body shape or menstruation may be related to gender identity or gender dysphoria; Ålgars, Alanko, Santtila, & Sandnabba, 2012; Murray, Boon, & Touyz, 2013). In addition, the presence of autism spectrum disorder may complicate a TGNC person's articulation and exploration of gender identity (Jones et al., 2012). In cases in which gender dysphoria is contributing to other mental health concerns, treatment of gender dysphoria may be helpful in alleviating those concerns as well (Keo-Meier et al., 2015).

A relationship also exists between mental health conditions and the psychological sequelae of minority stress that TGNC people can experience. Given that TGNC people experience physical and sexual violence (Clements-Nolle et al., 2006; Kenagy & Bostwick, 2005; Lombardi, Wilchins, Priesing, & Malouf, 2001; Xavier et al., 2005), general harassment and discrimination (Beemyn & Rankin, 2011; Factor & Rothblum, 2007), and employment and housing discrimination (Bradford et al., 2007), they are likely to experience significant levels of minority stress. Studies have demonstrated the disproportionately high levels of negative psychological sequelae related to minority stress, including suicidal ideation and suicide attempts (Center for Substance Abuse Treatment, 2012; Clements-Nolle et al., 2006; Cochran & Cauce, 2006; Nuttbrock et al., 2010; Xavier et al., 2005) and completed suicides (Dhejne et al., 2011; van Kesteren, Asscheman, Megens, & Gooren, 1997). Recent studies have begun to demonstrate an association between sources of external stress and psychological distress (Bockting et al., 2013; Nuttbrock et al., 2010), including suicidal ideation and attempts and self-injurious behavior (dickey, Reisner, & Juntunen, 2015; Goldblum et al., 2012; Testa et al., 2012).

The minority stress model accounts for both the negative mental health effects of stigma-related stress and the processes by which members of the minority group may develop resilience and resistance to the negative effects of stress (I. H. Meyer, 1995, 2003). Although the minority stress model was developed as a theory of the relationship between sexual orientation and mental disorders, the model has been adapted to TGNC populations (Hendricks & Testa, 2012).

Application. Because of the increased risk of stress-related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC people (Coleman et al., 2012). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC person is experiencing, nor erroneously

assume that those mental health problems are a result of the person's gender identity or gender expression. Psychologists are strongly encouraged to be cautious before determining that gender nonconformity or dysphoria is due to an underlying psychotic process, as this type of causal relationship is rare.

When TGNC people seek to access transition-related health care, a psychosocial assessment is often part of this process (Coleman et al., 2012). A comprehensive and balanced assessment typically includes not only information about a person's past experiences of antitrans prejudice or discrimination, internalized messages related to these experiences, and anticipation of future victimization or rejection (Coolhart, Provancher, Hager, & Wang, 2008), but also coping strategies and sources of resilience (Hendricks & Testa, 2012; Singh et al., 2011). Gathering information about negative life events directly related to a TGNC person's gender identity and gender expression may assist psychologists in understanding the sequelae of stress and discrimination, distinguishing them from concurrent and potentially unrelated mental health problems. Similarly, when a TGNC person has a primary presenting concern that is not gender focused, a comprehensive assessment takes into account that person's experience relative to gender identity and gender expression, including any discrimination, just as it would include assessing other potential trauma history, medical concerns, previous experience with helping professionals, important future goals, and important aspects of identity. Strategies a TGNC person uses to navigate antitrans discrimination could be sources of strength to deal with life challenges or sources of distress that increase challenges and barriers.

Psychologists are encouraged to help TGNC people understand the pervasive influence of minority stress and discrimination that may exist in their lives, potentially including internalized negative attitudes about themselves and their TGNC identity (Hendricks & Testa, 2012). With this support, clients can better understand the origins of their mental health symptoms and normalize their reactions when faced with TGNC-related inequities and discrimination. Minority stress models also identify potentially important sources of resilience. TGNC people can develop resilience when they connect with other TGNC people who provide information on how to navigate antitrans prejudice and increase access to necessary care and resources (Singh et al., 2011). TGNC people may need help developing social support systems to nurture their resilience and bolster their ability to cope with the adverse effects of antitrans prejudice and/or discrimination (Singh & McKleroy, 2011).

Feminizing or masculinizing hormone therapy can positively or negatively affect existing mood disorders (Coleman et al., 2012). Psychologists may also help TGNC people who are in the initial stages of hormone therapy adjust to normal changes in how they experience emotions. For example, trans women who begin estrogens and anti-androgens may experience a broader range of emotions than they are accustomed to, or trans men beginning testosterone might be faced with adjusting to a higher libido

and feeling more emotionally reactive in stressful situations. These changes can be normalized as similar to the emotional adjustments that cisgender women and men experience during puberty. Some TGNC people will be able to adapt existing coping strategies, whereas others may need help developing additional skills (e.g., emotional regulation or assertiveness). Readers are encouraged to refer to the World Professional Association for Transgender Health Standards of Care for discussion of the possible effects of hormone therapy on a TGNC person's mood, affect, and behavior (Coleman et al., 2012).

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Rationale. Research has primarily shown positive treatment outcomes when TGNC adults and adolescents receive TGNC-affirmative medical and psychological services (i.e., psychotherapy, hormones, surgery; Byne et al., 2012; R. Carroll, 1999; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Davis & Meier, 2014; De Cuypere et al., 2006; Gooren, Giltay, & Bunck, 2008; Kuhn et al., 2009), although sample sizes are frequently small with no population-based studies. In a meta-analysis of the hormone therapy treatment literature with TGNC adults and adolescents, researchers reported that 80% of participants receiving trans-affirmative care experienced an improved quality of life, decreased gender dysphoria, and a reduction in negative psychological symptoms (Murad et al., 2010).

In addition, TGNC people who receive social support about their gender identity and gender expression have improved outcomes and quality of life (Brill & Pepper, 2008; Pinto, Melendez, & Spector, 2008). Several studies indicate that family acceptance of TGNC adolescents and adults is associated with decreased rates of negative outcomes, such as depression, suicide, and HIV risk behaviors and infection (Bockting et al., 2013; Dhejne et al., 2011; Grant et al., 2011; Liu & Mustanski, 2012; Ryan, 2009). Family support is also a strong protective factor for TGNC adults and adolescents (Bockting et al., 2013; Moody & Smith, 2013; Ryan et al., 2010). TGNC people, however, frequently experience blatant or subtle antitrans prejudice, discrimination, and even violence within their families (Bradford et al., 2007). Such family rejection is associated with higher rates of HIV infection, suicide, incarceration, and homelessness for TGNC adults and adolescents (Grant et al., 2011; Liu & Mustanski, 2012). Family rejection and lower levels of social support are significantly correlated with depression (Clements-Nolle et al., 2006; Ryan, 2009). Many TGNC people seek support through peer relationships, chosen families, and communities in which they may be more likely to experience acceptance (Gonzalez & McNulty, 2010; Nuttbrock et al., 2009). Peer support from other TGNC people has been found to be a moderator between antitrans discrimination and mental health, with higher levels of peer support associated with better mental health (Bockting et al., 2013). For some TGNC people, support from religious and spiritual communities provides

an important source of resilience (Glaser, 2008; Kidd & Witten, 2008; Porter et al., 2013).

Application. Given the strong evidence for the positive influence of affirmative care, psychologists are encouraged to facilitate access to and provide trans-affirmative care to TGNC people. Whether through the provision of assessment and psychotherapy, or through assisting clients to access hormone therapy or surgery, psychologists may play a critical role in empowering and validating TGNC adults' and adolescents' experiences and increasing TGNC people's positive life outcomes (Bess & Stabb, 2009; Rachlin, 2002).

Psychologists are also encouraged to be aware of the importance of affirmative social support and assist TGNC adults and adolescents in building social support networks in which their gender identity is accepted and affirmed. Psychologists may assist TGNC people in negotiating family dynamics that may arise in the course of exploring and establishing gender identity. Depending on the context of psychological practice, these issues might be addressed in individual work with TGNC clients, conjoint sessions including members of their support system, family therapy, or group therapy. Psychologists may help TGNC people decide how and when to reveal their gender identity at work or school, in religious communities, and to friends and contacts in other settings. TGNC people who decide not to come out in all aspects of their lives can still benefit from TGNC-affirmative in-person or online peer support groups.

Clients may ask psychologists to assist family members in exploring feelings about their loved one's gender identity and gender expression. Published models of family adjustment (Emerson & Rosenfeld, 1996) may be useful to help normalize family members' reactions upon learning that they have a TGNC family member, and to reduce feelings of isolation. When working with family members or significant others, it may be helpful to normalize feelings of loss or fear of what may happen to current relationships as TGNC people disclose their gender identity and expression to others. Psychologists may help significant others adjust to changing relationships and consider how to talk to extended family, friends, and other community members about TGNC loved ones. Providing significant others with referrals to TGNC-affirmative providers, educational resources, and support groups can have a profound impact on their understanding of gender identity and their communication with TGNC loved ones. Psychologists working with couples and families may also help TGNC people identify ways to include significant others in their social or medical transition.

Psychologists working with TGNC people in rural settings may provide clients with resources to connect with other TGNC people online or provide information about in-person support groups in which they can explore the unique challenges of being TGNC in these geographic areas (Walinsky & Whitcomb, 2010). Psychologists serving TGNC military and veteran populations are encouraged to be sensitive to the barriers these individuals face, especially for people who are on active duty in the U.S. military

(OutServe-Servicemembers Legal Defense Network, n.d.). Psychologists may help TGNC military members and veterans establish specific systems of support that create a safe and affirming space to reduce isolation and to create a network of peers with a shared military experience. Psychologists who work with veterans are encouraged to educate themselves on recent changes to VA policy that support equal access to VA medical and mental health services (Department of Veterans Affairs, Veterans' Health Administration, 2013).

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Rationale. Relationships involving TGNC people can be healthy and successful (Kins, Hoebeke, Heylens, Rubens, & De Cuyprere, 2008; Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013) as well as challenging (Brown, 2007; Iantaffi & Bockting, 2011). A study of successful relationships between TGNC men and cisgender women found that these couples attributed the success of their relationship to respect, honesty, trust, love, understanding, and open communication (Kins et al., 2008). Just as relationships between cisgender people can involve abuse, so can relationships between TGNC people and their partners (Brown, 2007), with some violent partners threatening to disclose a TGNC person's identity to exact control in the relationship (FORGE, n.d.).

In the early decades of medical and social transition for TGNC people, only those whose sexual orientations would be heterosexual posttransition (e.g., trans woman with a cisgender man) were deemed eligible for medical and social transition (Meyerowitz, 2002). This restriction prescribed only certain relationship partners (American Psychiatric Association, 1980; Benjamin, 1966; Chivers & Bailey, 2000), denied access to surgery for trans men identifying as gay or bisexual (Coleman & Bockting, 1988), or trans women identifying as lesbian or bisexual, and even required that TGNC people's existing legal marriages be dissolved before they could gain access to transition care (Lev, 2004).

Disclosure of a TGNC identity can have an important impact on the relationship between TGNC people and their partners. Disclosure of TGNC status earlier in the relationship tends to be associated with better relationship outcomes, whereas disclosure of TGNC status many years into an existing relationship may be perceived as a betrayal (Erhardt, 2007). When a TGNC person comes out in the context of an existing relationship, it can also be helpful if both partners are involved in decision making about the use of shared resources (i.e., how to balance the financial costs of transition with other family needs) and how to share this news with shared supports (i.e., friends and family). Sometimes relationship roles are renegotiated in the context of a TGNC person coming out to their partner (Samons, 2008). Assumptions about what it means to be a "husband" or a "wife" can shift if the gender identity of one's spouse shifts

(Erhardt, 2007). Depending on when gender issues are disclosed and how much of a change this creates in the relationship, partners may grieve the loss of aspects of their partner and the way the relationship used to be (Lev, 2004).

Although increasing alignment between gender identity and gender expression, whether it be through dress, behavior, or through medical interventions (i.e., hormones, surgery), does not necessarily affect to whom a TGNC person is attracted (Coleman et al., 1993), TGNC people may become more open to exploring their sexual orientation, may redefine sexual orientation as they move through transition, or both (Daskalos, 1998; H. Devor, 1993; Schleifer, 2006). Through increased comfort with their body and gender identity, TGNC people may explore aspects of their sexual orientation that were previously hidden or that felt discordant with their sex assigned at birth. Following a medical and/or social transition, a TGNC person's sexual orientation may remain constant or shift, either temporarily or permanently (e.g., renewed exploration of sexual orientation in the context of TGNC identity, shift in attraction or choice of sexual partners, widened spectrum of attraction, shift in sexual orientation identity; Meier, Sharp et al., 2013; Samons, 2008). For example, a trans man previously identified as a lesbian may later be attracted to men (Coleman et al., 1993; dickey, Burnes, & Singh, 2012), and a trans woman attracted to women pretransition may remain attracted to women posttransition (Lev, 2004).

Some TGNC people and their partners may fear the loss of mutual sexual attraction and other potential effects of shifting gender identities in the relationship. Lesbian-identified partners of trans men may struggle with the idea that being in a relationship with a man may cause others to perceive them as a heterosexual couple (Califa, 1997). Similarly, women in heterosexual relationships who later learn that their partners are trans women may be unfamiliar with navigating stigma associated with sexual minority status when viewed as a lesbian couple (Erhardt, 2007). Additionally, partners may find they are not attracted to a partner after transition. As an example, a lesbian whose partner transitions to a male identity may find that she is no longer attracted to this person because she is not sexually attracted to men. Partners of TGNC people may also experience grief and loss as their partners engage in social and/or medical transitions.

Application. Psychologists may help foster resilience in relationships by addressing issues specific to partners of TGNC people. Psychologists may provide support to partners of TGNC people who are having difficulty with their partner's evolving gender identity or transition, or are experiencing others having difficulty with the partner's transition. Partner peer support groups may be especially helpful in navigating internalized antitrans prejudice, shame, resentment, and relationship concerns related to a partner's gender transition. Meeting or knowing other TGNC people, other partners of TGNC people, and couples who have successfully navigated transition may also help TGNC people and their partners and serve as a protective factor (Brown, 2007). When TGNC status is disclosed during an existing relationship, psychologists may help

couples explore which relationship dynamics they want to preserve and which they might like to change.

In working with psychologists, TGNC people may explore a range of issues in their relationships and sexuality (dickey et al., 2012), including when and how to come out to current or potential romantic and sexual partners, communicating their sexual desires, renegotiating intimacy that may be lost during the TGNC partner's transition, adapting to bodily changes caused by hormone use or surgery, and exploring boundaries regarding touch, affection, and safer sex practices (Iantaffi & Bockting, 2011; Sevelius, 2009). TGNC people may experience increased sexual self-efficacy through transition. Although psychologists may aid partners in understanding a TGNC person's transition decisions, TGNC people may also benefit from help in cultivating awareness of the ways in which these decisions influence the lives of loved ones.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Rationale. Psychologists work with TGNC people across the life span to address parenting and family issues (Kenagy & Hsieh, 2005). There is evidence that many TGNC people have and want children (Wierckx et al., 2012). Some TGNC people conceive a child through sexual intercourse, whereas others may foster, adopt, pursue surrogacy, or employ assisted reproductive technologies, such as sperm or egg donation, to build or expand a family (De Sutter, Kira, Verschoor, & Hotimsky, 2002). Based on a small body of research to date, there is no indication that children of TGNC parents suffer long-term negative impacts directly related to parental gender change (R. Green, 1978, 1988; White & Ettner, 2004). TGNC people may find it both challenging to find medical providers who are willing to offer them reproductive treatment and to afford the cost (Coleman et al., 2012). Similarly, adoption can be quite costly, and some TGNC people may find it challenging to find foster care or adoption agencies that will work with them in a nondiscriminatory manner. Current or past use of hormone therapy may limit fertility and restrict a TGNC person's reproductive options (Darnery, 2008; Wierckx et al., 2012). Other TGNC people may have children or families before coming out as TGNC or beginning a gender transition.

TGNC people may present with a range of parenting and family-building concerns. Some will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to make decisions regarding potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. The medical and/or social transition of a TGNC parent may shift family dynamics, creating challenges and opportunities for partners, children, and other family members. One study of therapists' reflections on their experiences with TGNC clients suggested that family constellation and the parental relationship was more significant for children than the parent's social and/or medical

transition itself (White & Ettner, 2004). Although research has not documented that the transitions of TGNC people have an effect on their parenting abilities, preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition (dickey et al., 2012). This may result in divorce or separation, which may affect the children in the family. A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children (Amato, 2001; White & Ettner, 2007). This seems to be the case especially when children are reminded of the parent's love and assured of the parent's continued presence in their life (White & Ettner, 2007). Based on a small body of literature available, it is generally the case that younger children are best able to incorporate the transition of a parent, followed by adult children, with adolescents generally having the most difficulty (White & Ettner, 2007). If separated or divorced from their partners or spouses, TGNC parents may be at risk for loss of custody or visitation rights because some courts presume that there is a nexus between their gender identity or gender expression and parental fitness (Flynn, 2006). This type of prejudice is especially common for TGNC people of color (Grant et al., 2011).

Application. Psychologists are encouraged to attend to the parenting and family-building concerns of TGNC people. When working with TGNC people who have previous parenting experience, psychologists may help TGNC people identify how being a parent may influence decisions to come out as TGNC or to begin a transition (Freeman, Tasker, & Di Ceglie, 2002; Grant et al., 2011; Wierckx et al., 2012). Some TGNC people may choose to delay disclosure until their children have grown and left home (Bethua & McCollum, 2013). Clinical guidelines jointly developed by a Vancouver, British Columbia, TGNC community organization and a health care provider organization encourage psychologists and other mental health providers working with TGNC people to plan for disclosure to a partner, previous partner, or children, and to pay particular attention to resources that assist TGNC people to discuss their identity with children of various ages in developmentally appropriate ways (Bockting et al., 2006). Lev (2004) uses a developmental stage framework for the process that family members are likely to go through in coming to terms with a TGNC family member's identity that some psychologists may find helpful. Awareness of peer support networks for spouses and children of TGNC people can also be helpful (e.g., PFLAG, TransYouth Family Allies). Psychologists may provide family counseling to assist a family in managing disclosure, improve family functioning, and maintain family involvement of the TGNC person, as well as aiding the TGNC person in attending to the ways that their transition process has affected their family members (Samons, 2008). Helping parents to continue to work together to focus on the needs of their children and to maintain family bonds is likely to lead to the best results for the children (White & Ettner, 2007).

For TGNC people with existing families, psychologists may support TGNC people in seeking legal counsel regarding parental rights in adoption or custody. Depending on the situation, this may be desirable even if the TGNC parent is biologically related to the child (Minter & Wald, 2012). Although being TGNC is not a legal impediment to adoption in the United States, there is the potential for overt and covert discrimination and barriers, given the widespread prejudice against TGNC people. The question of whether to disclose TGNC status on an adoption application is a personal one, and a prospective TGNC parent would benefit from consulting a lawyer for legal advice, including what the laws in their jurisdiction say about disclosure. Given the extensive background investigation frequently conducted, it may be difficult to avoid disclosure. Many lawyers favor disclosure to avoid any potential legal challenges during the adoption process (Minter & Wald, 2012).

In discussing family-building options with TGNC people, psychologists are encouraged to remain aware that some of these options require medical intervention and are not available everywhere, in addition to being quite costly (Coleman et al., 2012). Psychologists may work with clients to manage feelings of loss, grief, anger, and resentment that may arise if TGNC people are unable to access or afford the services they need for building a family (Bockting et al., 2006; De Sutter et al., 2002).

When TGNC people consider beginning hormone therapy, psychologists may engage them in a conversation about the possibly permanent effects on fertility to better prepare TGNC people to make a fully informed decision. This may be of special importance with TGNC adolescents and young adults who often feel that family planning or loss of fertility is not a significant concern in their current daily lives, and therefore disregard the long-term reproductive implications of hormone therapy or surgery (Coleman et al., 2012). Psychologists are encouraged to discuss contraception and safer sex practices with TGNC people, given that they may still have the ability to conceive even when undergoing hormone therapy (Bockting, Robinson, & Rosser, 1998). Psychologists may play a critical role in educating TGNC adolescents and young adults and their parents about the long-term effects of medical interventions on fertility and assist them in offering informed consent prior to pursuing such interventions. Although hormone therapy may limit fertility (Coleman et al., 2012), psychologists may encourage TGNC people to refrain from relying on hormone therapy as the sole means of birth control, even when a person has amenorrhea (Gorton & Grubb, 2014). Education on safer sex practices may also be important, as some segments of the TGNC community (e.g., trans women and people of color) are especially vulnerable to sexually transmitted infections and have been shown to have high prevalence and incidence rates of HIV infection (Kellogg, Clements-Nolle, Dilley, Katz, & McFarland, 2001; Nemoto, Operario, Keatley, Han, & Soma, 2004).

Depending on the timing and type of options selected, psychologists may explore the physical, social, and emotional implications should TGNC people choose to delay or

stop hormone therapy, undergo fertility treatment, or become pregnant. Psychological effects of stopping hormone therapy may include depression, mood swings, and reactions to the loss of physical masculinization or feminization facilitated by hormone therapy (Coleman et al., 2012). TGNC people who choose to halt hormone therapy during attempts to conceive or during a pregnancy may need additional psychological support. For example, TGNC people and their families may need help in managing the additional antitrans prejudice and scrutiny that may result when a TGNC person with stereotypically masculine features becomes visibly pregnant. Psychologists may also assist TGNC people in addressing their loss when they cannot engage in reproductive activities that are consistent with their gender identity, or when they encounter barriers to conceiving, adopting, or fostering children not typically faced by other people (Vanderburgh, 2007). Psychologists are encouraged to assess the degree to which reproductive health services are TGNC-affirmative prior to referring TGNC people to them. Psychologists are also encouraged to provide TGNC-affirmative information to reproductive health service personnel when there is a lack of trans-affirmative knowledge.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Rationale. Collaboration across disciplines can be crucial when working with TGNC people because of the potential interplay of biological, psychological, and social factors in diagnosis and treatment (Hendricks & Testa, 2012). The challenges of living with a stigmatized identity and the need of many TGNC people to transition, socially and/or medically, may call for the involvement of health professionals from various disciplines, including psychologists, psychiatrists, social workers, primary health care providers, endocrinologists, nurses, pharmacists, surgeons, gynecologists, urologists, electrologists, speech therapists, physical therapists, pastoral counselors and chaplains, and career or educational counselors. Communication, cooperation, and collaboration will ensure optimal coordination and quality of care. Just as psychologists often refer TGNC people to medical providers for assessment and treatment of medical issues, medical providers may rely on psychologists to assess readiness and assist TGNC clients to prepare for the psychological and social aspects of transition before, during, and after medical interventions (Coleman et al., 2012; Hembree et al., 2009; Lev, 2009). Outcome research to date supports the value and effectiveness of an interdisciplinary, collaborative approach to TGNC-specific care (see Coleman et al., 2012 for a review).

Application. Psychologists' collaboration with colleagues in medical and associated health disciplines involved in TGNC clients' care (e.g., hormonal and surgical treatment, primary health care; Coleman et al., 2012; Lev, 2009) may take many forms and should occur in a timely manner that does not complicate access to needed

services (e.g., considerations of wait time). For example, a psychologist working with a trans man who has a diagnosis of bipolar disorder may need to coordinate with his primary care provider and psychiatrist to adjust his hormone levels and psychiatric medications, given that testosterone can have an activating effect, in addition to treating gender dysphoria. At a basic level, collaboration may entail the creation of required documentation that TGNC people present to surgeons or medical providers to access gender-affirming medical interventions (e.g., surgery, hormone therapy; Coleman et al., 2012). Psychologists may offer support, information, and education to interdisciplinary colleagues who are unfamiliar with issues of gender identity and gender expression to assist TGNC people in obtaining TGNC-affirmative care (Holman & Goldberg, 2006; Lev, 2009). For example, a psychologist who is assisting a trans woman with obtaining gender-affirming surgery may, with her consent, contact her new gynecologist in preparation for her first medical visit. This contact could include sharing general information about her gender history and discussing how both providers could most affirmatively support appropriate health checks to ensure her best physical health (Holman & Goldberg, 2006).

Psychologists in interdisciplinary settings could also collaborate with medical professionals prescribing hormone therapy by educating TGNC people and ensuring TGNC people are able to make fully informed decisions prior to starting hormone treatment (Coleman et al., 2012; Deutsch, 2012; Lev, 2009). Psychologists working with children and adolescents play a particularly important role on the interdisciplinary team due to considerations of cognitive and social development, family dynamics, and degree of parental support. This role is especially crucial when providing psychological evaluation to determine the appropriateness and timeliness of a medical intervention. When psychologists are not part of an interdisciplinary setting, especially in isolated or rural communities, they can identify interdisciplinary colleagues with whom they may collaborate and/or refer (Walinsky & Whitcomb, 2010). For example, a rural psychologist could identify a trans-affirmative pediatrician in a surrounding area and collaborate with the pediatrician to work with parents raising concerns about their TGNC and questioning children and adolescents.

In addition to working collaboratively with other providers, psychologists who obtain additional training to specialize in work with TGNC people may also serve as consultants in the field (e.g., providing additional support to providers working with TGNC people or assisting school and workplaces with diversity training). Psychologists who have expertise in working with TGNC people may play a consultative role with providers in inpatient settings seeking to provide affirmative care to TGNC clients. Psychologists may also collaborate with social service colleagues to provide TGNC people with affirmative referrals related to housing, financial support, vocational/educational counseling and training, TGNC-affirming religious or spiritual communities, peer support, and other community resources (Gehi & Arkles, 2007). This collaboration might also in-

clude assuring that TGNC people who are minors in the care of the state have access to culturally appropriate care.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Rationale. Historically, in a set of demographic questions, psychological research has included one item on either sex or gender, with two response options—male and female. This approach wastes an opportunity to increase knowledge about TGNC people for whom neither option may fit their identity, and runs the risk of alienating TGNC research participants (IOM, 2011). For example, there is little knowledge about HIV prevalence, risks, and prevention needs of TGNC people because most of the research on HIV has not included demographic questions to identify TGNC participants within their samples. Instead, TGNC people have been historically subsumed within larger demographic categories (e.g., men who have sex with men, women of color), rendering the impact of the HIV epidemic on the TGNC population invisible (Herbst et al., 2008). Scholars have noted that this invisibility fails to draw attention to the needs of TGNC populations that experience the greatest health disparities, including TGNC people who are of color, immigrants, low income, homeless, veterans, incarcerated, live in rural areas, or have disabilities (Bauer et al., 2009; Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010; Shipherd et al., 2012; Walinsky & Whitcomb, 2010).

There is a great need for more research to inform practice, including affirmative treatment approaches with TGNC people. Although sufficient evidence exists to support current standards of care (Byne et al., 2012; Coleman et al., 2012), much is yet to be learned to optimize quality of care and outcome for TGNC clients, especially as it relates to the treatment of children (IOM, 2011; Mikalson et al., 2012). In addition, some research with TGNC populations has been misused and misinterpreted, negatively affecting TGNC people's access to health services to address issues of gender identity and gender expression (Namaste, 2000). This has resulted in justifiable skepticism and suspicion in the TGNC community when invited to participate in research initiatives. In accordance with the APA ethics code (APA, 2010), psychologists conduct research and distribute research findings with integrity and respect for their research participants. As TGNC research increases, some TGNC communities may experience being oversampled in particular geographic areas and/or TGNC people of color may not be well-represented in TGNC studies (Hwahng & Lin, 2009; Namaste, 2000).

Application. All psychologists conducting research, even when not specific to TGNC populations, are encouraged to provide a range of options for capturing demographic information about TGNC people so that TGNC people may be included and accurately represented

(Conron et al., 2008; Deutsch et al., 2013). One group of experts has recommended that population research, and especially government-sponsored surveillance research, use a two-step method, first asking for sex assigned at birth, and then following with a question about gender identity (GenIUSS, 2013). For research focused on TGNC people, including questions that assess both sex assigned at birth and current gender identity allows the disaggregation of subgroups within the TGNC population and has the potential to increase knowledge of differences within the population. In addition, findings about one subgroup of TGNC people may not apply to other subgroups. For example, results from a study of trans women of color with a history of sex work who live in urban areas (Nemoto, Operario, Keatley, & Villegas, 2004) may not generalize to all TGNC women of color or to the larger TGNC population (Bauer, Travers, Scanlon, & Coleman, 2012; Operario et al., 2008).

In conducting research with TGNC people, psychologists will confront the challenges associated with studying a relatively small, geographically dispersed, diverse, stigmatized, hidden, and hard-to-reach population (IOM, 2011). Because TGNC individuals are often hard to reach (IOM, 2011) and TGNC research is rapidly evolving, it is important to consider the strengths and limitations of the methods that have been or may be used to study the TGNC population, and to interpret and represent findings accordingly. Some researchers have strongly recommended collaborative research models (e.g., participatory action research) in which TGNC community members are integrally involved in these research activities (Clements-Nolle & Bachrach, 2003; Singh, Richmond, & Burnes, 2013). Psychologists who seek to educate the public by communicating research findings in the popular media will also confront challenges, because most journalists have limited knowledge about the scientific method and there is potential for the media to misinterpret, exploit, or sensationalize findings (Garber, 1992; Namaste, 2000).

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

Rationale. The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010) include gender identity as one factor for which psychologists may need to obtain training, experience, consultation, or supervision in order to ensure their competence (APA, 2010). In addition, when APA-accredited programs are required to demonstrate a commitment to cultural and individual diversity, gender identity is specifically included (APA, 2015). Yet surveys of TGNC people suggest that many mental health care providers lack even basic knowledge and skills required to offer trans-affirmative care (Bradford et al., 2007; O'Hara, Dispenza, Brack, & Blood, 2013; Xavier et al., 2005). The APA Task Force on Gender Identity and Gender Variance (2009) projected that many, if not most, psychologists and graduate psychology students will at some point encounter TGNC people among their clients, colleagues, and trainees. Yet professional education and training in psychology includes little or no preparation for

working with TGNC people (Anton, 2009; APA TFGIGV, 2009), and continuing professional education available to practicing mental health clinicians is also scant (Lurie, 2005). Only 52% percent of psychologists and graduate students who responded to a survey conducted by an APA Task Force reported having had the opportunity to learn about TGNC issues in school; of those respondents, only 27% reported feeling adequately familiar with gender concerns ($n = 294$; APA TFGIGV, 2009).

Training on gender identity in professional psychology has frequently been subsumed under discussions of sexual orientation or in classes on human sexuality. Some scholars have suggested that psychologists and students may mistakenly believe that they have obtained adequate knowledge and awareness about TGNC people through training focused on LGB populations (Harper & Schneider, 2003). However, Israel and colleagues have found important differences between the therapeutic needs of TGNC people and those of LGB people in the perceptions of both clients and providers (Israel et al., 2008; Israel, Walther, Gorcheva, & Perry, 2011). Nadal and colleagues have suggested that the absence of distinct, accurate information about TGNC populations in psychology training not only perpetuates misunderstanding and marginalization of TGNC people by psychologists but also contributes to continued marginalization of TGNC people in society as a whole (Nadal et al., 2010, 2012).

Application. Psychologists strive to continue their education on issues of gender identity and gender expression with TGNC people as a foundational component of affirmative psychological practice. In addition to these guidelines, which educators may use as a resource in developing curricula and training experiences, ACA (2010) has also adopted a set of competencies that may be a helpful resource for educators. In addition to including TGNC people and their issues in foundational education in health service psychology (e.g., personality development, multiculturalism, research methods), some psychology programs may also provide coursework and training for students interested in developing more advanced expertise on issues of gender identity and gender expression.

Because of the high level of societal ignorance and stigma associated with TGNC people, ensuring that psychological education, training, and supervision is affirmative, and does not sensationalize (Namaste, 2000), exploit, or pathologize TGNC people (Lev, 2004), will require care on the part of educators. Students will benefit from support from their educators in developing a professional, nonjudgmental attitude toward people who may have a different experience of gender identity and gender expression from their own. A number of training resources have been published that may be helpful to psychologists in integrating information about TGNC people into the training they offer (e.g., Catalano, McCarthy, & Shlasko, 2007; Stryker, 2008; Wentling, Schilt, Windsor, & Lucal, 2008). Because most psychologists have had little or no training on TGNC populations and do not perceive themselves as having sufficient understanding of issues related to gender identity and gender expression (APA TFGIGV, 2009), psycholo-

gists with relevant expertise are encouraged to develop and distribute continuing education and training to help to address these gaps. Psychologists providing education can incorporate activities that increase awareness of cisgender privilege, antitrans prejudice and discrimination, host a panel of TGNC people to offer personal perspectives, or include narratives of TGNC people in course readings (ACA, 2010). When engaging these approaches, it is important to include a wide variety of TGNC experiences to reflect the inherent diversity within the TGNC community.

REFERENCES

- Adelson, S. L., & The American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*, 957–974. <http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS089085671200500X.pdf> <http://dx.doi.org/10.1016/j.jaac.2012.07.004>
- Ålgars, M., Alanko, K., Santtila, P., & Sandnabba, N. K. (2012). Disordered eating and gender identity disorder: A qualitative study. *Eating Disorders: The Journal of Treatment & Prevention*, *20*, 300–311. <http://dx.doi.org/10.1080/10640266.2012.668482>
- Amato, P. R. (2001). Children of divorce in the 1990s: An update of the Amato and Keith (1991) meta-analysis. *Journal of Family Psychology*, *15*, 355–370.
- American Civil Liberties Union National Prison Project. (2005). *Still in danger: The ongoing threat of sexual violence against transgender prisoners*. Washington, DC: Author. Retrieved from <http://www.justdetention.org/pdf/stillindanger.pdf>
- American Counseling Association. (2010). American Counseling Association competencies for counseling with transgender clients. *Journal of LGBT Issues in Counseling*, *4*, 135–159. <http://dx.doi.org/10.1080/15538605.2010.524839>
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct* (2002, amended June 1, 2010). Retrieved from <http://www.apa.org/ethics/code/principles.pdf>
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist*, *67*, 10–42. <http://dx.doi.org/10.1037/a0024659>
- American Psychological Association. (2015). *Standards of accreditation for health service psychology*. Retrieved from <http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf>
- American Psychological Association & National Association of School Psychologists. (2014). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from http://www.nasponline.org/about_nasp/resolution/gender_sexual_orientation_diversity.pdf
- American Psychological Association Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. Washington, DC: Author. Retrieved from <http://www.apa.org/topics/immigration/report.aspx>
- American Psychological Association Task Force on Gender Identity and Gender Variance. (2009). *Report of the task force on gender identity and gender variance*. Washington, DC: Author. Retrieved from <http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf>
- Angello, M. (2013). *On the couch with Dr. Angello: A guide to raising & supporting transgender youth*. Philadelphia, PA: Author.

- Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, *64*, 372–453. <http://dx.doi.org/10.1037/a0015932>
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285. <http://dx.doi.org/10.1037/0003-066X.61.4.271>
- Auldridge, A., Tamar-Mattis, A., Kennedy, S., Ames, E., & Tobin, H. J. (2012). *Improving the lives of transgender older adults Recommendations for policy and practice*. New York, NY: Services and Advocacy for LGBT Elders & Washington, DC: National Center for Transgender Equality. Retrieved from <http://www.lgbtagingcenter.org/resources/resource.cfm?r=520>
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, *31*, 43–55. <http://dx.doi.org/10.1037/0012-1649.31.1.43>
- Baltieri, D. A., & De Andrade, A. G. (2009). Schizophrenia modifying the expression of gender identity disorder. *Journal of Sexual Medicine*, *6*, 1185–1188. <http://dx.doi.org/10.1111/j.1743-6109.2007.00655.x>
- Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). “I don’t think this is theoretical; this is our lives”: How erasure impacts health care for transgender people. *JANAC Journal of the Association of Nurses in AIDS Care*, *20*, 348–361. <http://dx.doi.org/10.1016/j.jana.2009.07.004>
- Bauer, G. R., Travers, R., Scanlon, K., & Coleman, T. A. (2012). High heterogeneity of HIV-related sexual risk among transgender people in Ontario, Canada: A province-wide respondent-driven sampling survey. *BMC Public Health*, *12*, 292. <http://dx.doi.org/10.1186/1471-2458-12-292>
- Bazargan, M., & Galvan, F. (2012). Perceived discrimination and depression among low-income Latina male-to-female transgender women. *BMC Public Health*, *12*, 663–670. <http://dx.doi.org/10.1186/1471-2458-12-663>
- Beemyn, G., & Rankin, S. (2011). *The lives of transgender people*. New York, NY: Columbia University.
- Bender-Baird, K. (2011). *Transgender employment experiences Gendered exceptions and the law*. Albany, NY: SUNY Press.
- Benjamin, H. (1966). *The transsexual phenomenon*. New York, NY: Warner.
- Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy An International Forum*, *25*, 17–40. <http://dx.doi.org/10.1080/08952833.2013.755081>
- Berger, J. C., Green, R., Laub, D. R., Reynolds, C. L., Jr., Walker, P. A., & Wollman, L. (1979). *Standards of care The hormonal and surgical sex reassignment of gender dysphoric persons*. Galveston, TX: The Janus Information Facility.
- Bess, J. A., & Stabb, S. D. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling*, *31*, 264–282. <http://dx.doi.org/10.17744/mehc.31.3.f624154681133w50>
- Bethea, M. S., & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A Systems Theory perspective. *Journal of Couple & Relationship Therapy*, *12*, 89–112. <http://dx.doi.org/10.1080/15332691.2013.779094>
- Bilodeau, B. L., & Renn, K. A. (2005). Analysis of LGBT identity development models and implications for practice. *New Directions for Student Services*, *2005*, 25–39. <http://dx.doi.org/10.1002/ss.171>
- Birren, J. E., & Schaie, K. W. (2006). *Handbook of the psychology of aging* (6th ed.). Burlington, MA: Elsevier Academic.
- Blosnich, J. R., Brown, G. R., Shipherd, J. C., Kauth, M., Piegari, R. I., & Bossarte, R. M. (2013). Prevalence of gender identity disorder and suicide risk among transgender veterans utilizing Veterans Health Administration care. *American Journal of Public Health*, *103*(10), e27–e32. <http://dx.doi.org/10.2105/AJPH.2013.301507>
- Bockting, W. O. (2008). Psychotherapy and the real life experience: From gender dichotomy to gender diversity. *Sexologies*, *17*, 211–224. <http://dx.doi.org/10.1016/j.sexol.2008.08.001>
- Bockting, W. O., Benner, A., & Coleman, E. (2009). Gay and bisexual identity development among female-to-male transsexuals in North America: Emergence of a transgender sexuality. *Archives of Sexual Behavior*, *38*, 688–701. <http://dx.doi.org/10.1007/s10508-009-9489-3>
- Bockting, W. O., & Cesaretti, C. (2001). Spirituality, transgender identity, and coming out. *The Journal of Sex Education*, *26*, 291–300.
- Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming-out process. In R. Ettner, S. Monstrey, & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York, NY: Haworth.
- Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, *9*, 35–82. http://dx.doi.org/10.1300/J485v09n03_03
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, *103*, 943–951. <http://dx.doi.org/10.2105/AJPH.2013.301241>
- Bockting, W. O., Robinson, B. E., & Rosser, B. R. S. (1998). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care*, *10*, 505–525. <http://dx.doi.org/10.1080/09540129850124028>
- Bolin, A. (1994). Transcending and transgenering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender, beyond sexual dimorphism in culture and history* (pp. 447–486). New York, NY: Zone Books.
- Bornstein, K., & Bergman, S. B. (2010). *Gender outlaws The next generation*. Berkeley, CA: Seal Press.
- Boulder Valley School District. (2012). *Guidelines regarding the support of students who are transgender and gender nonconforming*. Boulder, CO: Author. Retrieved from <http://www.bvdsd.org/policies/Policies/AC-E3.pdf>
- Bouman, W. P., Richards, C., Addinall, R. M., Arango de Montis, I., Arcelus, J., Duisin, D., . . . Wilson, D. (2014). Yes and yes again: Are standards of care which require two referrals for genital reconstructive surgery ethical? *Sexual and Relationship Therapy*, *29*, 377–389. <http://dx.doi.org/10.1080/14681994.2014.954993>
- Boylan, J. F. (2013). *She’s not there* (2nd ed.). New York, NY: Broadway Books.
- Bradford, J., Reisner, S. L., Honnold, J. A., & Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: Results from the Virginia Transgender Health Initiative Study. *American Journal of Public Health*, *103*, 1820–1829. <http://dx.doi.org/10.2105/AJPH.2012.300796>
- Bradford, J., Xavier, J., Hendricks, M., Rives, M. E., & Honnold, J. A. (2007). The health, health-related needs, and lifecourse experiences of transgender Virginians. *Virginia Transgender Health Initiative Study Statewide Survey Report*. Retrieved from <http://www.vdh.state.va.us/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTV01.pdf>
- Brewster, M. E., Velez, B. L., Mennicke, A., & Tebbe, E. (2014). Voices from beyond: A thematic content analysis of transgender employees’ workplace experiences. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 159–169. <http://dx.doi.org/10.1037/sgd0000030>
- Brill, S., & Pepper, R. (2008). *The transgender child A handbook for families and professionals*. San Francisco, CA: Cleis Press.
- Broido, E. M. (2000). Constructing identity: The nature and meaning of lesbian, gay, and bisexual lives. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 13–33). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/10339-001>
- Brothman, H. (2013). Transgender inmates: The dilemma. *American Jails*, *27*, 40–47.
- Brown, N. (2007). Stories from outside the frame: Intimate partner abuse in sexual-minority women’s relationships with transsexual men. *Feminism & Psychology*, *17*, 373–393.
- Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.
- Burnes, T. R., & Chen, M. M. (2012). The multiple identities of transgender individuals: Incorporating a framework of intersectionality to gender crossing. In R. Josselson & M. Harway (Eds.), *Navigating multiple identities Race, gender, culture, nationality, and roles* (pp. 113–128). New York, NY: Oxford University Press. <http://dx.doi.org/10.1093/acprof:oso/9780199732074.003.0007>
- Butler, J. (1990). *Gender trouble and the subversion of identity*. New York, NY: Routledge.

- Buzuvis, E. (2013). "On the basis of sex": Using Title IX to protect transgender students from discrimination in education. *Wisconsin Journal of Law, Gender & Society*, 28, 219–347.
- Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., . . . American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. (2012). Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. *Archives of Sexual Behavior*, 41, 759–796. <http://dx.doi.org/10.1007/s10508-012-9975-x>
- Califia, P. (1997). *Sex changes The politics of transgenderism*. San Francisco, CA: Cleis Press.
- Carroll, L. (2010). *Counseling sexual and gender minorities*. Upper Saddle River, NJ: Pearson/Merrill.
- Carroll, R. (1999). Outcomes of treatment for gender dysphoria. *Journal of Sex Education & Therapy*, 24, 128–136.
- Case, K. A., & Meier, S. C. (2014). Developing allies to transgender and gender-nonconforming youth: Training for counselors and educators. *Journal of LGBT Youth*, 11, 62–82. <http://dx.doi.org/10.1080/19361653.2014.840764>
- Catalano, C., McCarthy, L., & Shlasko, D. (2007). Transgender oppression curriculum design. In M. Adams, L. A. Bell, & P. Griffin (Eds.), *Teaching for diversity and social justice* (2nd ed., p. 219245). New York, NY: Routledge.
- Cavanaugh, J. C., & Blanchard-Fields, F. (2010). *Adult development and aging* (5th ed.). Belmont, CA: Wadsworth/Thomson Learning.
- Center for Substance Abuse Treatment. (2012). *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual and transgender individuals* (DHHS Pub. No. [SMA] 21–4104). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
- Cerezo, A., Morales, A., Quintero, D., & Rothman, S. (2014). Trans migrations: Exploring life at the intersection of transgender identity and immigration. *Psychology of Sexual Orientation and Gender Diversity*, 1, 170–180. <http://dx.doi.org/10.1037/sgd0000031>
- Chivers, M. L., & Bailey, J. M. (2000). Sexual orientation of female-to-male transsexuals: A comparison of homosexual and nonhomosexual types. *Archives of Sexual Behavior*, 29, 259–278. <http://dx.doi.org/10.1023/A:1001915530479>
- Clements-Nolle, K., & Bachrach, A. (2003). Community based participatory research with a hidden population: The transgender community health project. In M. Minkler & N. Wallerstein (Eds.), *Community based participatory research for health* (pp. 332–343). San Francisco, CA: Jossey-Bass.
- Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, 51, 53–69. http://dx.doi.org/10.1300/J082v51n03_04
- Cochran, B. N., & Cauce, A. M. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment*, 30, 135–146. <http://dx.doi.org/10.1016/j.jsat.2005.11.009>
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. G. (2008). The treatment of adolescent transsexuals: Changing insights. *Journal of Sexual Medicine*, 5, 1892–1897. <http://dx.doi.org/10.1111/j.1743-6109.2008.00870.x>
- Cole, B., & Han, L. (2011). *Freeing ourselves A guide to health and self love for brown bois*. Retrieved from https://brownboiproject.nationbuilder.com/health_guide
- Coleman, E., & Bockting, W. O. (1988). "Heterosexual" prior to sex reassignment, "homosexual" afterwards: A case study of a female-to-male transsexual. *Journal of Psychology & Human Sexuality*, 1, 69–82.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transgender, transsexual, and gender nonconforming people, 7th version. *International Journal of Transgenderism*, 13, 165–232. <http://dx.doi.org/10.1080/15532739.2011.700873>
- Coleman, E., Bockting, W. O., & Gooren, L. (1993). Homosexual and bisexual identity in sex-reassigned female-to-male transsexuals. *Archives of Sexual Behavior*, 22, 37–50. <http://dx.doi.org/10.1007/BF01552911>
- Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior*, 21, 313–321. <http://dx.doi.org/10.1007/BF01542999>
- Collins, P. H. (2000). *Black feminist thought Knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York, NY: Routledge.
- Conron, K. J., Scott, G., Stowell, G. S., & Landers, S. J. (2012). Transgender health in Massachusetts: Results from a household probability sample of adults. *American Journal of Public Health*, 102, 118–122. <http://dx.doi.org/10.2105/AJPH.2011.300315>
- Conron, K. J., Scout, & Austin, S. B. (2008). "Everyone has a right to, like, check their box": Findings on a measure of gender identity from a cognitive testing study with adolescents. *Journal of LGBT Health Research*, 4, 1–9.
- Cook-Daniels, L. (2006). Trans aging. In D. Kimmel, T. Rose, & S. David (Eds.), *Lesbian, gay, bisexual, and transgender aging Research and clinical perspectives* (pp. 20–35). New York, NY: Columbia University Press.
- Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing gender. *Journal of GLBT Family Studies*, 4, 301–324. <http://dx.doi.org/10.1080/15504280802177466>
- Currah, P., & Minter, S. P. (2000). *Transgender equality A handbook for activists and policymakers*. San Francisco, CA: National Center for Lesbian Rights; New York, NY: The Policy Institute of the National Gay & Lesbian Task Force. Retrieved from http://www.thetaskforce.org/static_html/downloads/reports/reports/TransgenderEquality.pdf
- Daley, A., Solomon, S., Newman, P. A., & Mishna, F. (2008). Traversing the margins: Intersectionalities in the bullying of lesbian, gay, bisexual, and transgender youth. *Journal of Gay & Lesbian Social Services Issues in Practice, Policy & Research*, 19, 9–29. <http://dx.doi.org/10.1080/10538720802161474>
- Daley, C. (2005, August 15). *Testimony before the National Prison Rape Elimination Commission*. Retrieved from <http://transgenderlawcenter.org/pdf/prisonrape.pdf>
- Darnerly, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky, & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615–644). Philadelphia, PA: Saunders.
- Daskalos, C. T. (1998). Changes in the sexual orientation of six heterosexual male-to-female transsexuals. *Archives of Sexual Behavior*, 27, 605–614. <http://dx.doi.org/10.1023/A:1018725201811>
- D'Augelli, A. R., & Hershberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology*, 21, 421–448. <http://dx.doi.org/10.1007/BF00942151>
- Davis, S. A., & Meier, S. C. (2014). Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people. *International Journal of Sexual Health*, 26, 113–128. <http://dx.doi.org/10.1080/19317611.2013.833152>
- De Cuypere, G., Elaut, E., Heylens, G., Van Maele, G., Selvaggi, G., T'Sjoen, G., . . . Monstrey, S. (2006). Long-term follow-up: Psychosocial outcomes of Belgian transsexuals after sex reassignment surgery. *Sexologies*, 15, 126–133. <http://dx.doi.org/10.1016/j.sexol.2006.04.002>
- Department of Defense. (2011). *Instruction Number 6130.03*. Retrieved from <http://www.dtic.mil/whs/directives/corres/pdf/613003p.pdf>
- Department of Veterans Affairs, Veterans' Health Administration. (2013). *Providing health care for transgender and intersex veterans (VHA Directive 2013–003)*. Retrieved from http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2863
- De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism*, 6(3), 215–221.
- Deutsch, M. B. (2012). Use of the informed consent model in provision of cross-sex hormone therapy: A survey of the practices of selected clinics. *International Journal of Transgenderism*, 13, 140–146. <http://dx.doi.org/10.1080/15532739.2011.675233>
- Deutsch, M. B., Green, J., Keatley, J. A., Mayer, G., Hastings, J., Hall, A. M., . . . the World Professional Association for Transgender Health EMR Working Group. (2013). Electronic medical records and the transgender patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group. *Journal of the American Medical Informatics Association*, 20, 700–703. <http://dx.doi.org/10.1136/amiajnl-2012-001472>

- Devor, A. H. (2004). Witnessing and mirroring: A fourteen-stage model of transsexual identity formation. *Journal of Gay & Lesbian Psychotherapy*, 8, 41–67.
- Devor, H. (1993). Sexual orientation identities, attractions, and practices of female-to-male transsexuals. *Journal of Sex Research*, 30, 303–315. <http://dx.doi.org/10.1080/00224499309551717>
- de Vries, A. L., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59, 301–320. <http://dx.doi.org/10.1080/00918369.2012.653300>
- de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134, 696–704. <http://dx.doi.org/10.1542/peds.2013-2958>
- de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936. <http://dx.doi.org/10.1007/s10803-010-0935-9>
- de Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283. <http://dx.doi.org/10.1111/j.1743-6109.2010.01943.x>
- de Vries, K. M. (2015). Transgender people of color at the center: Conceptualizing a new intersectional model. *Ethnicities*, 15, 3–27. <http://dx.doi.org/10.1177/1468796814547058>
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE*, 6(2), e16885. <http://dx.doi.org/10.1371/journal.pone.0016885>
- Diamond, L. M. (2013). Concepts of female sexual orientation. In C. J. Patterson & A. R. D'Augelli (Eds.), *Handbook of psychology and sexual orientation* (pp. 3–17). New York, NY: Oxford University Press.
- Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior*, 38, 172. <http://dx.doi.org/10.1007/s10508-008-9438-6>
- dickey, I. m., Burnes, T. R., & Singh, A. A. (2012). Sexual identity development of female-to-male transgender individuals: A grounded theory inquiry. *Journal of LGBT Issues in Counseling*, 6, 118–138. <http://dx.doi.org/10.1080/15538605.2012.678184>
- dickey, I. m., Reisner, S. L., & Juntunen, C. L. (2015). Non-suicidal self-injury in a large online sample of transgender adults. *Professional Psychology Research and Practice*, 46, 3–11. <http://dx.doi.org/10.1037/a0038803>
- Dispenza, F., Watson, L. B., Chung, Y. B., & Brack, G. (2012). Experience of career-related discrimination for female-to-male transgender persons: A qualitative study. *Career Development Quarterly*, 60, 65–81. <http://dx.doi.org/10.1002/j.2161-0045.2012.00006.x>
- Dreger, A. D. (1999). *Intersex in the age of ethics*. Hagerstown, MD: University Publishing Group.
- Drescher, J. (2014). Controversies in gender diagnosis. *LGBT Health*, 1, 10–14. <http://dx.doi.org/10.1089/lgbt.2013.1500>
- Drescher, J., & Byne, W. (Eds.). (2013). *Treating transgender children and adolescents An interdisciplinary discussion*. New York, NY: Routledge.
- Drummond, K. D., Bradley, S. J., Peterson-Badaali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45. <http://dx.doi.org/10.1037/0012-1649.44.1.34>
- Edelman, E. A. (2011). “This area has been declared a prostitution free zone”: Discursive formations of space, the state, and trans “sex worker” bodies. *Journal of Homosexuality*, 58, 848–864. <http://dx.doi.org/10.1080/00918369.2011.581928>
- Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary “Gender Management Service” (GeMS) in a major pediatric center. *Journal of Homosexuality*, 59, 321–336. <http://dx.doi.org/10.1080/00918369.2012.653302>
- Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the Standards of Care. *International Journal of Transgenderism*, 12, 198–210. <http://dx.doi.org/10.1080/15532739.2010.544235>
- Ehrensaft, D. (2012). From gender identity disorder to gender identity creativity: True gender self child therapy. *Journal of Homosexuality*, 59, 337–356. <http://dx.doi.org/10.1080/00918369.2012.653303>
- Ekins, R., & King, D. (2005). Virginia Prince: Pioneer of transgendering. *International Journal of Transgenderism*, 8, 5–15. http://dx.doi.org/10.1300/J485v08n04_02
- Elders, J., & Steinman, A. M. (2014). *Report of the transgender military service commission*. Retrieved from http://www.palmcenter.org/files/Transgender%20Military%20Service%20Report_0.pdf
- Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy*, 7, 1–12. http://dx.doi.org/10.1300/J085V07N03_01
- Erhardt, V. (2007). *Head over heels Wives who stay with cross-dressers and transsexuals*. New York, NY: Haworth.
- Erikson, E. H. (1968). *Identity, youth, and crisis*. New York, NY: Norton.
- Factor, R. J., & Rothblum, E. D. (2007). A study of transgender adults and their non-transgender siblings on demographic characteristics, social support and experiences of violence. *Journal of LGBT Health Research*, 3, 11–30. <http://dx.doi.org/10.1080/1557409802092879>
- Feinberg, L. (1996). *Transgender warriors Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.
- Flynn, T. (2006). The ties that (don't) bind. In P. Currah, R. M. Juang, & S. P. Minter (Eds.), *Transgender rights* (pp. 32–50). Minneapolis, MN: University of Minnesota.
- FORGE. (n.d.). *Trans-specific power and control tactics*. Retrieved from http://forge-forward.org/wp-content/docs/power-control-tactics-categories_FINAL.pdf
- Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., . . . Muraco, A. (2014). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist*, 54, 488–500. <http://dx.doi.org/10.1093/geront/gnt021>
- Fredriksen-Goldsen, K. I., Kim, H., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., . . . Petry, H. (2011). *The aging and health report Disparities and resilience among lesbian, gay, bisexual and transgender older adults*. Retrieved from <http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL.pdf>
- Freeman, D., Tasker, F., & Di Ceglie, D. (2002). Children and adolescents with transsexual parents referred to a specialist gender identity development service: A brief report of key development features. *Clinical Child Psychology and Psychiatry*, 7, 423–432. <http://dx.doi.org/10.1177/1359104502007003009>
- Fruhauf, C. A., & Orel, N. A. (2015). Fostering resilience in LGBT aging individuals and families. In N. A. Orel & C. A. Fruhauf (Eds.), *The lives of LGBT older adults Understanding challenges and resilience* (pp. 217–227). Washington, DC: American Psychological Association.
- Fuhrmann, M., & Craffey, B. (2014). *Lessons learned on the path to filial maturity*. Charleston, SC: Createspace.
- Fuhrmann, M., & Shevlowitz, J. (2006). *Sagacity What I learned from my elderly psychotherapy clients*. Bloomington, IN: IUUniverse.
- Gallagher, S. (2014). The cruel and unusual phenomenology of solitary confinement. *Frontiers in Psychology*, 5, 1–8. <http://dx.doi.org/10.3389/fpsyg.2014.00585>
- Garber, M. B. (1992). *Vested interests Cross-dressing & cultural anxiety*. New York, NY: Routledge.
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood, and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38, 230–236. <http://dx.doi.org/10.1016/j.jadohealth.2005.03.023>
- Gehi, P. S., & Arkles, G. (2007). Unraveling injustice: Race and class impact of Medicaid exclusions of transition-related health care for transgender people. *Sexuality Research & Social Policy*, 4, 7–35. <http://dx.doi.org/10.1525/srsp.2007.4.4.7>
- GenIUSS. (2013). *Gender-related measures overview*. Los Angeles, CA: Williams Institute. Retrieved from: <http://williamsinstitute.law.ucla.edu/wp-content/uploads/GenIUSS-Gender-related-Question-Overview.pdf>
- Glaser, C. (Ed.), (2008). *Gender identity and our faith communities A congregational guide to transgender advocacy*. Washington, DC:

- Human Rights Campaign Foundation. Retrieved from <http://www.hrc.org/resources/entry/gender-identity-and-our-faith-communities-a-congregational-guide-for-trans>
- Glezer, A., McNiel, D. E., & Binder, R. L. (2013). Transgendered and incarcerated: A review of the literature, current policies and laws and ethics. *Journal of the American Academy of Psychiatry Law, 41*, 551–559.
- Goldblum, P., Testa, R. J., Pflum, S., Hendricks, M. L., Bradford, J., & Bongar, B. (2012). In-school gender-based victimization and suicide attempts in transgender individuals. *Professional Psychology Research and Practice, 43*, 468–475. <http://dx.doi.org/10.1037/a0029605>
- Gonzalez, M., & McNulty, J. (2010). Achieving competency with transgender youth: School counselors as collaborative advocates. *Journal of LGBT Issues in Counseling, 4*, 176–186. <http://dx.doi.org/10.1080/15538605.2010.524841>
- Gooren, L. J., Giltay, E. J., Bunck, M. C. (2008). Long-term treatment of transsexuals with cross-sex hormones: Extensive personal experience. *Journal of Clinical Endocrinology & Metabolism Clinical and Experimental, 93*, 19–25. <http://dx.doi.org/10.1210/jc.2007-1809>
- Gorton, R. N., & Grubb, H. M. (2014). General, sexual, and reproductive health. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 215–240). New York, NY: Oxford University Press.
- Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Kiesling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality & National Gay and Lesbian Task Force. Retrieved from http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf
- Green, E. R. (2006). Debating trans inclusion in the feminist movement: A trans-positive analysis. *Journal of Lesbian Studies, 10*(1/2), 231–248. http://dx.doi.org/10.1300/J155v10n01_12
- Green, J. (2004). *Becoming a visible man*. Nashville, TN: Vanderbilt University.
- Green, R. (1978). Sexual identity of 37 children raised by homosexual and transsexual parents. *American Journal of Psychiatry, 135*, 692–697. <http://dx.doi.org/10.1176/ajp.135.6.692>
- Green, R. (1988). Transsexuals' children. *International Journal of Transgenderism, 2*(4).
- Green, R., & Money, J. (1969). *Transsexualism and sex reassignment*. Baltimore, MD: Johns Hopkins University Press.
- Grossman, A. H., & D'Augelli, A. R. (2006). Transgender youth: Invisible and vulnerable. *Journal of Homosexuality, 51*, 111–128. http://dx.doi.org/10.1300/J082v51n01_06
- Grossman, A. H., D'Augelli, A. R., Howell, T. H., & Hubbard, A. (2006). Parent reactions to transgender youth gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*, 3–16. http://dx.doi.org/10.1300/J041v18n01_02
- Gruberg, S. (2013). *Dignity denied: LGBT immigrants in U.S.* Retrieved from <https://www.americanprogress.org/issues/immigration/report/2013/11/25/79987/dignity-denied-lgbt-immigrants-in-u-s-immigration-detention/>
- Hanssmann, C., Morrison, D., Russian, E., Shiu-Thornton, S., & Bowen, D. (2010). A community-based program evaluation of community competency trainings. *Journal of the Association of Nurses in AIDS Care, 21*, 240–255. <http://dx.doi.org/10.1016/j.jana.2009.12.007>
- Hardy, S. E., Concato, J., & Gill, T. M. (2004). Resilience of community-dwelling older persons. *Journal of the American Geriatrics Society, 52*, 257–262. <http://dx.doi.org/10.1111/j.1532-5415.2004.52065.x>
- Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and transgendered people and communities: A challenge for community psychology. *American Journal of Community Psychology, 31*, 246–252. <http://dx.doi.org/10.1023/A:1023906620085>
- Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels and otherwise in the National Transgender Discrimination Study. *LGBT Policy Journal at the Harvard Kennedy School, 2*, 13–24. Retrieved from <http://isites.harvard.edu/icb/icb.do?keyword=k78405&pageid=icb.page497030>
- Hartzell, E., Frazer, M. S., Wertz, K., & Davis, M. (2009). *The state of transgender California: Results from the 2008 California Transgender Economic Health survey*. San Francisco, CA: Transgender Law Center. Retrieved from <http://transgenderlawcenter.org/pubs/the-state-of-transgender-california>
- Harvard Law Review Association. (2013). Recent case: Employment law: Title VII: EEOC affirms protections for transgender employees: *Macy v. Holder*. *Harvard Law Review, 126*, 1731–1738.
- Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery, 1*, 335–344.
- Hastings, D., & Markland, C. (1978). Post-surgical adjustment of twenty-five transsexuals (male-to-female) in the University of Minnesota study. *Archives of Sexual Behavior, 7*, 327–336. <http://dx.doi.org/10.1007/BF01542041>
- Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. E., Gooren, L. J., Meyer, W. J., III, Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology Metabolism, 94*, 3132–3154. <http://dx.doi.org/10.1210/jc.2009-0345>
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology Research and Practice, 43*, 460–467. <http://dx.doi.org/10.1037/a0029597>
- Hepp, U., Kraemer, B., Schnyder, U., Miller, N., & Delsignore, A. (2004). Psychiatric comorbidity in Gender Identity Disorder. *Journal of Psychosomatic Research, 58*, 259–261. <http://dx.doi.org/10.1016/j.jpsychores.2004.08.010>
- Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systemic review. *AIDS & Behavior, 12*, 1–17. <http://dx.doi.org/10.1007/s10461-007-9299-3>
- Herd, G. (1994). *Third sex, third gender, beyond sexual dimorphism in culture and history*. New York, NY: Zone Books.
- Herd, G., & Boxer, A. (1993). *Children of horizons: How gay and lesbian teens are leading a new way out of the closet*. Boston, MA: Beacon Press.
- Herman, J. L. (2013). Gendered restrooms and minority stress: The public regulation of gender and its impact on transgender people's lives. *Journal of Public Management and Social Policy, 19*, 65–80.
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garafalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56*, 285–290. <http://dx.doi.org/10.1159/00355235>
- Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex & Marital Therapy, 36*, 6–23. <http://dx.doi.org/10.1080/00926230903375560>
- Hirschfeld, M. (1991). *Transvestites: The erotic drive to crossdress* (M. Lombardi-Nash, trans.). Buffalo, NY: Prometheus Books. (Original work published 1910)
- Holman, C., & Goldberg, J. M. (2006). Social and medical transgender case advocacy. *International Journal of Transgenderism, 9*, 197–217. http://dx.doi.org/10.1300/J485v09n03_09
- Hughes, I. A., Houk, C., Ahmed, S. F., & Lee, P. A. (2006). Consensus statement on management of intersex disorders. *Journal of Pediatric Urology, 2*, 148–162. <http://dx.doi.org/10.1016/j.jpurol.2006.03.004>
- Hwahng, S. J., & Lin, A. (2009). The health of lesbian, gay, bisexual, transgender, queer, and questioning people. In C. Trinh-Shevrin, N. Islam, & M. Rey (Eds.), *Asian American communities and health: Context, research, policy, and action* (pp. 226–282). San Francisco, CA: Jossey-Bass.
- Hwahng, S. J., & Nuttbrock, L. (2007). Sex workers, fem queens, and cross-dressers: Differential marginalizations and HIV vulnerabilities among three ethnocultural male-to-female transgender communities in New York City. *Sexuality Research & Social Policy, 4*, 36–59. <http://dx.doi.org/10.1525/srsp.2007.4.4.36>
- Iantaffi, A., & Bockting, W. O. (2011). Views from both sides of the bridge? Gender, sexual legitimacy and transgender people's experiences of relationships. *Culture, Health, & Sexuality, 13*, 355–370. <http://dx.doi.org/10.1080/13691058.2010.537770>
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academy of Sciences.

- Ippolito, J., & Witten, T. M. (2014). Aging. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 476–497). New York, NY: Oxford University Press.
- Israel, T. (2005). . . and sometimes T: Transgender issues in LGBT psychology. *Newsletter of the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues*, 21, 16–18.
- Israel, T., Gorcheva, R., Burnes, T. R., & Walther, W. A. (2008). Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research*, 18, 294–305. <http://dx.doi.org/10.1080/10503300701506920>
- Israel, T., Walther, W. A., Gorcheva, R., & Perry, J. S. (2011). Policies and practices for LGBT clients: Perspectives of mental health services administrators. *Journal of Gay and Lesbian Mental Health*, 15, 152–168. <http://dx.doi.org/10.1080/19359705.2010.539090>
- Jones, R. M., Wheelwright, S., Farrell, K., Martin, E., Green, R., Di Ceglie, D., & Baron-Cohen, S. (2012). Brief report: Female-to-male transsexual people and autistic traits. *Journal of Autism Developmental Disorders*, 42, 301–306. <http://dx.doi.org/10.1007/s10803-011-1227-8>
- Kellogg, T. A., Clements-Nolle, K., Dilley, J., Katz, M. H., & McFarland, W. (2001). Incidence of human immunodeficiency virus among male-to-female transgendered persons in San Francisco. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 28, 380–384. <http://dx.doi.org/10.1097/00126334-200112010-00012>
- Kenagy, G. P., & Bostwick, W. B. (2005). Health and social service needs of transgender people in Chicago. *International Journal of Transgenderism*, 8, 57–66. http://dx.doi.org/10.1300/J485v08n02_06
- Kenagy, G. P., & Hsieh, C. (2005). Gender differences in social service needs of transgender people. *Journal of Social Service Research*, 31, 1–21. http://dx.doi.org/10.1300/J079v31n303_01
- Keo-Meier, C. L., Herman, L. I., Reisner, S. L., Pardo, S. T., Sharp, C., Babcock, J. C. (2015). Testosterone treatment and MMPI-2 improvement in transgender men: A prospective controlled study. *Journal of Consulting and Clinical Psychology*, 83, 143–156. <http://dx.doi.org/10.1037/a0037599>
- Kidd, J. D., & Witten, T. M. (2008). Understanding spirituality and religiosity in the transgender community: Implications for aging. *Journal of Religion, Spirituality & Aging*, 20, 29–62. <http://dx.doi.org/10.1080/15528030801922004>
- Kins, E., Hoebeke, P., Heylens, G., Rubens, R., & De Cuypere, G. (2008). The female-to-male transsexual and his female partner versus the traditional couple: A comparison. *Journal of Sex and Marital Therapy*, 34, 429–438. <http://dx.doi.org/10.1080/00926230802156236>
- Knochel, K. A., Croghan, C. F., Moore, R. P., & Quam, J. K. (2011). *Ready to serve? The aging network and LGB and T older adults*. Washington, DC: National Association of Area Agencies on Aging. Retrieved from <http://www.n4a.org/pdf/ReadyToServe1.pdf>
- Knudson, G., De Cuypere, G., & Bockting, W. O. (2010). Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of the World Professional Association for Transgender Health. *International Journal of Transgenderism*, 12, 115–118. <http://dx.doi.org/10.1080/15532739.2010.509215>
- Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82–173). Stanford, CA: Stanford University.
- Korell, S. C., & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender clients. In K. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 271–288). Washington, DC: American Psychological Association.
- Kosciw, J. G., Greytak, E. A., Palmer, N. A., & Boesen, M. J. (2014). *The 2013 National School Climate Survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. New York, NY: Gay, Lesbian & Straight Education Network. Retrieved from http://www.glsen.org/sites/default/files/2013%20National%20School%20Climate%20Survey%20Full%20Report_0.pdf
- Krieger, N. (2011). *Nina here nor there: My journey beyond gender*. Boston, MA: Beacon Press.
- Kuhn, A., Brodmer, C., Stadlmayer, W., Kuhn, P., Mueller, M. D., & Birkhauser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility*, 92, 1685–1689. <http://dx.doi.org/10.1016/j.fertnstert.2008.08.126>
- Kulick, D. (1998). *Travesti: Sex, gender, and culture among Brazilian transgendered prostitutes*. Chicago, IL: University of Chicago.
- Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research*, 49, 244–254. <http://dx.doi.org/10.1080/00224499.2011.596954>
- Lambda Legal. (2012). *Professional organization statements supporting transgender people in health care*. Retrieved from http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_1.pdf
- Lawrence, A. A. (2014). *Men trapped in men's bodies: Narratives of autogynephilic transsexualism*. New York, NY: Springer.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York, NY: Haworth Clinical Practice.
- Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11, 74–99. <http://dx.doi.org/10.1080/15532730903008032>
- Levy, D. L., & Lo, J. R. (2013). Transgender, transsexual, and gender queer individuals with a Christian upbringing: The process of resolving conflict between gender identity and faith. *Journal of Religion & Spirituality in Social Work: Social Thought*, 32, 60–83. <http://dx.doi.org/10.1080/15426432.2013.749079>
- Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *American Journal of Preventive Medicine*, 42, 221–228. <http://dx.doi.org/10.1016/j.amepre.2011.10.023>
- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42, 89–101. http://dx.doi.org/10.1300/J082v42n01_05
- Lurie, S. (2005). Identifying training needs of health care providers related to the treatment and care of transgender persons: A qualitative needs assessment in New England. *International Journal of Transgenderism*, 8, 93–112. http://dx.doi.org/10.1300/J485v08n02_09
- MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine*, 350, 367–378. <http://dx.doi.org/10.1056/NEJMra022784>
- Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*, 50, 453–470. <http://dx.doi.org/10.1111/j.1545-5300.2011.01371.x>
- Matarazzo, B. B., Barnes, S. M., Pease, J. L., Russell, L. M., Hanson, J. E., Soberay, K. A., & Gutierrez, P. M. (2014). Suicide risk among lesbian, gay, bisexual, and transgender military personnel and veterans: What does the literature tell us? *Suicide and Life-Threatening Behavior*, 44, 200–217. <http://dx.doi.org/10.1111/sltb.12073>
- McGuire, J. K., Anderson, C. R., & Toomey, R. B. (2010). School climate for transgender youth: A mixed method investigation of student experiences and school responses. *Journal of Youth and Adolescence*, 39, 1175–1188. <http://dx.doi.org/10.1007/s10964-010-9540-7>
- Meier, S. C., & Labuski, C. M. (2013). The demographics of the transgender population. In A. K. Baumle (Ed.), *International handbook of the demography of sexuality* (pp. 289–327). New York, NY: Springer.
- Meier, S. C., Pardo, S. T., Labuski, C., & Babcock, J. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archives of Sexual Behavior*, 42, 463–474. <http://dx.doi.org/10.1007/s10508-012-0052-2>
- Meier, S. C., Sharp, C., Michonski, J., Babcock, J. C., & Fitzgerald, K. (2013). Romantic relationships of female-to-male trans men: A descriptive study. *International Journal of Transgenderism*, 14, 75–85. <http://dx.doi.org/10.1080/15532739.2013.791651>
- Merkamer, J. (2011). *A place of respect: A guide for group care facilities serving transgender and gender non-conforming youth*. San Francisco, CA: National Center for Lesbian Rights; New York, NY: Sylvia Rivera Law Project. Retrieved from http://www.nclrights.org/wp-content/uploads/2013/07/A_Place_Of_Respect.pdf
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38–56. <http://dx.doi.org/10.2307/2137286>

- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*, 674–697. <http://dx.doi.org/10.1037/0033-2909.129.5.674>
- Meyer, W. J. (2009). World Professional Association of Transgender Health's Standards of Care requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism*, *11*, 127–132. <http://dx.doi.org/10.1080/15532730903008065>
- Meyerowitz, J. (2002). *How sex changed A history of transsexuality in the United States*. Cambridge, MA: Harvard University.
- Mikalson, P., Pardo, S., & Green, J. (2012). *First do no harm Reducing disparities for lesbian, gay, bisexual, transgender, queer, and questioning populations in California*. Retrieved from http://www.eqcai.org/atf/cf/%7B8cca0e2f-facc-46c1-8727-cb02a7d1b3cc%7D/FIRST_DO_NO_HARM-LGBTQ_REPORT.PDF
- Miller, J., & Nichols, A. (2012). Identity, sexuality and commercial sex among Sri Lankan nachchi. *Sexualities*, *15*, 554–569. <http://dx.doi.org/10.1177/1363460712446120>
- Minter, S. M., & Wald, D. H. (2012). Protecting parental rights. In J. L. Levi & E. E. Monnin-Browder (Eds.), *Transgender family law A guide to effective advocacy* (pp. 63–85). Bloomington, IN: Authorhouse.
- Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, *1*, 146–158. <http://dx.doi.org/10.1037/sgd0000029>
- Minac, M. E., Sheeran, T. H., Blissmer, B., Lees, F., Martins, D. (2011). Psychological resilience. In B. Resnick, L. P. Gwyther, & K. A. Roberto, *Resilience in aging* (pp. 67–87). New York, NY: Springer.
- Mollenkott, V. (2001). *Omnigender A trans-religious approach*. Cleveland, OH: Pilgrim Press.
- Moody, C. L., & Smith, N. G. (2013). Suicide protective factors among trans adults. *Archives of Sexual Behavior*, *42*, 739–752. <http://dx.doi.org/10.1007/s10508-013-0099-8>
- Morales, E. (2013). Latino lesbian, gay, bisexual, and transgender immigrants in the United States. *Journal of LGBT Issues in Counseling*, *7*, 172–184. <http://dx.doi.org/10.1080/15538605.2013.785467>
- Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systemic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, *72*, 214–231. <http://dx.doi.org/10.1111/j.1365-2265.2009.03625.x>
- Murray, S. B., Boon, E., & Touyz, S. W. (2013). Diverging eating psychopathology in transgendered eating disorder patients: A report of two cases. *Eating Disorders*, *21*, 70–74. <http://dx.doi.org/10.1080/10640266.2013.741989>
- Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, *100*, 2426–2432. <http://dx.doi.org/10.2105/AJPH.2009.178319>
- Nadal, K. L., Rivera, D. P., & Corpus, M. J. H. (2010). Sexual orientation and transgender microaggressions in everyday life: Experiences of lesbians, gays, bisexuals, and transgender individuals. In D. W. Sue (Ed.), *Microaggressions and marginality Manifestation, dynamics, and impact* (pp. 217–240). New York, NY: Wiley.
- Nadal, K. L., Skolnik, A., & Wong, Y. (2012). Interpersonal and systemic microaggressions toward transgender people: Implications for counseling. *Journal of LGBT Issues in Counseling*, *6*, 55–82. <http://dx.doi.org/10.1080/15538605.2012.648583>
- Namaste, V. K. (2000). *Invisible lives The erasure of transsexual and transgendered people*. Chicago, IL: University of Chicago.
- Nanda, S. (1999). *Neither man nor woman, the Hijras of India* (2nd ed.). Belmont, CA: Wadsworth Cengage Learning.
- National Center for Transgender Equality. (2012). *Reassessing solitary confinement The human rights, fiscal, and public safety consequences*. Retrieved from <http://www.scribd.com/doc/97473428/NCTE-Testimony-on-U-S-Senate-Solitary-Confinement-Hearing>
- National Center for Transgender Equality. (2014). *Medicare and transgender people*. Retrieved from <http://transequality.org/PDFs/MedicareAndTransPeople.pdf>
- National Coalition of Anti-Violence Programs. (2011). *Hate violence against lesbian, gay, bisexual, transgender, queer, and HIV-affected communities in the United States in 2011 A report from the National Coalition of Anti-Violence Programs*. New York, NY: Author. Retrieved from http://avp.org/storage/documents/Reports/2012_NCAVP_2011_HV_Report.pdf
- National LGBTQ Task Force. (2013). *Hate crimes laws in the U. S.* Washington, DC: Author. Retrieved from http://www.thetaskforce.org/static_html/downloads/reports/issue_maps/hate_crimes_06_13_new.pdf
- National Senior Citizens Law Center. (2011). *LGBT older adults in long-term care facilities Stories from the field*. Washington, DC: Author, National Gay and Lesbian Task Force, Services and Advocacy for GLBT Elders, Lambda Legal, National Center for Lesbian Rights, & National Center for Transgender Equality. Retrieved from <http://www.nslc.org/wp-content/uploads/2011/07/LGBT-Stories-from-the-Field.pdf>
- Nemoto, T., Operario, D., Keatley, J. A., Han, L., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health*, *94*, 1193–1199. <http://dx.doi.org/10.2105/AJPH.94.7.1193>
- Nemoto, T., Operario, D., Keatley, J., & Villegas, D. (2004). Social context of HIV risk behaviors among male-to-female transgenders of color. *AIDS Care*, *16*, 724–735. <http://dx.doi.org/10.1080/09540120413331269567>
- Nuttbrock, L. A., Bockting, W. O., Hwang, S., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2009). Gender identity affirmation among male-to-female transgender persons: A life course analysis across types of relationships and cultural/lifestyle factors. *Sexual and Relationship Therapy*, *24*, 108–125. <http://dx.doi.org/10.1080/14681990902926764>
- Nuttbrock, L., Hwang, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, *47*, 12–23. <http://dx.doi.org/10.1080/00224490903062258>
- O'Hara, C., Dispenza, F., Brack, G., & Blood, R. A. (2013). The preparedness of counselors in training to work with transgender clients: A mixed methods investigation. *Journal of LGBT Issues in Counseling*, *7*, 236–256. <http://dx.doi.org/10.1080/15538605.2013.812929>
- Operario, D., Soma, T., & Underhill, K. (2008). Sex work and HIV status among transgender women: Systematic review and meta-analysis. *Journal of Acquired Immunity Deficiency Syndromes*, *48*, 97–103. <http://dx.doi.org/10.1097/QAI.0b013e31816e3971>
- OutServe-Servicemembers Legal Defense Network. (n.d.). *Transgender service*. Retrieved from https://www.outserv-sldn.org/?p.=transgender_service
- Pinto, R. M., Melendez, R. M., & Spector, A. Y. (2008). Male-to-female transgender individuals building social support and capital from within a gender-focused network. *Journal of Gay and Lesbian Social Services*, *20*, 203–220. <http://dx.doi.org/10.1080/10538720802235179>
- Porter, K. E., Ronneberg, C. R., & Witten, T. M. (2013). Religious affiliation and successful aging among transgender older adults: Findings from the Trans MetLife Survey. *Journal of Religion, Spirituality & Aging*, *25*, 112–138. <http://dx.doi.org/10.1080/15528030.2012.739988>
- Preves, S. E. (2003). *Intersex and identity The contested self*. New Brunswick, NJ: Rutgers University Press.
- Pyne, J. (2014). Gender independent kids: A paradigm shift in approaches to gender non-conforming children. *The Canadian Journal of Human Sexuality*, *23*, 1–8. <http://dx.doi.org/10.3138/cjhs.23.1.C01>
- Rachlin, K. (2002). Transgender individuals' experience of psychotherapy. *International Journal of Transgenderism*, *6*(1).
- Reed, G. M., McLaughlin, C. J., & Newman, R. (2002). American Psychological Association policy in context: The development and evaluation of guidelines for professional practice. *American Psychologist*, *57*, 1041–1047. <http://dx.doi.org/10.1037/0003-066X.57.12.1041>
- Rodin, D., & Stewart, D. E. (2012). Resilience in elderly survivors of child maltreatment. *SAGE Open*, *2*, 1–9. <http://dx.doi.org/10.1177/2158244012450293>
- Rodriguez, E. M., & Follins, L. D. (2012). Did God make me this way? Expanding psychological research on queer religiosity and spirituality to include intersex and transgender individuals. *Psychology & Sexuality*, *3*, 214–225. <http://dx.doi.org/10.1080/19419899.2012.700023>
- Ryan, C. (2009). *Supportive families, healthy children Helping families with lesbian, gay, bisexual & transgender children*. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San

- Francisco State University. Retrieved from http://familyproject.sfsu.edu/files/FAP_English%20Booklet_pst.pdf
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescence and the Health of LGBT Young Adults*, 23, 205–213.
- Saffin, L. A. (2011). Identities under siege: Violence against transpersons of color. In E. A. Stanley & N. Smith (Eds.), *Captive genders Trans embodiment and the prison industrial complex* (pp. 141–162). Oakland, CA: AK Press.
- Samons, S. (2008). *When the opposite sex isn't Sexual orientation in male-to-female transgender people*. New York, NY: Routledge.
- Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual identity trajectories among sexual-minority youths: Gender comparisons. *Archives of Sexual Behavior*, 29, 607–627. <http://dx.doi.org/10.1023/A:1002058505138>
- Schleifer, D. (2006). Make me feel mighty real: Gay female-to-male transgenderists negotiating sex, gender, and sexuality. *Sexualities*, 9, 57–75. <http://dx.doi.org/10.1177/1363460706058397>
- Schmidt, J. (2003). Paradise lost? Social change and Fa'afafine in Samoa. *Current Sociology*, 51, 417–432. <http://dx.doi.org/10.1177/0011392103051003014>
- Serano, J. (2006). *Whipping girl A transsexual woman on sexism and the scapegoating of femininity*. Emeryville, CA: Seal Press.
- Services and Advocacy for GLBT Elders & National Center for Transgender Equality. (2012). *Improving the lives of transgender older adults*. New York, NY: Author. Retrieved from <http://transequality.org/Resources/TransAgingPolicyReportFull.pdf>
- Sevelius, J. (2009). "There's no pamphlet for the kind of sex I have": HIV-related risk factors and protective behaviors among transgender men who have sex with non-transgender men. *Journal of the Association of Nurses in AIDS Care*, 20, 398–410. <http://dx.doi.org/10.1016/j.jana.2009.06.001>
- Sheridan, V. (2009). *The complete guide to transgender in the workplace*. Santa Barbara, CA: Praeger.
- Sherman, M. D., Kauth, M. R., Shipherd, J. C., & Street, R. L., Jr. (2014). Communication between VA providers and sexual and gender minority veterans: A pilot study. *Psychological Services*, 11, 235–242. <http://dx.doi.org/10.1037/a0035840>
- Shipherd, J. C., Mizock, L., Maguen, S., & Green, K. E. (2012). Male-to-female transgender veterans and VA health care utilization. *International Journal of Sexual Health*, 24, 78–87. <http://dx.doi.org/10.1080/19317611.2011.639440>
- Shively, M. G., & De Cecco, J. P. (1977). Component of sexual identity. *Journal of Homosexuality*, 3, 41–48. http://dx.doi.org/10.1300/J082v03n01_04
- Siegel, M., & Robinson, J. (1987). Order effects in children's gender-constancy responses. *Developmental Psychology*, 23, 283–286. <http://dx.doi.org/10.1037/0012-1649.23.2.283>
- Singh, A. A. (2012). Transgender youth of color and resilience: Negotiating oppression, finding support. *Sex Roles A Journal of Research*, 68, 690–702. <http://dx.doi.org/10.1007/s11199-012-0149-z>
- Singh, A. A., & Burnes, T. R. (2009). Creating developmentally appropriate, safe counseling environments for transgender youth: The critical role of school counselors. *Journal of LGBT Issues in Counseling*, 3, 215–234. <http://dx.doi.org/10.1080/15538600903379457>
- Singh, A. A., & Burnes, T. R. (2010). Shifting the counselor role from gatekeeping to advocacy: Ten strategies for using the Competencies for Counseling with Transgender Clients for individual and social change. *Journal of LGBT Issues in Counseling*, 4, 241–255. <http://dx.doi.org/10.1080/15538605.2010.525455>
- Singh, A. A., Hays, D. G., & Watson, L. (2011). Strategies in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling and Development*, 89, 20–27. <http://dx.doi.org/10.1002/j.1556-6678.2011.tb00057.x>
- Singh, A. A., & Jackson, K. (2012). Queer and transgender youth: Education and liberation in our schools. In E. R. Meiners & T. Quinn (Eds.), *Sexualities in education A reader* (pp. 175–186). New York, NY: Peter Lang.
- Singh, A. A., & McKleroy, V. S. (2011). "Just getting out of bed is a revolutionary act": The resilience of transgender people of color who have survived traumatic life events. *Traumatology*, 20, 1–11. <http://dx.doi.org/10.1177/1534765610369261>
- Singh, A. A., Richmond, K., & Burnes, T. (2013). The practice of ethical and empowering participatory action research with transgender people and communities. *International Journal of Transgenderism*, 14, 93–104. <http://dx.doi.org/10.1080/15532739.2013.818516>
- Smith, L. C., Shin, R. Q., & Officer, L. M. (2012). Moving counseling forward on LGB and transgender issues: Speaking queerly on discourses and microaggressions. *The Counseling Psychologist*, 40, 385–408. <http://dx.doi.org/10.1177/0011000011403165>
- Spade, D. (2006). Compliance is gendered: Struggling for gender self-determination in a hostile economy. In P. Currah, R. M. Juang, & S. P. Minter (Eds.), *Transgender rights* (pp. 217–241). Minneapolis, MN: University of Minnesota Press.
- Spade, D. (2011a). *Normal life Administrative violence, critical trans politics, and the limits of the law*. Brooklyn, NY: South End.
- Spade, D. (2011b). Some very basic tips for making higher education more accessible to trans students and rethinking how we talk about gendered bodies. *Radical Teacher*, 92, 57–62.
- Stanley, E. A. (2011). Fugitive flesh: Gender self-determination, queer abolition, and trans resistance. In E. A. Stanley & N. Smith (Eds.), *Captive genders Trans embodiment and the prison industrial complex* (pp. 1–11). Oakland, CA: AK Press.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistance and persistence of childhood Gender Dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590. <http://dx.doi.org/10.1016/j.jaac.2013.03.016>
- Stein, E. (2012). Commentary on the treatment of gender variance and gender dysphoria in children and adolescents: Common themes and ethical reflections. *Journal of Homosexuality*, 59, 480–500. <http://dx.doi.org/10.1080/00918369.2012.653316>
- Stryker, S. (2008). *Transgender history*. Berkeley, CA: Seal Press.
- Tanis, J. E. (2003). *Trans-gendered Theology, ministry, and communities of faith*. Cleveland, OH: Pilgrim.
- Taylor, J. K. (2007). Transgender identities and public policy in the United States: The relevance for public administration. *Administration & Society*, 39, 833–856. <http://dx.doi.org/10.1177/0095399707305548k>
- Testa, R. J., Sciacca, L. M., Wang, F., Hendricks, M. L., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology Research and Practice*, 43, 452–459. <http://dx.doi.org/10.1037/a0029604>
- Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. H., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology Research and Practice*, 46, 37–45. <http://dx.doi.org/10.1037/a0037490>
- Transgender Law Center. (2005). *Peeing in peace A resource guide for transgender activists and allies*. San Francisco, CA: Author. Retrieved from <http://transgenderlawcenter.org/issues/public-accomodations/peeing-in-peace>
- Transgender Law Center. (n.d.). *Transgender health benefits Negotiating inclusive coverage*. Retrieved from <http://translaw.wpengine.com/issues/health/healthinsurance>
- Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papaimitriou, M. (2012). *Impacts of strong parental support for trans youth A report prepared for Children's Aid Society of Toronto and Delisle Youth Services*. Retrieved from <http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf>
- Vanderburgh, R. (2007). *Transition and beyond Observations on gender identity*. Portland, OR: Q Press.
- van Kesteren, P. J. M., Asscheman, H., Megens, J. O. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology*, 47, 337–342. <http://dx.doi.org/10.1046/j.1365-2265.1997.2601068.x>
- Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist*, 62, 878–885. <http://dx.doi.org/10.1037/0003-066X.62.8.878>
- Wahl, H. W., Iwarsson, S., & Oswald, F. (2012). Aging well and the environment: Toward and integrative model and research agenda for the future. *The Gerontologist*, 52, 306–316. <http://dx.doi.org/10.1093/geront/gnr154>

- Walinsky, D., & Whitcomb, D. (2010). Using the ACA Competencies for counseling with transgender clients to increase rural transgender well-being. *Journal of LGBT Issues in Counseling, 4*, 160–175. <http://dx.doi.org/10.1080/15538605.2010.524840>
- Wallace, R., & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: Toward a theoretical framework for evaluating clinical interventions. *International Journal of Transgenderism, 14*, 113–126. <http://dx.doi.org/10.1080/15532739.2013.824845>
- Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1413–1423. <http://dx.doi.org/10.1097/CHI.0b013e31818956b9>
- Warner, L. R. (2008). A best practices guide to intersectional approaches in psychological research. *Sex Roles: A Journal of Research, 59*, 454–463. <http://dx.doi.org/10.1186/1475-9276-9-5>
- Wentling, T., Schilt, K., Windsor, E., & Lucal, B. (2008). Teaching transgender. *Teaching Sociology, 36*, 49–57. <http://dx.doi.org/10.1177/0092055X0803600107>
- White, T., & Ettner, R. (2004). Disclosure, risks and protective factors for children whose parents are undergoing a gender transition. *Journal of Gay and Lesbian Psychotherapy, 8*, 129–147.
- White, T., & Ettner, R. (2007). Adaptation and adjustment in children of transsexual parents. *European Child and Adolescent Psychiatry, 16*, 215–221. <http://dx.doi.org/10.1007/s00787-006-0591-y>
- Whitman, J. (2013). Safe schools: Prevention and intervention for bullying and harassment. In E. Fisher & K. Hawkins (Eds.), *Creating school environments to support lesbian, gay, bisexual, transgender, and questioning students and families: A handbook for school professionals* (pp. 123–139). New York, NY: Routledge.
- Wiercx, K., Van Caenegem, E., Pennings, G., Elaut, E., Dedecker, D., Van de Peer, F., . . . T'Sjoen, G. (2012). Reproductive wish in transsexual men. *Human Reproduction, 27*, 483–487. <http://dx.doi.org/10.1093/humrep/der406>
- Witten, T. M. (2003). Life course analysis—The courage to search for something more: Middle adulthood issues in the transgender and intersex community. *Journal of Human Behavior in the Social Environment, 8*, 189–224. http://dx.doi.org/10.1300/J137v8no2_12
- Witten, T. M., & Eyler, A. E. (2012). *Gay, lesbian, bisexual, and transgender aging: Challenges in research, practice, and policy*. Baltimore, MD: Johns Hopkins University.
- World Health Organization. (2015). *Transsexualism F64.0*. Retrieved from <http://apps.who.int/classifications/icd10/browse/2015/en#/F64.0>
- Xavier, J. M. (2000). *The Washington, DC Transgender Needs Assessment Survey*. Washington, DC: Us Helping Us, People Into Living. Retrieved from <http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml>
- Xavier, J., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgender people of color living in Washington, DC. *International Journal of Transgenderism, 8*, 31–47. http://dx.doi.org/10.1300/J485v08n02_04
- Xavier, J., Bradford, J., Hendricks, M., Safford, L., McKee, R., Martin, E., & Honnold, J. A. (2012). Transgender health care access of Virginia: A qualitative study. *International Journal of Transgenderism, 14*, 3–17. <http://dx.doi.org/10.1080/15532739.2013.689513>
- Zucker, K. J. (2008a). Children with gender identity disorder. Is there a best practice? *Neuropsychiatrie de l'Enfance et de l'Adolescence, 56*, 358–364. <http://dx.doi.org/10.1016/j.neurenf.2008.06.003>
- Zucker, K. J. (2008b). On the “natural history” of gender identity disorder in children [Editorial]. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1361–1363. <http://dx.doi.org/10.1097/CHI.0b013e31818960cf>
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford Press.
- Zucker, K. J., Wood, H., Singh, D., & Bradley, S. J. (2012). A developmental, biopsychosocial model for the treatment of children with Gender Identity Disorder. *Journal of Homosexuality, 59*, 369–397. <http://dx.doi.org/10.1080/00918369.2012.653309>

Appendix A Definitions

Terminology within the health care field and transgender and gender nonconforming (TGNC) communities is constantly evolving (Coleman et al., 2012). The evolution of terminology has been especially rapid in the last decade, as the profession's awareness of gender diversity has increased, as more literature and research in this area has been published, and as voices of the TGNC community have strengthened. Some terms or definitions are not universally accepted, and there is some disagreement among professionals and communities as to the “correct” words or definitions, depending on theoretical orientation, geographic region, generation, or culture, with some terms seen as affirming and others as outdated or demeaning. American Psychological Association (APA) Task Force for *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* developed the definitions below by reviewing existing

definitions put forward by professional organizations (e.g., APA Task Force on Gender Identity and Gender Variance, 2009; the Institute of Medicine, 2011; and the World Professional Association for Transgender Health [Coleman et al., 2012]), health care agencies serving TGNC clients (e.g., Fenway Health Center), TGNC community resources (Gender Equity Resource Center, National Center for Transgender Equality), and professional literature. Psychologists are encouraged to refresh their knowledge and familiarity with evolving terminology on a regular basis as changes emerge in the community and/or the professional literature. The definitions below include terms frequently used within the *Guidelines*, by the TGNC community, and within professional literature.

Ally: a cisgender person who supports and advocates for TGNC people and/or communities.

(Appendices continue)

Antitrans prejudice (transprejudice, transnegativity, transphobia): prejudicial attitudes that may result in the devaluing, dislike, and hatred of people whose gender identity and/or gender expression do not conform to their sex assigned at birth. Antitrans prejudice may lead to discriminatory behaviors in such areas as employment and public accommodations, and may lead to harassment and violence. When TGNC people hold these negative attitudes about themselves and their gender identity, it is called *internalized transphobia* (a construct analogous to internalized homophobia). Transmisogyny describes a simultaneous experience of sexism and antitrans prejudice with particularly adverse effects on trans women.

Cisgender: an adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not TGNC.

