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# Resolving Identity Conflict: Gay, Lesbian, and Queer Individuals with a Christian Upbringing

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*Gay, lesbian, and queer individuals with a Christian upbringing often experience conflict between religion and sexual identity. The purpose of this grounded theory study was to understand how gay, lesbian, and queer-identified individuals with a Christian upbringing resolve conflict between sexual identity and religious beliefs. Analysis of in-depth interviews with 15 participants led to 3 conclusions. First, resolving the discord between sexual identity and religious beliefs is a five-stage process of internal conflict resolution. Second, personal and contextual factors affect every aspect of the resolution process. Finally, faith development and sexual identity development are intertwined and fluid constructions.*

*KEYWORDS* *sexuality, spirituality, identity, grounded theory*

> *I was mostly focused not just on what it was to be gay, but I was trying to figure out what it was to be gay and Christian. Because if I could not find some way to make the two things come together, there is no way I would have been able to come out, because it would have shattered my identity. (Mark)*

> *I couldn't give up on homosexuality. I knew that's who I was. It made me give up on Christianity. . . . It's a painful process to lose your faith. . . . Trust me. Having your faith die is not easy. (Allen)*

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## INTRODUCTION

For numerous Christians, religion is the foundation and centerpiece of their lives. Religious institutions provide a social network, a source of emotional support, and a value base. Many turn to religion as they make important decisions because their belief systems help answer some of life's essential questions (Deutsch, Coleman, & Marcus, 2006). But what happens when religious beliefs come into conflict with other aspects of identity? Most Christians and Christian churches contend that homosexuality is a sin (Levy, 2009). For example, the Southern Baptist Convention (1999–2007), which is the largest Protestant denomination in the United States and boasts more than 16 million members, has taken the following position: "Homosexuality is not a 'valid alternative lifestyle.' The Bible condemns it as sin. It is not, however, unforgivable sin. The same redemption available to all sinners is available to homosexuals. They, too, may become new creations in Christ" (*Sexuality*, paragraph 1). This belief has been echoed by numerous Christian denominations.

How, then, do gay, lesbian, and queer Christians deal with conflict between religious beliefs and sexual identity? In the existing research on this topic, several studies have sought to understand the ways in which gays and lesbians view their spiritual journeys (Shallenberger, 1996; Yip, 2003). As they develop spiritual and religious beliefs, many become critical of institutionalized religion (Yip, 2003), while others seek congregations that are accepting and welcoming (Rodriguez & Oullette, 2000). For those who attend gay-positive churches, such as the Metropolitan Community Church (MCC), involvement is highly correlated with the integration of sexual and Christian identity (Rodriguez & Ouellette, 2000). Unlike most denominations, these congregations acknowledge the compatibility between Christianity and same-sex attraction, thus providing a safe haven and spiritual home for gay, lesbian, and queer Christians.

Research also reveals that gay and lesbian individuals with a Christian upbringing commonly experience identity conflicts (Couch, Mulcare, Pitts, Smith, & Mitchell, 2008). Typically, individuals deal with these conflicts by doing one of the following:

1. rejecting their sexual identity,
2. rejecting their Christian identity,
3. integrating these two identities,
4. compartmentalizing, or
5. living with the conflict.

Although some studies (Buchanan, Dzelme, Harris, & Hecker, 2001; Rodriguez & Ouellette, 2000) highlight the questioning and confusion experienced by individuals during this conflict, little research examines the process of conflict resolution. Of the studies that do focus on process

(Donnelly, 2001; Mahaffy, 1996; Shallenberger, 1996; Thumma, 1991), none uses a sample that includes both Christian and non-Christian participants. In addition, the existing research on gay and lesbian individuals with a Christian upbringing does not incorporate postmodern notions of identity, nor does it frame identity development as occurring over the life span. Utilizing a postmodern notion of identity (Clark & Dirkx, 2000), this study brings a fresh perspective to the existing literature by viewing the construct of identity as fluid, ever-changing, and complex rather than as fixed, unitary, and stable. Instead of trying to find a point of resolution for this conflict, the study focuses on the process, inviting participants to share their experiences of transformation thus far. In other words, resolution of the conflict between sexual identity and religious beliefs did not occur as a single event or moment for these individuals; rather, resolution was and will be a continual process.

The purpose of this study was to understand the process by which gay, lesbian, and queer-identified individuals with a Christian upbringing resolve the conflict between their sexual identity and religious beliefs. Four research questions guided this study:

1. First, how do participants define the conflict between their sexual identity and religious beliefs?
2. Second, what personal and contextual factors shaped their efforts to resolve this conflict?
3. Third, what is the process by which individuals resolve this conflict?
4. Finally, how do participants describe their resolution of this conflict?

