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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 a 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 ones 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.

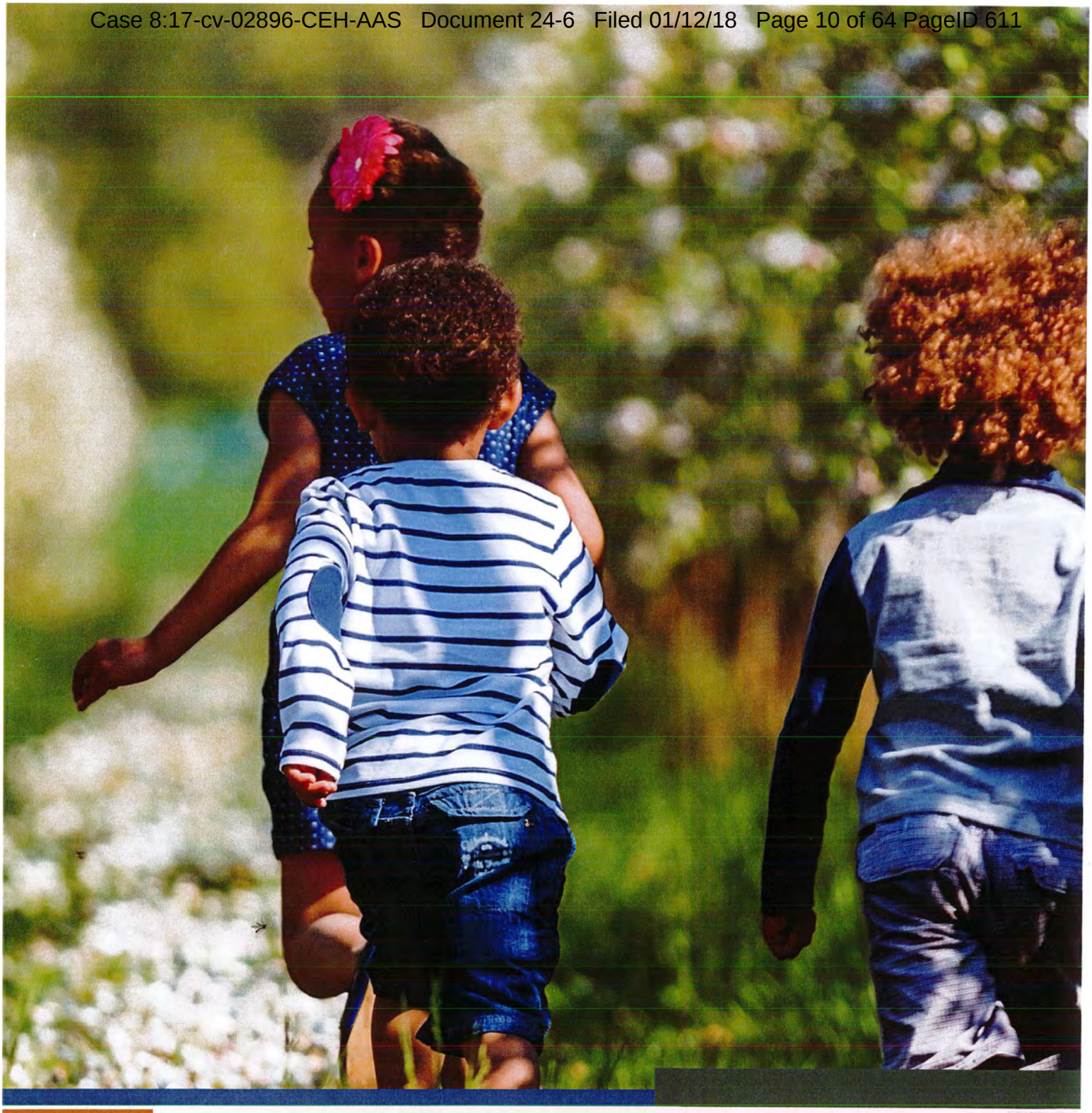
The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, 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.



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FOOTNOTE 10

Annals of Internal Medicine

POSITION PAPER

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

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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 transgender 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

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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.

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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.

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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' identification 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 nondiscrimination 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 multistakeholder 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 to 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 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 practice 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).

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FOOTNOTE 11

Policies on Lesbian, Gay, Bisexual, Transgender & Queer (LGBTQ) Issues

The American Medical Association (AMA) supports the equal rights, privileges and freedom of all individuals and opposes discrimination based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age.

Sexual orientation and gender identity are integral aspects of the AMA communities and AMA policies on LGBTQ issues that work to inform individuals about LGBTQ discrimination and abuse. AMA's policies for lesbian, gay, bisexual and transgender people's rights represent a multiplicity of identities and issues.

AMA Policies on LGBTQ Issues

Access full details of these policies and explore more policies.

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- H-65.992 Continued Support of Human Rights and Freedom
- H-65.983 Nondiscrimination Policy
- H-65.990 Civil Rights Restoration

Physician-centered Policies:

- B-1.40 Discrimination
- B-6.524 Council on Ethical and Judicial Affairs
- E-9.03 Civil Rights and Professional Responsibility
- E-9.12 Patient-Physician Relationship: Respect for Law and Human Rights
- H-200.951 Strategies for Enhancing Diversity in the Physician Workforce
- G-630.130 Discrimination
- G-630.140 Lodging, Meeting Venues and Social Functions
- H-295.969 Nondiscrimination Toward Medical School and Residency Applicants
- H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
- H-295.878 Eliminating Health Disparities: Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
- D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation
- H-295.955 Teacher-Learner Relationship in Medical Education
- H-225.961 Medical Staff Development Plans
- E-10.05 Potential Patients

Patient-centered Policies:

- H-160.991 Health Care Needs of the Homosexual Population
- H-65.973 Health Care Disparities in Same-sex Partner Households
- H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population
- D-65.996 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population
- H-460.907 Encouraging Research Into the Impact of Long-term Administration of Hormone Replacement Therapy in Transgender Patients
- H-65.972 Repeal of "Don't Ask, Don't Tell"
- H-270.997 Legal Restrictions on Sexual Behavior Between Consenting Adults
- D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families
- H-50.973 Blood Donor Referral Criteria

- H-50.975 Safety of Blood Donations and Transfusions
- H-60.940 Partner Co-adoption
- D-515.997 School Violence
- H-65.979 Sexual Orientation as an Exclusionary Criterion for Youth Organization
- H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria
- H-185.950 Removing Financial Barriers to Care for Transgender Patients
- H-185.958 Equity in Health Care for Domestic Partnerships
- H-215.965 Hospital Visitation Privileges for GLBT Patients
- H-295.879 Improving Sexual History Curriculum in the Medical School
- H-440.885 National Health Survey

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FOOTNOTE 12

WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours

Background

Recent controversies in many countries suggest a need for clarity on same-sex orientation, attraction, and behaviour (formerly referred to as homosexuality).

Along with other international organisations, World Psychiatric Association (WPA) considers sexual orientation to be innate and determined by biological, psychological, developmental, and social factors.

Over 50 years ago, Kinsey et al (1948) documented a diversity of sexual behaviours among people. Surprisingly for the time, he described that for over 10% of individuals this included same-sex sexual behaviours. Subsequent population research has demonstrated approximately 4% of people identify with a same-sex sexual orientation (e.g., gay, lesbian, and bisexual orientations). Another 0.5% identify with a gender identity other than the gender assigned at birth (e.g., transgender) (Gates 2011). Globally, this equates to over 250 million individuals.