Cisgenderism: a systemic bias based on the ideology that gender expression and gender identities are determined by sex assigned at birth rather than self-identified gender identity. Cisgenderism may lead to prejudicial attitudes and discriminatory behaviors toward TGNC people or to forms of behavior or gender expression that lie outside of the traditional gender binary.

Coming out: a process by which individuals affirm and actualize a stigmatized identity. Coming out as TGNC can include disclosing a gender identity or gender history that does not align with sex assigned at birth or current gender expression. Coming out is an individual process and is partially influenced by one's age and other generational influences.

Cross dressing: wearing clothing, accessories, and/or make-up, and/or adopting a gender expression not associated with a person's assigned sex at birth according to cultural and environmental standards (Bullough & Bullough, 1993). Cross-dressing is not always reflective of gender identity or sexual orientation. People who cross-dress may or may not identify with the larger TGNC community.

Disorders of sex development (DSD, Intersex): term used to describe a variety of medical conditions associated with atypical development of an individual's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). These conditions may involve differences of a person's internal and/or external reproductive organs, sex chromosomes, and/or sex-related hormones that may complicate sex assignment at birth. DSD conditions may be considered variations in biological diversity rather than disorders (M. Diamond, 2009); therefore some prefer the terms *intersex*, *intersexuality*, or *differences in sex development* rather than "disorders of sex development" (Coleman et al., 2012).

Drag: the act of adopting a gender expression, often as part of a performance. Drag may be enacted as a political

comment on gender, as parody, or as entertainment, and is not necessarily reflective of gender identity.

Female-to-male (FTM): individuals assigned a female sex at birth who have changed, are changing, or wish to change their body and/or gender identity to a more masculine body or gender identity. FTM persons are also often referred to as *transgender men*, *transmen*, or *trans men*.

Gatekeeping: the role of psychologists and other mental health professionals of evaluating a TGNC person's eligibility and readiness for hormone therapy or surgery according to the Standards of Care set forth by the World Professional Association for Transgender Health (Coleman et al., 2012). In the past, this role has been perceived as limiting a TGNC adult's autonomy and contributing to mistrust between psychologists and TGNC clients. Current approaches are sensitive to this history and are more affirming of a TGNC adult's autonomy in making decisions with regard to medical transition (American Counseling Association, 2010; Coleman et al., 2012; Singh & Burnes, 2010).

Gender-affirming surgery (sex reassignment surgery or gender reassignment surgery): surgery to change primary and/or secondary sex characteristics to better align a person's physical appearance with their gender identity. Gender-affirming surgery can be an important part of medically necessary treatment to alleviate gender dysphoria and may include mastectomy, hysterectomy, metoidioplasty, phalloplasty, breast augmentation, orchiectomy, vaginoplasty, facial feminization surgery, and/or other surgical procedures.

Gender binary: the classification of gender into two discrete categories of boy/man and girl/woman.

Gender dysphoria: discomfort or distress related to incongruence between a person's gender identity, sex assigned at birth, gender identity, and/or primary and secondary sex characteristics (Knudson, De Cuypere, & Bockting, 2010). In 2013, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association, 2013) adopted the term *gender dysphoria* as a diagnosis characterized by "a marked incongruence between" a person's gender assigned at birth and gender identity (American Psychiatric Association, 2013, p. 453). Gender dysphoria replaced the diagnosis of gender identity disorder (GID) in the previous version of the *DSM* (American Psychiatric Association, 2000).

Gender expression: the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person's gender identity.

(Appendices continue)

Gender identity: a person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Because gender identity is internal, a person's gender identity is not necessarily visible to others. "Affirmed gender identity" refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

Gender marker: an indicator (M, F) of a person's sex or gender found on identification (e.g., driver's license, passport) and other legal documents (e.g., birth certificate, academic transcripts).

Gender nonconforming (GNC): an adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex. Subpopulations of the TGNC community can develop specialized language to represent their experience and culture, such as the term "masculine of center" (MOC; Cole & Han, 2011) that is used in communities of color to describe one's GNC identity.

Gender questioning: an adjective to describe people who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

Genderqueer: a term to describe a person whose gender identity does not align with a binary understanding of gender (i.e., a person who does not identify fully as either a man or a woman). People who identify as genderqueer may redefine gender or decline to define themselves as gendered altogether. For example, people who identify as genderqueer may think of themselves as both man and woman (bigender, pangender, androgyne); neither man nor woman (genderless, gender neutral, neutrois, agender); moving between genders (genderfluid); or embodying a third gender.

Gender role: refers to a pattern of appearance, personality, and behavior that, in a given culture, is associated with being a boy/man/male or being a girl/woman/female. The appearance, personality, and behavior characteristics may or may not conform to what is expected based on a person's sex assigned at birth according to cultural and environmental standards. Gender role may also refer to the *social* role in which one is living (e.g., as a woman, a man, or another gender), with some role characteristics conforming and others not conforming to what is associated with girls/women or boys/men in a given culture and time.

Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy): the use of hormones to masculinize or feminize a person's body to better

align that person's physical characteristics with their gender identity. People wishing to feminize their body receive antiandrogens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

Male-to-female (MTF): individuals whose assigned sex at birth was male and who have changed, are changing, or wish to change their body and/or gender role to a more feminized body or gender role. MTF persons are also often referred to as *transgender women*, *transwomen*, or *trans women*.

Passing: the ability to blend in with cisgender people without being recognized as transgender based on appearance or gender role and expression; being perceived as cisgender. Passing may or may not be a goal for all TGNC people.

Puberty suppression (puberty blocking, puberty delaying therapy): a treatment that can be used to temporarily suppress the development of secondary sex characteristics that occur during puberty in youth, typically using gonadotropin-releasing hormone (GnRH) analogues. Puberty suppression may be an important part of medically necessary treatment to alleviate gender dysphoria. Puberty suppression can provide adolescents time to determine whether they desire less reversible medical intervention and can serve as a diagnostic tool to determine if further medical intervention is warranted.

Sex (sex assigned at birth): sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex, with the aim of assigning a sex that is most likely to be congruent with the child's gender identity (MacLaughlin & Donahoe, 2004). For most people, gender identity is congruent with sex assigned at birth (see *cisgender*); for TGNC individuals, gender identity differs in varying degrees from sex assigned at birth.

Sexual orientation: a component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Stealth (going stealth): a phrase used by some TGNC people across the life span (e.g., children, adolescents) who choose to make a transition in a new environment (e.g., school) in their affirmed gender without openly sharing their identity as a TGNC person.

(Appendices continue)

TGNC: an abbreviation used to refer to people who are transgender or gender nonconforming.

Trans: common short-hand for the terms transgender, transsexual, and/or gender nonconforming. Although the term “trans” is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Trans-affirmative: being respectful, aware and supportive of the needs of TGNC people.

Transgender: an adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term “transgender” is commonly accepted, not all TGNC people self-identify as transgender.

Transgender man, trans man, or transman: a person whose sex assigned at birth was female, but who identifies as a man (see FTM).

Transgender woman, trans woman, or transwoman: a person whose sex assigned at birth was male, but who identifies as a woman (see MTF).

Transition: a process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to

each person’s life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

Transsexual: term to describe TGNC people who have changed or are changing their bodies through medical interventions (e.g., hormones, surgery) to better align their bodies with a gender identity that is different than their sex assigned at birth. Not all people who identify as transsexual consider themselves to be TGNC. For example, some transsexual individuals identify as female or male, without identifying as TGNC. Transsexualism is used as a medical diagnosis in the [World Health Organization’s \(2015\) International Classification of Diseases version 10](#).

Two-spirit: term used by some Native American cultures to describe people who identify with both male and female gender roles; this can include both gender identity and sexual orientation. Two-spirit people are often respected and carry unique spiritual roles for their community.

Appendix B

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gen-

der expression may affect the quality of care they provide to TGNC people and their families.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Guideline 7. Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

(Appendices continue)

Life Span Development

Guideline 8. Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents and that not all youth will persist in a TGNC identity into adulthood.

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

Suggested citation:

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, 70 (9), 832-864. doi: 10.1037/a0039906

EXHIBIT 15



AMERICAN PSYCHOLOGICAL ASSOCIATION

Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools

Adopted by the Council of Representatives August 2014 Amended by the Council of Representatives February 2015
(Suggested citations included with references)

WHEREAS people express and experience great diversity in sexual orientation and gender identity and expression;

WHEREAS communities today are undergoing rapid cultural and political change around the treatment of sexual minorities and gender diversity;

WHEREAS all persons, including those who are sexual or gender minority children and adolescents, or those who are questioning their gender identities or sexual orientations, have the right to equal opportunity and a safe environment within all public educational institutions;

Sexual Orientation and Gender Identity

WHEREAS some children and adolescents are aware of their attraction to members of the same gender or of their status as lesbian, gay, or bisexual persons by early adolescence (Remafedi, 1987; Savin-Williams, 1990; Slater, 1988; Troiden, 1988), although this awareness may vary by culture and acculturation (Morales, 1990; Rosario, Schrimshaw & Hunter, 2004);

WHEREAS sexual orientation and gender identity are separate, but related, aspects of the human experience (Bockting & Gray, 2004; Chivers & Bailey, 2000; Coleman, Bockting, & Gooren, 1993; Docter & Fleming, 2001; Docter & Prince, 1997);

WHEREAS some children and adolescents may experience a long period of questioning their sexual orientations or gender identities, experiencing stress, confusion, fluidity or complexity in their feelings and social identities (Hollander, 2000; Remafedi, Resnick, Blum, & Harris, 1992);

WHEREAS there are few resources and supportive adults available and little peer support individually or within student groups for gender and sexual orientation diverse children and adolescents, particularly those residing in rural areas or small towns, (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; Robinson & Espelage, 2011);

Gender Diversity

WHEREAS a person's gender identity develops in early childhood and some young children may not identify with the gender assigned to them at birth (Brill & Pepper, 2008; Zucker, 2004);

WHEREAS it may be medically and therapeutically indicated for some transgender and other gender diverse children and adolescents to transition from one gender to another using any of the following: change of name, pronoun, hairstyle, clothing, pubertal suppression, cross-sex hormone treatment, and surgical treatment (Coleman et al., 2011; Forcier & Johnson, 2012; Olson, Forbes, & Belzer, 2011);

Consequences of Stigma and Minority Stress

WHEREAS minority stress is recognized as a primary mechanism through which the notable burden of stigma and discrimination affects minority persons health and well-being and generates health disparities (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 2003; Meyer, Schwartz, & Frost, 2008; Mirowsky & Ross, 1989);

WHEREAS many gender and sexual orientation diverse children and adolescents have reported higher rates of anxiety and depression, low self-esteem, engaging in self-injurious behaviors, suicide, substance use, homelessness, and eating disorders among other adverse outcomes (Austin et al., 2009; Corliss, Goodenow, Nichols, & Austin, 2011; Gibson, 1989; Gipson, 2002; Gonsiorek, 1988; Grossman & D'Augelli, 2007; Harry, 1989; Hetrick & Martin, 1988; Mustanski, Garofalo, & Emerson, 2010; Poteat, Aragon, Espelage, & Koenig, 2009; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Dias, & Sanchez, 2010; Savin-Williams, 1990; Schutzmann, Brinkmann, Schacht, & Richter-Appelt, 2009).

WHEREAS many transgender and gender diverse children and adolescents experience elevated rates of depression, anxiety, self-harm, and other health risk behaviors (American Psychological Association, 2009; Coleman et al., 2011; McGuire, Anderson, Toomey, & Russell, 2010);

WHEREAS some gender and sexual orientation diverse adolescents are at an increased risk for pregnancy (Goodenow, Szalacha, Robin, & Westheimer, 2008; Russell et al., 2011; Ryan et al., 2010; Saewyc, Poon, Homma, & Skay, 2008; Savin-Williams, 1990);

WHEREAS, some gender and sexual orientation diverse adolescent sub-populations, including young men who have sex with men, homeless adolescents, racial/ethnic minority adolescents, transgender women of color, and adolescents enrolled in alternative schools, are at heightened risk for sexually transmitted infections, including HIV (Center for Disease Control and Prevention, 2012; Markham et al., 2003), due to complex and interacting factors related to stigma, socioeconomic class and minority stress (Hatzenbuehler, Phelan & Link, 2013; Link & Phelan, 1995; Meyer, 2003; Phelan, Link, & Tehranifar, 2010);

WHEREAS some children and adolescents with intersex/DSD¹ conditions report rates of self-harm and suicidality comparable to individuals who have experienced physical or sexual abuse (Schutzmann, et al., 2009);

WHEREAS individuals with intersex/DSD conditions often report a history of silence, stigma, and shame regarding their bodies and medical procedures imposed on them (MacKenzie, Huntington, & Gilmour, 2009; Wiesemann, Udo-Koeller, Sinnecker, & Thyen, 2010);

WHEREAS invasive medical procedures that are not medically necessary in nature (e.g., genital surgery for purposes of normalization) continue to be recommended to parents of intersex/DSD children, often proceed without the affected individual's assent, and lack research evidence on long-term quality of life, reproductive functioning, and body satisfaction (Wiesemann et al., 2010);

WHEREAS adults with intersex/DSD conditions report negative emotional, psychological and physical consequences that result from repeated and often questionable medical exams and procedures that lack research evidence to support their purported long-term reduction of distress (MacKenzie et al., 2009; Wiesemann et al., 2010);

WHEREAS gender and sexual orientation diverse young people with intersecting identities face additional challenges to their psychological well-being as a result of the negative consequences of discrimination based on sexual orientation and ethnic/racial minority status, religious identity, and country of origin, among other characteristics (Garnets & Kimmel, 1991; Herek, Gillis, & Cogan, 2009; Moradi et al., 2010; Poteat et al., 2009; Russell et al., 2011; Ryan et al., 2009; Szymanski & Gupta, 2009);

WHEREAS gender and sexual orientation diverse children and adolescents who come from impoverished or low-income families may face additional risks (Gipson, 2002; Gordon, Schroeder, & Abramo, 1990; Russell et al., 2011);

WHEREAS gender and sexual orientation diverse children and adolescents in rural areas and small towns experience additional challenges, such as living in typically more conservative and less diverse communities (compared to those in urban settings) and having limited access to affirming community-based supports, which can lead to greater feelings of social isolation (Cohn & Leake, 2012; O'Connell, Atlas, Saunders, & Philbrick, 2010);

WHEREAS gender and sexual orientation diverse children and adolescents with physical or mental disabilities are at increased risk of negative health outcomes due to the consequences of societal prejudice toward persons with mental and physical disabilities (Duke, 2011; Hingsburger & Griffiths, 1986; Pendler & Hingsburger, 1991);

¹ **Intersex** refers to a range of conditions associated with atypical development of physical sex characteristics (American Psychological Association 2006). Intersex individuals may be born with chromosomes, genitalia, and/or gonads that do not fit typical female or male presentations (Organization for Intersex in the United States of America 2013). Since 2006, the medical and research community has used the term **Disorders of Sex Development**. This term refers to congenital conditions characterized by atypical development of chromosomal, gonadal, or anatomical sex (Houk, Hughes, Ahmed, Lee, & Wright, 2006). An alternate term — **Differences of Sex Development** — has been recommended to prevent a view of these conditions as diseased or pathological (Wiesemann, Udo-Kroeber, Smeekker, & Thyen 2010). In order to be inclusive of various terminology preferences, this document will use **intersex/DSD** when referring to individuals who are part of this community.

Concerns and Issues in the Context of Schools

WHEREAS many gender and sexual orientation diverse children and adolescents experience harassment, bullying, and physical violence in school environments (Brooks, 2000; Fineran, 2002; Greytak, Kosciw, & Diaz, 2009; Kosciw et al., 2010; McGuire et al., 2010; Poteat & Rivers, 2010; Russell, Franz, & Driscoll, 2001; Sausa, 2005);

WHEREAS low numbers of school personnel intervene to stop harassment or bullying against transgender and other gender diverse students in school settings and may even participate in harassment of transgender and gender diverse students (Greytak et al., 2009; McGuire et al., 2010; Sausa, 2005);

WHEREAS gender and sexual orientation diverse children and adolescents who are victimized in school are at increased risk for mental health problems, suicidal ideation and attempts, substance use, high-risk sexual activity, and poor academic outcomes, such as high level of absenteeism, low grade point averages, and low interest in pursuing post-secondary education (Birkett, Espelage, & Koenig, 2009; Bontempo & D'Augelli, 2002; D'Augelli, Pilkington, & Hershberger, 2002; Kosciw et al., 2010; O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004; Russell et al., 2011);

WHEREAS some studies suggest that transgender and other gender diverse students experience even poorer educational outcomes compared to lesbian, gay and bisexual students, including low achievement levels, higher likelihood of being "pushed out" of high school prior to graduation, low educational aspirations, and high incidences of truancy and weapons possession (Greytak et al., 2009; Toomey, Ryan, Diaz, Card, & Russell, 2010);

WHEREAS recent research has identified a number of school policies, programs, and practices that may help reduce risk and/or increase well-being for gender and sexual orientation diverse children and adolescents (Blake et al 2001; Eisenberg & Resnick, 2006; Goodenow, Szalacha, & Westheimer, 2006; Graybill, Varjas, Meyers, & Watson, 2009; Heck, Flentje, & Cochran 2011; Murdock & Bolch, 2005; Szalacha, 2003; Toomey et al., 2010; Walls, Kane, & Wisneski, 2010; Watson, Varjas, Meyers, & Graybill, 2010);

WHEREAS gender and sexual orientation diverse students report increased school connectedness and school safety when school personnel intervene in the following ways: (1) addressing and stopping bullying and harassment, (2) developing administrative policies that prohibit discrimination based on sexual orientation, gender identity and gender expression, (3) supporting the use of affirming classroom activities and the establishment of gender and sexual orientation diverse-affirming student groups, and (4) valuing education and training for students and staff on the needs of gender and sexual orientation diverse students (Case & Meier, 2014; Greytak et al., 2009; Kosciw et al., 2010; McGuire et al., 2010; National Association of School Psychologists, 2011; Sausa, 2005);

The Role of Mental Healthcare Professionals in Schools

WHEREAS school psychologists, school counselors, and school social workers advocate for inclusive policies, programs and practices within educational environments (NASP, 2010a; NASP 2010b; NASP, 2011), and

WHEREAS the field of psychology promotes the individual's healthy development of personal identity, which includes the sexual orientation, gender expression, and gender identity of all individuals (APA, 2002; APA, 2012; Coleman et al., 2011; NASP, 2010a; NASP, 2011);

THEREFORE BE IT RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists affirm that diverse gender expressions, regardless of gender identity, and

diverse gender identities, beyond a binary classification, are normal and positive variations of the human experience;

Policies

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will advocate for local, state and federal policies and legislation that promote safe and positive school environments free of bullying and harassment for all children and adolescents, including gender and sexual orientation diverse children and adolescents and those who are perceived to be lesbian, gay, bisexual, transgender or gender diverse;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend schools develop policies that respect the right to privacy for students, parents, and colleagues with regard to sexual orientation, gender identity, or transgender status, and that clearly state that school personnel will not share information with anyone about the sexual orientation, gender identity, intersex/DSD condition, or transgender status of a student, parent, or school employee without that individual's permission;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that school administrations and mental health providers, in the context of schools, develop partnerships and networks to promote cross-agency collaboration to create policies that directly affect the health and wellbeing of gender and sexual orientation diverse adolescents and children;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage state educational agencies to collect data on sexual orientation, taking care to ensure student anonymity, as part of efforts to monitor and study adolescents' risk behaviors in the CDC Youth Risk Behavior Survey, and to develop and validate measures of gender identity for inclusion in the Youth Risk Behavior Survey, as well;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that inclusive data collection be incorporated into the Department of Education's Mandatory Civil Rights Data Collection, another important measurement of youth experiences in schools that could help inform effective interventions to better support gender and sexual orientation diverse children and adolescents in schools;

Programs and Interventions

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support efforts to ensure the funding of basic and applied research, and scientific evaluations of interventions and programs, designed to address the issues of gender and sexual orientation diverse children and adolescents in the schools;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend the continued development and evaluation of school-level interventions that promote academic success and resiliency, that reduce bullying and harassment, that reduce risk for sexually transmitted infections, that reduce risk for pregnancy among adolescents,

that reduce risk for self-injurious behaviors, and that foster safe and supportive school environments for gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that special sensitivity be given to the diversity within the population of gender and sexual orientation diverse students, with new interventions that incorporate the concerns of sexual minorities often overlooked or underserved, and the concerns of racial/ethnic minorities and recently immigrant children and adolescents who are also gender and sexual orientation diverse students;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists support affirmative interventions with transgender and gender diverse children and adolescents that encourage self-exploration and self-acceptance rather than trying to shift gender identity and gender expression in any specific direction;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to advocate for efforts to educate and train school professionals about the full range of sex development, gender expression, gender identity, and sexual orientation;

Training and Education

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage education, training, and ongoing professional development about the needs and the supports for gender and sexual orientation diverse students for educators and trainers of school personnel, education and mental health trainees, school-based mental health professionals, administrators, and school staff, and such training and education should be available to students, parents, and community members;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will encourage school-based mental health professionals to learn how strictly binary notions of sex, sex development and gender limit all children from realizing their full potential, create conditions that exacerbate bullying, and prevent many students from fully focusing on and investing in their own learning;

Practices

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school-based mental health professionals to serve as allies and advocates for gender and sexual orientation diverse children and adolescents in schools, including advocacy for the inclusion of gender identity, gender expression and sexual orientation in all relevant school district policies, especially anti-bullying and anti-discrimination policies;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists encourage school staff to support the decisions of children, adolescents, and families regarding a student's gender identity or expression, including whether to seek treatments

and interventions, and discourage school personnel from requiring proof of medical treatments as a prerequisite for such support;

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists recommend that administrators create safer environments for gender diverse, transgender, and intersex/DSD students, allowing all students, staff, and teachers to have access to the sex-segregated facilities, activities, and programs that are consistent with their gender identity, including, but not limited to, bathrooms, locker rooms, sports teams, and classroom activities, and avoiding the use of gender segregation in school uniforms, school dances, and extracurricular activities, and providing gender neutral bathroom options for individuals who would prefer to use them; and

BE IT FURTHER RESOLVED that the American Psychological Association and the National Association of School Psychologists will work with other organizations in efforts to accomplish these ends.

Suggested Citation

American Psychological Association & National Association of School Psychologists. (2015). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from <http://www.apa.org/about/policy/orientation-diversity.aspx>

References

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073. doi: 10.1037/0003-066X.57.12.1060
- American Psychological Association. (2006). *Answers to your questions about individuals with intersex conditions*. Washington, DC. Retrieved from <http://www.apa.org/topics/sexuality/intersex.pdf>
- American Psychological Association. (2009). *Report of the task force on appropriate therapeutic responses to sexual orientation*. Retrieved from <http://www.apa.org/pi/gbt/resources/therapeutic-response.pdf>
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*, 10-42. doi: 10.1037/a0024659
- Austin, S. B., Ziyadeh, N. J., Coriss, H. L., Rosario, M., Wypij, D., Haines, J.,... & Field, A. E. (2009). Sexual orientation disparities in purging and binge eating from early to late adolescence. *Journal of Adolescent Health, 45* (3), 238-245. doi: 10.1016/j.jadohealth.2009.02.001
- Birkett, M., Espelage, D. L., & Koenig, B. (2009). LGB and questioning students in schools: The moderating effects of homophobic bullying and school climate on negative outcomes. *Journal of Youth and Adolescence, 38*, 989-1000. doi: 10.1007/s10964-008-9389-1
- Bake, S. M., Ledsky, R., Lehman, T., Goodenow, C., Sawyer, R., & Hack, T. (2001). Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: The benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health, 91*, 940-946.
- Bockting, W. O., & Gray, N. (2004, August). *Transgender identity and HIV risk: An Internet-based study*. Abstract presented at the 112th Annual Convention of the American Psychological Association, Honolulu, Hawaii.

Bontempo, D. E., & DAuge i, A. R. (2002). Effects of at-schoo victimization and sexua orientation on esbian, gay, or bisexua youths risk hea th risk behavior. *Journal of Adolescent Health, 31S*, 28-39.

Bri , S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berke ey, CA: Ceis Press.

Brooks, F. L. (2000). Beneath contempt: The mistreatment of nontraditiona /gender atypica boys. *Journal of Gay and Lesbian Social Services, 12* (1-2), 107-115. doi: 10.1300/J041v12n01_06

Case, K. & Meier, C. (2014). Deve oping a ies to transgender and gender non-conforming youth: Training for counse ors and educators. *Journal of LGBT Youth, 11* (1), 62-82. doi:10.1080/193653.2014.840764

Centers for Disease Contro and Prevention. (2012). *HIV Surveillance in Adolescents and Young Adults, 2012*. Retrieved from: <http://www.cdc.gov/hiv/ibrary/s ideSets/index.htm>

Chivers, M. L., & J. M. Bai ey (2000). Sexua orientation of fema e-to-ma e transsexua s: A 1615 comparison of homosexua and non-homosexua types. *Archives of Sexual Behavior, 29*, 1616 259-278. doi:10.1023/A:1001915530479

Cohn, T. J., & Leake, V. S. (2012). Affective distress among ado escents who endorse same-sex sexua attraction: Urban versus rura differences and the ro e of protective factors. *Journal of Gay & Lesbian Mental Health, 16* (4), 291-305. doi:10.1080/19359705.2012.690931

Co eman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Fe dman, J., ... Zucker, K. (2011). Standards of care for the hea th of transsexua , transgender, and gender nonconforming peop e, 7th version. *International Journal of Transgenderism, 13*, 165-232. doi: 10.1080/15532739.2011.700873

Co eman, E., Bockting, W. O., & Gooren, L. (1993). Homosexua and bisexua identity in sex-reassigned fema e-to-ma e transsexua s. *Archives of Sexual Behavior, 22* (1), 37-50.

Cor iss, H., Goodenow, C., Nicho s, L., & Austin, S. B. (2011). High burden of home ssness among sexua minority ado escents: Findings from a representative Massachusetts high schoo samp e. *American Journal of Public Health, 101*, 1683-1689. doi: 10.2105/AJPH.2011.300155

DAuge i, A. R., Pi kington, N., & Hershberger, S. (2002). ncidence and menta hea th impact of sexua orientation victimization of esbian, gay, and bisexua youths in high schoo . *School Psychology Quarterly, 17*, 148-167. doi:10.1521/scpq.17.2.148.20854

Docter, R. F., & F eming, J. S. (2001). Measures of transgender behavior. *Archives of Sexual Behavior, 30* (3), 255-271.

Docter, R. F., & Prince, V. (1997). Transvestism: A survey of 1032 cross-dressers. *Archives of Sexual Behavior, 26* (6), 589-605.

Duke, T. S. (2011). Lesbian, gay, bisexua , and transgender youth with disabi ities: a meta-synthesis. *Journal of LGBT Youth, 8* (1), 1-52. doi: 10.1080/19361653.2011.519181

Eisenberg, M. E. & Resnick, M. D. (2006). Suicida ity among gay, esbian, and bisexua ado escents: The ro e of protective factors. *Journal of Adolescent Health, 39*, 662-668.

Fineran, S. (2002). Sexua harassment between same-sex peers: ntersection of menta hea th, homophobia, and sexua vio ence in schoo s. *Social Work, 47* (1), 65-74.

Forcier, M. & Johnson, M. (2012). Screening, identification, and support of gender non-conforming children and families. *Journal of Pediatric Nursing*, 28, 100-102. doi:10.1016/j.pedn.2012.11.001

Garnets, L., & Kinme, D. (1991). Lesbian and gay male dimensions in the psychological study of human diversity. In J. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 143-192). Washington, DC: American Psychological Association.

Gibson, P. (1989). Gay male and lesbian youth suicide. In M. Feinleib, (Ed.), *Report of the secretary's task force on youth suicide* (Vol. 3, pp.110-142). Washington, DC: Department of Health and Human Services.

Gipson, M. L. (2002). Poverty, race and LGBT youth. *Poverty and Race*, 11 (2): 1-6, 11. Retrieved from http://www.prrac.org/fu_text.php?text_id=743&item_id=7785&newsletter_id=61&header=Race+%2F+Racism

Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care*, 9, 114-122. doi:10.1016/0197-0070(88)90057-5

Goodenow, C., Szaacha, L., Robin, L., & Westheimer, K. (2008). Dimensions of sexual orientation and HIV-related risk among adolescent females: Evidence from a statewide survey. *American Journal of Public Health*, 98, 1051-1058. doi: 10.2105/AJPH.2005.080531

Goodenow, C., Szaacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43, 573-589. doi: 10.1002/pits.20173

Gordon, B. N., Schroeder, C. S., & Abramo, J. M. (1990). Age and social class differences in children's knowledge of sexuality. *Journal of Clinical Child Psychology*, 19, 33-43. doi: 10.1207/s15374424jccp1901_5

Graybiel, E. C., Varjas, K., Meyers, J., & Watson, L. (2009). Content-specific strategies to advocate for lesbian, gay, bisexual, and transgender youth: An exploratory study. *School Psychology Review*, 38 (4), 570-584.

Greytak, E. A., Kosciw, J. G., & Diaz, E. M. (2009). *Harsh realities: The experiences of transgender youth in our nation's schools*. New York, NY: Gay, Lesbian, and Straight Education Network.

Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior*, 37 (5), 527-537.

Harry, J. (1989). Sexual identity issues. In M. Feinleib (Ed.), *Report of the Secretary's Task Force on Youth Suicide* (Vol. 2, pp. 131-142). Washington, DC: Department of Health and Human Services.

Hatzenbuehler, M., Pheasant, J., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, 103 (5), 813-821. doi: 10.2105/AJPH.2012.301069

Hatzenbuehler, M. L., Noen-Hoeksema, S., & Erickson, S. J. (2008). Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men. *Health Psychology*, 27, 455-462.

Heck, N., Fentje, A. & Cochran, B. (2011). Offsetting risks: high school gay-straight alliances and lesbian, gay, bisexual, and transgender (LGBT) youth. *School Psychology Quarterly*, 26 (2), 161-174.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, 56, 32-43.

Hetrick, E. S., & Martin, A. D. (1988). Developmental issues and their resolution for gay and lesbian adolescents. In E. Coleman (Ed.), *Integrated identity for gay men and lesbians: Psychotherapeutic approaches for emotional wellbeing* (pp. 25-43). Binghamton, NY: Harrington Park Press.

Hingsburger, D., & Griffiths, D. (1986). Dealing with sexuality in a community residential service. *Psychiatric Aspects of Mental Retardation Reviews*, 5 (12), 63-67.

Hosander, G. (2000). Questioning youths: Challenges to working with youths forming identities. *School Psychology Review*, 29 (2), 173-179.

Kosciw, J. G., Greytak, E. A., Diaz, E. M., & Barkiewicz, M. J. (2010). *The 2009 National School Climate Survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. New York, NY: Gay, Lesbian, and Straight Education Network.

Link, B. G. and Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, Extra Issue: Forty Years of Medical Sociology: The State of the Art and Directions for the Future*, 35, 80-94

MacKenzie, D., Huntington, A., & Gilmour, J. (2009). The experiences of people with an intersex condition: A journey from silence to voice. *Journal of Clinical Nursing*, 18, 1775-1783.

Markham, C. M., Tortoero, S. R., Escobar-Chaves, S. L., Parce, G. S., Harrist, R., Addy, R. C. (2003). Family connectedness and sexual risk-taking among urban youth attending alternative high schools. *Perspectives on Sexual and Reproductive Health*. 35 (4), 174-79.

McGuire, J. K., Anderson, C. R., Toomey, R. B., & Russell, S. T. (2010). School climate for transgender youth: A mixed method investigation of student experiences and school responses. *Journal of Youth and Adolescence*, 39 (10), 1175-1188.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674-697. doi:10.1037/0033-2909.129.5.674

Meyer, I. H., Schwartz, S., & Frost, D. M. (2008). Social patterning of stress and coping: Does disadvantaged social status confer more stress and fewer coping resources? *Social Science & Medicine*, 67, 368-379.

Mirowsky, J., & Ross, C. E. (1989). *Social causes of psychological distress*. Hawthorne, NY: Aldine de Gruyter.

Moradi, B., Wiseman, M. C., DeBriere, C., Goodman, M. B., Sarkees, A., Brewster, M. E., & Huang, Y. P. (2010). LGB of color and white individuals' perceptions of heterosexist stigma, internalized homophobia, and outness: Comparisons of levels and links. *The Counseling Psychologist*, 38, 397-424.

Moraes, E. S. (1990). Ethnic minority families and minority gays and lesbians. In F. W. Bozett & M. B. Sussman (Eds.), *Homosexuality and Family Relations* (pp. 217-239). New York: The Haworth Press.

Murdock, T. B., & Boich, M. B. (2005). Risk and protective factors for poor school adjustment in lesbian, gay, and bisexual (LGB) high school youth: Variable and person-centered analyses. *Psychology in the Schools*, 42, 159-172.

Mustanski, B., Garofalo, R., & Emerson, E. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, 100 (12), 2426-2432. doi:http://dx.doi.org/10.2105/AJPH.2009.178319

National Association of School Psychologists. (2010a). *Principles for professional ethics*. Retrieved from http://www.nasponline.org/standards/2010standards/1_%20Ethical%20Principles.pdf

National Association of School Psychologists. (2010b). *Model for comprehensive and integrated school psychological services*. Retrieved from http://www.nasponline.org/standards/2010standards/2_PracticeMode.pdf

National Association of School Psychologists. (2011). *Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth* [Position Statement]. Retrieved from http://www.nasponline.org/about_nasp/positionpapers/LGBTQ_Youth.pdf

Oson, J., Forbes, C., and Besser, M. (2011). Management of the transgender adolescent. *Archives of Pediatrics and Adolescent Medicine*, 165 (2), 171-176.

O'Connell, L. M., Atlas, J. G., Saunders, A. L., & Phibrick, R. (2010). Perceptions of rural school staff regarding sexual minority students. *Journal of LGBT Youth*, 7, 293-309.

O'Shaughnessy, M., Russe, S. T., Heck, K., Cahoun, C., & Laub, C. (2004). *Safe place to learn: Consequences of harassment based on actual or perceived sexual orientation and gender non-conformity and steps for making schools safer*. San Francisco: California Safe Schools Coalition and 4-H Center for Youth Development.

Organization Intersex International in the United States of America. (2013). Frequently Asked Questions. Retrieved from <http://oii-usa.org/category/faqs/>

Pender, B., & Hingsburger, D. (1991). Sexuality: Dealing with parents. *Sexuality and Disability*, 9, 123-130. doi:10.1007/BF01101737

Pheasant, J., Link, B. G., & Tehranifar, P. (2010). Social Conditions as Fundamental Causes of Health Inequities: Theory, Evidence, and Policy Implications. *Journal of Health and Social Behavior, Extra Issue: What do we know? Key findings from 50 years of medical sociology*, 51 (S), S28-S40.

Poteat, V. P., Aragon, S. R., Espeague, D. L., & Koenig, B. W. (2009). Psychosocial concerns of sexual minority youth: complexity and caution in group differences. *Journal of Consulting and Clinical Psychology*, 77 (1), 196.

Poteat, V. P., & Rivers, J. (2010). The use of homophobic language across bullying roles during adolescence. *Journal of Applied Developmental Psychology*, 31, 166-172.

Remafedi, G. (1987). Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics*, 79, 331-337.

Remafedi, G., Resnick, M., Blum, R., Harris, L. (1992). Demography of sexual orientation in adolescents. *Pediatrics*, 89 (4 Pt 2), 714-721.

Robinson, J. P., & Espeague, D. L. (2011). Inequities in educational and psychological outcomes between LGBTQ and straight students in middle and high school. *Educational Researcher*, 40 (7), 315-330.

Rosario, M., Schrimshaw, E.W., Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology*, 10 (3), 215-228. doi: 10.1037/1099-9809.10.3.215

Russe, S. T., Ryan, C., Toomey, R. B., Diaz, R. M., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: implications for young adult health and adjustment. *Journal of School Health*, 81 (5), 223-230.

Russe, S. T., Franz, B., & Driscoll, A. K. (2001). Same-sex romantic attraction and violence experiences in adolescence. *American Journal of Public Health*, 91, 907-914.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123 (1), 346-352.

Ryan, C., Russe, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23, 205-213. doi: 10.1111/j.1744-

Saewyc, E. M., Poon, C., Homma, Y., & Skay, C. L. (2008). Stigma management? The links between enacted stigma and teen pregnancy trends among gay, lesbian, and bisexual students in British Columbia. *Canadian Journal of Human Sexuality, 17*, 123-131.

Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay and Lesbian Issues in Education, 3*, 15-28.

Savin-Williams, R. C. (1990). *Gay and lesbian youth: Expressions of identity*. New York, NY: Hemisphere.

Schutzmann, K., Brinkmann, L., Schacht, M., & Richter-Appelt, H. (2009). Psychological Distress, Self-Harming Behavior, and Suicidal Tendencies in Adults with Disorders of Sex Development. *Archives of Sexual Behavior, 38*, 16-33.

Slater, B. R. (1988). Essential issues in working with lesbian and gay male youths. *Professional Psychology: Research and Practice, 19*, 226-235. doi:10.1037/0735-7028.19.2.226

Szaucha, L. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safe Schools Program for gay and lesbian students. *American Journal of Education, 110*, 58-88.

Szymanski, D. M., & Gupta, A. (2009). Examining the relationship between multiple internalized oppressions and African American lesbian, gay, bisexual, and questioning persons self-esteem and psychological distress. *Journal of Counseling Psychology, 56* (1), 110.

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A. and Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology, 46* (6), 1580-1589. doi: 10.1037/a0020705

Troiden, R. R. (1988). *Gay and lesbian identity: A sociological study*. Dix Hills, NY: General Hall.

Watts, N. E., Kane, S. B., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth and Society, 41*, 307-332. doi:10.1177/0044118X09334957

Watson, L., Varjas, K., Meyers, J., & Graybill, E. C. (2010). Gay-straight alliance advisors: Negotiating multiple ecological systems when advocating for LGBTQ Youth. *Journal of LGBT Youth, 7*, 100-128.

Wiesemann, C., Ude-Koehler, S., Sinnecker, G. H., & Thyen, U. (2010). Ethical principles and recommendations for the medical management of differences of sex development (DSD)/intersex in children and adolescents. *European Journal of Pediatrics, 169*, 671-679.

Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13* (3), 551-568. doi:10.1016/j.chc.2004.02.006

Find this article at:

<http://www.apa.org/about/policy/orientation-diversity.aspx>

EXHIBIT 16

TRANSGENDER HEALTH

INTRODUCTION

Over the last few decades, there has been a rapid expansion in the understanding of gender identity along with the implications for the care of transgender and gender incongruent individuals. In parallel with the greater societal awareness of transgender individuals, evidence-based and data-driven protocols have increased. While there continue to be gaps in knowledge about the optimal care for transgender individuals, the framework for providing care is increasingly well-established as is the recognition of needed policy changes.

BACKGROUND

The medical consensus in the late 20th century was that transgender and gender incongruent individuals suffered a mental health disorder termed “gender identity disorder.” Gender identity was considered malleable and subject to external influences. Today, however, this attitude is no longer considered valid. Considerable scientific evidence has emerged demonstrating a durable biological element underlying gender identity.^{1,2} Individuals may make choices due to other factors in their lives, but there do not seem to be external forces that genuinely cause individuals to change gender identity.

Although the specific mechanisms guiding the biological underpinnings of gender identity are not entirely understood, there is evolving consensus that being transgender is not a mental health disorder. Such evidence stems from scientific studies suggesting that: 1) attempts to change gender identity in intersex patients to match external genitalia or chromosomes are typically unsuccessful^{3,4}; 2) identical twins (who share the exact same genetic background) are more likely to both experience transgender identity as compared to fraternal (non-identical) twins⁵; 3) among individuals with female chromosomes (XX), rates of male gender identity are higher for those exposed to higher levels of androgens *in utero* relative to those without such

exposure, and male (XY)-chromosome individuals with complete androgen insensitivity syndrome typically have female gender identity⁶; and 4) there are associations of certain brain scan or staining patterns with gender identity rather than external genitalia or chromosomes^{7,8}.

CONSIDERATIONS

Transgender individuals are often denied insurance coverage for appropriate medical and psychological treatment. Over the last decade, there has been considerable research on and development of evidence-based standards of care that have proven to be both safe and efficacious for the treatment of gender dysphoria/gender incongruence. There is also a growing understanding of the impact that increased access to such treatments can have on the mental health of these individuals.

The Endocrine Society’s Clinical Practice Guideline on gender dysphoria/gender incongruence⁹ provides the standard of care for treating transgender individuals. The guideline establishes a framework for the appropriate treatment of these individuals and standardizes terminology to be used by healthcare professionals. These recommendations include evidence that treatment of gender dysphoria/incongruence is medically necessary and should be covered by insurance.

Despite increased awareness, many barriers to improving the health and well-being of transgender patients remain. Oftentimes, treatment for gender dysphoria/gender incongruence is considered elective by insurance companies, which fail to provide coverage for physician-prescribed treatment. Access to appropriately trained healthcare professionals can also be challenging as there is a lack of formal education on gender dysphoria/gender incongruence among clinicians trained in the United States. A 2016 survey of endocrinologists, the physicians most likely to care for these patients, found that over 80% have never received training on care of transgender patients¹⁰.

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

¹Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204.

²Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

³Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204

⁴Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

⁵Heylens G, et al. Gender Identity Disorder in Twins: A Review of the Case Report Literature. *J Sex Med.* 2012 Mar;9(3):751-7.

⁶Dessens AB, et al. Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia. *Arch Sex Behav.* 2005 Aug;34(4):389-97.

⁷Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204

⁸Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

⁹Endocrine Society Draft Clinical Practice Guideline on Gender Dysphoria/Gender Incongruence (publication expected September 13, 2017).

¹⁰Davidge-Pitts, C., et al. Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Program and Practicing Clinicians. *J Clin Endocrinol Metab.* (2017) 102(4):1286-1290.



POSITION STATEMENT

This can have an adverse impact on patient outcomes, particularly in rural and underserved areas. In fact, studies have indicated that 70% of transgender individuals have experienced maltreatment by medical providers, including harassment and violence.¹¹ Transgender individuals who have been denied care show an increased likelihood of committing suicide and self-harm.¹² It is critical that transgender individuals have access to the appropriate treatment and care to ensure their health and well-being.

FUTURE CONSIDERATIONS

While the data are strong for both a biological underpinning to gender identity and the relative safety of hormone treatment (when appropriately monitored medically), the gaps in knowledge to optimize care over a lifetime are profound. Comparative effectiveness research in hormone regimens is needed to determine: the best endocrine and surgical protocols, as it is not yet known if certain regimens are safer or more effective than others; the degree of improvement as a result of the intervention (e.g. decrease in mental health diagnoses); the need for training of health care providers and the most effective training methods; and whether there are cardiovascular, malignancy, or other long-term risks from hormone interventions, particularly as the transgender individual ages. Further, studies are needed to elucidate the biological processes underlying gender identity as well as to determine strategies for fertility preservation and for the optimal approaches to gender non-conforming children. To successfully establish and enact these protocols requires long-term, large-scale studies across countries that employ the same care protocols.

POSITIONS

- There is a durable biological underpinning to gender identity that should be considered in policy determinations.
- Medical intervention for transgender individuals (including both hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.¹³ Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have.
- Increased funding for national research programs is needed to close the gaps in knowledge regarding transgender medical care and should be made a priority.

¹¹ *Ibid.*

¹² *Ibid.*

¹³Endocrine Society Draft Clinical Practice Guideline on Gender Dysphoria/ Gender Incongruence (publication expected September 13, 2017).

EXHIBIT 17

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,¹ Peggy T. Cohen-Kettenis,² Louis Gooren,³ Sabine E. Hannema,⁴ Walter J. Meyer,⁵ M. Hassan Murad,⁶ Stephen M. Rosenthal,⁷ Joshua D. Safer,⁸ Vin Tangpricha,⁹ and Guy G. T'Sjoen¹⁰

¹New York Presbyterian Hospital, Columbia University Medical Center, New York, New York 10032 (Retired); ²VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ³VU University Medical Center, 1007 MB Amsterdam, Netherlands (Retired); ⁴Leiden University Medical Center, 2300 RC Leiden, Netherlands; ⁵University of Texas Medical Branch, Galveston, Texas 77555; ⁶Mayo Clinic Evidence-Based Practice Center, Rochester, Minnesota 55905; ⁷University of California San Francisco, Benioff Children's Hospital, San Francisco, California 94143; ⁸Boston University School of Medicine, Boston, Massachusetts 02118; ⁹Emory University School of Medicine and the Atlanta VA Medical Center, Atlanta, Georgia 30322; and ¹⁰Ghent University Hospital, 9000 Ghent, Belgium

***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society-appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. (*J Clin Endocrinol Metab* 102: 3869–3903, 2017)

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in pre-pubertal children with GD/gender incongruence. (1 ⊕⊕○○)
- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

2.0 Treatment of adolescents

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕○○)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 ⊕⊕○○)
- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)
- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 ⊕⊕○○).
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 ⊕⊕○○)

3.0 Hormonal therapy for transgender adults

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and

- the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕○)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 ⊕⊕⊕○)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕○○)
- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

4.0 Adverse outcome prevention and long-term care

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)
- 4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 ⊕⊕○○)
- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕○○)
- 4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕○○)
- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 ⊕⊕○○)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕○○○)
- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

- 5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)
- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on

clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these “Ungraded Good Practice Statement.” Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict of interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict of interest form. The CGS reviews all conflicts of interest before the Society’s Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline’s development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [e.g., stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers’ bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the

quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are “trapped” in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote “The Transsexual Phenomenon” (4), it was Hirschfeld who coined the term “transsexual” in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through “something in between” to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (e.g., Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale

studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.

Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is “non-transgender people.”

Gender-affirming (hormone) treatment: See “gender reassignment”

Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced “gender identity disorder” with “gender dysphoria” and changed the criteria for diagnosis.

Gender expression: This refers to external manifestations of gender, expressed through one’s name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.

Gender identity/experienced gender: This refers to one’s internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.

Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see “gender dysphoria”). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using “gender incongruence of childhood.”

Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity-related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.

Gender variance: See “gender incongruence”

Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.

Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.

Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.

Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.

Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.

Sexual orientation: This term describes an individual’s enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.

Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.

Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.

Transgender woman (also: trans woman, male-to-female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.

Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.

Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify

specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people’s lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether

this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

-
- A. A marked incongruence between one’s experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
 4. A strong desire to be of the other gender (or some alternative gender different from one’s designated gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender)
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s designated gender)
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify if:
1. The condition exists with a disorder of sex development.
 2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).
-

Reference: American Psychiatric Association (14).