## CONCEPTUAL FRAMEWORK

Because this study focused on both sexual and religious identity, multiple philosophical and theoretical conceptions informed the research: postmodern identity perspectives, faith development, sexual identity development, queer theory, and transformational learning theory. Historically, identity has been understood as unified, unwavering, and authentic (Clark & Dirkx, 2000). In “finding ourselves,” we seek an essential, core identity that is waiting to be discovered. Conversely, Clark and Dirkx posited that, in a postmodern world, the notion of the unified self is no longer applicable; it does not encapsulate the plurality of experiences and voices. Similarly, this study examined the conflict between sexual identity and religious beliefs with an eye for fluidity, flexibility, and plurality.

Several scholars have written about the development of religious identity, morality, and faith. The most well-known theory of religious identity development was proposed by Fowler (1981), who based his theory on interviews with more than 350 individuals. Fowler’s stage theory identified progressive periods of faith that people experience, and his linear conceptualization included six such periods: intuitive-projective, mythic-literal, synthetic-conventional, individuative-reflective, conjunctive, and universalizing faith.

Several widely cited theories of sexual identity development exist, with Cass's (1979) theory of gay and lesbian identity development, another stage theory, regarded as one of the most influential. Based on her work with lesbian and gay individuals, Cass (1979) proposed six stages of sexual identity formation: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. It should be noted that some theorists view stage models as problematic. Rust (2003), for example, explained that "although models are developed to *describe* psychological and social phenomena, when they are used in efforts to predict or facilitate the processes they describe, they become *prescriptive*" (p. 239). Especially challenging is the tendency to view stages as linear and essential in the "normal" developmental process.

Queer theory provides an alternative lens through which one can examine faith and sexual identity as fluid and intertwined concepts. Previously used as a slur against gay and lesbian individuals, the term queer has been reclaimed in recent years by individuals who resist a dichotomous view of gender and sexuality. Incorporating a nuanced meaning, queer is considered "sometimes as an umbrella term for a coalition of culturally marginal sexual self-identifications and at other times to describe a nascent theoretical model which has developed out of more traditional lesbian and gay studies" (Jagose, 1996, p. 1). Influenced by Foucault, Sedgwick, Butler, Derrida, and others, queer theory places value in unconventional or non-normative sexualities and characterizes identity as a cultural construction (Talburt & Steinberg, 2000).

A final theory informing this study is transformational learning theory. Transformational learning theory, proposed by Mezirow (1995) and developed further by Freire and other theorists, "is about change—dramatic, fundamental change in the way we see ourselves and the world in which we live" (Merriam, Caffarella, & Baumgartner, 2007, p. 130). Aptly titled, this theory describes the transformation that occurs through learning, which is defined as making new meanings in life. This transformation is considered a developmental progression that often begins with a disorienting dilemma such as the conflict between sexual identity and religious beliefs (Merriam et al., 2007; Taylor, 1998). There are four commonly recognized themes or components to transformative learning: centrality of experience, critical reflection, rational discourse, and action (Merriam et al., 2007; Taylor, 1998).

## METHODOLOGY

Although research to date has focused on the outcome of the conflict experienced by gay, lesbian, and queer individuals with a Christian upbringing, this study, which reports select findings from a larger research project (Levy, 2009), delineates the *process* by which individuals resolve this conflict. According to Padgett (1998), researchers should employ qualitative methods when they want to "explore a topic about which little is known . . . pursuing a topic of sensitivity and emotional depth . . . to capture the 'lived experience' from the perspectives of those who live it" (pp. 7–8). Grounded theory, a particular type of qualitative research, focuses on generating or discovering theory (Creswell, 2007; Glaser, 2007). It includes simultaneously collecting and analyzing data, generating codes and categories from the data, constantly comparing data, writing memos, and constructing a theory based on the data (Charmaz, 2006).

This study utilized a grounded theory approach and included in-depth interviews with 15 participants who were selected using both maximum variation and theoretical sampling. We began the study using maximum variation sampling, purposefully selecting diverse participants who experienced the conflict between religious beliefs and sexual identity differently. As the study progressed, we moved to theoretical sampling and identified participants who would inform specific concepts in the emerging theory. For example, we recruited two participants with very different religious upbringings, Lutheran and Free Will Baptist, to see if our theory of the five-stage process of conflict resolution would hold true for these individuals. Overall, the sample was diverse in terms of age, gender, religious background, and current faith identification. Table 1 provides demographic information about these participants, including pseudonyms. The semi-structured interviews lasted from 50 to 105 minutes and were conducted over a 12-month period in the participants' homes or in a university office. Interviews were audio

**TABLE 1** Participants' Demographic Information

| Name | Age | Race | Sex | Sexual Identity | Highest Degree | Religious Upbringing |
|---|---|---|---|---|---|---|
| Mark | 29 | Caucasian | M | Gay | Bachelor's | Jehovah's Witness |
| William | 43 | Caucasian | M | Gay | Master's | Southern Baptist |
| Jake | 31 | Caucasian | M | Gay, Queer | Associate's | Church of Christ |
| Allen | 39 | Caucasian | M | Gay | Bachelor's | Nondenominational Church of Christ |
| Sarah | 29 | Caucasian | F | Queer | Master's | Catholic |
| Jennifer | 26 | Caucasian | F | Lesbian | Bachelor's | Catholic |
| Logan | 29 | Caucasian | M | