2012 - Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression

The American Psychoanalytic Association affirms the right of all people to their sexual orientation, gender identity and gender expression without interference or coercive interventions attempting to change sexual orientation, gender identity or gender expression.

As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice.

Psychoanalytic technique does not encompass purposeful attempts to “convert,” “repair,” change or shift an individual’s sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.

Adopted June 2012. This position statement replaces APsaA’s December 1999 position statement on reparative therapy

APS Position Statement on Psychological Practices that attempt to change Sexual Orientation

Approaches to mental health practice variously referred to as 'reparative', 'conversion' or 'ex-gay' are based on the belief that homosexuality is a disorder, and that it can be 'cured'. No professional health organisation in Australia supports these approaches, for the following reasons:

1) There is no clinical evidence demonstrating that approaches that claim to change a person's sexual orientation are effective.
2) There is, however, a considerable body of evidence documenting the negative effects of stigma associated with homosexuality, including higher rates of depression.
3) There is also clinical evidence that reparative, conversion and ex-gay approaches can compound the challenges already faced by some lesbians and gay men. For example, the 'failure' of such approaches can further contribute to negative mental health outcomes.

As a professional organisation committed to evidence-based practice, the Australian Psychological Society strongly opposes any form of mental health practice that treats homosexuality as a disorder, or seeks to change a person's sexual orientation. Any psychologist attempting to do so is likely to be in breach of the APS Code of Ethics.

Instead, in response to an individual client who may be struggling with their homosexuality, the Australian Psychological Society recommends psychological approaches that attempt to:

- challenge negative stereotypes
- develop affirming social supports
- promote self-acceptance; and
- increase mental health literacy.

Such responses are in line with the APS *Code of Ethics* and Ethical *Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients.*

References

Australian Psychological Society. (2007). *Code of ethics*. Melbourne: APS.

Australian Psychological Society. (2010). *Ethical Guidelines for psychological practice with lesbian, gay and bisexual clients.* Melbourne: APS.

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Memorandum of Understanding on Conversion Therapy in the UK

Version 2

October 2017

The British Psychological Society
Promoting excellence in psychology

The Association for Child and Adolescent Mental Health

acc
Association of Christian Counsellors

GLADD
The Association of LGBT Doctors & Dentists

BABCP
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College of Sexual and Relationship Therapists

The National Counselling Society

NHS England

NHS Scotland

Pink Therapy
Working with gender, sexuality and relationship diversities

relate
the relationship people

RCGP
Royal College of General Practitioners

UKCP
UK Council for Psychotherapy

Purpose and Overarching Position:

1 The primary purpose of this Memorandum of Understanding (MoU) is the protection of the public through a commitment to ending the practice of 'conversion therapy' in the UK.

2 For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to supress an individual's expression of sexual orientation or gender identity on that basis.

These efforts are sometimes referred to by terms including, but not limited to, 'reparative therapy', 'gay cure therapy', or 'sexual orientation and gender identity change efforts', and sometimes may be covertly practised under the guise of mainstream practice without being named.

i) For the purpose of this document, sexual orientation refers to the sexual or romantic attraction someone feels to people of the same sex, opposite sex, more than one sex, or to experience no attraction.

ii) For the purposes of this document, gender identity is interpreted broadly to include all varieties of binary (male or female), non-binary and gender fluid identities.

3 Signatory organisations agree that the practice of conversion therapy, whether in relation to sexual orientation or gender identity, is unethical and potentially harmful.

4 Signatory organisations agree that neither sexual orientation nor gender identity in themselves are indicators of a mental disorder.

5 This MoU also intends to ensure that:

- the public are well informed about the risks of conversion therapy.
- healthcare professionals and psychological therapists are aware of the ethical issues relating to conversion therapy.
- new and existing psychological therapists are appropriately trained.
- evidence into conversion therapy is kept under regular review.
- professionals from across the health, care and psychological professions work together to achieve the above goals.

6 This position is not intended to deny, discourage or exclude those with uncertain feelings around sexuality or gender identity from seeking qualified and appropriate help.

This document supports therapists to provide appropriately informed and ethical practice when working with a client who wishes to explore, experiences conflict with or is in distress regarding, their sexual orientation or gender identity.

Nor is it intended to stop psychological and medical professionals who work with trans and gender questioning clients from performing a clinical assessment of suitability prior to medical intervention.

For people who are unhappy about their sexual orientation or their transgender status, there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance. Some people may benefit from the challenge of psychotherapy and counselling to help them manage dysphoria and to clarify their sense of themselves. Clients make healthy choices when they understand themselves better.

Ethical practice in these cases requires the practitioner to have adequate knowledge and understanding of gender and sexual diversity and to be free from any agenda that favours one gender identity or sexual orientation as preferable over other gender and sexual diversities. For this reason, it is essential for clinicians to acknowledge the broad spectrum of sexual orientations and gender identities and gender expressions.

Roles and responsibilities:

7 Signing this document commits signatory organisations to draw up an action plan to proactively implement the relevant actions below.

8 Where appropriate, the organisations undersigned will ensure that there is board-level support in carrying out the necessary measures to meet the commitments within the MoU.

9 While all parties share a common interest in ending conversion therapy, their remits and responsibilities differ.

10 This MoU does not exhaustively list every action which every organisation will take but sets out a framework for how organisations will respond to the issue in areas where they do have responsibility.

11 Organisations with practice members will ensure through training and/or published guidelines that the relevant over-arching ethical principles in their statements of ethical practice are understood and applied when working with sexually and gender diverse clients, as pertaining to the basic standards of honest, competent and non-discriminatory practice to which clients of all identities and orientations are entitled.

12 Organisations that work in the provision of mental or psychological health delivery or commissioning, such as the NHS, will seek to ensure they do not commission or provide conversion therapy.

13 Professional associations will work to ensure their memberships have access to the latest information regarding conversion therapy.

14 Professional associations will endeavour to make Continuing Professional Development (CPD) events available which help develop therapists' understanding and cultural competence in working with gender and sexually diverse clients.

15 Organisations will work together to create a shared information resource on conversion therapy, including Frequently Asked Questions (FAQs), and help and support for both members of the public and professionals.

16 Those with a responsibility for training will work to ensure that training prepares therapists to have sufficient levels of cultural competence such that they can work effectively with gender and sexually diverse clients.

17 Training organisations will refer to the latest British Psychological Society guidelines on working with gender and sexually diverse clients when reviewing their curriculum on equality and diversity issues.

18 Organisations will review their current guidelines and policies and consider the need to include more specific requirements to ensure individual practitioners and training organisations demonstrate awareness and understanding of policy regarding conversion therapy.

19 Campaigning bodies will work to ensure that their target audiences are aware of the basis for concern about any ongoing practice of conversion therapy.

Review & Research:

20 Signatory organisations will meet regularly to oversee the implementation of the MoU and monitor progress towards the realising its intentions and goals.

21 Within the next five years, if funded, signatory organisations will seek to ensure appropriate research into the prevalence and effects of conversion therapy in the UK, and into how best to work with gender and sexually diverse clients.

22 The text of the MoU will be kept under review and altered, if necessary, in the light of new research or the appearance of unintended consequences. A full formal review will be conducted within the next 12 months.

23 Signatory organisations will endeavour to keep abreast of international developments in addressing conversion therapy.

Mutual understanding:

24 The memorandum is not intended to and does not create any contractual obligations between these parties.

25 Instead, this memorandum is signed in recognition of a shared professional responsibility to improve the support and help available to those at risk from conversion therapy.

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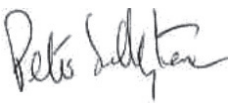

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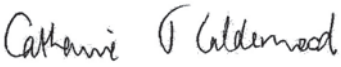

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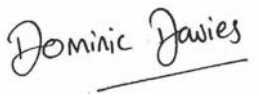

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SPECIAL FEATURE

Clinical Practice Guideline

Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline

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Objective: The aim was to formulate practice guidelines for endocrine treatment oftranssexual persons.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system to describe the strength of recommendations and the quality of evidence, which was low or very low.

Consensus Process: Committees and members of The Endocrine Society, European Society of Endocrinology, European Society for Paediatric Endocrinology, Lawson Wilkins Pediatric Endocrine Society, and World Professional Association for Transgender Health commented on preliminary drafts of these guidelines.

Conclusions: Transsexual persons seeking to develop the physical characteristics of the desired gender require a safe, effective hormone regimen that will 1) suppress endogenous hormone secretion determined by the person's genetic/biologic sex and 2) maintain sex hormone levels within the normal range for the person's desired gender. A mental health professional (MHP) must recommend endocrine treatment and participate in ongoing care throughout the endocrine transition and decision for surgical sex reassignment. The endocrinologist must confirm the diagnostic criteria the MHP used to make these recommendations. Because a diagnosis of transsexualism in a prepubertal child cannot be made with certainty, we do not recommend endocrine treatment of prepubertal children. We recommend treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may be given. We suggest suppressing endogenous sex hormones, maintaining physiologic levels of gender-appropriate sex hormones and monitoring for known risks in adult transsexual persons.
(*J Clin Endocrinol Metab* 94: 3132–3154, 2009)

Summary of Recommendations

1.0 Diagnostic procedure

1.1 We recommend that the diagnosis of gender identity disorder (GID) be made by a mental health professional (MHP). For children and adolescents, the MHP should also have training in child and adolescent developmental psychopathology. (1 ⊕⊕◯◯)

1.2 Given the high rate of remission of GID after the onset of puberty, we recommend against a complete social

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Abbreviations: BMD, Bone mineral density; FTM, female-to-male; GID, gender identity disorder; MHP, mental health professional; MTF, male-to-female; RLE, real-life experience.

role change and hormone treatment in prepubertal children with GID. (1 ⊕⊕◯◯)

1.3 We recommend that physicians evaluate and ensure that applicants understand the reversible and irreversible effects of hormone suppression (*e.g.* GnRH analog treatment) and cross-sex hormone treatment before they start hormone treatment.

1.4 We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults.

2.0 Treatment of adolescents

2.1. We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development. (1 ⊕◯◯◯)

2.2. We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3. (1 ⊕⊕◯◯)

2.3. We recommend that GnRH analogs be used to achieve suppression of pubertal hormones. (1 ⊕⊕◯◯)

2.4. We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 yr, using a gradually increasing dose schedule of cross-sex steroids. (2 ⊕◯◯◯)

2.5. We recommend referring hormone-treated adolescents for surgery when 1) the real-life experience (RLE) has resulted in a satisfactory social role change; 2) the individual is satisfied about the hormonal effects; and 3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

2.6 We suggest deferring surgery until the individual is at least 18 yr old. (2 ⊕◯◯◯)

3.0 Hormonal therapy for transsexual adults

3.1 We recommend that treating endocrinologists confirm the diagnostic criteria of GID or transsexualism and the eligibility and readiness criteria for the endocrine phase of gender transition. (1 ⊕⊕⊕◯)

3.2 We recommend that medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed prior to initiation of treatment (see Table 11: Medical conditions that can be exacerbated by cross-sex hormone therapy*)*. (1 ⊕⊕⊕◯)

3.3 We suggest that cross-sex hormone levels be maintained in the normal physiological range for the desired gender. (2 ⊕⊕◯◯)

3.4 We suggest that endocrinologists review the onset and time course of physical changes induced by cross-sex hormone treatment. (2 ⊕⊕◯◯)

4.0 Adverse outcome prevention and long-term care

4.1 We suggest regular clinical and laboratory monitoring every 3 months during the first year and then once or twice yearly. (2 ⊕⊕◯◯)

4.2 We suggest monitoring prolactin levels in male-to-female (MTF) transsexual persons treated with estrogens. (2 ⊕⊕◯◯)

4.3 We suggest that transsexual persons treated with hormones be evaluated for cardiovascular risk factors. (2 ⊕⊕◯◯)

4.4 We suggest that bone mineral density (BMD) measurements be obtained if risk factors for osteoporosis exist, specifically in those who stop hormone therapy after gonadectomy. (2 ⊕⊕⊕◯)

4.5 We suggest that MTF transsexual persons who have no known increased risk of breast cancer follow breast screening guidelines recommended for biological women. (2 ⊕⊕◯◯)

4.6 We suggest that MTF transsexual persons treated with estrogens follow screening guidelines for prostatic disease and prostate cancer recommended for biological men. (2 ⊕◯◯◯)

4.7 We suggest that female-to-male (FTM) transsexual persons evaluate the risks and benefits of including total hysterectomy and oophorectomy as part of sex reassignment surgery. (2 ⊕◯◯◯)

5.0 Surgery for sex reassignment

5.1 We recommend that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the MHP find surgery advisable. (1 ⊕◯◯◯)

5.2 We recommend that genital sex reassignment surgery be recommended only after completion of at least 1 yr of consistent and compliant hormone treatment. (1 ⊕◯◯◯)

5.3 We recommend that the physician responsible for endocrine treatment medically clear transsexual individuals for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery. (1 ⊕◯◯◯)

Introduction

Men and women have experienced the confusion and anguish resulting from rigid, forced conformity to sexual dimorphism throughout recorded history. Aspects

of gender variance have been part of biological, psychological, and sociological debates among humans in modern history. The 20th century marked the beginning of a social awakening for men and women "trapped" in the wrong body (1). Harry Benjamin and Magnus Hirschfeld, who met in 1907, pioneered the medical responses to those who sought relief from and resolution of their profound discomfort, enabling the "transsexual," a term coined by Hirschfeld in 1923, to live a gender-appropriate life, occasionally facilitated by surgery (2).

Endocrine treatment of transsexual persons [note: In the current psychiatric classification system, the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR), the term "gender identity disorder" is used instead of "transsexualism" (3)], previously limited to ineffective elixirs, creams, and implants, became reasonable with the availability of diethylstilbesterol in 1938 and after the isolation of testosterone in 1935. Personal stories of role models, treated with hormones and sex reassignment surgery, appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association (HBIGDA) was founded in September 1979; it is now known as the World Professional Association of Transgender Health (WPATH). The Association's "Standards of Care" (SOC) was first published by HBIGDA in 1979, and its sixth edition is currently being revised. These carefully prepared documents have provided mental health and medical professionals with general guidelines for the evaluation and treatment of transsexual persons.

Before 1975, few peer-reviewed articles were published concerning endocrine treatment of transsexual persons. Since that time, more than 800 articles about various aspects of transsexual care have appeared. It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable endocrinologists to provide safe and effective endocrine treatment for individuals diagnosed with GID or transsexualism by MHPs. In the future, rigorous evaluation of the effectiveness and safety of endocrine protocols is needed. What will be required is the careful assessment of: 1) the effects of prolonged delay of puberty on bone growth and development among adolescents; 2) in adults, the effects on outcome of both endogenous and cross-sex hormone levels during treatment; 3) the requirement for and the effects of antiandrogens and progestins during treatment; and 4) long-term medical and psychological risks of sex reassignment. These needs can be met only by a commitment of mental health and endocrine investigators to collaborate in long-term, large-scale studies across countries that employ the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools.

Terminology and its use vary and continue to evolve. Table 1 contains definitions of terms as they are used throughout the Guideline.

TABLE 1. Definitions of terms used in this guideline

Sex refers to attributes that characterize biological maleness or femaleness; the best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics
Gender identity is used to describe a person's fundamental sense of being a man, a woman, or of indeterminate sex.
Gender identity disorder (GID) is a DSM-IV-TR diagnosis. This psychiatric diagnosis is given when a strong and persistent cross-gender identification, combined with a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causes clinically significant distress.
Gender role is used to refer to behaviors, attitudes, and personality traits that a society, in a given culture and historical period, designates as masculine or feminine, that is, more "appropriate" to, or typical of, the social role as men or as women.
Gender dysphoria is the distress and unease experienced if gender identity and sex are not completely congruent.
Sexual orientation can be defined by a person's relative responsiveness to sexual stimuli. The most salient dimension of sexual orientation is the sex of the person to whom one is attracted sexually; sexual orientation is not entirely similar to *sexual identity*; a person may, for example, be predominantly aroused by homoerotic stimuli, yet not regard himself or herself to be gay or lesbian.
Sex reassignment refers to the complete treatment procedure for those who want to adapt their bodies to the desired sex.
Sex reassignment surgery refers only to the surgical part of this treatment.
Transsexual people identify as, or desire to live and be accepted as, a member of the gender opposite to that assigned at birth; the term *male-to-female* (MTF) *transsexual person* refers to a biological male who identifies as, or desires to be, a member of the female gender; *female-to-male* (FTM) *transsexual person* refers to a biological female who identifies as, or desires to be, a member of the male gender.
Transition refers to the period of time during which transsexual persons change their physical, social, and legal characteristics to the gender opposite that of their biological sex. Transition may also be regarded as an ongoing process of physical change and psychological adaptation.

Note: In this Guideline, we have chosen to use the term "transsexual" throughout as defined by the ICD-10 Diagnostic Code (see Table 3). We recognize that "transsexual" and "transgender" are terms often used interchangeably. However, because "transgender" may also be used to identify individuals whose gender identity does not conform to the conventional gender roles of either male or female and who may not seek endocrine treatment as described herein, we prefer to use "transsexual" as an adjective (*e.g.* when referring to persons, individuals, men, or women and, when appropriate, referring to subjects in research studies).

Etiology of Gender Identity Disorders

One's self-awareness as male or female evolves gradually during infant life and childhood. This process of cognitive and affective learning happens in interaction with parents, peers, and environment, and a fairly accurate timetable exists for the steps in this process (4). Normative psychological literature, however, does not address when gender identity becomes crystallized and what factors contribute to the development of an atypical gender identity. Factors that have been reported in clinical studies may well enhance or perpetuate rather than originate a GID (for an overview, see Ref. 5). Behavioral genetic studies suggest that, in children, atypical gender identity and role development has a heritable component (6, 7). Because, in most cases, GID does not persist into adolescence or adulthood, findings in children with GID cannot be extrapolated to adults.

In adults, psychological studies investigating etiology hardly exist. Studies that have investigated potential causal factors are retrospective and rely on self-report, making the results intrinsically unreliable.

Most attempts to identify biological underpinnings of gender identity in humans have investigated effects of sex steroids on the brain (functions) (for a review, see Ref. 8). Prenatal androgenization may predispose to development of a male gender identity. However, most 46,XY female-raised children with disorders of sex development and a history of prenatal androgen exposure do not develop a male gender identity (9, 10), whereas 46,XX subjects exposed to prenatal androgens show marked behavioral masculinization, but this does not necessarily lead to gender dysphoria (11–13). MTF transsexual individuals, with a male androgen exposure prenatally, develop a female gender identity through unknown mechanisms, apparently overriding the effects of prenatal androgens. There is no comprehensive understanding of hormonal imprinting on gender identity formation. It is of note that, in addition to hormonal factors, genetic mechanisms may bear on psychosexual differentiation (14).

Maternal immunization against the H-Y antigen has been proposed (15, 16). This hypothesis states that the repeatedly reported fraternal birth order effect reflects the progressive immunization of some mothers to Y-linked minor histocompatibility antigens (H-Y antigens) by each succeeding male fetus and the increasing effects of such immunization on the future sexual orientation of each succeeding male fetus. Sibling sex ratio studies have not been experimentally supported (17).

Studies have also failed to find differences in circulating levels of sex steroids between transsexual and nontranssexual individuals (18).

In summary, neither biological nor psychological studies provide a satisfactory explanation for the intriguing phenomenon of GIDs. In both disciplines, studies have been able to correlate certain findings to GIDs, but the findings are not robust and cannot be generalized to the whole population.

Method of Development of Evidence-based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee of The Endocrine Society deemed the diagnosis and treatment of transsexual individuals a priority area in need of practice guidelines and appointed a Task Force to formulate evidence-based recommendations. The Task Force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) group, an international group with expertise in development and implementation of evidence-based guidelines (19). A detailed description of the grading scheme has been published elsewhere (20). The Task Force used the best available research evidence that Task Force members identified and two commissioned systematic reviews (21, 22) to develop some of the recommendations. The Task Force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low quality evidence, ⊕⊕◯◯ denotes low quality, ⊕⊕⊕◯ denotes moderate quality, and ⊕⊕⊕⊕ denotes high quality. The Task Force has confidence that persons who receive care according to the strong recommendations will derive, on average, more good than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each "recommendation" is a description of the "evidence" and the "values" that panelists considered in making the recommendation; in some instances, there are "remarks," a section in which panelists offer technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the panelists and their values and preferences; therefore, these remarks should be considered suggestions. Some statements in this guideline (1.3 and 1.4) are not graded. These are statements the task force felt it was necessary to make, and it considers them matters about which no sensible health-

care professional could possibly consider advocating the contrary (*e.g.* clinicians should conduct an adequate history taking and physical examination, clinicians should educate patients about their condition). These statements have not been subject to structured review of the evidence and are thus not graded.

1.0 Diagnostic procedure

Sex reassignment is a multidisciplinary treatment. It requires five processes: diagnostic assessment, psychotherapy or counseling, RLE, hormone therapy, and surgical therapy. The focus of this Guideline is hormone therapy, although collaboration with appropriate professionals responsible for each process maximizes a successful outcome. It would be ideal if care could be given by a multidisciplinary team at one treatment center, but this is not always possible. It is essential that all caregivers be aware of and understand the contributions of each discipline and that they communicate throughout the process.

Diagnostic assessment and psychotherapy

Because GID may be accompanied with psychological or psychiatric problems (see Refs. 23–27), it is necessary that the clinician making the GID diagnosis be able 1) to make a distinction between GID and conditions that have similar features; 2) to diagnose accurately psychiatric conditions; and 3) to undertake appropriate treatment thereof. Therefore, the SOC guidelines of the WPATH recommend that the diagnosis be made by a MHP (28). For children and adolescents, the MHP should also have training in child and adolescent developmental psychopathology.

MHPs usually follow the WPATH's SOC. The main aspects of the diagnostic and psychosocial counseling are described below, and evidence supporting the SOC guidelines is given, whenever available.

During the diagnostic procedure, the MHP obtains information from the applicants for sex reassignment and, in the case of adolescents, the parents or guardians regarding various aspects of their general and psychosexual development and current functioning. On the basis of this information the MHP:

- decides whether the applicant fulfills DSM-IV-TR or ICD-10 criteria (see Tables 2 and 3) for GID;
- informs the applicant about the possibilities and limitations of sex reassignment and other kinds of treatment to prevent unrealistically high expectations; and
- assesses potential psychological and social risk factors for unfavorable outcomes of medical interventions.

In cases in which severe psychopathology or circumstances, or both, seriously interfere with the diagnostic work or make satisfactory treatment unlikely, management of the other issues should be addressed first. Literature on postoperative regret suggests that severe psychiatric comorbidity and lack of support may interfere with good outcome (30–33).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (34) and,

TABLE 2. DSM-IV-TR diagnostic criteria for GID (3)

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
   In children, the disturbance is manifested by four (or more) of the following:
   1. Repeatedly stated desire to be, or insistence that he or she is, the other sex.
   2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
   3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
   4. Intense desire to participate in the stereotypical games and pastimes of the other sex.
   5. Strong preference for playmates of the other sex.

   In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
   In children, the disturbance is manifested by any of the following:
   1. In boys, assertion that his penis or testes is disgusting or will disappear, or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities.
   2. In girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

   In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (*e.g.* request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Codes based on current age:
302.6 GID in children
302.85 GID in adolescents or adults

Specify whether (for sexually mature individuals):
Sexually attracted to males
Sexually attracted to females
Sexually attracted to both
Sexually attracted to neither

TABLE 3. ICD-10 criteria for transsexualism and GID of childhood (29)

Transsexualism (F64.0) criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 yr.
3. The disorder is not a symptom of another mental disorder or a genetic, intersex, or chromosomal abnormality.

GID of childhood (F64.2) has separate criteria for girls and for boys.

Criteria for girls:
1. The individual shows persistent and intense distress about being a girl and has a stated desire to be a boy (not merely a desire for any perceived cultural advantages of being a boy) or insists that she is a boy.
2. Either of the following must be present:
   a. Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing.
   b. Persistent repudiation of female anatomical structures, as evidenced by at least one of the following:
      i. An assertion that she has, or will grow, a penis.
      ii. Rejection of urination in a sitting position.
      iii. Assertion that she does not want to grow breasts or menstruate.
3. The girl has not yet reached puberty.
4. The disorder must have been present for at least 6 months.

Criteria for boys:
1. The individual shows persistent and intense distress about being a boy and has a desire to be a girl or, more rarely, insists that he is a girl.
2. Either of the following must be present:
   a. Preoccupation with stereotypic female activities, as shown by a preference for either cross-dressing or simulating female attire or by an intense desire to participate in the games and pastimes of girls and rejection of stereotypical male toys, games, and activities.
   b. Persistent repudiation of male anatomical structures, as evidenced by at least one of the following repeated assertions:
      i. That he will grow up to become a woman (not merely in the role).
      ii. That his penis or testes are disgusting or will disappear.
      iii. That it would be better not to have a penis or testes.
3. The boy has not reached puberty.
4. The disorder must have been present for at least 6 months.

preferably, a child psychiatric evaluation (by a clinician other than the diagnostician). Di Ceglie *et al.* (35) showed that 75% of the adolescents referred to their Gender Identity clinic in the United Kingdom reported relationship problems with parents. Therefore, a family evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic procedure.

The real-life experience

WPATH's SOC states that "the act of fully adopting a new or evolving gender role or gender presentation in everyday life is known as the real-life experience. The real-life experience is essential to the transition to the gender role that is congruent with the patient's gender identity. The real-life experience tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the MHP in their judgments about how to proceed" (28). During the RLE, the person should fully experience life in the desired gender role before irreversible physical treatment is undertaken. Living 12 months full-time in the desired gender role is recommended (28). Testing an applicant's ability to function in the desired gender assists the applicant, the MHP and the endocrinologist in their judgements about how to proceed. During the RLE, the person's feeling about the social transformation, including coping with the responses of others, is a major focus of the counseling. Applicants increasingly start the RLE long before they are referred for hormone treatment.

Eligibility and readiness criteria

The WPATH SOC document requires that both adolescents and adults applying for hormone treatment and surgery satisfy two sets of criteria— eligibility and readiness— before proceeding (28). There are eligibility and readiness criteria for hormone therapy for adults (Table 4) and eligibility cri-

TABLE 4. Hormone therapy for adults

Adults are **eligible** for cross-sex hormone treatment if they (28):
1. Fulfill DSM IV-TR or ICD-10 criteria for GID or transsexualism (see Tables 2 and 3).
2. Do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment.
3. Demonstrate knowledge and understanding of the expected outcomes of hormone treatment, as well as the medical and social risks and benefits; AND
4. Have experienced a documented RLE of at least 3-month duration OR had a period of psychotherapy (duration specified by the MHP after the initial evaluation, usually a minimum of 3 months).

Adults should fulfill the following **readiness criteria** before the cross-sex hormone treatment. The applicant:
1. Has had further consolidation of gender identity during a RLE or psychotherapy.
2. Has made some progress in mastering other identified problems leading to improvement or continuing stable mental health.
3. Is likely to take hormones in a responsible manner.

TABLE 5. Hormone therapy for adolescents

Adolescents are **eligible** and ready for GnRH treatment if they:
1. Fulfill DSM IV-TR or ICD-10 criteria for GID or transsexualism.
2. Have experienced puberty to at least Tanner stage 2.
3. Have (early) pubertal changes that have resulted in an increase of their gender dysphoria.
4. Do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment.
5. Have adequate psychological and social support during treatment, AND
6. Demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment, cross-sex hormone treatment, and sex reassignment surgery, as well as the medical and the social risks and benefits of sex reassignment.

Adolescents are **eligible** for cross-sex hormone treatment if they:
1. Fulfill the criteria for GnRH treatment, AND
2. Are 16 yr or older.

Readiness criteria for adolescents eligible for cross-sex hormone treatment are the same as those for adults.

teria for adolescents (Table 5). Eligibility and readiness criteria for sex reassignment surgery in adults and adolescents are the same (see *Section 5.0*). Although the eligibility criteria have not been evaluated in formal studies, a few follow-up studies on adolescents who fulfilled these criteria and had started cross-sex hormone treatment from the age of 16 indicate good postoperative results (36–38).

One study on MTF transsexual subjects reports that outcome was not associated with minimum eligibility requirements of the WPATH's SOC. However, this study was performed among a group of individuals with a relatively high socioeconomic background (39). One study investigating the need for psychotherapy for sex-reassignment applicants, based on questionnaire scores, suggests that "classical" forms of psychotherapy before medical interventions are not needed in about two thirds of the applicants (40).

Recommendations for those involved in the hormone treatment of applicants for sex reassignment

1.1 Recommendation

We recommend that the diagnosis of GID be made by a MHP. For children and adolescents, the MHP must also have training in child and adolescent developmental psychopathology. (1 ⊕⊕◯◯)

1.1 Evidence

GID may be accompanied with psychological or psychiatric problems (see Refs. 23–27). It is therefore necessary that the clinician making the GID diagnosis be able to make a distinction between GID and conditions that have similar features, to accurately diagnose psychiatric conditions, and to ensure that any such conditions are treated appropriately. One condition with similar features is body dysmorphic disorder or Skoptic syndrome, a condition in which a person is preoccupied with or engages in genital self-mutilation, such as castration, penectomy, or clitoridectomy (41).

1.1 Values and Preferences

The Task Force placed a very high value on avoiding harm from hormone treatment to individuals who have conditions other than GID and who may not be ready for the physical changes associated with this treatment, and it placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the strong recommendation in the face of low-quality evidence.

1.2 Recommendation

Given the high rate of remission of GID after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children with GID. (1 ⊕⊕◯◯)

1.2 Evidence

In most children with GID, the GID does not persist into adolescence. The percentages differ between studies, probably dependent upon which version of the DSM was used in childhood, ages of children, and perhaps culture factors. However, the large majority (75–80%) of prepubertal children with a diagnosis of GID in childhood do not turn out to be transsexual in adolescence (42–44); for a review of seven older studies see Ref. 45. Clinical experience suggests that GID can be reliably assessed only after the first signs of puberty.

This recommendation, however, does not imply that children should be entirely denied to show cross-gender behaviors or should be punished for exhibiting such behaviors.

1.2 Values and Preferences

This recommendation places a high value on avoiding harm with hormone therapy in prepubertal children who may have GID that will remit after the onset of puberty and places a relatively lower value on foregoing the potential benefits of early physical sex change induced by hormone therapy in prepubertal children with GID. This justifies the strong recommendation in the face of very low quality evidence.

1.3 Recommendation

We recommend that physicians evaluate and ensure that applicants understand the reversible and irreversible effects of hormone suppression (*e.g.* GnRH analog treat-

ment) and of cross-sex hormone treatment before they start hormone treatment.

1.3 Remarks

In all treatment protocols, compliance and outcome are enhanced by clear expectations concerning the effects of the treatment. The lengthy diagnostic procedure (GnRH analog treatment included, because this reversible treatment is considered to be a diagnostic aid) and long duration of the period between the start of the hormone treatment and sex reassignment surgery give the applicant ample opportunity to make balanced decisions about the various medical interventions. Clinical evidence shows that applicants react in a variety of ways to this treatment phase. The consequences of the social role change are sometimes difficult to handle, increasing understanding of treatment aspects may be frightening, and a change in gender dysphoric feelings may lead to confusion. Significant adverse effects on mental health can be prevented by a clear understanding of the changes that will occur and the time course of these changes.

1.4 Recommendation

We recommend that all transsexual individuals be informed and counseled regarding options for fertility before initiation of puberty suppression in adolescents and before treatment with sex hormones of the desired sex in both adolescents and adults.

1.4 Remarks

Persons considering hormone use for sex reassignment need adequate information about sex reassignment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision about this treatment. Because early adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormones, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding future fertility of adolescents or adults beginning sex reassignment treatment.

Prolonged pubertal suppression using GnRH analogs is reversible and should not prevent resumption of pubertal development upon cessation of treatment. Although sperm production and development of the reproductive tract in early adolescent biological males with GID are insufficient for cryopreservation of sperm, they should be counseled that sperm production can be initiated after prolonged gonadotropin suppression, before estrogen treatment. This sperm production can be accomplished by spontaneous gonadotropin (both LH and FSH) recovery after cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production. It should be noted that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6–12 months of gonadotropin treatment, although sperm numbers at the time of pregnancy in these patients are far below the normal range (46, 47).

Girls can expect no adverse effects when treated with pubertal suppression. They should be informed that no data are available regarding timing of spontaneous ovulation or response to ovulation induction after prolonged gonadotropin suppression.

All referred subjects who satisfy eligibility and readiness criteria for endocrine treatment, at age 16 or as adults, should be counseled regarding the effects of hormone treatment on fertility and available options that may enhance the chances of future fertility, if desired (48, 49). The occurrence and timing of potentially irreversible effects should be emphasized. Cryopreservation of sperm is readily available, and techniques for cryopreservation of oocytes, embryos, and ovarian tissue are being improved (50).

In biological males, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. Prolonged exposure of the testes to estrogen has been associated with testicular damage (51–53). Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In biological females, the effect of prolonged treatment with exogenous testosterone upon ovarian function is uncertain. Reports of an increased incidence of polycystic ovaries in FTM transsexual persons, both before and as a result of androgen treatment, should be acknowledged (54, 55). Pregnancy has been reported in FTM transsexual persons who have had prolonged androgen treatment, but no genital surgery (56). Counsel from a gynecologist before hormone treatment regarding potential fertility preservation after oophorectomy will clarify available and future options (57).

2.0 Treatment of adolescents

Over the past decade, clinicians have progressively acknowledged the suffering of young transsexual adolescents that is caused by their pubertal development. Indeed, an adolescent with GID often considers the pubertal physical changes to be unbearable. Because early medical intervention may prevent this psychological harm, various clinics have decided to start treating young adolescents

with GID with puberty-suppressing medication (a GnRH analog). As compared with starting sex reassignment long after the first phases of puberty, a benefit of pubertal suppression is relief of gender dysphoria and a better psychological and physical outcome.

The physical changes of pubertal development are the result of maturation of the hypothalamo-pituitary-gonadal axis and development of the secondary sex characteristics. Gonadotropin secretion increases with a day-night rhythm with higher levels of LH during the night. The nighttime LH increase in boys is associated with a parallel testosterone increase. Girls do not show a day-night rhythm, although in early puberty, the highest estrogen levels are observed during the morning as a result of a delayed response by the ovaries (58).

In girls the first physical sign of the beginning of puberty is the start of budding of the breasts, followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, with menarche occurring approximately 2 yr later. In boys the first physical change is testicular growth. A testicular volume equal to or above 4 ml is seen as the first pubertal increase. From a testicular volume of 10 ml, daytime testosterone levels increase, leading to virilization (59).

2.1–2.2 Recommendations

2.1 We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development. (1 ⊕◯◯◯)

2.2 We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3. (1 ⊕⊕◯◯)

2.1–2.2 Evidence

Pubertal suppression aids in the diagnostic and therapeutic phase, in a manner similar to the RLE (60, 61). Management of gender dysphoria usually improves. In addition, the hormonal changes are fully reversible, enabling full pubertal development in the biological gender if appropriate. Therefore, we advise starting suppression of puberty before irreversible development of sex characteristics.

The experience of full biological puberty, an undesirable condition, may seriously interfere with healthy psychological functioning and well-being. Suffering from gender dysphoria without being able to present socially in the desired social role or to stop the development of secondary sex characteristics may result in an arrest in emotional, social, or intellectual development.

Another reason to start sex reassignment early is that the physical outcome after intervention in adulthood is far less satisfactory than intervention at age 16 (36, 38). Looking like a man (woman) when living as a woman (man) creates difficult barriers with enormous lifelong disadvantages.

Pubertal suppression maintains end-organ sensitivity to sex steroids observed during early puberty, enabling satisfactory cross-sex body changes with low doses and avoiding irreversible characteristics that occur by midpuberty.

The protocol of suppression of pubertal development can also be applied to adolescents in later pubertal stages. In contrast to effects in early pubertal adolescents, physical sex characteristics, such as breast development in girls and lowering of the voice and outgrowth of the jaw and brow in boys, will not regress completely.

Unlike the developmental problems observed with delayed puberty, this protocol requires a MHP skilled in child and adolescent psychology to evaluate the response of the adolescent with GID after pubertal suppression. Adolescents with GID should experience the first changes of their biological, spontaneous puberty because their emotional reaction to these first physical changes has diagnostic value. Treatment in early puberty risks limited growth of the penis and scrotum that may make the surgical creation of a vagina from scrotal tissue more difficult.

2.1–2.2 Values and Preferences

These recommendations place a high value on avoiding the increasing likelihood of an unsatisfactory physical change when secondary sexual characteristics have become manifest and irreversible, as well as a high value on offering the adolescent the experience of the desired gender. These recommendations place a lower value on avoiding potential harm from early hormone therapy.

2.1–2.2 Remarks

Tanner stages of breast and male genital development are given in Table 6. Blood levels of sex steroids during Tanner stages of pubertal development are given in Table 7. Careful documentation of hallmarks of pubertal development will ensure precise timing of initiation of pubertal suppression.

Irreversible and, for transsexual adolescents, undesirable sex characteristics in female puberty are large breasts and short stature and in male puberty are Adam's apple; low voice; male bone configuration such as large jaws, big feet, and hands; tall stature; and male hair pattern on the face and extremities.

2.3 Recommendation

We recommend that GnRH analogs be used to achieve suppression of pubertal hormones. (1 ⊕⊕◯◯)

TABLE 6. Description of tanner stages of breast development and male external genitalia

For breast development:
1. Preadolescent.
2. Breast and papilla elevated as small mound; areolar diameter increased.
3. Breast and areola enlarged, no contour separation.
4. Areola and papilla form secondary mound.
5. Mature; nipple projects, areola part of general breast contour.

For penis and testes:
1. Preadolescent.
2. Slight enlargement of penis; enlarged scrotum, pink texture altered.
3. Penis longer, testes larger.
4. Penis larger, glans and breadth increase in size; testes larger, scrotum dark.
5. Penis and testes adult size.

Adapted from Ref. 62.

2.3 Evidence

Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with GnRH analogs and antagonists. Analogs suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion (64, 65). Because no long-acting antagonists are available for use as pharmacotherapy, long-acting analogs are the currently preferred treatment option.

During treatment with the GnRH analogs, slight development of sex characteristics will regress and, in a later phase of pubertal development, will be halted. In girls, breast development will become atrophic, and menses will stop; in boys, virilization will stop, and testicular volume will decrease (61).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploring of his/her reassignment wish, the applicant no longer desires sex reassignment, pubertal suppression can be discontinued. Spontaneous pubertal development will resume immediately (66).

TABLE 7. Estradiol levels in female puberty and testosterone levels in male puberty during night and day

Tanner stage	Nocturnal	Diurnal
Estradiol (pmol/liter)[a]		
B1	<37	<37
B2	38.5	56.3
B3	81.7	107.3
B4	162.9	132.3
B5	201.6	196.7
Testosterone (nmol/liter)[b]		
G1	<0.25	<0.25
G2	1.16	0.54
G3	3.76	0.62
G4	9.83	1.99
G5	13.2	7.80
Adult	18.8	17.0

Data represent median of hourly measurements from 2400–0600 h (nocturnal) and 1200–1800 h (diurnal).

[a] Adapted from Ref. 63.

[b] Adapted from Ref. 59.

Men with delayed puberty have decreased BMD. Treatment of adults with GnRH analogs results in loss of BMD (67). In children with central precocious puberty, bone density is relatively high for age. Suppressing puberty in these children using GnRH analogs will result in a further increase in BMD and stabilization of BMD SD scores (68). Initial data in transsexual subjects demonstrate no change of bone density during GnRH analog therapy (61). With cross-hormone treatment, bone density increases. The long-term effects on bone density and peak bone mass are being evaluated.

GnRH analogs are expensive and not always reimbursed by insurance companies. Although there is no clinical experience in this population, financial considerations may require treatment with progestins as a less effective alternative. They suppress gonadotropin secretion and exert a mild peripheral antiandrogen effect in boys. Depomedroxyprogesterone will suppress ovulation and progesterone production for long periods of time, although residual estrogen levels vary. In high doses, progestins are relatively effective in suppression of menstrual cycling in girls and women and androgen levels in boys and men. However, at these doses, side effects such as suppression of adrenal function and suppression of bone growth may occur (69). Antiestrogens in girls and antiandrogens in boys can be used to delay the progression of puberty (70, 71). Their efficacy, however, is far less than that of the GnRH analogs.

2.3 Values and Preferences

For persons who can afford the therapy, our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved, as compared with the alternatives, and a relatively lower value on limiting the cost of therapy. Of the available alternatives, a depot progestin preparation may be partially effective, but it is not as safe (69, 72); its lower cost may make it an acceptable treatment for persons who cannot afford GnRH.

2.3 Remarks

Measurements of gonadotropin and sex steroid levels give precise information about suppression of the gonadal axis. If the gonadal axis is not completely suppressed, the interval of GnRH analog injections should be shortened. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone accretion. The clinical protocol to be used is shown in Table 8.

TABLE 8. Follow-up protocol during suppression of puberty

Every 3 months
Anthropometry: height, weight, sitting height, Tanner stages
Laboratory: LH, FSH, estradiol/testosterone
Every year
Laboratory: renal and liver function, lipids, glucose, insulin, glycosylated hemoglobin
Bone density using dual-energy x-ray absorptiometry
Bone age on x-ray of the left hand

Glucose and lipid metabolism, complete blood counts, and liver and renal function should be monitored during suppression and cross-sex hormone substitution. For the evaluation of growth, anthropometric measurements are informative. To assess bone density, dual energy x-ray absorptiometry scans can be performed.

2.4 Recommendation

We suggest that pubertal development of the desired, opposite sex be initiated at the age of 16 yr, using a gradually increasing dose schedule of cross-sex steroids. (2 ⊕◯◯◯)

2.4 Evidence

In many countries, 16-yr-olds are legal adults with regard to medical decision making. This is probably because, at this age, most adolescents are able to make complex cognitive decisions. Although parental consent may not be required, obtaining it is preferred because the support of parents should improve the outcome during this complex phase of the adolescent's life (61).

For the induction of puberty, we use a similar dose scheme of induction of puberty in these hypogonadal transsexual adolescents as in other hypogonadal individuals (Table 9). We do not advise the use of sex steroid creams or patches because there is little experience for induction of puberty. The transsexual adolescent is hypogonadal and may be sensitive to high doses of cross-sex steroids, causing adverse effects of striae and abnormal breast shape in girls and cystic acne in boys.

In FTM transsexual adolescents, suppression of puberty may halt the growth spurt. To achieve maximum height, slow introduction of androgens will mimic a "pubertal" growth spurt. If the patient is relatively short, one may treat with oxandrolone, a growth-stimulating anabolic steroid also successfully applied in women with Turner syndrome (73–75).

In MTF transsexual adolescents, extreme tall stature is often a genetic probability. The estrogen dose may be increased by more rapid increments in the schedule. Estrogens may be started before the age of 16 (in exceptional cases), or estrogens can be prescribed in growth-inhibiting doses (61).

TABLE 9. Protocol induction of puberty

Induction of female puberty with oral 17-β estradiol, increasing the dose every 6 months:
5 μg/kg/d
10 μg/kg/d
15 μg/kg/d
20 μg/kg/d
Adult dose = 2 mg/d
Induction of male puberty with intramuscular testosterone esters, increasing the dose every 6 months:
25 mg/m^2 per 2 wk im
50 mg/m^2 per 2 wk im
75 mg/m^2 per 2 wk im
100 mg/m^2 per 2 wk im

We suggest that treatment with GnRH analogs be continued during treatment with cross-sex steroids to maintain full suppression of pituitary gonadotropin levels and, thereby, gonadal steroids. When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion (Table 7). The estrogen doses used may result in reactivation of gonadotropin secretion and endogenous production of testosterone that can interfere with the effectiveness of the treatment. GnRH analog treatment is advised until gonadectomy.

2.4 Values and Preferences

Identifying an age at which pubertal development is initiated will be by necessity arbitrary, but the goal is to start this process at a time when the individual will be able to make informed mature decisions and engage in the therapy, while at the same time developing along with his or her peers. Growth targets reflect personal preferences, often shaped by societal expectations. Individual preferences should be the key determinant, rather than the professional's deciding *a priori* that MTF transsexuals should be shorter than FTM transsexuals.

2.4 Remarks

Protocols for induction of puberty can be found in Table 9.

We recommend monitoring clinical pubertal development as well as laboratory parameters (Table 10). Sex

TABLE 10. Follow-up protocol during induction of puberty

Every 3 months
Anthropometry: height, weight, sitting height, Tanner stages
Laboratory: endocrinology, LH, FSH, estradiol/testosterone
Every year
Laboratory: renal and liver function, lipids, glucose, insulin, glycosylated hemoglobin
Bone density using dual-energy x-ray absorptiometry
Bone age on x-ray of the left hand

These parameters should also be measured at long term. For bone development, they should be measured until the age of 25–30 yr or until peak bone mass has been reached.

steroids of the desired sex will initiate pubertal development, which can be (partially) monitored using Tanner stages. In addition, the sex steroids will affect growth and bone development, as well as insulin sensitivity and lipid metabolism, as in normal puberty (76, 77).

2.5–2.6 Recommendations

2.5 We recommend referring hormone-treated adolescents for surgery when 1) the RLE has resulted in a satisfactory social role change, 2) the individual is satisfied about the hormonal effects, and 3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

2.6 We suggest deferring for surgery until the individual is at least 18 yr old. (2 ⊕◯◯◯)

2.5–2.6 Evidence

Surgery is an irreversible intervention. The WPATH SOC (28) emphasizes that the "threshold of 18 should be seen as an eligibility criterion and not an indication in itself for active intervention." If the RLE supported by sex hormones of the desired sex has not resulted in a satisfactory social role change, if the person is not satisfied with or is ambivalent about the hormonal effects, or if the person is ambivalent about surgery, then the applicant should not be referred for surgery (78, 79).

3.0 Hormonal therapy for transsexual adults

The two major goals of hormonal therapy are: 1) to reduce endogenous hormone levels and, thereby, the secondary sex characteristics of the individual's biological (genetic) sex and assigned gender; and 2) to replace endogenous sex hormone levels with those of the reassigned sex by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with cross-sex hormones is codetermined in collaboration with both the person pursuing sex change and the MHP who made the diagnosis, performed psychological evaluation, and recommended sex reassignment. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being.

3.1–3.3 Recommendations

3.1 We recommend that treating endocrinologists confirm the diagnostic criteria of GID or transsexualism and the eligibility and readiness criteria for the endocrine phase of gender transition. (1 ⊕⊕⊕◯)

3.2 We recommend that medical conditions that can be exacerbated by hormone depletion and cross-sex hormone treatment be evaluated and addressed before initiation of treatment (Table 11). (1 ⊕⊕⊕◯)

TABLE 11. Medical conditions that can be exacerbated by cross-sex hormone therapy

Transsexual female (MTF): estrogen
Very high risk of serious adverse outcomes
Thromboembolic disease
Moderate to high risk of adverse outcomes
Macroprolactinoma
Severe liver dysfunction (transaminases >3 × upper limit of normal)
Breast cancer
Coronary artery disease
Cerebrovascular disease
Severe migraine headaches
Transsexual male (FTM): testosterone
Very high risk of serious adverse outcomes
Breast or uterine cancer
Erythrocytosis (hematocrit >50%)
Moderate to high risk of adverse outcomes
Severe liver dysfunction (transaminases >3 × upper limit of normal)

3.3 We suggest that cross-sex hormone levels be maintained in the normal physiological range for the desired gender. (2 ⊕⊕◯◯)

3.1–3.3 Evidence

Although the diagnosis of GID or transsexualism is made by an MHP, the referral for endocrine treatment implies fulfillment of the eligibility and readiness criteria (see *Section 1*) (28). It is the responsibility of the physician to whom the transsexual person has been referred to confirm that the person fulfills these criteria for treatment. This task can be accomplished by the physician's becoming familiar with the terms and criteria presented in Tables 1–5, taking a thorough history from the person recommended for treatment, and discussing these criteria with the MHP. Continued evaluation of the transsexual person by the MHP, in collaboration with the treating endocrinologist, will ensure that the desire for sex change is appropriate, that the consequences, risks, and benefits of treatment are well understood, and that the desire for sex change persists.

FTM transsexual persons

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in FTM transsexual persons (80–84). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (85). Either parenteral or transdermal preparations can be used to achieve testosterone values in the normal male range (320–1000 ng/dl) (Table 12). Sustained supraphysiological levels of testosterone increase the risk of adverse reactions (see *Section 4.0*).

Similar to androgen therapy in hypogonadal men, testosterone treatment in the FTM individual results in increased

TABLE 12. Hormone regimens in the transsexual persons

	Dosage
MTF transsexual persons[a]	
Estrogen	
Oral: estradiol	2.0–6.0 mg/d
Transdermal: estradiol patch	0.1–0.4 mg twice weekly
Parenteral: estradiol valerate or cypionate	5–20 mg im every 2 wk 2–10 mg im every week
Antiandrogens	
Spironolactone	100–200 mg/d
Cyproterone acetate[b]	50–100 mg/d
GnRH agonist	3.75 mg sc monthly
FTM transsexual persons	
Testosterone	
Oral: testosterone undecanoate[b]	160–240 mg/d
Parenteral	
Testosterone enanthate or cypionate	100–200 mg im every 2 wk or 50% weekly
Testosterone undecanoate[b,c]	1000 mg every 12 wk
Transdermal	
Testosterone gel 1%	2.5–10 g/d
Testosterone patch	2.5–7.5 mg/d

[a] Estrogens used with or without antiandrogens or GnRH agonist.

[b] Not available in the United States.

[c] 1000 mg initially, followed by an injection at 6 wk, then at 12-wk intervals.

muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness, and increased libido (86). Specific to the FTM transsexual person, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, and, usually, cessation of menses. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, addition of a progestational agent or endometrial ablation may be considered (87, 88). GnRH analogs or depot medroxyprogesterone may also be used to stop menses before testosterone treatment and to reduce estrogens to levels found in biological males.

MTF transsexual persons

The hormone regimen for MTF transsexual individuals is more complex than the FTM regimen. Most published clinical studies report the use of an antiandrogen in conjunction with an estrogen (80, 82–84, 89).

The antiandrogens shown to be effective reduce endogenous testosterone levels, ideally to levels found in adult biological women, to enable estrogen therapy to have its fullest effect. Two categories of these medications are progestins with antiandrogen activity and GnRH agonists (90). Spironolactone has antiandrogen properties by directly inhibiting testosterone secretion and by inhibiting androgen binding to the androgen receptor (83, 84). It may also have estrogenic activity (91). Cyproterone acetate, a progestational compound with antiandrogenic properties (80, 82), is widely used in Europe. Flutamide blocks binding of androgens to the androgen receptor, but it does not lower serum testosterone levels; it has liver toxicity, and its efficacy has not been demonstrated.

Dittrich (90), reporting on a series of 60 MTF transsexual persons who used monthly the GnRH agonist goserelin acetate in combination with estrogen, found this regimen to be effective in reducing testosterone levels with low incidence of adverse reactions.

Estrogen can be given orally as conjugated estrogens, or 17β-estradiol, as transdermal estrogen, or parenteral estrogen esters (Table 12).

Measurement of serum estradiol levels can be used to monitor oral, transdermal, and im estradiol or its esters. Use of conjugated estrogens or synthetic estrogens cannot be monitored by blood tests. Serum estradiol should be maintained at the mean daily level for premenopausal women (<200 pg/ml), and the serum testosterone level should be in the female range (<55 ng/dl). The transdermal preparations may confer an advantage in the older transsexual women who may be at higher risk for thromboembolic disease (92).

Venous thromboembolism may be a serious complication. A 20-fold increase in venous thromboembolic disease was reported in a large cohort of Dutch transsexual subjects (93). This increase may have been associated with the use of ethinyl estradiol (92). The incidence decreased upon cessation of the administration of ethinyl estradiol (93). Thus, the use of synthetic estrogens, especially ethinyl estradiol, is undesirable because of the inability to regulate dose by measurement of serum levels and the risk of thromboembolic disease. Deep vein thrombosis occurred in 1 of 60 MTF transsexual persons treated with a GnRH analog and oral estradiol (90). The patient was found to have a homozygous C677 T mutation. Administration of cross-sex hormones to 162 MTF and 89 FTM transsexual persons was not associated with venous thromboembolism despite an 8.0 and 5.6% incidence of thrombophilia, respectively (94). Thombophilia screening of transsexual persons initiating hormone treatment should be restricted to those with a personal or family history of venous thromboembolism (94). Monitoring D-dimer levels during treatment is not recommended (95).

3.1–3.3 Values and Preferences

Our recommendation to maintain levels of cross-sex hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharma-

cological doses. Those receiving endocrine treatment who have relative contraindications to hormones (*e.g.* persons who smoke, have diabetes, have liver disease, *etc.*) should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

3.1–3.3 Remarks

All endocrine-treated individuals should be informed of all risks and benefits of cross-sex hormones before initiation of therapy. Cessation of tobacco use should be strongly encouraged in MTF transsexual persons to avoid increased risk of thromboembolism and cardiovascular complications.

3.4 Recommendation

We suggest that endocrinologists review with persons treated the onset and time course of physical changes induced by cross-sex hormone treatment. (2 ⊕⊕◯◯)

3.4 Evidence

FTM transsexual persons

Physical changes that are expected to occur during the first 3 months of initiation of testosterone therapy include cessation of menses, increased libido, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice, clitoromegaly, and, in some individuals, male pattern hair loss (83, 96, 97) (Table 13).

MTF transsexual persons

Physical changes that may occur in the first 3–6 months of estrogen and antiandrogen therapy include decreased libido, decreased facial and body hair, decreased oiliness of skin, breast tissue growth, and redistribution of fat mass (82, 83, 84, 96, 97) (Table 14). Breast development is generally maximal at 2 yr after initiation of hormones (82, 83, 84). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in MTF transsexual persons has been studied (97), precise information about other changes induced by sex hormones is lacking. There is a great deal of variability between individuals, as evidenced during pubertal development.

TABLE 13. Masculinizing effects in FTM transsexual persons

Effect	Onset (months)[a]	Maximum (yr)[a]
Skin oiliness/acne	1–6	1–2
Facial/body hair growth	6–12	4–5
Scalp hair loss	6–12	[b]
Increased muscle mass/strength	6–12	2–5
Fat redistribution	1–6	2–5
Cessation of menses	2–6	[c]
Clitoral enlargement	3–6	1–2
Vaginal atrophy	3–6	1–2
Deepening of voice	6–12	1–2

[a] Estimates represent clinical observations. See Refs. 81, 92, and 93.

[b] Prevention and treatment as recommended for biological men.

[c] Menorrhagia requires diagnosis and treatment by a gynecologist.

TABLE 14. Feminizing effects in MTF transsexual persons

Effect	Onset[a]	Maximum[a]
Redistribution of body fat	3–6 months	2–3 yr
Decrease in muscle mass and strength	3–6 months	1–2 yr
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	3–6 months
Decreased spontaneous erections	1–3 months	3–6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 months	2–3 yr
Decreased testicular volume	3–6 months	2–3 yr
Decreased sperm production	Unknown	>3 yr
Decreased terminal hair growth	6–12 months	>3 yr[b]
Scalp hair	No regrowth	[c]
Voice changes	None	[d]

[a] Estimates represent clinical observations. See Refs. 81, 92, and 93.

[b] Complete removal of male sexual hair requires electrolysis, or laser treatment, or both.

[c] Familial scalp hair loss may occur if estrogens are stopped.

[d] Treatment by speech pathologists for voice training is most effective.

3.4 Values and Preferences

Transsexual persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.* breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone-induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse outcome prevention and long-term care

Cross-sex hormone therapy confers the same risks associated with sex hormone replacement therapy in biological males and females. The risk of cross-sex hormone therapy arises from and is worsened by inadvertent or intentional use of supraphysiological doses of sex hormones or inadequate doses of sex hormones to maintain normal physiology (81, 89).

4.1 Recommendation

We suggest regular clinical and laboratory monitoring every 3 months during the first year and then once or twice yearly. (2 ⊕⊕◯◯)

4.1 Evidence

Pretreatment screening and appropriate regular medical monitoring is recommended for both FTM and MTF transsexual persons during the endocrine transition and periodically thereafter (13, 97). Monitoring of weight and blood pressure, directed physical exams, routine health questions focused on risk factors and medications, complete blood counts, renal and liver function, lipid and glucose metabolism should be carried out.

FTM transsexual persons

A standard monitoring plan for individuals on testosterone therapy is found in Table 15. Key issues include maintaining testosterone levels in the physiological normal male range and avoidance of adverse events resulting from chronic testosterone therapy, particularly erythrocytosis, liver dysfunction, hypertension, excessive weight gain, salt retention, lipid changes, excessive or cystic acne, and adverse psychological changes (85).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with the use parenteral or transdermal testosterone (98, 99). Still, periodic monitoring is recommended given that up to 15% of FTM persons treated with testosterone have transient elevations in liver enzymes (93).

MTF transsexual persons

A standard monitoring plan for individuals on estrogens, gonadotropin suppression, or antiandrogens is found in Table 16. Key issues include avoiding supraphysiological doses or blood levels of estrogen, which may lead to increased risk for thromboembolic disease, liver dysfunction, and development of hypertension.

4.2 Recommendation

We suggest monitoring prolactin levels in MTF transsexual persons treated with estrogens. (2 ⊕⊕◯◯)

4.2 Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term estrogen therapy (100–102). Up to 20% of transsexual women treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (103). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy (104).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Prolactin levels should be obtained at baseline and then at least annually during the transition period and biannually thereafter. Given that prolactinomas have been reported only in a few case reports and were not reported in large cohorts of estrogen-treated transsexual persons, the risk of prolactinoma is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in MTF transsexual persons, radiological examination of the pituitary may be carried out in those whose prolactin levels persistently increase despite stable or reduced estrogen levels.

Because transsexual persons are diagnosed and followed throughout sex reassignment by an MHP, it is likely that some will receive psychotropic medications that can increase prolactin levels.

4.3 Recommendation

We suggest that transsexual persons treated with hormones be evaluated for cardiovascular risk factors. (2 ⊕⊕◯◯)

4.3 Evidence

FTM transsexual persons

Testosterone administration to FTM transsexual persons will result in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride values (21, 105–107). Studies of the effect of testosterone on insulin sensitivity have mixed results (106, 108). A recent randomized, open-label uncontrolled safety study of FTM transsexual persons treated with testosterone undecanoate demonstrated no insulin resistance after 1 yr (109). Numerous studies have demonstrated

TABLE 15. Monitoring of MTF transsexual persons on cross-hormone therapy

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year afterward to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 months.
   a. Serum testosterone levels should be <55 ng/dl.
   b. Serum estradiol should not exceed the peak physiological range for young healthy females, with ideal levels <200 pg/ml.
   c. Doses of estrogen should be adjusted according to the serum levels of estradiol.
3. For individuals on spironolactone, serum electrolytes (particularly potassium) should be monitored every 2–3 months initially in the first year.
4. Routine cancer screening is recommended in nontranssexual individuals (breasts, colon, prostate).
5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (*e.g.* previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 and in those who are not compliant with hormone therapy.

TABLE 16. Monitoring of FTM transsexual persons on cross-hormone therapy

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 2–3 months until levels are in the normal physiological male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. If the level is >700 ng/dl or <350 ng/dl, adjust dose accordingly.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the next injection.
   c. For transdermal testosterone, the testosterone level can be measured at any time after 1 wk.
   d. For oral testosterone undecanoate, the testosterone level should be measured 3–5 h after ingestion.
   e. Note: During the first 3–9 months of testosterone treatment, total testosterone levels may be high, although free testosterone levels are normal, due to high SHBG levels in some biological women.
3. Measure estradiol levels during the first 6 months of testosterone treatment or until there has been no uterine bleeding for 6 months. Estradiol levels should be <50 pg/ml.
4. Measure complete blood count and liver function tests at baseline and every 3 months for the first year and then 1–2 times a year. Monitor weight, blood pressure, lipids, fasting blood sugar (if family history of diabetes), and hemoglobin A1c (if diabetic) at regular visits.
5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (*e.g.* previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 and in those who are not compliant with hormone therapy.
6. If cervical tissue is present, an annual pap smear is recommended by the American College of Obstetricians and Gynecologists.
7. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a] Adapted from Refs. 83 and 85.

effects of cross-sex hormone treatment on the cardiovascular system (107, 110–112). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (93). Likewise, a meta-analysis of 19 randomized trials examining testosterone replacement in men showed no increased incidence of cardiovascular events (113). A systematic review of the literature found that data were insufficient, due to very low quality evidence, to allow meaningful assessment of important patient outcomes such as death, stroke, myocardial infarction, or venous thromboembolism in FTM transsexual persons (21). Future research is needed to ascertain harms of hormonal therapies (21). Cardiovascular risk factors should be managed as they emerge according to established guidelines (114).

MTF transsexual persons

A prospective study of MTF subjects found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (106). However, these favorable lipid changes were attenuated by increased weight, blood pressure, and markers of insulin resistance. The largest cohort of MTF subjects (with a mean age of 41 yr) followed for a mean of 10 yr showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (93). Thus, there is limited evidence to determine whether estrogen is protective or detrimental in MTF transsexual persons (21). With aging there is usually an increase of body weight, and therefore, as with nontranssexual individuals, glucose and lipid metabolism and blood pressure should be monitored regularly and managed according to established guidelines (114).

4.4 Recommendation

We suggest that BMD measurements be obtained if risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (2 ⊕⊕⊕○)

4.4 Evidence

FTM transsexual persons

Adequate dosing of testosterone is important to maintain bone mass in FTM transsexual persons (115, 116). In one study (116), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol both systemically and locally in the bone.

MTF transsexual persons

Studies in aging genetic males suggest that serum estradiol more positively correlates with BMD than does testosterone (117–119) and is more important for peak bone mass (120). Estrogen preserves BMD in MTF transsexuals who continue on estrogen and antiandrogen therapies (116, 121, 122).

Fracture data in transsexual men and women are not available. Transsexual persons who have undergone gonadectomy may not continue consistent cross-sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss.

4.5–4.6 Recommendations

4.5 We suggest that MTF transsexual persons who have no known increased risk of breast cancer follow breast

screening guidelines recommended for biological women. (2 ⊕⊕◯◯)

4.6 We suggest that MTF transsexual persons treated with estrogens follow screening guidelines for prostatic disease and prostate cancer recommended for biological men. (2 ⊕◯◯◯)

4.5–4.6 Evidence

Breast cancer is a concern in transsexual women. A few cases of breast cancer in MTF transsexual persons have been reported in the literature (123–125). In the Dutch cohort of 1800 transsexual women followed for a mean of 15 yr (range, 1 to 30 yr), only one case of breast cancer was found. The Women's Health Initiative study reported that women taking conjugated equine estrogen without progesterone for 7 yr did not have an increased risk of breast cancer as compared with women taking placebo (126). Women with primary hypogonadism (XO) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (127, 128). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short-term (<20–30 yr). Long-term studies are required to determine the actual risk and the role of screening mammograms. Regular exams and gynecological advice should determine monitoring for breast cancer.

Prostate cancer is very rare, especially with androgen deprivation therapy, before the age of 40 (129). Childhood or pubertal castration results in regression of the prostate, and adult castration reverses benign prostate hypertrophy (130). Although van Kesteren (131) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostate of MTF transsexual persons, cases of benign prostate hypertrophy have been reported in MTF transsexual persons treated with estrogens for 20–25 yr (132, 133). Three cases of prostate carcinoma have been reported in MTF transsexual persons (134–136). However, these individuals initiated cross-hormone therapy after age 50, and whether these cancers were present before the initiation of therapy is unknown.

MTF transsexual persons may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for MTF transsexual persons who transitioned after age 20 to have annual screening digital rectal exams after age 50 and PSA tests consistent with the U.S. Preventive Services Task Force Guidelines (137).

4.7 Recommendation

We suggest that FTM transsexual persons evaluate the risks and benefits of including a total hysterectomy and oophorectomy as part of sex reassignment surgery. (2 ⊕◯◯◯)

4.7 Evidence

Although aromatization of testosterone to estradiol in FTM transsexual persons has been suggested as a risk factor for endometrial cancer (138), no cases have been reported. When FTM transsexual persons undergo hysterectomy, the uterus is small and there is endometrial atrophy (139, 140). The androgen receptor has been reported to increase in the ovaries after long-term administration of testosterone, which may be an indication of increased risk of ovarian cancer (141). Cases of ovarian cancer have been reported (142, 143). The relative safety of laparoscopic total hysterectomy argues for preventing the risks of reproductive tract cancers and other diseases through surgery (144).

4.7 Values and Preferences

Given the discomfort that FTM transsexual persons experience accessing gynecological care, our recommendation for total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

4.7 Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecological care required after transition. In addition, approval of birth certificate change of sex for FTM transsexual persons may be dependent upon having a complete hysterectomy; each patient should be assisted in researching and counseled concerning such nonmedical administrative criteria.

5.0 Surgery for sex reassignment

For many transsexual adults, genital sex reassignment surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. Although surgery on several different body structures is considered during sex reassignment, the most important issue is the genital surgery and removal of the gonads. The surgical techniques have improved markedly during the past 10 yr. Cosmetic genital surgery with preservation of neurological sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (22). In addition, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender identity treatment that

TABLE 17. Sex reassignment surgery eligibility and readiness criteria

Individuals treated with cross-sex hormones are considered eligible for sex reassignment surgery if they:
1. Are of the legal age of majority in their nation.
2. Have used cross-sex hormones continuously and responsibly during 12 months (if they have no medical contraindication).
3. Had a successful continuous full-time RLE during 12 months.
4. Have (if required by the MHP) regularly participated in psychotherapy throughout the RLE at a frequency determined jointly by the patient and the MHP.
5. Have shown demonstrable knowledge of all practical aspects of surgery (*e.g.* cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation, *etc.*).

Individuals treated with cross-sex hormones should fulfill the following readiness criteria prior to sex reassignment surgery:
1. Demonstrable progress in consolidating one's gender identity.
2. Demonstrable progress in dealing with work, family, and interpersonal issues, resulting in a significantly better state of mental health.

includes hormones and surgery (24). The person must be both eligible and ready for such a procedure (Table 17).

Sex reassignment surgeries available to the MTF transsexual persons consist of gonadectomy, penectomy, and creation of a vagina (145, 146). The skin of the penis is often inverted to form the wall of the vagina. The scrotum becomes the labia majora. Cosmetic surgery is used to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Most recently, plastic surgeons have developed techniques to fashion labia minora. Endocrinologists should encourage the transsexual person to use their tampon dilators to maintain the depth and width of the vagina throughout the postoperative period until the neovagina is being used frequently in intercourse. Genital sexual responsivity and other aspects of sexual function should be preserved after genital sex reassignment surgery (147).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. When possible, less surgery is desirable. For instance, voice therapy by a speech language pathologist is preferred to current surgical methods designed to change the pitch of the voice (148).

Breast size in genetic females exhibits a very broad spectrum. For the transsexual person to make the best-informed decision, breast augmentation surgery should be delayed until at least 2 yr of estrogen therapy has been completed, given that the breasts continue to grow during that time with estrogen stimulation (90, 97).

Another major effort is the removal of facial and masculine-appearing body hair using either electrolysis or laser treatments. Other feminizing surgery, such as that to feminize the face, is now becoming more popular (149–151).

Sex reassignment surgeries available to the FTM transsexual persons have been less satisfactory. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (152, 153). Neopenile erection can be achieved only if some mechanical device is imbedded in the penis, *e.g.* a rod or some inflatable apparatus (154). Many choose a metaidoioplasty that exteriorizes or brings forward the clitoris and allows for voiding while standing. The scrotum is created from the labia majora with a good cosmetic effect, and testicular prostheses can be implanted. These procedures, as well as oophorectomy, vaginectomy, and complete hysterectomy, are undertaken after a few years of androgen therapy and can be safely performed vaginally with laparoscopy.

The ancillary surgery for the FTM transition that is extremely important is the mastectomy. Breast size only partially regresses with androgen therapy. In adults, discussion about mastectomy usually takes place after androgen therapy is begun. Because some FTM transsexual adolescents present after significant breast development has occurred, mastectomy may be considered before age 18.

5.1–5.3 Recommendations

5.1 We recommend that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the MHP find surgery advisable. (1 ⊕◯◯◯)

5.2 We recommend that genital sex reassignment surgery be recommended only after completion of at least 1 yr of consistent and compliant hormone treatment. (1 ⊕◯◯◯)

5.3 We recommend that the physician responsible for endocrine treatment medically clear transsexual individuals for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery. (1 ⊕◯◯◯)

5.1–5.3 Evidence

When a transsexual individual decides to have sex reassignment surgery, both the endocrinologist and the MHP must certify that he or she satisfies the eligibility and readiness criteria of the SOC (28) (Table 17).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or after surgery (21). For this reason, the surgeon and the endocrinologist should collaborate in making a decision about the use of hormones during the month before surgery.

Although one study suggests that preoperative factors such as compliance are less important for patient satisfaction than are the physical postoperative results (39), other studies and clinical experience dictate that individuals who do not follow medical instructions and work with their physicians toward a common goal do not achieve treatment goals (155) and experience higher rates of postoperative infections and other complications (156, 157). It is also important that the person requesting surgery feel comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (78).

Transsexual individuals should be monitored by an endocrinologist after surgery. Those who undergo gonadectomy will require hormone replacement therapy or surveillance or both to prevent adverse effects of chronic hormone deficiency.

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References

1. **Bullough VL** 1975 Transsexualism in history. Arch Sex Behav 4:561–571
2. **Meyerowitz J** 2002 How sex changed: a history of transsexuality in the United States. Cambridge, MA: Harvard University Press
3. **American Psychiatric Association** 2000 Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Publishing, Inc.
4. **Ruble DN, Martin CL, Berenbaum SA** 2006 Gender development. In: Damon W, Lerner RM, Eisenberg N, eds. Handbook of child psychology, 6th ed. Vol. 3. New York: John Wiley & Sons; 858–932
5. **Zucker KJ** 2004 Gender identity development and issues. Child Adolesc Psychiatr Clin N Am 13:551–568, vii
6. **Coolidge FL, Thede LL, Young SE** 2002 The heritability of gender identity disorder in a child and adolescent twin sample. Behav Genet 32:251–257
7. **Knafo A, Iervolino AC, Plomin R** 2005 Masculine girls and feminine boys: genetic and environmental contributions to atypical gender development in early childhood. J Pers Soc Psychol 88:400–412
8. **Gooren L** 2006 The biology of human psychosexual differentiation. Horm Behav 50:589–601
9. **Meyer-Bahlburg HF** 2005 Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. Arch Sex Behav 34:423–438
10. **Reiner WG** 2005 Gender identity and sex-of-rearing in children with disorders of sexual differentiation. J Pediatr Endocrinol Metab 18:549–553
11. **Dessens AB, Slijper FM, Drop SL** 2005 Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. Arch Sex Behav 34:389–397
12. **Meyer-Bahlburg HF, Dolezal C, Baker SW, Carlson AD, Obeid JS, New MI** 2004 Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. Arch Sex Behav 33:97–104
13. **Meyer-Bahlburg HF, Dolezal C, Baker SW, Ehrhardt AA, New MI** 2006 Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. Arch Sex Behav 35:667–684
14. **Bocklandt S, Vilain E** 2007 Sex differences in brain and behavior: hormones versus genes. Adv Genet 59:245–266
15. **Blanchard R** 1997 Birth order and sibling sex ratio in homosexual versus heterosexual males and females. Annu Rev Sex Res 8:27–67
16. **Blanchard R** 2001 Fraternal birth order and the maternal immune hypothesis of male homosexuality. Horm Behav 40:105–114
17. **Whitehead NE** 2007 An antiboy antibody? Re-examination of the maternal immune hypothesis. J Biosoc Sci 39:905–921
18. **Gooren L** 1990 The endocrinology of transsexualism: a review and commentary. Psychoneuroendocrinology 15:3–14
19. **Atkins D, Best D, Briss PA, Eccles M, Falck-Ytter Y, Flottorp S, Guyatt GH, Harbour RT, Haugh MC, Henry D, Hill S, Jaeschke R, Leng G, Liberati A, Magrini N, Mason J, Middleton P, Mrukowicz J, O'Connell D, Oxman AD, Phillips B, Schünemann HJ, Edejer TT, Varonen H, Vist GE, Williams Jr JW, Zaza S** 2004 Grading quality of evidence and strength of recommendations. BMJ 328:1490

20. **Swiglo BA, Murad MH, Schünemann HJ, Kunz R, Vigersky RA, Guyatt GH, Montori VM** 2008 A case for clarity, consistency, and helpfulness: state-of-the-art clinical practice guidelines in endocrinology using the grading of recommendations, assessment, development, and evaluation system. J Clin Endocrinol Metab 93:666–673
21. **Elamin MB, Garcia MZ, Murad MH, Erwin PJ, Montori VM** 16 May 2009 Effect of sex steroid use on cardiovascular risk in transsexual individuals: a systematic review and meta-analysis. Clin Endocrinol (Oxf) 10.1111/j.1365–2265.2009.03632.x
22. **Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ, Montori VM** 16 May 2009 Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. Clin Endocrinol (Oxf) 10.1111/j.1365–2265.2009.03625.x
23. **Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ** 2003 Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. J Abnorm Child Psychol 31:41–53
24. **Cole CM, O'Boyle M, Emory LE, Meyer 3rd WJ** 1997 Comorbidity of gender dysphoria and other major psychiatric diagnoses. Arch Sex Behav 26:13–26
25. **Hepp U, Kraemer B, Schnyder U, Miller N, Delsignore A** 2005 Psychiatric comorbidity in gender identity disorder. J Psychosom Res 58:259–261
26. **Kersting A, Reutemann M, Gast U, Ohrmann P, Suslow T, Michael N, Arolt V** 2003 Dissociative disorders and traumatic childhood experiences in transsexuals. J Nerv Ment Dis 191:182–189
27. **Wallien MS, Swaab H, Cohen-Kettenis PT** 2007 Psychiatric comorbidity among children with gender identity disorder. J Am Acad Child Adolesc Psychiatry 46:1307–1314
28. **Meyer 3rd WJ, Bockting W, Cohen-Kettenis P, Coleman E, DiCeglie D, Devor H, Gooren L, Hage JJ, Kirk S, Kuiper B, Laub D, Lawrence A, Menard Y, Monstrey S, Patton J, Schaefer L, Webb A, Wheeler CC** 2001 Harry Benjamin International Gender Dysphoria Association's The Standards of Care for Gender Identity Disorders, 6th version. Int J Transgenderism, vol. 5, no. 1. Available at: http://www.symposion.com/ijt/soc_2001/index.htm
29. 1992 The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization
30. **Kuiper AJ, Cohen-Kettenis PT** 1998 Gender role reversal among postoperative transsexuals. Int J Transgenderism, vol. 2, no. 3. Available at: http://www.symposion.com/ijt/ijtc0502.htm
31. **Landén M, Wålinder J, Hambert G, Lundström B** 1998 Factors predictive of regret in sex reassignment. Acta Psychiatr Scand 97:284–289
32. **Olsson SE, Möller A** 2006 Regret after sex reassignment surgery in a male-to-female transsexual: a long-term follow-up. Arch Sex Behav 35:501–506
33. **Pfäfflin F, Junge A** 1992 Geschlechtsumwandlung: Abhandlungen zur Transsexualität [Sex change: treatises on transsexualism]. Stuttgart, Germany: Schattauer
34. **Cohen-Kettenis PT, Pfäfflin F** 2003 Transgenderism and intersexuality in childhood and adolescence: making choices. Thousand Oaks, CA: Sage Publications
35. **Di Ceglie D, Freedman D, McPherson S, Richardson P** 2002 Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics. Int J Transgenderism, vol. 6, no. 1. Available at: http://www.symposion.com/ijt/ijtvo06no01_01.htm
36. **Cohen-Kettenis PT, van Goozen SH** 1997 Sex reassignment of adolescent transsexuals: a follow-up study. J Am Acad Child Adolesc Psychiatry 36:263–271
37. **Smith YL, van Goozen SH, Cohen-Kettenis PT** 2001 Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. J Am Acad Child Adolesc Psychiatry 40:472–481
38. **Smith YL, Van Goozen SH, Kuiper AJ, Cohen-Kettenis PT** 2005 Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals. Psychol Med 35:89–99
39. **Lawrence AA** 2003 Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. Arch Sex Behav 32:299–315
40. **Seikowski K** 2007 Psychotherapy and transsexualism. Andrologia 39:248–252
41. **Coleman E, Cesnik J** 1990 Skoptic syndrome: the treatment of an obsessional gender dysphoria with lithium carbonate and psychotherapy. Am J Psychother 44:204–217
42. **Cohen-Kettenis PT** 2001 Gender identity disorder in DSM? J Am Acad Child Adolesc Psychiatry 40:391
43. **Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ** 2008 A follow-up study of girls with gender identity disorder. Dev Psychol 44:34–45
44. **Wallien MS, Cohen-Kettenis PT** 2008 Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry 47:1413–1423
45. **Zucker KJ, Bradley SJ** 1995 Gender identity disorder and psychosexual problems in children and adolescents. New York: Guilford Press
46. **Büchter D, Behre HM, Kliesch S, Nieschlag E** 1998 Pulsatile GnRH or human chorionic gonadotropin/human menopausal gonadotropin as effective treatment for men with hypogonadotropic hypogonadism: a review of 42 cases. Eur J Endocrinol 139:298–303
47. **Liu PY, Turner L, Rushford D, McDonald J, Baker HW, Conway AJ, Handelsman DJ** 1999 Efficacy and safety of recombinant human follicle stimulating hormone (Gonal-F) with urinary human chorionic gonadotrophin for induction of spermatogenesis and fertility in gonadotrophin-deficient men. Hum Reprod 14:1540–1545
48. **De Sutter P** 2001 Gender reassignment and assisted reproduction: present and future reproductive options for transsexual people. Hum Reprod 16:612–614
49. **De Sutter P** 2007 Reproduction and fertility issues for transpeople. In: Ettner R, Monstrey S, Eyler AE, eds. Principles of transgender medicine and surgery. New York: Haworth Press; 209–221
50. **Seli E, Tangir J** 2005 Fertility preservation options for female patients with malignancies. Curr Opin Obstet Gynecol 17:299–308
51. **Lübbert H, Leo-Rossberg I, Hammerstein J** 1992 Effects of ethinyl estradiol on semen quality and various hormonal parameters in a eugonadal male. Fertil Steril 58:603–608
52. **Schulze C** 1988 Response of the human testis to long-term estrogen treatment: morphology of Sertoli cells, Leydig cells and spermatogonial stem cells. Cell Tissue Res 251:31–43
53. **Thiagaraj D, Gunasegaram R, Loganath A, Peh KL, Kottegoda SR, Ratnam SS** 1987 Histopathology of the testes from male transsexuals on oestrogen therapy. Ann Acad Med Singapore 16:347–348
54. **Baba T, Endo T, Honnma H, Kitajima Y, Hayashi T, Ikeda H, Masumori N, Kamiya H, Moriwaka O, Saito T** 2007 Association between polycystic ovary syndrome and female-to-male transsexuality. Hum Reprod 22:1011–1016
55. **Spinder T, Spijkstra JJ, van den Tweel JG, Burger CW, van Kessel H, Hompes PG, Gooren LJ** 1989 The effects of long-term testosterone administration on pulsatile luteinizing hormone secretion and on ovarian histology in eugonadal female to male transsexual subjects. J Clin Endocrinol Metab 69:151–157
56. **Trebay G** 2008 He's pregnant, you're speechless. New York Times, June 28, 2008; 18
57. **De Sutter P** 2003 Donor inseminations in partners of female-to-male transsexuals: should the question be asked? Reprod Biomed Online 6:382; author reply 282–283
58. **Boyar RM, Wu RH, Roffwarg H, Kapen S, Weitzman ED, Hellman L, Finkelstein JW** 1976 Human puberty: 24-hour estradiol in pubertal girls. J Clin Endocrinol Metab 43:1418–1421

59. **Wennink JM, Delemarre-van de Waal HA, Schoemaker R, Schoemaker H, Schoemaker J** 1989 Luteinizing hormone and follicle stimulating hormone secretion patterns in boys throughout puberty measured using highly sensitive immunoradiometric assays. Clin Endocrinol (Oxf) 31:551–564
60. **Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ** 2008 The treatment of adolescent transsexuals: changing insights. J Sex Med 5:1892–1897
61. **Delemarre-Van de Waal HA, Cohen-Kettenis PT** 2006 Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155(Suppl 1):S131–S137
62. **Tanner JM** 1962 Growth at adolescence. 2nd ed. Oxford, UK: Blackwell Scientific Publications
63. **Wennink JM, Delemarre-van de Waal HA, Schoemaker R, Schoemaker H, Schoemaker J** 1990 Luteinizing hormone and follicle stimulating hormone secretion patterns in girls throughout puberty measured using highly sensitive immunoradiometric assays. Clin Endocrinol (Oxf) 33:333–344
64. **Roth C** 2002 Therapeutic potential of GnRH antagonists in the treatment of precocious puberty. Expert Opin Investig Drugs 11: 1253–1259
65. **Tuvemo T** 2006 Treatment of central precocious puberty. Expert Opin Investig Drugs 15:495–505
66. **Manasco PK, Pescovitz OH, Feuillan PP, Hench KD, Barnes KM, Jones J, Hill SC, Loriaux DL, Cutler Jr GB** 1988 Resumption of puberty after long term luteinizing hormone-releasing hormone agonist treatment of central precocious puberty. J Clin Endocrinol Metab 67:368–372
67. **Mittan D, Lee S, Miller E, Perez RC, Basler JW, Bruder JM** 2002 Bone loss following hypogonadism in men with prostate cancer treated with GnRH analogs. J Clin Endocrinol Metab 87:3656–3661
68. **Neely EK, Bachrach LK, Hintz RL, Habiby RL, Slemenda CW, Feezle L, Pescovitz OH** 1995 Bone mineral density during treatment of central precocious puberty. J Pediatr 127:819–822
69. **Raudrant D, Rabe T** 2003 Progestogens with antiandrogenic properties. Drugs 63:463–492
70. **Jain J, Dutton C, Nicosia A, Wajszczuk C, Bode FR, Mishell Jr DR** 2004 Pharmacokinetics, ovulation suppression and return to ovulation following a lower dose subcutaneous formulation of Depo-Provera. Contraception 70:11–18
71. **Mieszczak J, Eugster EA** 2007 Treatment of precocious puberty in McCune-Albright syndrome. Pediatr Endocrinol Rev 4(Suppl 4): 419–422
72. **Richman RA, Underwood LE, French FS, Van Wyk JJ** 1971 Adverse effects of large doses of medroxyprogesterone (MPA) in idiopathic isosexual precocity. J Pediatr 79:963–971
73. **Albanese A, Kewley GD, Long A, Pearl KN, Robins DG, Stanhope R** 1994 Oral treatment for constitutional delay of growth and puberty in boys: a randomised trial of an anabolic steroid or testosterone undecanoate. Arch Dis Child 71:315–317
74. **Nilsson KO, Albertsson-Wikland K, Alm J, Aronson S, Gustafsson J, Hagenäs L, Häger A, Ivarsson SA, Karlberg J, Kriström B, Marcus C, Moell C, Ritzen M, Tuvemo T, Wattsgård C, Westgren U, Westphal O, Aman J** 1996 Improved final height in girls with Turner's syndrome treated with growth hormone and oxandrolone. J Clin Endocrinol Metab 81:635–640
75. **Schroor EJ, van Weissenbruch MM, Knibbe P, Delemarre-van de Waal HA** 1995 The effect of prolonged administration of an anabolic steroid (oxandrolone) on growth in boys with constitutionally delayed growth and puberty. Eur J Pediatr 154:953–957
76. **Ball GD, Huang TT, Gower BA, Cruz ML, Shaibi GQ, Weigensberg MJ, Goran MI** 2006 Longitudinal changes in insulin sensitivity, insulin secretion, and β-cell function during puberty. J Pediatr 148: 16–22
77. **Reinehr T, Kiess W, Andler W** 2005 Insulin sensitivity indices of glucose and free fatty acid metabolism in obese children and adolescents in relation to serum lipids. Metabolism 54:397–402
78. **Monstrey S, De Cuypere G, Ettner R** 2007 Surgery: general principles. In: Ettner SR, Monstrey S, Eyler AE, eds. Principles of transgender medicine and surgery. New York: Haworth Press; 89–104
79. **Monstrey S, Hoebeke P, Dhont M, De Cuypere G, Rubens R, Moerman M, Hamdi M, Van Landuyt K, Blondeel P** 2001 Surgical therapy in transsexual patients: a multi-disciplinary approach. Acta Chir Belg 101:200–209
80. **Gooren L** 2005 Hormone treatment of the adult transsexual patient. Horm Res 64(Suppl 2):31–36
81. **Gooren LJ, Giltay EJ** 2008 Review of studies of androgen treatment of female-to-male transsexuals: effects and risks of administration of androgens to females. J Sex Med 5:765–776
82. **Levy A, Crown A, Reid R** 2003 Endocrine intervention for transsexuals. Clin Endocrinol (Oxf) 59:409–418
83. **Moore E, Wisniewski A, Dobs A** 2003 Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects. J Clin Endocrinol Metab 88:3467–3473
84. **Tangpricha V, Ducharme SH, Barber TW, Chipkin SR** 2003 Endocrinologic treatment of gender identity disorders. Endocr Pract 9:12–21
85. **Bhasin S, Cunningham GR, Hayes FJ, Matsumoto AM, Snyder PJ, Swerdloff RS, Montori VM** 2006 Testosterone therapy in adult men with androgen deficiency syndromes: an Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 91:1995–2010
86. **Boloña ER, Uraga MV, Haddad RM, Tracz MJ, Sideras K, Kennedy CC, Caples SM, Erwin PJ, Montori VM** 2007 Testosterone use in men with sexual dysfunction: a systematic review and meta-analysis of randomized placebo-controlled trials. Mayo Clin Proc 82:20–28
87. **Dickersin K, Munro MG, Clark M, Langenberg P, Scherer R, Frick K, Zhu Q, Hallock L, Nichols J, Yalcinkaya TM** 2007 Hysterectomy compared with endometrial ablation for dysfunctional uterine bleeding: a randomized controlled trial. Obstet Gynecol 110: 1279–1289
88. **Prasad P, Powell MC** 2008 Prospective observational study of Thermablate Endometrial Ablation System as an outpatient procedure. J Minim Invasive Gynecol 15:476–479
89. **Gooren LJ, Giltay EJ, Bunck MC** 2008 Long-term treatment of transsexuals with cross-sex hormones: extensive personal experience. J Clin Endocrinol Metab 93:19–25
90. **Dittrich R, Binder H, Cupisti S, Hoffmann I, Beckmann MW, Mueller A** 2005 Endocrine treatment of male-to-female transsexuals using gonadotropin-releasing hormone agonist. Exp Clin Endocrinol Diabetes 113:586–592
91. **Levy J, Burshell A, Marbach M, Afllalo L, Glick SM** 1980 Interaction of spironolactone with oestradiol receptors in cytosol. J Endocrinol 84:371–379
92. **Toorians AW, Thomassen MC, Zweegman S, Magdeleyns EJ, Tans G, Gooren LJ, Rosing J** 2003 Venous thrombosis and changes of hemostatic variables during cross-sex hormone treatment in transsexual people. J Clin Endocrinol Metab 88:5723–5729
93. **van Kesteren PJ, Asscheman H, Megens JA, Gooren LJ** 1997 Mortality and morbidity in transsexual subjects treated with cross-sex hormones. Clin Endocrinol (Oxf) 47:337–342
94. **Ott J, Kaufmann U, Bentz EK, Huber JC, Tempfer CB** 5 February 2009 Incidence of thrombophilia and venous thrombosis in transsexuals under cross-sex hormone therapy. Fertil Steril 10.1016/j.fertnstert.2008.12.017
95. **Righini M, Perrier A, De Moerloose P, Bounameaux H** 2008 D-Dimer for venous thromboembolism diagnosis: 20 years later. J Thromb Haemost 6:1059–1071
96. **Lapauw B, Taes Y, Simoens S, Van Caenegem E, Weyers S, Goemaere S, Toye K, Kaufman JM, T'Sjoen GG** 2008 Body composition, volumetric and areal bone parameters in male-to-female transsexual persons. Bone 43:1016–1021

97. **Meyer 3rd WJ, Webb A, Stuart CA, Finkelstein JW, Lawrence B, Walker PA** 1986 Physical and hormonal evaluation of transsexual patients: a longitudinal study. Arch Sex Behav 15:121–138
98. **Bird D, Vowles K, Anthony PP** 1979 Spontaneous rupture of a liver cell adenoma after long term methyltestosterone: report of a case successfully treated by emergency right hepatic lobectomy. Br J Surg 66:212–213
99. **Westaby D, Ogle SJ, Paradinas FJ, Randell JB, Murray-Lyon IM** 1977 Liver damage from long-term methyltestosterone. Lancet 2:262–263
100. **Gooren LJ, Assies J, Asscheman H, de Slegte R, van Kessel H** 1988 Estrogen-induced prolactinoma in a man. J Clin Endocrinol Metab 66:444–446
101. **Kovacs K, Stefaneanu L, Ezzat S, Smyth HS** 1994 Prolactin-producing pituitary adenoma in a male-to-female transsexual patient with protracted estrogen administration: a morphologic study. Arch Pathol Lab Med 118:562–565
102. **Serri O, Noiseux D, Robert F, Hardy J** 1996 Lactotroph hyperplasia in an estrogen treated male-to-female transsexual patient. J Clin Endocrinol Metab 81:3177–3179
103. **Asscheman H, Gooren LJ, Assies J, Smits JP, de Slegte R** 1988 Prolactin levels and pituitary enlargement in hormone-treated male-to-female transsexuals. Clin Endocrinol (Oxf) 28:583–588
104. **Gooren LJ, Harmsen-Louman W, van Kessel H** 1985 Follow-up of prolactin levels in long-term oestrogen-treated male-to-female transsexuals with regard to prolactinoma induction. Clin Endocrinol (Oxf) 22:201–207
105. **Berra M, Armillotta F, D'Emidio L, Costantino A, Martorana G, Pelusi G, Meriggiola MC** 2006 Testosterone decreases adiponectin levels in female to male transsexuals. Asian J Androl 8:725–729
106. **Elbers JM, Giltay EJ, Teerlink T, Scheffer PG, Asscheman H, Seidell JC, Gooren LJ** 2003 Effects of sex steroids on components of the insulin resistance syndrome in transsexual subjects. Clin Endocrinol (Oxf) 58:562–571
107. **Giltay EJ, Lambert J, Gooren LJ, Elbers JM, Steyn M, Stehouwer CD** 1999 Sex steroids, insulin, and arterial stiffness in women and men. Hypertension 34:590–597
108. **Polderman KH, Gooren LJ, Asscheman H, Bakker A, Heine RJ** 1994 Induction of insulin resistance by androgens and estrogens. J Clin Endocrinol Metab 79:265–271
109. **Meriggiola MC, Armillotta F, Costantino A, Altieri P, Saad F, Kalhorn T, Perrone AM, Ghi T, Pelusi C, Pelusi G** 2008 Effects of testosterone undecanoate administered alone or in combination with letrozole or dutasteride in female to male transsexuals. J Sex Med 5:2442–2453
110. **Giltay EJ, Hoogeveen EK, Elbers JM, Gooren LJ, Asscheman H, Stehouwer CD** 1998 Effects of sex steroids on plasma total homocysteine levels: a study in transsexual males and females. J Clin Endocrinol Metab 83:550–553
111. **Giltay EJ, Toorians AW, Sarabdjitsingh AR, de Vries NA, Gooren LJ** 2004 Established risk factors for coronary heart disease are unrelated to androgen-induced baldness in female-to-male transsexuals. J Endocrinol 180:107–112
112. **Giltay EJ, Verhoef P, Gooren LJ, Geleijnse JM, Schouten EG, Stehouwer CD** 2003 Oral and transdermal estrogens both lower plasma total homocysteine in male-to-female transsexuals. Atherosclerosis 168:139–146
113. **Calof OM, Singh AB, Lee ML, Kenny AM, Urban RJ, Tenover JL, Bhasin S** 2005 Adverse events associated with testosterone replacement in middle-aged and older men: a meta-analysis of randomized, placebo-controlled trials. J Gerontol A Biol Sci Med Sci 60: 1451–1457
114. **NCEP** 2002 Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. Circulation 106:3143–3421
115. **Turner A, Chen TC, Barber TW, Malabanan AO, Holick MF, Tangpricha V** 2004 Testosterone increases bone mineral density in female-to-male transsexuals: a case series of 15 subjects. Clin Endocrinol (Oxf) 61:560–566
116. **van Kesteren P, Lips P, Gooren LJ, Asscheman H, Megens J** 1998 Long-term follow-up of bone mineral density and bone metabolism in transsexuals treated with cross-sex hormones. Clin Endocrinol (Oxf) 48:347–354
117. **Amin S, Zhang Y, Sawin CT, Evans SR, Hannan MT, Kiel DP, Wilson PW, Felson DT** 2000 Association of hypogonadism and estradiol levels with bone mineral density in elderly men from the Framingham study. Ann Intern Med 133:951–963
118. **Gennari L, Khosla S, Bilezikian JP** 2008 Estrogen and fracture risk in men. J Bone Miner Res 23:1548–1551
119. **Gennari L, Khosla S, Bilezikian JP** 2008 Estrogen effects on bone in the male skeleton. In: Bilezikian JP, Martin TJ, Raisz LG, eds. Principles of bone biology. 3rd ed. San Diego: Academic Press; 1801–1818
120. **Khosla S, Melton 3rd LJ, Atkinson EJ, O'Fallon WM, Klee GG, Riggs BL** 1998 Relationship of serum sex steroid levels and bone turnover markers with bone mineral density in men and women: a key role for bioavailable estrogen. J Clin Endocrinol Metab 83: 2266–2274
121. **Mueller A, Dittrich R, Binder H, Kuehnel W, Maltaris T, Hoffmann I, Beckmann MW** 2005 High dose estrogen treatment increases bone mineral density in male-to-female transsexuals receiving gonadotropin-releasing hormone agonist in the absence of testosterone. Eur J Endocrinol 153:107–113
122. **Ruetsche AG, Kneubuehl R, Birkhaeuser MH, Lippuner K** 2005 Cortical and trabecular bone mineral density in transsexuals after long-term cross-sex hormonal treatment: a cross-sectional study. Osteoporos Int 16:791–798
123. **Ganly I, Taylor EW** 1995 Breast cancer in a trans-sexual man receiving hormone replacement therapy. Br J Surg 82:341
124. **Pritchard TJ, Pankowsky DA, Crowe JP, Abdul-Karim FW** 1988 Breast cancer in a male-to-female transsexual. A case report. JAMA 259:2278–2280
125. **Symmers WS** 1968 Carcinoma of breast in trans-sexual individuals after surgical and hormonal interference with the primary and secondary sex characteristics. Br Med J 2:83–85
126. **Anderson GL, Limacher M, Assaf AR, Bassford T, Beresford SA, Black H, Bonds D, Brunner R, Brzyski R, Caan B, Chlebowski R, Curb D, Gass M, Hays J, Heiss G, Hendrix S, Howard BV, Hsia J, Hubbell A, Jackson R, Johnson KC, Judd H, Kotchen JM, Kuller L, LaCroix AZ, Lane D, Langer RD, Lasser N, Lewis CE, Manson J, Margolis K, Ockene J, O'Sullivan MJ, Phillips L, Prentice RL, Ritenbaugh C, Robbins J, Rossouw JE, Sarto G, Stefanick ML, Van Horn L, Wactawski-Wende J, Wallace R, Wassertheil-Smoller S** 2004 Effects of conjugated equine estrogen in postmenopausal women with hysterectomy: the Women's Health Initiative randomized controlled trial. JAMA 291:1701–1712
127. **Bösze P, Tóth A, Török M** 2006 Hormone replacement and the risk of breast cancer in Turner's syndrome. N Engl J Med 355: 2599–2600
128. **Schoemaker MJ, Swerdlow AJ, Higgins CD, Wright AF, Jacobs PA** 2008 Cancer incidence in women with Turner syndrome in Great Britain: a national cohort study. Lancet Oncol 9:239–246
129. **Smith RA, Cokkinides V, Eyre HJ** 2006 American Cancer Society guidelines for the early detection of cancer, 2006. CA Cancer J Clin 56:11–25; quiz 49–50
130. **Wilson JD, Roehrborn C** 1999 Long-term consequences of castration in men: lessons from the Skoptzy and the eunuchs of the Chinese and Ottoman courts. J Clin Endocrinol Metab 84:4324–4331
131. **van Kesteren P, Meinhardt W, van der Valk P, Geldof A, Megens J, Gooren L** 1996 Effects of estrogens only on the prostates of aging men. J Urol 156:1349–1353
132. **Brown JA, Wilson TM** 1997 Benign prostatic hyperplasia requiring transurethral resection of the prostate in a 60-year-old male-to-female transsexual. Br J Urol 80:956–957
133. **Casella R, Bubendorf L, Schaefer DJ, Bachmann A, Gasser TC,**

Sulser T 2005 Does the prostate really need androgens to grow? Transurethral resection of the prostate in a male-to-female transsexual 25 years after sex-changing operation. Urol Int 75:288–290
134. **Dorff TB, Shazer RL, Nepomuceno EM, Tucker SJ** 2007 Successful treatment of metastatic androgen-independent prostate carcinoma in a transsexual patient. Clin Genitourin Cancer 5:344–346
135. **Thurston AV** 1994 Carcinoma of the prostate in a transsexual. Br J Urol 73:217
136. **van Haarst EP, Newling DW, Gooren LJ, Asscheman H, Prenger DM** 1998 Metastatic prostatic carcinoma in a male-to-female transsexual. Br J Urol 81:776
137. 2008 Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 149:185–191
138. **Futterweit W** 1998 Endocrine therapy of transsexualism and potential complications of long-term treatment. Arch Sex Behav 27: 209–226
139. **Miller N, Bédard YC, Cooter NB, Shaul DL** 1986 Histological changes in the genital tract in transsexual women following androgen therapy. Histopathology 10:661–669
140. **O'Hanlan KA, Dibble SL, Young-Spint M** 2007 Total laparoscopic hysterectomy for female-to-male transsexuals. Obstet Gynecol 110:1096–1101
141. **Chadha S, Pache TD, Huikeshoven JM, Brinkmann AO, van der Kwast TH** 1994 Androgen receptor expression in human ovarian and uterine tissue of long-term androgen-treated transsexual women. Hum Pathol 25:1198–1204
142. **Dizon DS, Tejada-Berges T, Koelliker S, Steinhoff M, Granai CO** 2006 Ovarian cancer associated with testosterone supplementation in a female-to-male transsexual patient. Gynecol Obstet Invest 62:226–228
143. **Hage JJ, Dekker JJ, Karim RB, Verheijen RH, Bloemena E** 2000 Ovarian cancer in female-to-male transsexuals: report of two cases. Gynecol Oncol 76:413–415
144. **Mueller A, Gooren L** 2008 Hormone-related tumors in transsexuals receiving treatment with cross-sex hormones. Eur J Endocrinol 159:197–202
145. **Selvaggi G, Ceulemans P, De Cuypere G, Van Landuyt K, Blondeel P, Hamdi M, Bowman C, Monstrey S** 2005 Gender identity disorder: general overview and surgical treatment for vaginoplasty in male-to-female transsexuals. Plast Reconstr Surg 116:135e–145e
146. **Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR** 2007 Current management of male-to-female gender identity disorder in the UK. Postgrad Med J 83:638–642
147. **Green R** 1998 Sexual functioning in post-operative transsexuals: male-to-female and female-to-male. Int J Impot Res 10 Suppl 1:S22–S24
148. **McNeill EJ** 2006 Management of the transgender voice. J Laryngol Otol 120:521–523
149. **Becking AG, Tuinzing DB, Hage JJ, Gooren LJ** 2007 Transgender feminization of the facial skeleton. Clin Plast Surg 34:557–564
150. **Giraldo F, Esteva I, Bergero T, Cano G, González C, Salinas P, Rivada E, Lara JS, Soriguer F** 2004 Corona glans clitoroplasty and urethropreputial vestibuloplasty in male-to-female transsexuals: the vulval aesthetic refinement by the Andalusia Gender Team. Plast Reconstr Surg 114:1543–1550
151. **Goddard JC, Vickery RM, Terry TR** 2007 Development of feminizing genitoplasty for gender dysphoria. J Sex Med 4:981–989
152. **Hage JJ, de Graaf FH, Bouman FG, Bloem JJ** 1993 Sculpturing the glans in phalloplasty. Plast Reconstr Surg 92:157–161; discussion 162
153. **Monstrey S, De Cuypere G, Ettner R** 2007 Surgery: female-to-male patient. In: Ettner SR, Monstrey S, Eyler AE, eds. Principles of transgender medicine and surgery. New York: The Haworth Press; 135–168
154. **Chen HC, Gedebou TM, Yazar S, Tang YB** 2007 Prefabrication of the free fibula osteocutaneous flap to create a functional human penis using a controlled fistula method. J Reconstr Microsurg 23: 151–154
155. **Liberopoulos EN, Florentin M, Mikhailidis DP, Elisaf MS** 2008 Compliance with lipid-lowering therapy and its impact on cardiovascular morbidity and mortality. Expert Opin Drug Saf 7:717–725
156. **Davis PJ, Spady D, de Gara C, Forgie SE** 2008 Practices and attitudes of surgeons toward the prevention of surgical site infections: a provincial survey in Alberta, Canada. Infect Control Hosp Epidemiol 29:1164–1166
157. **Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF** 2008 Implementation of evidence-based practices for surgical site infection prophylaxis: results of a pre- and postintervention study. J Am Coll Surg 207:336–341

National Association of Social Workers

National Committee on Lesbian, Gay, Bisexual, and Transgender Issues

Position Statement

Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons

NASW

National Association of Social Workers

MAY 2015

The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world. NASW works to enhance the professional growth and development of its members, to create and maintain standards for the profession, and to advance sound social policies. NASW also contributes to the well-being of individuals, families and communities through its advocacy.

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BACKGROUND

In 1992, the NASW National Committee on Lesbian and Gay Issues (NCLGI) issued a ground-breaking document focused on the negative and stigmatizing impact of the use of 'transformational ministries' or 'conversion or reparative therapies' in an attempt to change or modify a person's sexual orientation (NASW, 1992). Later that decade, the NASW National Committee on Lesbian, Gay, and Bisexual Issues (NCLGBI) updated the position statement. In 2000 the National NASW Board of Directors passed a 'motion to adopt' the *Reparative and Conversion Therapies for Lesbians and Gay Men Position Statement* (NASW, 2000). As advocacy efforts have grown, both for and against the use of conversion therapy, so has the need to educate clients and communities about the impact of these practices on individuals and families, and the implications for social work practice. In 2015, the NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI) updated the position statement utilizing the umbrella term *sexual orientation change efforts (SOCE).*

INTRODUCTION

Reparative therapy, conversion therapy, or transformational ministries (increasingly included within the term *sexual orientation change efforts (or SOCE),* received wider attention against the backdrop of a growing conservative religious political climate in the 1990s, and through ongoing social media supported by the Focus on the Family and affiliates (NASW, 1992; Johnston, J., 2011). Proponents of reparative therapy and conversion therapy claim that their processes are supported by scientific data. Of note is that an often cited researcher, Robert Spitzer, admitted flaws in his research and in 2012 formally retracted his 2001 study that claimed gay men and lesbians could switch their sexual orientation (Hein, L. & Matthews, A., 2010). Despite the lack of scientific evidence, supporters of these practices continue to believe sexual orientation can be successfully changed (Panozzo, D., 2013). While there is increased effort at the state and local level to pass laws against the use of *SOCE*, there is a growing movement to pass

legislation that will limit implementation of state law banning the use of *SOCE* with minors. Under the guise of 'parental and family rights', the proposed legislation will limit the ability for state governments to prohibit certain types of counseling for minors, with specific reference to the parental right to access SOCE for 'counseling' (Southern Poverty Law Center, 2014; Kern, S., and Brecheen, J., 2015). *SOCE, conversion therapy and reparative therapy* have been discredited or highly criticized by all major medical, psychiatric, psychological and professional mental health organizations, including the National Association of Social Workers.

What are sexual orientation change efforts?

The term *sexual orientation change efforts (or SOCE)* include any practice seeking to change a person's sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender. Within this position statement, SOCE includes any form of *reparative therapy, conversion therapy*, and/or *transformational ministries* that use interventions claiming to "repair" or "convert" a person in order to reduce or eliminate a person's sexual desire for a member of his or her own gender. The use of SOCE can include use of psychotherapy, medical approaches, aversion therapy, religious and spiritual approaches, as well as the use of sexual violence (referred to as 'corrective rape). There are no studies of adequate scientific rigor to conclude whether or not SOCE or conversion therapy can modify or change sexual orientation or gender identity or expression (APA, 2009).

What are sexual orientation, sexual identity, gender identity, and gender expression?

According to NASW's **"Definitions: A Primer"** (2009), *sex* is assigned at birth and determined usually by external, physical genitals. Additional sex markers include chromosomes and internal and external reproductive organs. *Gender* is an ascribed social status assigned at birth, which is

assumed to be congruent with the assigned birth sex, but may or may not be congruent with the anatomical sexual identifiers.

Sexual orientation is defined by whom people are emotionally, romantically, and erotically attracted to, for the most part and over a period of time. It exists on a continuum of feelings and attractions, and is not necessarily congruent with behavior.

Sexual identity refers to a person's self-perception of his or her sexual orientation, and *sexual behavior* refers to a person's sexual activities.

Gender Identity refers to the gender with which one identifies regardless of one's assigned sex at birth. *Gender expression* is the communication of gender through behaviors (mannerisms, speech patterns, etc.) and appearance (clothing, hair, accessories, etc.) culturally associated with a particular gender.

Can therapy change sexual orientation or gender identity?

People seek mental health services for many reasons. Accordingly, it is fair to assert that people who have same-sex attraction seek therapy for the same reasons that heterosexual people do. However, media campaigns, often coupled with coercive messages from family and community members, can create an environment in which LGBT persons are pressured to seek conversion therapy. The stigmatization of LGBT persons creates a threat to the health and well-being of those affected which, in turn, produces the social climate that pressures some people to seek change in sexual orientation or gender identity (Haldeman, D.,1994; HRC, 2015). However, no data demonstrate that SOCE or reparative therapy or conversion therapy is effective, rather have succeeded only in short term reduction of same-sex sexual behavior and negatively impact the mental health and self-esteem of the individual (Davison, G., 1991; Haldeman, D., 1994, APA, 2009).

The NASW National Committee on Lesbian, Gay, Bisexual, and Transgender Issues believes that SOCE can negatively affect one's mental health and cannot and will not change sexual orientation or gender identity.

Why is this issue relevant to the social work profession?

Social workers should have a broad-based knowledge about human sexuality, human sexual development across the life cycle, a high degree of comfort and skill in communicating and responding to such issues, and knowledge of appropriate community services (Harrison, D., 1995).

Social workers across fields of practice, including foster care, mental health, corrections, substance abuse, school social work, and prevention education, will encounter lesbian, gay, bisexual and transgender (LGBT) clients. Providing culturally competent services with LGBT youth and adults calls for a shift or transformation from reparative to affirmative practice and interventions (Hunter, S. & Hickerson, J., 2003; Mallon, G., 2009).

What are the value and ethical implications for social workers?

In discussing ethical decisions for social work practice, Loewenberg & Dolgoff (1996) stress "the priority of professional intervention at the individual level will be to help people achieve self-actualization, rather than helping them to learn how to adjust to the existing social order."

The practice of SOCE violates the very tenets of the social work profession as outlined in the NASW *Code of Ethics*. The NASW *Code of Ethics* (1998) enunciates principles that address ethical decision making in social work practice with lesbians, gay men, bisexual, and transgender people; for example: 1) social workers' commitment to clients' self-determination and competence, and to achieving cultural competence and understanding social diversity, 2) social workers' ethical responsibilities to colleagues, their commitment to interdisciplinary collaboration, and their responsibility to report unethical conduct of colleagues, 3) social workers' ethical responsibilities as professionals—maintaining competence, fighting discrimination, and avoiding misrepresentation, and 4) social workers' ethical responsibilities to the social work profession, to evaluation, and to research.

The National Committee on LGBT Issues asserts that conversion therapy or SOCE are an infringement of the guiding principles inherent to social worker ethics and values; a position affirmed by the NASW policy statement on "Lesbian, Gay, and Bisexual Issues" (NASW 2014).

How can I practice the nondiscrimination tenets of my profession?

As stated in the original NASW National Committee on Gay and Lesbian Issues - Position Statement on Reparative Therapy, "If a client is uncomfortable about his/her sexual orientation, the sources of discomfort must be explored, but without prior assumption that same-sex attraction is dysfunctional" (1992). Social workers must advocate against policy or practice interventions that create or reinforce the prejudice and discrimination towards gay men, lesbians, bisexual, and transgender persons and their families. Social workers are obligated to use nonjudgmental attitudes and to encourage nurturing practice environments for lesbians, gay men, bisexual, and transgender persons.

What policy exists to help guide social work practice?

The NASW Policy Statement on Lesbian, Gay, and Bisexual (LGB) Issues and the NASW Policy Statement on Transgender and Gender Identity Issues provide a "blueprint" for social work practice with gay, lesbian, bisexual, transgender clients and communities.

The policies state, "NASW supports the adoption of local, state, federal, and international policies and legislation that ban all forms of discrimination based on sexual orientation and gender identity" (NASW 2008), and further adds "NASW condemns the use of SOCE or so-called reparative therapy by any person identifying as a social worker or any agency that identifies as providing social work services. Public dollars should not be spent on programs that support SOCE" (NASW, 2014). The National Association of Social Workers reaffirms its stance against therapies and treatments designed to change sexual orientation or gender identity and against referring clients to practitioners or programs that claim to do so (NASW, 2014).

Position statement authored by members of the National Committee on Lesbian, Gay, Bisexual, and Transgender Issues (NCLGBTI), National Association of Social Workers (NASW) and NASW staff.[1]

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REFERENCES

American Psychological Association. (2009). *APA Task Force on Appropriate Therapeutic Responses to Sexual orientation. Report of the Task Force*. Washington, DC: American Psychological Association. [Online]: apa.org/pi/lgbt/resources/therapeutic-response.pdf

Davison, G., (1991). *Construction and morality in therapy for homosexuality*. In J.C. Gonsiorek & J.D. Weinrich (Eds.), With compassion toward some: Homosexuality and social work in America (pp. 115–136). New York: Harrington Press.

Haldeman, D., (1994). *The practice and ethics of sexual orientation conversion therapy*. Journal of Consulting and Clinical Psychology, 62, 211–221.

Harrison, D., (1995). *Human sexuality*. In R.L. Edwards (Ed.-in-Chief), Encyclopedia of social work (19th ed., Vol. 2, pp. 1418–1428). Washington, DC: NASW Press.

Hein, L., & Matthews, A., (2010). *Reparative therapies: The adolescent, the psych nurse, and the issues*. Journal of Child and Adolescent Psychiatric Nursing, 23, 29–35.

Human Rights Campaign. (2015). *The Lies and Dangers of Efforts to Change Sexual Orientation or Gender Identity*. [Online] hrc.org/resources/entry/the-lies-and-dangers-of-reparative-therapy

Hunter, S., and Hickerson, J. (2003). *Affirmative Practice, Understanding and Working with Lesbian, Gay, Bisexual, and Transgender Persons*. Washington, DC: NASW Press.

Kern, S., and Brecheen, J. (2015). *Parental and Family Rights in Counseling Protection Act, House Bill 1598*. State of Oklahoma. 55th Legislature. [Online] oklegislature.gov/index.aspx

Johnston, J. (2011). *Therapy for unwanted homosexuality – part one*. CitizenLink.

Focus on the Family. [Online] citizenlink.com/2011/07/27/therapy-for-unwanted-homosexuality-%E2%80%93-part-1/

Loewenberg, F., & Dolgoff, R. (1996). *Ethical decisions for social work practice.* F.E. Peacock Publishers, Inc.: Itasca, IL.

Mallon, G. (Ed.)., (2009). *Social Work Practice with Lesbian, Gay, Bisexual, and Transgender People.* 2nd Edition. Routledge Press: New York, NY.

National Association of Social Workers. (2014). *Lesbian, Gay, and Bisexual Issues.* In Social work speaks (10th ed.). Washington, DC: NASW Press.

National Association of Social Workers. (2009). *Training Curriculum for Child Welfare Services with Lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Out of Home Care.* Definitions: A Primer. Washington, DC: Author [Online] socialworkers.org/diversity/new/documents/Definitions%202011.pdf

National Association of Social Workers. (2008). *Transgender and Gender Identity Issues.* In Social work speaks (9th ed., pp. 337-345). Washington, DC: NASW Press.

NASW National Committee on Lesbian, Gay, and Bisexual Issues. (2000). *Position statement: Reparative or conversion therapies for lesbians and gay men.* Washington, DC: Author.

National Association of Social Workers. (1998). *Code of Ethics.* Washington, DC: Author. [Online]: socialworkers.org/pubs/code/default.asp

NASW National Committee on Lesbian and Gay Issues. (1992). *Position statement: Reparative or conversion therapies for lesbians and gay men.* Washington, DC: Author.

Panozzo, D. (2013). *Advocating for an end to reparative therapy: Methodological grounding and blueprint for change.* Journal of Gay and Lesbian Social Services, 25, 362–377.

Southern Poverty Law Center (SPLC), 2014. *Conversion Therapy.* [Online]: splcenter.org/conversion-therapy

RESOURCES

Gay and Lesbian Alliance Against Defamation
121 West 27th Street, Suite 804, New York, NY 10001; 212.629.3322 or 212.727.0135; glaad.org

Gay and Lesbian Medical Association
1326 18th Street NW, Washington, DC 20036; 202.600.8037; glma.org

Gay, Lesbian and Straight Education Network
90 Broad St., New York, NY 10004; 212.727.0135; glsen.org

Healthy Lesbian, Gay, and Bisexual Youth Project, American Psychological Association: Public Interest Directorate
750 First Street, NE, Washington, DC 20002-4242; 202.336.5977; apa.org/pi/lgbt/programs/hlgbsp/index.aspx

Human Rights Campaign
1640 Rhode Island Ave., NW, Washington, DC 20036; 202.628.4160; hrc.org

National Association of Social Workers, National Committee on Lesbian, Gay, Bisexual and Transgender Issues
750 First Street, NE, Suite 800, Washington, DC 20002-4241; 202.408.8600; socialworkers.org

National Center for Lesbian Rights
870 Market Street, Suite 370, San Francisco, CA 94102; 415.392.6257; nclrights.org; Born Perfect Project: nclrights.org/explore-the-issues/bornperfect/

Sexuality Information and Education Council of the United States
130 West 42nd Street, Suite 350, New York, NY 10036; 212.819.9770; siecus.org; siecus@siecus.org

World Health Organization (WHO)/Pan American Health Organization (PAHO). (2012). *"Therapies" to change sexual orientation lack medical justification and threaten health*; paho.org

NASW
National Association of Social Workers

750 First Street NE, Suite 800 | Washington, DC 20002-4241

Irish Council for Psychotherapy Position on Conversion Therapy, Reparative Therapy, Gay Cure and Transgender Conversion Therapy in Ireland

The Irish Council for Psychotherapy hereby wishes to clarify that efforts to try to change, manipulate or reverse sexual orientation and/or gender identity change through psychological therapies with different theoretical frameworks are unethical in accordance with the Irish Council for Psychotherapy's Ethical Guidelines.

Conversion Therapy, Reparative Therapy, Gay Cure and Transgender Conversion Therapy refer to a type of talking therapy or activity which attempts to change sexual orientation, gender identity or reduce attraction to others of the same sex.

This is usually pursued via non-scientifically proven and potentially harmful techniques.

The Irish Council for Psychotherapy fully endorses the UK Council of Psychotherapy Memorandum of Understanding on Conversion Therapy.

Link: http://www.psychotherapy.org.uk/news/memorandum-of-understanding

PsySSA
Psychological Society of South Africa

Practice Guidelines For Psychology Professionals

Working With Sexually And Gender-Diverse People

Psychological Society of South Africa. (2017). *Practice Guidelines For Psychology Professionals Working With Sexually And Gender-Diverse People*. Johannesburg: Psychological Society of South Africa.

This document can be accessed from http://www.psyssa.com

CONTENTS

Diversity Competence in a Multicultural Society:

Practice Guidelines For Psychology Professionals

In recent years, and in line with international trends in the profession, efforts are also underway in South Africa to identify competencies for psychology professionals. Given our country's history, our diverse society, and the significant issues around gender, race, culture, sexual orientation, and health status – including gender violence, hate crime and hate speech, and stigmatisation and prejudice around HIV status – it goes without saying that competencies in working with diversity, which include multicultural or cultural competence, are all important.

The 'International Declaration on Core Competencies in Professional Psychology' of the International Union of Psychological Science (IUPsyS) clearly outlines work with diversity, including cultural competence, as key for psychology professionals. This set of competencies includes:

- knowledge and understanding of the historical, political, social and cultural context of clients, colleagues, and relevant others;
- cultural humility;
- respecting diversity in relevant others;
- realising the impact of one's own values, beliefs, and experiences on one's professional behaviour, clients, and relevant others;
- working and communicating effectively with all forms of diversity in clients, colleagues, and relevant others; and
- inclusivity of all forms of diversity in working with clients, colleagues, and relevant others (IUPsyS, 2016).

Being competent may be viewed as "doing something successfully and satisfactorily, though not outstandingly well; being 'good enough' or simply adequate" (Naidu & Ramlall, 2016, p.83). IUPsyS defines competence as a "combination of practical and theoretical knowledge, cognitive skills, behaviour, and values used to perform a specific behaviour or set of behaviours to a standard, in professional practice settings associated with a professional role" (IUPsyS, 2016, p.4).

The term 'diversity' includes working with sexual and gender diversity, the specific area of application dealt with in the *PsySSA practice guidelines for psychology professionals working with sexually and gender-diverse people*. These are one of several sets of practice guidelines that will be developed by the Psychological Society of South Africa (PsySSA). Each set of guidelines in the series will address separate, but sometimes also intersectional[1] target groups (including, but not limited to, diversity based on race, ethnicity, culture, language, religion and/or spirituality; nationality, internally and externally displaced people and asylum seekers; socio-economic status, poverty and unemployment; physical, sensory and cognitive-emotional disabilities; etc.).

1 Intersectionality in psychology, as a concept, acknowledges diversity and focuses on attending to all the different forms of oppressions that occur in society – the different '-isms' – racism, ableism, heterosexism, sexism, classism, etc. and the ways they overlap and often reinforce a power that could potentially subjugate one cultural group. Being a minority within a minority (for example, being intersex and an immigrant) could deepen one's sense of isolation and disconnection from the statistical and cultural majority. The American Psychological Association (2012) notes that the cumulative effects of heterosexism, sexism, and racism, for instance, may put a person at special risk of stress, which adds to the vast range of contextual factors that worsen the effects of stigma. Multiple layers of discrimination that a person could potentially experience may create multiple and intersecting levels of stress.

Practice Guidelines For Psychology Professionals Working With Sexually And Gender-Diverse People

Introduction

These practice guidelines aim to increase psychological knowledge of human diversity in sexual orientations, gender identities, gender expressions and sex characteristics. They aim to facilitate the *application* of this knowledge in support of the well-being and human rights of all sexually and gender-diverse people. This constitutes the first version of the Psychological Society of South Africa (PsySSA) practice guidelines and, as such, is a pilot of what is very much deemed a 'living document': if and when revisions are indicated, they will be made at set intervals.

This project is a collaboration between PsySSA's Sexuality and Gender Division, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and the PsySSA African LGBTI Human Rights Project. Please see Appendix 1 for details about each organisation/structure/project. The collaborative project that informs this document seeks to contribute to developing, disseminating and implementing standards of care for sexually and gender-diverse people. The overall goal of this project is to build PsySSA's capacity in South Africa and Africa, more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics. (Although some abridged definitions are provided throughout the document, please see the Glossary where more terms are defined).

From Position Statement to Practice Guidelines

These practice guidelines draw on the PsySSA sexual and gender diversity position statement (PsySSA, 2013; Victor, Nel, Lynch, & Mbatha, 2014). The position statement communicates an affirmative stance on sexual and gender diversity, including Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual (hereafter LGBTIQA+). The + indicates, as per current practice, an openness to additional categorisation and self-claimed descriptors. The position statement was and is aimed primarily at psychology professionals in South Africa, though it is applicable to all mental health professionals on the continent of Africa. It supplements

SEXUAL ORIENTATION: A person's lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual/same-sex sexual orientation, bisexual or asexual).

GENDER IDENTITY: A person's private sense of being male, female or another gender. This may or may not match the biological sex that a person was assigned at birth.

SEX(UAL) CHARACTERISTICS: A sex organ (also called a reproductive organ, primary sex organ, or primary sexual characteristic) is any anatomical part of the body in a complex organism that is involved in sexual reproduction and constitutes part of the reproductive system. The external and visible organs, in males and females, are the primary sex organs known as the 'genitals' or 'genitalia'. The internal organs are known as the 'secondary sex organs' and are sometimes referred to as the 'internal genitalia'. The characteristics that begin to appear during puberty, such as, in humans, pubic hair on both sexes and facial hair on the male, are known as 'secondary sex characteristics'.

the harm-avoidance approach in the South African Health Professions Act (Department of Health, 2006) by outlining specific themes to consider in assuming an affirmative stance in psychological research and practice.

The PsySSA position statement acknowledges that, regardless of sexual or gender identification, individuals seeking psychological services may experience various difficulties in life, including the negative impact of prejudice, stigmatisation and victimisation associated with patriarchal and heteronormative societies (PsySSA, 2013; Victor et al., 2014). It proposes that as health professionals, we acknowledge how these difficulties have cultural, class, race and gender components that often overlap. The position statement suggests ways for thinking about addressing both past and ongoing harms and present contexts.

In a similar fashion, the PsySSA practice guidelines embrace an affirmative stance and intersectionality and are consistent with the South African Constitution and its Bill of Rights (Republic of South Africa [RSA], 1996), the South African Health Professions Act and associated general ethical rules for health professionals (Department of Health, 2006), as well as the PsySSA Constitution (PsySSA, 2012).

Purpose of Practice Guidelines

The purpose of these practice guidelines is to provide a guide and reference for psychology professionals to deal more sensitively and effectively with matters of sexual and gender diversity.[2] Whereas the position statement outlines PsySSA's stance on sexual and gender diversity, the practice guidelines are aspirational in nature – and will hopefully provide all psychology professionals

2 As will become evident from this guidelines document, 'biological variance' [which includes intersex] is subsumed in the term 'sexual and gender diversity', even though not, in fact, part of sexual diversity nor gender diversity, as defined in the glossary. There are several reasons for this inclusion in the guidelines, even though biological variance receives little direct attention, given the paucity in research to draw from. Most importantly, it serves to acknowledge the similarities in experiences [see the definition of LGBTIQA+ in the glossary]. This also highlights the need for psychology professionals to engage more actively in related work.

LGBTIQA+: An abbreviation referring to lesbian, gay, bisexual, transgender and intersex persons. 'LGB' refers to sexual orientations, while 'T' indicates a gender identity, 'I' a biological variant, 'Q' a queer identified person, 'A' for asexual, and '+' indicating other non-conforming minorities. These groups are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination and victimisation in a heteronormative and heterosexist society, in an effort to ensure equality before the law and equal protection by the law. However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences and needs of these people may in fact differ significantly and in several respects. In solidarity with the activist position regarding this matter, however, in this document, reference is made to LGBTIQA+, and distinctions among the diversity of identities that exist are minimised.

PSYCHOLOGY PROFESSIONAL: Inclusive of Health Professions Council of South Africa- (HPCSA-) registered psychologists, regardless of registration category (Clinical, Counselling, Educational, Industrial, Research), registered counsellors and psychometrists, as well as non-registered professionals with a qualification in psychology.

POSITION STATEMENT: Refers to a document outlining the stance of a professional body on a specified area.

HETERONORMATIVITY: Related to 'heterosexism', it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person's biological sex as assigned at birth, and that only sexual attraction between these 'opposite' genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities also, i.e. it serves to regulate not only sexuality but also gender.

PRACTICE GUIDELINES: Related to 'position statement', this term refers to recommendations regarding professional practice in a specified area. The function of practice guidelines in the field of psychology is to provide psychology professionals with applied tools to develop and maintain competencies and learn about new practice areas.

with recommendations and applied tools to develop and maintain a basic level of competency in the area of sexual and gender diversity. These guidelines are based on the most up-to-date research and our most in-depth current understanding, globally and particularly locally.

These practice guidelines should be distinguished from treatment guidelines. Whereas treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition, practice guidelines provide a general framework that can be used across different registration categories and scopes of practice (Reed, McLaughlin, & Newman, 2002).

The intended audience for these practice guidelines is thus primarily all South African psychology professionals dealing with matters of sexual and gender diversity. In addition, as with the PsySSA position statement, the guidelines may apply across mental health service provision and may well apply across the broader African continent.

The document contains 12 practice guidelines, each providing a review of current knowledge followed by potential application in psychological practice. Some content is applicable across more than one guideline. The research and writing team has tried to avoid unnecessary duplication and where possible, readers are directed to content that might be covered in other guidelines. This document contains a glossary of terms currently in use. A resource guide for professionals will additionally be added when the practice guidelines document is revised in the foreseeable future.

Need for Practice Guidelines

While the need for affirmative guidelines for psychotherapeutic practice in Africa has been highlighted repeatedly in recent years (Coetzee, 2009; Nel, 2007; Nel, Mitchell, & Lubbe-De Beer, 2010), some might question why psychology practitioners working with sexually and gender-diverse individuals need a *specialised set* of guidelines. Of course, respect, empathy and competence are professionally required from practitioners working with all people. How is working with sexually and gender-diverse individuals any different? Similarly, competent practitioners are expected to maintain an attitude of openness and curiosity, to be willing to learn, and to set aside personal biases and prejudices – even if they have had no targeted education or training in working with sexually and gender-diverse individuals. This is also true if they find themselves working in other contexts that involve sexual and gender diversity matters, such as policy or curriculum development.

In addition, in the South African context, sexual orientation and gender are protected by the Constitution and related constitutional and other legal challenges brought before South African courts, among other outcomes, have resulted in the legalisation of same-sex marriages, as well as the right to alter one's sex description on identity documents (IDs). This has also had a positive influence on legal rights of the sexually and gender diverse to adopt children. Global diagnostic systems such as the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association [APA], 2013) are increasingly moving away from pathologising sexual and gender diversity. There is a growing awareness of the indivisible human rights of sexually and gender-diverse individuals (International Commission of Jurists, 2007; UN Office of the High Commissioner for Human Rights [OHCHR], 2012). Sexual orientation and gender are grounds for non-discrimination and equality, according to the Constitution and its Bill of Rights (RSA, 1996). For this reason, health professionals are guided by the South African Health Professions

SEXUAL DIVERSITY: The range of different expressions of sexual orientation and sexual behaviour that span across the historically imposed heterosexual–homosexual binary.

GENDER DIVERSITY: The range of different gender expressions that spans across the historically imposed male–female binary. Referring to 'gender diversity' is generally preferred to 'gender variance' as 'variance' implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals.

Act (56 of 1974) to do no harm in their interactions with service users/clients/participants or patients (Department of Health, 2006).

Regrettably, and despite these protections and laws, severe human rights violations have occurred in psychological practice regardless of specific practitioner guidelines on ethics. In South Africa, many sexual and other minority groups have been oppressed by psychology due to silences or support for mainstream political discourses (July, 2009; Yen, 2007). On a global scale, psychology has also failed sexually and gender-diverse people through unethical and unscientific practices. For example, homosexuality was listed in the DSM as a mental illness until 1978, and differences in gender expression were treated as social deviance. Today, reparative therapies and efforts to change sexual orientation and gender identity to conform to normative societal standards of heterosexuality and cisgender, continue despite empirical evidence that such approaches are unethical and can be harmful (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Reports of attempts by practitioners to change people's sexual orientation or gender identity, either subtly or openly, continue to surface.

These practices take place despite the reality that psychological services may be the last safe space that sexually and gender-diverse people seek out away from persistent prejudice, violence and hate crimes that regularly occur.

Guidelines such as these are also necessary because, in South Africa, healthcare practices are still shaped by dominant heteronormative positions, which negatively affects the quality and access to healthcare services for sexually and gender-diverse individuals. Discrimination and negative encounters with healthcare providers have emerged in a number of studies (Graziano, 2005; A.C. Meyer, 2003; Müller, 2013; Rich, 2006; Stephens, 2010; Wells, 2005; Wells & Polders, 2003). Ignorance of matters related to sexual orientation and gender identity or the lack of adequate services is the norm for the majority of healthcare service providers (Klein, 2013; Nel, 2007; Nel & Judge, 2008; Nkoana & Nduna, 2012; Stevens, 2012).

How service providers deal with service users/clients/participants or patients' sexual orientation was identified in a recent study as a main cause of negative encounters with psychotherapists and counsellors (Victor, 2013; Victor & Nel, 2016). Such practices include:

- a heterosexist attitude that could suggest that the client's sexual orientation is abnormal;
- supporting negative lesbian, gay and bisexual lifestyle myths;
- regarding sexual orientation as fixed instead of fluid;
- ignoring the often-internalised homophobia of the client;
- ignorance of the particular negative societal experiences of LGBTIQA+ people; and
- focusing mainly or only on the client's sexual orientation, regardless of whether this is indicated (Victor, 2013; Victor & Nel, 2016).

The lack of training on healthcare matters related to sexually and gender-diverse people is a factor that contributes to practitioners' insufficient understanding of such groups (Coetzee, 2009; Müller, 2014; Nel, 2007). The absence of specific guidelines to help trainers and practitioners provide relevant and supportive services to sexually and gender-diverse people may be contributing to these training gaps.

REPARATIVE THERAPY: Also known as 'conversion therapy' or 'sexual orientation change efforts' (SOCE), it refers to psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change his or her sexual orientation.

CISGENDER: Often abbreviated to simply 'cis', a term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth.

These practice guidelines are aimed at filling some of these gaps and are based on local and international research that sexually and gender-diverse individuals require additional expertise and skills from psychology professionals in serving them. By creating these practice guidelines, it is acknowledged that the necessary foundational skills are already in place to enable practitioners to serve sexually and gender-diverse people efficiently, but that ongoing professional growth in this area will make us aware of the subtle diversities that can be overlooked, misread, accepted as a matter of fact, or simply be paid less attention to. Such introspection will enable practitioners to assess their own beliefs and prejudices about how they make sense of their work – in form and content – on an ongoing basis.

These practice guidelines will generally direct practitioners who may encounter sexual and gender diversity but they will not be able to address every exceptional situation, just as a roadmap does not indicate every pothole and speed bump. Hence, our work processes require reflexivity as an essential tool to hone our wisdom, humility and knowledge, and our understanding of what we do not know. With these practice guidelines, we hope to spur learning and unlearning: to acquire the ability to see new ways, to acknowledge our blind spots, our biases, our beliefs and conventions of how the world is, our knowledge gaps, our prejudices shaped by how we were taught, socialised and supervised, together with our norms and values that inhibit curiosity, respect and acceptance of diversity.

Selection of evidence

South Africa has a burgeoning but still relatively limited academic research output in the field of sexual and gender diversity. Nevertheless, the team has tried to use South African research from multiple disciplines, both published and unpublished, as well as local expert opinion. This body of work was supported by African literature where available, and international work in the absence of any local or regional material.

These practice guidelines have taken various international guidelines into account in the development process, but for this guide the authors have drawn strongly on local knowledge and understandings to better empower practitioners working in South Africa and in Africa more broadly.

A number of guidelines have been developed in other countries. These include:

- The American Psychological Association's (APA) "Practice guidelines for lesbian, gay and bisexual clients", which was originally adopted in 2000 and updated in 2011 (APA, 2011);
- The APA's "Guidelines for psychological practice with transgender and gender non-conforming people" (APA, 2015);
- The Australian Psychological Society's "Guidelines for psychological practice with lesbian, gay and bisexual clients" (Australian Psychological Society, 2010);
- The British Psychological Society's "Guidelines and literature review for psychologists working therapeutically with sexual and gender minority patients" (British Psychological Society, 2012);
- The "Competencies for counsellors working with gay, lesbian, bisexual and transgender clients" (Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling, 2003);
- The World Professional Association for Transgender Health's [WPATH] "Standards of care for the health of transsexual, transgender, and gender non-conforming people" (WPATH, 2011);
- The "Statement of the Psychological Association of the Philippines on non-discrimination based on sexual orientation, gender identity and expression" (Psychological Association of the Philippines, 2012); and
- The "Position Paper for Psychologists working with Lesbians, Gays, and Bisexual Individuals" (Hong Kong Psychological Society, 2012).

Development process

The development process for the PsySSA sexual and gender diversity position statement is outlined

in detail in Victor and Nel (2017). Following the ratification of the position statement by the PsySSA Council in 2013 and subsequent dissemination, a larger working group was established in September 2014, consisting of six core members and fourteen expert contributors/critical readers who are all listed in the Acknowledgement section. The core group, each with expertise in different areas of sexual and gender diversity practice, was tasked with the drafting of different sections of the guidelines document. Over a two-year period, the group had several meetings to consider literature and initial drafts of the practice guidelines. A final draft of the guidelines was sent to the extended group for feedback on iterations of the guidelines, including specific input from experts in particular areas (such as intersex matters). The draft practice guidelines were finalised in July 2017, after which the document was professionally edited before presenting it to the PsySSA Council for discussion and approval. The final practice guidelines were approved in September 2017.

To assist professionals in utilising the guidelines, it is envisaged that a resource directory will be included through a full mapping exercise, case material will be developed, curricula will be outlined and training courses developed and presented over the next period.

A final introductory note on how to engage with this document

- This is a 'living document' and subject to revisions when indicated
- Each guideline/section has been written as stand-alone, and, in fact, by different lead authors with unique styles. For the same reason, the guidelines/sections do not have a standard format across the document
- Importantly, all the guidelines/sections also cross-reference
- Therefore, skim-read the document, as a whole, before focusing on the guideline(s)/section(s) most relevant to your specific case/enquiry/concern
- Remember to consult the glossary when in doubt of the meaning of a specific term.

SUMMARY OF PRACTICE GUIDELINES[3]

Recognising the harm that has been done in the past to individuals and groups by the prejudice against sexual and gender diversity in South African society as well as in the profession of psychology, PsySSA hereby affirms:

GUIDELINE 1: **Non-discrimination**

Psychology professionals respect the human rights of sexually and gender-diverse people, and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity and biological variance

GUIDELINE 2: **Individual self-determination**

Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as 'coming out') of sexual orientation, or of gender diversity, or of biological variance

GUIDELINE 3: **Enhancing professional understanding**

Psychology professionals acknowledge and endeavour to understand sexual and gender diversity and fluidity, including biological variance

GUIDELINE 4: **Awareness of normative social contexts**

Psychology professionals are aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative and cisgender contexts

GUIDELINE 5: **Intersecting discriminations**

Psychology professionals are sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive-emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality

GUIDELINE 6: **Counteracting stigma and violence**

Psychology professionals have an understanding of stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals

GUIDELINE 7: **Recognising multiple developmental pathways**

Psychology professionals recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age

3 The guideline statements derive from the PsySSA sexual and gender diversity position statement (2013). Minor edits have been made to those original statements, where such changes were strongly indicated.

GUIDELINE 8: **Non-conforming family structures and relationships**

Psychology professionals understand the diversity and complexities of relationships that sexually and gender-diverse people have, which include the potential challenges:

- of sexually and gender-diverse parents and their children, including adoption and eligibility assessment;
- within families of origin and families of choice, such as those faced by parental figures, caregivers, friends, and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant others; and
- for people in different relationship configurations, including polyamorous relationships

GUIDELINE 9: **The necessity of an affirmative stance**

Psychology professionals adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training and education (including curriculum development, assessment and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions)

GUIDELINE 10: **Foregrounding global best practice care**

Psychology professionals support best practice care in relation to sexually and gender-diverse service users/clients/participants by:

- cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy;
- opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the World Professional Association for Transgender Health (WPATH); and
- encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons

GUIDELINE 11: **Disclosing and rectifying of personal biases**

Psychology professionals are, if it be the case, aware of their own cultural, moral or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist her or him in finding an alternative psychology professional should the client so wish

GUIDELINE 12: **Continued professional development**

Psychology professionals seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals

Practice Guidelines For Psychology Professionals:

Working With Sexually And Gender-Diverse People

GUIDELINE 1: Non-discrimination

Psychology professionals respect the human rights of sexually and gender-diverse people, and are committed to non-discrimination on the basis of sexuality and gender, including, but not limited to, sexual orientation, gender identity and biological variance

Rationale

South Africa has seen significant legal and social change with regard to the protection of the human rights of all people in the country. These laws and policies propagate respect for diversity and a concomitant commitment to non-discrimination based on, amongst others, gender and sexual orientation. The South African Constitution and the Bill of Rights within the Constitution inform these developments specifically (RSA, 1996).

The National Action Plan for the Protection and Promotion of Human Rights provides the tangible policy and legislative programme for the realisation of the fundamental human rights and freedoms outlined in the Constitution and Bill of Rights (Ally, Madonsela, Parsley, Thipanyan, & Lambert, 1998). Human rights are not special rights, and should rather be viewed as a set of checks and balances to ensure equal and equitable access and experiences for all citizens, including sexually and gender-diverse people (International Commission of Jurists, 2007; OHCHR, 2012).

These developments have brought about changes at institutional and disciplinary level with, for instance, the ethical rules of conduct for health practitioners, including a focus on human rights, diversity and non-discrimination within a general do-no-harm framework (Department of Health, 2006).

The African Commission on Human and Peoples' Rights (ACHPR) in its 55th Ordinary Session in Luanda, Angola in May 2014 passed a resolution noting that the Commission was alarmed that "acts of violence, discrimination and other human rights violations continue to be committed on individuals in many parts of Africa because of their actual or imputed sexual orientation or gender identity" (ACHPR, 2014, para 4). The resolution specifically condemns "the situation of systematic attacks by State and non-state actors against persons on the basis of their imputed or real sexual orientation or gender identity" and calls for states to "end all [such] acts of violence and abuse, whether committed by State or non-state actors" (ACHPR, 2014, para 11). In the context that could be construed as broadly applying to healthcare practitioners, the resolution also "calls on State Parties to ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities" (ACHPR, 2014, para 10).

Upholding human rights in our area of work as psychology professionals includes:

- conducting what we do without discrimination;

- respecting the autonomy and dignity of service users/participants;
- obtaining informed consent before action;
- providing all information necessary for decision-making by service users/participants;
- respecting service users'/participants' confidentiality;
- taking the service users'/participants' backgrounds into account; and
- maintaining professional competence at the highest possible level (International Federation of Health and Human Rights Organisations [IFHHRO], 2012).

Of particular relevance when working in the field of sexual and gender diversity, is sexual rights. Sexual rights are human rights applied to sexuality and reproduction. These include the right to enjoy, regardless of sex, sexuality or gender, the following:

- equality and freedom of all forms of discrimination;
- the right to free and meaningful participation;
- the right to life, liberty, security and bodily integrity;
- the right to privacy;
- the right to recognition before the law and autonomy over decisions related to sexuality;
- the right to exercise freedom of thought, opinion and expression around sexuality;
- the right to health and benefits of scientific progress;
- the right to comprehensive sexuality education;
- the right to choose whether or not to marry and found and plan a family, including decisions over how and when to have children; and
- the right to hold those responsible for protecting these rights accountable (International Planned Parenthood Federation [IPPF], 2008; World Association for Sexual Health [WAS], 2014).

PsySSA is a signatory to the IPsyNet policy statement and commitment on LGBTI matters, which provides a good introduction to some of the important considerations when dealing with sexual orientation and gender identity within the sexual and gender diversity area. This document is included as Appendix II for easy reference.

The onus is on every professional, individually, to ensure she or he practices within the confines of the law and ethically. A human rights framework not only represents the legal responsibility of psychology professionals, but also provides a strong basis for practitioners when thinking about providing affirmative practice for sexually and gender-diverse people, as reflected in these practice guidelines.

Application

Psychology professionals consider and ensure the application of human and sexual rights within their area of work

All registered psychology professionals in South Africa are legally and ethically bound to uphold the human rights of the people with whom they work. As outlined in Guideline 12, continued professional development (CPD) also requires a minimum level of ethical training on an ongoing basis. There are at least three levels where the human and sexual rights of service users/clients/participants need to be upheld and respected by psychology professionals:

- personal/individual level;
- institutional environment – the place where you and/or your work are situated; and
- larger contextual system (community, society, country, global) within which you operate.

When thinking about working with sexually and gender-diverse people, a potentially useful question at each level would be 'How does what I do uphold the human and sexual rights of sexually and gender-diverse service users/participants and

colleagues? And in which ways does what I do not uphold these rights?'

A psychology professional could influence the application of a human and sexual rights approach at each of these levels. Professionals should endeavour to exert their influence at all times in all three of these levels of their conduct and their provision of care.

In the continual process of ensuring the realisation of the human and sexual rights of sexually and gender-diverse service users/participants/colleagues, the following can be considered on each level:

In personal practice:

- Understanding and applying an affirmative stance in practice, as outlined in the PsySSA sexual and gender diversity position statement (2013) and in these guidelines (see Guideline 9 in particular)
- Continued adherence to, and professional development on, ethical practice within a human rights framework (see Guideline 12)
- Developing self-awareness of how psychology professionals' attitudes and knowledge regarding sexual and gender diversity is relevant to their practice
- Training, CPD and knowledge acquisition, including diversity appreciation and reduction of prejudice
- Reading and referring to key declarations pertaining to sexual rights, in general, including those of the IPPF (2008) and WAS (2014)
- Reading relevant professional policy documents relating to sexual and gender diversity matters, specifically the PsySSA sexual and gender diversity position statement (2013) and the IPsyNet policy statement and commitment on LGBTI issues (see Appendix II)
- Developing a reflexive practice to distinguish between personal opinions and professional best practice, to enhance the human and sexual rights of sexually and gender-diverse people
- Becoming a member of the PsySSA Sexuality and Gender Division, which embraces an affirmative stance (see Appendix III and http://www.psyssa.com/divisions/sexuality-and-gender-division-sgd).

In institutional/work environment:

- Arranging for sexual and gender diversity sensitisation training at your workplace
- Supporting the work of non-governmental organisations (NGOs) in this field, i.e. through corporate sponsorship and/or listings in workplace resource lists
- Assisting colleagues and service users/clients/participants in accessing resources as necessary, including legal resources when dealing with discriminatory practices, such as the barring of same-sex partners from work functions and/or refusal to address a transgender colleague with their preferred pronoun (he/she/him/her)
- Promoting access to resources within the area of sexual and gender diversity, i.e. through related listings in workplace directories.

In society more broadly:

- Exploring ways to advocate for human and sexual rights, in general, as outlined by the IPPF (2008) and WAS (2014) and those same rights for sexually and gender-diverse people specifically. This might include supporting trans and gender-diverse service users, among others, in:
  - » Accessing legal recognition to alter their sex description on their ID. The professional service provider might be engaged in various steps of the process,

TRANS: Commonly accepted shorthand for the terms transgender, transsexual, and/or gender non-conforming.

for example, writing a support letter that could be provided to the Department of Home Affairs by the transgender person

» Approaching their medical aid and/or health insurer (if they are in this position) to apply or appeal for certain health-related services that could be supported by medical aids in South Africa

» Raising awareness of avenues to report breaches of human rights and discriminatory practice in order to advise service users/clients/participants accordingly, including Chapter 9 institutions, such as the South African Human Rights Commission and Commission for Gender Equality, and the Equality Courts, as established by the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA).

GUIDELINE 2: Individual self-determination

Psychology professionals prioritise and privilege individual self-determination, including the choice of self-disclosure (also known as 'coming out') of sexual orientation, or of gender diversity, or of biological variance

Rationale

The South African Professional Conduct Guidelines in Psychology (PsySSA, 2007) encourage psychology professionals to respect the right to self-determination of service users/clients/participants/patients. This entails a process by which a person controls or determines the course of her or his own life. Self-determination includes the ability to seek treatment, consent to treatment, or refuse treatment. The informed consent process is one of the ways by which self-determination is maximised in psychotherapy (Glassgold et al., 2009).

The principle of self-determination has become controversial, as some have cautioned against providing interventions that have very limited evidence of effectiveness, run counter to current scientific knowledge, and have the potential for harm, despite client requests (Glassgold et al., 2009). Furthermore, research suggests prioritising and privileging individual self-determination are sometimes complex when dealing with sexually and gender-diverse service users/clients/participants (Beckstead & Israel, 2007).

Affirmative psychological support may be beneficial in the identity development and decision-making of transgender and gender non-conforming individuals regarding their social (and medical) transition. Closely aligned to some of the principles highlighted in Guideline 10 (Foregrounding global best practice care), this affirmative and transition-related healthcare support should be offered irrespective of whether the person has a binary or non-binary gender identity and whether they seek access to social or medical transition or one, several, or all treatments available.

In prioritising and privileging individual self-determination, it may serve psychology professionals well to remember that in accordance with the standards of care for the health of transgender and gender non-conforming individuals (Coleman et al., 2012; WPATH, 2011), these individuals have the right to define their identities, live according to their gender identity, as well as to decide on and to access medical, psychotherapeutic, and social support as needed. The full autonomy of transgender and gender nonconforming individuals in affirming their gender identities ought to be supported.

Trans people should be supported to make informed decisions about their bodies and gender expression without the gatekeeping of healthcare practitioners. In Appendix IV, an example is provided of a consent form that is available on the website of Gender DynamiX, a South African NGO that endeavours to advance transgender human rights. The consent form outlines risks associated with hormone treatment towards enabling informed decisions.

SOCIAL TRANSITION: The social portion of a transition, in which a transgender person makes others aware of her or his gender identity. Some parts of social transition could include telling people about your gender identity whether or not they are aware of your assigned gender/sex and/or transgender status.

TRANSITIONING: (Including social and medical transition) refers to the (permanent) adoption of the outward or physical characteristics of the gender with which one identifies, as opposed to those associated with one's gender/sex assigned at birth.

Psychology professionals, especially in contexts of psychotherapy and counselling, may at times experience difficulty reconciling their ethical obligations to do no harm; to be congruent by promoting accurate, honest and truthful engagement in their practice; and honouring the client's unique individuality, culture and roles and right to self-determination according to her or his own principles, values and needs. According to Beckstead and Israel (2007), a case in point is whether it can be expected of a sexual and gender diversity-affirming therapist/counsellor to embrace a specific client/patient's initial treatment goal calling for gender identity or sexual orientation change efforts (SOCE), knowing that internalised stigma and heteronormativity may, indeed, be at play. Accordingly, self-determination should rather be viewed together with other ethical principles, such as the provision of services that are likely to provide benefit and avoidance of services that are not effective or have the potential for harm.

Local and international evidence suggests that self-disclosure of sexual orientation, or any form of diversity or difference – while often very challenging – can be beneficial to individual mental health, including improved self-esteem (Matthews, 2007) and lower stress levels (Matthews, 2007). However, a number of factors need to be considered carefully by both the health professional and service users/clients/participants/patients. These include:

- Sexually and gender-diverse people are vulnerable to stigma, prejudice, discrimination and violence (Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008; Nel, 2014);
- 'Coming out' could have an influence on work, family, social standing and intimate relationships (Pachankis & Goldfried, 2013);
- External stigma and persistent discrimination could lead to internalised stigma, low self-esteem and impaired mental health (Matthews, 2007; Pachankis & Goldfried, 2013); and
- This could lead, for example, to some seeking professional help to change their sexual orientation (Greene, 2007).

Different sexual identity management strategies include 'passing', 'covering', 'implicitly out' and 'explicitly out'. Appropriate strategies are a function of both internal belief as well as external environmental factors. Different life contexts might, indeed, require different adaptive strategies (Lidderdale, Croteau, Anderson, Tovar-Murray, & Davis, 2003). In addition, in many societies, notions of 'the individual' are bound up with notions of family, community and context. Possible tensions between individual agency and a sense of belonging to a community/family need to be managed carefully (Mkhize, 2003).

Despite these challenges, numerous studies acknowledge that sexually and gender-diverse people are deeply resilient and are often able to negotiate hostile environments creatively (Freese, Ott, Rood, Reisner, & Pantalone, 2017).

Application

With regard to self-determination, psychology professionals are encouraged to consider and refine their practice to ensure –

A focus on resilience and agency

- Psychology professionals should assist in exploring issues of both external and internal stigma with service users/clients/participants, and how this potentially affects their thoughts, feelings and behaviours

SEXUAL ORIENTATION CHANGE EFFORTS (SOCE): Also known as 'reparative therapy' or 'conversion therapy' is psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change her or his sexual orientation.

INTERNALISED STIGMA/OPPRESSION: Also known as 'internalised homo-/transphobia' or 'internalised negativity', it refers to the internalisation or absorption of negative attitudes (a personal acceptance of such stigma as part of one's value system and self-concept).

- Psychology professionals should strive to help service users/clients/participants develop a positive sexual and gender identity and have them analyse, explain and deal with internalised stigma regarding their sense of self, sexual orientation, gender identity, biological variance and sexual practices that may be deemed 'safe, sane and consensual'

- Consideration should be given to placing an emphasis on developing the client's sense of agency, including the broadening of options and strategies for dealing with their contexts, and the confidence to explore these

- Psychology professionals respect the right of service users/clients/participants to be called by the name of their choice and relevant pronouns and accept individual choices as to the extent to which they wish to transition (i.e. in the case of a transgender person, either/or both hormones and surgery)

- Psychology professionals ensure that they and those they work with understand that 'coming out' is a process, and about much more than letting others know about their sexual orientation, gender identity and/or biological variance and sexual practices. It should be based on developing a positive sexual and/or gender identity and dealing with internalised stigma

- Coming out is not an all or nothing 'event' – it can start (and stop) with one person

- Coming out and developing positive stories to share with others is a process the individuals themselves control and direct

- Service users/clients/participants should be prepared for both positive and negative reactions to the affirmation of themselves, as well as their choice to share information about their sexuality, gender identity and expressions with selected others

- Coming out should be a decision that the service users/clients/participants make for themselves, taking into consideration the context of their individual situation. For instance, with regard to trans disclosure, individuals should be able to live 'stealth' if they want to

- Service users/clients/participants or patients should be guided to understand that 'coming out' is a lifelong process as there will be situations and times when further disclosure or discussions will be needed in the ongoing heteronormative context in South Africa

- Under no circumstances should psychology professionals attempt to pressurise service users/clients/participants to come out in the belief that this will be 'better' for them.

The duty of care

- Psychology professionals should strive to help service users/clients/participants assess their physical safety and should explore ways to mitigate negative reactions at the workplace, at home and in faith, health and education contexts.

- Psychology professionals should strive to ensure that service users/clients/participants have a network of support, including helping people to connect with non-governmental organisations (NGOs), online social networks and other supportive platforms.

Ethics and confidentiality

- Ethical matters, as it applies to communicating with the client's family, consulting with

STEALTH: For a trans person going stealth is generally the goal of transition. It means to live completely as her or his gender identity and to pass into the public sphere being sure most people are unaware of their transgender status. This does not mean their status is a secret to every single person; family and close friends may know. Some transsexuals and most genderqueer and bigender people purposely do not go stealth because they want the people around them to know they are trans. Some desire to go stealth, but are unable to pass convincingly enough. Historically, going stealth is a very recent phenomenon since, for many people, hormones are necessary to pass.

other professionals, as well as in providing assessment or evaluation reports, should be given careful consideration, as is general practice

- Psychology professionals are ethically bound to keep all information shared by service users/clients/participants confidential at all times, except if compelled to disclose such information by law, or to avoid immediate harm to the client or others

- Other than under these rare circumstances, no confidential information should ever be disclosed to other people without the informed consent of the client. Such consent should ideally be obtained in writing

- Service users/clients/participants should be aware of these conditions of utmost confidentiality and be reassured of them when necessary

- Thus, regardless of how significant a psychology professional might feel other people are in the client's life, no disclosure is made unless the informed consent of the client is obtained.

GUIDELINE 3: Enhancing professional understanding

Psychology professionals acknowledge and endeavour to understand sexual and gender diversity and fluidity, including biological variance

Rationale

For both psychology professionals and individuals seeking assistance, the language and concepts of sex, gender, identity and orientation can be complex and confusing. What does it mean to be gay or straight, a woman or a man? Or none of these social constructs? Meanings matter. The consequences of imprecision of language, lack of understanding and misunderstanding may be profound, particularly in terms of a reduced sense of agency and options for service users/clients/participants. The real-life experiences of individuals often do not conform to the academic categorisations that professionals use, and this might cause additional challenges (Niels, 2001).

In the English language, the distinction between 'sex' and 'gender' was only emphasised in the 1950s and 1960s by British and American psychiatrists and other medical professionals working with intersex and transsexual people (Esplen & Jolly, 2006). Professionals need to recognise how profoundly sex and gender are conflated in popular discourse. In reality, what it *means* to be a woman and what it *means* to be a man or neither differ among societies, and change over time even within societies. But many social forces, and socialising agents in society, including many religions and cultural systems, strive to make people believe that there are only two gender categories and that these gender categories – i.e. 'men' and 'women' – have fixed meanings, which are natural, eternally enduring and universal. An affirmative stance challenges these myths: for some persons, identity issues are not necessarily linear, moving in a 'forward' direction to an end point or on an inevitable journey from A to B. Trans persons, for instance, may seek to reverse certain processes or may arrive at a different understanding of who they are (now) as they age.

Psychology professionals should help service users/clients/participants understand that, although concepts of biological sex, sexuality and gender are interrelated, they are not necessarily dependent on each other. Towards enhanced professional understanding, these concepts are now analysed and evaluated.

Biological sex and variance

The biological sex of a person is the biological and physiological characteristics that are socially agreed upon as informing the classification of a person as male or female or intersex (Victor et al., 2014). Even these supposedly 'scientific' categories can differ from society to society. While the determination of 'sex at birth' ought to entail an assessment of complex biological components, including genitalia (internal and external reproductive organs), sex hormones and sex chromosomes, more often only external genitalia are considered. Other investigations often only occur in the event of ambiguity. Importantly, the biological sex assigned at the birth of a person is not an indication of the person's gender identity and/or expression, sexual orientation or sexual behaviour.

Intersex, as classification, is often insufficiently understood and under-recognised and therefore receives specific mention in this section about biological sex and variance. Intersex refers to the variations (genetic, physiological or anatomical)

BIOLOGICAL VARIANCE: A term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals.

in which a person's sexual and/or reproductive features and organs do not conform to the dominant and typical definitions of 'female' or 'male' (Fausto-Sterling, 2012; Harper, 2007). There are many different forms of intersex, including external genitals that cannot be easily classified as male or female; incomplete or unusual development of the internal reproductive organs; inconsistency between the external genitals and the internal reproductive organs; non-typical sex chromosomes; non-typical development of the testes or ovaries; over- or underproduction of sex-related hormones; and inability of the body to respond typically to sex-related hormones (Kemp, 2013; Rebello, Szabo, & Pitcher, 2008; Wiersma, 2004).

Early surgery, framed as normalising the genitalia of an intersex child, might lead to gender dysphoria and more generalised distress in later life (Rebello et al., 2008). The disclosure of an intersex diagnosis could be challenging for parents. In contexts where the family and the social environment are not supportive of sex markers outside the male–female binary, early determinacy of sex might be to the emotional benefit of the child, as experienced by two paediatric surgery units in Gauteng and KwaZulu-Natal (Rebello et al., 2008; Wiersma, 2004). Also, in some contexts where ignorance and prejudice are rife, a child presenting with externally visible differences may be at risk of harm by others.

Lev (2006, p.26) suggests withholding unnecessary surgeries until children are old enough to be involved in decisions regarding their medical treatment, to prevent psychological challenges, i.e. body image challenges associated with ambiguous genitalia, questions about sexual orientation, gender insecurity or doubts about correct gender assignment. Physical trauma from the surgery itself could create physical health problems, impaired fertility, physical scarring, cosmetic challenges, and decreased sexual response. Since intersex variations in families are often hidden, psychological support is often not requested or known to be available (see Guideline 10 for international best practice considerations).

Gender and how it is 'made'

The term 'gender' refers to the behaviour, activities, and attributes that a particular society claim men and women should have. 'Gender' is a specific social construct – every society teaches children and adults what it means 'to be a man' or 'to be a woman' in that society (Anova Health Institute, 2016). And, although most societies distinguish between two genders, corresponding to the understanding by those societies and their construction of biological sex, some societies recognise other gender possibilities (World Health Organization [WHO], 2015).

In many societies, deeply entrenched practices and systems of patriarchy have developed prescribing that certain behaviours, roles, tasks and even jobs are associated with a person's biological sex. These power systems are based on notions that men are considered 'superior' to women and their roles in society are elevated and privileged (Wilchins, 2014). In these societies, 'masculine' characteristics – such as rationality and competitiveness – are considered superior and valued above 'feminine' characteristics – such as emotionality, cooperativeness and nurturing – which are undervalued

INTERSEXUALITY: A term referring to a variety of conditions (genetic, physiological or anatomical) in which a person's sexual and/or reproductive features and organs do not conform to dominant and typical definitions of 'female' or 'male'. Such diversity in sex characteristics is also referred to as 'biological variance' – a term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals.

GENDER DYSPHORIA: Also known as gender identity disorder (GID), is the dysphoria (distress) a person experiences as a result of the sex and gender assigned to her or him at birth. In these cases, the assigned sex and gender do not match the person's gender identity, and the person is transgender. There is evidence suggesting that twins who identify with a gender different from their assigned sex may do so not only due to psychological or behavioural causes, but also biological ones related to their genetics or exposure to hormones before birth.

and sometimes even derided. In many societies, women perform the bulk of domestic labour in terms of cooking, cleaning and child rearing, despite also being part of the modern workforce (Wilchins, 2014).

These conventions have been challenged throughout history and in every society and are always being challenged or defended in different ways. More and more people realise that, despite these imposed social expectations, most people in reality have a combination of what are conventionally described as 'masculine' and 'feminine' characteristics and expressions. There is no task, or job, such as security that belongs to men, or nursing that belongs to women. Gender is more accurately viewed as a spectrum, rather than as binary 'opposites' and/or fixed positions (Wilchins, 2014).

In South African society, this kind of 'gender binary' approach and other key ideas of patriarchy are strongly upheld (Vipond, 2015). It is important to note that many of the key ideas – to cite just one example, that women should do all, or almost all housework, regardless of having other employment – are often reinforced with violence. South Africa has some of the highest levels of domestic violence in the world (Abrahams, Jewkes, Hoffman, & Laubsher, 2004; Abrahams, Jewkes, Martin, Matthews, Vetten, & Lombard, 2009). In addition, such a rigid and oppressive model of gender and sexuality limits the course of action available to men in that a normative male identity is associated with expectations of invulnerability and self-reliance (Lynch, Brouard, & Visser, 2010).

In addition to high levels of violence, and despite the progressive nature of South Africa's Constitution and some laws, there are still a number of areas which conflate biology and gender and segment gender in particular ways, or which reinforce narrow and often oppressive stereotypes. For example, there are now laws allowing a person to apply for a legal adjustment of their sex description without genital surgery (Klein, 2008). However, while intersex people are recognised by law, sex classifications do not reflect this and still only provide for two sexes (male and female), excluding intersex and so forth. This kind of conflation and confusion often underpin heterosexist assumptions and prejudice.

This broad term, 'gender', also encompasses transgender, queer, gender diverse, trans diverse, bigender, people who are androgynous, gender non-conforming, gender questioning and those who choose to defy what society 'tells them' is appropriate for their gender (APA, 2015). For example, a genderqueer person's gender identity falls outside of the gender binary (i.e. such a person identifies with neither or both genders). A genderqueer person may also identify as genderfluid, but may be uncomfortable or even reject self-identification as trans binary (APA, 2015).

'Queer', is a word that has been re-appropriated or reclaimed since the late 1980s with multiple, interlinked meanings. This includes using it as an expansive term covering the spectrum of sex, sexual, and gender differences, or of the term being used socio-politically by people who strongly reject traditional gender identities, reject distinct sexual orientation labels, or who actively reject heteronormativity and homonormativity.

Gender identity is also an important concept. It is a person's internal sense of being female, male or another gender (Müller, 2013). Gender identity is internal, and refers to how people *feel about themselves* in the world, that is, 'feminine' or 'masculine'. A person will use a word that describes her or his gender that makes sense to her or him. It is deeply rooted and a significant part of a person's being.

For cisgender people, this sense of being a woman or a man is congruent with their sex assigned at

GENDER ASSIGNED AT BIRTH: Gender assignment (sometimes known as sex assignment) is the determination of an infant's sex at birth. In the majority of births, a relative, midwife, nurse or physician inspects the genitalia when the baby is delivered, and sex and gender are assigned, without the expectation of ambiguity. Assignment may also be done prior to birth through prenatal sex discernment. AFAB (assigned female at birth) and AMAB (assigned male at birth) are commonly used terms to refer to gender/sex assigned at birth. While many people use the terms 'sex' and 'gender' interchangeably, they are, in fact, two separate characteristics.

birth (Müller, 2013; Wilson, Marais, De Villiers, Addinall, & Campbell, 2014). Transgender people experience themselves as being different from their natal sex and/or gender assigned at birth. Their gender identity and mental body image thus do not correlate with their physique and/or sex and/or gender assigned at birth (McLachlan, 2010) and they experience an incongruity between their birth gender and their self-identified gender (Sanchez, Sanchez, & Danoff, 2009). For instance, someone may be assigned male at birth (MAB), yet have a female or feminine gender identity.

An affirmative stance suggests that psychology professionals have a deep appreciation for the reality that gender and gender roles are not fixed. Society, social norms and culture are also forever changing. Gender is a spectrum, and there are people whose gender identity differs from the typical binary (Wilson et al., 2014).

Sexuality and sexual orientation

Attraction, emotional expressions of love, intimacy and desire differ greatly from one person to another. Sexuality, also, is a spectrum and some may move constantly along this spectrum. Sexual orientation refers to a person's enduring emotional, romantic, sexual or affectionate attraction to others and, although 'heterosexual' is the dominant and expected norm for sexual orientation, various other orientations including lesbian, gay, bisexual and many others are as valid, deeply felt and enduring (APA, 2012; Victor et al., 2014). It is very important to note that people may have sex with other people for a variety of reasons other than as an expression of their sexual orientation (Anova Health Institute, 2010). They may regularly have sex with others of the same gender, without seeing themselves as lesbian or gay (Brown, Duby, & Van Dyk, 2013). In the public health context, especially in relation to the prevention of human immunodeficiency virus (HIV) infection and other sexually transmitted infection (STI), the terms MSM (men who have sex with men) or WSW (women who have sex with women) are typically used, and refer to sexual behaviour, not sexual orientation.

Bisexuality is often misunderstood by both members of sexually and gender-diverse communities and heterosexual communities. Often which community is supportive of one's sexuality is dependent on the sex of your partner. Depending on the sex of your partner one may have to 'come out' and/or explain that a heterosexual pairing does not mean you are heterosexual. Such assumptions could often prevent clients from feeling safe (sexual identity should not be tied to sexual activity).

'Asexuality' is a sexual orientation that is often neglected and misunderstood. It is important to note that some people strongly assert no attraction to any sex, maintaining asexuality as their

MSM (MEN WHO HAVE SEX WITH MEN): Used in public health contexts to refer to men who engage in sexual activity with other men, including those who do not identify themselves as gay or bisexual, to avoid excluding men who identify as heterosexual. Note, trans men may also be included in such a description.

WSW (WOMEN WHO HAVE SEX WITH WOMEN): Used in public health contexts to refer to women who engage in sexual activity with other women, including those who do not identify themselves as lesbian or bisexual, to avoid excluding women who identify as heterosexual. Note, transwomen may also be included in such a description.

SEXUAL BEHAVIOUR: 'Sexual behaviour' is distinguished from 'sexual orientation' because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour. Individuals may engage in a wide range of behaviours and practices often associated with sexuality. These can include bondage and discipline and sadomasochism (BDSM), which have nothing to do with sexual orientation and/or gender identity. BDSM may also refer to a specific lifestyle or subculture comprising participants who regularly engage in such practices. Although some individuals are likely to participate in BDSM practices in various ways, many psychology professionals may be unfamiliar with the diversity, terminology, possible motivations and matters surrounding their service user/client/participant's lifestyle. BDSM potentially may be enriching and beneficial to many who safely participate (in this regard, the operative terms are 'safe, sane and consensual'), or it sometimes may be considered pathological and destructive.

sexual orientation (Academy of Science of South Africa [ASSAf], 2015).

A word of caution: The terms androphilia and gynaephilia may be useful in describing trans people's sexual orientation, which might be confusing and easily offensive (e.g. defining one's sexual orientation based on one's gender assigned at birth): it generally is less problematic to refer to who someone is attracted to without having to define that person's gender or sex.

Relationships

Although there are many types of intimate relationships and sexual partnerships in all societies, monogamy is often assumed to be the default relationship identity or orientation. But many people are in more than one relationship at the same time. Some of these might be publically known but many are kept secret because of a particular society's norms and expectations. In many societies, for example, 'polyamory' – where more than two people are in a relationship with each other at the same time – is fairly common. Polyamory is often based on openness, i.e. everyone involved has consented. Sometimes referred to as "multiple concurrent romantic relationships with the permission of their partners" polyamory is under-recognised and under-researched (McCoy, Stinson, Ross, & Hjelmstad, 2015, p.134).

Professionals need to be sensitive and open to challenging the heteronormative assumptions that the only legitimate relationships are those that occur between a single man and a single woman. Often such assumptions could prevent clients from feeling safe enough to speak about their relationship orientations with their psychology professionals, out of fear of judgment and a lack of understanding that people could have meaningful relationships outside of monogamy.

ASSAf affirms that the concepts 'sexuality', 'sexual orientation', and categories such as 'homosexuality', 'heterosexuality' 'bisexuality' and 'asexual', mean different things in different societies at different times (ASSAf, 2015). In South Africa, an understanding of these different concepts is important for a psychology professional.

Application

Psychology professionals are encouraged to be aware of the intricacies and complexities of human lived experience by:

- Recognising and understanding sexual and gender diversity from an affirmative stance, one that is consciously inclusive of the broad sexual and gender diversity spectrum
- Actively exploring and challenging one's own values and assumptions, and reflecting on the influence of socialisation on one's sexuality
- Striving for openness and acceptance of such diversity and respect for the unique and fluid lived experience of others
- Understanding that sexual orientations and

ASEXUAL: A person who has low or no sexual desire, little or no sexual behaviour, and a concomitant lack of subjective distress. Identifying as asexual does not preclude the ability for the person to have a romantic or love relationship with someone of the same and/or different gender.

ANDROPHILIA: 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation, as an alternative to a gender binary same-sex and heterosexual conceptualisation. Androphilia describes sexual attraction to men or masculinity.

GYNAEPHILIA: 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation as an alternative to a gender binary same-sex and heterosexual conceptualisation. Gynaephilia describes the sexual attraction to women or femininity.

POLYAMORY: A relationship configuration where a person has more than one intimate or sexual partner with the knowledge and consent of all partners involved, and with an emphasis on honesty and transparency within relationships. Polyamory is considered a minority relationship orientation, where monogamy is the dominant orientation. What makes polyamory seem deviant is the openness and honesty of being involved with multiple concurrent relationships, as opposed to cheating (hidden concurrent relationships), which is almost anticipated. It is also described as 'consensual non-monogamy'.

gender identities outside of the normative are not mental illnesses but are variants of human sexuality and gender identity and expression. These orientations are in no way abnormal, except in a strictly statistical or legalistic sense of 'not being the norm' in a given society at a given time

- Not assuming that mental health challenges are due to the individual's sexual orientation, sexuality, gender identity or expression. In this regard, being mindful of the therapeutic goals and what the person is consenting to focus on in the professional contact is important (For example, a trans person could present for bereavement and have no need or desire to focus on her or his gender identity)

- Taking into account the negative mental health effects of stigma-related stress and processes and how resilience could be developed to deal with negative effects of stress, as proposed in Meyer's minority stress model (I.H. Meyer, 2003) (see Guideline 6)

- Aiming for a deeper understanding of all the variations in the meaning of sexual and gender identity and relationship identity

- Being aware that some medical interventions at times required in intersex and transgender-affirming care, such as hormonal treatments, may affect emotional states and appropriate coping strategies for new emotional experiences

- Becoming familiar with alternative expressions of eroticism, creative sexual stimulation, and intimacy (see for instance https://fetlife.com/).

Psychology professionals are encouraged to understand sexual and gender diversity and fluidity in a non-binary and a non-heteronormative way by:

- Continuously exploring and questioning their own personal and professional knowledge and experiences, and how these could affect the individual seeking psychological assistance related to her or his sexuality or gender (Victor & Nel, 2017)

- Understanding that individuals could have a range of gender identities and expressions and their gender identity might not be aligned to sex and/or gender assigned at birth

- Ensuring that identity and orientation are not imposed or forced, whether overtly or covertly

- Understanding that the journey of identity development could be highly complex and bewildering for the client/patient/participant

- Assisting people to differentiate between gender identity, sexual orientation and sexual behaviour, also understanding that these might be intertwined yet separate journeys for the person, for example a transgender man could have any sexual orientation or a lesbian might have sex with a man, and still identify as lesbian

- Taking into account the person's cultural and social context, with an emphasis on the potential implications for violence and other forms of stigmatisation and discrimination with which the non-conforming person has to deal

- Keeping in mind how the resilience of individuals could be further affirmed, including engaging with the potential experience of ambiguity of feelings around assigned sex, gender identity and expression, sexual orientation and sexual behaviour.

The way the psychology professional uses sexual and gender diversity language should encourage acceptance. Psychology professionals are encouraged to consider carefully the use of language in all areas of practice. To do this, they should:

- Be mindful that the terms which the individual chooses to use to describe her- or himself, might not be academically or ethically acknowledged. Allow for self-identification and self-labelling

- Enquire which pronoun the client prefers to use, i.e. 'he', 'she', 'they' or 'them'

- Enquire which titles are preferred, including but not limited to the titles Mx, and not just Mr, Ms and Mrs

- Ensure that the ways in which questions are phrased and how they respond should be

inclusive rather than exclusive of the ways people express themselves. Here suggestions include providing a range of options for capturing demographic information to ensure inclusivity, for example:

» when taking a history, allow for identities other than male/female;

» be mindful of separating sex assigned at birth from gender identity and gender expression;

» measure sexual orientation using more complex methods by including self-identification, sexual and emotional attraction and not just sexual behaviour. This implies the need for questions about 'how do you think/feel about …', and not just questions such as 'what do you do sexually'; and

» be mindful that some service users/clients/participants may orientate to polyamorous relationships more than to monogamous relationship identities.

It is important to acknowledge that the client is best placed in guiding which identity options and pronouns to use.

GUIDELINE 4: Awareness of normative social contexts

Psychology professionals strive to be aware of the challenges faced by sexually and gender-diverse people in negotiating heteronormative, homonormative and cisnormative contexts

Rationale

Many assumptions accompany 'heterosexuality' and 'heteronormativity'. One such assumption is that there are only two fixed genders, and that gender always reflects the person's sex as assigned at birth. Most critically, an associated assumption is that only sexual attraction between the 'opposite' genders can be considered normal or natural. 'Heteronormativity' also refers to the privileged position associated with heterosexuality: societies are constructed to reward behaviours that conform to heterosexuality, and punish those that do not. As outlined in Guideline 3, the influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities as well, that is, it serves to regulate not only sexuality but also gender (Chambers, 2007; Rubin, 2011; Steyn & Van Zyl, 2009; Victor et al., 2014; Warner, 1999). For example, a key heteronormative assumption is that all people are attracted to the opposite sex, all people identify with their sex assigned at birth, all people should be in a single committed relationship with one other person, preferably for life, and all people wish to (and should) procreate.

Regardless of progressive laws, the prevailing culture and religious beliefs may be conservative and unsupportive of sexual and gender diversity. Sometimes there is a disjoint between policy and how it is actioned. Where normative beliefs are imposed on everyone, sexually and gender-diverse people are often seen as something 'lesser', and less deserving of social goods and affirmation. Marginalisation from the mainstream could undermine mental health and is often internalised by the person, who may not be aware that these are normative assumptions, and neither universal nor eternal 'truths'.

There are many examples of how heteronormativity is maintained and extended by South African society, also in health systems (Müller, 2015). These include the type of questions that are asked in a first interview, and subsequent sessions, and the way services are advertised (for example, many advertisements for health services might only feature images of heterosexual couples and 'nuclear families'). Heterosexuality is also reflected in curricula, school and tertiary education (Blake 2016; Müller & Crawford-Browne, 2013) and is usually strongly promoted. For example, from an early age, most children are exposed to cultural bias, which gives preference not only to men relative to women, but also to opposite-sex sexual relationships relative to same-gender sexual relationships. A heteronormative model suggests the traditional family unit consisting of a stereotypical mother–father with their own biological offspring as the only viable and affirmed model. When a construct like 'family' or 'marriage' is used, it is usually implied that these unions are heterosexual in nature. Often when referring to same-sex families, the phrases are given different and marginalising names, for example, a 'lesbian family' or a 'gay family' (Breshears & Lubbe-De Beer, 2016).

Furthermore, heteronormativity adversely affects sexually and gender-diverse people within their families, schools, legal systems, places of work, religious and cultural traditions and communities.

It is important to note that conversely, the notion of homonormativity also needs to be

HOMONORMATIVITY: The system of regulatory norms and practices that emerges within homosexual communities and which serves a normative and disciplining function. These regulatory norms and practices need not necessarily be modelled on heteronormative assumptions, but they often are.

understood. This refers to ways in which some gender non-conforming communities create and make their own norms and practices. These are not necessarily modelled on heteronormative assumptions, but they often are (Rabie & Lesch, 2009; Reygan & Lynette, 2014). For instance, Moodie (1987, p.16) refers to mine "wives", where younger men (*umfaan*) took on the behaviour of women in their relationships with their "spouses", the miners, thus mimicking the expected gender roles, the heteronormative ideal. Homonormative assumptions could create negative experiences for genderqueer people as they often misrepresent/dismiss their identity.

This is problematic because homonormativity not only often copies or mimics heteronormative characteristics, but often also privileges those whose identities match dominant 'socio-homo' norms more closely (Chappell, 2015). For example, many mainstream 'homosexual cultures' continue to privilege identities that mirror constructs of (Western-centric) hegemonic (hetero) masculinity, i.e. young, muscular, athletic, rich, white (Oswin, 2007). In doing so, older, poor, black, disabled queers and certain queer cultures are often excluded from homonormative spaces.

Furthermore, homonormative and heteronormative assumptions place trans–cisgender couples in a difficult position. For example, in a trans–cisgender relationship, the trans masculine person could view themself (note, 'himself' is not used as not all masculine off-centre people use he/him pronouns) as heterosexual, whereas the cisgender female partner may view themself as lesbian or queer. It would therefore be quite detrimental for this couple if the therapist assumed they are a heterosexual couple or a queer couple, per se. As previously established, identity-related definitions should be driven by the service user/client/participant, rather than the therapist. In addition, each individual in the couple's counselling session may well experience the appropriateness of psychotherapy considerably differently.

An issue of privilege

In most societies, heterosexuals are granted a form of automatic rights and privileges just by being born and living in a heteronormative society. For example, heterosexual and cisgender people are almost never confronted and asked to share intimate details about their sexual and gender identity. This is not the case for sexually and gender-diverse individuals. In a heteronormative, cisnormative society, being same-sex attracted, transgender or intersex is mostly shamed or misunderstood. Because of external stigma, for example, sexually and gender-diverse individuals may have negative self-beliefs, especially initially in the first stages of coming out. As explored in Guideline 2 (and later in Guideline 6), the negative self-hating and self-shaming views often manifest as internalised stigma and/or oppression, also called 'internalised homo-/transphobia'. Often this internalised shame is amplified by ongoing non-acceptance from significant people in the life of the sexually and gender-diverse individual (Vu, Tun, Sheehy, & Nel, 2011). As is further explored in Guideline 5, various privileges of orientation also intersect with privileges that derive from race, class, ethnicity and gender.

Application

Psychology professionals are encouraged to recognise that there is privilege embedded in being heterosexual, cisgender and typically sexed by:

- Understanding that affirmative practice could become a powerful tool in establishing rapport and a more trusting relationship
- Understanding that initially, a same-sex attracted person could present with severe ego-dystonic feelings related to her or his sexual orientation. The self-loathing and self-hatred could present in a desperate wish not to be attracted to members of the same sex. It is imperative for the psychology professional to understand the deeply entrenched conflict, fed by a heteronormative society, which the individual is experiencing
- Being mindful that same-sex attracted people often have to justify, rationalise and defend their love for another or their sexual attractions and desires to a person of the same sex or gender
- Being mindful that constructed norms about reproduction and family often present obstacles for the sexually and gender-diverse service user/client/participant, which they have to navigate carefully

- Being aware of the effect of homonormativity on individuals not fulfilling, for example, the hegemonic masculine ideal (for example, a middle-aged, disabled gay man)

- Evaluating the ways in which institutions enforce heteronormativity in areas such as recruitment, career assessment and promotion

- Assisting sexually and gender-diverse people in navigating the workplace, dealing with both the internalised stereotypes of the service user/client/participant, as well as their strategies for dealing with matters such as prejudice

- Being mindful that sexually and gender-diverse people might be distrustful of psychology professionals based on their previous experience of being pathologised or marginalised

- Considering the ways in which work settings may reflect a heteronormative or cisgender ideal that may be perceived as alienating, for example, portraits and paintings, facilities, or standard forms, reflecting exclusivity of sexual and gender diversity

- Understanding that, given the challenges faced by sexually and gender-diverse service users/clients/participants, the psychology professional might have to become an advocate for her or his client beyond the normal scope of individual practice. This could include training the broader institutional setting around sexual and gender diversity, as well as negotiating with institutions and contexts on behalf of the service user/client/participant

- Understanding that trans–cis couples might each have different expectations in a couple's counselling session/psychotherapy.

GUIDELINE 5: Intersecting discriminations

Psychology professionals are sensitised to the influence of multiple and intersecting forms of discrimination against sexually and gender-diverse people, which could include discrimination on the basis of gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory and cognitive–emotional disabilities; HIV and AIDS; internally and externally displaced people and asylum seekers; geographical differences such as urban/rural dynamics; and religion and spirituality

Rationale

People – including psychology professionals and their service users/clients/participants – have many different sides to their identity, and it is useful to think about everyone having a shifting *matrix of identities* that constitutes a whole person. The 'matrix of identities' is really about structural positions, not 'an inner sense of who people are', although people might express these as 'who they are'. These include gender; sexual orientation; biological variance; socio-economic status, poverty and unemployment; race, culture and language; age and life stage; physical, sensory, cognitive and emotional disabilities; health status, including HIV and AIDS status; being internally or externally displaced, including seeking asylum, geographical differences such as urban/rural dynamics, and matters of faith, religion and spirituality. Furthermore, identities operate in different ways – they are not all the same: 'life stage' and 'race' are not the same, and, of course, race is also a structural imposition.

Psychology professionals need to think about their own but also the identities of service users/clients/participants in a more subtle and nuanced way. Practitioners should strive to achieve a heightened sensitivity and empathy when these diverse identities intersect with a sexually or gender-diverse person.

Intersectionality in psychology, as a concept, acknowledges this diversity and focuses on attending to all the different forms of oppressions that occur in society – the different '-isms' – racism, ableism, heterosexism, sexism, classism, etc. and the ways they overlap and often reinforce a power that could potentially subjugate one cultural group in terms of another. Being a minority within a minority (for example, being intersex and an immigrant) could deepen one's sense of isolation and disconnection from the statistical and cultural majority. The APA (2012, p.12) notes, "the cumulative effects of heterosexism, sexism, and racism may put lesbian, gay, and bisexual racial/ethnic minorities at special risk for stress", which adds to the vast range of contextual factors that worsen the effects of stigma (Greene, 1994). This is often described as 'minority stress' (I.H. Meyer, 2003). Multiple layers of discrimination that a person might potentially experience could create multiple and intersecting levels of stress.

These potential sources of distress and conflict could present in countless, complex ways. Practitioners are therefore advised to remain aware of the challenges that sexually and gender-diverse individuals face having to negotiate multiple identities in a number of contexts. In some contexts, certain identities are advantageous and normative, and are therefore foregrounded, while in other contexts, those identities might be distressing or dangerous, and therefore downplayed. For example, being black in South Africa means being part of the numerical majority, despite ongoing structural racism; however, being black and gender non-conforming displaces one from this group. Additionally, being black, gender non-conforming and a refugee, living in an area where one is forced to speak a language with which one is unfamiliar, while looking for work add to the multiple intersecting identities the person must negotiate.

INTERSECTIONALITY: The interaction of different axes of identity, such as gender, race, sexual orientation, ability and socio-economic status, in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways.

People live very different lives, and an 'intersectional lens' could help psychology professionals to appreciate the complexities of these lives better. In the case of religion, for example, there are significant cultural differences in South Africa between being a gay Indian man who is Hindu and being a gay Indian man who is Muslim. There is a strong sense of Hinduism being generally neutral about sexually and gender-diverse people, and Islam being sternly disapproving, although collective Indian 'culture' in South Africa is generally critical of sexual and gender diversity (Pillay, 2014).

Researchers may often conflate religion and race and ignore the differences amongst groups that appear to share many similarities, e.g. ignoring the diverse religious affiliations amongst South African Indians, or among South African Africans, and among other groups, or underplaying the implications of these differences. Or, consider the negotiation of identities for openly lesbian black women who live and work in cosmopolitan urban areas and speak English in their multi-racial circle of middle-class friends – but who have to conceal numerous aspects of identity when visiting family in rural villages. In another context, for example, think of a transwoman, engaging in sex work, having to take HIV and tuberculosis (TB) treatment by accessing services at the local clinic where there are employees who live in her community. What are the consequences of this difficult negotiation on the well-being of the person? How are globalised and localised aspects of oneself, specifically with regard to gender and sexuality, internally and externally negotiated in different contexts?

It may serve us well to remember that both race and culture are dynamic constructs. Critical race theory tells us race is not a biological truth – and of course culture is made and remade every day – and so at an application level, white practitioners might impose essentialist ideas of race and culture and indeed within, say, African cultures and communities, both racial and cultural pride (or policing) might be used to exclude those who are 'un-'.

When using or producing research, psychology professionals should be aware of the intersectionalities reflected in the research. For instance, until recently, research in South Africa tended to reflect the experiences of white middle-class, urban men and, sometimes, white women (Gevisser & Cameron, 1995; Potgieter, 1997). Some academics have started expanding the research focus to explore the specific dynamics of intersecting identities and how these identities play out in diverse contexts. These new studies are now foregrounding and making race, class, geography and other previously marginalised dimensions of identity visible (see, for instance, Diesel, 2011; Graziano, 2004; Henderson & Shefer, 2008; Hoad, 2007; Livermon, 2012; Muholi, 2012; Pillay, 2014; Rankotha, 2005).

Despite sexual orientation change efforts (SOCE) being scientifically unsupported (whether psychological and/or those approaches that use a more religious frame), the effects of SOCE are poorly researched amongst minority groups in particular (APA, 2009). Given the pluralistic society within which they find themselves working, South African practitioners are likely to come across a multitude of traditional, indigenous, religious, 'tribal' and even quasi-scientific methods that sexually and gender-diverse people have to endure at the hands of people who want to change the sexual orientation, identity and/or behaviour of these sexually and gender-diverse people. These SOCE may appear in the guise of harmless religious or spiritual interventions, but could have longstanding negative consequences for the person. This is one example of many where cultural significance and meaning are often ignored in attempts to understand sexually and gender-diverse people (Murray & Roscoe, 1998).

Application

Practitioners are urged to remain aware of the multiple intersecting identities of sexually and gender-diverse individuals

Practitioners should not assume that sexual and gender diversity is necessarily the most prominent aspect of identity for sexually and gender-diverse people. Identity is influenced by many combinations of factors, which could be biological, psychological, social, economic, cultural, geographical and religious or spiritual. Practitioners must therefore always assess the relative influences of all these factors when attempting to understand or empathise with a client, student or research participant. At different points in one's lifespan, different factors might be foregrounded and be of particular significance to the person. During an initial interview for psychotherapy, for instance, a

psychotherapist should not assume that sexuality or gender is going to be the focus of discussion, point of departure, or therapeutic concern for a sexually and gender-diverse client. Instead, as Rothblum (2012: p.268) urges, "we must view our users/clients/participants, research participants, friends, neighbours, co-workers – as well as ourselves – as forming multiple, interlocking dimensions, each one adding colours, shades and hues to a rainbow tapestry".

Practitioners are urged to remain aware of the diversity of experiences amongst sexually and gender-diverse individuals

Practitioners must acknowledge the vastly different experiences of being sexually and gender diverse based on other contextual issues facing the sexually and gender-diverse individual. In a group context, for example, it is quite possible that individuals have as many differences as they have similarities; and one should not assume that all sexually and gender-diverse individuals' life experiences reflect similar processes, matters or events. In fact, given the high levels of inequality in South African society, different segments of society have substantially different lifestyles – dependent especially on race, class, health status and geographical location.

As explored in Guideline 2, coming out and disclosing one's sexual orientation to friends and family is often considered to be a healthy aspect of the process of accepting one's sexuality, but may not be an option for a gay individual who is at risk of being isolated from her or his community. For example, Bonthuys and Erlank's (2012, p.269) study of attitudes of Muslim people in Johannesburg revealed that community attitudes to homosexuality "usually involve denial and secrecy in order to maintain the social fabric of daily life and relationships between community members".

Practitioners should remain cognisant of the enduring effects of colonialism, apartheid and postcolonialism on the lives of sexually and gender-diverse individuals

Since 1652, when the first Dutch settlers arrived in South Africa, the lives of black South Africans have been consistently destabilised and dehumanised. Centuries of racial prejudice and discrimination, rooted in a worldview of white racial supremacy, manifested itself as slavery, apartheid, and more recently, neo-liberalism. Despite more than two decades of democracy since 1994, the enduring effects of apartheid's social engineering has left centuries of this inequality intact. As a result, heteronormativity operates within an equally problematic ideology of white supremacy, ordering and reinforcing normative values, attitudes, beliefs, behaviours, and cultural activities in society. These value systems sometimes filter into 'gay-friendly' spaces that mirror the racial dynamics of the broader society. For example, Tucker (2009) demonstrates how Cape Town's gay-tourism district contains nightclubs that admit to having informal policies to exclude coloured and black patrons. See in this regard also Matebeni (2017).

This places black sexually and gender-diverse people in a precarious and isolated place. Where black individuals might hope to find solidarity in a social community of sexually and gender-diverse people, this might not occur if the space is predominantly white or biased toward whiteness in its value systems, practices and expectations. And where black individuals find solidarity amongst their black peers and community in the fight against racism, they might experience alienation and discrimination in the fight against homophobia or transphobia. Caught between two communities where their sense of belonging is conditional and premised on impossible demands, black sexually and gender-diverse individuals may experience significant distress.

Pride marches are global events to celebrate sexual and gender diversity. Yet, in South Africa, Pride events are sometimes marred by how different LGBTIQA+ groups stigmatise and exclude others: often such events are more LGB-focused, excluding the 'TIQA+'. Pride events in South Africa have often become sites of contestation by black activists who feel that Pride is racially exclusionary, had lost its political agenda and is unable to represent their needs (Soldati-Kahimbaara & Sibeko, 2012). Sometimes these exclusions are articulated as being classed, not only raced. Responses from black queer communities to the white dominance (materially and symbolically) in gay venues and during Pride events have brought about the rise of township and inner-city spaces which are affirming of black queerness, and the proliferation of various Pride events as a response to white-dominated Prides (Matebeni, 2017).

Additionally, despite the historical documentation of fluid sexual practices in pre-colonial Africa and a greater acceptance for gender diversity in traditional African tribes (Epprecht, 2004; Murray & Roscoe, 1998), negative beliefs about sexually and gender-diverse people continue to exist. Practitioners must therefore be aware of the nuanced ways in which sources of support could also become sources of oppression.

Practitioners use cultural humility as a tool when working with cultures different from their own

Cultural humility is a lifelong commitment to self-evaluation and self-criticism to address the potential power imbalances between practitioners and the culturally diverse people with whom they work (Tervalon & Murray-Garcia, 1998).

The process of working with culturally diverse individuals or groups requires a multicultural orientation that includes an ongoing, active, aspirational process of assessing one's attitudes, knowledge and skills to improve one's ability to work with diverse groups of people (Sue & Sue, 2013; Tervalon & Murray-Garcia, 1998). Although CPD activities in this area will improve multicultural competence, a commitment to cultural humility ensures that expertise in this area is never finite or complete, and that ongoing reflective practice is what is mostly expected. This is what DasGupta (2008, p.980) similarly calls "narrative humility". For example, a client tells you that they chose you as their psychotherapist because of a similar cultural background and that you will understand them easily. Nevertheless, one should still be willing to have some cultural assumptions broken, by maintaining an attitude of openness and curiosity, by for instance, joining reading groups, supervision groups, and CPD activities which explore the ethical dimensions of working across differences.

For example, a black transwoman researcher from an affluent middle-class background in Durban, KwaZulu-Natal, is researching coloured transwomen's experiences in a working-class neighbourhood in the Northern Cape. While there may be some shared experiences in being a transwoman, differences in class, geography, race and language would implore the researcher to remain committed to cultural humility and not go into the process with an assumed expertise.

GUIDELINE 6: Counteracting stigma and violence

Psychology practitioners have an understanding of stigma, prejudice, discrimination and violence, and the potential detrimental effect of these factors on the mental health and well-being of sexually and gender-diverse individuals

Rationale

Sexually and gender-diverse people experience substantial discrimination and victimisation (Nel, 2014) or the fear of discrimination and ill treatment. This in turn is linked to a range of mental health issues, including greater vulnerability to depression, anxiety and substance use (Polders, Nel, Kruger, & Wells, 2008; Victor & Nel, 2017).

There is significant evidence that oppressive social environments increase minority stress, having severe negative consequences on the health of sexually and gender-diverse people. Alongside this, the health system is itself steeped in heteronormative assumptions, and often actively discriminates in the provision of treatment. This can negatively affect the quality of support to which sexually and gender-diverse persons gain access (Victor et al., 2014). Fear of poor treatment and judgmental attitudes often makes sexually and gender-diverse individuals less likely to access healthcare (ASSAf, 2015).

Practitioners need to be aware that stigma and discrimination on the basis of sexual and gender diversity are more deep-seated and pervasive, in Africa and elsewhere, than is acknowledged in the public domain. Thirty-four countries in Africa – out of a total of 53 sovereign states and territories – impose some kind of legal restrictions on certain sexual desires and practices (International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA], 2015). In much of sub-Saharan Africa, same-sex sexuality is held to be 'foreign', and is portrayed as 'un-African' and a product of colonialism. Some traditional beliefs suggest those of a same-sex sexual orientation are cursed or bewitched (Murray & Roscoe, 1998). In primarily Christian and Muslim African countries, gay men and lesbian women are confronted with religious condemnation.

Recent developments suggest that, instead of abating, negative attitudes in some African countries may, in fact, be intensifying against LGBTIQA+ persons. In January 2014, Nigeria enacted stringent anti-homosexual legislation, and in February 2014, Uganda passed its Anti-Homosexuality Bill into law, but this was subsequently struck down by the constitutional court on technical grounds. Both these 2014 laws facilitate the active persecution of LGB persons and their supporters and friends. This intensifying of attitudes, and the promulgation of new laws, are often fanned by right-wing religious organisations from the United States who are exporting Western 'culture wars' to Africa and are helping repressive governments to use "... out-dated colonial era laws, scapegoating during political conflicts, religiosity, rigid beliefs in cultural and family values, and a patriarchal mind-set", to keep their grips on power (Nel, 2014, p.145).

A great deal of evidence points to this stigmatisation, leading to deep-seated and widespread prejudice, discrimination and anti-homosexual harassment and violence, both state-sanctioned and extrajudicial. This includes increased rates of verbal and other forms of harassment, teasing, bullying at school or in the workplace, threats of violence and actual violence. Furthermore, criminalisation on the basis of sexual orientation has been found to exacerbate social discrimination and, in particular, to lead some health service providers to discount, ignore and neglect the needs of sexually and gender-diverse people, thus compounding their vulnerability (Dramé et al., 2013). The stigmatisation and criminalisation of same-sex sexuality has also made it difficult to implement public health interventions, such as HIV prevention programmes for MSM, effectively (ASSAf, 2015).

Even in South Africa, where such discrimination is prohibited by the Constitution, negative attitudes

towards sexually and gender-diverse people persist (Nel, 2014). South Africa has higher levels of violence than most countries, including violence against sexually and gender-diverse individuals (Peacock, 2013).

Examples of related institutionalised discrimination include the difficulties many sexually and gender-diverse people experience reporting hate crimes to the police without being subjected to further prejudice and/or trauma (Human Rights Watch [HRW], 2011; Nel & Judge, 2008). Problems are experienced with the Department of Home Affairs when trans people try to change their gender on their ID and are discriminated against by individual Home Affairs officers who hold the belief that this goes against the law. In some instances, the law falls short and this could lead to further prejudice and discrimination. Examples include the law not providing for non-binary gender categories, as well as trans–cis couples who are already married having problems with staying married legally, but still being able to change the gender of one of the spouses (Gender DynamiX & Legal Resource Centre, 2014).

An affirmative stance strongly urges practitioners to take steps to develop their contextual awareness of how prevalent homo- and transphobia, heterosexism, prejudice and stigma are, and which effect these have on mental health and well-being. Recent research on minority stress, as applied to LGBTIQ+ communities, is particular useful in exposing how deeply such stress could affect overall mental health. The Academy of Science of South Africa (ASSAf), in accordance with its mandate to provide evidence-based science advice to government and other stakeholders, recommends that to promote well-being and social justice, the psychology profession and other disciplines in Africa should engage more actively in research to reduce stigma. Practitioners should seek ways actively to promote access to healthcare and educational materials for sexually and gender-diverse communities (ASSAf, 2015).

Recognising the nature and extent of the harm caused by stigma, prejudice, discrimination and prejudice-motivated speech is crucial. Many jurisdictions, including Canada, Germany and the European Union, have provisions similar to those in South Africa, limiting the dissemination of hate speech. Provisions of this kind remind society of the value of diversity and the worth and dignity of every human being. Hate speech restrictions seek to combat the grave psychological and social consequences to individual members of the targeted group in terms of their psychological integrity and well-being, which result from the humiliation and degradation caused by hate speech. They also seek to prevent the harmful and polarising effect which hate speech has on society at large as it subtly and unconsciously absorbs the message that the targeted group is inferior and is to be detested and disparaged (Breen, Lynch, Nel, & Matthews, 2016; Nel & Breen, 2013).

Application

Psychology professionals are aware that all sexually and gender-diverse people, regardless of race and/or socio-economic status or culture, may have been subjected to systemic prejudice, discrimination and violence, albeit in varying forms and at different levels of intensity

South Africa's past is characterised by a state which categorised, discriminated and promoted prejudice. This history of institutionalised discrimination under apartheid and colonialism still forms the backdrop of hate-based discrimination and victimisation in South Africa (Nel & Judge, 2008). Nel and Judge (2008) argue that a key long-term effect of the structural discrimination of apartheid was to entrench social division actively on constructed notions of difference on the basis of, amongst others, race, gender and sexuality. In addition, hate speech played a central role in entrenching social values and practices that justified social division and associated discrimination.

It should be noted that hate speech has social and community consequences. It builds on and perpetuates 'us–them' divisions. Even where hate speech is directed at a particular person, the whole community of which that person is a member is affected, because hate speech targets key identity characteristics of a person with whom the rest of the community is associated. This could lead to decreased feelings of safety and security in the community generally (Nel & Breen, 2013).

Such violence and discrimination could also exacerbate negative feelings within sexually and gender-diverse persons towards their own sexual orientation or gender non-conformity. In this way, discrimination may lead to internalised stigma

and/or oppression. Research indicates that hate speech directed at lesbians and gay men makes victims significantly more vulnerable to a range of psychological harms, particularly a heightened risk of depression (Polders et al., 2008). Because hate speech targets a person's identity, it has an influence on self-esteem and self-worth. The perpetuation of negative images of sexually and gender-diverse individuals and experiences of discrimination may have a particularly detrimental effect on the psychological development of children and young adults (ASSAf, 2015; Sanger, 2013).

Dominant gender norms in any society shape the extent to which sexually and gender-diverse people can live out their genders and sexualities. Research shows, for example, that there is a close relationship between 'gender presentation' and vulnerability to victimisation (HRW, 2011; Nel & Judge, 2008). Sexually and gender-diverse people who present in gender non-conforming ways are more susceptible to both overt and covert discrimination than those who do not. People who present differently are sometimes punished or threatened, because they are perceived to disrupt the normative gender and sexual order (Nel & Judge, 2008). Furthermore, a person does not actually have to be gay or lesbian to experience discrimination, but may be victimised for having a non-conforming way of expressing gender. In other words, in South Africa, gay and lesbian people are discriminated against on the basis of *both* their sexuality and gender (Nel & Judge, 2008).

Practitioners are encouraged to recognise the nature and extent of bullying, hate speech and hate crime sexually and gender-diverse people endure

South African schools have been found to be homophobic (Bhana, 2012), with disturbingly high rates of verbal and physical harassment (Rich, 2006; Wells, 2005). Many learners do not feel safe in schools (Lee, 2014). At the same time, young people often are or feel alienated from their families who deprive them of emotional support which could otherwise offset the harmful effects of discrimination at school. Relentless bullying could affect both cognitive and non-cognitive skills develoment and influence long-term educational achievement and professional success (Lee, 2014).

Sexually and gender-diverse people are subject to bullying at three times the rate of the general population (ASSAf, 2015). A number of studies referenced in the ASSAf report have shown that in the United States, even with relatively high levels of acceptance of LGBTIQA+ rights and individuals, more than 80% of LGBT individuals experience verbal harassment at school; about 40% experience 'milder' forms of physical bullying, such as being pushed around. More than 20% report more serious physical assault related to their gender expression. Of particular concern is that very few victims felt able to report the assaults and those who did report the matter were more often than not disappointed with the support received (ASSAf, 2015; Nel & Breen, 2013).

Research has found that approximately 62% of the respondents in a study[4] had experienced negative jokes regarding their sexual orientation during their schooling (Nel & Judge, 2008). During the two-year period that the study was conducted, 37.1% of all respondents had experienced verbal abuse. This was the most prevalent form of victimisation across both sexes and all race groups. Actual physical abuse and assault was experienced by 15.6% of respondents, with almost 8% of respondents reporting sexual abuse (prevalence levels were similar between men and women). Sexual abuse levels in particular experienced by black women and men were much higher compared to their white counterparts. In addition, the findings confirmed that higher levels of 'outness' and integration into LGBTIQA+ communities and the adoption of gender roles associated with the opposite sex (i.e. increased visibility as gay or lesbian) led to increased rates in some forms of homophobic discrimination.

Other studies confirm the extent of discrimination and violence sexually and gender-diverse people endure in South Africa. Of the 121 black lesbians, transgender men and gender non-conforming women Human Rights Watch interviewed, almost all reported they had been verbally abused, ridiculed or harassed at some point in their life. A significant number of respondents reported such abuse *throughout* their lives (HRW, 2011).

4 The study was based on a representative quantitative study commissioned by the South African Joint Working Group (a national network of several LGBTIQA+-focused community organisations) of which the data was collected in Gauteng over a 24-month period between 2002 and 2003.

There is a strong correlation between hate speech and hate crimes perpetrated against vulnerable groups (Breen et al., 2016; Nel & Breen, 2013). Hate crimes mostly occur in contexts of sustained prejudice-motivated victimisation, including ongoing taunting (or hate speech), bullying or conflicts between people known to each other within specific settings, such as a school or a community. As such, hate speech (such as harassment, slurring, name-calling and other forms of verbal abuse) creates the breeding ground for hate-based attacks. Hate crimes – any incident that may or may not constitute a criminal offence, perceived as being motivated by prejudice or hate – can be seen as the extreme side of a continuum that starts off with verbal abuse, and the social acceptability of such abuse (Nel & Judge, 2008).

Practitioners should be aware that verbal abuse and harassment contribute to sexually and gender-diverse people becoming fearful and cautious, and heighten their vulnerability to depression (Polders et al., 2008). Left unchecked, such antipathy circulates and reinforces prejudices among and within communities. Verbal abuse and harassment that people face due to their gender expression and/or sexual orientation could create or enhance negative self-image, shape public opinion, instil fear and shame in people, and inhibit the victim's ability to access public space and seek redress or justice. It also creates and reinforces a climate of impunity within which violence could escalate from verbal harassment and abuse to physical and sexual attacks.

Practitioners can counteract this by paying attention to previous experiences of anti-LGBTIQA+ violence and by exploring the possible relationship between the presenting problem and such previous experiences.

Practitioners recognise and counteract the psychological effect of stigma, prejudice, discrimination and violence on the individual and targeted group/community

During an overview of related literature, it was found that the ASSAf report (2015) confirms that sexually and gender-diverse individuals fare poorly on most measures of health, from physical well-being to rates of STI prevalence, rates of mental illness and risk of suicide. Studies cited in the ASSAf report have confirmed this is a worldwide trend (Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). However, there is substantial evidence that such health disparities are not caused by individual sexual orientation or gender identity per se, but arise because of discrimination and prejudice and the inability of sexually and gender-diverse populations to live openly, access health information and access health and other state facilities freely (ASSAf, 2015; Nel, 2007).

Moreover, in many African countries, sexually and gender-diverse populations often suffer socio-economic discrimination of various kinds. They are also affected by other factors that affect their life choices and opportunities. These challenges can be particularly acute for adolescents and young adults, who often face intense pressure to conform to gender roles and identities in multiple domains – for example, in school, at home, in faith structures and from peers. The key reasons for these poor outcomes are the stress caused by high levels of social alienation, potential and substantive rejection by family and the community, bullying and violence, as well as state-supported violence and potential incarceration. These factors interact with a lack of health services or fear of using health services, a lack of educational material, and absence of any of the 'usual' channels of community support that are open to heterosexuals (ASSAf, 2015).

The central tenet of the minority stress model, as outlined previously, is that rejection, alienation, absence of social support, bullying and violence perniciously affect the self-image, educational attainment, economic integration and sense of belonging for sexually and gender-diverse individuals and communities. This causes a wide range of mental health disorders, including depression. This stress is then often 'self-medicated' by those who experience it through substance use and abuse, including a high prevalence of alcohol abuse (I.H. Meyer, 2003).

Homo- and transphobic violence and discrimination target a person as a result of her or his perceived sexual orientation and/or gender identity. It acts as a constant reminder that sexually and gender-diverse individuals face risks in making their minority status publically known, as this aspect of their identity may expose them to further discrimination, maltreatment or even violence. Such fears could have a chilling effect on the ways they present themselves in public. It often

encourages them to play down or conceal their sexual orientation or gender non-conformity, with a number of detrimental psychological effects. Not only do these strategies of self-preservation force sexually and gender-diverse individuals to choose between their safety and their identity, but they often also reduce the visibility and participation of the sexually and gender diverse, as an integral part of South African society (Nel & Judge, 2008). These types of effects are likely to be felt by other groups where there is victimisation based on other markers of identity, such as race or nationality, for example.

Practitioners could consider focusing on:

- Foregrounding internalised oppression, as core to psychological problems with self-image and social functioning in adolescence and adulthood. Building self-esteem, reducing internalised oppression and increasing visibility of positive sexually and gender-diverse role models are some of the vital interventions.

- Exploring, as outlined in Guideline 2, how self-determined disclosure could be beneficial to mental health, including improved self-esteem. Despite these possible benefits, practitioners should note that the potential for violence and threat could outweigh these potential benefits, and become an ethical issue around the protection of the individual and related advice given.

- Alleviating the significant distress due to external stigma, should this present, and helping negotiate what might be requests for help in changing of sexual orientation. Evidence of both the ineffectiveness of such approaches – there is no credible evidence that sexual orientation can be changed, even if there is some fluidity over a lifetime with some individuals along a continuum of attraction – and of possible kinds of harm should be shared candidly with clients.

- More importantly, service users/clients/participants should be helped to access their deepest appreciation of their own desires and innate orientation, and ways found to express those safely even in very oppressive social contexts.

Practitioners remain cognisant of the effect stigma, prejudice, discrimination and violence have on society in general

Given that hate speech stigmatises certain forms of identity, practice and expression, it reduces the space within which all members of society are free to express themselves as they choose. Hate speech clearly aims at sending a message that certain forms of identity and practice are to be socially excluded, detested and condemned. It increases intolerance in society at large and disparages non-conformist behaviours, identities and expressions (Nel & Breen, 2013).

Homo- and transphobic hate speech – just like other forms of hate speech – may therefore have detrimental implications for the pillars of human dignity, i.e. equality and freedom, which are meant to support South Africa's constitutional democracy. Fear, distrust, prejudice and renewed conflicts and previous areas of division in society may result in further polarisation and destabilisation, and restrict the full and unhindered participation of sexually and gender-diverse people in public and political life (Nel, 2007).

To promote human welfare, psychology professionals should advance well-being and social justice in their work. Accordingly, the UN High Commissioner for Human Rights, the President of the International Union of Psychological Science (IUPsyS), and others, drew definite links between human rights and health and well-being during the International Congress of Psychology in 2012, which was held for the first time on African soil (Nel, 2014). Practitioners should consider evidence that policies and practices that protect the human rights of sexually and gender-diverse individuals and communties are beneficial across entire societies. Such policies and practices protect these individuals against violence and discrimination, improve their health and well-being, increase their contribution to the economy, society, and culture, and promote intergroup contact that reduces prejudice against all minority groups in society.

GUIDELINE 7: Recognising multiple developmental pathways

Psychology professionals recognise the multiple and fluid sexual and gender developmental pathways of all people from infancy, childhood, and adolescence into adulthood and advanced age

Rationale

There has been a movement away from imposed identities, to self-chosen identities, in many areas of life and in many countries. People are insisting on their own agency and ability to define who they are, and to refine and adapt that in different contexts. In terms of sexuality, there are multiple, and often fluid, pathways in the development of sexual orientation. These are a normal aspect of human developmental variation (ASSAf, 2015). The same is true for gender and social identity. How people think about and talk about the people to whom they feel attracted, might be substantially different from what they claim as their identity or how they talk about their orientation, depending on various factors, for example, levels of stigma in their society and their own sense of personal agency (ASSAf, 2015). It is also possible to live with two identities – one public and one private (McLachlan, 2010).

Orientations, how we understand our attractions to others and identities evolve too, over a lifetime. Some people find their sexual orientations and sexual preferences evolve through different life stages. Less well understood is that some people's gender identities shift too, and not always in any obvious alignment to their orientations or sexual practices. Increasingly, globally, some people opt to reject gender binaries entirely, regardless of their sexual orientation.

Cultural and social contexts change over time, including expectations of people at different stages of life. The needs of individuals might also differ across their lifespans. Older sexually and gender-diverse people might, for instance, also face additional issues around health, retirement, finances and social support that are aggravated by the heteronormative expectations for older people. Practitioners need to be open to these life shifts.

Because identity and orientation are not the same, although these categories are often conflated, it is important to include sexual orientation and gender identity in the process of identity exploration. In this context, it should be recognised that the articulation of sexual orientation is made more complex when sex assigned at birth is not aligned with gender identity. Practitioners need to be sensitive that a person's gender identity cannot be determined by simply examining external appearance, expression or behaviour, but must incorporate a person's identity and self-identification (Broido, 2000).

In addition, many gender-diverse adults have disguised or rejected their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimise their fear of difference (Bockting, Milner, Swinburne Romine, Hamilton, & Coleman, 2012).

Psychology professionals need to create the space for hearing how service users/clients/participants refer to themselves and to help them assess meanings they attach to these words. Practitioners and researchers also need to be clear on how they define with whom they want to engage, and by implication whom they want to exclude from an intervention and/or programme, i.e. interviewing lesbian and gay people, per se, will exclude those people who may be same-sex attracted, but do not identify with the labels 'lesbian' and/or 'gay' (Sandfort & Dodge, 2009).

Sexual orientation development

Research indicates a significant potential biological basis for the development of sexual orientation. Sexual orientation may develop by different bioloical pathways for male- and female-identified people, but this always occurs in particular social and cultural ways (ASSAf, 2015). For many, sexual orientation is

mostly 'fixed' fairly early in life, but there are some indications that sexual orientation is more fixed for men and more fluid and changeable for women, which might reflect on socialisation to gender norms (Diamond, 2008, 2015; Dillon, Worthington, & Moradi, 2011; Farr, Diamond, & Baker, 2014; Savin-Williams & Diamond, 2000; Worthington, Savoy, Dillon, & Vernaglia, 2002). For most people, their sexual orientation is not experienced as being chosen and is generally not experienced as changeable at will, or at all (ASSAf, 2015).

There appears to be no significant evidence that the nature of parenting or early childhood experiences play any role in the formation of a person's basic sexual orientation (ASSAf, 2015). There is no empirical evidence indicating that sexual orientation may be acquired through contact with sexually and gender-diverse people, including the otherwise powerful mechanism of peer pressure (ASSAf, 2015). As explored in the ASSAf report, peer pressure has a significant influence on much social behaviour and on many cultural and political attitudes, but does not appear to have any influence on sexual orientation.

The expression of sexual orientation, on the other hand, is significantly influenced by social and cultural systems – sexual orientations may be defined in relatively distinctive ways in different societies, and over different times. In addition, personal agency also plays a role in the expression of sexual orientation.

Sexually diverse people face similar developmental tasks that accompany adolescence for all youth, including sexual identity development. However, they must also navigate awareness and acceptance of a socially marginalised sexual identity, potentially without family, community or societal support. This could increase their risk for psychological distress and substance use behaviours. On the other hand, supportive families, peers, school and community environments could improve psychosocial outcomes (SAMHSA, 2015).

For example, educational institutions could potentially be both an obstacle as well as opportunity for young sexually and gender-diverse people during their development (Francis, 2017). Heteronormativity and homophobia in the school system and the experience of sexually and gender-diverse learners, including bullying, have been investigated (Francis & Msibi, 2011; Msibi, 2012). Educational institutions have a social responsibility to manage possible discrimination and improve safety for all learners (Watson & Vally, 2011). Increasingly, localised resources are available to assist professionals in providing sexual and gender diversity-affirming education and environments (Reygan, 2016).

Recent models and research suggest same-sex attraction sexual identity development as a circular, dynamic process that entails the acquisition of an individual as well as a group identity. These two parallel paths – individual sexual identity and group identity development – influence each other, but not necessarily simultaneously (Coetzee, 2009). A key limitation of these models is that not all people label themselves in particular ways, nor do they attach the same meanings to some of the terms used. There is thus a need to be sensitive to the way in which people identify themselves rather than forcing them, almost linearly, into one or the other category (Page, 2007). For example, the idea of 'gay' identity development might require particular economic and social conditions, such as an urban environment where people have a high level of voluntary mobility or find themselves in loosened family relations (Leatt & Hendricks, 2005). Such concepts as 'gay' might feel alien and inappropriate in different cultural contexts.

Positive same-sex attraction sexual identity is related to healthy psychological adjustment (Nel, 2007). Without endeavouring to essentialise race and culture, and also keeping in mind potential significant variation within communities, research has indicated that racial and cultural intersectionalities currently also play an important part in defining one's sexual orientation. For example, for many white South Africans, sexual orientation is considered integral to identity. But in rural or poor black and coloured communities, sexual practices might not influence identity formation. For example, a 'gay' man who sees himself in a receptive role might refer to his sexual partners as 'straight' (Nel, 2007; Rabie & Lesch, 2009; Reid, 2013).

Gender Identity Development

Gender development begins in infancy and continues progressively through childhood. The child's gender role development is influenced by biological, cognitive and social factors (Alanko et

al., 2008). Although gender identity is usually established in childhood, individuals might become aware in childhood, adolescence, or adulthood that their gender identity is not in full alignment with sex assigned at birth. Some people also experience their gender identity as fluid to a more or lesser extent over time (Lev, 2004; McLachlan, 2010).

The experience of questioning one's gender could create significant confusion for some gender-diverse people and their significant others, especially for those who are unfamiliar with the range of possible gender identities that exist. This includes the lack of more nuanced terminology. For example, to explain any discordance that might be experienced between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, and/or gender role non-conformity and gender identity, some gender-diverse people may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009).

For many, gender dysphoria before puberty will not persist and they will develop a cisgender identity in adolescence or adulthood (WPATH, 2011). For some though, gender dysphoria in childhood will persist and usually worsen with the physical changes of adolescence. For others, gender dysphoria will only emerge after puberty with no history of gender non-conformity.

Different terminology is used by health practitioners when referring to children who present outside the gender norm. Some use more pathologising descriptors such as Gender Identity Disorder in Childhood (GIDC), Gender Incongruence in Childhood, or Gender Dysphoria. Others may view the child's behaviour as very possibly transient in nature and part of the development process in childhood, and use terms such as 'gender variance', 'gender atypical behaviour' or 'gender questioning' (McLachlan & Nel, 2015). Gender diversity in childhood is thus not seen as pathological.

Some gender questioning children and adolescents might have increased risk of depression, anxiety and behavioural matters. This might be related to negative social attitudes or rejection. Conversely, a supportive social network improves psychosocial outcomes (SAMHSA, 2015).

Puberty blockers/suppression may become a treatment option for the gender-diverse adolescent. These blockers, which are reversible, prevent the development of secondary sex characteristics which, in turn, could alleviate gender dysphoria (WPATH, 2011). Others find that to transition socially creates enough space to live out and explore their gender identity.

Application

Psychology professionals could:

- Assist people to differentiate between gender identity and sexual orientation including how social expectations to conform to strict gender norms could be harmful
- Normalise each individual's unique pathway in the development of her or his gender identity and sexual orientation, including highlighting the possibility that these identities are not necessarily fixed but might change over time
- Consider particular historical contexts of the life stage to which the client belongs. In addition, to consider the current social and cultural environment within which the person finds her- or himself in, e.g. media representations
- Discuss the potential phases of gender identity and sexual orientation development, making it clear that these are not fixed but are merely useful to assist in understanding and providing clarity. A number of models are available, and equally, there are some criticism of these models, which needs to be taken into account. See, for example, Robertson and Louw (2013) for a useful summary
- Provide information about both sexual orientation and gender identity, including the narratives of other sexually and gender-diverse people
- Be open and informed that the potential exists that individuals in relationships might identify their orientations differently (i.e. one partner might identify as heterosexual and the other partner as gay or bisexual)
- Be sensitised to the effect of stigma, prejudice, discrimination and violence on the

developmental health of sexually and gender-diverse people

- Consider matters of parental, partner and other social support and how to facilitate the provision of a strong social support network, including psycho-education

- Seek up-to-date information and resources for own learning and to assist clients.

GUIDELINE 8: Non-conforming family structures and relationships

Psychology professionals understand the diversity and complexities of relationships that sexually and gender-diverse people have, which include potential challenges –

- of sexually and gender-diverse parents and their children, including adoption and eligibility assessment;
- within families of origin and families of choice, such as those faced by parental figures, caregivers, friends, and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant other; and
- for people in different relationship configurations, including polyamorous relationships

Rationale

Potential challenges of sexually and gender-diverse parents and their children, including adoption and eligibility assessments

Many sexually and gender-diverse people are parents or want to have children. Some sexually and gender-diverse people have their own biological children, others choose to adopt, foster or pursue surrogacy. Sexually and gender-diverse people sometimes become parents before coming out. Sometimes their sexual and gender diversity becomes part of custody proceedings or other kinds of settlements. More and more countries allow sexual and gender-diverse persons to raise biological, foster and adopted children (ASSAf, 2015).

Since 2002, South Africa has been the only African country where gay and lesbian people have been able to adopt children (Klein, 2013). But, for many sexually and gender-diverse people adopting or fostering a child is fraught with difficulties. This includes having to find a non-discriminatory organisation/agency or social worker to facilitate the adoption or foster process. This is not only a South African issue; these problems are common around the world (APA, 2015).

Practitioners should be aware of and sensitive to the stress of the adoption process, and to any additional stressors that might be causing distress due to homophobia and transphobia.

Some lesbian people, gender non-conforming people and trans men choose to fall pregnant. Many choosing this require reproductive treatment. There are sometimes issues finding medical professionals willing to assist (Swain & Frizelle, 2013). In addition, the hormonal treatment received by some transgender and gender non-conforming people could limit their reproductive choices (APA, 2015; De Villiers & De Vries, 2013). For other gender-diverse people, their future plans of parenthood and conceiving naturally could influence their choice of starting with hormonal therapy and undergoing gender-affirming surgery. So, for example, gender-diverse people could be counselled to consider choosing to store their eggs/sperm.

Transgender and gender non-conforming people who choose to change their gender marker at the Department of Home Affairs might be burdened by their marriage status. As the Marriage Act (25 of 1961) as well as the Recognition of Customary

GENDER-AFFIRMING SURGERY/TREATMENT/PROCEDURE: Also sometimes referred to as 'sex-reassignment surgery', this refers to medical treatment and other procedures, such as cross-gender hormones and gender-affirming surgeries, which transgender persons could choose to undergo in order to make their bodies more congruent with their gender identity, thus affirming their gender.

Marriage Act (120 of 1998) do not recognise same-sex marriages, the married couple has to divorce in order to remarry in terms of the Civil Union Act (17 of 2006) (Gender DynamiX & Legal Resource Centre, 2014). This puts additional strain on the couple as well as on the family and could even have an effect regarding custody issues of children during this process.

A variety of global studies have shown that children from sexually and gender-diverse parents do not experience more psychopathology than children from other families (see, for instance, Breshears & Lubbe-De Beer, 2016 and Breshears & Le Roux, 2013). In South Africa, there are some signs that societal acceptance of non-normative families is increasing. While this is leading to a more supportive environment for the children from these families (Breshears & Le Roux, 2013), many families still face complex and often discriminatory social environments.

Although research is limited, there is no indication that children of gender-diverse parents suffer any long-term negative effects due to transitioning by a parent (APA, 2015). In terms of the well-being of members of a family, the structure and form of the family are less important than the quality of the relationships within that family (Lubbe-De Beer, 2013).

Potential challenges of family of origin and family of choice

There is considerable evidence that a more repressive environment increases minority stress and this could have a negative effect on a gender and sexually diverse person's health (ASSAf, 2015). The reverse is also true: several studies have indicated that gender-diverse adults and adolescents who experience acceptance from their family of origin have significantly decreased rates of negative outcomes such as depression and suicide (APA, 2015).

Some sexually and gender-diverse people have experienced abuse and violence in their family of origin (APA, 2015; Nuttbrock et al., 2014). Due to the high prevalence of stigma, rejection and negative social responses (Meier, Pardo, Labuski, & Babcock, 2013), they often experience a lack of affirmation and belonging (Benestad, 2002). This creates additional stressors, which could contribute to mental health challenges and problems (APA, 2012; ASSAf, 2015; Meier et al., 2013; Wolf & Dew, 2012). Many sexually and gender-diverse people experience rejection or a feeling of not belonging to their family of origin. For some of them, it becomes important to form a new family of choice.

Families of sexually and gender-diverse people often also require support when dealing with sexual and gender diversity.

In the face of weakened family of origin ties, sexually and gender-diverse people often form extended networks of friends who could provide role models and become the family the person feels she or he might not have in her or his family of origin, partially as her or his family of origin might consist solely of cis-gender and heterosexual individuals. Some research has indicated that these extended circles might also include previous romantic and sexual partners as close friends. Both the family of origin and the family of choice could provide strong support systems on which the person could rely as she or he navigates the road to making sense of societal rejection and discrimination, dealing with her or his own sense of shame and loss, to developing a strong connected identity (Pachankis & Goldfried, 2013).

Potential challenges of different relationship configurations

Following on from the discussion initiated in Guideline 3, different relationship configurations exist within the sexually and gender-diverse community with some being in monogamous relationships and others in non-monogamous relationships (British Psychological Society, 2012). Furthermore, as a person goes through different life stages and/or as relationships develop, the fluidity of monogamy/non-monogamy could come to the forefront.

Regardless of sexual orientation, couples might negotiate different forms of monogamy or non-monogamy as a potential process through the course of their relationship. The notion that bisexual people are often non-monogamous is as fallacious as making this assumption about any other orientation (Lynch, 2013). The term 'couple' here should not imply two people only, as couples could have relationships in multiple configurations, such as found in polyamorous and polygamous relationships.

In South Africa, even though same-sex marriage is legal and diverse family structures, for example polygamous formations, are considered acceptable (Breshears & Le Roux, 2013), heterosexual, monogamous marriage is privileged as part of broader social patterns of heteronormativity (Lynch & Maree, 2013). Many people in relationship configurations that do not uphold these heterosexual expressions and relationships experience hostility, even to the point of violent opposition (Marnell, 2013). Sexually diverse people take different and shifting positions regarding the heteronormative discourse regarding relationships, at times being restricted by it, at other times in opposition to it and/or challenging it (Lynch & Maree, 2013) and at yet other times, attempting to redefine their relationships to reflect this dominant discourse.

Gender-diverse people may also experience stressors as they negotiate their relationships with their significant other. Disclosure of a gender-diverse identity early in a relationship correlates with a better relationship outcome, as a later disclosure could be perceived and experienced by the partner as a betrayal (APA, 2015). In an existing relationship, the couple often both need to be involved in the decision-making process regarding the use of resources for gender-affirming treatment as well as sharing the news with family members, the community of care, other support structures and within the community (APA, 2015).

Couples often need to renegotiate relationship roles, interrogate the meaning of being a partner and understanding of the roles, and at times even grieve the loss of aspects of their partner and/or relationship (APA, 2015). For the intimate partner, being in a relationship with a person who transitioned may entail questioning her or his own sexuality and sexual identity. Furthermore, some partners of transgender persons experience transphobia and transphobic violence (Theron, 2009). For some couples, the stressors, new roles and identities become too challenging and the couple may separate or divorce. Some trans–cisgender couples renegotiate the 'new identities' and relationship roles through introducing structures such as negotiated open relationships or polygamy. This is particularly in relation to couples who want to remain staying together; however, the trans person's sexual orientation might have shifted after or during transition.

For gender-diverse persons, it can also be very stressful as they engage in the dating scene, especially when they present differently from their sex assigned at birth. Some gender-diverse people experience a shift in their sexuality or question their sexuality as they transition (APA, 2015; Meier et al., 2013). Others may identify as gay although living their preferred gender while dating a person with the same natal sex as them, whereas another may identify as straight/heterosexual (Meier et al., 2013). Some gender-diverse people who have transitioned and are living the opposite gender as their sex assigned at birth, dating the same sex as their preferred gender may identify as gay/lesbian or as heterosexual/bisexual/asexual and so forth (Meier et al., 2013). Furthermore, after transitioning, some gender-diverse people experience a shift in their sexuality and sexual identity. The gender-diverse person navigates the world of relationships as she or he also explores her or his own understanding of sexuality – the process of making sense and finding a new identity within communities should be supported with empathy and care.

As in any other relational configuration, power inequalities also exist in sexually and gender-diverse relationships and this could lead to intimate partner violence (Henderson, 2012; Khan & Moodley, 2013; Müller, 2013). In this sense, the results of intimate partner violence on partners become an important area of work for psychology professionals.

Application

Psychology professionals work with sexually and gender-diverse persons across the lifespan to address family, relationship and parenting issues (APA, 2015).

Sexually and gender-diverse parents and their children, including adoption and eligibility assessment

Practitioners could provide support and guidance to the sexually and gender-diverse parent and person who wants to become a parent. The professional could support and guide the person/couple/people in the relationship as they navigate their quest of becoming parents. As a psychology professional, the person needs to aspire to create a safe space where the person/people could explore the different options available to them.

The psychology professional could also provide affirmative therapy as the sexually and gender-diverse persons negotiate their status as an 'alternative family' within the community.

Psychological screening and assessment as part of the adoption process:

The psychology professional could assess the client's psychological well-being as part of the screening for adoption. Furthermore, the professional could also assess the relationship structure and dynamics as part of the screening process.

Eligibility assessment:

The psychology professional could furthermore be involved in the eligibility assessment during divorce and separation proceedings. The professional needs to be cognisant of her or his own internalised homophobia/transphobia and her or his own inherent beliefs of what an ideal family constellation entails. The psychology professional needs to forefront the best interest of the child and work within the ethical guidelines of the profession.

Families of origin and families of choice (such as those faced by parental figures, caregivers, friends and other people in their support networks, for example, in coming to terms with the diversity, non-conformity, and/or minority status of their sexually and gender-diverse significant other)

Practitioners could help sexually and gender-diverse people to negotiate family dynamics (APA, 2015). This might mean individual work as well as family therapy as the person explores and establishes her or his sexual and gender identity (APA, 2015) to assist in negotiation and renegotiation of relationships and the roles and rules of those relationships. At times, this could also involve dealing with the loss of a daughter or son as the person transitions and relationships change.

The disclosure (or non-disclosure) of sexual and gender-diverse identities could also be supported by the professional as the gender-diverse person negotiates her or his relationships as well as intimate relationships. In the case of gender diversities, the psychology professional could also focus on fostering resilience in the relationships and could provide support to the intimate partners of gender-diverse clients, whether on individual level or through partner/peer support groups (APA, 2015). Psychology professionals may also need to explore the fluidity in sexual orientation that might occur during the transitioning period of the gender-diverse client (Meier et al., 2013).

People in different relationship configurations, including polyamorous relationships

Regardless of sexual orientations, some people feel monogamy is unsuitable, and the expectations affiliated with a monogamous relationship model 'set them up for failure' as the commitment required to agree to it is too restrictive. Practitioners could help those in polyamorous or 'open' relationships establish ethical boundaries and informed consent. As with any relationship configuration, an absence of coercion and high levels of trust are important baselines to establish.

The psychology professional could assist the gender and sexually diverse client exploring and embracing a variety of relationship configurations. Practitioners could also work with the relationship unit as they explore their roles and understanding of their relationship configuration.

GUIDELINE 9: The necessity of an affirmative stance

Psychology professionals adhere to an affirmative stance towards sexual and gender diversity in policy development and planning, research and publication, training and education (including curriculum development, assessment and evaluation of assessment tools), and intervention design and implementation (including psychotherapeutic interventions)

Rationale

What does it mean to take an affirmative stance? Psychology practitioners recognise that previous therapeutic approaches often pathologised and caused harm to sexually and gender-diverse individuals. Past approaches were not neutral: psychology as a social science and as a service was 'part of the problem'. In the 21st century, it is not enough for practitioners and the profession to just stop doing harm. Psychology professionals need to be and could be part of a set of solutions and approaches that provide responsible, affirming and comprehensive mental health care for sexually and gender-diverse individuals. This is the essence of an affirmation stance – going out of our way to redress past imbalances and prejudices, with the aim of providing optimal mental health systems.

An affirmative stance implies specific positive assumptions about sexual and gender diversity, which informs all areas of professional practice (PsySSA, 2013). These assumptions include the core premise that sexual and gender diversity are recognised as normal and natural variances of the human experience, and are not per se the cause of psychological difficulties. There is considerable and up-to-date multinational research to support this view. This also demands a broader contextual awareness of how minority stress in the form of homophobia, transphobia, heterosexism, prejudice and stigma affect the mental health and well-being of sexually and gender-diverse people (PsySSA 2013).

As a member of IPsyNet, PsySSA advocates that sexually and gender-diverse people be included as experts and active, equal partners in research and policy development for research and policy initiatives that concern them (see policy statement attached as Appendix II). PsySSA, furthermore, supports the development of psychological research and education that is not hetero- or cisnormative. This research and education must be based on scientifically grounded knowledge. Where possible, researchers should actively advocate for greater awareness of the health and well-being needs of sexually and gender-diverse people in order to improve public policy and sexually and gender-diverse communities (IPsyNet, 2016). This affirmative stance is particularly important because of the widespread failure to incorporate sexual and gender diversity into professional psychology practice and training. An affirmative stance is also needed to counteract the frequent downplaying of sexual and gender diversity concerns when designing, implementing or evaluating a range of interventions, such as national or organisational policies, psychometric tests, teaching methods, curricula, psychotherapies, research agendas and tools or public health programmes. These interventions are usually seeped in heteronormative assumptions.

An affirmative approach respectfully recognises diversity, including the expertise found in sexually and gender-diverse people's own lived experiences. It seeks to use this knowledge to inform interventions and practice. Psychotherapy and counselling, as one of the hallmark activities of the psychology profession, requires a radical sensitisation towards sexual and gender diversity matters in order for the process to be conducive to developing and maintaining a therapeutic alliance, which research shows to be the core facet of enduring healing processes.

Beyond psychotherapy, research practitioners should strive to be sensitive to the ways in which data is collected and whether the tools and forms they use are sensitive and inclusive of sexual and gender diversity (Davies, 1996; Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Harrison, 2000; Johnson 2012; Korell & Lorah, 2007; Milton, Coyle, & Legg, 2002; Pachankis & Goldfried, 2013; Ritter & Terndrup, 2002).

Application

Practitioners are urged to remain aware of heteronormative biases when planning interventions, and to take an active affirmative and inclusive stance in their implementation

As a general rule of thumb, it is, for instance, better to err on the side of being overly inclusive rather than being conservative or exclusionary. Practical ways of evaluating whether an intervention is affirmative and inclusive is to read it or imagine its implementation while keeping sexually and gender-diverse populations in mind, or allowing a few sexually and gender-diverse individuals to assess the intervention to see whether it is experienced as exclusionary, or to have it assessed by a known expert in the area of affirmative interventions. For example, LGBTI Cultural Competency Framework of Australia's LGBTI Health Alliance specifically includes LGBTI people working in mental health and suicide prevention organisations (Walker & Mars, 2013).

Practitioners involved in policy development and planning must ensure that the policy is written in an affirmative manner, sensitive to sexually and gender-diverse experiences, and is planned in such a way that it would not be exclusionary in its implementation

LGBTIQA+ people must be included as experts and as active, equal partners in research and policy development for research and policy initiatives that concern them to ensure the development of psychology research and education that is not hetero- or cis-normative (e.g. Clarke, Ellis, Peel, & Riggs, 2010; Doan, 2011; McNulty, Richardson, & Monro, 2010).

Practitioners involved in all forms of training, education, teaching, examinations, interviews and selections, assessments, and curriculum development and appraisal must remain aware of the effect of those processes and its content on sexually and gender-diverse students or participants, and should strive to ensure that those processes and content are affirmative and inclusive

Practitioners who are progressively involved in the current processes of 'decolonisation' of psychology curricula, for example, acknowledge that psychology is taught from a predominantly North American and European vantage point. Such knowledge is often steeped in patriarchal and heteronormative assumptions and values. Decolonising curricula, therefore, is as much about the changing content and pedagogy, as it is about actively endorsing, for example, a feminist and queer lens to the content and teaching practices. Such revisions to curricula and teaching practice need to include sexual and gender-diverse frameworks in the process.

Educational psychologists working in schools must, for instance, be aware of how schools could become sites that (re)produce heterosexism and homophobia. Teachers' personal viewpoints on sexual and gender diversity could often become official school policies on what is appropriate behaviour, leading to victimisation and marginalisation of students who do not fit into the predetermined, expected norms of behaviour and interaction (Bhana, 2012; Deacon, Morrell, & Prinsloo, 1999; Msibi, 2012).

Practitioners practice affirmative forms of psychotherapy and counselling, and if their client's sexual orientation has not been revealed, the practitioner must not assume that the client is heterosexual

Practitioners should draw on the wide variety of useful and pragmatic case studies detailing how a practitioner would go about using an affirmative orientation when counselling or treating a sexually and gender-diverse client (e.g. the case of 'Felix' by Glassgold [2009] and 'Adam' by Mandel [2014]).

After a systematic review of the literature assessing the effectiveness of affirmative psychotherapy on LGBTI service users/clients/participants, the British Association for Counselling and Psychotherapy (BACP) (2007, p.33) for instance recommended "all psychotherapy training institutes regard knowledge of LGBTI development and lifestyles as part of *core training*" (emphasis added). The onus therefore is on training centres to ensure that appropriate sexual and gender diversity content be incorporated into the curricula.

GUIDELINE 10: Foregrounding global best practice care

Psychology professionals support best practice care in relation to sexually and gender-diverse service users/clients/participants by:

- cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy;
- opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the WPATH; and
- encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons

Rationale

To supplement the guidelines, it is advised that psychology professionals keep abreast of global and local best practice care. Of particular importance here are three areas of work, namely:

- conversion therapy, which includes scientific and ethical views on conversion therapy and requests to change sexual orientation;
- best practice care for transgender persons embarking on a journey of gender-affirming surgery and treatment; and
- surgical interventions in the case of intersex infants.

In discussing each of these areas, the citations for the current state-of-the-science best practice reference material are provided and listed in the References.

Cautioning against interventions aimed at changing a person's sexual orientation or gender expression, such as 'reparative' or conversion therapy

Sexual orientation change efforts (SOCE) and gender identity/expression change efforts are based on the idea that sexual and gender diversity are maladies that require treatment (ASSAf, 2015; British Psychological Society, 2012; SAMHSA, 2015). Evidence for considering non-heterosexual sexuality as an abnormality or some kind of disorder has been systematically debunked in the past few decades. Many high-quality studies indicate that the higher prevalence of certain psychological problems in some sexually and gender-diverse individuals stem not from inherent pathology, but from prejudice and discrimination. Living in hostile environments creates the conditions for what has been theorised and studied as 'minority stress' (ASSAf, 2015) and the symptoms of this stress have often been confused and wrongly attributed to distress related to sexual orientation.

Many studies, and overviews of current knowledge, such as the ASSAf (2015) study also show that same-sex orientation cannot be changed by reparative or conversion therapy. The APA (2012, p.17) states, "Reviews of the literature, spanning several decades, have consistently found that efforts to change sexual orientation were ineffective." In the United States, some people have successfully sued organisations offering such change therapies on the grounds of their deceptive advertising, as evidence of lack of efficacy has been strengthened by recent research (American Counselling Association, 2010; British Psychological Society, 2012).

Furthermore, studies note that SOCE in all its various forms is dangerous and in conflict with medical ethics. SOCE could result in real harm (American Counselling Association, 2010; APA,

2012; ASSAf, 2015). Some of the negative consequences of SOCE, conversion and reparative therapy include:

- increased levels of self-hatred;
- decreased self-esteem;
- increased anxiety and aggression;
- social isolation;
- depression;
- 'self-medication', such as substance abuse; and
- an increase in suicidal ideation (American Counselling Association, 2010; ASSAf, 2015).

Although SOCE does not work (APA, 2012) and could cause harm, some organisations and therapists continue to offer these treatments (ASSAf, 2015). An affirmative stance, as proposed in these guidelines, strongly encourages practitioners to develop and offer culturally responsive and appropriate care. Training for how to engage in 'best practice care' inclusive of sexual and gender diversity should be part of all mental health curricula across the training continuum. Such care could help practitioners recognise the gaps in scientific knowledge that perpetuate mental health disparities among the sexually and gender diverse, and should incorporate an understanding of harmful practices to avoid, such as SOCE, which have been shown to affect mental health adversely.

SOCE 'reparative therapy' is harmful for adults, but it is particularly harmful when offered to or forced onto children and adolescents. Children displaying any kind of gender-atypical behaviour could be subject to such therapy by parents, schools or religious organisations. Besides the harm such efforts could cause to the individual, it could also put family ties and bonds under pressure, and could lead to alienation from close relatives at the very time when families should be young people's primary sources of emotional support. Young people whose families do not accept their gender and sexual diversity are at heightened risk of depression and suicide and other mental health and substance abuse problems (Nell & Shapiro, 2011; Sanger, 2013).

Opposing the withholding of best practice gender-affirming surgery and treatment and best practice transgender healthcare as outlined by the WPATH (2011)

Even with the improvement in South Africa's legal approach, most gender-diverse service users/clients/participants struggle to access trans and gender-affirming healthcare, particularly in less-resourced contexts (Klein, 2013; Meier et al., 2013; Nkoana & Nduna, 2012). For many gender-diverse people, gender-affirming treatment is not a choice but a necessity in order to live authentically (McLachlan, 2010). Research studies have found that most gender-diverse service users/clients/participants receiving gender-affirming medical and psychological treatment have positive treatment outcomes, an improved quality of life and a reduction in negative psychological symptoms, as well as decreased gender dysphoria (APA, 2015).

However, it is important for practitioners to note that not all gender-diverse service users/clients/participants wish or require medical interventions (Müller, 2012). As the Standards of Care (SOC-7) developed by WPATH states, "The *SOC* articulate standards of care while acknowledging the role of making informed choices and the value of harm reduction approaches" (WPATH, 2011, p.1).

In South Africa, transgender and gender non-conforming people often find it hard to access appropriate surgery and hormone therapy, and many are unable to transition physically (Jobson, Theron, Kaggwa, & Kim, 2012; Klein, 2009; Morgan, Marais, & Wellbeloved, 2009; Nkoana & Nduna, 2012; Prinsloo, 2011). Most medical aids do not cover gender-affirming treatment (Bateman, 2011) and only a few government hospitals provide gender-affirming surgery and hormone treatment (Wilson et al., 2014). Due to the economic divide that exists within South Africa, people from lower socio-economic classes struggle even more to access appropriate healthcare (Klein, 2009; Klein, 2013). Gender-affirming treatment is not easily accessible within public health (Klein, 2013; Müller, 2012; Wilson et al., 2014). This lack of affirmative practices and support structures could lead to secondary victimisation and minority stress (APA, 2012; ASSAf, 2015; Nel, 2014).

For the gender-diverse adolescent, the onset of irreversible and possibly unwanted physiological

changes can be a cause of much distress (Bateman, 2011; McLachlan, 2010). According to Wilson et al. (2014), non-intervention could cause much harm and the possibility to delay puberty needs to be explored. Refer to Guideline 2 for a discussion around models of informed consent.

Encouraging parents to look at alternatives to surgical intervention in the case of intersex infants, unless for pertinent physical health reasons

Intersexuality has unfortunately long been regarded as a 'treatable medical condition' in South Africa. Where children were born with sexually ambiguous genitalia, urgent surgical treatment had been the preferred option (Swarr, 2009). But recent South African research has strongly suggested that surgery, when not urgently medically required, should only be performed when a child is able to participate in the decision (Wiersma, 2011).

This could cause a great deal of tension. Intense professional and community support may be needed for parents who decide to defer 'corrective surgery' until their child is able to give consent (British Psychological Society, 2012). In South Africa, intersex children as well as their parents are faced with discrimination, marginalisation and rejection within their respective communities. In some cultures, intersex children can even be regarded as 'bewitched' (Rebelo et al., 2008). See related discussion in Guideline 3.

In South Africa, a person can only identify legally as female or male (Klein, 2013). For many intersex people, the notion that their body is different and even viewed as unacceptable within the 'norm' stated by society creates high levels of distress as their body is viewed as requiring 'corrective' surgery (Husakouskaya, 2013).

Application

Conversion or reparative therapy

A person requesting SOCE should be counselled with accurate and up-to-date information regarding sexual diversity and the scientific evidence around conversion or reparative therapy (APA, 2012; ASSAf, 2015). Perspectives and overviews, such as the ASSAf report, or other resources that show that sexual and gender diversity are no longer regarded as conditions to be treated, but as normal and natural variations of human sexuality, could be shared with service users. The psychology professional might be faced with clients who experience significant and acute stress and conflict around their sexual orientation, beyond what might be expected as people deal with issues of developing a non-normative identity. Sources of conflict could include cultural or religious conflicts. The ethical conundrum for the therapist or counsellor might be in negotiating the line between doing no harm and respecting client values and needs. The issue of self-determination has been dealt with in Guideline 2. A client's autonomy and choice may be restricted as a result of her or his belief in heterosexist ideals and as a result of internalised stigma. The professional will need to explore these biases about sexuality in an affirming, empathic manner, thus balancing how to act both affirmatively and ethically. For further reading, see Haldeman (2004).

The practitioner aspires to be primarily evaluative and supportive in trans healthcare

The gender-diverse individual is no longer required to undergo mandatory psychotherapy to access gender-affirming treatment, and the mental health practitioner's role is primarily evaluative and supportive (Wilson et al., 2014; WPATH, 2011). Although psychology professionals are no longer 'gatekeepers' in terms of this decision-making, they could provide and facilitate access to trans- and gender-affirming care (APA, 2015). Indeed, most intersex and transgender service users/clients/participants are not referred to psychology professionals before surgery, even though research indicates many intersex service users/clients/participants wished for psychological support (Husakouskaya, 2013).

It should be noted that reports are often required from the psychology professional to access trans- and gender-affirming care in South Africa. Practitioners should work at all times from an informed consent model (WPATH, 2011). Informed consent is a process which occurs between a client/patient and a provider (such as an endocrinologist or general practitioner [GP] who prescribes hormones). Increasingly, there is a move in certain areas in South Africa towards a more participatory model, rather than only a medical or rights-based approach. The process should include an individualised discussion of the

risks, benefits, unknowns and alternatives, against the risk of no treatment. While Appendix III provides an example of a consent form for hormone therapy, a related discussion and shared decision-making between client/patient and provider is strongly recommended.

Awareness of transphobic social pressures, prejudice and discrimination could broaden the psychology professional's understanding and assist in assessing, treating, supporting and advocating for the gender-diverse client (APA, 2015; Wilson et al., 2014). The psychology professional could play a valuable role in the gender-diverse client's right to autonomy and self-identification (Wilson et al., 2014). Psychology professionals, furthermore, have a role to play in the empowerment and enabling of service users/clients/participants to recognise and resist prejudice, oppression and marginalisation (Wolf & Dew, 2012) by identifying possible courses of action, navigating public spaces and healthcare, developing self-advocacy strategies and identifying supportive resources (APA, 2015). Another role that WPATH (2011) advocates for is that healthcare providers need to advocate for their service users/clients/participants to receive gender-affirming healthcare if need be. The psychology professional could play a critical role in validating and empowering the gender-diverse person (APA, 2015).

Gender-diverse service users/clients/participants who have been traumatised by emotional and physical violence and/or hate crimes may need therapeutic support (APA, 2015; Müller, 2012). The psychology professional could also play an advocacy role in this regard. Advocating for gender-neutral bathrooms and better human resource (HR) practices are affirming examples.

Counselling parents of intersex infants

In counselling parents of intersex infants, the affirming practitioner would be supportive in exploring the fears that parents might have about their child. Exploring heterosexist assumptions and highlighting the resilience of people in dealing with diversity would be important, whilst recognising and being empathetic towards the difficulties parents face. Examples and role models, such as found with the South African athlete and world champion, Caster Semenya, who is an intersex person, are often useful in creating an alternative and positive future vision for their child.

GUIDELINE 11: Disclosing and rectifying of personal biases

Psychology professionals are, if it be the case, aware of their own cultural, moral or religious difficulties with a client's sexuality and/or gender identity, in which case they should disclose this to the client and assist her or him in finding an alternative psychology professional should the client so wish

Rationale

Whereas mental health professions have previously been complicit in causing harm to sexually and gender-diverse individuals by pathologising them, there is now broad consensus that mental health care has a significant role to play to promote optimal mental health and resilience for sexually and gender-diverse individuals (IPsyNet, 2016; PsySSA, 2013; World Psychiatric Association, 2016). However, psychology professionals' own explicit or implicit heterosexist biases, attitudes and assumptions could affect the quality of service they provide. Psychology professionals who themselves identify as sexually and gender diverse may also hold attitudes and assumptions that could affect the quality of service they provide. Bias can take the form of language used, and the choice and framing of interventions. The lack of training and knowledge of the particular issues dealt with by sexually and gender-diverse people could limit the ability of psychology professionals to provide appropriate services. Sexually and gender-diverse people have indicated that the healthcare provider's lack of knowledge and skills had a significant negative influence on their experience/outcome (Victor & Nel, 2016).

Utilising a sexual and gender-neutral model has at times been proposed for use by psychology professionals. Unfortunately, this approach – similar to a race-neutral approach – ignores or even denies the particular life experiences of sexually and gender-diverse people, and potentially perpetuates a heteronormative model that might be unhelpful to service users/clients/participants.

Disclosing and rectifying personal biases are important. It is also important that psychology professionals practice within the boundaries of their competence, as well as established professional and scientific knowledge. In this regard, but also in terms of referrals, the South African ethical rules for psychology professionals are clear:

Competency limits

- A psychologist shall limit her or his practice to areas within the boundaries of her or his competency based on her or his formal education, training, supervised experience and/or appropriate professional experience.

- A psychologist shall ensure that her or his work is based on established scientific and professional knowledge of the discipline of psychology (Department of Health, 2006, pp.16–17).

Interruption of psychological services

- A psychologist shall not abandon a client by terminating the professional relationship prematurely or abruptly, but shall –

  - » make appropriate arrangements for another psychologist to deal with the needs of the client in the event of an emergency during periods of foreseeable absence when the psychologist will not be available; and

  - » make every reasonable effort to plan for continuity of service in the event that such service is interrupted by factors such as the psychologist's illness, death, unavailability or relocation or by the client's relocation or financial limitations (Department of Health, 2006, p.22).

Application

Psychology professionals may be working with sexually and gender-diverse people in various

ways. The level of knowledge and competency required differs depending on the type of service offered. Regardless, psychology professionals ought to demonstrate insight and understanding about stigma, power dynamics, emotions, and human responses to emotions and the way implicit bias and assumptions about sexual and gender diversity may affect client care negatively.

Psychology professionals are urged to:

- Develop cultural humility, which includes avoiding making assumptions about the client. In the view of the International Union of Psychological Sciences (IUPsyS), cultural humility requires that psychologists strive to achieve humbleness in their interactions with clients; recognize that they are not the expert, and that they actively commit to being self-reflective and self-critiquing. Cultural humility entails the active inclusion of others' cultural worldviews to develop authentic and respectful relationships; reflection on one's thoughts, feelings and behaviour about their client's cultural worldview, and commitment to engaging in a life-long learning process towards humility and respect for others (IUPsyS, 2016, p.5)

- Use self-exploration, self-reflection and self-education, including exploration of own sexuality, gender identification and expression, to ensure an affirmative stance to sexual and gender diversity. This includes being aware of their own biases (explicit and implicit), background and values and how these might affect their work

- Be upfront during the initial intake/telephonic screening with potential service users/clients/participants regarding their own limitations/related expertise/(un)availability

- Facilitate referral processes, especially when a therapeutic relationship has already been established with the client. Psychology professionals have an ethical duty to refer clients appropriately in cases where their own values and worldview (for instance their religious beliefs) are discordant with the needs and diversities of the client. In accordance with Guideline 12, psychology professionals may similarly require engaging in appropriate self-reflection and introspection in such instances

- If in a position of leadership, confront stigma, minority stress and implicit bias in mental health settings with trainees and colleagues and engage in systems-based improvements to eliminate related adverse effects

- Seek additional training and supervision to ensure competence based on evidence-based practice on a continuous basis. This might also include first-hand accounts of the lived experiences of sexually and gender-diverse people

- Seek collaboration with service users/clients/participants or groups representing service users/clients/participants to enable their active decision-making in their own processes

- As affirmative practitioners, advocate for sexually and gender-diverse clients when working or dealing with colleagues. This would include highlighting issues around heterosexist biases and the effect of this in working with sexually and gender-diverse people

- Realise that psychology professionals who, themselves, identify as sexually and gender diverse are not above holding heterosexist biases, particularly given the lack of training in affirmative practice in South Africa. Thus, all psychology professionals need to cultivate cultural humility in their practice, and explore their own biases and the potential negative outcome on sexually and gender-diverse individuals.

GUIDELINE 12: Continued professional development

Psychology professionals seek continued professional development (CPD) regarding sexual and gender diversity, including developing a social awareness of the needs and concerns of sexually and gender-diverse individuals, which includes promoting the use of affirmative community and professional resources to facilitate optimal referrals

Rationale

The rules of conduct for the profession of psychology, as outlined in the Health Profession Act (56 of 1974) are clear that psychology professionals must not only develop, but also maintain a high standard of professional competence (Department of Health, 2006). Continued professional development (CPD) is key to this. The Health Professions Council of South Africa (HPCSA) strongly encourages and mandates professions to maintain and update professional competencies in the interest of service users and participants (HPCSA, 2017).

Ethical practice requires commitment to lifelong learning as a part of the beneficence principle. This is all the more important in terms of affirmative practice for the sexually and gender diverse, given that related content is mostly absent from undergraduate and postgraduate curricula in South Africa.

However, while CPD points are important, and the regulations provide good incentives, it is important for practitioners to actively develop a scientifically grounded resource base on which they can draw, and to keep updating this. In order to advocate and meet the mental health needs of sexually and gender-diverse people better, an affirmative stance requires keeping current with a variety of academic and popular culture trends.

These areas are and will remain contentious, and there will be public and professional debates. There are a number of areas where good local research is urgently needed, and some areas where even globally there is a lack of well-designed credible studies. It is important to know what we do not know, and to think about how we can be part of shaping local and international research agendas. An essence of an affirmative stance is sharing knowledge and speaking up when gaps in the knowledge are inhibiting the treatment, care and counselling of service users/clients/participants.

Application

Psychology professionals could consider the following:

- Doing more CPD activities to improve, in particular self-reflection, skills and knowledge about matters of sexuality and gender. This can include attending specialised training workshops
- Using the substantial online resources available for trainers and trainees, including these guidelines, to provide both more generalised information as well as to assist in developing more advanced expertise
- Having an updated list of relevant local community and potential referral sources. Research has indicated that access to community resources improves psychological well-being (D'Augelli & Garnets, 1995). Sometimes, sexually and gender-diverse individuals are not familiar with resources available to assist them. Awareness and ability to access and refer to community resources could then become important.

IN CLOSING

The authors felt it was critical to develop a document that is specific to the South African context, rather than adopting guidelines developed for other countries. Although this was challenging, it was also highly enriching.

The final document reflects a relatively comprehensive overview of current understanding in this field. As such, we believe that it forms the basis to support all psychology practitioners in their work, including researchers, trainers and professionals working in specific contexts such as education and industry. The guidelines represent a foundation for further work in this area, including developing research agendas, supporting policy work and development of curricula, both for new professionals as well as for CPD.

While the guidelines are primarily aimed at South African qualified professionals, our experience in the utilisation of the PsySSA sexual and gender diversity position statement has indicated that its applicability might well be broader, namely to include health professions in areas outside South Africa as well.

In addition, the guidelines and the process of development provide useful frameworks for the development of guidelines in other areas of work, and assisting those tasked with this development in planning and execution.

Finally, it is our sincere hope that you found the document useful, at times challenging, illuminating and an enriching experience. As mentioned in the introduction to the document, there are several streams of work already planned around the guidelines. Given this, we would really appreciate feedback on your experience with using the guidelines in your area of work.

GLOSSARY

This section outlines and explains a number of key terms, which psychology professionals might find useful in practice. These explanations and definitions are mostly taken from PsySSA (2013), APA (2015) and Queer (2016). Some of these terms have been discussed in the guidelines. As mentioned in the guidelines, care should be taken when using language in this area of work. These terms could potentially mean different things in different cultural and social contexts. People might attribute different meanings to the terms when they define their own identities and journeys. Within academic circles, terminology is also developing quickly to take into account our improved understanding of this area of work within the broader affirmative framework.

ANDROPHILIA: Androphilia and gynaephilia are terms used in behavioural science to describe sexual orientation, as an alternative to a gender binary same-sex and heterosexual conceptualisation. Androphilia describes sexual attraction to men or masculinity; gynaephilia describes the sexual attraction to women or femininity (also see Gynaephilia and Sexual orientation).

ASEXUAL: A person who has low or no sexual desire, little or no sexual behaviour, and a concomitant lack of subjective distress. Identifying as asexual does not preclude the ability for the person to have a romantic or love relationship with someone of the same and/or different gender.

BIOLOGICAL SEX: The biological and physiological characteristics that are socially agreed upon as informing the classification of a person as male or female.

BIOLOGICAL VARIANCE: A term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals (see Intersexuality).

BISEXUAL: A person who is capable of having sexual, romantic and intimate feelings for or a love relationship with someone of the same gender and/or with someone of other genders. Such an attraction to different genders is not necessarily simultaneous or equal in intensity.

CISGENDER: Often abbreviated to simply 'cis', a term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth.

CISNORMATIVITY: Also referred to as 'cissexism' and 'cisgenderism', a placing of more emphasis on societal norms that enforce the gender binary, but which are occasionally used synonymously with transphobia.

GAY: A man who has sexual, romantic and intimate feelings for or a love relationship with another man (or men). In the South African context, some lesbians also identify as 'gay' which, again, emphasises the importance of enquiring about self-naming and honouring such naming.

GENDER: The socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for either men or women.

GENDER-AFFIRMING SURGERY/TREATMENT/PROCEDURE: Also sometimes referred to as 'sex-reassignment surgery', this refers to medical treatment and other procedures, such as

cross-gender hormones and gender-affirming surgeries, which transgender persons could choose to undergo in order to make their bodies more congruent with their gender identity, thus affirming their gender.

GENDER ASSIGNED AT BIRTH: Gender assignment (sometimes known as sex assignment) is the determination of an infant's sex at birth. In the majority of births, a relative, midwife, nurse or physician inspects the genitalia when the baby is delivered, and sex and gender are assigned, without the expectation of ambiguity. Assignment may also be done prior to birth through prenatal sex discernment. AFAB (assigned female at birth) and AMAB (assigned male at birth) are commonly used terms to refer to gender/sex assigned at birth. While many people use the terms 'sex' and 'gender' interchangeably, they are, in fact, two separate characteristics (see Sex assigned at birth).

GENDER DIVERSITY: The range of different gender expressions that spans across the historically imposed male–female binary. Referring to 'gender diversity' is generally preferred to 'gender variance' as 'variance' implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals (also see Sexual diversity and Gender non-conformity).

GENDER DYSPHORIA: Also known as 'gender identity disorder' (GID), is the dysphoria (distress) a person experiences as a result of the sex and gender assigned to her or him at birth. In these cases, the assigned sex and gender do not match the person's gender identity, and the person is transgender. There is evidence suggesting that twins who identify with a gender different from their assigned sex may do so not only due to psychological or behavioural causes, but also biological ones related to their genetics or exposure to hormones before birth.

GENDER IDENTITY: A person's private sense of being male, female or another gender. This may or may not match the biological sex that a person was assigned at birth.

GENDER NON-CONFORMITY: Also referred to by some as 'gender variance', 'gender atypical' or 'genderqueer', is displaying gender traits that are not normatively associated with a person's biological sex. 'Feminine' behaviour or appearance in a male is considered gender non-conforming, as is 'masculine' behaviour or appearance in a female. In the case of transgender people, they may be perceived, or they perceive themselves as, gender non-conforming before transitioning, but might not be perceived as such after transitioning. Some intersex people may also exhibit gender non-conformity (also see Gender diverse and genderqueer).

GENDERQUEER: Also termed 'non-binary', is a catch-all category for gender identities that are not exclusively masculine or feminine, i.e. identities, which are thus outside of the gender binary and cisnormativity. 'Androgynous' (also 'androgyne') is frequently used as a descriptive term for people in this category. However, not all persons identify as androgynous. Genderqueer people may identify as either having an overlap of or indefinite lines between gender identity; having two or more genders (being bigender, trigender or pangender); having no gender (being agender, non-gendered, genderless, or genderfree); moving between genders or having a fluctuating gender identity (genderfluid); or being third gender or other-gendered, a category which includes those who do not place a name to their gender.

GYNAEPHILIA: 'Androphilia' and 'gynaephilia' are terms used in behavioural science to describe sexual orientation as an alternative to a gender binary same-sex and heterosexual conceptualisation. 'Gynaephilia' describes the sexual attraction to women or femininity (also see Androphilia and Sexual orientation).

HETERONORMATIVITY: Related to 'heterosexism', it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person's biological sex as assigned at birth, and that only sexual attraction between these 'opposite' genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality to determine what is regarded as viable or socially valued masculine and feminine identities also, i.e. it serves to regulate not only sexuality but also gender (see Homonormativity).

HETEROSEXISM: A system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. It assumes that heterosexuality is the only normal or natural option for human relationships, and posits that all

other sexual relationships are either subordinate to or perversions of heterosexual relationships. In everyday life, this manifests as the assumption that everyone is heterosexual until proven otherwise (see Heteronormativity).

HETEROSEXUAL: Having sexual, romantic and intimate feelings for or a love relationship with a person or persons of a gender other than one's own.

HOMONORMATIVITY: The system of regulatory norms and practices that emerges within homosexual communities and which serves a normative and disciplining function. These regulatory norms and practices need not necessarily be modelled on heteronormative assumptions, but they often are (see Heteronormativity).

HOMOPHOBIA: Also termed 'homoprejudice', it refers to an emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards lesbian women and gay men (or women), or same-sex sexuality more generally. Homophobia is a type of prejudice and discrimination similar to racism and sexism, and lesbian and gay black, coloured or Indian people are often subjected to all three forms of discrimination at once (also see Transphobia).

INTERNALISED STIGMA/OPPRESSION: Also known as 'internalised homo-/transphobia' or 'internalised negativity', it refers to the internalisation or absorption of negative attitudes (a personal acceptance of such stigma as part of one's value system and self-concept).

INTERSECTIONALITY: The interaction of different axes of identity, such as gender, race, sexual orientation, ability and socio-economic status, in multiple and intersecting ways, resulting in different forms of oppression affecting a person in interrelated ways.

INTERSEXUALITY: A term referring to a variety of conditions (genetic, physiological or anatomical) in which a person's sexual and/or reproductive features and organs do not conform to dominant and typical definitions of 'female' or 'male'. Such diversity in sex characteristics is also referred to as 'biological variance' – a term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals.

LESBIAN: A woman who has sexual, romantic and intimate feelings for or a love relationship with another woman (or women). Note, some lesbians prefer referring to themselves as 'gay'.

LGBTIQA+: An abbreviation referring to lesbian, gay, bisexual, transgender and intersex persons. 'LGB' refers to sexual orientations, while 'T' indicates a gender identity, 'I' a biological variant, 'Q' a queer identified person, 'A' for asexual, and '+' indicating other non-conforming minorities. These groups are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination and victimisation in a heteronormative and heterosexist society, in an effort to ensure equality before the law and equal protection by the law. However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences and needs of these people may in fact differ significantly and in several respects. In solidarity with the activist position regarding this matter, however, in this document, reference is made to LGBTIQA+, and distinctions among the diversity of identities that exist are minimised.

MSM (MEN WHO HAVE SEX WITH MEN): Used in public health contexts to refer to men who engage in sexual activity with other men, including those who do not identify themselves as gay or bisexual, to avoid excluding men who identify as heterosexual. Note, trans men may also be included in such a description (also see WSW and Sexual behaviour).

POSITION STATEMENT: Refers to a document outlining the stance of a professional body on a specified area.

PRACTICE GUIDELINES: Related to 'position statement', this term refers to recommendations regarding professional practice in a specified area. The function of practice guidelines in the field of psychology is to provide psychology professionals with applied tools to develop and maintain competencies and learn about new practice areas.

PSYCHOLOGY PROFESSIONAL: Inclusive of Health Professions Council of South Africa-(HPCSA-) registered psychologists, regardless of

registration category (Clinical, Counselling, Educational, Industrial, Research), registered counsellors and psychometrists, as well as non-registered professionals with a qualification in psychology.

POLYAMORY: A relationship configuration where a person has more than one intimate or sexual partner with the knowledge and consent of all partners involved, and with an emphasis on honesty and transparency within relationships. Polyamory is considered a minority relationship orientation, where monogamy is the dominant orientation. What makes polyamory seem deviant is the openness and honesty of being involved with multiple concurrent relationships, as opposed to cheating (hidden concurrent relationships), which is almost anticipated. It is also described as 'consensual non-monogamy'.

QUEER: An inclusive term that refers not only to lesbian and gay persons, but also to trans and gender non-conforming persons, or anyone else who feels marginalised because of her or his sexual practices, or who resists the heteronormative system regarding sex/gender/sexual identity. Historically, a word meaning 'odd', 'curious' or 'peculiar' and later used as a derogatory term for LGB persons.

REPARATIVE THERAPY: Also known as 'conversion therapy' or 'sexual orientation change efforts' (SOCE), it refers to psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change his or her sexual orientation (see Sexual orientation change efforts).

SEX ASSIGNED AT BIRTH: At birth, a child is usually assigned a sex according to the body parts with which that child is born (Also see Gender assigned at birth).

SEX(UAL) CHARACTERISTICS: A sex organ (also called a reproductive organ, primary sex organ, or primary sexual characteristic) is any anatomical part of the body in a complex organism that is involved in sexual reproduction and constitutes part of the reproductive system. The external and visible organs, in males and females, are the primary sex organs known as the 'genitals' or 'genitalia'. The internal organs are known as the 'secondary sex organs' and are sometimes referred to as the 'internal genitalia'. The characteristics that begin to appear during puberty, such as, in humans, pubic hair on both sexes and facial hair on the male, are known as 'secondary sex characteristics'.

SEXUAL BEHAVIOUR: 'Sexual behaviour' is distinguished from 'sexual orientation' because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour. Individuals may engage in a wide range of behaviours and practices often associated with sexuality. These can include bondage and discipline and sadomasochism (BDSM), which have nothing to do with sexual orientation and/or gender identity. BDSM may also refer to a specific lifestyle or subculture comprising participants who regularly engage in such practices. Although some individuals are likely to participate in BDSM practices in various ways, many psychology professionals may be unfamiliar with the diversity, terminology, possible motivations and matters surrounding their service user/client/participant's lifestyle. BDSM potentially may be enriching and beneficial to many who safely participate (in this regard, the operative terms are 'safe, sane and consensual'), or it sometimes may be considered pathological and destructive (see the DSM V; see also MSM and WSW).

SEXUAL DIVERSITY: The range of different expressions of sexual orientation and sexual behaviour that span across the historically imposed heterosexual–homosexual binary (also see Gender diversity).

SEXUAL ORIENTATION: A person's lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual/same-sex sexual orientation, bisexual or asexual).

SEXUAL ORIENTATION CHANGE EFFORTS (SOCE): Also known as 'reparative therapy' or 'conversion therapy' is psychiatric and other treatment, which is based upon the assumption that same-sex sexuality per se is a mental disorder or based upon the supposition that the client/patient should change her or his sexual orientation (see Reparative therapy).

SOCIAL TRANSITION: The social portion of a transition, in which a transgender person makes others aware of her or his gender identity. Some parts of social transition could include telling

people about your gender identity whether or not they are aware of your assigned gender/sex and/or transgender status (see Transitioning).

STEALTH: For a trans person going stealth is generally the goal of transition. It means to live completely as her or his gender identity and to pass into the public sphere being sure most people are unaware of their transgender status. This does not mean their status is a secret to every single person; family and close friends may know. Some transsexuals and most genderqueer and bigender people purposely do not go stealth because they want the people around them to know they are trans. Some desire to go stealth, but are unable to pass convincingly enough. Historically, going stealth is a very recent phenomenon since, for many people, hormones are necessary to pass.

TRANS: Commonly accepted shorthand for the terms transgender, transsexual, and/or gender non-conforming.

TRANSGENDER: A term for people who have a gender identity, and often a gender expression that is different to the sex they were assigned at birth by default on account of their primary sexual characteristics. It is also used to refer to people who challenge society's view of gender as fixed, unmoving, dichotomous and inextricably linked to one's biological sex. Gender is more accurately viewed as a spectrum, rather than as a polarised, dichotomous construct. This broad term encompasses transsexuals, genderqueers, people who are androgynous, and those who defy what society tells them is appropriate for their gender. Transgender people could be heterosexual, bisexual, same-sex attracted or asexual.

TRANS(GENDER) MAN: A person who was assigned 'female' at birth, but identifies as male. Such a person is also referred to as a 'female-to-male (FtM) trans person'. Note, the term 'FtM' has become somewhat controversial as many in the trans community feel that they were never female to begin with. Instead, 'masculine presenting' is preferred.

TRANS(GENDER) WOMAN: A person who was assigned 'male' at birth, but identifies as female. Such a person is also referred to as a 'male-to-female (MtF) trans person'. Note, the term 'MtF' has become somewhat controversial as many in the trans community feel that they were never male to begin with. Instead, 'feminine presenting' is preferred.

TRANSPHOBIA: Emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards people who do not conform to the gender expectations of society. It is often expressed alongside homophobic views and hence is often considered an aspect of homophobia. Transphobia is a type of prejudice and discrimination similar to racism and sexism, and transgender black, coloured or Indian people are often subjected to all three forms of discrimination at once (see Homophobia).

TRANSITIONING: (Including social and medical transition) refers to the (permanent) adoption of the outward or physical characteristics of the gender with which one identifies, as opposed to those associated with one's gender/sex assigned at birth (see Social transition).

TRANSSEXUAL: A medical term used to describe transgender persons who may or may not opt to undergo gender-affirming treatment to align their body with their self-identified sex and gender identity. Not commonly used anymore and considered offensive by some.

WSW (WOMEN WHO HAVE SEX WITH WOMEN): Used in public health contexts to refer to women who engage in sexual activity with other women, including those who do not identify themselves as lesbian or bisexual, to avoid excluding women who identify as heterosexual. Note, transwomen may also be included in such a description (also see MSM and Sexual behaviour).

REFERENCES

Abrahams, N., Jewkes, R., Hoffman, M., & Laubsher, R. (2004). Sexual violence against intimate partners in Cape Town: Prevalence and risk factors reported by men. *Bulletin of the World Health Organization, 82*(5), 330–337.

Abrahams, N., Jewkes, R., Martin, L. J., Mathews, S., Vetten, L., & Lombard, C. (2009). Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and Victims, 24*(4), 546–556.

African Commission on Human and Peoples' Rights. (2014). *Resolution on protection against violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity.* Retrieved from http://www.achpr.org/sessions/55th/resolutions/275/

Alanko, K., Santtila, P., Harlaar, N., Witting, K., Varjonen, M., Jern, P., ... Sandnabba, N. K. (2008). The association between childhood gender atypical behavior and adult psychiatric symptoms is moderated by parenting style. *Sex Roles, 58*, 837–847.

Ally, R., Madonsela, T., Parsley, J., Thipanyane, T., Yigen, K., & Lambert, P. (1998). *The national action plan for the protection and promotion of human rights*. Retrieved from . http://www.dhnet.org.br/dados/pp/nacionais/pndh_africa_do_sul_1998.pdf

American Counseling Association. (2010). American Counseling Association competencies for counselling with transgender clients. *Journal of LGBT Issues in Counseling, 4,* 135–159.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2009). *Report of the APA task force on appropriate therapeutic responses to sexual orientation.* Washington, DC: Task force on appropriate therapeutic responses to sexual orientation. Retrieved from http://www.apa.org/pi/lgbc/publications/ therapeutic-resp.html .

American Psychological Association. (2011). *Practice guidelines for LGB clients.* Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/pi/lgbt/resources/guidelines.aspx.

American Psychological Association. (2012). Guidelines for psychotherapy practice with lesbian, gay, and bisexual clients. *American Psychologist, 67,* 10–42.

American Psychological Association. (2015). *Guidelines for psychological practice with transgender and gender nonconforming people.* Washington, DC: Author. Retrieved from https://www.apa.org/practice/guidelines/transgender.pdf

Anova Health Institute. (2010). *From top to bottom: A sex-positive approach for men who have sex with men – a manual for healthcare providers*. Johannesburg: Author.

Anova Health Institute. (2016). *Transgender health training for facilitators/trainers.* Johannesburg: Author.

Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling. (2003). *Competencies for counseling gay, lesbian, bisexual, and transgender (LGBT) clients.* Retrieved from http://www.algbtic.org/resources/competencies.html

Australian Psychological Society. (2010). *Guidelines for psychological practice with lesbian, gay and bisexual clients.* Melbourne: Australian Psychological Society.

Bateman, C. (2011). Transgender patients sidelined by attitudes and labelling. *South African Medical Journal, 101*(2), 91–93.

Beckstead, L., & Israel, T. (2007). Affirmative counseling and psychotherapy focused on issues related to sexual orientation conflicts. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 221-244). Washington, DC: American Psychological Association.

Benestad, E. E. P. (2002). Gender belonging: Children, adolescents, adults and the role of the therapist. In D. Denborough (Ed.), *Queer counselling and narrative practice* (pp. 204–225). Adelaide: Dulwich Centre Publications.

Bhana, D. (2012). Understanding and addressing homophobia in schools: A view from teachers. *South African Journal of Education, 32,* 307–318.

Blake, C. (2016). *The value of sexual health education in South Africa: A retrospective evaluation by recent matriculants* (Unpublished master's thesis). University of Witwatersrand, Johannesburg.

Bockting, W. O., Benner, A., & Coleman, E. (2009). Gay and bisexual identity development among female-to-male transsexuals in North America: Emergence of a transgender sexuality. *Archives of Sexual Behaviour, 38*(5), 688–701.

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming-out process. In R. Ettner, S. Monstrey, & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York, NY: Haworth.

Bockting, W. O., Milner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health and the resilience in an online sample of the US transgender population. *American Journal of Public Health, 103*, 943–951.

Bonthuys, E., & Erlank, N. (2012). Modes of (in) tolerance: South African Muslims and same-sex relationships. *Culture, Health and Sexuality, 14*(3/4), 269–283.

Breen, D., Lynch, I., Nel, J. A., & Matthews, I. (2016). Hate crime in transitional societies: The case of South Africa. In J. Schweppe & M. A. Walters (Eds.), *The globalisation of hate: Internationalizing hate crime?* (pp. 126-141). Oxford. Oxford University Press.

Breshears, D., & Le Roux, A. (2013). Outsider discourse surrounding children's experience of familial identity in same-sex-parented families. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 1–20). Johannesburg: Jacana Media.

Breshears, D., & Lubbe-De Beer, C. L. (2016). Same-sex parented families' negotiation of minority social identity in South Africa. *Journal of GLBT Family Studies, 12*(4), 346–364.

British Association for Counselling and Psychotherapy. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people.* Leicestershire: Author.

British Psychological Society. (2012). *Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients.* Retrieved from http://www.bps.org.uk/sites/default/files/images/rep_92.pdf

Broido, E. M. (2000). Constructing identity: The nature and meaning of lesbian, gay, and bisexual lives. In R. Perez, K. DeBord, & K. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian gay, and bisexual clients* (pp. 13–33). Washington, DC: American Psychological Association.

Brown, B., Duby, Z., & Van Dyk. D. (2013). *Health care provision for men who have sex with men, sex workers and people who use drugs: An introductory manual for health care workers in South Africa.* Cape Town: The Desmond Tutu HIV Foundation.

Chambers, S. A. (2007). 'An incalculable effect': Subversions of heteronormativity. *Political Studies, 55*(3), 656–679.

Chappell, P. (2015). Queering the social emergence of disabled sexual identities: Linking queer theory with disability studies in the South African context. *Agenda, 29*(1), 54–62.

Clarke, V., Ellis, S. J., Peel, E., & Riggs, D. W. (2010). *Lesbian, gay, bisexual, trans and queer psychology: An introduction*. Cambridge: Cambridge University Press.

Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., & Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care, 20*(9), 1105–1110.

Coetzee, C. A. (2009). *The development and evaluation of a programme to promote sensitive psychotherapeutic practice with gay men and lesbians* (Unpublished doctoral thesis). Rhodes University, Grahamstown.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7th version). *International Journal of Transgenderism, 13,* 165–232.

DasGupta, S. (2008). The art of medicine: Narrative humility. *The Lancet, 371,* 980–981.

D'Augelli, A. R., & Garnets, L. D. (1995). Lesbian, gay, and bisexual communities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities over the lifespan* (pp. 293–320). New York, NY: Oxford University Press.

Davies, D. (1996). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay and bisexual clients.* (pp. 24–40). Philadelphia, PA: Open University Press.

Deacon, R., Morrell, R., & Prinsloo, J. (1999). Discipline and homophobia in South African schools: The limits of legislated transformation. In D. Epstein & J. Sears (Eds.), *A dangerous knowing: sexuality, pedagogy and popular culture* (pp. 164-180). London: Cassell.

Department of Health. (2006). *Ethical rules of conduct for practitioners registered under the Health Professions Act, 1974.* Retrieved from http://www.hpcsa.co.za/Conduct/Ethics

De Villiers, A., & De Vries, E. (2013). *The adult transgender patient. A guide for general practice: Hormone transition therapy.* Cape Town: SATHRI project.

Diamond, L. M. (2008). Female bisexuality from adolescence to adulthood: Results from a 10-year longitudinal study. *Developmental Psychology, 44*, 5–14.

Diamond, L. M. (2015). Sexual fluidity. In P. Whelehan & A. Bolin (Eds.), *The International Encyclopedia of Human Sexuality.* (pp. 1115–1354). San Francisco, CA: Wiley.

Diesel, A. (Ed.). (2011). *Reclaiming the L-word: Sappho's daughters out in Africa*. Athlone: Modjaji Books.

Dillon, F. R., Worthington, R. L., & Moradi, B. (2011). Sexual identity as a universal process. In S. J. Schwartz & E. Al (Eds.), *Handbook of identity theory and research* (pp. 649–670). New York, NY: Springer.

Doan, P. L. (Ed.). (2011). *Queerying planning: Challenging heteronormative assumptions and reframing planning practice.* Farnham: Ashgate.

Dramé, F. M., Peitzmeier, S., Lopes, M., Ndaw, M., Sow, A., Diouf, D., & Baral, S. (2013). Gay men and other men who have sex with men in West Africa: Evidence from the field. *Culture, Health and Sexuality, 15*, Suppl. 7–21. doi:10.1080/13691058.2012.748935

Edwards-Leeper, L., Leibowitz, S., & Sangganjanavanich, V. F. (2016). Affirmative practice with transgender and gender nonconforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 165–172.

Epprecht, M. (2004). *Hungochani: The history of a dissident sexuality in Southern Africa*. London: McGill-Queens University Press.

Esplen, E., & Jolly, S. (2006). *Gender and sex: A sample of definition*. Retrieved from http://www.iwtc.org/ideas/15_definitions.pdf

Farr, R. H., Diamond, L. M., & Baker, S. M. (2014). Female same-sex sexuality from a dynamical systems perspective: Sexual desire, motivation, and behaviour. *Archives of Sexual Behaviour, 43*(8), 1477–1490.

Fausto-Sterling, A. (2012). *Sex/ Gender: Biology in a social world.* New York, NY: Routledge.

Francis, D., & Msibi, T. (2011). Teaching about heterosexism: Challenging homophobia in South Africa. *Journal of LGBT Youth*, *8*(2), 157–173. doi:10.1080/19361653.2011.553713

Francis, D. A. (2017). "I think we had one or two of those, but they weren't really": Teacher and learner talk on bisexuality in South African schools. *Journal of Bisexuality, 17*(2), 206–224.

Freese, R., Ott, M. Q., Rood, B. A., Reisner, S. L., & Pantalone, D. W. (2017). Distinct coping profiles are associated with mental health differences in transgender and gender nonconforming adults. *Journal of Clinical Psychology.* Advance online publication. doi:10.1002/jclp.22490

Gender DynamiX and Legal Resource Centre. (2014). *Alteration of sex description and sex status act, No. 49 of 2003.* Cape Town: Authors.

Gevisser, M., & Cameron, E. (Eds.). (1995). *Defiant desire: Gay and lesbian lives in South Africa. Abingdon-on-Thames*: Routledge.

Glassgold, J. M. (2009). The case of Felix: An example of gay-affirmative, cognitive-behavioral therapy. *Pragmatic Case Studies in Psychotherapy, 5*(4), 1-21.

Glassgold, J. M., Beckstead, L., Drescher, J., Greene, B., Lin Miller, R., & Worthington, R. L. (2009). *Appropriate therapeutic responses to sexual orientation*. Washington, DC: American Psychological Association Task Force. doi:10.1037/e548572011-001

Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2014). Minority stress and substance use in sexual minority adolescents: A meta-analysis. *Prevention Science, 15*(3), 350–363. doi:10.1007/s11121-013-0393-7

Graziano, K. J. (2004). Oppression and resiliency in a post-apartheid South Africa: Unheard voices of black gay men and lesbians. *Cultural Diversity and Ethnic Minority Psychology, 10*(3), 302–316.

Graziano, K. J. (2005). Reflections from university students in a South African gay and lesbian society. *International Journal for the Advancement of Counselling, 27*(2), 299–310.

Greene, B. (1994). Ethnic minority lesbians and gay men: Mental health and treatment issues. *Journal of Consulting and Clinical Psychology, 62,* 243–251.

Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 181-199). Washington, DC: American Psychological Association.

Haldeman, D. C. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist, 32*, 691–715.

Harper, C. (2007). *Intersex.* Oxford: Berg.

Harrison, N. (2000). Gay affirmative therapy: A critical analysis of the literature. *British Journal of Guidance & Counseling*, *28*, 37–53.

Health Professions Council of South Africa. (2017). *Continued professional development*. Retrieved from http://www.hpcsa.co.za/CPD

Henderson, N. (2012). Narratives of power and abuse in gay relationships in the Cape Metropole. *South African Journal of Psychology, 42*(3), 323–332.

Henderson, N., & Shefer, T. (2008). Practices of power and abuse in gay male relationships. *South African Journal of Psychology*, *38*(1), 1–20.

Hoad, N. (2007). *African intimacies: Race, homosexuality and globalisation.* Minneapolis, MN: University of Minnesota Press.

Hong Kong Psychological Society. (2012). *Position paper for psychologists working with lesbians, gays, and bisexual individuals*. Hong Kong: Author.

Human Rights Watch. (2011). *World report 2011: The events of 2010.* Geneva: Author.

Husakouskaya, N. (2013). Rethinking gender and human rights through transgender and intersex experiences in South Africa. *Agenda: Empowering Women for Gender Equity, 27*(4), 10–24.

International Commission of Jurists. (2007). *Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity*. Retrieved from http://www.refworld.org/docid/48244e602.html

International Federation of Health and Human Rights Organisations. (2012). *Step for change: A human rights action guide for health workers.* Retrieved from https://www.ifhhro.org/images/stories/ifhhro/manuals_and_guidelines/ifhhro_steps_for_change_en.pdf

International Lesbian, Gay, Bisexual, Trans and Intersex Association. (2015). *State sponsored homophobia.* Retrieved from http:/old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2015.pdf

International Planned Parenthood Federation. (2008). *Sexual rights: An IPPF declaration.* Retrieved from http://www.ippf.org/resource/sexual-rights-ippd-declaration

International Union of Psychological Sciences. (2016). *International Declaration on Core Competences in Professional Psychology.* Retrieved from http://www.iupsys.net/dotAsset/1fd6486e-b3d5-4185-97d0-71f512c42c8f.pdf

IPsyNet. (2016). *The International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues*. Retrieved from http://www.apa.org/ipsynet/

Jobson, G. A., Theron, L. B., Kaggwa, J. K., & Kim, H. (2012). Transgender in Africa: Invisible, inaccessible, or ignored? *Journal of Social Aspects of HIV/AIDS, 9*(3), 160–163.

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516–522.

July, E. (2009). *Awareness, attitudes and referral practices of health care providers to psychological services in Botswana* (Unpublished master's dissertation). Nelson Mandela Metropolitan University, Port Elizabeth.

Kemp, T. (2013). Three siblings with complete androgen insensitivity syndrome. *Journal of Endocrinology, Metabolism and Diabetes of South Africa, 18*(3), 159–163.

Khan, G., & Moodley, Y. (2013). Breaking the silence: A discussion on intimate partner violence in gay-male relationships. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 237–258). Auckland Park: Fanele.

Klein, T. (2008). Querying medical and legal discourses of queer sexes and genders in South Africa. *Anthropology Matters Journal, 10*(2), 1–17.

Klein, T. (2009). Intersex and transgender activism in South Africa. *LIMINALIS, 3*, 15–41.

Klein, T. (2013). Necessity is the mother of invention: Access inequalities to medical technologies faced by transgender South Africans. *Technology and Innovation, 15,* 165–179.

Korell, S. C., & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender clients. In K. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 271–288). Washington, DC: American Psychological Association.

Leatt, A., & Hendricks, G. (2005). Beyond identity politics: Homosexuality and gayness in South Africa. In M. van Zyl & M. Steyn (Eds.), *Performing queer: Shaping sexualities* (pp. 303–322). Cape Town: Kwela Books.

Lee, J. (2014). Too cruel for school: LGBT bullying, noncognitive skill development, and the educational rights of students. *Harvard Civil Rights-Civil Liberties Law Review, 49*(1), 261–290.

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

Lev, A. I. (2006). Intersexuality in the family: An unacknowledged trauma. *Journal of Gay & Lesbian Psychotherapy, 10*(2), 27–56.

Lidderdale, M. A., Croteau, J. M., Anderson, M. Z., Tovar-Murray, D., & Davis, J. M. (2003). Building lesbian, gay, and bisexual vocational psychology: A theoretical model of workplace identity management. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (pp. 245-270). Washington, DC: American Psychological Association.

Livermon, X. (2012). Queer(y)ing freedom: Black queer visibilities in postapartheid South Africa. *GLQ: A Journal of Lesbian and Gay Studies, 18,* 2–3.

Lubbe-De Beer, C. (2013). Planned lesbian parenting in South Africa: Reflections on the process of clinically assisted donor insemination. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 159–184). Auckland Park: Fanele.

Lynch, I. (2013). Erased, elided and made invisible? A critical analysis of research on bisexual parenthood and families. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 68–86). Auckland Park: Fanele.

Lynch, I., Brouard, P. W., & Visser, M. J. (2010). Constructions of masculinity among a group of South African men living with HIV/AIDS: Reflections on resistance and change. *Culture Health and Sexuality, 12*(1), 15–27.

Lynch, I., & Maree, D. J. F. (2013). Negotiating heteronormativity: Exploring South African bisexual women's constructions of marriage and family. *Feminism & Psychology, 23*(4), 459–477.

Mandel, S. H. (2014). Targeting sexual stigma: The hybrid case study of "Adam". *Pragmatic Case Studies in Psychotherapy, 10*(2), 48–105.

Marnell, J. (2013). Home affairs: A photographic essay celebrating family diversity. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 89–92). Auckland Park: Fanele.

Matebeni, Z. (Ed.). (2017). *Queering Cape Town: Queer in Africa III.* Heinrich Boell Foundation. Retrieved from https://za.boell.org/sites/default/files/queering_cape_town_web.pdf

Matthews, C. R. (2007). Affirmative lesbian, gay and bisexual counseling with all clients. In R. M. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients* (pp. 201–219). Washington DC: American Psychological Association.

McCoy, M. A., Stinson, M. A., Ross, D. B., & Hjelmstad, L. R. (2015). Who's in our clients' bed? A case illustration of sex therapy with a polyamorous couple. *Journal of Sex & Marital Therapy, 41*(2), 134-144.

McLachlan, C. (2010). *Queering gender: An exploration of the subjective experience of the development of a transgender identity* (Unpublished master's dissertation). University of KwaZulu-Natal, Pietermaritzburg.

McLachlan, C., & Nel, J. (2015, September). *Queering 'trans' children: Is psychology's treatment of gender non-conforming children benevolent?* Paper presented at the 21st annual South African Psychology Congress, Johannesburg.

McNulty, A., Richardson, D., & Monro, S. (2010) *Lesbian, gay, bisexual and trans (LGBT) equalities and local governance research report for practitioners and policy makers*. (Research report). Retrieved from University of Huddersfield Repository: http://eprints.hud.ac.uk/id/eprint/14271/1/selgreportmarch2010.pdf

Meier, S. C., Pardo, S. T., Labuski, C., & Babcock, J. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archive of Sexual Behaviour, 42,* 463–474.

Meyer, A. C. (2003). *Riglyne aan opvoedkundige sielkundiges vir die hantering van die homoseksuele kliënt* (Unpublished master's dissertation). University of South Africa, Pretoria.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674–697.

Milton, M., Coyle, A., & Legg, C. (2002). Lesbian and gay affirmative psychotherapy: Defining the domain. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and gay psychology* (pp. 175–197). Oxford: Blackwell.

Mkhize, N. J. (2003). *Culture and the self in moral and ethical decision-making: A dialogical approach* (Unpublished doctoral dissertation). University of Natal, Pietermaritzburg.

Moodie, T. D. (1987). *Migrancy and male sexuality on South African gold mines.* Retrieved from http://wiredspace.wits.ac.za/bitstream/handle/10539/8008/HWS-289.pdf?sequence=1&origin=publication_detail

Morgan, R., Marais, C., & Wellbeloved, R. J. (2009). *Trans:Transgender life stories from South Africa.* Auckland Park: Fanele.

Msibi, T. (2012). 'I'm used to it now': Experiences of homophobia among queer youth in South African township schools. *Gender and Education, 24*(5), 515–533. doi:10.1080/09540253.2011.645021

Muholi, Z. (2012). *Faces and phases*. Johannesburg: Prestel.

Müller, A. (2012). *Sexual and reproductive health for transgender and gender non-conforming people: Guidelines for healthcare workers in primary care*. Cape Town: Gender DynamiX.

Müller, A. (2013). Teaching lesbian, gay, bisexual and transgender health in South African health sciences faculty: Addressing the gap. *BMC Medical Education, 13,* 174.

Müller, A. (2014). Professionalism is key in providing services to lesbian, gay, bisexual, transgender and intersex South Africans. *South African Medical Journal, 104*(8), 558–559.

Müller, A. (2015). Strategies to include sexual orientation and gender identity in health professions education. *African Journal of Health Professions Education 7*(1), 4–7.

Müller, A., & Crawford-Browne, S. (2013). Challenging medical knowledge at the source: Attempting critical teaching in the health sciences. *Agenda: Empowering Women for Gender Equity*, *27*(4), 25–34.

Murray, S., & Roscoe, W. (Eds.). (1998). *Boy-wives and female husbands: Studies of African homosexualities.* New York, NY: St. Martin's Press.

Naidu, T., & Ramlall, S. (2016). Establishing competence in talk therapy. In T. Naidu & S. Ramlall (Eds.), *Talk therapy toolkit: Theory and practice of counselling and psychotherapy* (pp. 80–101). Pretoria: Van Schaik.

Nel, J. A. (2007). *Towards the 'good society': Healthcare provision for victims of hate crime from periphery to centre stage* (Unpublished doctoral thesis). University of South Africa, Pretoria.

Nel, J. A. (2014). Editorial: South African psychology can and should provide leadership in advancing understanding of sexual and gender diversity on the African continent. *South African Journal of Psychology, 44*(2), 145–148. doi:10.1177/0081246314530834

Nel, J. A., & Breen, D. (2013). Victims of hate crime. In R. Peacock (Ed.), *Victimology in South Africa* (2nd ed., pp. 239–253). Pretoria: Van Schaik.

Nel, J. A., & Judge, M. (2008). Exploring homophobic victimisation in Gauteng, South Africa: Issues, impacts and responses. *Acta Criminologica, 21*(3), 19–36.

Nel, J. A., Mitchell, Y., & Lubbe-De Beer, C. (2010, August). *Advocacy in working with LGBTI health and well-being issues.* Presentation at the Round Table Discussion at the PsySSA Congress, Durban.

Nell, M., & Shapiro, J. (2011). *Out of the box: Queer youth in South Africa today*. The Atlantic Philanthropies. Retrieved from http://www.atlanticphilanthropies.org/news/out-box-queer-youth-south-africa-today

Niels, T. (2001). Same-sex sexuality in Africa: A case study from Senegal. *AIDS and Behavior, 5*(2), 173–182.

Nkoana, T., & Nduna, M. (2012). Engaging primary health care providers in transgender community health care: Observations from the field. *New Voices in Psychology, 8*(2), 120–129.

Nuttbrock, L., Bockting, W., Rosenblum, A., Hwahng, S., Mason, M., Macri, M., & Becker, J. (2014). Gender abuse and major depression among transgender women: A prospective study of vulnerability and resilience. *American Journal of Public Health, 104*(11), 2191–2198.

Oswin, N. (2007). Producing homonormativity in Neoliberal South Africa: Recognition, redistribution, and the equality project. *Signs, 32*(3), 649–669.

Pachankis, J. E., & Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity, 1*(s), 45–58.

Page, E. (2007). Bisexual women's and men's experiences of psychotherapy. In B. A. Firestein (Ed.), *Becoming visible: Counselling bisexuals across the lifespan* (pp. 52–71). New York, NY: Columbia University Press.

Peacock, R. (Ed.). (2013). *Victimology in South Africa* (2nd ed.). Pretoria: Van Schaik.

Pillay, S. R. (2014, September). *The absence of gay Indians in the post-apartheid research agenda.* Paper presented at 20th National Psychology Congress of the Psychological Society of South Africa, Durban International Convention Centre, Durban.

Polders, L. A., Nel, J. A., Kruger, P., & Wells, H. L. (2008). Factors affecting vulnerability to depression among gay men and lesbian women in Gauteng, South Africa. *South African Journal of Psychology, 38*(4), 673–687. doi:10.1177/008124630803800407

Potgieter, C. (1997). From apartheid to Mandela's constitution: Black South African lesbians in South Africa. In B. Greene (Ed.), *Psychological perspectives on lesbian and gay issues: Ethnic and Cultural diversity among lesbians and gay men* (Vol. 3, pp. 88–116). Thousand Oaks, CA: Sage.

Prinsloo, J. (2011). Negotiating transgender identities on the internet a South African study. *Agenda: Empowering Women for Gender Equity, 25*(4), 30–41.

Psychological Association of the Philippines. (2012). Statement of the Psychological Association of the Philippines on non-discrimination based on sexual orientation. *Gender Identity and Expression, 44*(2), 229–230.

Psychological Society of South Africa. (2007). *South African professional guidelines in psychology*. Johannesburg: Author.

Psychological Society of South Africa. (2012). *Psychological Society of South Africa.* Retrieved from http://www.psyssa.com/about-us/what-is-psyssa

Psychological Society of South Africa. (2013). *Sexual and gender diversity position statement.* Johannesburg: Author.

Queer. (2016). *In Wikipedia*. Retrieved from https://en.wikipedia.org/w/index.php?title=Queer&oldid=741155160

Rabie, F., & Lesch, E. (2009). 'I am like a woman': Constructions of sexuality among gay men in a low-income South African community. *Culture, Health & Sexuality, 11*(7), 717–729.

Rankotha, S. (2005). How black men involved in same-sex relationships construct their masculinities. In M. van Zyl & M. Steyn (Eds.), *Performing queer: Shaping sexualities in 1994–2004* (Vol. 1, pp. 165–175). Cape Town: Kwela Books.

Rebello, E., Szabo, C. P., & Pitcher, G. (2008). Gender assignment surgery on children with disorders of sex development: A case report and discussion from South Africa. *Journal of Child Health Care*, *12*(1), 49–59.

Reed, G. M., McLaughlin, C. J., & Newman, R. (2002). American Psychological Association policy in context: The development and evaluation of guidelines for professional practice. *American Psychologist, 57*, 1041–1047. doi:10.1037/0003-066X.57.12.1041

Reid, G. (2013). *How to be a real gay: Gay identities in small-town South Africa.* Scottsville: University of KwaZulu-Natal Press.

Republic of South Africa. (1996). Constitution of the Republic of South Africa (Act 108 of 1996). *Government Gazette*, *38*. Pretoria: Government Printers.

Reygan, F. (2016). Making schools safer in South Africa: An antihomophobic bullying educational resource. *Journal of LGBT Youth, 13*(1/2), 173–191.

Reygan, F., & Lynette, A. (2014). Heteronormativity, homophobia and "culture" arguments in KwaZulu-Natal, South Africa. *Sexualities, 17*(5/6), 707–723.

Rich, E. (2006). *Overall research findings on levels of empowerment among LGBT people in Western Cape, South Africa* (Unpublished report). University of South Africa, Pretoria.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men.* New York, NY: The Guilford Press.

Robertson, V., & Louw, C. (2013). Coming out to families: Adolescent disclosure practices in the Western Cape. In C. Lubbe-De Beer & J. Marnell, J. (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 259-286). Johannesburg: Jacana Media.

Rothblum, E. D. (2012). From invert to intersectionality: Understanding the past and future of sexuality. In R. Das Nair & E. D. Butler (Eds.), *Intersectionality, sexuality and psychological therapies: Working with lesbian, gay and bisexual diversity* (pp. 263–268). West Sussex: Wiley.

Rubin, G. (2011). *Blood under the bridge: Reflections on "thinking sex"* . London: Duke University Press.

Sanchez, J. P., Sanchez, M. P. H., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health, 99*(4), 713–719.

Sandfort, T. G. M., & Dodge, B. (2009). Homosexual and bisexual labels and behaviors among men: The need for clear conceptualizations, accurate operationalizations, and appropriate methodological designs. In V. Reddy, T. G. M. Sandfort, & R. Rispel (Eds.), *Perspectives on same-sex sexuality, gender and HIV/AIDS in South Africa: From social silence to social science* (pp. 51–57). Pretoria: Human Siences Research Council.

Sanger, N. (2013). *Safely queer on the urban peripheries of Cape Town.* Retrieved from http://www.hsrc.ac.za/ Research_Publication-22769.phtml

Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual identity trajectories among sexual-minority youths: Gender comparisons. *Archives of Sexual Behavior, 29,* 607–627. Doi:10.1023/A:1002058505l3

Smith, A. D., Tapsoba, P., Peshu, N., Sanders, E. J., & Jaffe, H. W. (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet, 374*(9687), 416–422. doi:10.1016/S0140-6736(09)61118-1

Soldati-Kahimbaara, K., & Sibeko, B. (2012). Gay Pride 2012. *New Voices in Psychology, 8*(2), 163–168.

Stephens, A. V. (2010). *An exploration of hate crime and homophobia in Pietermaritzburg, KwaZulu-Natal: A research report commissioned by the Gay and Lesbian Network*. Pietermaritzburg: Gay & Lesbian Network.

Stevens, M. (2012). *Transgender access to sexual health services in South Africa: Findings from a key informant survey.* Gender Dynamix. Retrieved from http://www.genderdynamix.org.za/wp-content/uploads/2012/10/Transgender-access-to-sexual-health-services-in-South-Africa.pdf

Steyn, M., & Van Zyl, M. (2009). *The prize and the price: Shaping sexualities in South Africa*. Cape Town: HSRC Press.

Substance Abuse and Mental Health Services Administration. (2015). *Ending conversion therapy: Supporting and affirming LGBTQ youth.* HHS publication no. (SMA) 15-4928. Rockville, MD: SAMHSA.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

Swain, K., & Frizelle, K. (2013). Resistance and re(production): Becoming lesbian parents through assisted reproductive technologies. In C. Lubbe-De Beer & J. Marnell (Eds.), *Home affairs: Rethinking lesbian, gay, bisexual and transgender families in contemporary South Africa* (pp. 185–207). Auckland Park: Fanele.

Swarr, A. L. (2009). "Stabane", intersexuality, and same-sex relationships in South Africa. *Feminist Studies, 35*(3), 524–548.

Tervalon, M., & Murray-Garcia, J. M. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Undeserved, 9*(2), 117–125.

The Academy of Science of South Africa. (2015). *Diversity in human sexuality: Implications for policy in Africa*. Retrieved from http://dx.doi.org/10.17159/assaf/0022

Theron, L. (2009). Trans-hate at the core of gender based violence? *Concerned Africa Scholars, 83,* 36–38.

Tucker, A. (2009). Framing exclusion in Cape Town's gay village: The discursive and material perpetration of inequitable queer subjects. *Area, 41*(2), 186–197.

UN Office of the High Commissioner for Human Rights. (2012, September). *Born free and equal: Sexual orientation and gender identity in international human rights law.* HR/PUB/12/06. Retrieved from http://www.refworld.org/docid/5065a43f2.html

Victor, C. J. (2013). *Lesbian, gay and bisexual clients' experience of psychotherapy and counselling: The search for LGBTI-affirmative practice* (Unpublished master's dissertation). University of South Africa, Pretoria.

Victor, C. J., & Nel, J. A. (2016). Lesbian, gay, and bisexual clients' experience with counselling and psychotherapy in South Africa: Implications for affirmative practice. *South African Journal of Psychology, 46*(3), 351–363.

Victor, C. J., & Nel, J. A. (2017). Developing an affirmative position statement on sexual and gender diversity for psychology professionals in South Africa. *Psychology in Russia: State of the Art, 10*(2), 87–102.

Victor, C. J., Nel, J. A., Lynch, I., & Mbatha, K. (2014). The Psychological Society of South Africa sexual and gender diversity position statement: Contributing towards a just society. *South African Journal of Psychology, 44*(3), 292–302. doi:10.1177/0081246314533635

Vipond, E. (2015). Resisting transnormativity: Challenging the medicalization and regulation of trans bodies. *Theory in Action, 8*(2), 21–44.

Vu, L., Tun, W., Sheehy, M., & Nel, D. (2011). Levels and correlates of internalized homophobia among men who have sex with men in Pretoria, South Africa. *AIDS Behaviour, 16,* 717–723.

Walker, B., & Mars, M. (2013). *LGBTI Cultural Competency Framework: Including LGBTI people in mental health and suicide prevention organisations.* Newtown: National LGBTI Health Alliance.

Warner, M. (1999). *The trouble with normal: Sex, ethics and the politics of queer life*. Cambridge, MA: Harvard University Press.

Watson, P., & Vally, S. (2011). *Sexual orientation and gender identity rights in education.* Johannesburg: Education Rights Project/ GALA.

Wells, H. (2005). *Overall research findings on levels of empowerment among LGBT people in KwaZulu-Natal.* Pretoria: OUT LGBT Well-being.

Wells, H., & Polders, L. (2003). *Gay and lesbian people's experience of the healthcare sector in Gauteng.* Retrieved from file:///C:/Users/psych/Downloads/healthcare_in_gauteng_research_findings%20(1).pdf

Wiersma, R. (2004). True hermaphroditism in southern Africa: The clinical picture. *Paediatric Surgery International, 20*(5), 363–368.

Wiersma, R. (2011). The clinical spectrum and treatment of ovotesticular disorder of sexual development. In M. I. New & J. L. Simpson (Eds.), *Hormonal and genetic basis of sexual differentiation disorders and hot topics in endocrinology* (pp. 101–103). New York, NY: Springer.

Wilchins, R. (2014). *Queer theory, gender theory: An instant primer*. Los Angeles, CA: Riverdale.

Wilson, D., Marais, A., De Villiers, A., Addinall, R., & Campbell, M. M. (2014). Transgender issues in South Africa, with particular reference to the Groote Schuur Hospital Transgender Unit. *South African Medical Journal, 104*(6), 449–451.

Wolf, E. C. M., & Dew, B. J. (2012). Understanding risk factors contributing to substance use among MTF transgender persons. *Journal of LGBT Issues in Counselling, 6,* 237–256.

World Association for Sexual Health. (2014). *Declaration of sexual rights*. Retrieved from http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf

World Health Organization. (2015). *Policy brief: Transgender people and HIV.* Geneva: Author.

World Professional Association for Transgender Health. (2011). *Standards of care for the health of transsexual, transgender and gender non-conforming people.* Retrieved from http://www.wpath.org/documents/SOC%20V7%2003-17-12.pdf

World Psychiatric Association. (2016). *Working group on sex, sexual and gender diversity: Medical education in psychiatry* (Unpublished manuscript).

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30*(4), 498–531. dol:10.1177/00100002030004002

Yen, J. (2007). A history of 'community' and community psychology in South Africa. In N. Duncan, B. Bowman, A. Naidoo, J. Pillay, & V. Roos (Eds.), *Community psychology: Analysis, context and action* (pp. 67–83). Cape Town: UCT Press.

APPENDIX I:

Collaborating Organisations

As indicated in the introductory section, the project that informs this guidelines document is a collaboration between PsySSA's Sexuality and Gender Division, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and the PsySSA African LGBTI Human Rights Project.

Psychological Society of South Africa (PsySSA)

PsySSA is a non-profit association of psychology practitioners and persons involved in the academic research and practical application of the discipline of psychology. Established in 1994, it is the nationally representative professional body for psychology in South Africa. PsySSA is committed to the transformation and development of South African psychology to serve the needs and interests of all South Africa's people. PsySSA advances psychology as a science, a profession and a means of promoting human well-being (see www.psyssa.com).

PsySSA's Sexuality and Gender Division

As a division of the Psychological Society of South Africa (PsySSA), the mission of the Sexuality and Gender Division (SGD) is to promote a psychological understanding of the fields of sexuality and gender. The goal is to support PsySSA in its endeavour to ensure human well-being and social justice for all people. This is realised through SGD member participation in research, clinical practice, education and training, connectivity within and across disciplines, and advocacy that promotes understanding and inclusivity of all sexual and gender identities and expressions, and biological sex variances (see http://www.psyssa.com/divisions/sexuality-and-gender-division-sgd/).

International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet)

PsySSA is a member of the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world working together to increase understanding of sexual orientation and gender-diverse people and to promote their human rights and well-being (see www.ipsynet.org).

PsySSA African LGBTI Human Rights Project

A significant innovation for PsySSA as a professional voluntary association has been the international and local donor-funded PsySSA African LGBTI Human Rights Project within the SGD. The overall goal of this project is to build PsySSA capacity in South Africa, and sub-Saharan Africa more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics.

APPENDIX II:

IPsyNet Policy Statement And Commitment On LGBTI Issues

1. We acknowledge, as subscribers to the principle that human rights are universal, and that all human beings are worthy of dignity and respect, including respect for diversity on the basis of sexual orientation, gender identity and gender expression, or differences in sex development. We believe that discrimination and psychological maltreatment are not consistent with international human rights aspirations (Universal Declaration of Ethical Principles for Psychologists, 2008). We actively support the development of and support for LGBTIQ+ affirmative and inclusive treatment as well as service provision.

2. We concur that psychology as a science and a profession has expertise based upon decades of research demonstrating that LGBTIQ+ identities and expressions are normal and healthy variations of human functioning and relationships. For example, as set out in the World Health Organization's ICD-10 (p. 11) homosexuality is not a diagnosable mental disorder. We actively challenge claims made by political, scientific, religious or other groups that claim or profess that LGBTIQ+ identities, expressions, and sex characteristics are abnormal or unhealthy.

3. As LGBTIQ+ identities and orientations are normative variations of human experience and are not diagnosable mental disorders, they do not require therapeutic interventions to change them.

   We support affirmative approaches to therapy for LGBTQ+ people and reject sexual orientation and gender identity change efforts that stigmatise same-sex orientations and transgender identities, because they encourage prejudice and discrimination and have the potential for harm.

4. Transgender and gender nonconforming individuals have the right to live according to their gender identity and to access medical, psychotherapeutic, and social support as needed. This support should be offered irrespective of whether the person has a binary or nonbinary gender identity and whether they seek access to social or medical transition or one, several, or all treatments available. We furthermore support the full autonomy of transgender and gender nonconforming individuals in affirming their gender identities. Affirmative psychological support may be beneficial in their identity development and decision-making regarding social and medical transition (Coleman et al., 2012). We strongly oppose regulations forcing transgender and gender nonconforming individuals to undergo sterilization, divorce, or other procedures that might have stigmatizing or mentally, physically, or socially harmful effects in order to access desired transition supports. We affirm that transgender and gender nonconforming individuals have the right to define their identities as well as to decide on and access affirmative and transition-related health care as desired (Yogyakarta Principles, International Panel of Experts, 2007).

5. Some LGBTIQ+ people may experience psychological distress because of the impact of social stigma and prejudice against LGBTIQ+ people in general or their individual identity within the LGBTIQ+ spectrum. LGBTIQ+ individuals with non-monosexual (e.g., bisexual, pansexual) and non-cis identities (e.g., trans, nonbinary, agender), as well as LGBTIQ+ individuals with inter'sectional minority identities (e.g., based on race, ethnicity, disability, religion, gender, social class) may be especially at risk for minority stress, discrimination, both within and outside the LGBTIQ+ population, and resultant

psychological difficulties. We condemn discrimination on the basis of intersecting minority identities within and beyond the LGBTIQ+ population. We furthermore actively support psychological research and practice that fully considers the intersectionality of LGBTIQ+ identities with others' identities such as ethnicity, social class, and religion.

6. Efforts to re-pathologise LGBTIQ+ orientations, identities or people by linking them to poor mental health misconstrue the effects of stigmatization and environmental hostility as inherent to LGBTIQ+ sexual orientations, gender identities and expressions, or biological variance. We advocate for the removal of the stigma of psychopathology from LGBTIQ+ identities and expressions, and oppose the misuse of research on health inequalities faced by LGBTIQ+ people that seek to misinform the public and attempt to re-pathologise LGBTIQ+ people.

7. Psychologists' lack of information and misinformation about LGBTIQ+ people and identities can perpetuate discrimination, stereotyping, and the potential for physical and mental health abuse. We advocate that LGBTIQ+ people are included as experts and active, equal partners in research and policy development for research and policy initiatives that concern them. We support the development of psychological research and education that is not hetero- or cis-normative (e.g., Clarke et al., 2010). Moreover, we provide psychological knowledge to psychological networks, organizations, policymakers, the media and the public. Finally, based on scientifically-grounded knowledge we advocate for greater awareness of the health and well-being needs of LGBTIQ+ people in order to improve public policy and LGBTIQ+ communities.

APPENDIX III:

PsySSA Sexuality and Gender Division

OUR MISSION

As a division of the Psychological Society of South Africa (PsySSA), the mission of the Sexuality and Gender Division (SGD) is to promote a psychological understanding of the fields of sexuality and gender. The goal is to support PsySSA in its endeavour to ensure human well-being and social justice for all people. This is realised through SGD member participation in research, clinical practice, education and training, connectivity within and across disciplines, and advocacy that promotes understanding and inclusivity of all sexual and gender identities and expressions, and biological sex variances.

The SGD focuses its efforts within the unique South African context, but also cultivates continental and international networks for mutual interest in the fields of sexuality and gender in Psychology. Within the area of sexuality and gender, we are committed to cooperative relationships across disciplines - within PsySSA, the International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet) and other professional organisations, including relevant civil society organisations; research, training and education institutions; applied entities and individuals, and the general public - in achieving our objectives.

OUR MEMBERS

Our membership consists of a diverse group of psychology professionals including clinicians, researchers, teachers, community practitioners, health workers and students from a variety of disciplines across South Africa and the rest of the continent. To all mental health professionals who are interested in the social and mental well-being of all South Africans

"A division in a voluntary professional association is the sum of its active members, no more, no less. A division only shines through in its potential to provide a sense of belonging. This sense is made possible by the professional and collegial mutual efforts of the individuals, groups and organisations involved in the division – only the strength of the engaged 'we' can realise this potential to the benefit of all stakeholders."

Niel Victor, 2016

To join, or find out more:

www.psyssa.com/divisions/sexuality-and-gender-division-sgd/

The website contains useful additional information and resources, as well as the contact details for the current SGD Executive. Visit regularly for updates.

www.facebook.com/**sgdpsyssa** **@SGDPsySSA**

Contact the PsySSA office:

+27 11 486 3322 / info@psyssa.com

IPsyNet **www.ipsynet.org**

SEXUALITY AND GENDER DIVISION

OUR WORK

The SGD is active in a range of activities across diverse contexts towards the achievement of our goals:

Research

Our members are continuously involved in empirical and theoretical work on sexual orientation, gender identity and biological sex, as well as work on gender-based violence, intersectionality and social justice, and sexual and reproductive health. Much of this is reflected in the strong sexuality and gender focused stream at PsySSA congresses as well as academic and general publications.

Education

We provide training and workshops for students, clinicians, health workers and academics, informed by the PsySSA Sexual and Gender Diversity Position Statement (2013), amongst others, on the provision of sexual and gender-affirming and inclusive practices. This includes both general training offered as well as customised programmes based on specific requests and needs.

Advocacy and Expert Opinion

We engage in advocacy efforts and policy development on issues concerning sexual and gender rights, both in South Africa and elsewhere. Through our network, we are also able to provide expert opinions related to this field of interest.

Practice

We are committed to the development and dissemination of sexual and gender-affirmative practice across the spectrum of mental health providers in South Africa. This includes PsySSA's first position statement, namely on sexual and gender diversity, that was approved in 2013.

IPsyNet

PsySSA is a member of the **International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet)**, and two SGD executive members serve on the network. IPsyNet consists of psychological organisations around the world working together to increase understanding of sexual orientation and gender-diverse people and promote their human rights and well-being.

Sexual diversity: The range of different expressions of sexual orientation and sexual behaviour that spans across the historically imposed heterosexual-homosexual binary.

(PsySSA Sexual and Gender Diversity Position Statement, 2013)*

PsySSA African LGBTI Human Rights Project

A significant innovation for PsySSA as a professional voluntary association, has been the international and local donor funded 'PsySSA African LGBTI Human Rights Project' within the SGD. The overall goal of this project is to build PsySSA capacity in South Africa, and Sub-Saharan Africa more broadly, to engage with issues related to sexual orientation, gender identity, gender expression, and sex characteristics. A fantastic opportunity for researchers, practitioners and activists to get involved in this area of work!

* Psychological Society of South Africa (PsySSA). (2013). Sexual and gender diversity position statement. Retrieved from http://www.psyssa.com/wp-content/uploads/2015/12/PsySSA_position_statement_sexual_gender-1.pdf

SOME OF OUR MILESTONES

2007	PsySSA joins IPsyNET (International Psychology Network for LGBTI Issues)
2009	First focused LGBTI programming at a PsySSA Congress, which has grown to be a premier annual event bringing together the best scholarly and applied work around sexuality and gender in Psychology in South Africa
2010	Statement to the Ugandan government offering a science-based assessment of the proposed "Anti-Homosexuality Bill of 2009" and calling upon them to abandon or defeat it
2010	Open statement to the United Nations (UN) following and condemning the South African vote to remove a reference to sexual orientation from the UN resolution condemning extrajudicial, summary and arbitrary executions and other killings
2011	Recipient of substantial international funding to support the activities of the Division – the first PsySSA Division/ Interest Group to do so
2013	Development and adoption of the PsySSA Sexual and Gender Diversity Position Statement– a first for the Society, which promotes an affirmative stance in working with sexually and gender diverse South Africans in the mental health context
2014	Official launch of the Division at the 20th PsySSA Congress
2014	Receive an award at the PsySSA AGM for Most Improved Division
2015	SGD Executive Member Prof Juan Nel contributes to the publication of Diversity in Human Sexuality: Implications for Policy in Africa, by the Academy of Science of South Africa (ASSAf)
2016	Endorsement by PsySSA Presidency of IPsyNet Statement and Commitment to LGBTIQ+ Affirmative Psychological & Psychotherapeutic Practice and Research

APPENDIX IV:

Example Of General Practitioner Consent Form

Informed Consent Form:[5]

Feminising Hormone Therapy

Hormone therapy changes your body so that it becomes more like that of a woman.

It can take many months before the changes become obvious and some changes can take years before being complete. Patients respond in different ways to hormones, and changes do not happen at the same time or in the same way for everyone. Patients do not all take the same hormones or at the same dose.

Taking more hormones than prescribed will not make your body change faster and may even slow down or stop these changes.

The changes:

Breasts:

If you are taking oestrogen, you will probably develop breasts. It may take a couple or more years to develop to their full size. The changes may be permanent even after stopping therapy.

Skin and hair:

Your skin may become softer. Facial hair may grow more slowly but will not disappear.

If you have already started to develop baldness on your head, the hair will probably not grow back naturally.

Body shape:

Your muscles will become smaller and lose some strength.

Body fat will gather in new parts of the body, which should give the body a female shape.

Genitals, sexual function and fertility:

You may become permanently infertile.

In the meantime, however, you might still be able to make someone pregnant and should consider using condoms or other methods if necessary.

If you wish to have children, you should discuss fertility options with your doctor before you start taking hormones.

The testicles will become smaller and make less testosterone.

There may be a lower sex drive and fewer – and weaker – erections.

Voice:

Your natural voice will not change and the Adam's apple will not get smaller.

Mood:

Your mood may change and you may feel more emotional.

Risks and side effects:

The risks of taking feminising therapy for many years are not yet fully known. The more common or serious known side-effects of therapy are mentioned here:

Liver inflammation or liver damage

- Thrombosis or blood clots:
  Oestrogen increases the risk of blood clots, which could result in a stroke, heart attack and sometimes death. Oestrogen may increase the risk of diabetes, high blood pressure and heart disease.

5 Based on the Callen Lorde consent form, adapted by Dr Arnaud de Villiers as part of the Gender DynamiX (2013) hormone guidelines (see https://genderdynamix.org.za).

Tumours:

- Oestrogen may increase the risk of tumours of the pituitary, a gland in the brain. It is not common, is not cancerous and can be treated. It could affect eyesight and cause severe headaches.
- Hormones may put you at higher risk of breast cancer.

Other effects:

- Spironolactone may cause low blood pressure and changes to the heart rhythm, which could be life-threatening.
- Feminising medication could interact with some other drugs. Always check with your doctor or pharmacist.

Extra risk:

- There is a greater risk of the dangerous side effects from oestrogen if you smoke, are overweight, over 40 years old, or have a history of blood clots, high blood pressure, or a family history of breast cancer.
- You are strongly advised to stop smoking completely before starting oestrogen.
- Too much alcohol puts an extra strain on your liver.
- To help reduce or identify any possible complications of therapy, you should have regular check-ups as part of your treatment plan. Breasts and prostates should be checked regularly according to the cancer-prevention programme.
- You should not change or stop your hormone treatment without consulting your doctor.

Patient's declaration:

I confirm that I have read and understand the information above.

I confirm that my doctor has told me about the effects of feminising hormone treatment, including the more common or serious risks and side-effects as mentioned above. I understand that some of these effects may be permanent. I understand that, as part of my treatment plan, I shall take my medication as prescribed and have check-ups, including blood tests, as required.

I hereby agree that my doctor start/continue treating me with feminising hormone therapy.

Patient Signature	Date	Place

Prescribing clinician Signature	Date	Place

For official use:

This form is for use within an informed consent healthcare model. It is not intended to substitute any aspect of clinical interaction between the clinician and the patient including, but not limited to, health education, behaviour modification and counselling.

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(From left to right): Delene van Dyk, Chris McLachlan, Liesl Theron, Cornelius Victor, Suntosh Pillay, Juan Nel

Core team members:

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Assisted by Mr Suntosh Pillay, Revd Chris McLachlan, Ms Delene van Dyk and Ms Liesl Theron

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Mr Pierre Brouard, Dr Peace Kiguwa, Prof. Melanie Judge, Ms Ella Kotze, Mr Jonathan Bosworth, Ms Angeline Stephens, Ms Lusajo Kajula (Tanzania), Dr Elma de Vries, Ms Casey Blake, Ms Letitia Rambally Greener, Mr Joachim Ntetmen (Cameroon), Ms Carol Musikanth, Dr Yaseen Alley and Mr Graeme Hendricks

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6 Unless indicated, otherwise, all members of the team are from South Africa

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

The World Professional Association for Transgender Health

Version 7

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

for the Health of Transsexual, Transgender, and Gender-Nonconforming People

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7th Version[1] | www.wpath.org

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1 This is the seventh version of the *Standards of Care* since the original 1979 document. Previous revisions were in 1980, 1981, 1990, 1998, and 2001. Version seven was published in the International Journal of Transgenderism, 13(4), 165–232. doi:10.1080/15532739.2011.700873

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Purpose and Use of the *Standards of Care*

The World Professional Association for Transgender Health (WPATH)[I] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health. The vision of WPATH is a world wherein transsexual, transgender, and gender-nonconforming people benefit from access to evidence-based health care, social services, justice, and equality.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[II] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

I Formerly the Harry Benjamin International Gender Dysphoria Association

II The *Standards of Care (SOC), Version 7,* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender-nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The *Standards of Care* Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria—broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As in all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm-reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Global Applicability of the *Standards of Care*

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender-nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender-nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender-nonconforming people in these settings are forced to be hidden and, therefore, may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world—even in areas with limited resources and training opportunities—can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender-nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culture- and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

The Difference Between Gender Nonconformity and Gender Dysphoria

Being Transsexual, Transgender, or Gender-Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender-nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming.

Gender Nonconformity Is Not the Same as Gender Dysphoria

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender-nonconforming people may experience gender dysphoria at some points in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender-nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

IV
Epidemiologic Considerations

Formal epidemiologic studies on the incidence[III] and prevalence[IV] of transsexualism specifically or transgender and gender-nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender-nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria—distinct from one's gender identity—is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender-nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender-nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974),

III **incidence**—the number of new cases arising in a given period (e.g., a year)
IV **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1965 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (e.g., Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

V

Overview of Therapeutic Approaches for Gender Dysphoria

Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1–1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate

gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender-nonconforming individuals has come of age—many of whom have benefitted from different therapeutic approaches—they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender-nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves to be either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experiences that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that are comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological- and medical-treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- In-person and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- In-person and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

VI

Assessment and Treatment of Children and Adolescents With Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particularly in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

Differences Between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[V] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6–23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12–27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty-suppressing hormones, all continued with actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria—in children, adolescents, and adults—are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

V Gender-nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender-nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have coexisting internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autism spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

Phenomenology in Adolescents

In most children, gender dysphoria will disappear before, or early in, puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender-nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment—starting with GnRH analogues to suppress puberty in the first Tanner stages—differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., 2012). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have coexisting internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any coexisting mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender-nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multidisciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any coexisting mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance, and alleviation of secrecy, can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment—covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement—should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

   Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

3. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

4. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

5. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives might respond.

6. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

7. Mental health professionals should strive to maintain a therapeutic relationship with gender-nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender-role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

Fully Reversible Interventions

Adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach have only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty-suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for Puberty-Suppressing Hormones

In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

Regimens, Monitoring, and Risks for Puberty Suppression

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients.

During pubertal suppression, an adolescent's physical development should be carefully monitored—preferably by a pediatric endocrinologist—so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone mineral density) (Hembree et al., 2009).

Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analogue use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest-treated patients reach the appropriate age.

Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).

Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

VII
Mental Health

Transsexual, transgender, and gender-nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender-nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming-out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); psychotherapy unrelated to gender concerns; or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

Tasks Related to Assessment and Referral

1. Assess Gender Dysphoria

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in-person or online contact with other transsexual, transgender, or gender-nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to, or better accounted for, by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

2. Provide Information Regarding Options for Gender Identity and Expression and Possible Medical Interventions

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender-nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

3. Assess, Diagnose, and Discuss Treatment Options for Coexisting Mental Health Concerns

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat coexisting mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of coexisting mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to, or concurrent with, treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these coexisting mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

4. If Applicable, Assess Eligibility, Prepare, and Refer for Hormone Therapy

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (e.g., client has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost a client's decisions—as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant coexisting mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional should provide documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the patient's chart.

5. If Applicable, Assess Eligibility, Prepare, and Refer for Surgery

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are

considering surgery to be both psychologically prepared (e.g., has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming-out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions—as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated by a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation—in the chart and/or referral letter—of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and Other Health Professionals

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

Tasks Related to Psychotherapy

1. Psychotherapy Is Not an Absolute Requirement for Hormone Therapy and Surgery

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy—although highly recommended—is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all phases of exploration of gender identity, gender expression, and possible transition—not just prior to any possible medical interventions. Third, clients and their psychotherapists differ in their abilities to attain similar goals in a specified time period.

2. Goals of Psychotherapy for Adults with Gender Concerns

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender-nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

3. Psychotherapy for Transsexual, Transgender, and Gender-Nonconforming Clients, Including Counseling and Support for Changes in Gender Role

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender-nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming-out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill-prepared to accommodate and respect transgender, transsexual, and gender-nonconforming people. Psychotherapy can also aid in alleviating any coexisting mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender-nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging—often more so than the physical aspects. Because changing gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender-nonconforming people will present for care without ever having been related to, or accepted in, the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fears about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender-nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

4. Family Therapy or Support for Family Members

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for, not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy-related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise

for working with family members or to sources of peer support (e.g., in-person or offline support networks of partners or families).

5. Follow-Up Care Throughout Life

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

6. E-Therapy, Online Counseling, or Distance Counseling

Online or e-therapy has been shown to be particularly useful for people who have difficulty accessing competent in-person psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, e-therapy may be a useful modality for psychotherapy with transsexual, transgender, and gender-nonconforming people. E-therapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less well-defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of e-therapy is available, caution in its use is advised.

Mental health professionals engaging in e-therapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to e-therapy has been published (Fraser, 2009b).

Other Tasks of Mental Health Professionals

1. Educate and Advocate on Behalf of Clients Within Their Community (Schools, Workplaces, Other Organizations) and Assist Clients with Making Changes in Identity Documents

Transsexual, transgender, and gender-nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006; Currah & Minter, 2000). This role may involve consultation

with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.

2. Provide Information and Referral for Peer Support

For some transsexual, transgender, and gender-nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

Culture and Its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender-nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long-term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with, or inexperienced in, working with transsexual, transgender, and gender-nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.

Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender-nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatments to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm-reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

VIII
Hormone Therapy

Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy—the administration of exogenous endocrine agents to induce feminizing or masculinizing changes—is a medically necessary intervention for many transsexual, transgender, and gender-nonconforming individuals with gender dysphoria

(Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009). Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

Criteria for Hormone Therapy

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* outlined in section VI);
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of coexisting mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to, or concurrent with, treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients

who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing nonhormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.

Informed Consent

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

Relationship Between the *Standards of Care* and Informed Consent Model Protocols

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender

dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of coexisting mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7,* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased erectile function, decreased testicular size, and increased percentage of body fat compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Skin oiliness/acne	1–6 months	1–2 years
Facial/body hair growth	3–6 months	3–5 years
Scalp hair loss	>12 months[C]	Variable
Increased muscle mass/strength	6–12 months	2–5 years[D]
Body fat redistribution	3–6 months	2–5 years
Cessation of menses	2–6 months	n/a
Clitoral enlargement	3–6 months	1–2 years
Vaginal atrophy	3–6 months	1–2 years
Deepened voice	3–12 months	1–2 years

A Adapted with permission from Hembree et al.(2009). Copyright 2009, The Endocrine Society.
B Estimates represent published and unpublished clinical observations.
C Highly dependent on age and inheritance; may be minimal.
D Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected onset[B]	Expected maximum effect[B]
Body fat redistribution	3–6 months	2–5 years
Decreased muscle mass/ strength	3–6 months	1–2 years[C]
Softening of skin/decreased oiliness	3–6 months	Unknown
Decreased libido	1–3 months	1–2 years
Decreased spontaneous erections	1–3 months	3–6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 months	2–3 years
Decreased testicular volume	3–6 months	2–3 years
Decreased sperm production	Variable	Variable
Thinning and slowed growth of body and facial hair	6–12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1–3 months	1–2 years

[A] Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy—with the possible exception of voice deepening in FtM persons—can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, comorbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender-nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).

TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

Risk Level	Feminizing hormones	Masculinizing hormones
Likely increased risk	**Venous thromboembolic disease**[A] Gallstones Elevated liver enzymes Weight gain **Hypertriglyceridemia**	**Polycythemia** Weight gain Acne Androgenic alopecia (balding) Sleep apnea
Likely increased risk with presence of additional risk factors[B]	Cardiovascular disease	
Possible increased risk	**Hypertension** Hyperprolactinemia or prolactinoma	Elevated liver enzymes **Hyperlipidemia**
Possible increased risk with presence of additional risk factors[B]	**Type 2 diabetes**[A]	**Destabilization of certain psychiatric disorders**[C] **Cardiovascular disease** **Hypertension** **Type 2 diabetes**
No increased risk or inconclusive	**Breast cancer**	Loss of bone density **Breast cancer** **Cervical cancer** **Ovarian cancer** **Uterine cancer**

* **Note:** Risk is greater with oral estrogen administration than with transdermal estrogen administration.

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.

[B] Additional risk factors include age.

[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners, physician assistants, and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of comorbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender-nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.

1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the Internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1–6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

2. Hormone Therapy Following Gonad Removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and comorbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

3. Hormone Maintenance Prior to Gonad Removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

4. Initiating Hormonal Feminization/Masculinization

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender-nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

Preventive Care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

Risk Assessment and Modification for Feminizing Hormone Therapy (MtF)

There are no absolute contraindications to feminizing therapy per se, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Risk Assessment and Modification for Masculinizing Hormone Therapy (FtM)

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Comorbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease. (Dhejne et al., 2011).

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender-nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (*Physicians' Desk Reference,* 2010), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

Clinical Monitoring During Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with comorbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

Efficacy and Risk Monitoring During Feminizing Hormone Therapy (MtF)

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual comorbidities and risk factors, and the specific hormone regimen itself. Specific lab-monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Efficacy and Risk Monitoring During Masculinizing Hormone Therapy (FtM)

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of blood pressure, weight, and pulse; and heart, lung, and skin exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual comorbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

Regimens for Feminizing Hormone Therapy (MtF)

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular doses resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen-reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen-reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin-releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

Regimens for Masculinizing Hormone Therapy (FtM)

Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecanoate, available outside the United States, results in lower serum testosterone levels than nonoral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2–4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecanoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

Bioidentical and Compounded Hormones

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

IX
Reproductive Health

Many transgender, transsexual, and gender-nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals—including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons—should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing

the production of mature gametes (Payer, Meyer, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignancies that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm-preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to release eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender-nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross-gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender-nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender-Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender-nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender-nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender-nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication—style, voice, choice of language, etc.—is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender-role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice-and-communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and nonverbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice-and-communication treatment can be considered in

developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations After Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender-nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn nonpitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage & Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved

without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and patients share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, is/are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on his/her/their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly

via the Internet) and be given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

For the Male-to-Female (MtF) Patient, Surgical Procedures May Include the Following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Nongenital, nonbreast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

For the Female-to-Male (FtM) Patient, Surgical Procedures May Include the Following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Nongenital, nonbreast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary—with unquestionable therapeutic results—and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

Criteria for Breast/Chest Surgery (One Referral)

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for Genital Surgery (Two Referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

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

1. Persistent, well-documented gender dysphoria;

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

3. Age of majority in a given country;

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

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

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

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

1. Persistent, well-documented gender dysphoria;

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

3. Age of majority in a given country;

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

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

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

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries—i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging—

often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

Surgery for People with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. (Dhejne et al., 2011). Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national

and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called “chest reconstruction”) is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or “male chest contouring” procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid

transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour

modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

XII

Postoperative Care and Follow-Up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

XIII

Lifelong Preventive and Primary Care

Transsexual, transgender, and gender-nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender-nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender-nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender-nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be

both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

XIV

Applicability of the *Standards of Care* to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender-nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have coexisting mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations *(Kosilek v. Massachusetts Department of Corrections/Maloney,* C.A. No. 92–12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender-nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender-nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.

XV

Applicability of the *Standards of Care* to People With Disorders of Sex Development

Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES/ESPE Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to DSD during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term DSD in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains

open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Rationale for Addition to the *SOC*

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization—which explicitly differentiates between gender dysphoric individuals with and without a DSD—is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals—during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered—the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.

Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam—both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg, Dolezal, et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, 2011). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010).

However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, 2011). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, 2011).

Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

References

Abramowitz, S. I. (1986). Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology, 54*(2), 183–189. doi:10.1037/0022–006X.54.2.183

ACOG Committee of Gynecologic Practice. (2005). Committee opinion #322: Compounded bioidentical hormones. *Obstetrics & Gynecology, 106*(5), 139–140.

Adler, R. K., Hirsch, S., & Mordaunt, M. (2006). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Pub.

American Academy of Family Physicians. (2005). *Definition of family medicine*. Retrieved from http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

American Medical Association. (2008). *Resolution 122 (A-08)*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (4th ed., text rev.). Washington, DC: Author.

American Speech-Language-Hearing Association. (2011). *Scope of practice*. Retrieved from www.asha.org

Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the council of representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the board of directors. *American Psychologist, 64*, 372–453. doi:10.1037/a0015932

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*(4), 635–642. doi:10.1530/EJE-10–1038

Baba, T., Endo, T., Honnma, H., Kitajima, Y., Hayashi, T., Ikeda, H., . . . Saito, T. (2007). Association between polycystic ovary syndrome and female-to-male transsexuality. *Human Reproduction, 22*(4), 1011–1016. doi:10.1093/humrep/del474

Bakker, A., Van Kesteren, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87*(4), 237–238. doi:10.1111/j.1600–0447.1993.tb03364.x

Balen, A. H., Schachter, M. E., Montgomery, D., Reid, R. W., & Jacobs, H. S. (1993). Polycystic ovaries are a common finding in untreated female to male transsexuals. *Clinical Endocrinology, 38*(3), 325–329. doi:10.1111/j.1365–2265.1993.tb01013.x

Basson, R. (2001). Towards optimal hormonal treatment of male to female gender identity disorder. *Journal of Sexual and Reproductive Medicine, 1*(1), 45–51.

Basson, R., & Prior, J. C. (1998). Hormonal therapy of gender dysphoria: The male-to-female transsexual. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 277–296). New York, NY: Garland.

Benjamin, H. (1966). *The transsexual phenomenon*. New York, NY: Julian Press.

Besnier, N. (1994). Polynesian gender liminality through time and space. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 285–328). New York: Zone Books.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *Siecus Report, 28*(1), 3–7.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211–224. doi:10.1016/j.sexol.2008.08.001

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York, NY: The Haworth Press.

Bockting, W. O., & Goldberg, J. M. (2006). Guidelines for transgender care (Special issue). *International Journal of Transgenderism, 9*(3/4).

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35–82. doi:10.1300/J485v09n03_03

Bolin, A. (1988). *In search of Eve* (pp. 189–192). New York, NY: Bergin & Garvey.

Bolin, A. (1994). Transcending and transgendering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 447–486). New York, NY: Zone Books.

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York, NY: Routledge.

Bosinski, H. A. G., Peter, M., Bonatz, G., Arndt, R., Heidenreich, M., Sippell, W. G., & Wille, R. (1997). A higher rate of hyperandrogenic disorders in female-to-male transsexuals. *Psychoneuroendocrinology, 22*(5), 361–380. doi:10.1016/S0306–4530(97)00033–4

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Brown, G. R. (2009). Recommended revisions to The World Professional Association for Transgender Health's *Standards of Care* section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*(2), 133–139. doi:10.1080/15532730903008073

Brown, G. R. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 12*(1), 31–39. doi:10.1080/15532731003688970

Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.

Callen Lorde Community Health Center. (2000). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Callen Lorde Community Health Center. (2011). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Canadian Association of Speech-Language Pathologists and Audiologists. (n.d.). CASLPA *clinical certification program*. Retrieved from http://www.caslpa.ca/

Carew, L., Dacakis, G., & Oates, J. (2007). The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. *Journal of Voice, 21*(5), 591–603. doi:10.1016/j.jvoice.2006.05.005

Carnegie, C. (2004). Diagnosis of hypogonadism: Clinical assessments and laboratory tests. *Reviews in Urology, 6*(Suppl 6), S3–8.

Cattrall, F. R., & Healy, D. L. (2004). Long-term metabolic, cardiovascular and neoplastic risks with polycystic ovary syndrome. *Best Practice & Research Clinical Obstetrics & Gynaecology, 18*(5), 803–812. doi:10.1016/j.bpobgyn.2004.05.005

Center of Excellence for Transgender Health, UCSF. (2011). *Primary care protocol for transgender health care*. Retrieved from http://transhealth.ucsf.edu/trans?page=protocol-00–00

Chiñas, B. (1995). Isthmus Zapotec attitudes toward sex and gender anomalies. In S. O. Murray (Ed.), *Latin American male homosexualities* (pp. 293–302). Albuquerque, NM: University of New Mexico Press.

Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism, 3*(1), 2–17.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 391–391. doi:10.1097/00004583–200104000–00006

Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5α-reductase-2 deficiency and 17β-hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior, 34*(4), 399–410. doi:10.1007/s10508–005–4339–4

Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington & H. C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695–725). New York, NY: Cambridge University Press.

Cohen-Kettenis, P. T. (2010). Psychosocial and psychosexual aspects of disorders of sex development. *Best Practice & Research Clinical Endocrinology & Metabolism, 24*(2), 325–334. doi:10.1016/j.beem.2009.11.005

Cohen-Kettenis, P. T., & Kuiper, A. J. (1984). Transseksualiteit en psychothérapie. *Tijdschrift Voor Psychotherapie, 10*, 153–166.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31*(1), 41–53. doi:10.1023/A:1021769215342

Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499–513. doi:10.1007/s10508–009–9562-y

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior, 40*(4), 843–847. doi:0.1007/s10508–011–9758–9

Cohen-Kettenis, P. T., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national, cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry, 11*(3), 397–405. doi:10.1177/1359104506059135

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1), 13–26.

Coleman, E. (2009a). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism, 11*(1), 1–7. doi: 10.1080/15532730902799912

Coleman, E. (2009b). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Psychological assessment and approaches to treatment. *International Journal of Transgenderism, 11*(2), 69–73. doi: 10.1080/15532730903008008

Coleman, E. (2009c). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Hormonal and surgical approaches to treatment. *International Journal of Transgenderism, 11*(3), 141–145. doi: 10.1080/15532730903383740

Coleman, E. (2009d). Toward version 7 of the World Professional Association for Transgender Health's *Standards of Care*: Medical and therapeutic approaches to treatment. *International Journal of Transgenderism, 11*(4), 215–219. doi: 10.1080/15532730903439450

Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior, 21*(3), 313–321.

Costa, L. M., & Matzner, A. (2007). *Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*. Binghamton, NY: Haworth Press.

Currah, P., Juang, R. M., & Minter, S. (2006). *Transgender rights*. Minneapolis, MN: University of Minnesota Press.

Currah, P., & Minter, S. (2000). Unprincipled exclusions: The struggle to achieve judicial and legislative equality for transgender people. *William and Mary Journal of Women and Law, 7*, 37–60.

Dacakis, G. (2000). Long-term maintenance of fundamental frequency increases in male-to-female transsexuals. *Journal of Voice, 14*(4), 549–556. doi:10.1016/S0892–1997(00)80010–7

Dahl, M., Feldman, J. L., Goldberg, J. M., & Jaberi, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism, 9*(3), 111–134. doi:10.1300/J485v09n03_06

Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615–644). Philadelphia: Saunders.

Davies, S., & Goldberg, J. M. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism, 9*(3–4), 167–196. doi:10.1300/J485v09n03_08

de Bruin, M. D., Coerts, M. J., & Greven, A. J. (2000). Speech therapy in the management of male-to-female transsexuals. *Folia Phoniatrica Et Logopaedica, 52*(5), 220–227.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679–690. doi:10.1007/s10508–005–7926–5

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., . . . Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*(3), 137–141. doi:10.1016/j.eurpsy.2006.10.002

De Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH *standards of care*. *International Journal of Transgenderism, 11*(3), 194–205. doi:10.1080/15532730903383781

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P.T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology,* 155(Suppl 1), S131–S137. doi:10.1530/eje.1.02231

Delemarre-van de Waal, H. A., van Weissenbruch, M. M., & Cohen Kettenis, P. T. (2004). Management of puberty in transsexual boys and girls. *Hormone Research in Paediatrics,* 62(Suppl 2), 75–75. doi:10.1159/000081145

de Lignières, B. (1999). Oral micronized progesterone. *Clinical Therapeutics, 21*(1), 41–60. doi:10.1016/S0149–2918(00)88267–3

Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice.* New York, NY: W.W. Norton.

Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior,* 34(4), 389–397. doi:10.1007/s10508-005-4338-5

De Sutter, P. (2009). Reproductive options for transpeople: Recommendations for revision of the WPATH's *standards of care*. *International Journal of Transgenderism, 11*(3), 183–185. doi:10.1080/15532730903383765

De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism, 6*(3), retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97–03/numbers/symposion/ijtvo06no03_02.htm

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model. *Journal of Gay and Lesbian Psychotherapy,* 8(1/2), 41–67.

de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9*(3–4), 83–94. doi:10.1300/J485v09n03_04

de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry.* Advance online publication. doi:10.1111/j.1469–7610.2011.02426.x

de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders, 40*(8), 930–936. doi:10.1007/s10803–010–0935–9

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*. Advance online publication. doi:10.1111/j.1743–6109.2010.01943.x

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Langstrom, N., & Landen, M. (2011). Longterm follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PloS ONE,* 6(2), 1–8. doi:10.1371/journal.pone.0016885

Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior, 38*(2), 172–172. doi:10.1007/s10508–008–9438–6

Di Ceglie, D., & Thümmel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387–396. doi:10.1177/1359104506064983

Dobs, A. S., Meikle, A. W., Arver, S., Sanders, S. W., Caramelli, K. E., & Mazer, N. A. (1999). Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3469–3478. doi:10.1210/jc.84.10.3469

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York, NY: Plenum Press.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34–45. doi:10.1037/0012–1649.44.1.34

Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the *standards of care*. *International Journal of Transgenderism, 12*(4), 198–2010. doi:10.1080/15532739.2010.544235

Ekins, R., & King, D. (2006). *The transgender phenomenon*. Thousand Oaks, CA: Sage.

Eklund, P. L., Gooren, L. J., & Bezemer, P. D. (1988). Prevalence of transsexualism in the Netherlands. *British Journal of Psychiatry, 152*(5), 638–640.

Eldh, J., Berg, A., & Gustafsson, M. (1997). Long-term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery, 31*(1), 39–45.

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7*(3), 1–12. doi:10.1300/J085V07N03_01

Emory, L. E., Cole, C. M., Avery, E., Meyer, O., & Meyer III, W. J. (2003). *Client's view of gender identity: Life, treatment status and outcome*. Paper presented at 18th Biennial Harry Benjamin Symposium, Gent, Belgium.

Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of transgender medicine and surgery*. Binghamton, NY: Haworth Press.

Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15–32). Binghamton, NY: Haworth Press.

Factor, R. J., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MtFs, FtMs, and genderqueers. *Health Sociology Review, 17*(3), 235–253.

Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.

Feldman, J. (2005, April). *Masculinizing hormone therapy with testosterone 1% topical gel*. Paper presented at the 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.

Feldman, J. (2007). Preventive care of the transgendered patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender surgery and medicine* (pp. 33–72). Binghamton, NY: Haworth Press.

Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism, 9*(3), 3–34. doi:10.1300/J485v09n03_02

Feldman, J., & Safer, J. (2009). Hormone therapy in adults: Suggested revisions to the sixth version of the *standards of care*. *International Journal of Transgenderism, 11*(3), 146–182. doi:10.1080/15532730903383757

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2004). *Myths and realities of online clinical work, observations on the phenomena of online behavior, experience, and therapeutic relationships. A 3rd-year report from ISMHO's clinical case study group*. Retrieved from https://www.ismho.org/myths_n_realities.asp

Fenway Community Health Transgender Health Program. (2007). *Protocol for hormone therapy.* Retrieved from http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181

Fisk, N. M. (1974). Editorial: Gender dysphoria syndrome—the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine, 120*(5), 386–391.

Fitzpatrick, L. A., Pace, C., & Wiita, B. (2000). Comparison of regimens containing oral micronized progesterone or medroxyprogesterone acetate on quality of life in postmenopausal women: A cross-sectional survey. *Journal of Women's Health & Gender-Based Medicine, 9*(4), 381–387.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Fraser, L. (2009a). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126–142. doi:10.1080/14681990903003878

Fraser, L. (2009b). E-therapy: Ethical and clinical considerations for version 7 of The World Professional Association for Transgender Health's *Standards of Care*. *International Journal of Transgenderism, 11*(4), 247–263. doi:10.1080/15532730903439492

Fraser, L. (2009c). Psychotherapy in The World Professional Association for Transgender Health's *Standards of Care*: Background and recommendations. *International Journal of Transgenderism, 11*(2), 110–126. doi:10.1080/15532730903008057

Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. *European Urology, 57*(4), 715–722. doi:10.1016/j.eururo.2009.05.018

Gelder, M. G., & Marks, I. M. (1969). Aversion treatment in transvestism and transsexualism. In R. Green, & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 383–413). Baltimore, MD: Johns Hopkins University Press.

Gelfer, M. P. (1999). Voice treatment for the male-to-female transgendered client. *American Journal of Speech-Language Pathology, 8*(3), 201–208.

Gharib, S., Bigby, J., Chapin, M., Ginsburg, E., Johnson, P., Manson, J., & Solomon, C. (2005). *Menopause: A guide to management*. Boston, MA: Brigham and Women's Hospital.

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178–224.

Gold, M., & MacNish, M. (2011). *Adjustment and resiliency following disclosure of transgender identity in families of adolescents and young adults: Themes and clinical implications*. Washington, DC: American Family Therapy Academy.

Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378–392. doi:10.1007/s10508–007–9307–8

Gooren, L. (2005). Hormone treatment of the adult transsexual patient. *Hormone Research in Paediatrics, 64*(Suppl 2), 31–36. doi:10.1159/000087751

Gorton, R. N., Buth, J., & Spade, D. (2005). *Medical therapy and health maintenance for transgender men: A guide for health care providers*. San Francisco, CA: Lyon-Martin Women's Health Services.

Green, R. (1987). *The* "sissy boy syndrome" *and the development of homosexuality*. New Haven, CT: Yale University Press.

Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*(1), 163–174.

Greenson, R. R. (1964). On homosexuality and gender identity. *International Journal of Psycho-Analysis, 45*, 217–219.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent's reactions to transgender youth's gender-nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3–16. doi:10.1300/J041v18n01_02

Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71–92.

Grumbach, M. M., Hughes, I. A., & Conte, F. A. (2003). Disorders of sex differentiation. In P. R. Larsen, H. M. Kronenberg, S. Melmed & K. S. Polonsky (Eds.), *Williams textbook of endocrinology* (10th ed., pp. 842–1002). Philadelphia, PA: Saunders.

Hage, J. J., & De Graaf, F. H. (1993). Addressing the ideal requirements by free flap phalloplasty: Some reflections on refinements of technique. *Microsurgery, 14*(9), 592–598. doi:10.1002/micr.1920140910

Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. *Plastic and Reconstructive Surgery, 105*(3), 1222–1227.

Hancock, A. B., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*. Advance online publication. doi:10.1016/j.jvoice.2010.07.013

Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery, 1*(2), 335–344.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132–3154. doi:10.1210/jc.2009–0345

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender-variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy, 36*(1), 6–23. doi:10.1080/00926230903375560

Hoebeke, P., Selvaggi, G., Ceulemans, P., De Cuypere, G. D., T'Sjoen, G., Weyers, S., . . . Monstrey, S. (2005). Impact of sex reassignment surgery on lower urinary tract function. *European Urology, 47*(3), 398–402. doi:10.1016/j.eururo.2004.10.008

Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry, 124*(579), 181–190. doi:10.1192/bjp.124.2.181

Hughes, I. A., Houk, C. P., Ahmed, S. F., Lee, P. A., & LWPES1/ESPE Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood, 91*(7), 554–563. doi:10.1136/adc.2006.098319

Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. *American Family Physician, 62*(5), 1079–1095.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Jackson, P. A., & Sullivan, G. (Eds.). (1999). *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand*. Binghamton, NY: Haworth Press.

Jockenhövel, F. (2004). Testosterone therapy-what, when and to whom? *The Aging Male, 7*(4), 319–324. doi:10.1080/13685530400016557

Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior, 39*(6), 1429–1437. doi:10.1007/s10508–009–9551–1

Joint LWPES/ESPE CAH Working Group, Clayton, P. E., Miller, W. L., Oberfield, S. E., Ritzen, E. M., Sippell, W. G., & Speiser, P. W. (2002). Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. *Journal of Clinical Endocrinology & Metabolism, 87*(9), 4048–4053. doi:10.1210/jc.2002–020611

Jurgensen, M., Hiort, O., Holterhus, P. M., & Thyen, U. (2007). Gender role behavior in children with XY karyotype and disorders of sex development. *Hormones and Behavior, 51*(3), 443–453. doi:0.1016/j.yhbeh.2007.01.001

Kanagalingam, J., Georgalas, C., Wood, G. R., Ahluwalia, S., Sandhu, G., & Cheesman, A. D. (2005). Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. *The Laryngoscope, 115*(4), 611–618. doi:10.1097/01.mlg.0000161357.12826.33

Kanhai, R. C. J., Hage, J. J., Karim, R. B., & Mulder, J. W. (1999). Exceptional presenting conditions and outcome of augmentation mammaplasty in male-to-female transsexuals. *Annals of Plastic Surgery, 43*(5), 476–483.

Kimberly, S. (1997). I am transsexual - hear me roar. *Minnesota Law & Politics, June*, 21–49.

Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). *The Journal of Sexual Medicine, 6*(11), 2922–2939. doi:10.1111/j.1743–6109.2009.01370.x

Knudson, G., De Cuypere, G., & Bockting, W. (2010a). Process toward consensus on recommendations for revision of the DSM diagnoses of gender identity disorders by The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 54–59. doi:10.1080/15532739.2010.509213

Knudson, G., De Cuypere, G., & Bockting, W. (2010b). Recommendations for revision of the *DSM* diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 115–118. doi:10.1080/15532739.2010.509215

Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92–12820-MLW (U.S. Federal District Court, Boston, MA, 2002).

Krege, S., Bex, A., Lümmen, G., & Rübben, H. (2001). Male-to-female transsexualism: A technique, results and long-term follow-up in 66 patients. *British Journal of Urology, 88*(4), 396–402. doi:10.1046/j.1464–410X.2001.02323.x

Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility, 92*(5), 1685–1689. doi:10.1016/j.fertnstert.2008.08.126

Kuhn, A., Hiltebrand, R., & Birkhauser, M. (2007). Do transsexuals have micturition disorders? *European Journal of Obstetrics & Gynecology and Reproductive Biology, 131*(2), 226–230. doi:10.1016/j.ejogrb.2006.03.019

Landén, M., Wålinder, J., & Lundström, B. (1998). Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. *Acta Psychiatrica Scandinavica, 97*(3), 189–194. doi:10.1111/j.1600–0447.1998.tb09986.x

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299–315. doi:10.1023/A:1024086814364

Lawrence, A. A. (2006). Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 35*(6), 717–727. doi:10.1007/s10508–006–9104–9

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of The World Professional Association for Transgender Health's *standards of care*. *International Journal of Transgenderism, 11*(2), 74–99. doi:10.1080/15532730903008032

Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology, 59*(4), 409–418. doi:10.1046/j.1365–2265.2003.01821.x

MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine, 350*(4), 367–378.

Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum.

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453–470 doi: 10.1111/j.1545–5300.2011.01371.x

Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior, 34*(4), 411–421. doi:10.1007/s10508–005–4341-x

McNeill, E. J. M. (2006). Management of the transgender voice. *The Journal of Laryngology & Otology, 120*(07), 521–523. doi:10.1017/S0022215106001174

McNeill, E. J. M., Wilson, J. A., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice, 22*(6), 727–733. doi:10.1016/j.jvoice.2006.12.010

Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(8), 1010–1013. doi:10.1097/00004583–200208000–00021

Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*(2), 262–265.

Meyer, J. K., & Reter, D. J. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry, 36*(9), 1010–1015.

Meyer, W. J. III. (2009). World Professional Association for Transgender Health's *standards of care* requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism, 11*(2), 127–132. doi:10.1080/15532730903008065

Meyer, W. J. III. Webb, A., Stuart, C. A., Finkelstein, J. W., Lawrence, B., & Walker, P. A. (1986). Physical and hormonal evaluation of transsexual patients: A longitudinal study. *Archives of Sexual Behavior, 15*(2), 121–138. doi:10.1007/BF01542220

Meyer-Bahlburg, H. F. L. (2002). Gender assignment and reassignment in intersexuality: Controversies, data, and guidelines for research. *Advances in Experimental Medicine and Biology, 511*, 199–223. doi:10.1007/978–1-4615–0621–8_12

Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior, 34*(4), 423–438. doi:10.1007/s10508–005–4342–9

Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie De l'Enfance Et De l'Adolescence, 56*(6), 345–349. doi:10.1016/j.neurenf.2008.06.002

Meyer-Bahlburg, H. F. L. (2009). Variants of gender differentiation in somatic disorders of sex development. *International Journal of Transgenderism, 11*(4), 226–237. doi:10.1080/15532730903439476

Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*(2), 461–476. doi:10.1007/s10508–009–9532–4

Meyer-Bahlburg, H. F. L. (2011). Gender monitoring and gender reassignment of children and adolescents with a somatic disorder of sex development. *Child & Adolescent Psychiatric Clinics of North America. 20*(4), 639–649. doi: 10.1016/;. ch.2011.07.002.

Meyer-Bahlburg, H. F. L., & Blizzard, R. M. (2004). Conference proceedings: Research on intersex: Summary of a planning workshop. *The Endocrinologist, 14*(2), 59–69. doi:10.1097/01.ten.0000123701.61007.4e

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Carlson, A. D., Obeid, J. S., & New, M. I. (2004). Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 33*(2), 97–104. doi:10.1023/B:ASEB.0000014324.25718.51

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior, 35*(6), 667–684. doi:10.1007/s10508–006–9068–9

Meyer-Bahlburg, H. F. L., Migeon, C. J., Berkovitz, G. D., Gearhart, J. P., Dolezal, C., & Wisniewski, A. B. (2004). Attitudes of adult 46,XY intersex persons to clinical management policies. *The Journal of Urology, 171*(4), 1615–1619. doi:10.1097/01.ju.0000117761.94734.b7

Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl*. Baltimore, MD: Johns Hopkins University Press.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*(1), 29–41. doi:10.1093/jpepsy/4.1.29

Monstrey, S., Hoebeke, P., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Blondeel, P., . . . De Cuypere, G. (2009). Penile reconstruction: Is the radial forearm flap really the standard technique? *Plastic and Reconstructive Surgery, 124*(2), 510–518.

Monstrey, S., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Bowman, C., Blondeel, P., . . . De Cuypere, G. (2008). Chest-wall contouring surgery in female-to-male transsexuals: A new algorithm. *Plastic and Reconstructive Surgery, 121*(3), 849–859. doi:10.1097/01.prs.0000299921.15447.b2

Moore, E., Wisniewski, A., & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. *Journal of Clinical Endocrinology & Metabolism, 88*(8), 3467–3473. doi:10.1210/jc.2002–021967

More, S. D. (1998). The pregnant man – an oxymoron? *Journal of Gender Studies, 7*(3), 319–328. doi:10.1080/09589236.1998.9960725

Mount, K. H., & Salmon, S. J. (1988). Changing the vocal characteristics of a postoperative transsexual patient: A longitudinal study. *Journal of Communication Disorders, 21*(3), 229–238. doi:10.1016/0021–9924(88)90031–7

Mueller, A., Kiesewetter, F., Binder, H., Beckmann, M. W., & Dittrich, R. (2007). Long-term administration of testosterone undecanoate every 3 months for testosterone supplementation in female-to-male transsexuals. *Journal of Clinical Endocrinology & Metabolism, 92*(9), 3470–3475. doi:10.1210/jc.2007–0746

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*(2), 214–231. doi:10.1111/j.1365–2265.2009.03625.x

Nanda, S. (1998). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth.

Nestle, J., Wilchins, R. A., & Howell, C. (2002). *Genderqueer: Voices from beyond the sexual binary*. Los Angeles, CA: Alyson Publications.

Neumann, K., & Welzel, C. (2004). The importance of voice in male-to-female transsexualism. *Journal of Voice, 18*(1), 153–167.

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*(9), 1447–1457. doi:10.1007/s11136–006–0002–3

Nieschlag, E., Behre, H. M., Bouchard, P., Corrales, J. J., Jones, T. H., Stalla, G. K., . . . Wu, F. C. W. (2004). Testosterone replacement therapy: Current trends and future directions. *Human Reproduction Update, 10*(5), 409–419. doi:10.1093/humupd/dmh035

North American Menopause Society. (2010). Estrogen and progestogen use in postmenopausal women: 2010 position statement. *Menopause, 17*(2), 242–255. doi:10.1097/gme.0b013e3181d0f6b9

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12–23. doi:10.1080/00224490903062258

Oates, J. M., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism—a review. *International Journal of Language & Communication Disorders, 18*(3), 139–151. doi:10.3109/13682828309012237

Olyslager, F., & Conway, L. (2007). *On the calculation of the prevalence of transsexualism*. Paper presented at the World Professional Association for Transgender Health 20th International Symposium, Chicago, Illinois. Retrieved from http://www.changelingaspects.com/PDF/2007–09–06-Prevalence_of_Transsexualism.pdf

Oriel, K. A. (2000). Clinical update: Medical care of transsexual patients. *Journal of the Gay and Lesbian Medical Association, 4*(4), 185–194. doi:1090–7173/00/1200–0185$18.00/1

Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry, 13*(2), 172–181.

Pauly, I. B. (1981). Outcome of sex reassignment surgery for transsexuals. *Australian and New Zealand Journal of Psychiatry, 15*(1), 45–51. doi:10.3109/00048678109159409

Payer, A. F., Meyer, W. J. III. & Walker, P. A. (1979). The ultrastructural response of human leydig cells to exogenous estrogens. *Andrologia, 11*(6), 423–436. doi:10.1111/j.1439–0272.1979.tb02232.x

Peletz, M. G. (2006). Transgenderism and gender pluralism in southeast Asia since early modern times. *Current Anthropology, 47*(2), 309–340. doi:10.1086/498947

Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology & Human Sexuality, 5*(4), 69–85.

Pfäfflin, F., & Junge, A. (1998). Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991. *International Journal of Transgenderism*. Retrieved from http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm

Physicians' desk reference. (61st ed.). (2007). Montvale, NJ: PDR.

Physicians' desk reference. (65th ed.). (2010). Montvale, NJ: PDR.

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender noncomformity and homosexual childhood* (pp. 34–51). New York: New York University Press.

Pope, K. S., & Vasquez, M. J. (2011). *Ethics in psychotherapy and counseling: A practical guide* (4TH ed.). Hoboken, NJ: John Wiley.

Prior, J. C., Vigna, Y. M., & Watson, D. (1989). Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior, 18*(1), 49–57. doi:10.1007/BF01579291

Prior, J. C., Vigna, Y. M., Watson, D., Diewold, P., & Robinow, O. (1986). Spironolactone in the presurgical therapy of male to female transsexuals: Philosophy and experience of the Vancouver Gender Dysphoria Clinic. *Journal of Sex Information & Education Council of Canada, 1*, 1–7.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved from http://www.WPATH.org

Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97–03/numbers/symposion/ijtvo06no01_03.htm.

Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality, 54*(3), 243–258. doi:10.1080/00918360801982124

Rachlin, K., Hansbury, G., & Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism, 12*(3), 155–166. doi:10.1080/15532739.2010.514220

Reed, B., Rhodes, S., Schofield, P. & Wylie, K. (2009). *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution.* Retrieved June 8, 2011, from http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf

Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior, 28*(1), 71–89. doi:10.1023/A:1018745706354

Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy, 24*(2), 143–151. doi:10.1080/14681990902951358

Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 619–621. doi:10.1097/00004583–200205000–00020

Rossouw, J. E., Anderson, G. L., Prentice, R. L., LaCroix, A. Z., Kooperberg, C., Stefanick, M. L., . . . Johnson, K. C. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the women's health initiative randomized controlled trial. *JAMA: The Journal of the American Medical Association, 288*(3), 321–333.

Royal College of Speech Therapists, United Kingdom. http://www.rcslt.org/

Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6TH ed., pp. 858–932). Hoboken, NJ: John Wiley.

Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay & Lesbian Issues in Education, 3*(1), 15–28. doi:10.1300/J367v03n01_04

Simpson, J. L., de la Cruz, F., Swerdloff, R. S., Samango-Sprouse, C., Skakkebaek, N. E., Graham, J. M. J., . . . Willard, H. F. (2003). Klinefelter syndrome: Expanding the phenotype and identifying new research directions. *Genetics in Medicine, 5*(6), 460–468. doi:10.1097/01.GIM.0000095626.54201.D0

Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89–99. doi:10.1017/S0033291704002776

Sood, R., Shuster, L., Smith, R., Vincent, A., & Jatoi, A. (2011). Counseling postmenopausal women about bioidentical hormones: Ten discussion points for practicing physicians. *Journal of the American Board of Family Practice, 24*(2), 202–210. doi:10.3122/jabfm.2011.02.100194

Speech Pathology Australia. http://www.speechpathologyaustralia.org.au/

Speiser, P. W., Azziz, R., Baskin, L. S., Ghizzoni, L., Hensle, T. W., Merke, D. P., . . . Oberfield, S. E. (2010). Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 95*(9), 4133–4160. doi:10.1210/jc.2009–2631

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*. Advance online publication. doi:10.1177/1359104510378303

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior, 40*(4), 649–650. doi:10.1007/s10508–011–9752–2

Stikkelbroeck, N. M. M. L., Beerendonk, C., Willemsen, W. N. P., Schreuders-Bais, C. A., Feitz, W. F. J., Rieu, P. N. M. A., . . . Otten, B. J. (2003). The long term outcome of feminizing genital surgery for congenital adrenal hyperplasia: Anatomical, functional and cosmetic outcomes, psychosexual development, and satisfaction in adult female patients. *Journal of Pediatric and Adolescent Gynecology, 16*(5), 289–296. doi:10.1016/S1083–3188(03)00155–4

Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220–226.

Stone, S. (1991). The empire strikes back: A posttransexual manifesto. In J. Epstein, & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280–304). London: Routledge.

Tangpricha, V., Ducharme, S. H., Barber, T. W., & Chipkin, S. R. (2003). Endocrinologic treatment of gender identity disorders. *Endocrine Practice, 9*(1), 12–21.

Tangpricha, V., Turner, A., Malabanan, A., & Holick, M. (2001). Effects of testosterone therapy on bone mineral density in the FtM patient. *International Journal of Transgenderism, 5*(4).

Taywaditep, K. J., Coleman, E., & Dumronggittigule, P. (1997). Thailand (Muang Thai). In R. Francoeur (Ed.), *International encyclopedia of sexuality*. New York, NY: Continuum.

Thole, Z., Manso, G., Salgueiro, E., Revuelta, P., & Hidalgo, A. (2004). Hepatotoxicity induced by antiandrogens: A review of the literature. *Urologia Internationalis, 73*(4), 289–295. doi:10.1159/000081585

Tom Waddell Health Center. (2006). *Protocols for hormonal reassignment of gender.* Retrieved from http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

Tsoi, W. F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica, 78*(4), 501–504. doi:10.1111/j.1600–0447.1988.tb06373.x

Van den Broecke, R., Van der Elst, J., Liu, J., Hovatta, O., & Dhont, M. (2001). The female-to-male transsexual patient: A source of human ovarian cortical tissue for experimental use. *Human Reproduction, 16*(1), 145–147. doi:10.1093/humrep/16.1.145

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal, 26*(2), 135–154. doi:10.1007/s10560–008–0158–5

van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology, 47*(3), 337–343. doi:10.1046/j.1365–2265.1997.2601068.x

van Kesteren, P. J. M., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior, 25*(6), 589–600. doi:10.1007/BF02437841

van Trotsenburg, M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism, 11*(4), 238–246. doi:10.1080/15532730903439484

Vilain, E. (2000). Genetics of sexual development. *Annual Review of Sex Research, 11*, 1–25.

Wålinder, J. (1968). Transsexualism: Definition, prevalence and sex distribution. *Acta Psychiatrica Scandinavica, 43*(S203), 255–257.

Wålinder, J. (1971). Incidence and sex ratio of transsexualism in Sweden. *The British Journal of Psychiatry, 119*(549), 195–196.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1413–1423. doi:10.1097/CHI.0b013e31818956b9

Wallien, M. S. C., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307–1314. doi:10.1097/chi.0b013e3181373848

Warren, B. E. (1993). Transsexuality, identity and empowerment. A view from the frontlines. *SIECUS Report, February/March,* 14–16.

Weitze, C., & Osburg, S. (1996). Transsexualism in Germany: Empirical data on epidemiology and application of the German Transsexuals' Act during its first ten years. *Archives of Sexual Behavior, 25*(4), 409–425.

Wilson, J. D. (1999). The role of androgens in male gender role behavior. *Endocrine Reviews, 20*(5), 726–737. doi:10.1210/er.20.5.726

Winter, S. (2009). Cultural considerations for The World Professional Association for Transgender Health's *standards of care*: The Asian perspective. *International Journal of Transgenderism, 11*(1), 19–41. doi:10.1080/15532730902799938

Winter, S., Chalungsooth, P., Teh, Y. K., Rojanalert, N., Maneerat, K., Wong, Y. W., . . . Macapagal, R. A. (2009). Transpeople, transprejudice and pathologization: A seven-country factor analytic study. *International Journal of Sexual Health, 21*(2), 96–118. doi:10.1080/19317610902922537

Wisniewski, A. B., Migeon, C. J., Malouf, M. A., & Gearhart, J. P. (2004). Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The Journal of Urology, 171*(6, Part 1), 2497–2501. doi:10.1097/01.ju.0000125269.91938.f7

World Health Organization. (2007). *International classification of diseases and related health problems-10th revision*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008). *The world health report 2008: Primary health care—now more than ever*. Geneva, Switzerland: World Health Organization.

World Professional Association for Transgender Health, Inc. (2008). *WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A.* Retrieved from http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf

WPATH Board of Directors. (2010). *De-psychopathologisation statement released May 26, 2010.* Retrieved from http://wpath.org/announcements_detail.cfm?pk_announcement=17

Xavier, J. M. (2000). *The Washington, D.C. transgender needs assessment survey: Final report for phase two*. Washington, DC: Administration for HIV/AIDS of District of Columbia Government.

Zhang, G., Gu, Y., Wang, X., Cui, Y., & Bremner, W. J. (1999). A clinical trial of injectable testosterone undecanoate as a potential male contraceptive in normal Chinese men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3642–3647. doi:10.1210/jc.84.10.3642

Zitzmann, M., Saad, F., & Nieschlag, E. (2006, April). *Long term experience of more than 8 years with a novel formulation of testosterone undecanoate (nebido) in substitution therapy of hypogonadal men.* Paper presented at European Congress of Endocrinology, Glasgow, UK.

Zucker, K. J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*(1), 1–69.

Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(3), 551–568. doi:10.1016/j.chc.2004.02.006

Zucker, K. J. (2006). "I'm half-boy, half-girl": Play psychotherapy and parent counseling for gender identity disorder. In R. L. Spitzer, M. B. First, J. B. W. Williams & M. Gibbons (Eds.), *DSM-IV-TR casebook, volume 2* (pp. 321–334). Arlington, VA: American Psychiatric Publishing, Inc.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477–498. doi:10.1007/s10508–009–9540–4

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex & Marital Therapy, 34*(4), 287–290. doi:10.1080/00926230802096192

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (in press). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy, 38*(2), 151–189.

Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the *standards of care* of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*(1), 8–18. doi:10.1080/15532730902799946

Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*(3), 398–411.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90–97.

APPENDIX A
GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender-nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite*—and, some would argue, the more recent term *transgender*—have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender-nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

Bioidentical hormones: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

Bioidentical compounded hormone therapy (BCHT): Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

Cross-dressing (transvestism): Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

Disorders of sex development (DSD): Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

Female-to-Male (FtM): Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

Gender dysphoria: Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

Gender identity: A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

Gender identity disorder: Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender-nonconforming: Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender role or expression: Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

Genderqueer: Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

Internalized transphobia: Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

Male-to-Female (MtF): Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

Natural hormones: Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

Sex: Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender-nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

Sex reassignment surgery (gender affirmation surgery): Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

Transgender: Adjective to describe a diverse group of individuals who cross or transcend culturally defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

Transition: Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that are most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition are variable and individualized.

Transsexual: Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

APPENDIX B
OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

Risks of Feminizing Hormone Therapy (MtF)

Likely Increased Risk:

Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal (versus oral) route of estradiol administration, which is recommended for patients at higher risk of VTE.

Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

Possible Increased Risk:

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk is unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

Inconclusive or No Increased Risk:

Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

Other Side Effects of Feminizing Therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

Risks of Anti-Androgen Medications:

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

Risks of Masculinizing Hormone Therapy (FtM)

Likely Increased Risk:

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk.

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

Possible Increased Risk:

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing, may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

Inconclusive or No Increased Risk:

Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall, unless other risk factors are present.
- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

Other Side Effects of Masculinizing Therapy:

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.

- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

APPENDIX C
SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care—and the *SOC*—to evolve.

Criteria for Feminizing/Masculinizing Hormone Therapy (One Referral or Chart Documentation of Psychosocial Assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well controlled.

Criteria for Breast/Chest Surgery (One Referral)

Mastectomy and Creation of a Male Chest in FtM Patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Breast Augmentation (Implants/Lipofilling) in MtF Patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for Genital Surgery (Two Referrals)

Hysterectomy and Salpingo-Oophorectomy in FtM Patients and Orchiectomy in MtF Patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;

3. Age of majority in a given country;

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

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

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or Phalloplasty in FtM Patients and Vaginoplasty in MtF Patients:

1. Persistent, well documented gender dysphoria;

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

3. Age of majority in a given country;

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

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

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

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries—that is, that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

APPENDIX D
EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who had undergone sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment were not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery.) In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

Two long-term observational studies, both retrospective, compared the mortality and psychiatric morbidity of transsexual adults to those of general population samples (Asscheman et al., 2011; Dhejne et al., 2011). An analysis of data from the Swedish National Board of Health and Welfare information registry found that individuals who had received sex reassignment surgery (191 MtF and 133 FtM) had significantly higher rates of mortality, suicide, suicidal behavior, and psychiatric morbidity than those for a nontranssexual control group matched on age, immigrant status, prior psychiatric morbidity, and birth sex (Dhejne et al., 2011). Similarly, a study in the Netherlands reported a higher total mortality rate, including incidence of suicide, in both pre- and post-surgery transsexual patients (966 MtF and 365 MtF) than in the general population of that country (Asscheman et al., 2011). Neither of these studies questioned the efficacy of sex reassignment; indeed, both lacked an adequate comparison group of transsexuals who either did not receive treatment or who received treatment other than genital surgery. Moreover, transsexual people in these studies were treated as far back as the 1970s. However, these findings do emphasize the need to have good long-term psychological and psychiatric care available for this population. More studies are needed that focus on the outcomes of current assessment and treatment approaches for gender dysphoria.

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 3000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990).

Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E
DEVELOPMENT PROCESS FOR THE *STANDARDS OF CARE,* VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International*

Journal of Transgenderism (IJT). Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1–4) in 2009, making them available for discussion and debate.

After these articles were published, an *SOC* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender-nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision—both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion—and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized, it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revisions. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7,* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7,* and posting a free downloadable copy on the WPATH website;

6. Plenary session to launch the *Standards of Care, Version 7,* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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AMERICAN PSYCHIATRIC ASSOCIATION

< News Releases

Nov 15, 2018

APA Reiterates Strong Opposition to Conversion Therapy

Washington, D.C. – In the wake of recent popular entertainment portrayals of conversion therapy, the American Psychiatric Association (APA) today reiterates its long-standing opposition to the practice. APA made clear with its 1998 position statement that "APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation."

APA expanded on that position with a statement in 2013: "The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed."

Conversion therapy is banned in 14 states as well as the District of Columbia. The APA calls upon other lawmakers to ban the harmful and discriminatory practice.

American Psychiatric Association

The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,800 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

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The American Psychiatric Association (APA) is committed to ensuring accessibility of its website to people with disabilities. If you have trouble accessing any of APA's web resources, please contact us at 202-559-3900 for assistance.

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Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)

Approved by the Board of Trustees, March 2000
Approved by the Assembly, May 2000

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

Preamble

In December of 1998, the Board of Trustees issued a position statement (see attached) that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation. In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Association of Social Workers (1).

The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It *augments* rather than replaces the 1998 statement.

Position Statement

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such an integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Even though there are little data about patients, it is still possible to evaluate the theories which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologize homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

References

1. National Association for Research and Treatment of Homosexuality, (1999), American Counseling Association Passes Resolution to Oppose Reparative Therapy. NARTH Web site: (www.narth.com/docs/acaresolution.html).
2. Bayer, R. (1981), Homosexuality and American Psychiatry; The Politics of Diagnosis. New York: Basic Books.
3. Haldeman, D. (1991), Sexual orientation conversion therapy for gay men and lesbians: A scientific examination. In Homosexuality: Research Implications for Public Policy, ed. J. C. Gonsiorek & J. D. Weinrich. Newbury Park, CA: Sage Pub., pp. 149-161.
4. Haldeman, D. (1994), The practice and ethics of sexual orientation conversion therapy. J. Consulting & Clin. Psychol., 62(2):221-227.
5. Brown, L. S. (1996), Ethical concerns with sexual minority patients. In: Textbook of Homosexuality and Mental Health. ed. R. Cabaj & T. Stein. Washington: American Psychiatric Press, pp. 897-916.
6. Drescher, J. (1997), What needs changing? Some questions raised by reparative therapy practices. New York State Psychiatric Society Bulletin, 40(1):8-10.
7. Duberman, M. (1991), Cures: A Gay Man's Odyssey. New York: Dutton.
8. White, M. (1994), Stranger at the Gate: To be Gay and Christian in America. New York: Simon & Schuster.
9. Isay, R. (1996), Becoming Gay: The Journey to Self-Acceptance. New York: Pantheon.

10. Freud, S. (1905), Three essays on the theory of sexuality. Standard Edition, 7:123-246. London: Hogarth Press, 1953.
11. Rado, S. (1940), A critical examination of the concept of bisexuality. Psychosomatic Medicine, 2:459-467. Reprinted in Sexual Inversion: The Multiple Roots of Homosexuality, ed. J. Marmor. New York: Basic Books, 1965, pp. 175-189.
12. Bieber, I., Dain, H., Dince, P., Drellich, M., Grand, H., Gundlach, R., Kremer, M., Rifkin, A., Wilbur, C., & Bieber T. (1962), Homosexuality: A Psychoanalytic Study. New York: Basic Books.
13. Socarides, C. (1968), The Overt Homosexual. New York: Grune & Stratton.
14. Ovesey, L. (1969), Homosexuality and Pseudohomosexuality. New York: Science House.
15. Hatterer, L. (1970), Changing Homosexuality in the Male. New York: McGraw Hill.
16. Moberly, E. (1983), Homosexuality: A New Christian Ethic. Cambridge, UK: James Clarke & Co.
17. Harvey, J. (1987), The Homosexual Person: New Thinking in Pastoral Care. San Francisco, CA: Ignatius.
18. Nicolosi, J. (1991), Reparative Therapy of Male Homosexuality: A New Clinical Approach. Northvale, NJ: Aronson.
19. Kinsey, A., Pomeroy, W., & Martin, C. (1948), Sexual Behavior in the Human Male. Philadelphia, PA: Saunders.
20. Kinsey, A., Pomeroy, W., & Martin, C. and Gebhard, P. (1953), Sexual Behavior in the Human Female. Philadelphia, PA: Saunders.
21. Ford, C. & Beach, F. (1951), Patterns of Sexual Behavior. New York: Harper.
22. Hooker, E. (1957), The adjustment of the male overt homosexual. J Proj Tech, 21:18-31.
23. Bell, A .& Weinberg, M. (1978), Homosexualities: A Study of Diversity Among Men and Women. New York: Simon and Schuster.
24. Bell, A., Weinberg, M. & Hammersmith S. (1981), Sexual Preference: Its Development in Men and Women. Bloomington, IN: Indiana University Press.
25. LeVay, S. (1991), A difference in hypothalamic structure between heterosexual and homosexual men. Science, 253:1034-1037.
26. Hamer, D., Hu, S., Magnuson, V., Hu, N. & Pattatucci, A. (1993), A linkage between DNA markers on the X-chromosome and male sexual orientation. Science, 261:321-327.
27. Bem, D. (1996), Exotic becomes erotic: A developmental theory of sexual orientation. Psychol. Review, 103(2):320-335.
28. Marmor, J., ed. (1965), Sexual Inversion: The Multiple Roots of Homosexuality. New York: Basic Books.
29. Mitchell, S. (1978), Psychodynamics, homosexuality, and the question of pathology. Psychiatry, 41:254-263.
30. Marmor, J., ed. (1980), Homosexual Behavior: A Modern Reappraisal. New York: Basic Books.
31. Mitchell, S. (1981), The psychoanalytic treatment of homosexuality: Some technical considerations. Int. Rev. Psycho-Anal., 8:63-80.
32. Morgenthaler, F. (1984), Homosexuality Heterosexuality Perversion, trans. A. Aebi. Hillsdale, NJ: The Analytic Press, 1988.
33. Lewes, K. (1988), The Psychoanalytic Theory of Male Homosexuality. New York: Simon and Schuster. Reissued as Psychoanalysis and Male Homosexuality (1995), Northvale, NJ: Aronson.
34. Friedman, R.C. (1988), Male Homosexuality: A Contemporary Psychoanalytic Perspective. New Haven: Yale University Press.
35. Isay, R. (1989), Being Homosexual: Gay Men and Their Development. New York: Farrar, Straus and Giroux.
36. O'Connor, N. & Ryan, J. (1993), Wild Desires and Mistaken Identities: Lesbianism & Psychoanalysis. New York: Columbia University.
37. Domenici, T. & Lesser, R., eds. (1995), Disorienting Sexuality: Psychoanalytic Reappraisals of Sexual Identities. New York: Routledge.
38. Magee, M. & Miller, D. (1997), Lesbian Lives: Psychoanalytic Narratives Old and New. Hillsdale, NJ: The Analytic Press.
39. Drescher, J. (1998) Psychoanalytic Therapy and The Gay Man. Hillsdale, NJ: The Analytic Press.
40. Boswell, J. (1980), Christianity, Social Tolerance and Homosexuality. Chicago, IL: University of Chicago Press.
41. McNeil, J. (1993), The Church and the Homosexual, Fourth Edition. Boston, MA: Beacon.
42. Pronk, P. (1993), Against Nature: Types of Moral Argumentation Regarding Homosexuality. Grand Rapids, MI: Eerdmans.
43. Boswell, J. (1994), Same-Sex Unions in Premodern Europe. New York: Villard Books.
44. Helminiak, D. (1994), What the Bible Really Says About Homosexuality. San Francisco, CA: Alamo Press.
45. Gomes, P. J. (1996). The Good Book: Reading the Bible with Mind and Heart. New York: Avon.
46. Carrol, W. (1997), On being gay and an American Baptist minister. The InSpiriter, Spring, pp. 6-7,11.

Position Statement on Psychiatric Treatment and Sexual Orientation

Approved by the Board of Trustees, December 1998
Approved by the Assembly, November 1998
Reaffirmed , March 2000

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

The Board of Trustees of the American Psychiatric Association (APA) removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 after reviewing evidence that it was not a mental disorder. In 1987 ego-dystonic homosexuality was not included in the revised third edition of DSM (DSM-II-R) after a similar review.

APA does not currently have a formal position statement on treatments that attempt to change a person's sexual orientation, also known as "reparative therapy" or "conversion therapy." In 1997 APA produced a fact sheet on homosexual and bisexual issues, which states that "there is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation."

The potential risks of "reparative therapy" are great and include depression, anxiety, and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone "reparative therapy" relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian are not presented, nor are alternative approaches to dealing with the effects of societal stigmatization discussed. APA recognizes that in the course of ongoing psychiatric treatment, there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations, including the American Psychological Association, the National Association of Social Workers, and the American Academy of Pediatrics, have made statements against "reparative therapy" because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice, and unethical treatment on a variety of issues, including discrimination on the basis of sexual orientation.

Therefore, APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.

An initial version of this position statement was proposed in September 1998 by the Committee on Gay, Lesbian, and Bisexual Issues of the Council on National Affairs. It was revised and approved by the APA Assembly in November 1998. The revised version was approved by the Board of Trustees in December 1998. The committee members as of September 1998 were Lowell D. Tong, M.D. (chairperson), Leslie G. Goransson, M.D., Mark H. Townsend, M.D., Diana C. Miller, M.D., Cheryl Ann Clark, M.D., Kenneth Ashley, M.D. (consultant); corresponding members*: Stuart M. Sotsky, M.D., Howard C. Rubin, M.D., Daniel W. Hicks, M.D., Ronald L. Cowan, M.D.; Robert J. Mitchell, M.D. (Assembly liaison), Karine Igartua, M.D. (APA/Glaxo Wellcome Fellow), Steven Lee, M.D. (APA/Bristol-Myers Squibb Fellow), and Petros Levounis, M.D. (APA/Center for mental Health Services Fellow).*

APA Background Statement

Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): SUPPLEMENT

Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to First, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality, it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determine "reparative" therapy's risks versus its benefits.