Psychiatrists have a social responsibility to advocate for a reduction in social inequalities for all individuals, including inequalities related to gender identity and sexual orientation.

Despite an unfortunate history of perpetuating stigma and discrimination, it has been decades since modern medicine abandoned pathologising same-sex orientation and behaviour (APA 1980) The World Health Organization (WHO) accepts same-sex orientation as a normal variant of human sexuality (WHO 1992). The United Nations Human Rights Council (2012) values Lesbian Gay Bisexual and Transgender (LGBT) rights. In two major diagnostic and classification systems (International

Classification of Diseases (ICD-10) and DSM-5), same sex sexual orientation, attraction, and behaviour and gender identity are not seen as pathologies (WHO 1993, APA 2013).

There is considerable research evidence to suggest that sexual behaviours and sexual fluidity depend upon a number of factors (Ventriglio et al 2016). Furthermore, it has been shown conclusively that LGBT individuals show higher than expected rates of psychiatric disorders (Levounis et al 2012, Kalra et al 2015), and once their rights and equality are recognised these rates start to drop (Gonzales 2014, Hatzenbuehler et al 2009, 2012, Padula et al 2015)

People with diverse sexual orientations and gender identities may have grounds for exploring therapeutic options to help them live more comfortably, reduce distress, cope with structural discrimination, and develop a greater degree of acceptance of their sexual orientation or gender identity. Such principles apply to any individual who experiences distress relating to an aspect of their identity, including heterosexual individuals.

WPA believes strongly in evidence-based treatment. There is no sound scientific evidence that innate sexual orientation can be changed. Furthermore, so-called treatments of homosexuality can create a setting in which prejudice and discrimination flourish, and they can be potentially harmful (Rao and Jacob 2012). The provision of any intervention purporting to "treat" something that is not a disorder is wholly unethical.

Action

1. The World Psychiatric Association (WPA) holds the view that lesbian, gay, bisexual, and transgender individuals are and should be regarded as valued members of society, who have exactly the same rights and responsibilities as all other citizens. This includes equal access to

healthcare and the rights and responsibilities that go along with living in a civilised society.

2. WPA recognises the universality of same-sex expression, across cultures. It holds the position that a same-sex sexual orientation per se does not imply objective psychological dysfunction or impairment in judgement, stability, or vocational capabilities.

3. WPA considers same-sex attraction, orientation, and behaviour as normal variants of human sexuality. It recognises the multi-factorial causation of human sexuality, orientation, behaviour, and lifestyle. It acknowledges the lack of scientific efficacy of treatments that attempt to change sexual orientation and highlights the harm and adverse effects of such "therapies".

4. WPA acknowledges the social stigma and consequent discrimination of people with same-sex sexual orientation and transgender gender identity. It recognises that the difficulties they face are a significant cause of their distress and calls for the provision of adequate mental health support.

5. WPA supports the need to de-criminalise same-sex sexual orientation and behaviour and transgender gender identity, and to recognise LGBT rights to include human, civil, and political rights. It also supports anti-bullying legislation; anti-discrimination student, employment, and housing laws; immigration equality; equal age of consent laws; and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.

6) WPA emphasises the need for research on and the development of evidence-based medical and social interventions that support the mental health of lesbian, gay, bisexual, and transgender individuals

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The writing group was led by Professor Dinesh Bhugra and constituted Drs Kristen Eckstrand (USA), Petros Levounis (USA),Anindya Kar(India), Kenneth R Javate (Philippines)

FOOTNOTE 13

NASW
National Association of Social Workers

"Reparative" and "Conversion" Therapies for Lesbians and Gay Men

Position Statement

by: National Committee on Lesbian, Gay, and Bisexual Issues, NASW

January 21, 2000

"When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect the clients from harm" (NASW, 1996).

The social worker should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of . . . sexual orientation . . ." (NASW, 1996)

What are "reparative" or "conversion" therapies?

Reparative or conversion therapies claim, through the use of psychotherapy or other interventions, to eliminate a person's sexual desire for a member of his or her own gender. The National Association of Social Workers' National Committee on Lesbian, Gay, and Bisexual Issues (NCLGB) recognizes the emergence of these misleading therapies. Reparative and conversion therapies, sometimes called "transformational ministries," have received wider attention against the backdrop of a growing conservative religious political climate (NASW, 1992), and through recent media campaigns supported by the Christian Coalition and the Family Research Council. By advancing their efforts through such propaganda, proponents of reparative and conversion therapies, such as the most commonly cited group NARTH, claim that their processes are supported by scientific data; however, such scientific support is replete with confounded research methodologies (Mills, 1999).

What are sexual orientation, sexual identity, and sexual behavior?

Sexual orientation is defined by the sex of individuals for whom one feels an attraction and affection, both physical and emotional. Sexual orientation includes "sexual activity with members of one's own sex (homosexual orientation), the opposite sex (heterosexual orientation), or both (bisexual orientation)" (Barker, 1999, pp. 439–440). Moreover, sexual orientation differs from other mistakenly ascribed concepts, such as sexual identity and sexual 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. In an effort to understand human relationships and human sexuality, "social workers must be knowledgeable about biological factors, as well as about the roles played by psychological, cultural, and social factors in sexual expressions" (Harrison, 1995, p. 1419).

Can therapy change sexual orientation?

People seek mental health services for many reasons. Accordingly, it is fair to assert that lesbians and gay men seek therapy for the same reasons that heterosexual people do. However, the increase in media campaigns, often coupled with coercive messages from family and community members, has created an environment in which lesbians and gay men often are pressured to seek reparative or conversion therapies, which ***cannot and will not change sexual***

orientation. *Aligned with the American Psychological Association's (1997) position, NCLGB believes that such treatment potentially can lead to severe emotional damage. Specifically, transformational ministries are fueled by stigmatization of lesbians and gay men, which in turn produces the social climate that pressures some people to seek change in sexual orientation (Haldeman, 1994). No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful (Davison, 1991; Haldeman, 1994).*

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 a knowledge of appropriate community services (Harrison, 1995). Social workers across fields of practice, including foster care, mental health, corrections, substance abuse, school social work, and prevention education, may encounter lesbian and gay clients. The literature indicates that "interventative therapies" that attempt to alter sexual orientation of lesbians and gay men have succeeded only in reducing sexual behavior and self-esteem rather than shaping attractions of opposite gender (Haldman, 1994).

What are the value and ethical implications for social workers?

NCLGB asserts that conversion and reparative therapies are an infringement to the guiding principles inherent to social worker ethics and values. This belief is affirmed by the NASW policy statement on "Lesbian, Gay, and Bisexual Issues" (1996). In discussing ethical decisions for social work practice, Loewenberg and Dolgoff (1996) noted, "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" (p. 47). The NASW Code of Ethics enunciates principles that address ethical decision making in social work practice with lesbians, gay men, and bisexual people—for example, social workers' commitment to clients' self-determination and competence, to achieving cultural competence and understanding social diversity, and to clients who lack decision-making capacity; social workers' ethical responsibilities to colleagues, their commitment to interdisciplinary collaboration, and their responsibility to report unethical conduct of colleagues; social workers' ethical responsibilities as professionals—maintaining competence, fighting discrimination, and avoiding misrepresentation; social workers' ethical responsibilities to the social work profession, to evaluation, and to research.

How can I practice the nondiscrimination tenets of my profession?

A social worker may apply techniques that may cause considerable harm and anguish for a client while reinforcing the existing prejudice and homophobia that gay men and lesbians experience daily. The use of these therapies deny the viability of same-gender relationships as fulfilling and natural; many lesbians and gay men in such arrangements report significant satisfaction and contentment. Social workers need to be aware of the scripted attitudes toward lesbians and gay men (NASW, 1992). As first asserted in the original NCGLB reparative therapy position statement (1992), "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" (pp. 1, 2). Social workers are obligated to use nonjudgmental attitudes and to encourage nurturing practice environments for lesbians, gay men, and bisexuals. NASW discourages social workers from providing treatments designed to change sexual orientation or from referring clients to practitioners or programs that claim to do so (NASW, 1992).

What can social workers do?

NASW's policy statement on lesbian, gay, and bisexual issues can be viewed as a "blueprint" for social work's role in addressing the concerns and strengths of gay, lesbian, and bisexual clients and communities both within and outside the profession. The policy states, "NASW supports legislation, regulation, policies, judicial review, political action, and changes in social work policy statements and the NASW Code of Ethics (1996), and any other means necessary to establish and protect the equal rights of all people without regard to sexual orientation" (p. 202).

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Additional Resources

Gay and Lesbian Alliance Against Defamation, 1825 Connecticut Avenue, NW, Washington, DC 20009; (202) 986-1360; www.glaad.orgGay, Lesbian and Straight Education Network, 121 West 27th Street, Suite 804, New York, NY 10001; (212) 727-0135; www.glsen.orgHealthy Lesbian, Gay, and Bisexual Youth Project, American Psychological Association: Public Interest Directorate, 750 First Street, NE, Washington, DC 20002-4242; (202) 336-5977; (202) 336-5662 TTY; publicinterest@apa.orgHuman Rights Campaign, 1101 14th Street, NW, Washington, DC 20005; (202) 628-4160; www.hrc.orgNational Youth Advocacy Coalition, 1638 R Street, NW, Suite 300, Washington, DC 20009; (202) 319-7596; www.nyacyouth.orgNational Association of Social Workers, National Committee on Lesbian, Gay, and Bisexual Issues, 750 First Street, NE, Suite 700, Washington, DC 20002-4241; (202) 408-8600; www.socialworkers.orgSexuality Information and Education Council of the United States, 130 West 42nd Street, Suite 350, New York, NY 10036; (212) 819-9770; www.siecus.org; siecus@siecus.org

Selected Readings

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Press Contacts

Leticia Linn (mailto:mediateam@paho.org)
—Tel. 202 974 3440
Daniel Epstein (mailto:mediateam@paho.org)
—Tel 202 974-3579
Sebastián Oliel (mailto:mediateam@paho.org)
—Tel. 202 974 3459
Sonia Mey Schmidt (mailto:mediateam@paho.org)
—Tel 202 974 3036
Javier Muñoz (mailto:mediateam@paho.org)
—Tel 202 974 3553

FOOTNOTE 14

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Practice parameter on gay, lesbian or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents.

Bibliographic Source(s)

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012 Sep;51(9):957-74. [110 references] PubMed

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Principle 1. A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.

The psychiatric evaluation of every patient should take into consideration psychosexual development in a way that is appropriate to developmental level and the clinical situation. Questions about sexual feelings, experiences, and identity or about gender role behavior and gender identity can help clarify any areas of concern related to sexuality. The history should be obtained in a nonjudgmental way, for example without assuming any particular sexual orientation or implying that one is expected. This can be conveyed, for example, by the use of gender-neutral language related to the aim of affection (e.g., asking "is there someone special in your life?" rather than "do you have a boyfriend/girlfriend?") until the adolescent reveals a particular sexual orientation.

Sexual and gender minority adolescents very frequently face unique developmental challenges, as described above. If an initial screen indicates that issues of sexual orientation, gender nonconformity, or gender identity are of clinical significance, these challenges can be explored in greater depth.

Principle 2. The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.

Issues of confidentiality are important with all patients; they are particularly so with sexual and gender minority youth, who require a clinical environment in which they can explore their developing orientation and identity. Prior experiences of rejection and hostility may lead them to watch social cues vigilantly to determine whether they can safely reveal their sexual orientation to others without fear of bias or judgment. Any sign of these in a mental health professional may induce shame and undermine the clinical alliance.

Clinicians should bear in mind potential risks to patients of premature disclosure of sexual orientation, such as family rejection or alienation from support systems, which might precipitate a crisis. They should be familiar with standard confidentiality practices for minors, and should protect confidentiality when possible to preserve the clinical alliance. This is particularly true when using media such as electronic health records, in which

sensitive information can be easily disseminated. It is often helpful to emphasize reasonable expectations of privacy in the clinical relationship with sexual and gender minority youth—not to express shame, but to permit the exploration of sexual identity free from fear and with a sense of control over disclosure. As the development of sexual identity is variable, it is often desirable to allow youth to set the pace of self-discovery.

Principle 3. Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of the cultural values of the youth, family, and community.

Families of sexual or gender minority youth may consult mental health professionals for a variety of reasons, for example, to ask whether a disclosure of being gay represents a temporary stage, to request support for an adolescent, or to address problems such as bullying, anxiety, or depression. Just as some adults try to alter their sexual orientation, some parents may similarly hope to prevent their children from being gay. Difficulty coping with prejudice and stigma are often the appropriate focus of treatment.

Families treat gay or gender-discordant children with considerable variation. Whereas some accept their children, others explicitly or implicitly disparage or reject them, evoking shame and guilt; some force them to leave home. Although some are surprised by a child's coming out, others are not, and some are supportive. Families may have to fundamentally alter their ideas about a child who comes out, confront misconceptions, and grieve over lost hopes and/or expectations. Most parents experience distress following a child's coming out, frequently experiencing cognitive dissonance or feelings of anxiety, anger, loss, shame, or guilt; despite this, over time the majority become affirming and are not distressed. Children frequently predict their parents' reactions poorly. Ideally, families will support their child as the same person they have known and loved, although doing so may require time.

Youth who are rejected by their parents can experience profound isolation that adversely affects their identity formation, self-esteem, and capacity for intimacy; stigmatized teens are often vulnerable to dropping out of school, homelessness (which may lead to exploitation or heightened sexual risk), substance abuse, depression and suicide. Clinicians should aim to alleviate any irrational feelings of shame and guilt, and preserve empathic and supportive family relationships where possible. They should assess parents' ideas about what constitutes normal, acceptable behavior, their cultural background, and any misconceptions or distorted expectations about homosexuality. These may include fears that their child will have only casual relationships, is fated to contract human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), cannot become a parent if desired, or will be ostracized. Stereotyped views of gay males as engaging only in numerous, indiscriminate sexual encounters are not supported by empirical research except in rare cases. If such behavior is present and cannot be explained as part of normal adolescent sexual drive or identity formation, factors known to be associated with excessive sexuality in youth, such as a history of sexual abuse, family dysfunction, a pattern of conduct problems, or mood disorder such as bipolar disorder or depression, should be considered. Clinicians should screen for all forms of abuse or neglect (as in any evaluation), with careful attention to adverse family reactions to a youth's sexual or gender development. If these are suspected, they should involve child protective services as clinical appropriateness and ethical and legal mandates warrant. Support groups may be helpful for families in distress. In cases of protracted turmoil or family pathology, referrals to family therapy, individual or couples therapy may be appropriate.

Sexual and gender minority youth may experience unique developmental challenges relating to the values and norms of their ethnic group. Various groups may place different emphasis on ideals of masculinity or femininity, on family loyalty, or on social conformity; some with authoritarian parenting ideals may sanction youth who reject traditional mores.

For gay and lesbian adolescents who are also members of ethnic minorities, the deleterious effect of anti-homosexual bias may be compounded by the effect of racial prejudice. In response to unique pressures to gain group acceptance, they may give particular weight to negative group stereotyping of gay people. Gay and lesbian youth who are also members of ethnic minorities may be less likely than nonminority youth to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity. In caring for youth who are members of both ethnic and sexual minorities, mental health professionals should take into account the unique complexities of identity formation for these groups.

Religion, often a valued aspect of identity, can vary widely regarding tolerance for sexual minorities. Membership in relatively more liberal or conservative religious groups is a significant influence on one's "sexual script," or social pattern in the expression of sexuality. Some minority denominations hold strong religious injunctions against homosexuality and stricter views about gender roles. As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. However, many religious groups are reconciling their traditions with more inclusive values. This remains an area of active social and cultural debate and change. Clinicians should respect the religious values of their patients, and should be aware of ongoing developments in religious thinking that may provide opportunities to integrate the religious and sexual aspects of identity.

Principle 4. Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.

Bullying. Gay, lesbian, bisexual, and gender nonconforming youth are regularly exposed to hostile peers. Victims of peer harassment experience

serious adverse mental health consequences including chronic depression, anxiety, and suicidal thoughts. Sexual and gender minority youth may benefit from support for coping with peer harassment. School programs including no-tolerance policies for bullying have proved effective. Family treatment may be useful when sexual and gender minority youth are harassed in their families. Psychotherapy may help to avert or alleviate self-loathing related to identification with the aggressor. Clinicians should consider environmental interventions such as consultation or advocacy with schools, police, or other agencies and institutions advocating enforcement of zero tolerance policies to protect youth who may be victims of harassment or bullying.

Suicide. Rates of suicidal thoughts and suicide attempts among gay, lesbian, and gender-variant youth are elevated in comparison with the general population. The developmental interval following same-sex experience but before self-acceptance as gay may be one of especially elevated risk. Suicidal thoughts, depression, and anxiety are especially elevated among gay males who were gender-variant as children. Family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts.

High-Risk Behaviors. Unique factors promoting risk-taking among gay and lesbian youth include maladaptive coping with peer, social and family ostracism, emotional and physical abuse, and neglect. Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution. Positive coping skills and intact support systems can act as protective factors. Lesbian youth have higher rates of unintended pregnancy than heterosexual female youth, perhaps due to anxiety about their same-sex attractions and a desire to "fit in," an assumption birth control is unnecessary, or high-risk behavior rooted in psychological conflict. Clinicians should monitor for these risks or provide anticipatory guidance for them when appropriate.

Substance Abuse. Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used. These youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs. Lesbian and bisexual girls and boys describing themselves as "mostly heterosexual" (as opposed to unambiguously hetero- or homosexual) are at increased risk for alcohol use. A subgroup of gay youth displays higher rates of use of alcohol and drugs including marijuana, cocaine, inhalants, designer, and injectable drugs. They may use drugs and alcohol to achieve a sense of belonging or to relieve painful affects such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings.

HIV/AIDS and Other Sexually Transmitted Illnesses. Adolescents are at risk for acquiring sexually transmitted illnesses included HIV infection through sexual risk taking, especially those who feel invulnerable or fatalistic, or who lack mature judgment, self-confidence, or the mature interpersonal skills needed to negotiate safe sexual experiences. Programs aimed at reducing adolescent sexual risk taking that are successful not only increase information about how HIV and sexually transmitted diseases are acquired and prevented, but also provide emotionally relevant and practical help in having safe sexual experiences that are developmentally relevant to youth. Adolescent gay males may be at particular risk of acquiring HIV sexually because of its high prevalence among men who have sex with men. Factors such as substance abuse or internalized homophobia associated with shame, guilt, or low self-esteem may interfere with an individual's motivation to use knowledge effectively about how to protect oneself from acquiring HIV infection. If present, these issues should be addressed clinically. Special HIV-prevention programs have been developed for and tested in gay youth and have demonstrated promising results.

Principle 5. Clinicians should aim to foster healthy psychosexual development in sexual and gender minority youth and to protect the individual's full capacity for integrated identity formation and adaptive functioning.

Protecting the opportunity to achieve full developmental potential is an important clinical goal in working with sexual and gender minority youth. The psychological acceptability of homosexual feelings to an individual and his or her family, and the individual's capacity to incorporate them into healthy relationships, can change with therapeutic intervention, and are an appropriate focus of clinical attention. Clinicians should strive to support healthy development and honest self-discovery as youth navigate family, peer, and social environments that may be hostile. Family rejection and bullying are often the proper focus of psychiatric treatment rather than current or future sexual orientation.

Sometimes questions about a youth's future sexual orientation come to psychiatric attention. When they do, it may be most useful to explore what this issue means to the adolescent and significant persons in his/her life. It may be preferable to indicate that it is too early to know an adolescent's sexual orientation rather than to refer to such feelings as a "phase," which may have connotations of disapproval.

When working clinically with youth whose sexual orientation or gender identity is uncertain, protecting the opportunity for healthy development without prematurely foreclosing any developmental possibility is an important goal. Clinicians should evaluate and support each child's ability to integrate awareness of his or her sexual orientation into his or her sexual identity while developing age-appropriate capacities in the areas of emotional stability, behavior, relationships, academic functioning, and progress toward an adult capacity for work, play, and love.

The availability of role models for sexual and gender minority youth varies greatly. The increasing visibility of gay people in society may decrease the isolation and loneliness of some gay youth, but others may be confronted with information that forces self-labeling before they are able to cope with irrational bias and feeling different. Some have access to positive role models or opportunities to form an affirming sexual identity among

family, friends, the media, or through school programs such as gay–straight alliances. Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

Principle 6. Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.

There is no established evidence that change in a predominant, enduring homosexual pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree— identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter homosexuality. Psychiatric efforts to alter sexual orientation through "reparative therapy" in adults have found little or no change in sexual orientation, while causing significant risk of harm to self-esteem. A study of efforts to do so in adults has been criticized for failure to adequately consider risks such as increased anguish, self-loathing, depression, anxiety, substance abuse and suicidality, and for failure to support appropriate coping with prejudice and stigma.

There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts. As bullies typically identify their targets on the basis of adult attitudes and cues, adult efforts to prevent homosexuality by discouraging gender variant traits in "prehomosexual children" may risk fomenting bullying. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.

Principle 7. Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.

A majority of children display gender role behavior that adult caregivers regard as departing from gender role norms in toy preferences at least some of the time (demonstrating a difference between that which is culturally expected and that which is actually statistically normal). However, a smaller group of children demonstrate a consistent difference in gender role behavior from social norms. In different children, this may be true to varying degrees. In some, it may involve only a few areas—for example, an aversion to rough-and-tumble sports in boys, or tomboyishness in girls. In others, it may involve several areas, including dress, speech, and use of social styles and mannerisms. It is important to distinguish those who display only variation in gender role behavior (gender nonconformity, which is not a Diagnostic and Statistical Manual of Mental Disorders [DSM] diagnosis) from those who also display a gender identity discordant from their socially assigned birth gender and biological sex (gender discordance, reflected in the DSM-IV diagnosis Gender Identity Disorder when accompanied by marked gender nonconformity).

A clinical interview using DSM criteria is the gold standard for making a DSM diagnosis. In some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-sex wishes. To assist clinicians in determining whether gender discordance is present, in addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children, the Gender Identity Questionnaire for Children, and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults. In using such instruments, clinicians should bear in mind that the American Psychiatric Association's Gender Identity Disorder subworkgroup for DSM-5 is currently debating areas of controversy in the diagnostic criteria for gender identity disorder (GID), including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.

Disorders of sex development are an important differential diagnosis in gender discordant children and adolescents, for which endocrinological treatment may be indicated. When the clinical history suggests that a somatic intersex condition may be present, clinicians should consider consultation with a pediatric endocrinologist or other specialist familiar with these conditions.

Children. Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity. There have been no randomized controlled trials of any treatment. Early treatments for gender discordance developed in the 1970s included behavioral paradigms; their long-term risks and benefits have not been followed up in controlled trials, and have been rejected on ethical grounds as having an inappropriately punitive and coercive basis. Psychodynamically based psychotherapy for gender discordance in boys has been proposed based on a psychodynamic hypothesis that gender discordance is a defense in fantasy against profound, early separation anxiety; like other treatment strategies, this has not been empirically tested in controlled trials.

Recent treatment strategies based upon uncontrolled case series have been described that focus on parent guidance and peer group interaction. One seeks to hasten desistence of gender discordance in boys through eclectic interventions such as behavioral and milieu techniques, parent guidance and school consultation aimed at encouraging positive relationships with father and male peers, gender-typical skills, and increased

maternal support for male role-taking and independence. Another approach encourages tolerance of gender discordance, while setting limits on expression of gender-discordant behavior that may place the child at risk for peer or community harassment. Desistence of gender discordance has been described in both treatment approaches, as it is in untreated children.

As an ethical guide to treatment, "the clinician has an obligation to inform parents about the state of the empiric database," including information about both effectiveness and potential risks. As children may experience imperatives to shape their communications about gender discordant wishes in response to social norms, a true change in gender discordance must be distinguished from simply teaching children to hide or suppress their feelings. Similarly, the possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth, the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.

Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed.

There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender-discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so. Social gender assignment appears to exert partial influence on the gender identity of infants with disorders of sex development. At the same time, countervailing biological factors may override social gender assignment and contribute significantly to gender discordance in many cases. Therefore, the possibility that sending a child to school in his/her desired gender may consolidate gender discordance or expose the child to bullying should be weighed against risks of not doing so, such as distress, social isolation, depression, or suicide due to lack of social support. Further research is needed to guide clinical decision making in this area.

Adolescents. For some individuals, discordance between gender and phenotypic sex presents in adolescence or adulthood. Sometimes it emerges in parallel with puberty and secondary sex characteristics, causing distress leading to a developmental crisis. Transgender adolescents and adults often wish to bring their biological sex into conformity with their gender identity through strategies that include hormones, gender correction surgery, or both, and may use illicitly obtained sex hormones or other medications with hormonal activity to this end. They may be at risk from side effects of unsupervised medication or sex hormone use.

One goal of treatment for adolescents in whom a desire to be the other sex is persistent is to help them make developmentally appropriate decisions about sex reassignment, with the aim of reducing risks of reassignment and managing associated comorbidity. In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent. Transgender youth may face special risks associated with hormone misuse, such as short- and long-term side effects, improper dosing, impure or counterfeit medications, and infection from shared syringes.

For situations in which deferral of sex-reassignment decisions until adulthood is not clinically feasible, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues that reversibly delay the development of secondary sexual characteristics. The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex. Prospective, case-controlled study of such treatment to delay puberty has shown some beneficial effects on behavioral and emotional problems, depressive symptoms, and general functioning (although not on anxiety or anger), and appears to be well tolerated acutely. In addition, gender discordance is associated with lower rates of mental health problems when it is treated in adolescence than when it is treated in adulthood. Therefore, such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.

Treatment approaches for GID using guidelines based on the developmental trajectories of gender-discordant adolescents have been described. In one approach, puberty suppression is considered beginning at age 12, cross-sex hormone treatment is considered beginning at age 16, and gender reassignment surgery at age 18. Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and treatment of associated mental health problems. In another approach based on stage of physical development rather than age, pubertal suppression has been described at Tanner stage 2 in adolescents with persistent GID; risks requiring management include effects on growth, future fertility, uterine bleeding, and options for subsequent genital surgery and cross-sex hormone use. For families of transgender adolescents, a therapeutic group approach has been described that encourages parental acceptance. This approach may help to mitigate psychopathology and other deleterious effects of environmental nonacceptance. Further research is needed to definitively establish the effectiveness and acceptability of these treatment approaches.

Principle 8. Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youth and their families.

Evaluating youths' school, community, and culture—essential in any psychiatric evaluation—is particularly important for sexual and gender minority youth. Clinicians should seek information about the sexual beliefs, attitudes, and experiences of these social systems, and whether they are supportive or hostile in the patient's perception and in reality. Clinicians should not assume that all parties involved in a youth's social system know about his or her sexual identity. They should review with the youth what information can be shared with whom, and elicit concerns regarding specific caregivers. If appropriate, the clinician can consider interventions to enhance support, with the youth's knowledge and assent.

As consultants, mental health professionals can help to raise awareness of issues affecting sexual and gender minority youth in schools and communities, and advise programs that support them. Clinicians can consider advocating for policies and legislation supporting nondiscrimination against and equality for sexual and gender minority youth and families, and the inclusion of related information in school curricula and in libraries.

Principle 9. Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youth.

Many community-based organizations and programs provide sexual and gender minority students with supportive, empowering experiences safe from stigma and discrimination (e.g., the Harvey Milk School at the Hetrick Martin Institute, www.hmi.org ; Gay-Straight Alliances, www.gsanetwork.org).

There are many books and Internet resources for youth and families on issues such as discovering whether one is gay or lesbian. Clinicians should consider exploring what youth and families read, and help them to identify useful resources. Organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN) provide support and resources for families, youth, and educators. These organizations have programs in a number of communities. Clinicians can obtain information through professional channels such as the American Academy of Child & Adolescent Psychiatry (AACAP) Sexual Orientation and Gender Identity Issues Committee (www.aacap.org), the American Psychiatric Association (www.psych.org), the Lesbian and Gay Child and Adolescent Psychiatric Association (www.lagcapa.org), and the Association for Gay and Lesbian Psychiatrists (www.aglp.org).

The Model Standards Project, published by the Child Welfare League of America, is a practice tool related to the needs of lesbian, gay, bisexual, and transgender (LGBT) youth in foster care or juvenile justice systems available at www.cwla.org . The Standards of Care for Gender Identity Disorders, including psychiatric and medical care, are published by the World Professional Association for Transgender Health (www.wpath.org).

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Psychosocial distress that can develop in child and adolescent members of sexual minorities (homosexual, lesbian, bisexual, gender variant, or transgender) including:

- Depression
- Anxiety disorders
- Substance abuse
- Suicidality

Guideline Category

Assessment of Therapeutic Effectiveness

Counseling

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Endocrinology

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Nurses

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To foster clinical competence in those caring for children and adolescents who are growing up gay, lesbian, bisexual, gender variant, or transgender, reflecting what is currently known about best clinical practices for these youth

Target Population

Children and adolescents who are growing up gay, lesbian, bisexual, gender variant, or transgender

Interventions and Practices Considered

1. Comprehensive diagnostic evaluation with an assessment of psychosexual development
2. Confidentiality
3. Exploration of family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity
4. Awareness of psychiatric risk and a healthy psychosexual development should be fostered
5. Utilization of current evidence in choosing treatment goals and modality
6. Liaison with schools, community agencies, and other health care providers
7. Community and professional resources

Note: Sexual therapy is not recommended since there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.

Major Outcomes Considered

- Rate of persistence/desistence of gender nonconformity or discordance

- Incidence of bullying of gay, lesbian, bisexual, or transgender (GLBT) youth
- Incidence of suicide, drug abuse, and sexually transmitted diseases in GLBT youth
- Side effects of hormone or surgical treatment

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The list of references for this Practice Parameter was developed by online searches of Medline and PsycINFO. A search of PsycINFO articles published since 1806 and Medline articles published from 1950 through April 27, 2010, of key-word terms "sexual orientation," "gay," "homosexuality," "male homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender variant," "gender atypical," "gender identity disorder," and "homosexuality, attitudes toward" limited to English language, human subjects, and ages 0–17 years (PsycINFO) or 0–18 years (Medline) produced 7,825 unique and 967 duplicate references.

To take full advantage of the MeSH Subject Headings database, a subsequent search was conducted of articles in the Medline database through May 3, 2010 using MeSH Subject Headings terms "homosexuality, "male homosexuality," "female homosexuality," "bisexuality," "transsexualism," and limiting articles to those written in English and related to human subjects, all child and adolescent ages (0–18 years). This search produced 2,717 references.

Similarly, to take full advantage of the Thesaurus Terms (Descriptors) database, a subsequent search was conducted of articles in the PsycINFO articles through May 14, 2010 using Thesaurus Terms (Descriptors) "sexual orientation," "homosexuality," "male homosexuality," "female homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender identity disorder," and "homosexuality (attitudes toward)" and limiting articles to those written in English and related to human subjects of childhood age (0–12) and adolescent age (13–17). This search produced 1,751 references.

The combined search in Medline MeSH Subject Headings and PsycINFO Thesaurus Terms (Descriptors) databases produced 4,106 unique references and 361 duplicate references. Of the 4,106 unique references, the following were winnowed out: 345 books or book sections; 94 dissertation abstracts; 18 editorials; 13 articles whose focus was primarily historical; 104 theoretical formulation or comment without peer review; 163 case reports or brief series; 32 related primarily to policy or law; 19 related to news; 74 related primarily to research methods; 736 primarily about human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) and an additional 404 about early HIV/AIDS or other sexually transmitted illness; one each related to an award, book review, or interview; 168 that dealt primarily with diseases, reproduction, paraphilia or intersex conditions beyond the scope of the Parameter; an additional 8 that fell outside the specified age range; an additional 26 duplicates that were found; and 10 dating from 1960 to 1975 related to aversive or "reparative" techniques intended to change sexual orientation that are inconsistent with current ethical position statements of the American Psychiatric Association. This winnowing process yielded 1,889 references.

To help ensure completeness of the search strategies, the search results using Medline MeSH terms and PsycINFO Thesaurus terms (Descriptors) were compared to key-word terms of the Medline and PsycINFO databases. This comparison demonstrated 1,113 overlapping references, with 6,712 unique to the key-word search and 2,993 unique to the combined Thesaurus Term (Descriptor) and MeSH searches.

An updated Medline search of articles through March 3, 2011, of the MeSH database using the same Subject Headings and limits used in the previous search produced 138 references. An updated PsycINFO search of articles through March 3, 2011, of the Thesaurus database using the same Terms (Descriptors) and limits used in the previous search produced 107 references. Throughout the search, the bibliographies of source materials including books, book chapters, and review articles were consulted for additional references that were not produced by the online searches. Bibliographies of publications by selected experts were also examined to find additional pertinent articles not produced by online searches. Recent studies and discussions at scientific meetings in the past decade were considered for inclusion.

From the list of references assembled in this way, references were selected whose primary focus was mental health related to sexual orientation, gender nonconformity, and gender discordance in children and adolescents. References that were not a literature review, published in peer-reviewed literature, or based on methodologically sound strategies such as use of population-based, controlled, blinded, prospective, or multi-site evidence were eliminated. References were selected that illustrated key points related to clinical practice. When more than one reference illustrated a key point around which there is general consensus, preference was given to those that were more recent, relevant to the U.S. population, most illustrative of key clinical concepts, based upon larger samples, prospective study design, or meta-analysis. When discussing issues around which consensus is not yet established, citations illustrating a representative sample of multiple viewpoints were selected.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Not stated

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed by the AACAP Committee on Quality Issues (CQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP website

AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This Practice Parameter was reviewed at the Member Forum at the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting in October 2010.

From September 2011 to February 2012, this Parameter was reviewed by a Consensus Group convened by the Committee on Quality Issues (CQI).

This Practice Parameter was approved by the AACAP Council on May 31, 2012.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of children and adolescents who are growing up to be gay, lesbian, bisexual, gender variant, or transgender

Potential Harms

Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

Contraindications

Contraindications

Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.

Qualifying Statements

Qualifying Statements

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and that patient's family, the diagnostic and treatment options available, and other available resources.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Adelson SL, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012 Sep;51(9):957-74. [110 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2012 Sep

Guideline Developer(s)

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American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI)

Composition of Group That Authored the Guideline

Committee Members: Stewart L. Adelson, M.D. and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI): Heather J. Walter, M.D., M.P.H., and Oscar G. Bukstein, M.D., M.P.H., Co-Chairs, and Christopher Bellonci, M.D., R. Scott Benson, M.D., Allan Chrisman, M.D., Tiffany R. Farchione, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Nicole Quiterio, M.D., Ulrich Schoettle, M.D., Matthew Siegel, M.D., and Saundra Stock, M.D.

AACAP Liaison: Jennifer Medicus

Financial Disclosures/Conflicts of Interest

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Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site

Availability of Companion Documents

None available

Patient Resources

The following is available:

- Gay, Lesbian and Bisexual Adolescents. Facts for families. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2006 Dec. Electronic copies: Available from the American Academy of Child and Adolescent Psychiatry Web site

NGC Status

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FOOTNOTE 15

740 F.3d 1208
United States Court of Appeals,
Ninth Circuit.

David H. PICKUP; Christopher H. Rosick; Joseph Nicolosi; Robert Vazzo; National Association for Research and Therapy of Homosexuality, a Utah non-profit organization; American Association of Christian Counselors, a Virginia non-profit association; Jack Doe 1, Parent of John Doe 1; Jane Doe 1, Parent of John Doe 1; John Doe 1, a minor, guardian ad litem Jane Doe, guardian ad litem Jack Doe; Jack Doe 2, Parent of John Doe 2; Jane Doe 2, Parent of John Doe 2; John Doe 2, a minor, guardian ad litem Jack Doe, guardian ad litem Jane Doe, Plaintiffs–Appellants,
v.
Edmund G. BROWN, Jr., Governor of the State of California, in his official capacity; Anna M. Caballero, Secretary of the California State and Consumer Services Agency, in her official capacity; Sharon Levine, President of the Medical Board of California, in her official capacity; Kim Madsen, Executive Officer of the California Board of Behavioral Sciences, in her official capacity; Michael Erickson, President of the California Board of Psychology, in his official capacity, Defendants–Appellees,
and
Equality California, Intervenor–Defendant–Appellee.
Donald Welch; Anthony Duk; Aaron Bitzer, Plaintiffs–Appellees,
v.
Edmund G. Brown, Jr., Governor of the State of California, in his official capacity; Anna M. Caballero, Secretary of California State and Consumer Services Agency, in her official capacity; Denise Brown, Case Manager, Director of Consumer Affairs, in her official capacity; Christine Wietlisbach, Patricia Lock Dawson, Samara Ashley, Harry Douglas, Julia Johnson, Sarita Kohli, Renee Lonner, Karen Pines, Christina Wong, in their official capacities as members of the California Board of Behavioral Sciences; Sharon Levine, Michael Bishop, Silvia Diego, Dev Gnanadev, Reginald Low, Denise Pines, Janet Salomonson, Gerrie Schipske, David Serrano Sewell, Barbara Yaroslavsky, in their official capacities as members of the Medical Board of California, Defendants–Appellants.

Nos. 12–17681, 13–15023.
|
Argued and Submitted April 17, 2013.
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Filed Aug. 29, 2013.
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Amended Jan. 29, 2014.

Synopsis

Background: Mental health providers that offered sexual orientation change efforts (SOCE) therapy, organizations that advocated SOCE therapy, and children undergoing SOCE therapy and their parents brought actions seeking declaratory judgment that state law prohibiting licensed mental health providers from providing SOCE therapy to children under 18 violated their constitutional rights. The United States District Court for the Eastern District of California, Kimberly J. Mueller, J., 2012 WL 6021465,denied plaintiffs' motion for preliminary injunction, and the United States District Court for the Eastern District of California, William B. Shubb, Senior Judge, 907 F.Supp.2d 1102, granted plaintiff's motion for preliminary injunction. Interlocutory appeals were taken.

Holdings: The Court of Appeals, Graber, Circuit Judge, held that:

[1] providers' claim that statute violated their free speech rights was subject to rational basis review;

[2] statute was rationally related to state's legitimate interest in protecting minors;

[3] therapist-client relationship was not protected intimate human relationship;

[4] statute was not facially void for vagueness;

[5] statute was not overbroad; and

[6] statute did not infringe on parents' fundamental right to make decisions regarding care, custody, and control of their children.

Affirmed in part, reversed in part, and remanded.

Rehearing en banc denied.

O'Scannlain, Circuit Judge, joined by Bea and Ikuta, Circuit Judges, dissented from denial of rehearing en banc, and filed opinion.

West Headnotes (32)

[1] **Federal Courts**
Preliminary injunction;temporary restraining order

Although Court of Appeals generally reviews for abuse of discretion district court's decision to grant or deny preliminary injunction, it may undertake plenary review of issues if district court's ruling rests solely on premise as to applicable rule of law, and facts are established or of no controlling relevance.

Cases that cite this headnote

[2] **Federal Courts**
Failure to mention or inadequacy of treatment of error in appellate briefs

Federal Courts
Lack or inadequacy of citations to record

Parties challenging constitutionality of state law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 waived appellate review of their claim that statute violated First Amendment's religion clauses, where their response brief contained single paragraph regarding claim, which cited neither record nor any case. U.S.C.A. Const.Amend. 1; West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

Cases that cite this headnote

[3] **Constitutional Law**
Health care professions

Health
Regulation of Professional Conduct; Boards and Officers

Mental health providers' claim that state law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 violated their First Amendment free speech rights was subject to rational basis review, rather than strict scrutiny, even though SOCE therapy could be performed through speech alone; regulated activities were therapeutic, not symbolic, and law only banned form of medical treatment for minors, but allowed discussions about treatment, recommendations to obtain treatment, and expressions of opinions about SOCE and homosexuality. U.S.C.A. Const.Amend. 1; West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

11 Cases that cite this headnote

[4] **Constitutional Law**
Health care professions

Doctor-patient communications about medical treatment receive substantial First Amendment protection, but government has more leeway to regulate conduct necessary to administering treatment itself. U.S.C.A. Const.Amend. 1.

5 Cases that cite this headnote

[5] **Constitutional Law**
Health care professions

Psychotherapists are not entitled to special First Amendment protection merely because mechanism used to deliver mental health treatment is spoken word. U.S.C.A. Const.Amend. 1.

Cases that cite this headnote

[6] **Constitutional Law**

Health care professions

Communication that occurs during psychotherapy does receive some protection under First Amendment, but it is not immune from regulation. U.S.C.A. Const.Amend. 1.

1 Cases that cite this headnote

[7] **Constitutional Law**
Health care professions

Where medical professional is engaged in public dialogue, First Amendment protection is at its greatest, but First Amendment protection of medical professional's speech is somewhat diminished within confines of professional relationship. U.S.C.A. Const.Amend. 1.

13 Cases that cite this headnote

[8] **Constitutional Law**
Health care professions
Health
Negligence, malpractice, or incompetence

Doctor may not counsel patient to rely on quack medicine; First Amendment would not prohibit doctor's loss of license for doing so. U.S.C.A. Const.Amend. 1.

2 Cases that cite this headnote

[9] **Constitutional Law**
Sanctions or discipline for unprofessional conduct, in general

Lawyer may be disciplined for divulging confidences of his client, even though such disclosure is pure speech. U.S.C.A. Const.Amend. 1.

Cases that cite this headnote

[10] **Constitutional Law**
Health care professions

Most, if not all, medical and mental health treatments require speech, but that fact does not give rise to First Amendment claim when state bans particular treatment. U.S.C.A. Const.Amend. 1.

2 Cases that cite this headnote

[11] **Health**
Regulation of Professional Conduct; Boards and Officers

Pursuant to its police power, state has authority to regulate licensed mental health providers' administration of therapies that legislature has deemed harmful.

Cases that cite this headnote

[12] **Constitutional Law**
Health care professions
Health
Validity

State law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 was rationally related to state's legitimate interest in protecting physical and psychological well-being of minors, including lesbian, gay, bisexual and transgender youth, and in protecting its minors against exposure to serious harms caused by sexual orientation change efforts, and thus did not violate mental health providers' First Amendment free speech rights, despite some evidence that SOCE was safe and effective, where report by national psychological association concluded that SOCE had not been demonstrated to be effective, other professional associations opposed use of SOCE, concluding, among other things, that homosexuality was not illness and did not require treatment, and there were anecdotal reports of harm, including depression, suicidal thoughts or actions, and substance abuse. U.S.C.A.Const.Amend. 1; West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

4 Cases that cite this headnote

[13] **Federal Courts**
Waiver of Error in Appellate Court

Rule of waiver is discretionary, and Court of Appeals has discretion to address argument that otherwise would be waived when issue presented is purely one of law and either does not depend on factual record developed below, or pertinent record has been fully developed.

1 Cases that cite this headnote

[14] **Constitutional Law**
Intimate association;dating relationships in general
Constitutional Law
Familial association

First type of association protected by First Amendment concerns intimate human relationships, which are implicated in personal decisions about marriage, childbirth, raising children, cohabiting with relatives, and the like, and receives protection as fundamental element of personal liberty. U.S.C.A.Const.Amend. 1.

1 Cases that cite this headnote

[15] **Constitutional Law**
Right of Assembly
Constitutional Law
Right to Petition for Redress of Grievances
Constitutional Law
Freedom of Association

First Amendment protects association for purpose of engaging in those activities protected by First Amendment, speech, assembly, petition for redress of grievances, and exercise of religion. U.S.C.A.Const.Amend. 1.

1 Cases that cite this headnote

[16] **Constitutional Law**
Freedom of Association
Health
Nature and existence of relation

Therapist-client relationship is not close-knit, intimate human relationship that receives protection as fundamental element of personal liberty under First Amendment freedom of association. U.S.C.A.Const.Amend. 1.

1 Cases that cite this headnote

[17] **Constitutional Law**
Health care professionals
Health
Validity

State law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 was not facially void for vagueness under Due Process Clause, despite providers' contention that they could not ascertain where line was between what was prohibited and what was permitted, where reasonable person would understand statute to regulate only mental health treatment, including psychotherapy, that aimed to alter minor patient's sexual orientation, law applied only to licensed professionals who had specialized knowledge, and term "sexual orientation" was defined in other statutory provisions. U.S.C.A. Const.Amend. 14; West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

1 Cases that cite this headnote

[18] **Constitutional Law**
Certainty and definiteness;vagueness

It is basic principle of due process that enactment is void for vagueness if its prohibitions are not clearly defined. U.S.C.A. Const.Amend. 14.

1 Cases that cite this headnote

[19] **Constitutional Law**
Certainty and definiteness;vagueness
Constitutional Law
Speech, press, assembly, and petition

Perfect clarity and precise guidance have never been required even of regulations that

restrict expressive activity to avoid being void for vagueness under Due Process Clause. U.S.C.A. Const.Amend. 14.

1 Cases that cite this headnote

[20] **Constitutional Law**
Certainty and definiteness;vagueness

Uncertainty at statute's margins will not warrant facial due process void for vagueness invalidation if it is clear what statute proscribes in vast majority of its intended applications. U.S.C.A. Const.Amend. 14.

1 Cases that cite this headnote

[21] **Constitutional Law**
Vagueness as to Covered Conduct or Standards of Enforcement;Offenses and Penalties

Defendant is deemed to have fair notice of offense if reasonable person of ordinary intelligence would understand that his or her conduct is prohibited by law in question.

Cases that cite this headnote

[22] **Constitutional Law**
Certainty and definiteness;vagueness

If statutory prohibition involves conduct of select group of persons having specialized knowledge, and challenged phraseology is indigenous to idiom of that class, standard for whether statute regulating that conduct is void for vagueness under Due Process Clause is lowered, and court may uphold statute that uses words or phrases having technical or other special meaning, well enough known to enable those within its reach to correctly apply them. U.S.C.A. Const.Amend. 14.

Cases that cite this headnote

[23] **Constitutional Law**
Health care professions
Health
Validity

Any incidental effect on speech resulting from state law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 was small in comparison to its plainly legitimate sweep, and thus statute was not overbroad under First Amendment, where statute's plainly legitimate sweep included SOCE techniques such as inducing vomiting or paralysis, administering electric shocks, and performing castrations. U.S.C.A. Const.Amend. 1; West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

Cases that cite this headnote

[24] **Constitutional Law**
Prohibition of substantial amount of speech

Overbreadth doctrine permits facial invalidation of laws that prohibit substantial amount of constitutionally protected speech. U.S.C.A. Const.Amend. 1.

Cases that cite this headnote

[25] **Constitutional Law**
Statutes in general

Mere fact that one can conceive of some impermissible applications of statute is not sufficient to render it susceptible to overbreadth challenge.

Cases that cite this headnote

[26] **Constitutional Law**
Prohibition of substantial amount of speech

Particularly where conduct and not merely speech is involved, statute's overbreadth under First Amendment must not only be real, but substantial as well, judged in relation to statute's plainly legitimate sweep. U.S.C.A. Const.Amend. 1.

Cases that cite this headnote

[27] **Health**

Minors in general;consent of parent or guardian

Infants

Health, Safety, and Morals

Parents do not have fundamental right to choose for their children particular type of provider for particular medical or mental health treatment that state has deemed harmful.

2 Cases that cite this headnote

[28] Parent and Child

Care, Custody, and Control of Child; Child Raising

Parents have constitutionally protected right to make decisions regarding care, custody, and control of their children, but that right is not without limitations.

Cases that cite this headnote

[29] Education

Compulsory Attendance

Infants

Prohibited hours and premises;curfew

States may require school attendance and mandatory school uniforms, and they may impose curfew laws applicable only to minors.

Cases that cite this headnote

[30] Health

Minors in general;consent of parent or guardian

Infants

Medical and dental

In health arena, states may require compulsory vaccination of children, subject to some exceptions, and may intervene when parent refuses necessary medical care for child.

Cases that cite this headnote

[31] Infants

Health, Safety, and Morals

State is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.

1 Cases that cite this headnote

[32] Health

Validity

State law prohibiting licensed mental health providers from providing sexual orientation change efforts (SOCE) therapy to children under 18 did not infringe on parents' fundamental right to make decisions regarding care, custody, and control of their children, where state had determined that SOCE therapy was harmful to minors. West's Ann.Cal. Bus. & Prof.Code § 865 et seq.

3 Cases that cite this headnote

West Codenotes

Negative Treatment Reconsidered

West's Ann.Cal.Bus. & Prof.Code §§ 865, 865.1, 865.2

Attorneys and Law Firms

*1213 Mathew D. Staver (argued) and Anita L. Staver, Liberty Counsel, Maitland, FL; Mary E. McAlister, Stephen M. Crampton, and Daniel J. Schmid, Liberty Counsel, Lynchburg, VA, for Plaintiffs–Appellants David H. Pickup et al.

Alexandra Robert Gordon (argued), Deputy Attorney General, Kamala D. Harris, Attorney General of California, Douglas J. Woods, Senior Assistant Attorney General, Tamar Pachter, Supervising Deputy Attorney General, and Daniel J. Powell and Rei R. Onishi, Deputy Attorneys General, San Francisco, CA, for Defendants–Appellees Edmund G. Brown, Jr., et al.

Shannon P. Minter (argued), National Center for Lesbian Rights, San Francisco, CA; David C. Dinielli, Munger, Tolles & Olson LLP, Los Angeles, CA, for Intervenor/Defendant–Appellee.

Robert P. Taylor, Arnold & Porter LLP, San Francisco, CA, for Amici Curiae American Association for Marriage