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they

start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

- 1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)
- 1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
 2. The transsexual identity has been present persistently for at least 2 y.
 3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.
-

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
 - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
 - gender dysphoria worsened with the onset of puberty,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
 - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,
2. And the adolescent:
 - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
 - agrees with the indication for GnRH agonist treatment,
 - has confirmed that puberty has started in the adolescent (Tanner stage \geq G2/B2),
 - has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
 - the persistence of gender dysphoria,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
 - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
2. And the adolescent:
 - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
 - agrees with the indication for sex hormone treatment,
 - has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

- 1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).
- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 ⊕⊕○○)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the

GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the “normal range” (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent

psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥ 4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 $\oplus\oplus\circ\circ$)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 $\oplus\oplus\circ\circ$)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference

ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:

1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:

1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 mL

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after “gender-reassignment surgery” (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD z scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD z scores and of bone mineral apparent density z scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (± 1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (± 1.4)

years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (± 2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD z scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog-treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D-deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog-treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 ⊕⊕○○)
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 ⊕⊕○○)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual energy X ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β -estradiol, increasing the dose every 6 mo:

5 $\mu\text{g}/\text{kg}/\text{d}$

10 $\mu\text{g}/\text{kg}/\text{d}$

15 $\mu\text{g}/\text{kg}/\text{d}$

20 $\mu\text{g}/\text{kg}/\text{d}$

Adult dose = 2–6 mg/d

In postpubertal transgender female adolescents, the dose of 17β -estradiol can be increased more rapidly:

1 mg/d for 6 mo

2 mg/d

Induction of female puberty with transdermal 17β -estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):

6.25–12.5 $\mu\text{g}/24$ h (cut 25- μg patch into quarters, then halves)

25 $\mu\text{g}/24$ h

37.5 $\mu\text{g}/24$ h

Adult dose = 50–200 $\mu\text{g}/24$ h

For alternatives once at adult dose, see Table 11.

Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):

25 mg/m²/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)

50 mg/m²/2 wk

75 mg/m²/2 wk

100 mg/m²/2 wk

Adult dose = 100–200 mg every 2 wk

In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:

75 mg/2 wk for 6 mo

125 mg/2 wk

For alternatives once at adult dose, see Table 11.

Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).

Adapted from Hembree et al. (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk

assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo

- Anthropometry: height, weight, sitting height, blood pressure, Tanner stages

Every 6–12 mo

- In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
- In transgender females: prolactin, estradiol, 25OH vitamin D

Every 1–2 y

- BMD using DXA
- Bone age on X-ray of the left hand (if clinically indicated)

BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).

For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree et al. (118).

Abbreviation: DXA, dual energy X ray absorptiometry.

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β -estradiol may be an alternative for oral 17β -estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an

adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕⊕○)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 ⊕⊕⊕⊕○)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕○⊕○)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 “Adverse Outcome Prevention and Long-Term Care”) and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen

Very high risk of adverse outcomes:

- Thromboembolic disease

Moderate risk of adverse outcomes:

- Macroprolactinoma
- Breast cancer
- Coronary artery disease
- Cerebrovascular disease
- Cholelithiasis
- Hypertriglyceridemia

Transgender male: testosterone

Very high risk of adverse outcomes:

- Erythrocytosis (hematocrit > 50%)

Moderate risk of adverse outcomes:

- Severe liver dysfunction (transaminases > threefold upper limit of normal)
- Coronary artery disease
- Cerebrovascular disease
- Hypertension
- Breast or uterine cancer

Table 11. Hormone Regimens in Transgender Persons

Transgender females ^a	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate ^b	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate ^c	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6% ^d	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

^aEstrogens used with or without antiandrogens or GnRH agonist.

^bNot available in the United States.

^cOne thousand milligrams initially followed by an injection at 6 wk then at 12 wk intervals.

^dAvoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen

receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5 α -Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17 β -estradiol, or transdermal 17 β -estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the “first pass effect” than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include

cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and anti-androgen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	— ^a
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	— ^b
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Assche man *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

^aPrevention and treatment as recommended for biological men.

^bMenorrhagia requires diagnosis and treatment by a gynecologist.

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y ^a
Scalp hair	Variable	— ^b
Voice changes	None	— ^c

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

^aComplete removal of male sexual hair requires electrolysis or laser treatment or both.

^bFamilial scalp hair loss may occur if estrogens are stopped.

^cTreatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone-induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every

3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:^a
 - a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
 - b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
 - c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

^aAdapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

- 4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 | ⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose

estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
 - a. Serum testosterone levels should be <50 ng/dL.
 - b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low-quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥ 24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should

monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

- 4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pre-treatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than -2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (e.g., when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 ⊕⊕○○)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕○○○)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1–30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of

transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the “threshold of 18 should not be seen as an indication in itself for active intervention.” If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have

reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsiveness and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (e.g., cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinnervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically

necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)

- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

Financial Disclosures of the Task Force*

Wylie C. Hembree (chair)—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Peggy T. Cohen-Kettenis**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Louis Gooren**—financial or business/organizational interests: none declared, significant financial

interest or leadership position: none declared. **Sabine E. Hannema**—financial or business/organizational interests: none declared, significant financial interest or leadership position: Ferring Pharmaceuticals Inc. (lecture/conference), Pfizer (lecture). **Walter J. Meyer**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **M. Hassan Murad****—financial or business/organizational interests: Mayo Clinic, Evidence-based Practice Center, significant financial interest or leadership position: none declared. **Stephen M. Rosenthal**—financial or business/organizational interests: AbbVie (consultant), National Institutes of Health (grantee), significant financial interest or leadership position: Pediatric Endocrine Society (immediate past president). **Joshua D. Safer, FACP**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared. **Vin Tangpricha**—financial or business/organizational interests: Cystic Fibrosis Foundation (grantee), National Institutes of Health (grantee), significant financial interest or leadership position, Elsevier *Journal of Clinical and Translational Endocrinology* (editor). **Guy G. T'Sjoen**—financial or business/organizational interests: none declared, significant financial interest or leadership position: none declared.* Financial, business, and organizational disclosures of the task force cover the year prior to publication. Disclosures prior to this time period are archived.**Evidence-based reviews for this guideline were prepared under contract with the Endocrine Society.

Acknowledgments

Correspondence and Reprint Requests: The Endocrine Society, 2055 L Street NW, Suite 600, Washington, DC 20036. E mail: publications@endocrine.org; Phone: 202971 3636.

Disclosure Summary: See Financial Disclosures.

Disclaimer: The Endocrine Society's clinical practice guidelines are developed to be of assistance to endocrinologists by providing guidance and recommendations for particular areas of practice. The guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgement of healthcare providers and each patient's individual circumstances.

The Endocrine Society makes no warranty, express or implied, regarding the guidelines and specifically excludes any warranties of merchantability and fitness for a particular use or purpose. The Society shall not be liable for direct, indirect,

special, incidental, or consequential damages related to the use of the information contained herein.

References

- Atkins D, Best D, Briss PA, Eccles M, Falck Ytter Y, Flottorp S, Guyatt GH, Harbour RT, Haugh MC, Henry D, Hill S, Jaeschke R, Leng G, Liberati A, Magrini N, Mason J, Middleton P, Mrukowicz J, O'Connell D, Oxman AD, Phillips B, Schunemann HJ, Edejer T, Varonen H, Vist GE, Williams JW, Jr, Zaza S; GRADE Working Group. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.
- Swiglo BA, Murad MH, Schunemann HJ, Kunz R, Vigersky RA, Guyatt GH, Montori VM. A case for clarity, consistency, and helpfulness: state of the art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. *J Clin Endocrinol Metab*. 2008;93(3):666-673.
- Bullough VL. Transsexualism in history. *Arch Sex Behav*. 1975;4(5):561-571.
- Benjamin H. The transsexual phenomenon. *Trans N Y Acad Sci*. 1967;29(4):428-430.
- Meyerowitz J. *How Sex Changed: A History of Transsexuality in the United States*. Cambridge, MA: Harvard University Press; 2002.
- Hirschfeld M. *Was muss das Volk vom Dritten Geschlecht wissen*. Verlag Max Spohr, Leipzig; 1901.
- Fisk NM. Editorial: Gender dysphoria syndrome—the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *West J Med*. 1974;120(5):386-391.
- Diamond L. Transgender experience and identity. In: Schwartz SJ, Luyckx K, Vignoles VL, eds. *Handbook of Identity Theory and Research*. New York, NY: Springer; 2011:629-647.
- Queen C, Schimmel L, eds. *PoMoSexuals: Challenging Assumptions About Gender and Sexuality*. San Francisco, CA: Cleis Press; 1997.
- Case LK, Ramachandran VS. Alternating gender incongruity: a new neuropsychiatric syndrome providing insight into the dynamic plasticity of brain sex. *Med Hypotheses*. 2012;78(5):626-631.
- Johnson TW, Wassersug RJ. Gender identity disorder outside the binary: when gender identity disorder not otherwise specified is not good enough. *Arch Sex Behav*. 2010;39(3):597-598.
- Wibowo E, Wassersug R, Warkentin K, Walker L, Robinson J, Brotto L, Johnson T. Impact of androgen deprivation therapy on sexual function: a response. *Asian J Androl*. 2012;14(5):793-794.
- Pasquosoone V. 7 countries giving transgender people fundamental rights the U.S. still won't. 2014. Available at: <https://mic.com/articles/87149/7-countries-giving-transgender-people-fundamental-rights-the-u-s-still-won-t>. Accessed 26 August 2016.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association Publishing.
- Drescher J, Cohen Kettner P, Winter S. Minding the body: situating gender identity diagnoses in the ICD 11. *Int Rev Psychiatry*. 2012;24(6):568-577.
- World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. Available at: http://www.wpath.org/site/page.cfm?pk_association_webpage_menu_1351&pk_association_webpage_3926. Accessed 1 September 2017.
- Kreukels BP, Haraldsen IR, De Cuypere G, Richter Appelt H, Gijs L, Cohen Kettner PT. A European network for the investigation of gender incongruence: the ENIGI initiative. *Eur Psychiatry*. 2012;27(6):445-450.
- Dekker MJ, Wierckx K, Van Caenegem E, Klaver M, Kreukels BP, Elaut E, Fisher AD, van Trotsenburg MA, Schreiner T, den Heijer M, T'Sjoen G. A European network for the investigation of gender incongruence: endocrine part. *J Sex Med*. 2016;13(6):994-999.
- Ruble DN, Martin CL, Berenbaum SA. Gender development. In: Damon WL, Lerner RM, Eisenberg N, eds. *Handbook of Child Psychology: Social, Emotional, and Personality Development*. Vol. 3. 6th ed. New York, NY: Wiley; 2006:858-931.
- Steensma TD, Kreukels BP, de Vries AL, Cohen Kettner PT. Gender identity development in adolescence. *Horm Behav*. 2013;64(2):288-297.
- Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab*. 2014;99(12):4379-4389.
- Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract*. 2015;21(2):199-204.
- Gooren L. The biology of human psychosexual differentiation. *Horm Behav*. 2006;50(4):589-601.
- Berenbaum SA, Meyer Bahlburg HF. Gender development and sexuality in disorders of sex development. *Horm Metab Res*. 2015;47(5):361-366.
- Dessens AB, Slijper FME, Drop SLS. Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Arch Sex Behav*. 2005;34(4):389-397.
- Meyer Bahlburg HFL, Dolezal C, Baker SW, Ehrhardt AA, New MI. Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Arch Sex Behav*. 2006;35(6):667-684.
- Frisén L, Nordenstrom A, Falhammar H, Filipsson H, Holmdahl G, Janson PO, Thorén M, Hagenfeldt K, Moller A, Nordenskjöld A. Gender role behavior, sexuality, and psychosocial adaptation in women with congenital adrenal hyperplasia due to CYP21A2 deficiency. *J Clin Endocrinol Metab*. 2009;94(9):3432-3439.
- Meyer Bahlburg HFL, Dolezal C, Baker SW, Carlson AD, Obeid JS, New MI. Prenatal androgenization affects gender related behavior but not gender identity in 5-12 year old girls with congenital adrenal hyperplasia. *Arch Sex Behav*. 2004;33(2):97-104.
- Cohen Kettner PT. Gender change in 46,XY persons with 5 α reductase 2 deficiency and 17 β hydroxysteroid dehydrogenase 3 deficiency. *Arch Sex Behav*. 2005;34(4):399-410.
- Reiner WG, Gearhart JP. Discordant sexual identity in some genetic males with cloacal exstrophy assigned to female sex at birth. *N Engl J Med*. 2004;350(4):333-341.
- Meyer Bahlburg HFL. Gender identity outcome in female raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Arch Sex Behav*. 2005;34(4):423-438.
- Coolidge FL, Thede LL, Young SE. The heritability of gender identity disorder in a child and adolescent twin sample. *Behav Genet*. 2002;32(4):251-257.
- Heylens G, De Cuypere G, Zucker KJ, Schelfaut C, Elaut E, Vanden Bossche H, De Baere E, T'Sjoen G. Gender identity disorder in twins: a review of the case report literature. *J Sex Med*. 2012;9(3):751-757.
- Fernández R, Esteva I, Gómez Gil E, Rumbo T, Almaraz MC, Roda E, Haro Mora J J, Guillamón A, Pávaro E. Association study of ER β , AR, and CYP19A1 genes and MtF transsexualism. *J Sex Med*. 2014;11(12):2986-2994.
- Henningson S, Westberg L, Nilsson S, Lundstrom B, Ekselius L, Bodlund O, Lindstrom E, Hellstrand M, Rosmond R, Eriksson E, Landén M. Sex steroid related genes and male to female transsexualism. *Psychoneuroendocrinology*. 2005;30(7):657-664.
- Hare L, Bernard P, Sánchez FJ, Baird PN, Vilain E, Kennedy T, Harley VR. Androgen receptor repeat length polymorphism associated with male to female transsexualism. *Biol Psychiatry*. 2009;65(1):93-96.
- Lombardo F, Toselli L, Grassetti D, Paoli D, Masciandaro P, Valentini F, Lenzi A, Gandini L. Hormone and genetic study in

- male to female transsexual patients. *J Endocrinol Invest.* 2013;36(8):550 557.
38. Ujike H, Otani K, Nakatsuka M, Ishii K, Sasaki A, Oishi T, Sato T, Okahisa Y, Matsumoto Y, Namba Y, Kimata Y, Kuroda S. As sociation study of gender identity disorder and sex hormone related genes. *Prog Neuropsychopharmacol Biol Psychiatry.* 2009;33(7):1241 1244.
 39. Kreukels BP, Guillamon A. Neuroimaging studies in people with gender incongruence. *Int Rev Psychiatry.* 2016;28(1): 120 128.
 40. Steensma TD, Biemond R, de Boer F, Cohen Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow up study. *Clin Child Psychol Psychiatry.* 2011;16(4):499 516.
 41. Wallien MSC, Cohen Kettenis PT. Psychosexual outcome of gender dysphoric children. *J Am Acad Child Adolesc Psychiatry.* 2008;47(12):1413 1423.
 42. Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow up study. *J Am Acad Child Adolesc Psychiatry.* 2013;52(6):582 590.
 43. Cohen Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross national, cross clinic comparative analysis. *J Abnorm Child Psychol.* 2003;31(1):41 53.
 44. Dhejne C, Van Vlerken R, Heylens G, Arcelus J. Mental health and gender dysphoria: a review of the literature. *Int Rev Psychiatry.* 2016;28(1):44 57.
 45. Pasterski V, Gilligan L, Curtis R. Traits of autism spectrum dis orders in adults with gender dysphoria. *Arch Sex Behav.* 2014; 43(2):387 393.
 46. Spack NP, Edwards Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, Vance SR. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics.* 2012;129(3):418 425.
 47. Terada S, Matsumoto Y, Sato T, Okabe N, Kishimoto Y, Uchitomi Y. Factors predicting psychiatric co morbidity in gender dysphoric adults. *Psychiatry Res.* 2012;200(2 3):469 474.
 48. VanderLaan DP, Leef JH, Wood H, Hughes SK, Zucker KJ. Autism spectrum disorder risk factors and autistic traits in gender dysphoric children. *J Autism Dev Disord.* 2015;45(6):1742 1750.
 49. de Vries ALC, Doreleijers TAH, Steensma TD, Cohen Kettenis PT. Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry.* 2011;52(11):1195 1202.
 50. de Vries ALC, Noens ILJ, Cohen Kettenis PT, van Berckelaer Onnes IA, Doreleijers TA. Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord.* 2010; 40(8):930 936.
 51. Wallien MSC, Swaab H, Cohen Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. *J Am Acad Child Adolesc Psychiatry.* 2007;46(10):1307 1314.
 52. Kuiper AJ, Cohen Kettenis PT. Gender role reversal among postoperative transsexuals. Available at: https://www.atria.nl/eazines/web/IJT/97_03/numbers/symposium/ijtc0502.htm. Accessed 26 August 2016.
 53. Landén M, Wålinder J, Lambert G, Lundstrom B. Factors pre dictive of regret in sex reassignment. *Acta Psychiatr Scand.* 1998; 97(4):284 289.
 54. Olsson S E, Moller A. Regret after sex reassignment surgery in a male to female transsexual: a long term follow up. *Arch Sex Behav.* 2006;35(4):501 506.
 55. Pfafflin F, Junge A, eds. *Geschlechtsumwandlung: Abhand lungen zur Transsexualität.* Stuttgart, Germany: Schattauer; 1992.
 56. Lawrence AA. Factors associated with satisfaction or regret fol lowing male to female sex reassignment surgery. *Arch Sex Behav.* 2003;32(4):299 315.
 57. Cohen Kettenis PT, Pfafflin F. *Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices.* Thousand Oaks, CA: SAGE Publications; 2003.
 58. Di Ceglie D, Freedman D, McPherson S, Richardson P. Children and adolescents referred to a specialist gender identity devel opment service: clinical features and demographic character istics. Available at: https://www.researchgate.net/publication/276061306_Children_and_Adolescents_Referred_to_a_Specialist_Gender_Identity_Development_Service_Clinical_Features_and_Demographic_Characteristics. Accessed 20 July 2017.
 59. Gijs L, Brewaeyns A. Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges. *Annu Rev Sex Res.* 2007;18:178 224.
 60. Cohen Kettenis PT, van Goozen SHM. Sex reassignment of ad olescent transsexuals: a follow up study. *J Am Acad Child Adolesc Psychiatry.* 1997;36(2):263 271.
 61. Smith YLS, van Goozen SHM, Cohen Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow up study. *J Am Acad Child Adolesc Psychiatry.* 2001;40(4):472 481.
 62. Smith YLS, Van Goozen SHM, Kuiper AJ, Cohen Kettenis PT. Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychol Med.* 2005;35(1):89 99.
 63. de Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics.* 2014;134(4):696 704.
 64. Cole CM, O'Boyle M, Emory LE, Meyer WJ III. Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Arch Sex Behav.* 1997;26(1):13 26.
 65. Cohen Kettenis PT, Schagen SEE, Steensma TD, de Vries ALC, Delemarre van de Waal HA. Puberty suppression in a gender dysphoric adolescent: a 22 year follow up. *Arch Sex Behav.* 2011; 40(4):843 847.
 66. First MB. Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder. *Psychol Med.* 2005;35(6): 919 928.
 67. Wierckx K, Van Caenegem E, Pennings G, Elaut E, Dedecker D, Van de Peer F, Weyers S, De Sutter P, T'Sjoen G. Reproductive wish in transsexual men. *Hum Reprod.* 2012;27(2):483 487.
 68. Wierckx K, Stuyver I, Weyers S, Hamada A, Agarwal A, De Sutter P, T'Sjoen G. Sperm freezing in transsexual women. *Arch Sex Behav.* 2012;41(5):1069 1071.
 69. Bertelloni S, Baroncelli GI, Ferdeghini M, Menchini Fabris F, Saggese G. Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin releasing hormone analogues. *Eur J Pediatr.* 2000;159(5):369 374.
 70. Buchter D, Behre HM, Kliesch S, Nieschlag E. Pulsatile GnRH or human chorionic gonadotropin/human menopausal gonadotro pin as effective treatment for men with hypogonadotropic hypogonadism: a review of 42 cases. *Eur J Endocrinol.* 1998; 139(3):298 303.
 71. Liu PY, Turner L, Rushford D, McDonald J, Baker HW, Conway AJ, Handelsman DJ. Efficacy and safety of recombinant human follicle stimulating hormone (Gonal F) with urinary human chorionic gonadotrophin for induction of spermatogenesis and fertility in gonadotrophin deficient men. *Hum Reprod.* 1999; 14(6):1540 1545.
 72. Pasquino AM, Pucarelli I, Accardo F, Demiraj V, Segni M, Di Nardo R. Long term observation of 87 girls with idiopathic central precocious puberty treated with gonadotropin releasing hormone analogs: impact on adult height, body mass index, bone mineral content, and reproductive function. *J Clin Endocrinol Metab.* 2008;93(1):190 195.
 73. Magiakou MA, Manousaki D, Papadaki M, Hadjidakis D, Levidou G, Vakaki M, Papaefstathiou A, Lalioti N, Kanaka Gantenbein C, Piaditis G, Chrousos GP, Dacou Voutetakis C. The

- efficacy and safety of gonadotropin releasing hormone analog treatment in childhood and adolescence: a single center, long term follow up study. *J Clin Endocrinol Metab.* 2010;**95**(1):109-117.
74. Baba T, Endo T, Honnma H, Kitajima Y, Hayashi T, Ikeda H, Masumori N, Kamiya H, Moriwaka O, Saito T. Association between polycystic ovary syndrome and female to male transsexuals. *Hum Reprod.* 2007;**22**(4):1011-1016.
 75. Spinder T, Spijkstra JJ, van den Tweel JG, Burger CW, van Kessel H, Hompes PGA, Gooren LJG. The effects of long term testosterone administration on pulsatile luteinizing hormone secretion and on ovarian histology in eugonadal female to male transsexual subjects. *J Clin Endocrinol Metab.* 1989;**69**(1):151-157.
 76. Baba T, Endo T, Ikeda K, Shimizu A, Honnma H, Ikeda H, Masumori N, Ohmura T, Kiya T, Fujimoto T, Koizumi M, Saito T. Distinctive features of female to male transsexualism and prevalence of gender identity disorder in Japan. *J Sex Med.* 2011;**8**(6):1686-1693.
 77. Vujovic S, Popovic S, Sbutega Milosevic G, Djordjevic M, Gooren L. Transsexualism in Serbia: a twenty year follow up study. *J Sex Med.* 2009;**6**(4):1018-1023.
 78. Ikeda K, Baba T, Noguchi H, Nagasawa K, Endo T, Kiya T, Saito T. Excessive androgen exposure in female to male transsexual persons of reproductive age induces hyperplasia of the ovarian cortex and stroma but not polycystic ovary morphology. *Hum Reprod.* 2013;**28**(2):453-461.
 79. Trebay G. He's pregnant. You're speechless. *New York Times.* 22 June 2008.
 80. Light AD, Obedin Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female to male gender transitioning. *Obstet Gynecol.* 2014;**124**(6):1120-1127.
 81. De Sutter P. Donor inseminations in partners of female to male transsexuals: should the question be asked? *Reprod Biomed Online.* 2003;**6**(3):382, author reply 282-283.
 82. De Roo C, Tilleman K, T'Sjoen G, De Sutter P. Fertility options in transgender people. *Int Rev Psychiatry.* 2016;**28**(1):112-119.
 83. Wennink JMB, Delemarre van de Waal HA, Schoemaker R, Schoemaker H, Schoemaker J. Luteinizing hormone and follicle stimulating hormone secretion patterns in boys throughout puberty measured using highly sensitive immunoradiometric assays. *Clin Endocrinol (Oxf).* 1989;**31**(5):551-564.
 84. Cohen Kettenis PT, Delemarre van de Waal HA, Gooren LJG. The treatment of adolescent transsexuals: changing insights. *J Sex Med.* 2008;**5**(8):1892-1897.
 85. Delemarre van de Waal HA, Cohen Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *Eur J Endocrinol.* 2006;**155**:S131-S137.
 86. de Vries ALC, Steensma TD, Doreleijers TAH, Cohen Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow up study. *J Sex Med.* 2011;**8**(8):2276-2283.
 87. Bouman MB, van Zeijl MCT, Buncamper ME, Meijerink WJHJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function. *J Sex Med.* 2014;**11**(7):1835-1847.
 88. Carel JC, Eugster EA, Rogol A, Ghizzoni L, Palmert MR, Antoniazzi F, Berenbaum S, Bourguignon JP, Chrousos GP, Coste J, Deal S, de Vries L, Foster C, Heger S, Holland J, Jahnukainen K, Juul A, Kaplowitz P, Lahlou N, Lee MM, Lee P, Merke DP, Neely EK, Oostdijk W, Phillip M, Rosenfield RL, Shulman D, Styne D, Tauber M, Wit JM; ESPE LWPEES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin releasing hormone analogs in children. *Pediatrics.* 2009;**123**(4):e752-e762.
 89. Roth CL, Brendel L, Ruckert C, Hartmann K. Antagonistic and agonistic GnRH analogue treatment of precocious puberty: tracking gonadotropin concentrations in urine. *Horm Res.* 2005;**63**(5):257-262.
 90. Roth C. Therapeutic potential of GnRH antagonists in the treatment of precocious puberty. *Expert Opin Investig Drugs.* 2002;**11**(9):1253-1259.
 91. Tuvemo T. Treatment of central precocious puberty. *Expert Opin Investig Drugs.* 2006;**15**(5):495-505.
 92. Schagen SE, Cohen Kettenis PT, Delemarre van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. *J Sex Med.* 2016;**13**(7):1125-1132.
 93. Manasco PK, Pescovitz OH, Feuillan PP, Hench KD, Barnes KM, Jones J, Hill SC, Loriaux DL, Cutler GB, Jr. Resumption of puberty after long term luteinizing hormone releasing hormone agonist treatment of central precocious puberty. *J Clin Endocrinol Metab.* 1988;**67**(2):368-372.
 94. Klink D, Caris M, Heijboer A, van Trotsenburg M, Rotteveel J. Bone mass in young adulthood following gonadotropin releasing hormone analog treatment and cross sex hormone treatment in adolescents with gender dysphoria. *J Clin Endocrinol Metab.* 2015;**100**(2):E270-E275.
 95. Finkelstein JS, Klibanski A, Neer RM. A longitudinal evaluation of bone mineral density in adult men with histories of delayed puberty. *J Clin Endocrinol Metab.* 1996;**81**(3):1152-1155.
 96. Bertelloni S, Baroncelli GI, Ferdeghini M, Perri G, Saggese G. Normal volumetric bone mineral density and bone turnover in young men with histories of constitutional delay of puberty. *J Clin Endocrinol Metab.* 1998;**83**(12):4280-4283.
 97. Darelid A, Ohlsson C, Nilsson M, Kindblom JM, Mellstrom D, Lorentzon M. Catch up in bone acquisition in young adult men with late normal puberty. *J Bone Miner Res.* 2012;**27**(10):2198-2207.
 98. Mittan D, Lee S, Miller E, Perez RC, Basler JW, Bruder JM. Bone loss following hypogonadism in men with prostate cancer treated with GnRH analogs. *J Clin Endocrinol Metab.* 2002;**87**(8):3656-3661.
 99. Saggese G, Bertelloni S, Baroncelli GI, Battini R, Franchi G. Reduction of bone density: an effect of gonadotropin releasing hormone analogue treatment in central precocious puberty. *Eur J Pediatr.* 1993;**152**(9):717-720.
 100. Neely EK, Bachrach LK, Hintz RL, Habiby RL, Slemenda CW, Feezle L, Pescovitz OH. Bone mineral density during treatment of central precocious puberty. *J Pediatr.* 1995;**127**(5):819-822.
 101. Bertelloni S, Baroncelli GI, Sorrentino MC, Perri G, Saggese G. Effect of central precocious puberty and gonadotropin releasing hormone analogue treatment on peak bone mass and final height in females. *Eur J Pediatr.* 1998;**157**(5):363-367.
 102. Thornton P, Silverman LA, Geffner ME, Neely EK, Gould E, Danoff TM. Review of outcomes after cessation of gonadotropin releasing hormone agonist treatment of girls with precocious puberty. *Pediatr Endocrinol Rev.* 2014;**11**(3):306-317.
 103. Lem AJ, van der Kaay DC, Hokken Koelega AC. Bone mineral density and body composition in short children born SGA during growth hormone and gonadotropin releasing hormone analog treatment. *J Clin Endocrinol Metab.* 2013;**98**(1):77-86.
 104. Antoniazzi F, Zamboni G, Bertoldo F, Lauriola S, Mengarda F, Pietrobelli A, Tatò L. Bone mass at final height in precocious puberty after gonadotropin releasing hormone agonist with and without calcium supplementation. *J Clin Endocrinol Metab.* 2003;**88**(3):1096-1101.
 105. Calcaterra V, Mannarino S, Corana G, Codazzi AC, Mazzola A, Brambilla P, Larizza D. Hypertension during therapy with triptorelin in a girl with precocious puberty. *Indian J Pediatr.* 2013;**80**(10):884-885.
 106. Siomou E, Kosmeri C, Pavlou M, Vlahos AP, Argyropoulou MI, Siamopoulou A. Arterial hypertension during treatment with triptorelin in a child with Williams Beuren syndrome. *Pediatr Nephrol.* 2014;**29**(9):1633-1636.
 107. Staphorsius AS, Kreukels BPC, Cohen Kettenis PT, Veltman DJ, Burke SM, Schagen SEE, Wouters FM, Delemarre van de Waal

- HA, Bakker J. Puberty suppression and executive functioning: an fMRI study in adolescents with gender dysphoria. *Psychoneuroendocrinology*. 2015;56:190–199.
108. Hough D, Bellingham M, Haraldsen IR, McLaughlin M, Rennie M, Robinson JE, Solbakk AK, Evans NP. Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. *Psychoneuroendocrinology*. 2017;75:173–182.
 109. Collipp PJ, Kaplan SA, Boyle DC, Plachte F, Kogut MD. Constitutional Isosexual Precocious Puberty. *Am J Dis Child*. 1964;108:399–405.
 110. Hahn HB, Jr, Hayles AB, Albert A. Medroxyprogesterone and constitutional precocious puberty. *Mayo Clin Proc*. 1964;39:182–190.
 111. Kaplan SA, Ling SM, Irani NG. Idiopathic isosexual precocity. *Am J Dis Child*. 1968;116(6):591–598.
 112. Schoen EJ. Treatment of idiopathic precocious puberty in boys. *J Clin Endocrinol Metab*. 1966;26(4):363–370.
 113. Gooren L. Hormone treatment of the adult transsexual patient. *Horm Res*. 2005;64(Suppl 2):31–36.
 114. Moore E, Wisniewski A, Dobs A. Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. *J Clin Endocrinol Metab*. 2003;88(8):3467–3473.
 115. Krueger RB, Hembree W, Hill M. Prescription of medroxyprogesterone acetate to a patient with pedophilia, resulting in Cushing's syndrome and adrenal insufficiency. *Sex Abuse*. 2006;18(2):227–228.
 116. Lynch MM, Khandheria MM, Meyer WJ. Retrospective study of the management of childhood and adolescent gender identity disorder using medroxyprogesterone acetate. *Int J Transgenderism*. 2015;16:201–208.
 117. Tack LJW, Craen M, Dhondt K, Vanden Bossche H, Laridaen J, Cools M. Consecutive lynestrenol and cross sex hormone treatment in biological female adolescents with gender dysphoria: a retrospective analysis. *Biol Sex Differ*. 2016;7:14.
 118. Hembree WC, Cohen Kettenis P, Delemarre van de Waal HA, Gooren LJ, Meyer WJ 3rd, Spack NP, Tangpricha V, Montori VM; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94(9):3132–3154.
 119. Mann L, Harmoni R, Power C. Adolescent decision making: the development of competence. *J Adolesc*. 1989;12(3):265–278.
 120. Stultiens L, Goffin T, Borry P, Dierickx K, Nys H. Minors and informed consent: a comparative approach. *Eur J Health Law*. 2007;14(1):21–46.
 121. Arshagouni P. "But I'm an adult now ... sort of". Adolescent consent in health care decision making and the adolescent brain. Available at: <http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1124&context=jhclp>. Accessed 25 June 2017.
 122. NHS. Prescribing of cross sex hormones as part of the gender identity development service for children and adolescents. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/08/clinical_com_pol_16046p.pdf. Accessed 14 June 2017.
 123. Ankarberg Lindgren C, Kristrom B, Norjavaara E. Physiological estrogen replacement therapy for puberty induction in girls: a clinical observational study. *Horm Res Paediatr*. 2014;81(4):239–244.
 124. Olson J, Schrager SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous testosterone: an effective delivery mechanism for masculinizing young transgender men. *LGBT Health*. 2014;1(3):165–167.
 125. Spratt DI, Stewart I, Savage C, Craig W, Spack NP, Chandler DW, Spratt LV, Eimicke T, Olshan JS. Subcutaneous injection of testosterone is an effective and preferred alternative to intramuscular injection: demonstration in female to male transgender patients. *J Clin Endocrinol Metab*. 2017. doi:10.1210/jc.2017 00359
 126. Eisenegger C, von Eckardstein A, Fehr E, von Eckardstein S. Pharmacokinetics of testosterone and estradiol gel preparations in healthy young men. *Psychoneuroendocrinology*. 2013;38(2):171–178.
 127. de Ronde W, ten Kulve J, Woerdeman J, Kaufman J M, de Jong FH. Effects of oestradiol on gonadotrophin levels in normal and castrated men. *Clin Endocrinol (Oxf)*. 2009;71(6):874–879.
 128. Money J, Ehrhardt A. Man & woman, boy & girl: differentiation and dimorphism of gender identity from conception to maturity. Baltimore, MD: Johns Hopkins University Press; 1972:202–206.
 129. Heylens G, Verroken C, De Cock S, T'Sjoen G, De Cuypere G. Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *J Sex Med*. 2014;11(1):119–126.
 130. Costa R, Colizzi M. The effect of cross sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. *Neuropsychiatr Dis Treat*. 2016;12:1953–1966.
 131. Gooren LJG, Giltay EJ. Review of studies of androgen treatment of female to male transsexuals: effects and risks of administration of androgens to females. *J Sex Med*. 2008;5(4):765–776.
 132. Levy A, Crown A, Reid R. Endocrine intervention for transsexuals. *Clin Endocrinol (Oxf)*. 2003;59(4):409–418.
 133. Tangpricha V, Ducharme SH, Barber TW, Chipkin SR. Endocrinologic treatment of gender identity disorders. *Endocr Pract*. 2003;9(1):12–21.
 134. Meriggiola MC, Gava G. Endocrine care of transpeople part I. A review of cross sex hormonal treatments, outcomes and adverse effects in transmen. *Clin Endocrinol (Oxf)*. 2015;83(5):597–606.
 135. Bhasin S, Cunningham GR, Hayes FJ, Matsumoto AM, Snyder PJ, Swerdloff RS, Montori VM. Testosterone therapy in adult men with androgen deficiency syndromes: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab*. 2006;91(6):1995–2010.
 136. Pelusi C, Costantino A, Martelli V, Lambertini M, Bazzocchi A, Ponti F, Battista G, Venturoli S, Meriggiola MC. Effects of three different testosterone formulations in female to male transsexual persons. *J Sex Med*. 2014;11(12):3002–3011.
 137. Anderson GL, Limacher M, Assaf AR, Bassford T, Beresford SA, Black H, Bonds D, Brunner R, Brzyski R, Caan B, Chlebowski R, Curb D, Gass M, Hays J, Heiss G, Hendrix S, Howard BV, Hsia J, Hubbell A, Jackson R, Johnson KC, Judd H, Kotchen JM, Kuller L, LaCroix AZ, Lane D, Langer RD, Lasser N, Lewis CE, Manson J, Margolis K, Ockene J, O'Sullivan MJ, Phillips L, Prentice RL, Ritenbaugh C, Robbins J, Rossouw JE, Sarto G, Stefanick ML, Van Horn L, Wactawski-Wende J, Wallace R, Wassertheil-Smoller S; Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. *JAMA*. 2004;291(14):1701–1712.
 138. Dickersin K, Munro MG, Clark M, Langenberg P, Scherer R, Frick K, Zhu Q, Hallock L, Nichols J, Yalcinkaya TM; Surgical Treatments Outcomes Project for Dysfunctional Uterine Bleeding (STOP DUB) Research Group. Hysterectomy compared with endometrial ablation for dysfunctional uterine bleeding: a randomized controlled trial. *Obstet Gynecol*. 2007;110(6):1279–1289.
 139. Gooren LJ, Giltay EJ, Bunck MC. Long term treatment of transsexuals with cross sex hormones: extensive personal experience. *J Clin Endocrinol Metab*. 2008;93(1):19–25.
 140. Prior JC, Vigna YM, Watson D. Spironolactone with physiological female steroids for presurgical therapy of male to female transsexualism. *Arch Sex Behav*. 1989;18(1):49–57.
 141. Dittrich R, Binder H, Cupisti S, Hoffmann I, Beckmann MW, Mueller A. Endocrine treatment of male to female transsexuals using gonadotropin releasing hormone agonist. *Exp Clin Endocrinol Diabetes*. 2005;113(10):586–592.

142. Striipp B, Taylor AA, Bartter FC, Gillette JR, Loriaux DL, Easley R, Menard RH. Effect of spironolactone on sex hormones in man. *J Clin Endocrinol Metab.* 1975;41(4):777 781.
143. Levy J, Burshell A, Marbach M, Aflalo L, Glick SM. Interaction of spironolactone with oestradiol receptors in cytosol. *J Endocrinol.* 1980;84(3):371 379.
144. Wierckx K, Elaut E, Van Hoorde B, Heylens G, De Cuypere G, Monstrey S, Weyers S, Hoebeke P, T'Sjoen G. Sexual desire in trans persons: associations with sex reassignment treatment. *J Sex Med.* 2014;11(1):107 118.
145. Chiriaco G, Cauci S, Mazzon G, Trombetta C. An observational retrospective evaluation of 79 young men with long term adverse effects after use of finasteride against androgenetic alopecia. *Andrology.* 2016;4(2):245 250.
146. Gava G, Cerpolini S, Martelli V, Battista G, Seracchioli R, Meriggiola MC. Cyproterone acetate vs leuprolide acetate in combination with transdermal oestradiol in transwomen: a comparison of safety and effectiveness. *Clin Endocrinol (Oxf).* 2016; 85(2):239 246.
147. Casper RF, Yen SS. Rapid absorption of micronized estradiol 17 beta following sublingual administration. *Obstet Gynecol.* 1981; 57(1):62 64.
148. Price TM, Blauer KL, Hansen M, Stanczyk F, Lobo R, Bates GW. Single dose pharmacokinetics of sublingual versus oral administration of micronized 17 β estradiol. *Obstet Gynecol.* 1997;89(3): 340 345.
149. Toorians AWFT, Thomassen MCLGD, Zweegman S, Magdeleyns EJP, Tans G, Gooren LJG, Rosing J. Venous thrombosis and changes of hemostatic variables during cross sex hormone treatment in transsexual people. *J Clin Endocrinol Metab.* 2003;88(12): 5723 5729.
150. Mepham N, Bouman WP, Arcelus J, Hayter M, Wylie KR. People with gender dysphoria who self prescribe cross sex hormones: prevalence, sources, and side effects knowledge. *J Sex Med.* 2014; 11(12):2995 3001.
151. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non binary or genderqueer genders. *Int Rev Psychiatry.* 2016; 28(1):95 102.
152. Cosyns M, Van Borsel J, Wierckx K, Dedeker D, Van de Peer F, Daelman T, Laenen S, T'Sjoen G. Voice in female to male transsexual persons after long term androgen therapy. *Laryngoscope.* 2014;124(6):1409 1414.
153. Deuster D, Matulat P, Knief A, Zitzmann M, Rosslau K, Szukaj M, am Zehnhoff Dinnesen A, Schmidt CM. Voice deepening under testosterone treatment in female to male gender dysphoric individuals. *Eur Arch Otorhinolaryngol.* 2016;273(4):959 965.
154. Lapauw B, Taes Y, Simoens S, Van Caenegem E, Weyers S, Goemaere S, Toye K, Kaufman J M, T'Sjoen GG. Body composition, volumetric and areal bone parameters in male to female transsexual persons. *Bone.* 2008;43(6):1016 1021.
155. Meyer III WJ, Webb A, Stuart CA, Finkelstein JW, Lawrence B, Walker PA. Physical and hormonal evaluation of transsexual patients: a longitudinal study. *Arch Sex Behav.* 1986;15(2): 121 138.
156. Asscheman H, Gooren LJ, Assies J, Smits JP, de Slegte R. Prolactin levels and pituitary enlargement in hormone treated male to female transsexuals. *Clin Endocrinol (Oxf).* 1988;28(6):583 588.
157. Gooren LJ, Harmsen Louman W, van Kessel H. Follow up of prolactin levels in long term oestrogen treated male to female transsexuals with regard to prolactinoma induction. *Clin Endocrinol (Oxf).* 1985;22(2):201 207.
158. Wierckx K, Van Caenegem E, Schreiner T, Haraldsen I, Fisher AD, Toye K, Kaufman JM, T'Sjoen G. Cross sex hormone therapy in trans persons is safe and effective at short time follow up: results from the European network for the investigation of gender incongruence. *J Sex Med.* 2014;11(8):1999 2011.
159. Ott J, Kaufmann U, Bentz EK, Huber JC, Tempfer CB. Incidence of thrombophilia and venous thrombosis in transsexuals under cross sex hormone therapy. *Fertil Steril.* 2010;93(4):1267 1272.
160. Giltay EJ, Hoogeveen EK, Elbers JMH, Gooren LJG, Asscheman H, Stehouwer CDA. Effects of sex steroids on plasma total homocysteine levels: a study in transsexual males and females. *J Clin Endocrinol Metab.* 1998;83(2):550 553.
161. van Kesteren PJM, Asscheman H, Megens JAJ, Gooren LJG. Mortality and morbidity in transsexual subjects treated with cross sex hormones. *Clin Endocrinol (Oxf).* 1997;47(3): 337 343.
162. Wierckx K, Gooren L, T'Sjoen G. Clinical review: breast development in trans women receiving cross sex hormones. *J Sex Med.* 2014;11(5):1240 1247.
163. Bird D, Vowles K, Anthony PP. Spontaneous rupture of a liver cell adenoma after long term methyltestosterone: report of a case successfully treated by emergency right hepatic lobectomy. *Br J Surg.* 1979;66(3):212 213.
164. Westaby D, Ogle SJ, Paradinas FJ, Randell JB, Murray Lyon IM. Liver damage from long term methyltestosterone. *Lancet.* 1977; 2(8032):262 263.
165. Weinand JD, Safer JD. Hormone therapy in transgender adults is safe with provider supervision; a review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocrinol.* 2015;2(2):55 60.
166. Roberts TK, Kraft CS, French D, Ji W, Wu AH, Tangpricha V, Fantz CR. Interpreting laboratory results in transgender patients on hormone therapy. *Am J Med.* 2014;127(2):159 162.
167. Vesper HW, Botelho JC, Wang Y. Challenges and improvements in testosterone and estradiol testing. *Asian J Androl.* 2014;16(2): 178 184.
168. Asscheman H, T'Sjoen G, Lemaire A, Mas M, Meriggiola MC, Mueller A, Kuhn A, Dhejne C, Morel Journal N, Gooren LJ. Venous thrombo embolism as a complication of cross sex hormone treatment of male to female transsexual subjects: a review. *Andrologia.* 2014;46(7):791 795.
169. Righini M, Perrier A, De Moerloose P, Bounameaux H. D dimer for venous thromboembolism diagnosis: 20 years later. *J Thromb Haemost.* 2008;6(7):1059 1071.
170. Gooren LJ, Assies J, Asscheman H, de Slegte R, van Kessel H. Estrogen induced prolactinoma in a man. *J Clin Endocrinol Metab.* 1988;66(2):444 446.
171. Kovacs K, Stefaneanu L, Ezzat S, Smyth HS. Prolactin producing pituitary adenoma in a male to female transsexual patient with protracted estrogen administration. A morphologic study. *Arch Pathol Lab Med.* 1994;118(5):562 565.
172. Serri O, Noiseux D, Robert F, Hardy J. Lactotroph hyperplasia in an estrogen treated male to female transsexual patient. *J Clin Endocrinol Metab.* 1996;81(9):3177 3179.
173. Cunha FS, Domenice S, Câmara VL, Sircili MH, Gooren LJ, Mendonça BB, Costa EM. Diagnosis of prolactinoma in two male to female transsexual subjects following high dose cross sex hormone therapy. *Andrologia.* 2015;47(6):680 684.
174. Nota NM, Dekker MJHJ, Klaver M, Wiepjes CM, van Trotsenburg MA, Heijboer AC, den Heijer M. Prolactin levels during short and long term cross sex hormone treatment: an observational study in transgender persons. *Andrologia.* 2017;49(6).
175. Bunck MC, Debono M, Giltay EJ, Verheijen AT, Diamant M, Gooren LJ. Autonomous prolactin secretion in two male to female transgender patients using conventional oestrogen doses. *BMJ Case Rep.* 2009;2009:bcr0220091589.
176. Elamin MB, Garcia MZ, Murad MH, Erwin PJ, Montori VM. Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta analyses. *Clin Endocrinol (Oxf).* 2010;72(1):1 10.
177. Berra M, Armillotta F, D'Emidio L, Costantino A, Martorana G, Pelusi G, Meriggiola MC. Testosterone decreases adiponectin

- levels in female to male transsexuals. *Asian J Androl.* 2006;8(6):725-729.
178. Elbers JMH, Giltay EJ, Teerlink T, Scheffer PG, Asscheman H, Seidell JC, Gooren LJG. Effects of sex steroids on components of the insulin resistance syndrome in transsexual subjects. *Clin Endocrinol (Oxf).* 2003;58(5):562-571.
 179. Giltay EJ, Lambert J, Gooren LJG, Elbers JMH, Steyn M, Stehouwer CDA. Sex steroids, insulin, and arterial stiffness in women and men. *Hypertension.* 1999;34(4 Pt 1):590-597.
 180. Polderman KH, Gooren LJ, Asscheman H, Bakker A, Heine RJ. Induction of insulin resistance by androgens and estrogens. *J Clin Endocrinol Metab.* 1994;79(1):265-271.
 181. Maraka S. Effect of sex steroids on lipids, venous thromboembolism, cardiovascular disease and mortality in transgender individuals: a systematic review and meta analysis. Available at: <http://press.endocrine.org/doi/abs/10.1210/endo-meetings.2016.RE.15.FRI.136>. Accessed 3 July 2017.
 182. Meriggiola MC, Armillotta F, Costantino A, Altieri P, Saad F, Kalhorn T, Perrone AM, Ghi T, Pelusi C, Pelusi G. Effects of testosterone undecanoate administered alone or in combination with letrozole or dutasteride in female to male transsexuals. *J Sex Med.* 2008;5(10):2442-2453.
 183. Giltay EJ, Toorians AW, Sarabdjitsingh AR, de Vries NA, Gooren LJ. Established risk factors for coronary heart disease are unrelated to androgen induced baldness in female to male transsexuals. *J Endocrinol.* 2004;180(1):107-112.
 184. Giltay EJ, Verhoef P, Gooren LJG, Geleijnse JM, Schouten EG, Stehouwer CDA. Oral and transdermal estrogens both lower plasma total homocysteine in male to female transsexuals. *Athérosclerosis.* 2003;168(1):139-146.
 185. Calof OM, Singh AB, Lee ML, Kenny AM, Urban RJ, Tenover JL, Bhasin S. Adverse events associated with testosterone replacement in middle aged and older men: a meta analysis of randomized, placebo controlled trials. *J Gerontol A Biol Sci Med Sci.* 2005;60(11):1451-1457.
 186. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). *JAMA.* 2001;285(19):2486-2497.
 187. Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM. Hormonal therapy and sex reassignment: a systematic review and meta analysis of quality of life and psychosocial outcomes. *Clin Endocrinol (Oxf).* 2010;72(2):214-231.
 188. Van Caenegem E, Wierckx K, Taes Y, Schreiner T, Vandewalle S, Toye K, Lapauw B, Kaufman JM, T'Sjoen G. Body composition, bone turnover, and bone mass in trans men during testosterone treatment: 1 year follow up data from a prospective case controlled study (ENIGI). *Eur J Endocrinol.* 2015;172(2):163-171.
 189. Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, Tangpricha V. Testosterone increases bone mineral density in female to male transsexuals: a case series of 15 subjects. *Clin Endocrinol (Oxf).* 2004;61(5):560-566.
 190. van Kesteren P, Lips P, Gooren LJG, Asscheman H, Megens J. Long term follow up of bone mineral density and bone metabolism in transsexuals treated with cross sex hormones. *Clin Endocrinol (Oxf).* 1998;48(3):347-354.
 191. Van Caenegem E, Taes Y, Wierckx K, Vandewalle S, Toye K, Kaufman JM, Schreiner T, Haraldsen I, T'Sjoen G. Low bone mass is prevalent in male to female transsexual persons before the start of cross sex hormonal therapy and gonadectomy. *Bone.* 2013;54(1):92-97.
 192. Amin S, Zhang Y, Sawin CT, Evans SR, Hannan MT, Kiel DP, Wilson PW, Felson DT. Association of hypogonadism and estradiol levels with bone mineral density in elderly men from the Framingham study. *Ann Intern Med.* 2000;133(12):951-963.
 193. Gennari L, Khosla S, Bilezikian JP. Estrogen and fracture risk in men. *J Bone Miner Res.* 2008;23(10):1548-1551.
 194. Khosla S, Melton LJ III, Atkinson EJ, O'Fallon WM, Klee GG, Riggs BL. Relationship of serum sex steroid levels and bone turnover markers with bone mineral density in men and women: a key role for bioavailable estrogen. *J Clin Endocrinol Metab.* 1998;83(7):2266-2274.
 195. Mueller A, Dittrich R, Binder H, Kuehnel W, Maltaris T, Hoffmann I, Beckmann MW. High dose estrogen treatment increases bone mineral density in male to female transsexuals receiving gonadotropin releasing hormone agonist in the absence of testosterone. *Eur J Endocrinol.* 2005;153(1):107-113.
 196. Ruetsche AG, Kneubuehl R, Birkhaeuser MH, Lippuner K. Cortical and trabecular bone mineral density in transsexuals after long term cross sex hormonal treatment: a cross sectional study. *Osteoporos Int.* 2005;16(7):791-798.
 197. Ganly I, Taylor EW. Breast cancer in a transsexual man receiving hormone replacement therapy. *Br J Surg.* 1995;82(3):341.
 198. Pritchard TJ, Pankowsky DA, Crowe JP, Abdul Karim FW. Breast cancer in a male to female transsexual. A case report. *JAMA.* 1988;259(15):2278-2280.
 199. Symmers WS. Carcinoma of breast in transsexual individuals after surgical and hormonal interference with the primary and secondary sex characteristics. *BMJ.* 1968;2(5597):83-85.
 200. Brown GR. Breast cancer in transgender veterans: a ten case series. *LGBT Health.* 2015;2(1):77-80.
 201. Shao T, Grossbard ML, Klein P. Breast cancer in female to male transsexuals: two cases with a review of physiology and management. *Clin Breast Cancer.* 2011;11(6):417-419.
 202. Nikolic DV, Djordjevic ML, Granic M, Nikolic AT, Stanimirovic VV, Zdravkovic D, Jelic S. Importance of revealing a rare case of breast cancer in a female to male transsexual after bilateral mastectomy. *World J Surg Oncol.* 2012;10:280.
 203. Bosze P, Tóth A, Torok M. Hormone replacement and the risk of breast cancer in Turner's syndrome. *N Engl J Med.* 2006;355(24):2599-2600.
 204. Schoemaker MJ, Swerdlow AJ, Higgins CD, Wright AF, Jacobs PA; UK Clinical Cytogenetics Group. Cancer incidence in women with Turner syndrome in Great Britain: a national cohort study. *Lancet Oncol.* 2008;9(3):239-246.
 205. Smith RA, Cokkinides V, Eyre HJ. American Cancer Society guidelines for the early detection of cancer, 2006. *CA Cancer J Clin.* 2006;56(1):11-25, quiz 49-50.
 206. Wilson JD, Roehrborn C. Long term consequences of castration in men: lessons from the Skoptzy and the eunuchs of the Chinese and Ottoman courts. *J Clin Endocrinol Metab.* 1999;84(12):4324-4331.
 207. van Kesteren P, Meinhardt W, van der Valk P, Geldof A, Megens J, Gooren L. Effects of estrogens only on the prostates of aging men. *J Urol.* 1996;156(4):1349-1353.
 208. Brown JA, Wilson TM. Benign prostatic hyperplasia requiring transurethral resection of the prostate in a 60 year old male to female transsexual. *Br J Urol.* 1997;80(6):956-957.
 209. Casella R, Bubendorf L, Schaefer DJ, Bachmann A, Gasser TC, Sulser T. Does the prostate really need androgens to grow? Transurethral resection of the prostate in a male to female transsexual 25 years after sex changing operation. *Urol Int.* 2005;75(3):288-290.
 210. Dorff TB, Shazer RL, Nepomuceno EM, Tucker SJ. Successful treatment of metastatic androgen independent prostate carcinoma in a transsexual patient. *Clin Genitourin Cancer.* 2007;5(5):344-346.
 211. Thurston AV. Carcinoma of the prostate in a transsexual. *Br J Urol.* 1994;73(2):217.

212. van Harst EP, Newling DW, Gooren LJ, Asscheman H, Prenger DM. Metastatic prostatic carcinoma in a male to female transsexual. *BJU Int*. 1998;81:776.
213. Turo R, Jallad S, Prescott S, Cross WR. Metastatic prostate cancer in transsexual diagnosed after three decades of estrogen therapy. *Can Urol Assoc J*. 2013;7(7-8):E544 E546.
214. Miksad RA, Bubley G, Church P, Sanda M, Rofsky N, Kaplan I, Cooper A. Prostate cancer in a transgender woman 41 years after initiation of feminization. *JAMA*. 2006;296(19):2316 2317.
215. Moyer VA; U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2012;157(2):120 134.
216. Futterweit W. Endocrine therapy of transsexualism and potential complications of long term treatment. *Arch Sex Behav*. 1998;27(2):209 226.
217. Miller N, Bédard YC, Cooter NB, Shaul DL. Histological changes in the genital tract in transsexual women following androgen therapy. *Histopathology*. 1986;10(7):661 669.
218. O'Hanlan KA, Dibble SL, Young Spint M. Total laparoscopic hysterectomy for female to male transsexuals. *Obstet Gynecol*. 2007;110(5):1096 1101.
219. Dizon DS, Tejada Berges T, Koelliker S, Steinhoff M, Granai CO. Ovarian cancer associated with testosterone supplementation in a female to male transsexual patient. *Gynecol Obstet Invest*. 2006;62(4):226 228.
220. Hage JJ, Dekker JJML, Karim RB, Verheijen RHM, Bloemena E. Ovarian cancer in female to male transsexuals: report of two cases. *Gynecol Oncol*. 2000;76(3):413 415.
221. Mueller A, Gooren L. Hormone related tumors in transsexuals receiving treatment with cross sex hormones. *Eur J Endocrinol*. 2008;159(3):197 202.
222. Coleman E, Bockting W, Botzer M, Cohen Kettner P, DeCuypere G, Feldman J, Fraser L, Green J, Knudson G, Meyer WJ, Monstrey S, Adler RK, Brown GR, Devor AH, Ehrbar R, Ettner R, Eyrler E, Garofalo R, Karasic DH, Lev AL, Mayer G, Meyer Bahlburg H, Hall BP, Pfaefflin F, Rachlin K, Robinson B, Schechter LS, Tangpricha V, van Trotsenburg M, Vitale A, Winter S, Whittle S, Wylie KR, Zucker K. Standards of care for the health of transsexual, transgender, and gender nonconforming people, version 7. *Int J Transgenderism*. 2012;13:165 232.
223. Colebunders B, D'Arpa S, Weijers S, Lumen N, Hoebeke P, Monstrey S. Female to male gender reassignment surgery. In: Ettner R, Monstrey S, Coleman E, eds. *Principles of Transgender Medicine and Surgery*. 2nd ed. New York, NY: Routledge Taylor & Francis Group; 2016:279 317.
224. Monstrey S, Hoebeke P, Dhont M, De Cuypere G, Rubens R, Moerman M, Hamdi M, Van Landuyt K, Blondeel P. Surgical therapy in transsexual patients: a multi disciplinary approach. *Acta Chir Belg*. 2001;101(5):200 209.
225. Selvaggi G, Ceulemans P, De Cuypere G, VanLanduyt K, Blondeel P, Hamdi M, Bowman C, Monstrey S. Gender identity disorder: general overview and surgical treatment for vaginoplasty in male to female transsexuals. *Plast Reconstr Surg*. 2005;116(6):135e 145e.
226. Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR. Current management of male to female gender identity disorder in the UK. *Postgrad Med J*. 2007;83(984):638 642.
227. Horbach SER, Bouman M B, Smit JM, Ozer M, Buncamper ME, Mullender MG. Outcome of vaginoplasty in male to female transsexuals: a systematic review of surgical techniques. *J Sex Med*. 2015;12(6):1499 1512.
228. Wroblewski P, Gustafsson J, Selvaggi G. Sex reassignment surgery for transsexuals. *Curr Opin Endocrinol Diabetes Obes*. 2013;20(6):570 574.
229. Morrison SD, Satterwhite T, Grant DW, Kirby J, Laub DR, Sr, VanMaasdam J. Long term outcomes of rectosigmoid neo colporrhaphy in male to female gender reassignment surgery. *Plast Reconstr Surg*. 2015;136(2):386 394.
230. Dessy LA, Mazzocchi M, Corrias F, Ceccarelli S, Marchese C, Scuderi N. The use of cultured autologous oral epithelial cells for vaginoplasty in male to female transsexuals: a feasibility, safety, and advantageousness clinical pilot study. *Plast Reconstr Surg*. 2014;133(1):158 161.
231. Li FY, Xu YS, Zhou CD, Zhou Y, Li SK, Li Q. Long term outcomes of vaginoplasty with autologous buccal micromucosa. *Obstet Gynecol*. 2014;123(5):951 956.
232. Kanhai RC. Sensate vagina pedicled spot for male to female transsexuals: the experience in the first 50 patients. *Aesthetic Plast Surg*. 2016;40(2):284 287.
233. Straayer C. Transplants for transsexuals? Ambitions, concerns, ideology. Paper presented at: Trans*Studies: An International Transdisciplinary Conference on Gender, Embodiment, and Sexuality; 7-10 September 2016; University of Arizona, Tucson, AZ.
234. Bucci S, Mazzon G, Liguori G, Napoli R, Pavan N, Bormioli S, Olandini G, De Concilio B, Trombetta C. Neovaginal prolapse in male to female transsexuals: an 18 year long experience. *Biomed Res Int*. 2014;2014:240761.
235. Raigosa M, Avvedimento S, Yoon TS, Cruz Gimeno J, Rodriguez G, Fontdevila J. Male to female genital reassignment surgery: a retrospective review of surgical technique and complications in 60 patients. *J Sex Med*. 2015;12(8):1837 1845.
236. Green R. Sexual functioning in post operative transsexuals: male to female and female to male. *Int J Impot Res*. 1998;10(Suppl 1):S22 S24.
237. Hess J, Rossi Neto R, Panic L, Rubben H, Senf W. Satisfaction with male to female gender reassignment surgery. *Dtsch Arztebl Int*. 2014;111(47):795 801.
238. Nygren U, Nordenskjold A, Arver S, Sodersten M. Effects on voice fundamental frequency and satisfaction with voice in trans men during testosterone treatment a longitudinal study. *J Voice*. 2016;30(6):766.e23 766.e34.
239. Becking AG, Tuinzing DB, Hage JJ, Gooren LJG. Transgender feminization of the facial skeleton. *Clin Plast Surg*. 2007;34(3):557 564.
240. Giraldo F, Esteva I, Bergero T, Cano G, González C, Salinas P, Rivada E, Lara JS, Soriguer F; Andalusia Gender Team. Corona glans clitoroplasty and urethrapreputial vestibuloplasty in male to female transsexuals: the vulval aesthetic refinement by the Andalusia Gender Team. *Plast Reconstr Surg*. 2004;114(6):1543 1550.
241. Goddard JC, Vickery RM, Terry TR. Development of feminizing genitoplasty for gender dysphoria. *J Sex Med*. 2007;4(4 Pt 1):981 989.
242. Hage JJ, de Graaf FH, Bouman FG, Bloem JJAM. Sculpturing the glans in phalloplasty. *Plast Reconstr Surg*. 1993;92(1):157 161, discussion 162.
243. Thiagaraj D, Gunasegaram R, Loganath A, Peh KL, Kottegoda SR, Ratnam SS. Histopathology of the testes from male transsexuals on oestrogen therapy. *Ann Acad Med Singapore*. 1987;16(2):347 348.
244. Monstrey SJ, Ceulemans P, Hoebeke P. Sex reassignment surgery in the female to male transsexual. *Semin Plast Surg*. 2011;25(3):229 244.
245. Perovic SV, Djinovic R, Bumbasirevic M, Djordjevic M, Vukovic P. Total phalloplasty using a musculocutaneous latissimus dorsi flap. *BJU Int*. 2007;100(4):899 905, discussion 905.
246. Vesely J, Hyza P, Ranno R, Cigna E, Monni N, Stupka I, Justan I, Dvorak Z, Novak P, Ranno S. New technique of total phalloplasty with reinnervated latissimus dorsi myocutaneous free flap in female to male transsexuals. *Ann Plast Surg*. 2007;58(5):544 550.
247. Ranno R, Vesely J, Hýza P, Stupka I, Justan I, Dvorák Z, Monni N, Novák P, Ranno S. Neo phalloplasty with re innervated latissimus dorsi free flap: a functional study of a novel technique. *Acta Chir Plast*. 2007;49(1):3 7.

248. Garcia MM, Christopher NA, De Luca F, Spilotros M, Ralph DJ. Overall satisfaction, sexual function, and the durability of neophallus dimensions following staged female to male genital gender confirming surgery: the Institute of Urology, London U.K. experience. *Transl Androl Urol.* 2014;3(2):156 162.
249. Chen H C, Gedebou TM, Yazar S, Tang Y B. Prefabrication of the free fibula osteocutaneous flap to create a functional human penis using a controlled fistula method. *J Reconstr Microsurg.* 2007;23(3):151 154.
250. Hoebeke PB, Decaestecker K, Beysens M, Opdenakker Y, Lumen N, Monstrey SM. Erectile implants in female to male transsexuals: our experience in 129 patients. *Eur Urol.* 2010;57(2):334 341.
251. Hage JJ. Metaidoioplasty: an alternative phalloplasty technique in transsexuals. *Plast Reconstr Surg.* 1996;97(1):161 167.
252. Cohanzad S. Extensive metoidioplasty as a technique capable of creating a compatible analogue to a natural penis in female transsexuals. *Aesthetic Plast Surg.* 2016;40(1):130 138.
253. Selvaggi G, Hoebeke P, Ceulemans P, Hamdi M, Van Landuyt K, Blondeel P, De Cuyper G, Monstrey S. Scrotal reconstruction in female to male transsexuals: a novel scrotoplasty. *Plast Reconstr Surg.* 2009;123(6):1710 1718.
254. Bjerrome Ahlin H, Kolby L, Elander A, Selvaggi G. Improved results after implementation of the Ghent algorithm for subcutaneous mastectomy in female to male transsexuals. *J Plast Surg Hand Surg.* 2014;48(6):362 367.
255. Wolter A, Diedrichson J, Scholz T, Arens Landwehr A, Liebau J. Sexual reassignment surgery in female to male transsexuals: an algorithm for subcutaneous mastectomy. *J Plast Reconstr Aesthet Surg.* 2015;68(2):184 191.
256. Richards C, Barrett J. The case for bilateral mastectomy and male chest contouring for the female to male transsexual. *Ann R Coll Surg Engl.* 2013;95(2):93 95.
257. Sutcliffe PA, Dixon S, Akehurst RL, Wilkinson A, Shippam A, White S, Richards R, Caddy CM. Evaluation of surgical procedures for sex reassignment: a systematic review. *J Plast Reconstr Aesthet Surg.* 2009;62(3):294 306, discussion 306 308.
258. Selvaggi G, Elander A. Penile reconstruction/formation. *Curr Opin Urol.* 2008;18(6):589 597.
259. Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Långström N, Landén M. Long term follow up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One.* 2011;6(2):e16885.
260. Kuhn A, Bodmer C, Stadlmayr W, Kuhn P, Mueller MD, Birkhauser M. Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertil Steril.* 2009;92(5):1685 1689.e3.
261. Papadopulos NA, Lellé JD, Zavlin D, Herschbach P, Henrich G, Kovacs L, Ehrenberger B, Kluger AK, Machens HG, Schaff J. Quality of life and patient satisfaction following male to female sex reassignment surgery. *J Sex Med.* 2017;14(5):721 730.
262. Simonsen RK, Hald GM, Kristensen E, Giraldo A. Long term follow up of individuals undergoing sex reassignment surgery: somatic morbidity and cause of death. *Sex Med.* 2016;4(1):e60 e68.
263. Djordjevic ML, Bizic MR, Duisin D, Bouman MB, Buncamper M. Reversal Surgery in regretful male to female transsexuals after sex reassignment surgery. *J Sex Med.* 2016;13(6):1000 1007.
264. Liberopoulos EN, Florentin M, Mikhailidis DP, Elisaf MS. Compliance with lipid lowering therapy and its impact on cardiovascular morbidity and mortality. *Expert Opin Drug Saf.* 2008;7(6):717 725.
265. Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF. Implementation of evidence based practices for surgical site infection prophylaxis: results of a pre and postintervention study. *J Am Coll Surg.* 2008;207(3):336 341.
266. Davis PJ, Spady D, de Gara C, Forgie SE. Practices and attitudes of surgeons toward the prevention of surgical site infections: a provincial survey in Alberta, Canada. *Infect Control Hosp Epidemiol.* 2008;29(12):1164 1166.

EXHIBIT 18

National Association of Social Workers

National Committee on Lesbian, Gay,
Bisexual, and Transgender Issues
Position Statement



**Sexual Orientation
Change Efforts (SOCE)
and Conversion Therapy
with Lesbians, Gay Men,
Bisexuals, and
Transgender Persons**



MAY 2015

The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world. NASW works to enhance the professional growth and development of its members, to create and maintain standards for the profession, and to advance sound social policies. NASW also contributes to the well-being of individuals, families and communities through its advocacy.

The National Association of Social Workers (NASW) is located at 750 First Street, NE, Suite 800, Washington, DC 20002. Telephone: 202.408.8600. Website: SocialWorkers.org

Approved by the National Association of Social Workers Board of Directors. May 1, 2015.

TABLE OF CONTENTS

Background2

Introduction2

 What are sexual orientation change efforts?3

 What are sexual orientation, sexual identity, gender identity,
 and gender expression?3

 Can therapy change sexual orientation or gender identity?4

 Why is this issue relevant to the social work profession?.....5

 What are the value and ethical implications for social workers?5

 How can I practice the nondiscrimination tenets of my profession?6

 What policy exists to help guide social work practice?6

References7

Resources9



BACKGROUND

In 1992, the NASW National Committee on Lesbian and Gay Issues (NCLGI) issued a ground-breaking document focused on the negative and stigmatizing impact of the use of 'transformational ministries' or 'conversion or reparative therapies' in an attempt to change or modify a person's sexual orientation (NASW, 1992). Later that decade, the NASW National Committee on Lesbian, Gay, and Bisexual Issues (NCLGBI) updated the position statement. In 2000 the National NASW Board of Directors passed a 'motion to adopt' the *Reparative and Conversion Therapies for Lesbians and Gay Men Position Statement* (NASW, 2000). As advocacy efforts have grown, both for and against the use of conversion therapy, so has the need to educate clients and communities about the impact of these practices on individuals and families, and the implications for social work practice. In 2015, the NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI) updated the position statement utilizing the umbrella term *sexual orientation change efforts (SOCE)*.

INTRODUCTION

Reparative therapy, conversion therapy, or transformational ministries (increasingly included within the term *sexual orientation change efforts (or SOCE)*), received wider attention against the backdrop of a growing conservative religious political climate in the 1990s, and through ongoing social media supported by the Focus on the Family and affiliates (NASW, 1992; Johnston, J., 2011). Proponents of reparative therapy and conversion therapy claim that their processes are supported by scientific data. Of note is that an often cited researcher, Robert Spitzer, admitted flaws in his research and in 2012 formally retracted his 2001 study that claimed gay men and lesbians could switch their sexual orientation (Hein, L. & Matthews, A., 2010). Despite the lack of scientific evidence, supporters of these practices continue to believe sexual orientation can be successfully changed (Panozzo, D., 2013). While there is increased effort at the state and local level to pass laws against the use of *SOCE*, there is a growing movement to pass

legislation that will limit implementation of state law banning the use of SOCE with minors. Under the guise of ‘parental and family rights’, the proposed legislation will limit the ability for state governments to prohibit certain types of counseling for minors, with specific reference to the parental right to access SOCE for ‘counseling’ (Southern Poverty Law Center, 2014; Kern, S., and Brecheen, J., 2015). SOCE, *conversion therapy and reparative therapy* have been discredited or highly criticized by all major medical, psychiatric, psychological and professional mental health organizations, including the National Association of Social Workers.

What are sexual orientation change efforts?

The term *sexual orientation change efforts (or SOCE)* include any practice seeking to change a person’s sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender. Within this position statement, SOCE includes any form of *reparative therapy, conversion therapy, and/or transformational ministries* that use interventions claiming to “repair” or “convert” a person in order to reduce or eliminate a person’s sexual desire for a member of his or her own gender. The use of SOCE can include use of psychotherapy, medical approaches, aversion therapy, religious and spiritual approaches, as well as the use of sexual violence (referred to as ‘corrective rape’). There are no studies of adequate scientific rigor to conclude whether or not SOCE or conversion therapy can modify or change sexual orientation or gender identity or expression (APA, 2009).

What are sexual orientation, sexual identity, gender identity, and gender expression?

According to NASW’s “Definitions: A Primer” (2009), sex is assigned at birth and determined usually by external, physical genitals. Additional sex markers include chromosomes and internal and external reproductive organs. *Gender* is an ascribed social status assigned at birth, which is

assumed to be congruent with the assigned birth sex, but may or may not be congruent with the anatomical sexual identifiers.

Sexual orientation is defined by whom people are emotionally, romantically, and erotically attracted to, for the most part and over a period of time. It exists on a continuum of feelings and attractions, and is not necessarily congruent with behavior.

Sexual identity refers to a person's self-perception of his or her sexual orientation, and *sexual behavior* refers to a person's sexual activities.

Gender Identity refers to the gender with which one identifies regardless of one's assigned sex at birth. *Gender expression* is the communication of gender through behaviors (mannerisms, speech patterns, etc.) and appearance (clothing, hair, accessories, etc.) culturally associated with a particular gender.

Can therapy change sexual orientation or gender identity?

People seek mental health services for many reasons. Accordingly, it is fair to assert that people who have same-sex attraction seek therapy for the same reasons that heterosexual people do. However, media campaigns, often coupled with coercive messages from family and community members, can create an environment in which LGBT persons are pressured to seek conversion therapy. The stigmatization of LGBT persons creates a threat to the health and well-being of those affected which, in turn, produces the social climate that pressures some people to seek change in sexual orientation or gender identity (Haldeman, D., 1994; HRC, 2015). However, no data demonstrate that SOCE or reparative therapy or conversion therapy is effective, rather have succeeded only in short term reduction of same-sex sexual behavior and negatively impact the mental health and self-esteem of the individual (Davison, G., 1991; Haldeman, D., 1994, APA, 2009).

The NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues believes that SOCE can negatively affect one's mental health and cannot and will not change sexual orientation or gender identity.

Why is this issue relevant to the social work profession?

Social workers should have a broad-based knowledge about human sexuality, human sexual development across the life cycle, a high degree of comfort and skill in communicating and responding to such issues, and knowledge of appropriate community services (Harrison, D., 1995).

Social workers across fields of practice, including foster care, mental health, corrections, substance abuse, school social work, and prevention education, will encounter lesbian, gay, bisexual and transgender (LGBT) clients. Providing culturally competent services with LGBT youth and adults calls for a shift or transformation from reparative to affirmative practice and interventions (Hunter, S. & Hickerson, J., 2003; Mallon, G., 2009).

What are the value and ethical implications for social workers?

In discussing ethical decisions for social work practice, Loewenberg & Dolgoff (1996) stress “the priority of professional intervention at the individual level will be to help people achieve self-actualization, rather than helping them to learn how to adjust to the existing social order.”

The practice of SOCE violates the very tenets of the social work profession as outlined in the *NASW Code of Ethics*. The *NASW Code of Ethics* (1998) enunciates principles that address ethical decision making in social work practice with lesbians, gay men, bisexual, and transgender people; for example: 1) social workers’ commitment to clients’ self-determination and competence, and to achieving cultural competence and understanding social diversity, 2) social workers’ ethical responsibilities to colleagues, their commitment to interdisciplinary collaboration, and their responsibility to report unethical conduct of colleagues, 3) social workers’ ethical responsibilities as professionals—maintaining competence, fighting discrimination, and avoiding misrepresentation, and 4) social workers’ ethical responsibilities to the social work profession, to evaluation, and to research.

The National Committee on LGBT Issues asserts that conversion therapy or SOCE are an infringement of the guiding principles inherent to social worker ethics and values; a position affirmed by the NASW policy statement on “Lesbian, Gay, and Bisexual Issues” (NASW 2014).

How can I practice the nondiscrimination tenets of my profession?

As stated in the original NASW National Committee on Gay and Lesbian Issues - Position Statement on Reparative Therapy, “If a client is uncomfortable about his/her sexual orientation, the sources of discomfort must be explored, but without prior assumption that same-sex attraction is dysfunctional” (1992). Social workers must advocate against policy or practice interventions that create or reinforce the prejudice and discrimination towards gay men, lesbians, bisexual, and transgender persons and their families. Social workers are obligated to use nonjudgmental attitudes and to encourage nurturing practice environments for lesbians, gay men, bisexual, and transgender persons.

What policy exists to help guide social work practice?

The NASW Policy Statement on Lesbian, Gay, and Bisexual (LGB) Issues and the NASW Policy Statement on Transgender and Gender Identity Issues provide a “blueprint” for social work practice with gay, lesbian, bisexual, transgender clients and communities.

The policies state, “NASW supports the adoption of local, state, federal, and international policies and legislation that ban all forms of discrimination based on sexual orientation and gender identity” (NASW 2008), and further adds “NASW condemns the use of SOCE or so-called reparative therapy by any person identifying as a social worker or any agency that identifies as providing social work services. Public dollars should not be spent on programs that support SOCE” (NASW, 2014). The National Association of Social Workers reaffirms its stance against therapies and treatments designed to change sexual orientation or gender identity and against referring clients to practitioners or programs that claim to do so (NASW, 2014).

Position statement authored by members of the National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI), National Association of Social Workers (NASW) and NASW staff.¹

¹ Paula Foster, LCSW, Kristina Smith, LCSW, James Martin, PhD, Zander Keig, MSW, ASW, Marshall Wong, MSW; and (past members): Heather Craig-Oldsen, MSW, Josephine Tittsworth, LMSW, Eleni Carr, MSW. (Staff): Evelyn Tomaszewski, MSW

REFERENCES

American Psychological Association. (2009). *APA Task Force on Appropriate Therapeutic Responses to Sexual orientation. Report of the Task Force*. Washington, DC: American Psychological Association. [Online]: apa.org/pi/lgbt/resources/therapeutic-response.pdf

Davison, G., (1991). *Construction and morality in therapy for homosexuality*. In J.C. Gonsiorek & J.D. Weinrich (Eds.), *With compassion toward some: Homosexuality and social work in America* (pp. 115–136). New York: Harrington Press.

Haldeman, D., (1994). *The practice and ethics of sexual orientation conversion therapy*. *Journal of Consulting and Clinical Psychology*, 62, 211–221.

Harrison, D., (1995). *Human sexuality*. In R.L. Edwards (Ed.-in-Chief), *Encyclopedia of social work* (19th ed., Vol. 2, pp. 1418–1428). Washington, DC: NASW Press.

Hein, L., & Matthews, A., (2010). *Reparative therapies: The adolescent, the psych nurse, and the issues*. *Journal of Child and Adolescent Psychiatric Nursing*, 23, 29–35.

Human Rights Campaign. (2015). *The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*. [Online] hrc.org/resources/entry/the-lies-and-dangers-of-reparative-therapy

Hunter, S., and Hickerson, J. (2003). *Affirmative Practice, Understanding and Working with Lesbian, Gay, Bisexual, and Transgender Persons*. Washington, DC: NASW Press.

Kern, S., and Brecheen, J. (2015). *Parental and Family Rights in Counseling Protection Act, House Bill 1598*. State of Oklahoma. 55th Legislature. [Online] oklegislature.gov/index.aspx

Johnston, J. (2011). *Therapy for unwanted homosexuality – part one*. CitizenLink.

Focus on the Family. [Online] citizenlink.com/2011/07/27/therapy-for-unwanted-homosexuality%E2%80%93part-1/

Loewenberg, F., & Dolgoff, R. (1996). *Ethical decisions for social work practice*. F.E. Peacock Publishers, Inc.: Itasca, IL.

Mallon, G. (Ed.), (2009). *Social Work Practice with Lesbian, Gay, Bisexual, and Transgender People*. 2nd Edition. Routledge Press: New York, NY.

National Association of Social Workers. (2014). *Lesbian, Gay, and Bisexual Issues*. In *Social work speaks* (10th ed.). Washington, DC: NASW Press.

National Association of Social Workers. (2009). *Training Curriculum for Child Welfare Services with lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Out of Home Care*. Definitions: A Primer. Washington, DC: Author [Online] socialworkers.org/diversity/new/documents/Definitions%202011.pdf

National Association of Social Workers. (2008). *Transgender and Gender Identity Issues*. In *Social work speaks* (9th ed., pp. 337-345). Washington, DC: NASW Press.

NASW National Committee on Lesbian, Gay, and Bisexual Issues. (2000). *Position statement: Reparative or conversion therapies for lesbians and gay men*. Washington, DC: Author.

National Association of Social Workers. (1998). *Code of Ethics*. Washington, DC: Author. [Online]: socialworkers.org/pubs/code/default.asp

NASW National Committee on Lesbian and Gay Issues. (1992). *Position statement: Reparative or conversion therapies for lesbians and gay men*. Washington, DC: Author.

Panozzo, D. (2013). *Advocating for an end to reparative therapy: Methodological grounding and blueprint for change*. *Journal of Gay and Lesbian Social Services*, 25, 362-377.

Southern Poverty Law Center (SPLC), 2014. *Conversion Therapy*. [Online]: splcenter.org/conversion-therapy

RESOURCES

Gay and Lesbian Alliance Against Defamation

121 West 27th Street, Suite 804, New York, NY 10001; 212.629.3322 or 212.727.0135; glaad.org

Gay and Lesbian Medical Association

1326 18th Street NW, Washington, DC 20036; 202.600.8037; glma.org

Gay, Lesbian and Straight Education Network

90 Broad St., New York, NY 10004; 212.727.0135; glsen.org

Healthy Lesbian, Gay, and Bisexual Youth Project, American Psychological Association: Public Interest Directorate

750 First Street, NE, Washington, DC 20002-4242; 202.336.5977; apa.org/pi/lgbt/programs/hlgbsp/index.aspx

Human Rights Campaign

1640 Rhode Island Ave., NW, Washington, DC 20036; 202.628.4160; hrc.org

National Association of Social Workers, National Committee on Lesbian, Gay, Bisexual and Transgender Issues

750 First Street, NE, Suite 800, Washington, DC 20002-4241; 202.408.8600; socialworkers.org

National Center for Lesbian Rights

870 Market Street, Suite 370, San Francisco, CA 94102; 415.392.6257; nclrights.org; Born Perfect Project: nclrights.org/explore-the-issues/bornperfect/

Sexuality Information and Education Council of the United States

130 West 42nd Street, Suite 350, New York, NY 10036; 212.819.9770; siecus.org; siecus@siecus.org

World Health Organization (WHO)/Pan American Health Organization (PAHO).

(2012). *"Therapies" to change sexual orientation lack medical justification and threaten health*; paho.org



750 First Street NE, Suite 800 | Washington, DC 20002-4241

EXHIBIT 19

Transgender and Gender Identity Issues

BACKGROUND

Gender is a human social system of differentiation by sex for roles, behaviors, characteristics, appearances, and identities (for example, "man" or "woman"), which maps cultural meanings and norms about both sex and gender onto human bodies. Everyone has an internal sense of his or her "gender," and this sense is called "gender identity" (Stone, 2004). "Most people's gender identity is congruent with their assigned sex, but many people experience their gender identity to be discordant with their natal sex" (Lev, 2004, p. 397).

"Transgender" is a broad term used to describe those whose gender, gender identity, or gender expression is in some sense different from, or transgresses social norms for, their assigned birth sex. Transgender may include those who identify as being transsexual, cross-dressers, androgynous, bi-gender, no-gender, multi-gender, genderqueer, and a growing number of people who do not identify as belonging to any gender category at all. For some transgender individuals the discomfort with social gender role is accompanied by a profound sense of mismatch of the physical body to their internal bodily experience. This body dysphoria (known as "gender dysphoria") causes significant distress, negatively affects daily functioning and well-being, and requires medical services to realign the body with the self. Although there are many transgender people with medically diagnosed intersex conditions (Xavier, Honnold, & Bradford, 2007) most people with intersex conditions are not transgender (Intersex Society of North America, n.d.; Koyama, n.d.).

In the absence of systematic data collection, estimates vary widely as to the number of transgender individuals in the United States, rang-

ing from 3 million to as many as 9 million individuals (Bushong, 1995; Olyslager & Conway, 2007). Prevalence of transgender identities is "likely to be on the order of at least 1:100 (i.e., 1%)" (Olyslager & Conway, 2007, p. 23), and transsexualism is also not rare, with prevalence now being estimated at between 1:2000 and 1:500 (Olyslager & Conway, 2007). Reports now indicate there may be roughly equal numbers of male-to-female and female-to-male transsexual people (Bullough, Bullough, & Elias, 1997; MacKenzie, 1994).

Transgender people encounter difficulties in virtually every aspect of their lives, both in facing the substantial hostility that society associates with those who do not conform to gender norms and in coping with their own feelings of difference. Considerable verbal harassment and physical violence accompany the powerful social stigma faced by transgender people (Clements-Nolles, Marx, & Katz, 2006; Lombardi, Wilchins, Priesing, & Malouf, 2001; Wyss, 2004) and may be accompanied by racial and ethnic discrimination (Juang, 2006). Transgender people also experience dismissal from jobs, eviction from housing, and denial of services, even by police officers and medical emergency professionals (Xavier, 2000; Xavier, Honnold, & Bradford, 2007). Restrooms, the most mundane of public and workplace amenities, often become sites of harassment and confrontation, with access often denied (Transgender Law Center, 2005).

Transgender and transsexual people are often denied appropriate medical and mental health care and are uniquely at risk of adverse health outcomes (Dean et al., 2000; Xavier et al., 2004). Basic services may be denied because of ignorance about or discomfort with a transgen-

der client. To align the physical body with the experienced sense of self, usually as an integral part of social transition away from the sex assigned at birth, transsexuals and some other individuals require medical services (for example, hormone replacement, facial electrolysis, or surgical and other procedures, as appropriate to the individual). Despite ongoing evidence that the vast majority who access such services achieve congruence and well-being (De Cuypere et al., 2005; Newfield, Hart, Dibble, & Kohler, 2006; Pfafflin & Junge, 1998; Rehman, Lazer, Benet, Schaefer, & Melman, 1999; Ross & Need, 1989), medical and mental health providers routinely refuse to provide such services, and health insurance carriers and governmental payers (for example, Medicare, Medicaid, VA, and Tri-Care) routinely deny coverage for them, sometimes under the belief that such care is "experimental" or "cosmetic" (Dean et al., 2000; JSI Research and Training Institute, Inc., 2000; Middleton, 1997; Spack, 2005; Spade, 2006; Thaler, 2007). Access to medically necessary transition-related services is thus largely limited to a privileged few who can pay out-of-pocket for services. Continued barriers to health care may have been shown to contribute to lowered self-esteem and well being, or may be experienced as posttraumatic stress, and may lead some to self-medicate through street hormones or over-the-counter treatments or to resort to high-risk injection silicone use—all without medical supervision (Risser & Shelton, 2002; Xavier, 2000). It is important to underscore the denial of basic health care, and also the extreme race and socioeconomic status disparities: Needs assessments in major cities show that severe marginalization and barriers to transition contribute to high rates of joblessness and disproportionately affect people of color. Lack of employment leaves many without health insurance, and because insurance carriers often deny coverage for transgender individuals' other nontransition-related services, transgender individuals often lack access to all ongoing basic health services, even when employed (Xavier et al., 2004).

Gender identity disorder, or GID (American Psychiatric Association, 2000), a diagnosis often required by providers as a prerequisite to transgender transition-related health services,

is also seen as a barrier to health care. GID has been criticized for further stigmatizing nontypical gender expression and reinforcing gender stereotypes, for pathologizing transgender realities as mental illness, and for failing to accurately describe the "symptoms" experienced by transsexual people. The diagnosis is vague regarding the medical necessity for and demonstrated success of treatment, particularly medically assisted transsexual transition, which prevents insurance reimbursements for care and leaves transgender youths and adults vulnerable to so-called "reparative" treatment (Bockting & Ehrbar, 2005; Hill, Rozanski, Carfagnini, & Willoughby, 2005; Lev, 2005; Spack, 2005; Winters, 2005). Although some individuals experience the current diagnosis as a good fit, many transgender health advocates seek either greatly revised language or a medical (physical, nonpsychiatric) diagnosis to replace it (Green, 2004; Lev, 2004; Stone, 2004).

Mental health providers, including social workers, are often positioned as "gatekeepers" in the medical process (for example, as providers of referrals for hormonal therapy and surgery), which may hamper the therapeutic alliance between them and their transgender clients. More recently, many community-based urban clinics and individual providers have developed protocols and practices that do not require a GID diagnosis (Lev, 2004; Tom Waddell Health Center, 2001). Clients benefit from treatment with therapists who have expertise in transgender issues (Lurie, 2005; Rachlin, 2002). Those therapists with little training or familiarity in this arena often require that a diagnosis be assigned, and apply its criteria narrowly, denying access to nontranssexual transgender people or forcing clients to wait months or years before they can obtain medicalized transition services (Califia, 1997; Lev, 2004; Meyerowitz, 2002).

Many transgender children and youths face harassment and violence in school environments, and those who do not feel safe or valued at school cannot reach their potential and may drop out (D'Augelli, Grossman, & Starks, 2006; Gay, Lesbian and Straight Education Network, 2004; Grossman, D'Augelli, & Slater, 2006; Wyss, 2004). Although medical protocols exist for children whose body dysphoria may

lead to severe depression and suicidality, including endocrinologic intervention to prevent or delay unwanted puberty (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001; Spack, 2005), there are still few support resources for transgender children, their parents, or surrounding social institutions, leaving transgender youths particularly vulnerable to so-called “reparative” treatments. (Menvielle, Tuerk, & Perrin, 2005; PFLAG, 2004).

Although there is no federal law protecting individuals from discrimination on the basis of gender identity or gender expression, a handful of states and a growing number of local jurisdictions, as well as employers, are beginning to extend such protections (Lambda Legal Defense Fund, n.d.). Federal administrations and most states require proof of genital or other surgery before altering the sex marker on passports, birth certificates, or other documents. Such policies reinforce the myth that all transgender people undergo a single “sex change operation,” regardless of an individual’s need or ability to undergo, or afford, transition procedures (Thaler, 2007). Inaccurate identity documentation is a common barrier to employment, housing, and appropriate services from gender-segregated facilities. The increased vulnerability—to violence and harassment, to loss of social support and mounting despair—suggests that policies that prevent changing documentation to align with gender identity represent serious barriers to health and well-being. Transsexual individuals and their partners may also be denied access to civil marriage on the basis that they are in a same-sex relationship (Minter, 2003) or be denied access to same-sex domestic partnerships or to same-sex domestic partnerships on the basis that they are in an opposite-sex relationship, and thus are denied access to the social status, rights, and privileges of civil marriage or domestic partnerships.

A host of institutional settings in the United States are hostile to transgender people, especially those that are segregated by sex, many of which require transgender individuals to have undergone genital surgery to be placed according to their gender identity. Homeless shelters and other facilities that refuse to house clients with the appropriate gender place individuals

at risk of sexual propositions, harassment, and assault. Sex-based dress codes affect youths in particular, who are often disciplined and ejected from the facilities for violating such policies (Mottet & Ohle, 2003; Ray, 2006). Those incarcerated in jails and prisons face similar barriers to accessing gender-appropriate facilities, and in many jurisdictions, transgender people in state custody are also denied access to ongoing hormone therapy and other transgender transition-related procedures, including surgery (Jenness et al., 2007; Rosenblum, 2000; Sylvia Rivera Law Project, 2007; Thaler, 2007; Women in Prison Project, 2007). Although few resources exist regarding aging and the transgender population, residential and care facilities may pose familiar barriers such as sex segregation and lack of culturally competent caregivers at a time of life when transgender individuals may be unable to advocate for themselves; many older transgender people may also fear abuse and neglect (Cook-Daniels, 1997, 2002; Gapka & Raj, 2003).

Lack of appropriately trained service providers, including mental health providers, makes it hard to obtain culturally competent legal, medical, and advocacy services (Lurie, 2005; Xavier et al., 2004). Although social workers are frontline providers of mental health and other services for many transgender individuals, most schools of social work have little in their curriculums on transgender issues.

Transgender individuals and communities are increasingly impatient with a backseat role in shaping policies that affect their lives. In the face of stigma, increasing numbers of transgender individuals are becoming powerful community advocates and are encouraging others to join with them.

ISSUE STATEMENT

Transgender people experience the stigma, prejudice, discrimination, and extreme hostility known as transphobia on a daily basis. Although gender nonconforming experience can be traced across history and the successful social and medical transition of transsexuals is well documented since the middle of the 20th century, only in recent years has this emerged in

the public discourse. Unfortunately, most in our society have little or no understanding of the profound discomfort some may feel in trying to conform to rigid gender roles assigned to them by virtue of their physiology. Similarly, ignorance and insensitivity prevail regarding the debilitating distress that accompanies body dysphoria, and the damage done to those left without access to medical and social transition.

Social workers have the responsibility to understand and appreciate the full range of differences that exist among human beings and to explore any and all prejudices that result in oppressive and unjust treatment. It is incumbent upon the social work profession to embrace and explore this domain of human variation and help educate the public in a manner that mitigates stigma and supports the rights of transgender, transsexual, and gender nonconforming individuals, consistent with NASW's *Code of Ethics* (2000) which states the following:

- "Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability." (pp. 22–23)
- "Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups." (p. 27)
- "Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people." (p. 27)

Social workers are trained to work with clients who are different along many dimensions of diversity. Gender-diverse individuals should be included among this constituency. As clinicians, social workers must be equipped to provide their clients with education and re-

sources on gender experience, gender expression and sexuality, including specific examples of successful role models in society. Social workers must also be prepared to provide services and referrals for those clients who may require social or medical transition to a sex different from that assigned at birth. All legal impediments to the full equality of rights and opportunities for anyone, regardless of that person's gender identity or expression must be eliminated. Individuals, families, schools, and communities should have the resources to welcome and support gender-diverse people. At the community and policy-making levels, inclusive environments and provision for access to services should all be respected, valued, and empowered. Social workers should be partnered with the transgender community to modify laws, medical protocols, research, and policies in ways that preserve and protect the quality of life for transgender, transsexual, and gender nonconforming citizens. In the domain of gender diversity, prejudice and oppression should be replaced with compassion, support, and celebration of difference.

POLICY STATEMENT

NASW recognizes the considerable diversity in gender expression and identity among our population. NASW believes that people of diverse gender—including all those who are included under the transgender umbrella—should be afforded the same respect and rights as that for any other people. NASW asserts that discrimination and prejudice directed against any individuals on the basis of gender identity or gender expression, whether real or perceived, are damaging to the social, emotional, psychological, physical, and economic well-being of the affected individuals, as well as society as a whole, and NASW seeks the elimination of the same both inside and outside the profession, in public and private sectors.

NASW believes that a nonjudgmental and affirming attitude toward gender diversity enables social workers to provide maximum support and services to those whose gender departs from the expected norm. Social workers and the social work profession can support and

empower such people in all aspects of their development, helping them to lead fully actualized and engaged lives on the basis of their genuine gender identities. NASW supports the development of supportive and knowledgeable practice environments for those struggling with gender expression and identity issues (both clients and colleagues) and for those who are struggling with prejudices, biases, and transphobia.

Professional and Continuing Education

- NASW supports curriculum policies in schools of social work that eliminate discrimination against those who are transgender, transsexual, genderqueer, cross-dressers, and of other minority gender identities; provide equal opportunities to all students for investigating issues of relevance to these populations; develop and provide training for classroom instructors, field supervisors, and field advisors regarding gender diversity issues; and seek field opportunities for students interested in working with transgender people.
- NASW encourages the implementation of continuing education programs on practice and policy issues relevant to gender diversity, to include the distinctive, complex biopsychosocial needs of transgender individuals and their families, legal and employment issues, ethical dilemmas and responsibilities, and effective interventions and community resources.

Antidiscrimination

- NASW reaffirms a commitment to human rights and freedom and opposes all public and private discrimination on the basis of gender identity and of gender expression, whether actual or perceived, and regardless of assigned sex at birth, including denial of access to employment, housing, education, appropriate treatment in gender segregated facilities, appropriate medical care and health care coverage, appropriate identity documents, and civil marriage and all its attendant benefits, rights, and privileges.

- NASW encourages the repeal of discriminatory legislation and the passage of legislation protecting the rights, legal benefits, and privileges of people of all gender identities and expressions.

- NASW encourages all institutions that train or employ social workers to broaden any nondiscriminatory statement made to students, faculty, staff, or clients, to include "gender identity or expression" in all nondiscrimination statements.

Public Awareness and Advocacy

- NASW supports efforts to provide safe and secure educational environments, at all levels of education, that promote an understanding and acceptance of self and in which all youths, including youths of all gender identities and expressions, may be free to express their genuine gender identity and obtain an education free from discrimination, harassment, violence, and abuse.

- NASW supports the development of, and participation in, coalitions with other professional associations and progressive organizations to lobby on behalf of the civil rights for all people of diverse gender expression and identity.

- NASW supports collaboration with organizations and groups supportive of the transgender community to develop programs to increase public awareness of the mistreatment and discrimination experienced by transgender people and of the contributions they make to society.

- NASW encourages the development of programs, training, and information that promote proactive efforts to eliminate psychological, social, and physical harm directed toward transgender people and to portray them accurately and compassionately.

- NASW supports the development of programs within schools and other child and youth services agencies that educate students, faculty, and staff about the range of gender diversity and the needs of transgender children and youths.

■ NASW supports the creation of scientific and educational resources that inform public discussion about gender identity and gender diversity, to promote public policy development and to strengthen societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals, regardless of gender identity or gender expression.

Health and Mental Health Services

■ NASW endorses policies in the public and private sectors that ensure nondiscrimination, that are sensitive to the health and mental health needs of transgender people, and that promote an understanding of gender expression and gender identity issues.

■ NASW advocates for the availability of comprehensive psychological and social support services for transgender people and their families that are respectful and sensitive to individual concerns.

■ NASW supports the rights of all individuals to receive health insurance and other health coverage without discrimination on the basis of gender identity, and specifically without exclusion of services related to transgender or transsexual transition (or sex change), to receive medical and mental health services through their primary care physician and the appropriate referrals to medical specialists, which may include hormone replacement therapy, surgical interventions, prosthetic devices, and other medical procedures.

■ NASW encourages the development of an appropriate, non-stigmatizing medical diagnosis for transgender individuals whose self-experienced gender does not match the sex assigned at birth and who require medical services to align the body with the experienced self.

■ NASW supports the collaboration of organizations with the U.S. surgeon general to implement data collection and production of comprehensive reports on prevention of hate crimes against adults and youth violence prevention, including such issues as bullying, prejudice, and discrimination, including violence and dis-

crimination that are based on gender identity, gender expression, or both.

■ NASW advocates for the implementation of programs to address the education, housing, employment, health, and mental health needs of adults and youths who are struggling with gender issues and who are thus at high risk of suicide, vulnerable to violence or assault, at increased risk of HIV/AIDS, or otherwise at risk.

■ NASW supports the creation of a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents); that includes questions on gender identity, gender expression, and sexual orientation; and that explores the barriers to health care experienced by transgender people. NASW also supports inclusion of transgender individuals in existing national and state health surveys and data collection, by inclusion of questions on gender identity, to enable research on health and other disparities in the transgender population.

Legal and Political Action

■ NASW advocates for increased funding for education, treatment services, and research on behalf of people of diverse gender expression and gender identity.

■ NASW supports the legal recognition of transgender individuals as members of the gender with which they identify, regardless of assigned sex at birth or subsequent surgical or other medical interventions.

■ NASW supports the legal recognition of marriage, domestic partnership, and civil unions, regardless of either the sex or gender status of the betrothed or partnered individuals.

■ NASW encourages the repeal of laws and discriminatory practices that impede individuals in their identification with, and their expression of, the gender that matches their sense of themselves, in all areas of the public arena, especially employment, health care, education, and housing, including in custodial settings.

■ NASW encourages the adoption of laws that will prohibit discrimination against, protect

the civil rights of, and preserve the access to health care and well-being of, individuals who identify with and express their gender identities, in education, housing, inheritance, health and other types of insurance, child custody, property, and other areas. NASW particularly encourages such protections in education; housing, including custodial settings; inheritance and pensions; health coverage and all other types of insurance; provision of health care and medical services; child custody; property; as well as other areas.

■ NASW acknowledges the importance of social group work and community organizing to support transgender community development and help the larger community to overcome ignorance and fear of transgender people, and to move toward inclusion, equality, and justice.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Bockting, W. O., & Ehrbar, R. D. (2005). Commentary: Gender variance, dissonance, or identity disorder? *Journal of Human Sexuality, 17*(3/4), 125–134.
- Bullough, V. L., Bullough, B., & Elias, J. (1997). *Gender blending*. New York: Prometheus Books.
- Bushong, C. W. (1995). The multi-dimensionality of gender. *Transgender Tapestry, 72*, 33–37.
- Califa, P. (1997). *Sex changes: The politics of transgenderism*. San Francisco: Cleis Press.
- Clements-Nolles, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality, 51*(3), 53–69.
- Cohen-Kettenis, P. T., & van Goozen, S. H. M. (1997). Sex reassignment of adolescent transsexuals: A follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(2), 263–271.
- Cook-Daniels, L. (1997). Lesbian, gay male, bisexual and transgendered elders: Elder abuse and neglect issues. *Journal of Elder Abuse & Neglect, 9*(2), 35–49.
- Cook-Daniels, L. (2002). *Transgender elders and SOFFAS: A primer*. Paper presented at the 110th Convention of the American Psychological Association. Retrieved August 13, 2004, from <http://www.forge-forward.org/handouts/TransEldersSOFFAs-web.pdf>
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence, 21*, 1462–1482.
- Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., Bowen, D. J., Bradford, J., Rothblum, E., White, J., Dunn, P., Lawrence, A., Wolfe, D., & Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4*(3), 102–151.
- De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., Monstrey, S., Vansteenwegen, A., & Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*, 679–690.
- Gapka, S., & Raj, R. (2003). *Trans Health Project: A position paper and resolution*. Retrieved July 14, 2007, from: http://www.opha.on.ca/ppres/2003-06_pp.pdf
- Gay, Lesbian and Straight Education Network. (2004). *2003 National School Climate Survey: The school-related experiences of our nation's lesbian, gay, bisexual and transgender youth*. New York: Author.
- Green, J. (2004). *Becoming a visible man*. Nashville, TN: Vanderbilt University Press.
- Grossman, A. H., D'Augelli, A. R., & Slater, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71–92.
- Hill, D. B., Rozanski, C., Carfagnini, J., & Willoughby, B. (2005). Gender identity disorders in childhood and adolescence: A critical inquiry. *Journal of Human Sexuality, 17*(3/4), 7–34.
- Intersex Society of North America. (n.d.). *What's the difference between being transgender or*

- transsexual and having an intersex condition?* Retrieved July 15, 2007, from <http://www.isna.org/faq/transgender>
- Jenness, V., Maxson, C. L., Matsuda, K. N., & Sumner, J. M. (2007, April). *Violence in California correctional facilities: An empirical examination of sexual assault*. Report submitted to the California Department of Corrections & Rehabilitation, Center for Evidence-Based Corrections, University of California, Irvine.
- JSI Research and Training Institute, Inc. (2000). *Access to health care for transgendered persons in greater Boston*. Boston: Author.
- Juang, R. M. (2006). Transgendering the politics of recognition. In S. Stryker & S. Whittle (Eds.), *The transgender studies reader* (pp. 706–717). New York: Routledge.
- Koyama, E. (n.d.). *Is gender identity disorder an intersex condition?* Retrieved July 12, 2007, from <http://www.intersexinitiative.org/articles/gid.html>
- Lambda Legal Defense Fund. (n.d.). *The rights of transgender people*. Retrieved May 7, 2007, from <http://www.lambdalegal.org/our-work/issues/rights-of-transgender-people/>
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.
- Lev, A. I. (2005). Disordering gender identity: Gender identity in the DSM-IV-TR. *Journal of Human Sexuality*, 17(3/4), 35–69.
- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42(1), 89–101.
- Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. *International Journal of Transgenderism*, 3(2/3), 93–112.
- MacKenzie, G. O. (1994). *Transgender nation*. Bowling Green, OH: Bowling Green State University, Popular Press.
- Menvielle, E. J., Tuerk, C., & Perrin, E. C. (2005). To the beat of a different drummer: The gender-variant child. *Contemporary Pediatrics*, 22(2), 38–46.
- Meyerowitz, J. (2002). *How sex changed: A history of transsexuality in the United States*. Cambridge, MA: Harvard University Press.
- Middleton L. (1997). Insurance and the reimbursement of transgender health care. In G. Israel & D. Tarver (Eds.), *Transgender care: Recommended guidelines, practical information & personal accounts* (pp. 215–224). Philadelphia: Temple University Press.
- Minter, S. (2003). *Representing transsexual clients: Selected legal issues*. Retrieved August 3, 2004, from <http://www.transgenderlaw.org/resources/translaw.htm>
- Mottet, L., & Ohle, J. (2003). *Transitioning our shelters: A guide to making homeless shelters safe for transgender people*. Retrieved September 9, 2005, from http://www.thetaskforce.org/reports_and_research/trans_homeless
- National Association of Social Workers. (2000). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.
- Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, 15, 1447–1457.
- Olyslager, F., & Conway, L. (2007, September). *On the calculation of the prevalence of transsexualism*. Paper presented at the WPATH 20th International Symposium, Chicago.
- Pfafflin, F., & Junge, A. (1998). *Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991*. Retrieved November 22, 2007, from <http://www.symposion.com/ijt/pfaefflin/1000.htm>
- PFLAG North Bay Chapter. (2004). *The transgender umbrella: Parents, Families and Friends of Lesbians and Gays North Bay Chapter*. San Francisco: Author.
- Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism*, 6(1). Retrieved November 22, 2007, from http://www.symposion.com/ijt/ijto06no01_03.htm
- Ray, N. (2006). *Lesbian, gay, bisexual, and transgender youth: An epidemic of homelessness*. Washington, DC: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. Retrieved July 14, 2007, from <http://www.thetaskforce.org/downloads/HomelessYouth.pdf>

- Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior*, 28(1), 71–89.
- Risser, J., & Shelton, A. (2002). *Behavioral assessment of the transgender population, Houston, Texas*. Galveston: University of Texas School of Public Health.
- Rosenblum, D. (2000). 'Trapped' in Sing Sing: Transgendered prisoners caught in the gender binarism. *Michigan Journal of Gender & Law*, 6, 522–526.
- Ross, M. W., & Need, J. A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: A follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior*, 18(2), 145–153.
- Smith, Y. L. S., van Goozen, S. H. M., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: A prospective follow-up study. *Journal of American Academy of Child and Adolescent Psychiatry*, 40, 472–481.
- Spack, N. (2005, Fall). Transgenderism. *Lahey Clinic Journal of Medical Ethics*. Retrieved February 13, 2007, from http://www.lahey.org/NewsPubs/Publications/Ethics/JournalFall2005/Journal_Fall2005_Feature.asp
- Spade, D. (2006). Compliance is gendered: Struggling for self-determination in a hostile economy. In P. Currah, R. M. Juang, & S. M. Minter (Eds.), *Transgender rights* (pp. 217–241). Minneapolis: University of Minnesota Press.
- Stone, M. R. (2004, September 10). *Gender identity is for everyone: Creating a paradigm of change*. Paper presented at the 6th International Congress on Sex and Gender Diversity, Manchester, England.
- Sylvia Rivera Law Project. (2007). *It's war in here: A report on the treatment of transgender and intersex people in New York State men's prisons*. Retrieved March 19, 2008, from <http://www.srlp.org/index.php?sec=03N&page=warinhere>
- Thaler, C. (2007). *Putting transgender health care myths on trial*. Retrieved July 14, 2007, from <http://www.lambdalegal.org/our-work/publications/page.jsp?itemID=32007335>
- Tom Waddell Health Center. (2001). *Protocols for hormonal reassignment of gender*. Retrieved July 15, 2007, from <http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf>
- Transgender Law Center. (2005). *Peeing in peace: A resource guide for transgender activists and allies*. San Francisco: Author.
- Winters, K. W. (2005). Gender dissonance: Diagnostic reform of gender identity for adults. *Journal of Human Sexuality*, 17(3/4), 71–89.
- Women in Prison Project (WIPP). (2007). *Transgender issues and the criminal justice system*. Retrieved April 24, 2007, from <http://www.correctionalassociation.org/publications/factsheets.htm>
- Wyss, S. E. (2004). 'This was my hell': The violence experienced by gender non-conforming youth in US high schools. *International Journal of Qualitative Studies in Education*, 17, 709–730.
- Xavier, J. (2000). *Final report of the Washington Transgender Needs Assessment Survey*. Retrieved June 18, 2004, from <http://www.gender.org/resources/dge/gea01011.pdf>
- Xavier, J., Hitchcock, D., Hollinshead, S., Keisling, M., Lewis, Y., Lombardi, E., Lurie, S., Sanchez, D., Singer, B., Stone, M. R., & Williams, B. (2004). *An overview of U.S. trans health priorities: A report by the Eliminating Disparities Working Group*. Retrieved March 26, 2006, from <http://www.nctequality.org/HealthPriorities.pdf>
- Xavier, J., Honnold, J. A., & Bradford, J. (2007). *The health, health-related needs, and lifecourse experiences of transgender Virginians*. Richmond: Virginia Department of Health.

Policy statement approved by the NASW Delegate Assembly, August 2008. This policy statement supersedes the policy statement on Transgender and Gender Identity Issues approved by the Delegate Assembly in 1999 and referred by the 2005 Delegate Assembly to the 2008 Delegate Assembly for revision. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700, Washington, DC 20002-4241. Telephone: 202-408-8600 or 800-638-8799; e-mail: press@naswdc.org

EXHIBIT 20

Statement on Gender Affirmative Approach to Care from the Pediatric Endocrine Society Special Interest Group on Transgender Health

The purpose of this Position Statement is to emphasize the importance of an affirmative approach to the health care of transgender individuals, as well as to improve the understanding of the rights of transgender youth. The Endocrine Society and the World Professional Association of Transgender Health provide detailed clinical practice guidelines elsewhere [1, 2]. The need for this Statement emerged in light of controversies in the medical community around the approach to mental health and medical care of transgender youth, including the risks involved in this care, and around support of transgender rights such as restroom use. This document provides a summary of relevant definitions, information and current literature on which the medical management and affirmative approach to care of transgender youth are based.

The Pediatric Endocrine Society Special Interest Group on Transgender Health supports the concept that sex chromosomes and/or genitalia do not determine one's gender identity, and endorses a gender affirmative approach to care for transgender youth.

The American Psychological Association defines gender as "a non-binary construct that allows for a range of *gender identities* and that a person's *gender identity* may not align with sex assigned at birth" [3]. Gender identity is the innermost concept of self as male, female, a blend of both or neither. It also encompasses how individuals perceive themselves and what they call themselves.

Sex is not equivalent to gender identity. Sex, typically but not always, categorized as male or female, is determined by factors that include chromosomes, gonads, internal reproductive organs and external genitalia.

Sex and gender identity align in the majority of the population, and when they do not, individuals may categorize themselves as transgender. Transgender refers to a transient or persistent identification with a gender that is different from the gender implied by the birth sex assignment. Gender dysphoria, defined in the DSM-5, refers to the discomfort or distress that may occur when one's gender identity does not match the sex assigned at birth [4]. Gender dysphoria may or may not be present in transgender individuals [4], since it may improve or even disappear with a gender affirmative approach

or treatment such as social transition (change in clothing, attire, name and pronouns), parental and social support, as well as hormonal therapy with or without surgical intervention [5-11]. In our experience, transgender children and adolescents often suffer from discrimination if they do not have a supportive environment in school, e.g. if they are not allowed to use the restroom, locker room, or participate in the sports teams and other activities consistent with their gender identity.

There are no data to support the use of “reparative or conversion” therapy with the intention of changing one’s gender identity or sexual orientation. Furthermore, the American Psychological Association, the American Psychiatric Association and the American Academy of Pediatrics, reject this form of therapy and support a more “trans-affirmative” model of care [3, 12, 13].

While rates of depression are 2-3 times higher in transgender youth vs. non-transgender peers [14], there are data to suggest that much of the psychiatric comorbidity in transgender adolescents derives from discrimination, peer rejection and lack of social support [15]. On the other hand, the best predictor of positive psychological outcomes is parental support [16], and a recent study published in the journal “Pediatrics” showed that transgender children that undergo a social transition have rates of depression comparable to non-transgender children [17].

It is important to note that not all young gender-nonconforming children will persist as such into adolescence, and that there might be different paths of gender development and degrees of complexity [18, 19]. This has raised the concern about supporting an early social transition in young children who may not persist into adolescence. However, previous studies may have underestimated or misunderstood the likelihood of long-term persistence. It is worth noting, common terms used to describe this are “persisters” for those individuals for whom gender dysphoria persists into and beyond adolescence and “desisters” for those individuals for whom it does not. A key issue is that criteria for gender identity disorder (GID) from earlier versions of the DSM on which the studies were based included diagnosis on the basis of gender atypical expression alone, which may or may not be independent of gender identity. Some have suggested that the proportion of persisters would likely be higher by applying current gender dysphoria criteria and, for example, including individuals who continued to express a desire to be of the opposite sex or to believe that they were the opposite sex, regardless of gender-stereotypical behaviors per se. A second methodologic criticism is that most of the youth studied had not actually been followed into adulthood, suggesting that with longer follow-up, the number of apparent desisters might be lower. It seems clear, however, that most (>90%) children whose

gender-variant identity persists into adolescence develop an adult transgender identity [7, 20, 21]. In these cases puberty, with attainment of secondary sex characteristics, is often a source of significant distress [18, 20].

Referral to a mental health provider with experience in gender identity concerns is always preferred to guide families in a variety of ways, such as: helping youth understand and reflect on their gender issues and choices; helping youth and family with difficult decisions such as potential benefits and risks of social transition and medical intervention [22, 23]; providing counseling at times of family conflict and distress; assisting with advocacy in schools and other community settings; helping youth and families navigate and problem-solve social challenges; assessing for and treating mental health and developmental morbidities and assessing for risk; and to provide continuity of care throughout a child's gender exploration and hormonal treatment. Medical intervention before adulthood in transgender adolescents is recommended by the Endocrine Society and the Pediatric Endocrine Society for selected patients that have undergone an appropriate psychological assessment [1, 24]. This protocol includes puberty suppression with gonadotropin releasing hormone (GnRH) agonists after initiation of puberty (Tanner stage \geq II for breast or testicular development), followed by cross-sex hormones around age 16 (though most experts agree that there may be compelling reasons not to wait until age 16 years in some adolescents). Puberty suppression has the purpose of delaying the development of secondary sex characteristics while providing time for continued exploration of the adolescent's gender identity, as well as allowing for gender continuity in those who have already socially transitioned. This treatment has been used by pediatric endocrinologists for more than 30 years for patients with precocious puberty and its safety and efficacy profile is well known [25-27].

Fertility is likely to be will be compromised if GnRH agonists are started in early puberty (Tanner stage II-III), and endogenous puberty is not allowed to complete. Research is underway to determine if prepubertal gonadal tissue can be differentiated to result in mature sperm or oocytes [28, 29].

Cross-sex hormones (estrogen or testosterone), also known as hormone replacement therapy (HRT), have the purpose of inducing secondary sex characteristics that enable the individual to present in accordance with their affirmed gender identity. Testosterone induces amenorrhea in postmenarchal transmales; however it seems to be reversible as there are number of cases of unplanned pregnancy while on treatment, as well as planned pregnancy and uneventful child birth after interruption of testosterone treatment [30]. Estrogen treatment may lead to sterility, and implications for fertility as

well as other reproductive options need to be thoroughly discussed with the patient and legal guardian(s) [1]. In our experience, adolescent patients and parents prioritize treatment that will help affirm patients' gender identity over attaining or preserving fertility.

Long-term data from transgender patients treated as adults show that this therapy is overall safe and there are no data to suggest that use of estrogen or testosterone, when used at physiologic doses, leads to a cancer risk higher than expected for the average adult male, in the case of transmales, or the adult female, in the case of transfemales [30-32]. The thromboembolic risk was significant with ethinyl estradiol preparations [32], but is very low (<2%) with the current oral and patch 17-beta estradiol formulations [30, 31]. There is a theoretical concern that testosterone may worsen the cardiovascular profile of transmen, but this is in comparison with women; therefore, since men are known to have a higher cardiovascular risk by nature, this possible increased cardiovascular risk is not unexpected. Furthermore, this increased cardiovascular risk has not been proven, and a recent study on overall mortality in transgender individuals showed that transmen followed for more than 18 years of testosterone treatment, did not show a significant increase in mortality due to cardiovascular incidents [32]. Overall, the risk benefit ratio of puberty suppression and cross-sex hormones is low in contrast with the high rate of suicidal attempt of transgender individuals of 41% [33].

While many studies demonstrate that hormone replacement therapy and gender affirming surgery lead to improved gender dysphoria and quality of life in adults [6, 34-36], a long-term follow up study revealed persistence of psychiatric comorbidity and death from suicide in transgender patients after gender affirming surgery [37]. However, the authors comment that the results should not be interpreted such that sex reassignment increases morbidity and mortality given that the overall mortality rate was only significantly increased for the group operated on before 1989; therefore, the results might be explained by improved health care for transgender adults during 1990s, along with altered societal attitudes towards gender non-conforming individuals. Another limitation of this study is that this group was compared with non-transgender controls. A more appropriate control group would have been transgender individuals who did not undergo gender reassignment surgery, which may have revealed worse outcomes without treatment.

A recent long term study of 55 transgender adolescents who underwent puberty suppression and cross-sex hormones followed by gender affirming surgery in early adulthood, showed complete resolution of

gender dysphoria, and psychological outcomes that were similar or better than non-transgender, age-matched young adults. In addition, none of these patients regretted their decision to transition [21].

The Pediatric Endocrine Society Special Interest Group on Transgender Health supports the United States Department of Education and the Department of Justice guidance on the rights of transgender students [38], which recommends that students use the restroom that is consistent with their gender identity. School support in acknowledging a young person's true gender identity is crucial for their long-term well-being. When transgender children and adolescents present according to their gender identity but are forced to use the restroom that matches their genitalia, they are often harassed both physically and verbally, and in some cases are questioned or pulled out. While some schools have provided accommodations to use a staff (gender neutral) restroom, this leads to segregation and other psychological and medical problems including being questioned by peers and school staff not aware of their transgender status, sanctions for being late because the allowable restroom is often not close to the classrooms, avoidance of using the restroom resulting in refusing to drink fluids and withholding urination potentially leading to urinary tract infections, as well as school avoidance.

Almost universally, transgender students do not want to bring attention or expose themselves publicly; on the contrary, they want to be accepted like any other youth. There are no reported cases in which allowing a transgender child to use the bathroom that matches their gender identity has led to inappropriate self-exposure or sexual advances. Self-exposure, voyeurism and sexual assault already constitute criminal offenses and policies supporting the rights of transgender individuals do not change that.

In conclusion, transgender youth have optimal outcomes when affirmed in their gender identity, through support by their families and their environment, as well as appropriate mental health and medical care. For this reason, the Pediatric Endocrine Society Special Interest Group on Transgender Health joins other academic societies involved in the care of children and adolescents in supporting policies that promote a safe and accepting environment for gender-nonconforming/transgender youth, as well as adequate mental health and medical care.

References:

1. Hembree, W.C., et al., *Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline*. J Clin Endocrinol Metab, 2009. **94**(9): p. 3132-54.
2. *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People*. The World Professional Association for Transgender Health. 2011(Version 7).
3. American Psychological, A., *Guidelines for psychological practice with transgender and gender nonconforming people*. Am Psychol, 2015. **70**(9): p. 832-64.
4. *American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders*. Fifth ed. 2013: American Psychiatric Publishing.
5. Cohen-Kettenis, P.T. and S.H. van Goozen, *Sex reassignment of adolescent transsexuals: a follow-up study*. J Am Acad Child Adolesc Psychiatry, 1997. **36**(2): p. 263-71.
6. Smith, Y.L., S.H. van Goozen, and P.T. Cohen-Kettenis, *Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study*. J Am Acad Child Adolesc Psychiatry, 2001. **40**(4): p. 472-81.
7. de Vries, A.L., et al., *Young adult psychological outcome after puberty suppression and gender reassignment*. Pediatrics, 2014. **134**(4): p. 696-704.
8. Cohen-Kettenis, P.T., H.A. Delemarre-van de Waal, and L.J. Gooren, *The treatment of adolescent transsexuals: changing insights*. J Sex Med, 2008. **5**(8): p. 1892-7.
9. Steensma, T.D. and P.T. Cohen-Kettenis, *Gender transitioning before puberty?* Arch Sex Behav, 2011. **40**(4): p. 649-50.
10. Mayer, K.H., R. Garofalo, and H.J. Makadon, *Promoting the successful development of sexual and gender minority youths*. Am J Public Health, 2014. **104**(6): p. 976-81.
11. Marco A. Hidalgo DE, A.C.T., Leslie F. Clark, Robert Garofalo, Stephen M. Rosenthal, Norman P. Spack, Johanna Olson, *The Gender Affirmative Model: What We Know and What We Aim to Learn*. Human Development, 2013. **56**: p. 285-90.
12. Committee On, A., *Office-based care for lesbian, gay, bisexual, transgender, and questioning youth*. Pediatrics, 2013. **132**(1): p. 198-203.
13. Association, A.P., *Position statement on Access to Care for Transgender and Gender Variant Individuals*. 2013.
14. Reisner, S.L., et al., *Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study*. J Adolesc Health, 2015. **56**(3): p. 274-9.
15. Budge, S.L., J.L. Adelson, and K.A. Howard, *Anxiety and depression in transgender individuals: the roles of transition status, loss, social support, and coping*. J Consult Clin Psychol, 2013. **81**(3): p. 545-57.
16. Travers R, B.G., Pyne J, et al. for the Trans PULSE Project, Gale L, Papadimitriou M, *Impacts of strong parental support for trans youth: A report prepared for children's aid society of Toronto and Delisle youth services*. 2012: p. 1-5.
17. Olson, K.R., et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*. Pediatrics, 2016. **137**(3): p. 1-8.
18. Wallien, M.S. and P.T. Cohen-Kettenis, *Psychosexual outcome of gender-dysphoric children*. J Am Acad Child Adolesc Psychiatry, 2008. **47**(12): p. 1413-23.
19. Steensma, T.D. and P.T. Cohen-Kettenis, *More than two developmental pathways in children with gender dysphoria?* J Am Acad Child Adolesc Psychiatry, 2015. **54**(2): p. 147-8.
20. Steensma, T.D., et al., *Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study*. Clin Child Psychol Psychiatry, 2011. **16**(4): p. 499-516.
21. de Vries, A.L., et al., *Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study*. J Sex Med, 2011. **8**(8): p. 2276-83.

22. Vance, S.R., Jr., D. Ehrensaft, and S.M. Rosenthal, *Psychological and medical care of gender nonconforming youth*. Pediatrics, 2014. **134**(6): p. 1184-92.
23. Lopez, X., S. Stewart, and E. Jacobson-Dickman, *Approach to Children and Adolescents with Gender Dysphoria*. *Pediatr Rev*, 2016. **37**(3): p. 89-98.
24. Eli Coleman, W.B., Marsha Botzer, et.al. , *Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People*. The World Professional Association for Transgender Health, 2012(7th Version.): p. 1-112.
25. Kappy, M., et al., *Suppression of gonadotropin secretion by a long-acting gonadotropin-releasing hormone analog (leuprolide acetate, Lupron Depot) in children with precocious puberty*. J Clin Endocrinol Metab, 1989. **69**(5): p. 1087-9.
26. Lahlou, N., et al., *Pharmacokinetics and pharmacodynamics of GnRH agonists: clinical implications in pediatrics*. J Pediatr Endocrinol Metab, 2000. **13 Suppl 1**: p. 723-37.
27. Carel, J.C., et al., *Consensus statement on the use of gonadotropin-releasing hormone analogs in children*. Pediatrics, 2009. **123**(4): p. e752-62.
28. Heger, S., et al., *Long-term GnRH agonist treatment for female central precocious puberty does not impair reproductive function*. Mol Cell Endocrinol, 2006. **254-255**: p. 217-20.
29. Weinbauer, G.F., et al., *Reversibility of long-term effects of GnRH agonist administration on testicular histology and sperm production in the nonhuman primate*. J Androl, 1987. **8**(5): p. 319-29.
30. Meriggiola, M.C. and M. Berra, *Safety of hormonal treatment in transgenders*. Curr Opin Endocrinol Diabetes Obes, 2013. **20**(6): p. 565-9.
31. Wierckx, K., et al., *Long-term evaluation of cross-sex hormone treatment in transsexual persons*. J Sex Med, 2012. **9**(10): p. 2641-51.
32. Asscheman, H., et al., *A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones*. Eur J Endocrinol, 2011. **164**(4): p. 635-42.
33. Grant, J.M., Mottet, L.A., Tanis, J., et al *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. 2011.
34. Ross, M.W. and J.A. Need, *Effects of adequacy of gender reassignment surgery on psychological adjustment: a follow-up of fourteen male-to-female patients*. Arch Sex Behav, 1989. **18**(2): p. 145-53.
35. Cohen-Kettenis, P.T. and L.J. Gooren, *Transsexualism: a review of etiology, diagnosis and treatment*. J Psychosom Res, 1999. **46**(4): p. 315-33.
36. Johansson, A., et al., *A five-year follow-up study of Swedish adults with gender identity disorder*. Arch Sex Behav, 2010. **39**(6): p. 1429-37.
37. Dhejne, C., et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*. PLoS One, 2011. **6**(2): p. e16885.
38. *Dear Colleague Letter on Transgender Students* United States Department of Education Office of Civil rights and the Department of Justice Civil Rights Division, 2016.

EXHIBIT 21

March 2017



6728 Old McLean Village Drive • McLean • VA • 22101 • 703-556-9222 • www.pedsendo.org

PES Statement Promoting Safety of Transgender Youth

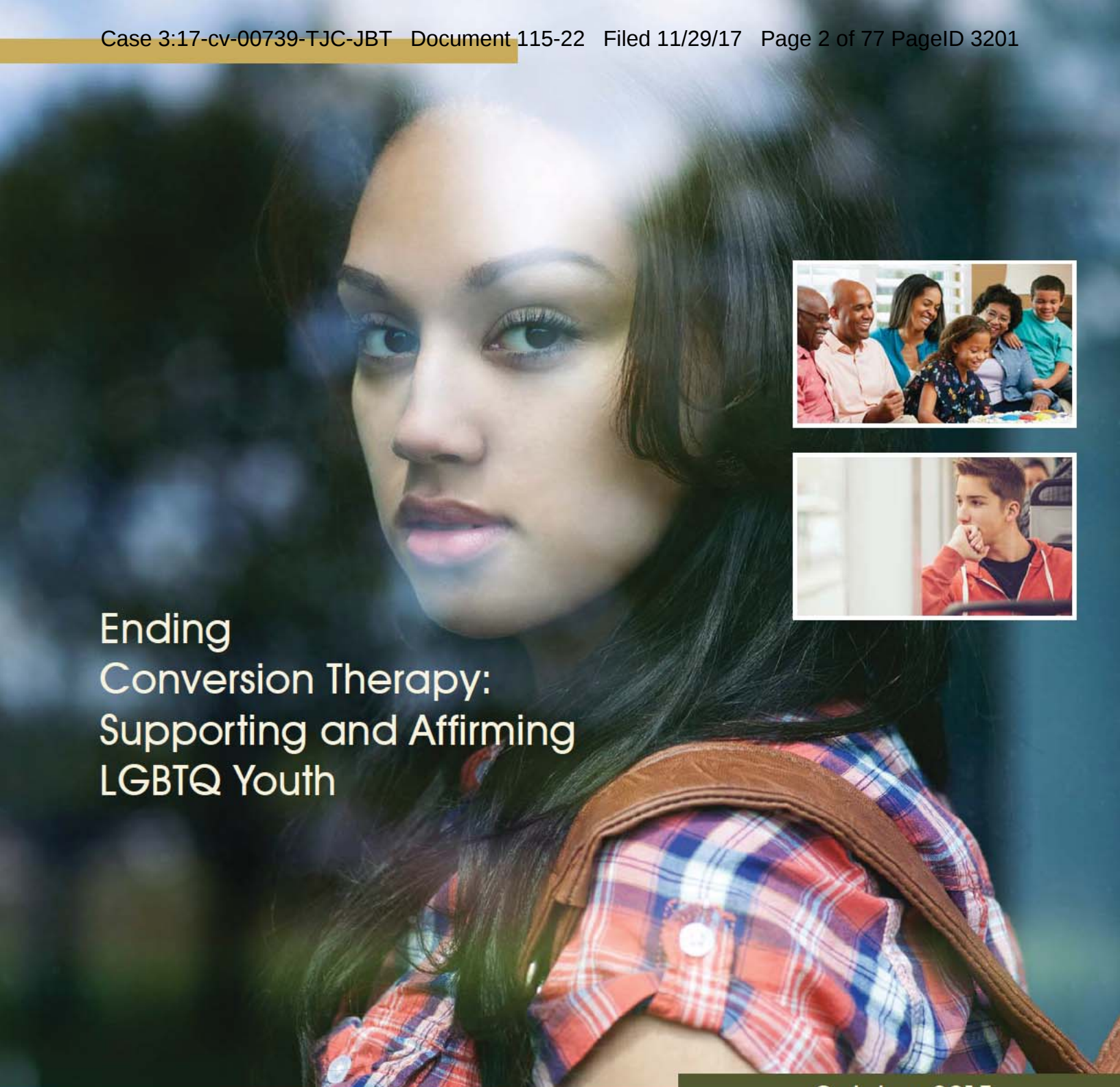
The Pediatric Endocrine Society (PES), the leading professional society for this specialty in the United States, strongly opposes the guidance issued on February 22, 2017, by the Departments of Justice and Education, which eliminates protection of the rights of transgender youth.

As medical providers of transgender youth, we have seen the discrimination and safety concerns that this population faces, which may lead to mental illness and high risk of suicide. Transgender children and adolescents need a safe and supportive school environment in order to thrive like any other young person. Not allowing them to use the restroom that matches their gender identity is a violation of human rights and sends a message of intolerance that will promote further discrimination and segregation.

Furthermore, it is known that verbal, physical and sexual assault have occurred when transgender individuals living according to their gender identity enter a restroom that does not match their gender identity. On the other hand, no adverse consequences have occurred when schools have allowed transgender students to use the restroom that is consistent with their gender identity. In fact, many transgender individuals easily blend in to society as their affirmed gender, never having publicly disclosed their transgender status. It would be inappropriate for them to enter a bathroom based on their sex assigned at birth, as individuals in the community in which they live often don't realize that they are transgender.

As experts in the care of transgender youth, we strongly oppose the decision by the Departments of Justice and Education and ask that the rights and safety of transgender children and adolescents be protected.

EXHIBIT 22



Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015



PAGE INTENTIONALLY LEFT BLANK

Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth

October 2015

PAGE INTENTIONALLY LEFT BLANK

Acknowledgements

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS. Listings of any non-Federal resources are not all-inclusive and inclusion of a listing does not constitute endorsement by SAMHSA or HHS.

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Printed Copies

This publication may be downloaded or ordered at <http://store.samhsa.gov>. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Originating Office

Division of Systems Development, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services.



Contents

Executive Summary	1
Introduction	7
Professional Consensus Process	9
Statements of Professional Consensus.....	11
Research Overview.....	15
Approaches to Ending the Use of Conversion Therapy	37
Guidance for Families, Providers, and Educators	41
Summary and Conclusion.....	51
References.....	52
Appendix A: Glossary of Terms	64
Appendix B: Acknowledgments	64
Endnotes.....	66



Executive Summary

Lesbian, gay, bisexual, and transgender youth, and those who are *questioning* their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's *LGBTQ* identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority*¹ youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression²—is a practice that is not supported by credible evidence and

has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as *LGBTQ* is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender³sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21st century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons, 2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the

assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth (Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood

(Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

Therapeutic Efforts with Sexual and Gender Minority Youth⁴

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and families, appropriate therapeutic approaches

include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and well-being of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

Ending the Use of Conversion Therapy for Minors

Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

PAGE INTENTIONALLY LEFT BLANK



Introduction

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual’s sexual orientation, gender identity, or gender expression⁵—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g., psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights [areas of opportunity for future research](#), and provides an overview of [mechanisms to eliminate the use of harmful therapies](#). In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on several topics, including: [Family and Community Acceptance](#),

“Being gay is not a disorder. Being transgender is not a malady that requires a cure.”

—Vice Admiral Vivek H. Murthy,
19th U.S. Surgeon General

[School-Based Issues](#), [Pediatric Considerations](#), and [Affirmative Exploratory Therap](#). In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population

SAMHSA’s mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.⁶As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.



Professional Consensus Process

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

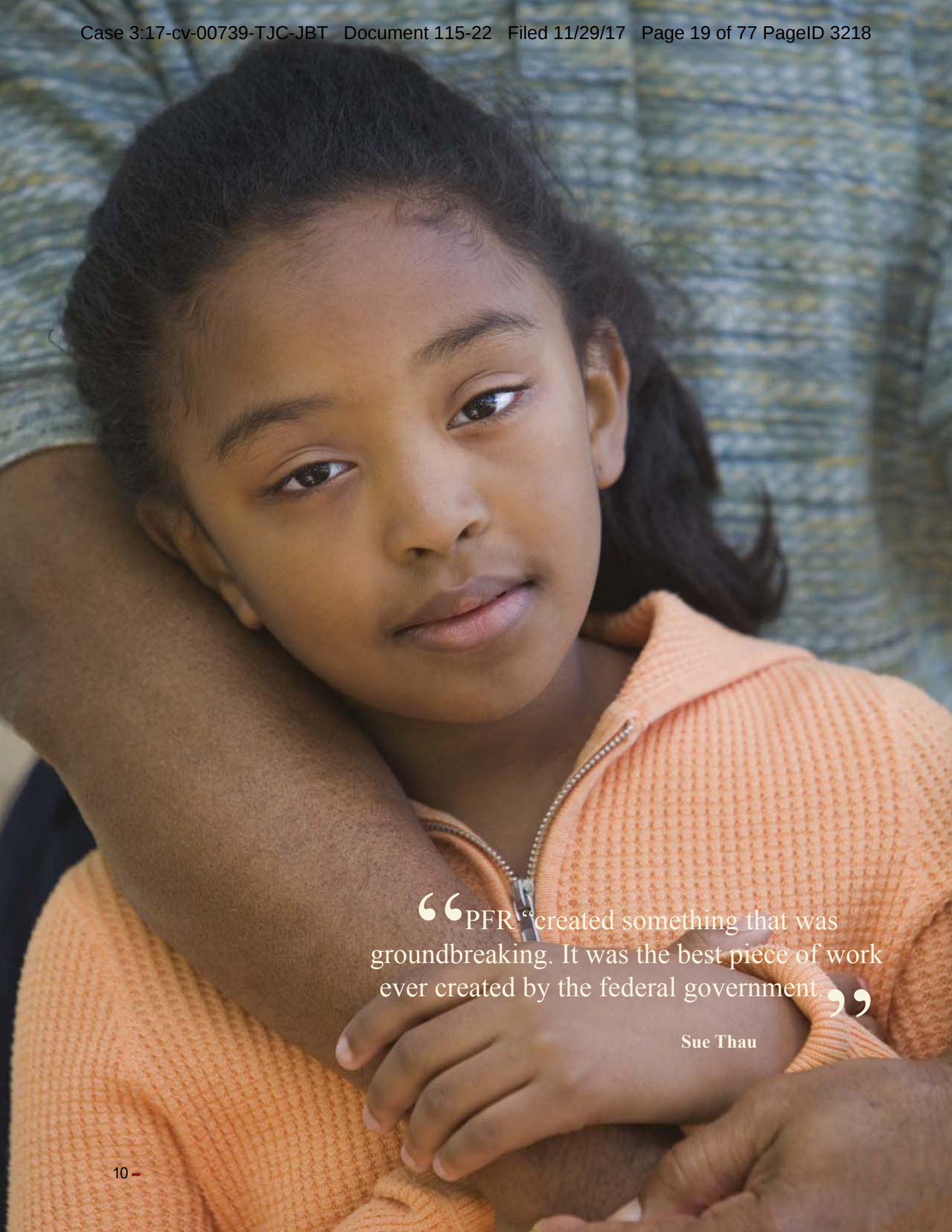
APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B.

Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would constitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.



“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Statements of Professional Consensus

The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals' work in this area.

Guiding Principles

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of “self-determination” requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of “justice” and “beneficence and nonmaleficence” require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional Consensus on Conversion Therapy with Minors

1. Same-gender⁷sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

Professional Consensus on Gender Identity and Gender Expression in Youth

Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.
5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peri-pubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in pre-pubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics⁸, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

Research Overview

Sexual Orientation

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalytic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)⁹.

Gender

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth¹⁰. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or

male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression¹¹(American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned at birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman,

a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuyper, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth (i.e., gender dysphoria) as well as distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

Sexual Orientation and Gender in Childhood

Sexual Orientation in Childhood

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited

research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder¹²(APA Task Force on Gender Identity and Gender Variance, 2009). Though there

have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic

criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two trajectories¹³: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive ("I am a girl") rather than affective ("I feel like a girl") assertion of gender; consistent and firm gender-

fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender

typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014). Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

Sexual Orientation and Gender in Adolescence

Sexual Orientation in Adolescence

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)¹⁴. Compared to earlier cohorts, today's sexual minority adolescents are developing an awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or "coming out" as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

Clinical Issues in Adolescence

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic

in Amsterdam, Netherlands as compared to the general population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

Influences on Health and Well-Being

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)¹⁵. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing

not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar,

2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities – may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005)). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity.

Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school

from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the over-representation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where

sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore,

important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, & Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

Therapeutic Efforts with Sexual and Gender Minority Youth

Introduction¹⁶

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers should consider the following as the scientific basis of treatment¹⁷:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to

change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting

& Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria

(Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting

behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.

Appropriate Interventions for Distress in Children, Adolescents, and Families¹⁸

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding. A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health

and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-appropriate milestones and facilitating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and lives of *lesbian, gay, bisexual, transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and

adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link

between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader principles and

concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral

health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further, behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual

and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that

adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone

therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disciplinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescents' gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of

hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal

of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults, withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options

related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mammoplasty beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

Future Directions for Research

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for

more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identity among youth.

Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.
- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and

how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

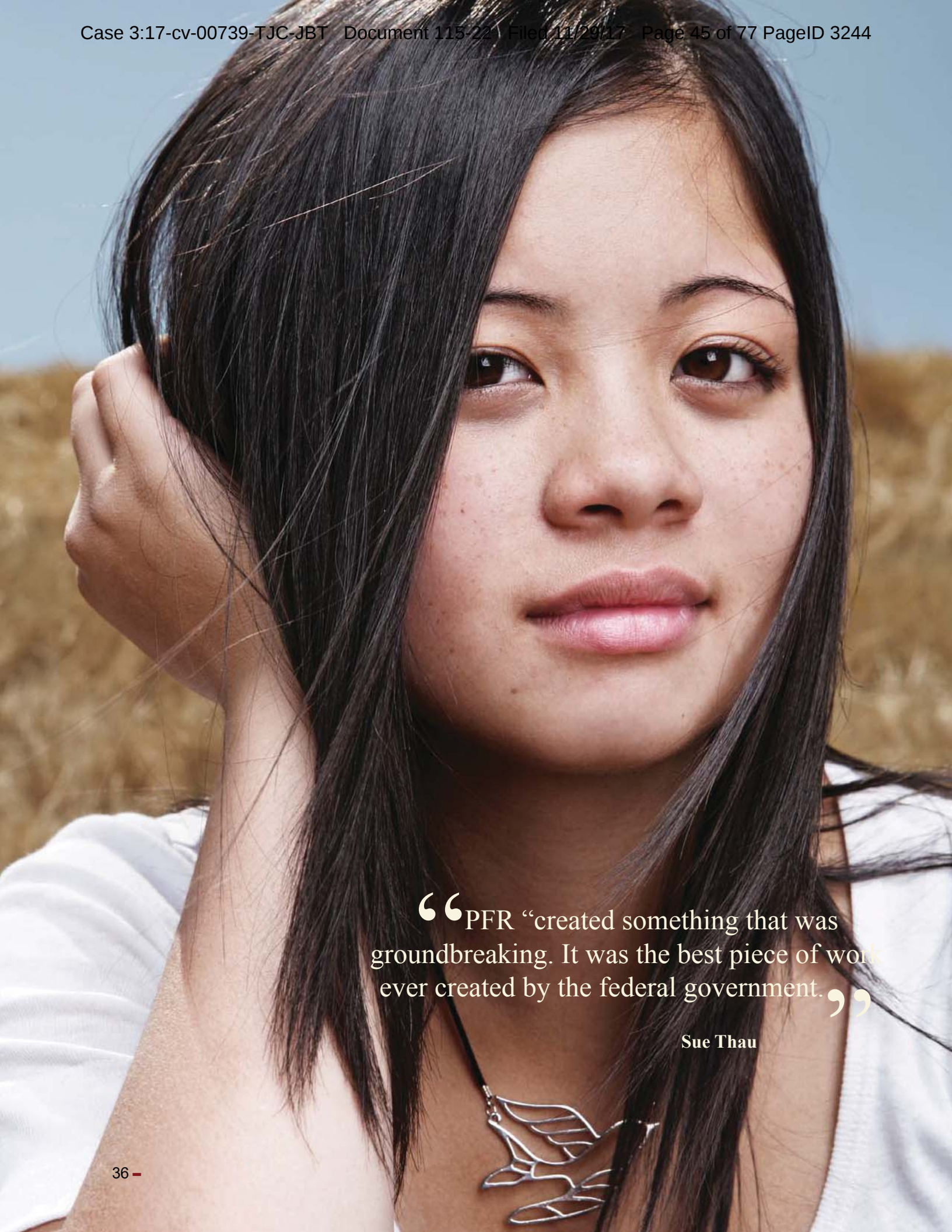
Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, [stating in part](#):

“When assessing the validity of conversion therapy, or other practices that seek to change an individual’s gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.

As part of our dedication to protecting America’s youth, this Administration supports efforts to ban the use of conversion therapy for minors.” (Jarrett, 2015)

PAGE INTENTIONALLY LEFT BLANK



“PFR “created something that was groundbreaking. It was the best piece of work ever created by the federal government.”

Sue Thau

Approaches to Ending the Use of Conversion Therapy

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
 - Adoption of public policies that end discrimination
 - Increasing access to health care
 - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
 - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
 - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
 - Inclusion of affirmative information and treatment models in professional training curriculum
 - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts
 - State and federal legislation that bans sexual orientation and gender identity change efforts
 - Federal and state regulatory actions and additional Administration activities
 - Legal action

Reducing discrimination and negative social attitudes towards LGBT identities and individuals

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,¹⁹ including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the “Don’t Ask, Don’t Tell” policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;
- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the “It Gets Better” Project, which aims to give LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more

accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.²⁰

Dissemination of information, training and education for behavioral health providers

The major health associations have issued policy statements critical of conversion therapy including the [World Health Organization](#), the [American Medical Association](#), the [American Academy of Pediatrics](#), the [American Academy of Child and Adolescent Psychiatry](#), the [American Psychological Association](#), [American Counseling Association](#), [American Psychoanalytic Association](#), and the [National Association of Social Workers](#), among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.²¹

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*. As part of this publication, the association indicates that “doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by [...] identifying various harmful practices (e.g., historical practice of using

‘reparative’ therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients.”

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.

Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of “*Do No Harm*” through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people’s dignity.

Legislative, regulatory, and legal efforts

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.

- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.²³

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."²⁴



Guidance for Families, Providers, and Educators

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*).

Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

Promoting Family and Community Acceptance and Support

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of “connectedness” has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been

shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

Key Points:

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent’s sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child’s gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child’s overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.
- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child’s sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent’s identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child “fit in,” have a good life and be accepted by others. The Family Acceptance Project’s research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family’s cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual’s dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child’s risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don’t have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child’s well-being - without “accepting” an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child’s experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child’s safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

Resources

Family Acceptance Project: <http://familyproject.sfsu.edu/>

Gender Spectrum: www.genderspectrum.org

Institute for the Study of Sexual Identity: www.sexualidentityinstitute.org

PFLAG: www.pflag.org

References

- Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press
- Centers for Disease Control and Prevention. (2009). *Strategic direction for the prevention of suicidal behavior: Promoting individual, family, and community connectedness to prevent suicidal behavior*. Atlanta, GA: Retrieved from www.cdc.gov/ViolencePrevention/pdf/SuicideStrategic_Direction_Full_Version-a.pdf.
- Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*, 50(4), 453–470.
- Ryan, C. (2009). Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524
- Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Seil, K. S., Desai, M. M., & Smith, M. V. (2014).

Sexual orientation, adult connectedness, substance use, and mental health outcomes among adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health*, 104(10), 1950-1956.

Substance Abuse and Mental Health Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. (HHS Publication No. PEP14-LGBTKIDS). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from <http://store.samhsa.gov/product/PEP14-LGBTKIDS>.

Bullying, Harassment, and Other School-Based Issues

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise

mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.

- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.
- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the

context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.

- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students. Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH): www.cdc.gov/HealthyYouth/

GLSEN: www.glsen.org

Human Rights Campaign, Welcoming Schools Initiative: www.welcomingschools.org

National Center for Lesbian Rights, Youth Project: www.nclrights.org/our-work/youth

National Association for School Psychologists, Committee on GLBTQ Issues: www.nasponline.org/advocacy/glb.apsx

PFLAG: www.pflag.org

Safe & Supportive Schools Project: <http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx>

References

American Psychological Association & National Association of School Psychologists. (2014). Resolution on gender and sexual orientation diversity in children and adolescents in schools. Retrieved from http://www.nasponline.org/about_nasp/resolution/gender_sexual_orientation_diversity.pdf

Fisher, E., & Komosa-Hawkins, K. (Eds.). (2013). *Creating safe and supportive learning environments a guide for working with lesbian, gay, bisexual, transgender, and questioning youth, and families* (1 ed.). London: Routledge.

National Association of School Psychologists. (2014). NASP Position statement: Safe schools for transgender and gender diverse students, from http://www.nasponline.org/about_nasp/positionpapers/Transgender_PositionStatement.pdf

Orr, A., Baum, J., Gill, E., Kahn, E., & Salem, A. (2015, August). Schools in transition: A guide for supporting transgender students in K-12 schools, from <http://www.ncrights.org/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf>

Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, 46(6), 1580-1589. doi: 10.1037/a0020705

U.S. Department of Education. (2014). Questions and answers on Title IX and sexual violence, from <http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf>

U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S.

“ When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl’s clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression. Thankfully, one of my friends recognized the warning signs and called social services, which intervened and got me the housing and medical care I needed. It is always darkest before the dawn, but I’m living proof that a smart bystander can save a life. ”

—Amy

Department of Justice, Civil Rights Division, from <http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf>

Pediatric Care Considerations for LGBTQ Children and Adolescents

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond

to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.

- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of

reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.
- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral

health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

- American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, 132(1), 198 -203 doi: 10.1542/peds.2013-1282
- Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

References:

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>

“ Having my family reject me because I’m trans broke my heart into more pieces than I could have imagined. Even more painful was the feeling they no longer loved or valued me. Having my Grandmother take me in restored my belief in love. To have her arms to fall into meant that I no longer was alone, that death did not seem like the only road to stability, comfort, and joy. That perhaps I should build a future because I again had someone to help me do so and enjoy it with me.”

—Malachi

Affirmative Care for Gender Minority Youth

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child’s developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi: 10.1542/peds.2007-3524

Here are a few key points to keep in mind when considering a supportive and balanced approach for transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender non-conforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy **and** a psychological/readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.
- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or implicitly make an adolescent feel “stuck” in a gender identity.
- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.

- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider's input is valued and perceived as equally critical to the care of the individual patients served.

Resources

TransYouth Family Allies: www.imatyfa.org/

Trans Youth Equality Foundation: www.transyouthequality.org

PFLAG Transgender Network: <http://community.pflag.org/transgender>

Gender Spectrum: www.genderspectrum.org

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children* (1 ed.). New York: The Experiment.

References

Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & dickey, I. M. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.

Edwards-Leeper, L., Leibowitz, S., Sangganjanavanich, V.F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.

Hidalgo et al., 2013. The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56, 285-290.

“During my senior year of high school, my English teacher would sit with me every day after school and listen as I told him how confused I was over my sexuality. He was one of the very few I told about being in conversion therapy. He told me that I had to listen to my heart and follow it, and not to try and force any specific outcome. He was the only person in my life at the time who gave me any assurance that I was going to make it through this.”

”

—Mathew

Summary and Conclusion

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition

and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

“It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life.”

—Sam

References

- Adelson, S. L., & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Alanko, K., Santtila, P., Witting, K., Varjonen, M., Jern, P., Johansson, A., . . . Kenneth Sandnabba, N. (2009). Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. *J Sex Res*, *46*(5), 494-504.
- Almeida, J., Johnson, R. M., Corliss, H. L., Molnar, B. E., & Azrael, D. (2009). Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*, *38*(7), 1001-1014.
- American Bar Association. (2015). Resolution 112: Commission on sexual orientation and gender identify section of individual rights and responsibilities commission on youth at risk, from <https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf>
- American Medical Association. (2008). Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients, from http://www.tgender.net/taw/ama_resolutions.pdf
- American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5 ed.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013b). Principles of Medical Ethics, from <http://www.psychiatry.org/psychiatrists/practice/ethics>
- American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Washington, DC: American Psychological Association.
- American Psychological Association. (2008). Report of the APA task force on gender identity and gender variance (pp. 28). Washington, DC: American Psychological Association.
- American Psychological Association. (2009). Resolution on appropriate therapeutic response to sexual orientation distress and change efforts Retrieved August 26, 2015, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- American Psychological Association. (2010). Ethical Principles of Psychologists and Code of Conduct from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association (2011). Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients. Washington, DC: APA.
- American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *Am Psychol*, *67*(1), 10-42.
- American Psychological Association. (2015a). Guidelines for psychological practice with transgender and gender nonconforming people, from <http://www.apa.org/practice/guidelines/transgender.pdf>
- American Psychological Association. (2015b). Standards of accreditation for health service psychology. Washington, DC: American Psychological Association.

- American Psychological Association & National Association of School Psychologists. (2015c). *Resolution on gender and sexual orientation diversity in children and adolescents in schools*. Retrieved from <http://www.apa.org/about/policy/orientation-diversity.aspx>
- Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors. *American Psychologist*, *64*(5), 372-453. doi: 10.1037/a0015932
- APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). Report of the Task Force on appropriate therapeutic responses to sexual orientation, from <http://www.apa.org/about/policy/sexual-orientation.aspx>
- APA Task Force on Gender Identity and Gender Variance. (2009). Report of the Task Force on gender identity and gender variance. Washington, DC: American Psychological Association.
- Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>
- Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, *31*, 43-55.
- Bartoli, E., & Gillem, A. R. (2008). Continuing to depolarize the debate on sexual orientation and religious identity and the therapeutic process. *Professional Psychology: Research and Practice*, *39*, 202-209.
- Ben-Ari, A. (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality*, *30*, 89-112.
- Bethea, M. S., & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A Systems Theory perspective *Journal of Couple & Relationship Therapy*, *12*, 89-112. doi: 10.1080/15332691.2013.779094
- Bockting, W. O., & Ehrbar, R. (2005). Commentary: Gender variance, dissonance, or identity disorder. *Journal of Psychology and Human Sexuality*, *17*(3/4), 125-134.
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, *103* (5), 943-951.
- Bontempo, D., & D'Augelli, A. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *Journal of Adolescent Health*, *30*, 364-374.
- Bouris, A., Guilamo-Ramos, V., Pickard, A., Shiu, C., Loosier, P. S., Dittus, P., & Waldmiller, J. M. (2010). A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda. *The Journal of Primary Prevention*, *31*(5-6), 273-309.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard.
- Bronfenbrenner, U. (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.

- Burton, C. M., Marshal, M. P., Chisolm, D. J., Sucato, G. S., & Friedman, M. S. (2013). Sexual minority-related victimization as a mediator of mental health disparities in sexual minority youth: a longitudinal analysis. *J Youth Adolesc*, 42(3), 394-402.
- Byne, W., Bradley, S. J., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., . . . Tompkins, D. A. (2012). Report of the APA Task Force on treatment of gender identity disorder. *American Journal of Psychiatry, Suppl. 1-35*.
- Carver, P., Yunger, J., & Perry, D. (2003). Gender identity and adjustment in middle childhood. *Sex Roles*, 49(3-4), 95-109. doi: 10.1023/a:1024423012063
- Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4, 219-235.
- Cass, V. C. (1996). Sexual orientation identity formation: A western phenomenon. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 227-251). Washington, DC: American Psychiatric Press, Inc.
- Cochran, S. D., Drescher, J., Kismödi, E., Giami, A., García-Moreno, C., Atalla, E., Marais, E. M. V., & Reed, G. M. (2014). Proposed declassification of disease categories related to sexual orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). *Bulletin of the World Health Organization*, 92, 672-679. doi: 10.2471/BLT.14.135541
- Cohen-Kettenis, P. T. (2005). *Gender identity disorders*. Cambridge, MA: Cambridge University Press.
- Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. G. (2008). The treatment of adolescent transsexuals: Changing Insights. *Journal of Sexual Medicine*, 5(8), 1892-1897.
- Cohen-Kettenis, P. T., & Klink, D. (2015). Adolescents with gender dysphoria. *Best Pract Res Clin Endocrinol Metab*, 29(3), 485-495.
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.
- Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A., (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow up. *Archives of Sexual Behavior*, 40(4), 843-847.
- Cohen-Kettenis PT, Schagen SE, Steensma TD, de Vries AL, Delemarre-van de Waal HA. Puberty suppression in a gender-dysphoric adolescent: a 22-year follow-up. *Arch Sex Behav*. 2011;40(4):843–847
- Cohen-Kettenis, P. T., & van Goozen, S. H. (1997). Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*, 36(2), 263-271.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.
- Corby, B. C., Hodges, E. V. E., & Perry, D. G. (2007). Gender identity and adjustment in Black, Hispanic, and White preadolescents. *Developmental Psychology*, 43(1), 261-266.
- Corliss, H. L., Rosario, M., Wypij, D., Wylie, S. A., Frazier, A. L., & Austin, S. B. (2010). Sexual orientation and drug use in a longitudinal cohort study of U.S. adolescents. *Addictive Behaviors*, 35(5), 517-521. doi: 10.1016/j.addbeh.2009.12.019
- Cotton, S., Zebracki, K., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: a review. *J Adolesc Health*, 38(4), 472-480.

- Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241-1299.
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, *21*, 1-21.
- D'Augelli, A. R., & Patterson, C. J. (2001). *Lesbian, gay, and bisexual identities and youths: Psychological perspectives*. New York: Oxford University Press.
- Daley, A., Solomon, S., Newman, P. A., & Mishna, F. (2008). Traversing the margins: Intersectionalities in the bullying of lesbian, gay, bisexual and transgender youth. *Journal of Gay & Lesbian Social Services*, *19*(3-4), 9-29. doi: 10.1080/10538720802161474
- Delemarre-van de Waal, H.A. & Cohen-Kettenis, P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, *155*(suppl 1):S131–S137.
- de Vries, A., Steensma, T., Doreleijers, T., & Cohen-Kettenis, P. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*, *8*(8), 2276–2283.
- de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *J Child Psychol Psychiatry*, *52*(11), 1195-1202.
- de Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Dev Disord*, *40*(8), 930-936.
- Diamond, L. M. (2015). Sexual fluidity. *The International Encyclopedia of Human Sexuality*, 1115–1354.
- Diamond, L. M., & Butterworth, M. (2008). Questioning gender and sexual identity: Dynamic links over time. *Sex Roles*, *59*(5-6), 365-376. doi: 10.1007/s11199-008-9425-3
- Diamond, L. M., & Savin-Williams, R. C. (2000). Explaining diversity in the development of same-sex sexuality among young women. *Journal of Social Issues*, *56*, 297-313.
- Diamond, M. L. (2006). Careful what you ask for: Reconsidering feminist epistemology and autobiographical narrative in research on sexual identity development. *Signs: Journal of Women and Culture and Society*, *31*, 471-492.
- Diamond, M. L. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology*, *44*, 5-14.
- Doty, N. D., & Brian, L. B. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *Journal of Youth and Adolescence*, *39*, 1134–1147.
- Doty, N. D., Willoughby, B. L., Lindahl, K. M., & Malik, N. M. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *J Youth Adolesc*, *39*(10), 1134-1147.
- Drescher, J. (2014). Controversies in gender diagnoses. *LGBT Health*, *1*(1), 10-14. doi: 10.1089/lgbt.2013.1500
- Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Dev Psychol*, *44*(1), 34-45.
- Dube, E. M., & Savin-Williams, R. C. (1999). Sexual identity development among ethnic sexual-minority male youths. *Developmental Psychology*, *34*, 1389-1398.

- Durso, L. E., & Gates, G. J. (2012). *Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.
- Edwards-Leeper, L. (in press). Affirmative care of transgender and gender non-conforming children and adolescents. In Singh, A. A. & Dickey, L. M. (Eds.), *Affirmative Psychological Practice with Transgender and Gender Nonconforming Clients*. Washington, D.C.: American Psychological Association.
- Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.
- Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary “Gender Management Service” (GeMS) in a major pediatric center. *Journal of Homosexuality*, 59(3), 321-336.
- Egan, S. K., & Perry, D. G. (2001). Gender identity: A multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology*, 37(4), 451-463.
- Elizur, Y., & Ziv, M. (2001). Family support and acceptance, gay male identity formation, and psychological adjustment: a path model. *Fam Process*, 40(2), 125-144.
- Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
- Fisher, C. (2015, August 31). Email – “Relevant APA Ethical Standards”.
- Floyd, F. J., & Bakeman, R. (2006). Coming-out across the life course: implications of age and historical context. *Arch Sex Behav*, 35(3), 287-296.
- Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health*, 101(8), 1481-1494.
- Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, 38(3), 230–236.
- Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: a meta-analysis. *Prev Sci*, 15(3), 350-363.
- Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43 573-589.
- Grossman, A., & D’Augelli, A. (2007). Transgender youth and life-threatening behaviors. *Suicide Life Threat Behav*, 375, 527–537.
- Grov, C., Bimbi, D. S., Nanin, J. E., & Parsons, J. T. (2006). Race, ethnicity, gender, and generational factors associated with the coming-out process among gay, lesbian, and bisexual individuals. *Journal of Sex Research*, 43, 115–121.
- Harari, E., Glenwick, D. S., & Cecero, J. J. (2014). The relationship between religiosity/spirituality and well-being in gay and heterosexual Orthodox Jews. *Mental Health, Religion and Culture*, 17(9), 886-897.
- Harper, G. W. (2007). Sex isn’t that simple: culture and context in HIV prevention interventions for gay and bisexual male adolescents *American Psychologist*, 62(8), 806.

- Harper, G. W., Jamil, O. B., & Wilson, B. D. M. (2007). Collaborative community-based research as activism: Giving voice and hope to lesbian, gay, and bisexual youth. *Journal of Lesbian and Gay Psychotherapy, 11*(3/4), 99-119.
- Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and Transgendered people and communities: a challenge for community psychology. *Am J Community Psychol, 31*(3-4), 243-252.
- Harrison, J., Grant, J., & Herman, J. L. (2012). A gender not listed here: Genderqueers, gender rebels and otherwise in the National Transgender Discrimination Study *LGBT Policy Journal at the Harvard Kennedy School, 2*, 13-24.
- Hatzenbuehler, M. L. (2011). The Social Environment and Suicide Attempts in Lesbian, Gay, and Bisexual Youth. *Pediatrics, 127*(5), 896-903. doi: 10.1542/peds.2010-3020
- Hatzenbuehler, M. L., Pachankis, J. E., & Wolff, J. (2012). Religious climate and health risk behaviors in sexual minority youths: A population-based study. *American Journal of Public Health, 102*(4), 657-663. doi: 10.2105/ajph.2011.300517
- Hembree, W. C., Cohen-Kettenis, P., Waal, H. A. D.-v. d., Gooren, L. J., Walter J. Meyer, I., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132-3154. doi: doi:10.1210/jc.2009-0345
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice, 43*(5), 460-467. doi: <http://dx.doi.org/10.1037/a0029597>
- Herek, G. M. (2010). Sexual orientation differences as deficits: Science and stigma in the history of American psychology. *Perspectives on Psychological Science, 5*, 693-699.
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . Olson, J. (2013). The Gender Affirmative Model: What we know and what we aim to learn. *Human Development, 56*, 285-290.
- Hidalgo, M. A., Kuhns, L. M., Kwon, S., Mustanski, B., & Garofalo, R. (2015). The impact of childhood gender expression on childhood sexual abuse and psychopathology among young men who have sex with men. *Child Abuse & Neglect, 46*, 103-112.
- Horowitz, J. L., & Newcomb, M. D. (2001). A multidimensional approach to homosexual identity. *J Homosex, 42*(2), 1-19.
- Hughes, I. A., Houk, C., Ahmed, S. F., & Lee, P. A. (2006). Consensus statement on management of intersex disorders. *Journal of pediatric urology, 2*(3), 148-162.
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academy of Sciences.
- Jarrett, V. (2015). Official White House response to enact Leelah's Law to ban all LGBTQ+ Conversion Therapy from <https://petitions.whitehouse.gov/response/response-your-petition-conversion-therapy>
- Kann, L., Olsen, E., McManus, T., Kinchen, S., Chyen, D., Harris, W., . . . Centers for Disease Control and Prevention (CDC). (2011). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12--youth risk behavior surveillance, selected sites, United States, 2001-2009. *MMWR Surveill Summ, 60*(7), 1-133.

- Knudson, G., De Cuypere, G., & Bockting, W. (2010). Recommendations for revision of the *DSM* diagnoses of Gender Identity Disorders: Consensus statement of the World Professional Association for Transgender Health. *International Journal of Transgenderism*, *12*(2), 115-118.
- Kohlberg, L. (1966). *A cognitive-developmental analysis of children's sex-role concepts and attitudes*. Stanford, CA: Stanford University.
- Kosciw, J. G., & Diaz, E. M. (2006). The 2005 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our schools. . New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kosciw, J. G., Greytak, E. A., & Diaz, E. M. (2009). Who, what, where, when, and why: Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence*, *38*(7), 976-988. doi: 10.1007/s10964-009-9412-1
- Kosciw, J. G., Greytak, E. A., Diaz, E. M., & Bartkiewicz, M. J. (2010). The 2009 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York, NY: GLSEN.
- Kosciw, J. G., Greytak, E. A., Palmer, N. A., & Boesen, M. J. (2014). The 2013 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York: Gay, Lesbian & Straight Education Network (GLSEN).
- Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research*, *49*, 244-254. doi: 10.1080/00224499.2011.596954
- Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology*, *52*(3), 378-388. doi: 10.1037/0022-0167.52.3.378
- Lee, P. A. (1980). Normal ages of pubertal events among American males and females. *Journal of Adolescent Health Care*, *1*(1), 26-29.
- Leibowitz, S., & Telingator, C. (2012). Assessing gender identity concerns in children and adolescents: evaluation, treatments, and outcomes. *Curr Psychiatry Rep*, *14*(2), 111-120.
- Leibowitz, S. F., & Spack, N. P. (2011). The development of a gender identity psychosocial clinic: Treatment issues, logistical considerations, interdisciplinary cooperation, and future initiatives. *Child Adolesc Psychiatric Clin N Am*, *20*, 701-724.
- Lev, A. (2005). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Clinical Practice Press.
- Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *Am J Prev Med*, *42*(3), 221-228.
- Majd, K., Marksamer, J., & Reyes, C. (2009). *Hidden Injustice: Lesbian, gay, bisexual, and transgender youth in juvenile courts*. New York: The Equity Project.
- Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., . . . Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, *49*(2), 115-123. doi: 10.1016/j.jadohealth.2011.02.005
- Maslowe, K.E. & Yarhouse, M.A. (2015). Christian parental reactions when a LGB child comes out. *The American Journal of Family Therapy*, *43*, 1-12.

- Mattison, A. M., & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. *Psychiatric Clinics of North America*.
- Meanley, S., Pingel, E. S., & Bauermeister, J. A. (2015). Psychological Well-being Among Religious and Spiritual-identified Young Gay and Bisexual Men. *Sexuality Research and Social Policy*. Advance online publication. 10.1007/s13178-015-0199-4
- Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender non-conforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 1010-1013.
- Menvielle, E. J., Tuerk, C., & Perrin, E. C. (2005). To the beat of a different drummer: The gender variant child. *Contemporary Pediatrics*, 22, 38-39, 41, 43, 45-46.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), 674.
- Minter, S. (2012). Supporting transgender children: new legal, social, and medical approaches. *J Homosex*, 59(3), 422-433.
- Moon, D. (2014). Beyond the dichotomy: six religious views of homosexuality. *J Homosex*, 61(9), 1215-1241.
- Mustanski, B., Birkett, M., Greene, G. J., Hatzenbuehler, M. L., & Newcomb, M. E. (2013). Envisioning an America without sexual orientation inequities in adolescent health. *American Journal of Public Health*, 104(2), 218-225. doi: 10.2105/ajph.2013.301625
- Mustanski, B., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *Am J Public Health*, 100(12), 2426-2432.
- Nakajima, G. A. (2003). The emergence of an international lesbian, gay, and bisexual psychiatric movement. *Journal of Gay & Lesbian Psychotherapy*, 7(1/2), 165-188.
- National Association of Social Workers. (2008). Code of Ethics of the National Association of Social Workers, from <http://www.naswdc.org/pubs/code/code.asp>
- Olson, K., Key, A., & Eaton, N. (2015). Gender cognition in transgender children. *Psychological Science*, 1-8.
- Ott, M. Q., Corliss, H. L., Wypij, D., Rosario, M., & Austin, S. B. (2010). Stability and change in self-reported sexual orientation identity in young people: Application of mobility metrics. *Archives of Sexual Behavior*, 40(3), 519-532. doi: 10.1007/s10508-010-9691-3
- Page, M. J. L., Lindahl, K. M., & Malik, N. M. (2013). The role of religion and stress in sexual Identity and mental health among lesbian, gay, and bisexual youth. *Journal of Research on Adolescence*, 23(4), 665-677. doi: 10.1111/jora.12025
- Parent, M. C., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles*, 68(11-12), 639-645. doi: 10.1007/s11199-013-0283-2
- Perrin, E. C. (2002). *Sexual orientation in child and adolescent health care*. New York: Kluwer/Plenum.
- Ray, N., & National Gay and Lesbian Task Force. (2006). *Lesbian, gay, bisexual, and transgender youth: An epidemic of homelessness*. Washington, DC: National Gay and Lesbian Task Force Policy Institute.

- Ream, G. L., & Savin-Williams, R. C. (2005). Reconciling Christianity and positive non-heterosexual identity in adolescence, with implications for psychological well-being. *Journal of Gay & Lesbian Issues in Education, 2*(3), 19-36. doi: 10.1300/J367v02n03_03
- Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood gender nonconformity: A risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics, 129*, 410-417. doi: 10.1542/peds.2011-1804
- Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: An 11-year longitudinal study. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*(2), 143-152. doi: 10.1016/j.jaac.2012.11.006
- Russell, S., Ryan, C., Toomey, R., Diaz, R., & Sanchez, J. (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health, 81*, 223-230.
- Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist, 46*(9), 1241-1257. doi: 10.1177/0002764202250667
- Russell, S. T., Toomey, R. B., Ryan, C., & Diaz, R. M. (2014). Being out at school: The implications for school victimization and young adult adjustment. *American Journal of Orthopsychiatry, 84*(6), 635-643. doi: 10.1037/ort0000037
- Ryan, C., & Diaz, R. (2005). *Family responses as a source of risk and resiliency for LGBT youth*. Paper presented at the Child Welfare League of America Preconference Institute, Washington, DC.
- Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. doi: 10.1542/peds.2007-3524
- Ryan, C., & Rees, R. A. (2012). Supportive families, healthy children: Helping Latter-day Saint families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Family Acceptance Project, Marian Wright Edelman Institute, San Francisco State University.
- Ryan, C., Russell, S., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205-213. doi: 10.1111/j.1744-6171.2010.00246.x
- Saewyc, E. M. (2007). Contested conclusions: Claims that can (and cannot) be made from the current research on gay, lesbian, and bisexual teen suicide attempts. *Journal of LBG Health Research, 3*(1), 79-87.
- Saewyc, E. M. (2011). Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. *Journal of Research on Adolescence, 21*, 256-272. doi: 10.1111/j.1532-7795.2010.00727
- Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology, 67*, 859-866.
- Salzburg, S. (2004). Learning that an adolescent child is gay or lesbian: The parent experience. *Social Work, 49*, 109-118.
- Salzburg, S. (2007). Narrative therapy pathways for reauthoring with parents of adolescents coming-out as lesbian, gay, and bisexual. *Contemporary Family Therapy, 29*, 57-69.

- Savin-Williams, R. (1994). Verbal and physical abuse as stressors in the lives of sexual minority youth: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62*, 261-269. doi: 10.1037/0022-006X.62.2.261
- Savin-Williams, R. C. (2001). *Mom, dad, I'm gay: How families negotiate coming out*. Washington, DC: American Psychological Press.
- Savin-Williams, R. C. (2005). *The New Gay Teenager*. Cambridge, MA.: Harvard University Press.
- Savin-Williams, R. C., & Ream, G. L. (2006). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior, 36*(3), 385-394. doi: 10.1007/s10508-006-9088-5
- Schlatter, E., & Southern Poverty Law Center. (2014, Dec. 13). North Carolina church members indicted for kidnapping and assaulting gay man, *Salon*. Retrieved from http://www.salon.com/2014/12/13/north_carolina_church_members_indicted_for_kidnapping_and_assaulting_gay_man_partner/
- Schope, R. D. (2002). The decision to tell: Factors influencing the disclosure of sexual orientation by gay men. *Journal of Gay and Lesbian Social Services, 14*(1), 1-22.
- Schope, R. D., & Eliason, M. J. (2000). Thinking versus acting: Assessing the relationship between heterosexual attitudes and behaviors towards homosexuals. *Journal of Gay & Lesbian Social Services, 11*, 69-92.
- Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301-311. doi: doi:10.1007/s11199-008-9501-8
- Siegel, M., & Robinson, J. (1987). Order effects in children's gender-constancy responses *Developmental Psychology, 23*, 283-286. doi: 10.1037/0012-1649.23.2.283
- Simons, L. K., Leibowitz, S. F., & Hidalgo, M. A. (2014). Understanding gender variance in children and adolescents. *Pediatr Ann, 43*(6), 00904481-20140522.
- Siraj, A. (2012). "I Don't Want to Taint the Name of Islam": The Influence of Religion on the Lives of Muslim Lesbians. *Journal of Lesbian Studies, 16*(4), 449-467.
- Smith, T. E., & Leaper, C. (2006). Self-perceived gender typicality and the peer context during adolescence. *Journal of Research on Adolescence, 16*, 91-104.
- Smith, Y. L., van Goozen, S. H., & Cohen-Kettenis, P. T. (2001). Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry, 40*(4), 472-481.
- Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations, 64*(3), 420-430. doi: 10.1111/fare.12124
- Spack, N. P., Edwards-Leeper, L., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. doi: 10.1542/peds.2011-0907
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry, 16*(4), 499-516.
- Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Arch Sex Behav, 40*(4), 649-650. doi: 10.1007/s10508-011-9752-2

- Steensma, T. D., Kreukels, B. P., de Vries, A. L., & Cohen-Kettenis, P. T. (2013). Gender identity development in adolescence. *Horm Behav*, *64*(2), 288-297.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*, *52*(6), 582-590.
- Stewart, B. T., Heck, N. C., & Cochran, B. N. (2015). A comparison of sexual minority youth who attend religiously affiliated schools and their nonreligious-school-attending counterparts *Journal of LGBT Youth*, *12*(2), 170-188.
- Szalacha, L. A. (2003). Safer sexual diversity climates: Lessons learned from an evaluation of Massachusetts Safe Schools Program for Gay and Lesbian Students. *American Journal of Education*, *110*, 58-88.
- Toomey, R. B., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment. *Developmental Psychology*, *46*(6), 1580-1589. doi: 10.1037/a0020705
- Toomey, R. B., Ryan, C., Diaz, R. M., & Russell, S. T. (2011). High school Gay–Straight Alliances (GSAs) and young adult well-being: An examination of GSA presence, participation, and perceived effectiveness. *Applied Developmental Science*, *15*(4), 175-185. doi: 10.1080/10888691.2011.607378
- Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papadimitriou, M. (2012). Impacts of strong parental support for trans youth: A report prepared for Children’s Aid Society New York: Children’s Aid Society.
- Troiden, R. R. (1988). Homosexual identity development. *Journal of Adolescent Health Care*, *9*, 105-113.
- Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality*, *17*(1), 43-73.
- Vance, S. R., Jr., Ehrensaft, D., & Rosenthal, S. M. (2014). Psychological and medical care of gender nonconforming youth. *Pediatrics*, *134*(6), 1184-1192.
- Vrangalova, Z., & Savin-Williams, R. C. (2012). Mostly heterosexual and mostly gay/lesbian: Evidence for new sexual orientation identities. *Archives of sexual behavior*, *41*(1), 85-101.
- Wallace, R., & Russell, H. (2013). Attachment and shame in gender-nonconforming children and their families: toward a theoretical framework for evaluating clinical interventions. *Int J Transgenderism*, *14*(3), 113–126.
- Wallien, M. S. C., & Cohen-Kettenis, P. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(12), 1413-1423.
- Walls, N. E., Kane, S. B., & Wisneski, H. (2010). Gay-straight alliances and school experiences of sexual minority youth. *Youth & Society*, *41*, 307–332. doi: DOI: 10.1177/0044118X09334957
- Wilbur, S., Ryan, C., & Marksamer, J. (2006). Serving LGBT youth in out-of-home care: Best practices guide. Washington, DC: Child Welfare League of America.
- Willoughby, B. L., Doty, N. D., & Malik, N. M. (2010). Victimization, family rejection, and outcomes of gay, lesbian, and bisexual young people: the role of negative GLB identity. *Journal of GLBT Family Studies*, *6*, 403-424.
- World Health Organization. (1992). The International Classification of Disease 10th Revision (ICD 10). *Classification of mental and behavioural disorders—Clinical descriptions and diagnostic guidelines*. Geneva: WHO.

- World Professional Association for Transgender Health, I., . (2008). WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A., from http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947
- Yakushko, O. (2005). Influence of social support, existential well-being, and stress over sexual orientation on self esteem of gay, lesbian, and bisexual individuals. *International Journal for the Advancement of Counselling*, 27(1), 131-143.
- Yarhouse, M. A. (1998). When families present with concerns about an adolescent's experience of same-sex attraction. *The American Journal of Family Therapy*, 26, 321-330.
- Yarhouse, M. A. (2015a, July 7 and August 6). [Family approaches in therapeutic intervention].
- Yarhouse, M.A. (2015b, August. Family and Community Acceptance – focus on conventionally religious communities. Unpublished paper.
- Yarhouse, M.A. (2015c). Understanding gender dysphoria: Navigating transgender issues in a changing culture. Downer's Grove, IL: InterVarsity Press.
- Yarhouse, M. A., & Tan, E. S. N. (2005). Addressing religious conflicts in adolescents who experience sexual identity confusion. *Professional Psychology: Research and Practice*, 6, 530-536.
- Yunger, J. L., Carver, P. R., & Perry, D. G. (2004). Does gender identity influence children's psychological well-being? *Dev Psychol*, 40(4), 572-582.
- Zucker, K. (2004). Gender identity development and issues. *Child Adolesc Psychiatric Clin N Am*, 13, 551-568.
- Zucker, K. (2005). Gender identity disorder in children and adolescents. *Annu Rev Clin Psychol*, 1, 467-492.
- Zucker, K., & Bradley, S. (1995). Gender identity disorder and psychosexual problems in children and adolescents. New York: The Guilford Press.

Appendix A: Glossary of Terms

Cisgender: A person whose gender identity, gender expression, and sex assigned at birth all align.

Conversion therapy: Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

Gender dysphoria: Psychological distress due to the incongruence between one's body and gender identity.

Gender expression: The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

Gender identity: A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

Gender nonconforming, gender diverse: A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth which may or may not differ from their gender identity later in life.

Questioning: Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring one's sexual orientation and/or gender identity.

Sex assigned at birth: The sex designation given to an individual at birth.

Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

Transgender: A person who feels that their gender identity does not match their physical body and differs from the gender that others observed and gave them at birth (assigned or birth gender).

Transition: A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

Appendix B: Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with SAMHSA, U.S. Department of Health and Human Services (HHS). David Lamont Wilson served as the Government Project Officer. Elliot Kennedy served as the Task Lead.

The lead scientific writer for this report was Laura Jadwin-Cakmak, MPH with support from W. Alexander Orr, MPH as the Task Lead from Abt Associates.

The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, Director LGBT Office) and Judith Glassgold, PsyD (Associate Executive Director, Government Relations, Public Interest Directorate).

The Expert Panel consisted of a panel of researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel included experts with a background in family therapy and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark A. Yarhouse, PsyD.

Endnotes

1. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, particularly common when youth are the population of focus.
7. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that “sexual orientation by itself is not to be considered a disorder.” Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD (Cochran, S. D., Drescher, J., Kismödi, Giami, García-Moreno, Atalla, . . . , & Reed, 2014).
10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one’s assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.

12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term “gender dysphoria” (lowercase) is used to broadly describe the discomfort or distress caused by the discrepancy between a person’s gender identity and that person’s sex assigned at birth and/or primary or secondary sex characteristics. We will use the term “individuals with gender dysphoria” throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.
13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.
16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources [Strengthening Protection against Discrimination](#).
20. For example, “A Practitioner’s Resource Guide: Helping Families to Support Their LGBT Children” <http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS>. Another helpful resources is “Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children” http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.
21. See for instance, American Psychological Association (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.
22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at <https://www.aamc.org/download/414172/data/lgbt.pdf>.
23. Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at <https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf>.



HHS Publication No. (SMA) 15-4928

EXHIBIT 23



WMA STATEMENT ON TRANSGENDER PEOPLE

Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015

PREAMBLE

In most cultures, an individual's sex is assigned at birth according to primary physical sex characteristics. Individuals are expected to identify with their assigned sex (gender identity) and behave according to specific cultural norms strongly associated with this (gender expression). Gender identity and gender expression make up the concept of "gender" itself.

There are individuals who experience different manifestations of gender that do not conform to those typically associated with their sex assigned at birth. The term "transgender" refers to people who experience gender incongruence, which is defined as a marked mismatch between one's gender and the sex assigned at birth.

While conceding that this is a complex ethical issue, the WMA would like to acknowledge the crucial role played by physicians in advising and consulting with transgender people and their families about desired treatments. The WMA intends this statement to serve as a guideline for patient-physician relations and to foster better training to enable physicians to increase their knowledge and sensitivity toward transgender people and the unique health issues they face.

Although being transgender does not in itself imply any mental impairment, transgender people may require counseling to help them understand their gender and to address the complex social and relational issues that are affected by it. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5) uses the term “gender dysphoria” to classify people who experience clinically significant distress resulting from gender incongruence.

Evidence suggests that treatment with sex hormones or surgical interventions can be beneficial to people with pronounced and long-lasting gender dysphoria who seek gender transition. However, transgender people are often denied access to appropriate and affordable transgender healthcare (e.g. sex hormones, surgeries, mental healthcare) due to, among other things, the policies of health insurers and national social security benefit schemes, or to a lack of relevant clinical and cultural competence among healthcare providers. Transgender persons may be more likely to forego healthcare due to fear of discrimination.

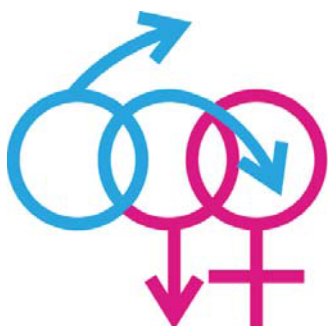
Transgender people are often professionally and socially disadvantaged, and experience direct and indirect discrimination, as well as physical violence. In addition to being denied equal civil rights, anti-discrimination legislation, which protects other minority groups, may not extend to transgender people. Experiencing disadvantage and discrimination may have a negative impact upon physical and mental health.

RECOMMENDATIONS

1. The WMA emphasises that everyone has the right to determine one’s own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual’s right to self-identification with regards to gender.
2. The WMA asserts that gender incongruence is not in itself a mental disorder; however it can lead to discomfort or distress, which is referred to as gender dysphoria (DSM-5).

4. The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria.
5. The WMA explicitly rejects any form of coercive treatment or forced behaviour modification. Transgender healthcare aims to enable transgender people to have the best possible quality of life. National Medical Associations should take action to identify and combat barriers to care.
6. The WMA calls for the provision of appropriate expert training for physicians at all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender healthcare.
7. The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights. As role models, individual physicians should use their medical knowledge to combat prejudice in this respect.
8. The WMA reaffirms its position that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation (WMA Statement on Forced and Coerced Sterilisation). This also includes sterilisation as a condition for rectifying the recorded sex on official documents following gender reassignment.
9. The WMA recommends that national governments maintain continued interest in the healthcare rights of transgender people by conducting health services research at the national level and using these results in the development of health and medical policies. The objective should be a responsive healthcare system that works with each transgender person to identify the best treatment options for that individual.

EXHIBIT 24



WPATH WORLD PROFESSIONAL
ASSOCIATION for
TRANSGENDER HEALTH

21 December 2016

Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.

The World Professional Association for Transgender Health (WPATH) is an international, interdisciplinary, professional association devoted to the understanding and treatment of individuals with Gender Dysphoria (GD). Founded in 1979, and currently with over 1500 medical, mental health, social scientist, and legal professional members, all of whom are engaged in clinical practice and/or research that affects the lives of transgender and transsexual people, WPATH is the oldest professional association in the world that continuously has been concerned with this clinical specialty.

Gender Dysphoria (GD), often associated with transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5, 2013), published by the American Psychiatric Association. Previous nomenclature for gender dysphoria includes transsexualism and gender identity disorder (GID), conditions which are also recognized in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, published by the World Health Organization, of which the United States is a member. Nomenclature is subject to changes, and new terminology and classifications may be arrived at by various medical organizations or administrative bodies, but these events shall not in themselves change the meaning or intent of this WPATH statement.

The criteria currently listed for GD are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity. Gender identity is common to all human beings, is developed in early childhood, and is thought to be firmly established in most people—transgender or not—by age 4,¹ though for some transgender individuals, gender identity may remain somewhat fluid for many years,² while for others, conditions specific to individual lives may constrain a person from acknowledging or even recognizing any gender dysphoria they may experience until they

¹ American Academy of Pediatrics, 1999.

² Fraser L and De Cuypere G, 2016.

are well into adulthood. The various The DSM-5 descriptive criteria for gender dysphoria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment that is frequently, though not universally, associated with transsexual and transgender conditions.

The WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (SOC) were first issued in 1979, and articulate the “professional consensus about the psychiatric, psychological, medical and surgical management of GD.” Periodically revised to reflect evolution in evidence-based clinical practice and scientific research, the Standards also unequivocally reflect this Association’s conclusion that treatment is medically necessary. The most recent version of the SOC (Version 7) was published in 2012.³ WPATH recommends that medical and mental health providers and administrators check www.wpath.org regularly to ensure they are working with the most up-to-date revision of the SOC.

MEDICAL NECESSITY is a term common to health care coverage and insurance policies in the United States. A common definition of medical necessity as used by insurers is:

“[H]ealth care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

“Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.”⁴

The current Board of Directors of the WPATH herewith expresses its considered opinion based on clinical and peer reviewed evidence that gender affirming/confirming treatments and surgical procedures, properly indicated and performed as provided by the Standards of Care, have proven to be beneficial and effective in the treatment of individuals with transsexualism or gender dysphoria. Gender affirming/confirming surgery, also known as sex reassignment surgery, plays an undisputed role in contributing toward favorable outcomes. Treatment includes legal name and sex or gender change on identity

³ Coleman E, Bocking W, Botzer M, et al. 2012.

⁴ Definition from Blue Cross Blue Shield Settlement (Section 7.16(a)) available at www.hmosettlements.com

documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures required to effectively treat an individual's gender dysphoria. Neither genital appearance nor reconstruction is required for social gender recognition, and so no surgery should be a prerequisite for identity document or record changes; changes to documentation so that identity documents reflect the individual's current lived expression and experience are crucial aids to social functioning, and can be a necessary component of the social transition and/or pre-surgical process. Delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

In addition to hormonal balancing, medically necessary gender affirming/confirming surgical procedures are described in section XI of the SOC. These procedures include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient, including nipple resizing or placement of breast prostheses, as necessary; genital reconstruction by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, scrotoplasty, and penile and testicular prostheses, as necessary; facial hair removal, certain facial plastic reconstruction, voice therapy and/or surgery, and gender affirming counseling or psychotherapeutic treatment, as appropriate to the patient.

“Non-genital surgical procedures are routinely performed... notably, subcutaneous mastectomy in female-to-male transsexuals, and facial feminization surgery, and/or breast augmentation in male-to-female transsexuals. These surgical interventions are often of greater practical significance in the patient's daily life than reconstruction of the genitals.”⁵

It is important to understand that every patient will not have a medical need for identical procedures. Clinically appropriate treatments must be determined on an individualized and contextual basis, in consultation with the patient's medical providers.

The medical procedures attendant to gender affirming/confirming surgeries are not “cosmetic” or “elective” or “for the mere convenience of the patient.” These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.⁶ In some cases, such surgery is the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.

These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals

⁵ Monstrey S, De Cuypere G, Ettner R (eds). (2007).

⁶ Victoria L. Davidson v. Aetna Insurance. (1979). Judicial finding that “...the treatment and surgery...is of a medical nature and is feasible and required for the health and well-being of the patient.”

found significantly improved quality of life following cross-gender hormonal therapy.⁷ Moreover, those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health.⁸

“[Hormone therapy and surgical] SRS [sex reassignment surgery] is an effective treatment for transsexualism and the only treatment that has been evaluated empirically with large clinical case series.”⁹

Available routinely in the United States and in many other countries, these treatments are cost effective rather than cost prohibitive. In the United States, numerous large employers (e.g., City and County of San Francisco, University of California, Emory University, University of Michigan, IBM, Johnson & Johnson, Bank of America, Apple, and hundreds more¹⁰) have negotiated contracts with their insurance carriers to enable medically necessary treatment for transsexualism and/or GD to be provided to covered individuals. As more carriers realize the validity and effectiveness of treatment (Aetna, Cigna, United Healthcare, and many others now have medical guidelines for transgender care), coverage is being offered, often at very low or no additional premium cost.¹¹ More than 15 states currently have regulations in place prohibiting insurance carriers from offering policies that contain exclusions restricting transgender people from accessing needed healthcare.¹² Further, in a decision rendered 30 May 2014, the US Department of Health and Human Services Departmental Appeals Board found that “transsexual surgery” should not be considered experimental or dangerous as it has been proven to be an effective treatment for gender dysphoria when properly diagnosed and administered, lifting a longstanding Medicare program ban on this treatment.¹³ More recently, in June, 2016, the Department of Defense lifted its ban on transgender military service, and will offer medically necessary hormone and surgical therapies for transgender active duty and reserve servicemen and women.¹⁴

⁷ Keo-Meier C L, et al. (2014).

⁸ Newfield E, et al. (2006).

⁹ Gijs L & Brewaeys A. (2007).

¹⁰ See the latest Corporate Equality Index, maintained by the Human Rights Campaign Workplace Project at www.hrc.org for the list of companies that have scored 100% in current and past years (since 2002).

¹¹ Herman JL. (2013).

¹² See <http://www.transequality.org/blog/pennsylvania-makes-17-states-dc-banning-trans-health-exclusions-hawaii-likely-next-0> for further information.

¹³ www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf; last accessed 11-03-2016.

¹⁴ Department of Defense Instruction (DoDI) 1300.28, “In-Service Transition for Transgender Service Members,” June 30, 2016, and Directive-Type Memorandum (DTM) 16-005, “Military Service of Transgender Service Members,” June 30, 2016.

“Professionals who provide services to patients with gender conditions understand the necessity of SRS, and concur that it is reconstructive, and as such should be reimbursed, as would any other medically necessary treatment.”¹⁵

Professional associations that have issued statements in support of the WPATH Standards of Care include the American Medical Association, the Endocrine Society, the American Psychiatric Association, the American Psychological Association, the American Academy of Family Physicians, the National Commission of Correctional Health Care, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, the American Society of Plastic Surgeons, and the World Health Organization.

The WPATH Board of Directors urges health insurance carriers and healthcare providers in the United States to eliminate transgender or transsexual exclusions from their policy documents and medical guidelines, and to provide coverage for transgender patients; also to include in their policy documents and medical guidelines the medically prescribed sex reassignment or gender affirming/confirming services necessary for subscribers’ treatment and well-being; and to ensure that ongoing healthcare, both routine and specialized, is readily accessible and affordable to all their subscribers on an equal basis.

¹⁵ Monstrey S, De Cuypere G, Ettner R (eds). (2007).

This position statement constitutes the professional and clinical opinions of the signers below, comprising all members of the WPATH Board of Directors and Executive Officers as of this date, 21 December 2016.

Gail Knudson, M.D. (Canada) President
Vin Tangpricha, M.D., Ph.D. (USA) President Elect
Jamison Green, Ph.D., M.F.A. (USA) Past President
Walter Pierre Bouman, M.D. (UK) Treasurer
Randi Ettner, Ph.D. (USA) Secretary
Tamara Adrian, J.D. (Venezuela)
Luke Allen M.A. (USA) Student Representative
Griet DeCuypere, M.D., Ph.D. (Belgium) EPATH Representative
Tone Maria Hansen (Norway)
Dan Karasic, M.D. (USA)
Baudewijntje Kreukels, Ph.D. (Netherlands)
Katherine Rachlin, Ph.D. (USA)
Loren Schechter, M.D. (USA)
Sam Winter, Ph.D. (Australia)

References:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. Washington, DC:author.

Coleman E, Bockting W, Botzer M, Cohen-Kettenis, P, et al. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. *International Journal of Transgenderism*, 11(1), 1-7.

Ettner R. and Guillamon A. (2016). Theories of the Etiology of Transgender Identity. In Ettner R et al. (eds.) *Principles of Transgender Medicine and Surgery: Second Edition*. New York: Haworth Press; pp3-15.

Ettner R, Monstrey S, Eyler A (eds.). (2007). *Principles of Transgender Medicine and Surgery*. New York: Haworth Press.

Ettner R, Monstrey S, Coleman E (eds.). (2016). *Principles of Transgender Medicine and Surgery: Second Edition*. New York: Haworth Press.

Fraser L and De Cuypere G. (2016). Psychotherapy with Transgender People. In Ettner R et al (eds.) *Principles of Transgender Medicine and Surgery*. New York: Haworth Press; pp120-136.

Gijs L and Brewaeys A. (2007). Surgical Treatment of Gender Dysphoria in Adults and Adolescence: Recent Developments, Effectiveness, and Challenges, *Annual Review of Sex Research*, 18:1, 178-224. doi:10.1037/a0037599

Herman JL. (2013). Costs and Benefits of Providing Transition-related Health Care Coverage in Employee Health Benefit Plans: Findings from a Survey of Employers. The Williams Institute, UCLA School of Law. Available at <http://williamsinstitute.law.ucla.edu/category/research/transgender-issues/page/2/>; last accessed 11-03-2016.

Keo-Meier C L, et al. (2014). Testosterone Treatment and MMPI-2 Improvement in Transgender Men: A Prospective Controlled Study. *Journal of Consulting and Clinical Psychology* 2015, Vol. 83, No. 1, 143-156.

Monstrey S, De Cuypere G, Ettner R. (2007). Surgery: General Principles. In Ettner R et al (eds.) *Principles of Transgender Medicine and Surgery*. New York: Haworth Press; pp89-104.

Newfield E, Hart, S, Dibble S, Kohler L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, 15(9): 1447-57; November, 2006.

Schor, EL (ed.). (1999). *Caring for your school age child: Ages 5-12*. [American Academy of Pediatrics] New York: Bantam Books.

Victoria L. Davidson v. Aetna Life & Casualty Insurance Co. 101 Misc.2d 1, 420 N.Y.S. 2d 450 (Sup. Ct., 1979).

EXHIBIT 25



WPATH WORLD PROFESSIONAL
ASSOCIATION for
TRANSGENDER HEALTH

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health





Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version¹ | www.wpath.org

¹ This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

Table of Contents

I. Purpose and Use of the Standards of Care	1
II. Global Applicability of the Standards of Care	3
III. The Difference between Gender Nonconformity and Gender Dysphoria	4
IV. Epidemiologic Considerations	6
V. Overview of Therapeutic Approaches for Gender Dysphoria	8
VI. Assessment and Treatment of Children and Adolescents with Gender Dysphoria	10
VII. Mental Health	21
VIII. Hormone Therapy	33
IX. Reproductive Health	50
X. Voice and Communication Therapy	52
XI. Surgery	54
XII. Postoperative Care and Follow-Up	64
XIII. Lifelong Preventive and Primary Care	65
XIV. Applicability of the <i>Standards of Care</i> to People Living in Institutional Environments	67
XV. Applicability of the <i>Standards of Care</i> to People With Disorders of Sex Development	69
References	72
Appendices:	
A. Glossary	95
B. Overview of Medical Risks of Hormone Therapy	97
C. Summary of Criteria for Hormone Therapy and Surgeries	104
D. Evidence for Clinical Outcomes of Therapeutic Approaches	107
E. Development Process for the <i>Standards of Care, Version 7</i>	109

Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)¹ is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The SOC are based on the best available science and expert professional consensus.² Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the SOC to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the SOC.

The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.



Global Applicability of the Standards of Care

While the SOC are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the SOC to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the SOC according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The SOC are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the SOC. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the SOC are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.



The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that “the expression of gender characteristics, including identities, that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative.”

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in “minority stress” (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one’s relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases (ICD)* (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV

Epidemiologic Considerations

Formal epidemiologic studies on the incidence³ and prevalence⁴ of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one’s gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)

4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wälinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.



Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a “transition,” because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one’s gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the SOC offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.⁵ Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

⁵ Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;
2. Trained in childhood and adolescent developmental psychopathology;
3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).
2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.
3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.
4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.
5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).
6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.
2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).
3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.
2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.
3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.
4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.
5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions.* These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.
2. *Partially reversible interventions.* These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).
3. *Irreversible interventions.* These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for puberty suppressing hormones

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
2. Gender dysphoria emerged or worsened with the onset of puberty;
3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, monitoring, and risks for puberty suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII

Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the SOC focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.
2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.
3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.
4. Documented supervised training and competence in psychotherapy or counseling.
5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.
6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess gender dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called “a qualified mental health professional”) are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider’s health care team.

2. Provide information regarding options for gender identity and expression and possible medical interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If applicable, assess eligibility, prepare, and refer for hormone therapy

The SOC provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

5. If applicable, assess eligibility, prepare, and refer for surgery

The SOC also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The SOC do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).
- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy is not an absolute requirement for hormone therapy and surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The SOC do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

2. Goals of psychotherapy for adults with gender concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing

gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family therapy or support for family members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).

5. Follow-up care throughout life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. Etherapy, online counseling, or distance counseling

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenemy, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

Other Tasks of the Mental Health Professional

1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide information and referral for peer support

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the SOC have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII

Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the SOC. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the SOC, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship between the Standards of Care and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The SOC are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the SOC). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.
- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES ^A

Effect	Expected Onset^B	Expected Maximum Effect^B
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months ^C	variable
Increased muscle mass/strength	6-12 months	2-5 years ^D
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

^A Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society.*

^B Estimates represent published and unpublished clinical observations.

^C Highly dependent on age and inheritance; may be minimal.

^D Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES^A

Effect	Expected Onset ^B	Expected Maximum Effect ^B
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years ^C
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years ^D
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

^A Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society.*

^B Estimates represent published and unpublished clinical observations.

^C Significantly dependent on amount of exercise.

^D Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaber, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	Venous thromboembolic disease ^A Gallstones Elevated liver enzymes Weight gain Hypertriglyceridemia	Polycythemia Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors ^B	Cardiovascular disease	
Possible increased risk	Hypertension Hyperprolactinemia or prolactinoma ^A	Elevated liver enzymes Hyperlipidemia
Possible increased risk with presence of additional risk factors ^B	Type 2 diabetes^A	Destabilization of certain psychiatric disorders ^C Cardiovascular disease Hypertension Type 2 diabetes
No increased risk or inconclusive	Breast cancer	Loss of bone density Breast cancer Cervical cancer Ovarian cancer Uterine cancer

^A Risk is greater with oral estrogen administration than with transdermal estrogen administration.

^B Additional risk factors include age.

^C Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyer, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.
2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).
3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.
4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.
5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.
6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the SOC (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens*, below).

4. Initiating hormonal feminization/masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk assessment and modification for masculinizing hormone therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and risk monitoring during feminizing hormone therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and risk monitoring during masculinizing hormone therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or economic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for feminizing hormone therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications (“anti-androgens”)

A combination of estrogen and “anti-androgens” is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.
- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).
- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadotropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.
- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for masculinizing hormone therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and compounded hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX

Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignancies that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.



Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.
2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the SOC; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissing, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI

Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the SOC. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve “ideal” results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversible, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the male-to-female (MtF) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the female-to-male (FtM) patient, surgical procedures may include the following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered “aesthetic” surgery or “reconstructive” surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The SOC do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for breast/chest surgery (one referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

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

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one’s gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient’s experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruyssen, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dysphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or “male chest contouring” procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled “purely aesthetic,” these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long

distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such

as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hildebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the Standards of Care to People Living in Institutional Environments

The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the SOC can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A “freeze frame” approach is not considered appropriate care in most situations (*Kosilek v. Massachusetts Department of Corrections/Maloney*, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the Standards of Care to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPE1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the “disorder” label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the *SOC*

Previously, individuals with a DSD who also met the *DSM-IV-TR*'s behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a “Gender Identity Disorder - Not Otherwise Specified.” They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the SOC.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the SOC. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).



References

- Abramowitz, S. I. (1986). Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology*, 54(2), 183-189. doi:10.1037/0022-006X.54.2.183
- Adler, R. K., Hirsch, S., & Mordaunt, M. (2006). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Pub.
- ACOG Committee of Gynecologic Practice. (2005). Committee opinion #322: Compounded bioidentical hormones. *Obstetrics & Gynecology*, 106(5), 139-140.
- American Academy of Family Physicians. (2005). *Definition of family medicine*. Retrieved August 10, 2009, from <http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html>

- American Medical Association. (2008). *Resolution 122 (A-08)*. Retrieved from <http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (4th ed., text rev.). Washington, DC: Author.
- American Speech-Language-Hearing Association. (2011). *Scope of practice*. Retrieved from www.asha.org
- Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the council of representatives, February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the board of directors. *American Psychologist*, 64, 372-453. doi:10.1037/a0015932
- Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology*, 164(4), 635-642. doi:10.1530/EJE-10-1038
- Baba, T., Endo, T., Honnma, H., Kitajima, Y., Hayashi, T., Ikeda, H., . . . Saito, T. (2007). Association between polycystic ovary syndrome and female-to-male transsexuality. *Human Reproduction*, 22(4), 1011-1016. doi:10.1093/humrep/del474
- Bakker, A., Van Kesteren, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica*, 87(4), 237-238. doi:10.1111/j.1600-0447.1993.tb03364.x
- Balen, A. H., Schachter, M. E., Montgomery, D., Reid, R. W., & Jacobs, H. S. (1993). Polycystic ovaries are a common finding in untreated female to male transsexuals. *Clinical Endocrinology*, 38(3), 325-329. doi:10.1111/j.1365-2265.1993.tb01013.x
- Basson, R. (2001). Towards optimal hormonal treatment of male to female gender identity disorder. *Journal of Sexual and Reproductive Medicine*, 1(1), 45-51.
- Basson, R., & Prior, J. C. (1998). Hormonal therapy of gender dysphoria: The male-to-female transsexual. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 277-296). New York: Garland Publishing, Inc.
- Benjamin, H. (1966). *The transsexual phenomenon*. New York: Julian Press.
- Besnier, N. (1994). Polynesian gender liminality through time and space. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 285-328). New York: Zone Books.
- Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *Siecus Report*, 28(1), 3-7.

- Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies*, 17(4), 211-224. doi:10.1016/j.sexol.2008.08.001
- Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: The Haworth Press.
- Bockting, W. O., & Goldberg, J. M. (2006). Guidelines for transgender care (special issue). *International Journal of Transgenderism*, 9(3/4).
- Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, 9(3/4), 35-82. doi:10.1300/J485v09n03_03
- Bolin, A. (1988). *In search of Eve* (pp. 189-192). New York: Bergin & Garvey.
- Bolin, A. (1994). Transcending and transgenering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 447-486). New York: Zone Books.
- Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York: Routledge.
- Bosinski, H. A. G., Peter, M., Bonatz, G., Arndt, R., Heidenreich, M., Sippell, W. G., & Wille, R. (1997). A higher rate of hyperandrogenic disorders in female-to-male transsexuals. *Psychoneuroendocrinology*, 22(5), 361-380. doi:10.1016/S0306-4530(97)00033-4
- Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.
- Brown, G. R. (2009). Recommended revisions to The World Professional Association for Transgender Health's Standards of Care section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism*, 11(2), 133-139. doi:10.1080/15532730903008073
- Brown, G. R. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism*, 12(1), 31-39. doi:10.1080/15532731003688970
- Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.
- Callen Lorde Community Health Center. (2000). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

- Callen Lorde Community Health Center. (2011). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf
- Canadian Association of Speech-Language Pathologists and Audiologists. <http://www.caspa.ca/>
- Carew, L., Dacakis, G., & Oates, J. (2007). The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. *Journal of Voice*, 21(5), 591-603. doi:10.1016/j.jvoice.2006.05.005
- Carnegie, C. (2004). Diagnosis of hypogonadism: Clinical assessments and laboratory tests. *Reviews in Urology*, 6(Suppl 6), S3-8.
- Cattrall, F. R., & Healy, D. L. (2004). Long-term metabolic, cardiovascular and neoplastic risks with polycystic ovary syndrome. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 18(5), 803-812. doi:10.1016/j.bpobgyn.2004.05.005
- Center of Excellence for Transgender Health, UCSF. (2011). *Primary care protocol for transgender health care*. Retrieved from <http://transhealth.ucsf.edu/trans?page=protocol-00-00>
- Chiñas, B. (1995). Isthmus Zapotec attitudes toward sex and gender anomalies. In S. O. Murray (Ed.), *Latin American male homosexualities* (pp. 293-302). Albuquerque, NM: University of New Mexico Press.
- Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism*, 3(1), 2-17.
- Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(4), 391-391. doi:10.1097/00004583-200104000-00006
- Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5 α -reductase-2 deficiency and 17 β -hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior*, 34(4), 399-410. doi:10.1007/s10508-005-4339-4
- Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington & H. C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695-725). New York: Cambridge University Press.
- Cohen-Kettenis, P. T. (2010). Psychosocial and psychosexual aspects of disorders of sex development. *Best Practice & Research Clinical Endocrinology & Metabolism*, 24(2), 325-334. doi:10.1016/j.beem.2009.11.005
- Cohen-Kettenis, P. T., & Kuiper, A. J. (1984). Transseksualiteit en psychotherapie. *Tijdschrift Voor Psychotherapie*, 10, 153-166.

- Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31(1), 41-53. doi:10.1023/A:1021769215342
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage Publications, Inc.
- Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior*, 39(2), 499-513. doi:10.1007/s10508-009-9562-y
- Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior*, 40(4), 843-847. doi:0.1007/s10508-011-9758-9
- Cohen-Kettenis, P. T., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national, cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry*, 11(3), 397-405. doi:10.1177/1359104506059135
- Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior*, 26(1), 13-26.
- Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior*, 21(3), 313-321.
- Costa, L. M., & Matzner, A. (2007). *Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*. Binghamton, NY: Haworth Press.
- Currah, P., Juang, R. M., & Minter, S. (2006). *Transgender rights*. Minneapolis, MN: University of Minnesota Press.
- Currah, P., & Minter, S. (2000). Unprincipled exclusions: The struggle to achieve judicial and legislative equality for transgender people. *William and Mary Journal of Women and Law*, 7, 37-60.
- Dacakis, G. (2000). Long-term maintenance of fundamental frequency increases in male-to-female transsexuals. *Journal of Voice*, 14(4), 549-556. doi:10.1016/S0892-1997(00)80010-7
- Dahl, M., Feldman, J. L., Goldberg, J. M., & Jaber, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism*, 9(3), 111-134. doi:10.1300/J485v09n03_06

- Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615-644). Philadelphia: Saunders.
- Davies, S., & Goldberg, J. M. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism*, 9(3-4), 167-196. doi:10.1300/J485v09n03_08
- de Bruin, M. D., Coerts, M. J., & Greven, A. J. (2000). Speech therapy in the management of male-to-female transsexuals. *Folia Phoniatica Et Logopaedica*, 52(5), 220-227.
- De Cuyper, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior*, 34(6), 679-690. doi:10.1007/s10508-005-7926-5
- De Cuyper, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., . . . Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry*, 22(3), 137-141. doi:10.1016/j.eurpsy.2006.10.002
- De Cuyper, G., & Vercruyse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH standards of care. *International Journal of Transgenderism*, 11(3), 194-205. doi:10.1080/15532730903383781
- de Lignières, B. (1999). Oral micronized progesterone. *Clinical Therapeutics*, 21(1), 41-60. doi:10.1016/S0149-2918(00)88267-3
- De Sutter, P. (2009). Reproductive options for transpeople: Recommendations for revision of the WPATH's standards of care. *International Journal of Transgenderism*, 11(3), 183-185. doi:10.1080/15532730903383765
- De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism*, 6(3), retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no03_02.htm
- de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism*, 9(3-4), 83-94. doi:10.1300/J485v09n03_04
- de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*. Advance online publication. doi:10.1111/j.1469-7610.2011.02426.x

- de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders, 40*(8), 930-936. doi:10.1007/s10803-010-0935-9
- de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*. Advance online publication. doi:10.1111/j.1743-6109.2010.01943.x
- Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology, 155*(suppl 1), S131-S137. doi:10.1530/eje.1.02231
- Delemarre-van de Waal, H. A., van Weissenbruch, M. M., & Cohen Kettenis, P. T. (2004). Management of puberty in transsexual boys and girls. *Hormone Research in Paediatrics, 62*(suppl 2), 75-75. doi:10.1159/000081145
- Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice*. New York: W.W. Norton & Co.
- Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 34*(4), 389-397. doi:10.1007/s10508-005-4338-5
- Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model. *Journal of Gay and Lesbian Psychotherapy, 8*(1/2), 41-67.
- Di Ceglie, D., & Thümmel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387-396. doi:10.1177/1359104506064983
- Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior, 38*(2), 172-172. doi:10.1007/s10508-008-9438-6
- Dobs, A. S., Meikle, A. W., Arver, S., Sanders, S. W., Caramelli, K. E., & Mazer, N. A. (1999). Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3469-3478. doi:10.1210/jc.84.10.3469
- Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York: Plenum Press.
- Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34-45. doi:10.1037/0012-1649.44.1.34

- Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the standards of care. *International Journal of Transgenderism*, 12(4), 198-2010. doi:10.1080/15532739.2010.544235
- Ekins, R., & King, D. (2006). *The transgender phenomenon*. Thousand Oaks, CA: SAGE Publications Ltd.
- Eklund, P. L., Gooren, L. J., & Bezemer, P. D. (1988). Prevalence of transsexualism in the Netherlands. *British Journal of Psychiatry*, 152(5), 638-640.
- Eldh, J., Berg, A., & Gustafsson, M. (1997). Long-term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery*, 31(1), 39-45.
- Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy*, 7(3), 1-12. doi:10.1300/J085V07N03_01
- Emory, L. E., Cole, C. M., Avery, E., Meyer, O., & Meyer III, W. J. (2003). Client's view of gender identity: Life, treatment status and outcome. *18th Biennial Harry Benjamin Symposium*, Gent, Belgium.
- Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of transgender medicine and surgery*. Binghamton, NY: The Haworth Press.
- Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15-32). Binghamton, NY: The Haworth Press.
- Factor, R. J., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review*, 17(3), 235-253.
- Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.
- Feldman, J. (2005, April). *Masculinizing hormone therapy with testosterone 1% topical gel*. Paper presented at the 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.
- Feldman, J. (2007). Preventive care of the transgendered patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender surgery and medicine* (pp. 33-72). Binghamton, NY: The Haworth Press.
- Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism*, 9(3), 3-34. doi:10.1300/J485v09n03_02
- Feldman, J., & Safer, J. (2009). Hormone therapy in adults: Suggested revisions to the sixth version of the standards of care. *International Journal of Transgenderism*, 11(3), 146-182. doi:10.1080/15532730903383757

- Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2004). *Myths and realities of online clinical work, observations on the phenomena of online behavior, experience, and therapeutic relationships. A 3rd-year report from ISMHO's clinical case study group*. Retrieved May 24, 2011, from https://www.ismho.org/myths_n_realities.asp
- Fenway Community Health Transgender Health Program. (2007). *Protocol for hormone therapy*. Retrieved from http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181
- Fisk, N. M. (1974). Editorial: Gender dysphoria syndrome--the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine*, 120(5), 386-391.
- Fitzpatrick, L. A., Pace, C., & Wiita, B. (2000). Comparison of regimens containing oral micronized progesterone or medroxyprogesterone acetate on quality of life in postmenopausal women: A cross-sectional survey. *Journal of Women's Health & Gender-Based Medicine*, 9(4), 381-387.
- Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (Third ed.). Baltimore, MD: Johns Hopkins University Press.
- Fraser, L. (2009a). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy*, 24(2), 126-142. doi:10.1080/14681990903003878
- Fraser, L. (2009b). Etherapy: Ethical and clinical considerations for version 7 of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism*, 11(4), 247-263. doi:10.1080/15532730903439492
- Fraser, L. (2009c). Psychotherapy in The World Professional Association for Transgender Health's standards of care: Background and recommendations. *International Journal of Transgenderism*, 11(2), 110-126. doi:10.1080/15532730903008057
- Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. *European Urology*, 57(4), 715-722. doi:10.1016/j.eururo.2009.05.018
- Gelder, M. G., & Marks, I. M. (1969). Aversion treatment in transvestism and transsexualism. In R. Green, & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 383-413). Baltimore, MD: Johns Hopkins Press.
- Gelfer, M. P. (1999). Voice treatment for the male-to-female transgendered client. *American Journal of Speech-Language Pathology*, 8(3), 201-208.
- Gharib, S., Bigby, J., Chapin, M., Ginsburg, E., Johnson, P., Manson, J., & Solomon, C. (2005). *Menopause: A guide to management*. Boston, MA: Brigham and Women's Hospital.

- Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178-224.
- Gold, M., & MacNish, M. (2011). *Adjustment and resiliency following disclosure of transgender identity in families of adolescents and young adults: Themes and clinical implications*. Washington, DC: American Family Therapy Academy.
- Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378-392. doi:10.1007/s10508-007-9307-8
- Gooren, L. (2005). Hormone treatment of the adult transsexual patient. *Hormone Research in Paediatrics, 64*(Suppl 2), 31-36. doi:10.1159/000087751
- Gorton, R. N., Buth, J., & Spade, D. (2005). *Medical therapy and health maintenance for transgender men: A guide for health care providers*. San Francisco, CA: Lyon-Martin Women's Health Services.
- Green, R. (1987). *The "sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.
- Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*(1), 163-174.
- Greenson, R. R. (1964). On homosexuality and gender identity. *International Journal of Psycho-Analysis, 45*, 217-219.
- Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent's reactions to transgender youth's gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3-16. doi:10.1300/J041v18n01_02
- Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71-92.
- Grumbach, M. M., Hughes, I. A., & Conte, F. A. (2003). Disorders of sex differentiation. In P. R. Larsen, H. M. Kronenberg, S. Melmed & K. S. Polonsky (Eds.), *Williams textbook of endocrinology* (10th ed., pp. 842-1002). Philadelphia, PA: Saunders.
- Hage, J. J., & De Graaf, F. H. (1993). Addressing the ideal requirements by free flap phalloplasty: Some reflections on refinements of technique. *Microsurgery, 14*(9), 592-598. doi:10.1002/micr.1920140910
- Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. *Plastic and Reconstructive Surgery, 105*(3), 1222-1227.

- Hancock, A. B., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*. Advance online publication. doi:10.1016/j.jvoice.2010.07.013
- Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery*, 1(2), 335-344.
- Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 94(9), 3132-3154. doi:10.1210/jc.2009-0345
- Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender-variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy*, 36(1), 6-23. doi:10.1080/00926230903375560
- Hoebeke, P., Selvaggi, G., Ceulemans, P., De Cuypere, G. D., T'Sjoen, G., Weyers, S., . . . Monstrey, S. (2005). Impact of sex reassignment surgery on lower urinary tract function. *European Urology*, 47(3), 398-402. doi:10.1016/j.eururo.2004.10.008
- Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry*, 124(579), 181-190. doi:10.1192/bjp.124.2.181
- Hughes, I. A., Houk, C. P., Ahmed, S. F., Lee, P. A., & LWPES1/ESPE2 Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood*, 91(7), 554-563. doi:10.1136/adc.2006.098319
- Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. *American Family Physician*, 62(5), 1079-1095.
- Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.
- Jackson, P. A., & Sullivan, G. (Eds.). (1999). *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand*. Binghamton, NY: The Haworth Press.
- Jockenhövel, F. (2004). Testosterone therapy-what, when and to whom? *The Aging Male*, 7(4), 319-324. doi:10.1080/13685530400016557
- Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior*, 39(6), 1429-1437. doi:10.1007/s10508-009-9551-1

- Joint LWPES/ESPE CAH Working Group, Clayton, P. E., Miller, W. L., Oberfield, S. E., Ritzen, E. M., Sippell, W. G., & Speiser, P. W. (2002). Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. *Journal of Clinical Endocrinology & Metabolism*, *87*(9), 4048-4053. doi:10.1210/jc.2002-020611
- Jurgensen, M., Hiort, O., Holterhus, P. M., & Thyen, U. (2007). Gender role behavior in children with XY karyotype and disorders of sex development. *Hormones and Behavior*, *51*(3), 443-453. doi:0.1016/j.yhbeh.2007.01.001
- Kanagalingam, J., Georgalas, C., Wood, G. R., Ahluwalia, S., Sandhu, G., & Cheesman, A. D. (2005). Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. *The Laryngoscope*, *115*(4), 611-618. doi:10.1097/01.mlg.0000161357.12826.33
- Kanhai, R. C. J., Hage, J. J., Karim, R. B., & Mulder, J. W. (1999). Exceptional presenting conditions and outcome of augmentation mammoplasty in male-to-female transsexuals. *Annals of Plastic Surgery*, *43*(5), 476-483.
- Kimberly, S. (1997). I am transsexual - hear me roar. *Minnesota Law & Politics*, *June*, 21-49.
- Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). *The Journal of Sexual Medicine*, *6*(11), 2922-2939. doi:10.1111/j.1743-6109.2009.01370.x
- Knudson, G., De Cuypere, G., & Bockting, W. (2010a). Process toward consensus on recommendations for revision of the DSM diagnoses of gender identity disorders by The World Professional Association for Transgender Health. *International Journal of Transgenderism*, *12*(2), 54-59. doi:10.1080/15532739.2010.509213
- Knudson, G., De Cuypere, G., & Bockting, W. (2010b). Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *International Journal of Transgenderism*, *12*(2), 115-118. doi:10.1080/15532739.2010.509215
- Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW (U.S. Federal District Court, Boston, MA, 2002).
- Krege, S., Bex, A., Lümmer, G., & Rübber, H. (2001). Male-to-female transsexualism: A technique, results and long-term follow-up in 66 patients. *British Journal of Urology*, *88*(4), 396-402. doi:10.1046/j.1464-410X.2001.02323.x

- Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility*, *92*(5), 1685-1689. doi:10.1016/j.fertnstert.2008.08.126
- Kuhn, A., Hildebrand, R., & Birkhauser, M. (2007). Do transsexuals have micturition disorders? *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *131*(2), 226-230. doi:10.1016/j.ejogrb.2006.03.019
- Landén, M., Wälinder, J., & Lundström, B. (1998). Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. *Acta Psychiatrica Scandinavica*, *97*(3), 189-194. doi:10.1111/j.1600-0447.1998.tb09986.x
- Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior*, *32*(4), 299-315. doi:10.1023/A:1024086814364
- Lawrence, A. A. (2006). Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery. *Archives of Sexual Behavior*, *35*(6), 717-727. doi:10.1007/s10508-006-9104-9
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.
- Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism*, *11*(2), 74-99. doi:10.1080/15532730903008032
- Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology*, *59*(4), 409-418. doi:10.1046/j.1365-2265.2003.01821.x
- MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine*, *350*(4), 367-378.
- Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Malpas, J. (in press). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process*.
- Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior*, *34*(4), 411-421. doi:10.1007/s10508-005-4341-x
- McNeill, E. J. M. (2006). Management of the transgender voice. *The Journal of Laryngology & Otology*, *120*(07), 521-523. doi:10.1017/S0022215106001174

- McNeill, E. J. M., Wilson, J. A., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice*, 22(6), 727-733. doi:10.1016/j.jvoice.2006.12.010
- Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(8), 1010-1013. doi:10.1097/00004583-200208000-00021
- Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health*, 93(2), 262-265.
- Meyer, J. K., & Reter, D. J. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry*, 36(9), 1010-1015.
- Meyer III, W. J. (2009). World Professional Association for Transgender Health's standards of care requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism*, 11(2), 127-132. doi:10.1080/15532730903008065
- Meyer III, W. J., Webb, A., Stuart, C. A., Finkelstein, J. W., Lawrence, B., & Walker, P. A. (1986). Physical and hormonal evaluation of transsexual patients: A longitudinal study. *Archives of Sexual Behavior*, 15(2), 121-138. doi:10.1007/BF01542220
- Meyer-Bahlburg, H. F. L. (2002). Gender assignment and reassignment in intersexuality: Controversies, data, and guidelines for research. *Advances in Experimental Medicine and Biology*, 511, 199-223. doi:10.1007/978-1-4615-0621-8_12
- Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior*, 34(4), 423-438. doi:10.1007/s10508-005-4342-9
- Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie De l'Enfance Et De l'Adolescence*, 56(6), 345-349. doi:10.1016/j.neurenf.2008.06.002
- Meyer-Bahlburg, H. F. L. (2009). Variants of gender differentiation in somatic disorders of sex development. *International Journal of Transgenderism*, 11(4), 226-237. doi:10.1080/15532730903439476
- Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior*, 39(2), 461-476. doi:10.1007/s10508-009-9532-4
- Meyer-Bahlburg, H. F. L. (in press). Gender monitoring and gender reassignment of children and adolescents with a somatic disorder of sex development. *Child & Adolescent Psychiatric Clinics of North America*.

- Meyer-Bahlburg, H. F. L., & Blizzard, R. M. (2004). Conference proceedings: Research on intersex: Summary of a planning workshop. *The Endocrinologist*, 14(2), 59-69. doi:10.1097/01.ten.0000123701.61007.4e
- Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Carlson, A. D., Obeid, J. S., & New, M. I. (2004). Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Archives of Sexual Behavior*, 33(2), 97-104. doi:10.1023/B:ASEB.0000014324.25718.51
- Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior*, 35(6), 667-684. doi:10.1007/s10508-006-9068-9
- Meyer-Bahlburg, H. F. L., Migeon, C. J., Berkovitz, G. D., Gearhart, J. P., Dolezal, C., & Wisniewski, A. B. (2004). Attitudes of adult 46,XY intersex persons to clinical management policies. *The Journal of Urology*, 171(4), 1615-1619. doi:10.1097/01.ju.0000117761.94734.b7
- Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl*. Baltimore, MD: The Johns Hopkins University Press.
- Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4(1), 29-41. doi:10.1093/jpepsy/4.1.29
- Monstrey, S., Hoebeke, P., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Blondeel, P., . . . De Cuypere, G. (2009). Penile reconstruction: Is the radial forearm flap really the standard technique? *Plastic and Reconstructive Surgery*, 124(2), 510-518.
- Monstrey, S., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Bowman, C., Blondeel, P., . . . De Cuypere, G. (2008). Chest-wall contouring surgery in female-to-male transsexuals: A new algorithm. *Plastic and Reconstructive Surgery*, 121(3), 849-859. doi:10.1097/01.prs.0000299921.15447.b2
- Moore, E., Wisniewski, A., & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. *Journal of Clinical Endocrinology & Metabolism*, 88(8), 3467-3473. doi:10.1210/jc.2002-021967
- More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies*, 7(3), 319-328. doi:10.1080/09589236.1998.9960725
- Mount, K. H., & Salmon, S. J. (1988). Changing the vocal characteristics of a postoperative transsexual patient: A longitudinal study. *Journal of Communication Disorders*, 21(3), 229-238. doi:10.1016/0021-9924(88)90031-7

- Mueller, A., Kiesewetter, F., Binder, H., Beckmann, M. W., & Dittrich, R. (2007). Long-term administration of testosterone undecanoate every 3 months for testosterone supplementation in female-to-male transsexuals. *Journal of Clinical Endocrinology & Metabolism*, *92*(9), 3470-3475. doi:10.1210/jc.2007-0746
- Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, *72*(2), 214-231. doi:10.1111/j.1365-2265.2009.03625.x
- Nanda, S. (1998). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth Publishing.
- Nestle, J., Wilchins, R. A., & Howell, C. (2002). *Genderqueer: Voices from beyond the sexual binary*. Los Angeles, CA: Alyson Publications.
- Neumann, K., & Welzel, C. (2004). The importance of voice in male-to-female transsexualism. *Journal of Voice*, *18*(1), 153-167.
- Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research*, *15*(9), 1447-1457. doi:10.1007/s11136-006-0002-3
- Nieschlag, E., Behre, H. M., Bouchard, P., Corrales, J. J., Jones, T. H., Stalla, G. K., . . . Wu, F. C. W. (2004). Testosterone replacement therapy: Current trends and future directions. *Human Reproduction Update*, *10*(5), 409-419. doi:10.1093/humupd/dmh035
- North American Menopause Society. (2010). Estrogen and progestogen use in postmenopausal women: 2010 position statement. *Menopause*, *17*(2), 242-255. doi:10.1097/gme.0b013e3181d0f6b9
- Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research*, *47*(1), 12-23. doi:10.1080/00224490903062258
- Oates, J. M., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism—a review. *International Journal of Language & Communication Disorders*, *18*(3), 139-151. doi:10.3109/13682828309012237
- Olyslager, F., & Conway, L. (2007). On the calculation of the prevalence of transsexualism. Paper presented at the *World Professional Association for Transgender Health 20th International Symposium*, Chicago, Illinois. Retrieved April 22, 2010 from http://www.changelingaspects.com/PDF/2007-09-06-Prevalence_of_Transsexualism.pdf

- Oriel, K. A. (2000). Clinical update: Medical care of transsexual patients. *Journal of the Gay and Lesbian Medical Association*, 4(4), 185-194. doi:10.90-7173/00/1200-0185\$18.00/1
- Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry*, 13(2), 172-181.
- Payer, A. F., Meyer III, W. J., & Walker, P. A. (1979). The ultrastructural response of human leydig cells to exogenous estrogens. *Andrologia*, 11(6), 423-436. doi:10.1111/j.1439-0272.1979.tb02232.x
- Peletz, M. G. (2006). Transgenderism and gender pluralism in southeast asia since early modern times. *Current Anthropology*, 47(2), 309-340. doi:10.1086/498947
- Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology & Human Sexuality*, 5(4), 69-85.
- Pfäfflin, F., & Junge, A. (1998). Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961-1991. *International Journal of Transgenderism*. Retrieved from <http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm>
- Physicians' desk reference*. (61st ed.). (2007). Montvale, NJ: PDR.
- Physicians' desk reference*. (65th ed.). (2010). Montvale, NJ: PDR.
- Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender nonconformity and homosexual childhood* (pp. 34-51). New York: New York University Press.
- Pope, K. S., & Vasquez, M. J. (2011). *Ethics in psychotherapy and counseling: A practical guide* (Fourth ed.). Hoboken, NJ: John Wiley & Sons, Inc.
- Prior, J. C., Vigna, Y. M., & Watson, D. (1989). Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior*, 18(1), 49-57. doi:10.1007/BF01579291
- Prior, J. C., Vigna, Y. M., Watson, D., Diewold, P., & Robinow, O. (1986). Spironolactone in the presurgical therapy of male to female transsexuals: Philosophy and experience of the Vancouver Gender Dysphoria Clinic. *Journal of Sex Information & Education Council of Canada*, 1, 1-7.
- Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism*, 3(3). Retrieved from <http://www.WPATH.org>

- Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism*, 6(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposium/ijtvo06no01_03.htm.
- Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality*, 54(3), 243-258. doi:10.1080/00918360801982124
- Rachlin, K., Hansbury, G., & Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism*, 12(3), 155-166. doi:10.1080/15532739.2010.514220
- Reed, B., Rhodes, S., Schofield, P. & Wylie, K. (2009). *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution*. Retrieved June 8, 2011, from <http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf>
- Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior*, 28(1), 71-89. doi:10.1023/A:1018745706354
- Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy*, 24(2), 143-151. doi:10.1080/14681990902951358
- Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(5), 619-621. doi:10.1097/00004583-200205000-00020
- Rossouw, J. E., Anderson, G. L., Prentice, R. L., LaCroix, A. Z., Kooperberg, C., Stefanick, M. L., . . . Johnson, K. C. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the women's health initiative randomized controlled trial. *JAMA: The Journal of the American Medical Association*, 288(3), 321-333.
- Royal College of Speech Therapists, United Kingdom. <http://www.rcslt.org/>
- Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6th ed., pp. 858-932). Hoboken, NJ: John Wiley & Sons, Inc.
- Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay & Lesbian Issues in Education*, 3(1), 15-28. doi:10.1300/J367v03n01_04
- Simpson, J. L., de la Cruz, F., Swerdloff, R. S., Samango-Sprouse, C., Skakkebaek, N. E., Graham, J. M. J., . . . Willard, H. F. (2003). Klinefelter syndrome: Expanding the phenotype and identifying new research directions. *Genetics in Medicine*, 5(6), 460-468. doi:10.1097/01.GIM.0000095626.54201.DO

- Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89-99. doi:10.1017/S0033291704002776
- Sood, R., Shuster, L., Smith, R., Vincent, A., & Jatoi, A. (2011). Counseling postmenopausal women about bioidentical hormones: Ten discussion points for practicing physicians. *Journal of the American Board of Family Practice, 24*(2), 202-210. doi:10.3122/jabfm.2011.02.100194
- Speech Pathology Australia. <http://www.speechpathologyaustralia.org.au/>
- Speiser, P. W., Azziz, R., Baskin, L. S., Ghizzoni, L., Hensle, T. W., Merke, D. P., . . . Oberfield, S. E. (2010). Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 95*(9), 4133-4160. doi:10.1210/jc.2009-2631
- Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*. Advance online publication. doi:10.1177/1359104510378303
- Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior, 40*(4), 649-650. doi:10.1007/s10508-011-9752-2
- Stikkelbroeck, N. M. M. L., Beerendonk, C., Willemssen, W. N. P., Schreuders-Bais, C. A., Feitz, W. F. J., Rieu, P. N. M. A., . . . Otten, B. J. (2003). The long term outcome of feminizing genital surgery for congenital adrenal hyperplasia: Anatomical, functional and cosmetic outcomes, psychosexual development, and satisfaction in adult female patients. *Journal of Pediatric and Adolescent Gynecology, 16*(5), 289-296. doi:10.1016/S1083-3188(03)00155-4
- Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220-226.
- Stone, S. (1991). The empire strikes back: A posttranssexual manifesto. In J. Epstein, & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280-304). London: Routledge.
- Tangpricha, V., Ducharme, S. H., Barber, T. W., & Chipkin, S. R. (2003). Endocrinologic treatment of gender identity disorders. *Endocrine Practice, 9*(1), 12-21.
- Tangpricha, V., Turner, A., Malabanan, A., & Holick, M. (2001). Effects of testosterone therapy on bone mineral density in the FTM patient. *International Journal of Transgenderism, 5*(4).
- Taywaditep, K. J., Coleman, E., & Dumronggittigule, P. (1997). Thailand (muang thai). In R. Francouer (Ed.), *International encyclopedia of sexuality*. New York: Continuum.

- The World Professional Association for Transgender Health, Inc. (2008). *WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A.* Retrieved from <http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf>
- Thole, Z., Manso, G., Salgueiro, E., Revuelta, P., & Hidalgo, A. (2004). Hepatotoxicity induced by antiandrogens: A review of the literature. *Urologia Internationalis*, 73(4), 289-295. doi:10.1159/000081585
- Tom Waddell Health Center. (2006). *Protocols for hormonal reassignment of gender.* Retrieved from <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>
- Tsoi, W. F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica*, 78(4), 501-504. doi:10.1111/j.1600-0447.1988.tb06373.x
- Van den Broecke, R., Van der Elst, J., Liu, J., Hovatta, O., & Dhont, M. (2001). The female-to-male transsexual patient: A source of human ovarian cortical tissue for experimental use. *Human Reproduction*, 16(1), 145-147. doi:10.1093/humrep/16.1.145
- van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology*, 47(3), 337-343. doi:10.1046/j.1365-2265.1997.2601068.x
- van Kesteren, P. J. M., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior*, 25(6), 589-600. doi:10.1007/BF02437841
- van Trotsenburg, M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism*, 11(4), 238-246. doi:10.1080/15532730903439484
- Vancouver Coastal Health, Vancouver, British Columbia, Canada. <http://www.vch.ca/>
- Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal*, 26(2), 135-154. doi:10.1007/s10560-008-0158-5
- Vilain, E. (2000). Genetics of sexual development. *Annual Review of Sex Research*, 11, 1-25.
- Wålinder, J. (1968). Transsexualism: Definition, prevalence and sex distribution. *Acta Psychiatrica Scandinavica*, 43(S203), 255-257.
- Wålinder, J. (1971). Incidence and sex ratio of transsexualism in Sweden. *The British Journal of Psychiatry*, 119(549), 195-196.
- Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(12), 1413-1423. doi:10.1097/CHI.0b013e31818956b9

- Wallien, M. S. C., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(10), 1307-1314. doi:10.1097/chi.0b013e3181373848
- Warren, B. E. (1993). Transsexuality, identity and empowerment. A view from the frontlines. *SIECUS Report, February/March*, 14-16.
- Weitze, C., & Osburg, S. (1996). Transsexualism in Germany: Empirical data on epidemiology and application of the German Transsexuals' Act during its first ten years. *Archives of Sexual Behavior*, 25(4), 409-425.
- Wilson, J. D. (1999). The role of androgens in male gender role behavior. *Endocrine Reviews*, 20(5), 726-737. doi:10.1210/er.20.5.726
- Winter, S. (2009). Cultural considerations for The World Professional Association for Transgender Health's standards of care: The Asian perspective. *International Journal of Transgenderism*, 11(1), 19-41. doi:10.1080/15532730902799938
- Winter, S., Chalungsooth, P., Teh, Y. K., Rojanalert, N., Maneerat, K., Wong, Y. W., . . . Macapagal, R. A. (2009). Transpeople, transprejudice and pathologization: A seven-country factor analytic study. *International Journal of Sexual Health*, 21(2), 96-118. doi:10.1080/19317610902922537
- Wisniewski, A. B., Migeon, C. J., Malouf, M. A., & Gearhart, J. P. (2004). Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The Journal of Urology*, 171(6, Part 1), 2497-2501. doi:10.1097/01.ju.0000125269.91938.f7
- World Health Organization. (2007). *International classification of diseases and related health problems-10th revision*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2008). *The world health report 2008: Primary health care - now more than ever*. Geneva, Switzerland: World Health Organization.
- WPATH Board of Directors. (2010). *De-psycho-pathologisation statement released May 26, 2010*. Retrieved from http://wpath.org/announcements_detail.cfm?pk_announcement=17
- Xavier, J. M. (2000). *The Washington, D.C. transgender needs assessment survey: Final report for phase two*. Washington, DC: Administration for HIV/AIDS of District of Columbia Government.
- Zhang, G., Gu, Y., Wang, X., Cui, Y., & Bremner, W. J. (1999). A clinical trial of injectable testosterone undecanoate as a potential male contraceptive in normal Chinese men. *Journal of Clinical Endocrinology & Metabolism*, 84(10), 3642-3647. doi:10.1210/jc.84.10.3642

- Zitzmann, M., Saad, F., & Nieschlag, E. (2006, April). *Long term experience of more than 8 years with a novel formulation of testosterone undecanoate (nebido) in substitution therapy of hypogonadal men*. Paper presented at European Congress of Endocrinology, Glasgow, UK, April 2006.
- Zucker, K. J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*(1), 1-69.
- Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(3), 551-568. doi:10.1016/j.chc.2004.02.006
- Zucker, K. J. (2006). 'I'm half-boy, half-girl': Play psychotherapy and parent counseling for gender identity disorder. In R. L. Spitzer, M. B. First, J. B. W. Williams & M. Gibbons (Eds.), *DSM-IV-TR casebook, volume 2* (pp. 321-334). Arlington, VA: American Psychiatric Publishing, Inc.
- Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477-498. doi:10.1007/s10508-009-9540-4
- Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex & Marital Therapy, 34*(4), 287-290. doi:10.1080/00926230802096192
- Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (in press). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy*.
- Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the standards of care of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*(1), 8-18. doi:10.1080/15532730902799946
- Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*(3), 398-411.
- Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90-97.

APPENDIX A

GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the SOC are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Crossdressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the “disorder” label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

Transphobia, internalized: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B

OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely increased risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible increased risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other side effects of feminizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of anti-androgen medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the SOC. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely increased risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible increased risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

Inconclusive or no increased risk: Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other side effects of masculinizing therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C

SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the SOC for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D

EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically been doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p < .001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijls & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E

DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial SOC “work group” was established in 2006. Members were invited to examine specific sections of SOC, *Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the SOC as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of SOC, *Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of SOC, *Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader SOC Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader SOC Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the SOC and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the SOC.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;
2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;
3. Working meeting of the Writing Group;
4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;
5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

Members of the Standards of Care Revision Committee¹

Eli Coleman, PhD (USA)* - Committee chair	Arlene Istar Lev, LCSW (USA)
Richard Adler, PhD (USA)	Gal Mayer, MD (USA)
Walter Bockting, PhD (USA)*	Walter Meyer, MD (USA)*
Marsha Botzer, MA (USA)*	Heino Meyer-Bahlburg, Dr. rer.nat. (USA)
George Brown, MD (USA)	Stan Monstrey, MD, PhD (Belgium)*
Peggy Cohen-Kettenis, PhD (Netherlands)*	Blaine Paxton Hall, MHS-CL, PA-C (USA)
Griet DeCuypere, MD (Belgium)*	Friedmann Pfaefflin, MD, PhD (Germany)
Aaron Devor, PhD (Canada)	Katherine Rachlin, PhD (USA)
Randall Ehrbar, PsyD (USA)	Bean Robinson, PhD (USA)
Randi Ettner, PhD (USA)	Loren Schechter, MD (USA)
Evan Eyler, MD (USA)	Vin Tangpricha, MD, PhD (USA)
Jamie Feldman, MD, PhD (USA)*	Mick van Trotsenburg, MD (Netherlands)
Lin Fraser, EdD (USA)*	Anne Vitale, PhD (USA)
Rob Garofalo, MD, MPH (USA)	Sam Winter, PhD (Hong Kong)
Jamison Green, PhD, MFA (USA)*	Stephen Whittle, OBE (UK)
Dan Karasic, MD (USA)	Kevan Wylie, MB, MD (UK)
Gail Knudson, MD (Canada)*	Ken Zucker, PhD (Canada)

International Advisory Group Selection Committee

Walter Bockting, PhD (USA)	Evan Eyler, MD (USA)
Marsha Botzer, MA (USA)	Jamison Green, PhD, MFA (USA)
Aaron Devor, PhD (Canada)	Blaine Paxton Hall, MHS-CL, PA-C (USA)
Randall Ehrbar, PsyD (USA)	

¹ * Writing Group member

All members of the *Standards of Care, Version 7 Revision Committee* donated their time to work on this revision.

International Advisory Group

Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FTM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Tone Marie Hansen, Harry Benjamin Resource Center (Norway)
Rupert Raj, Shelburne Health Center (Canada)
Masae Torai, FTM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)

Technical Writer

Anne Marie Weber-Main, PhD (USA)

Editorial Assistance

Heidi Fall (USA)



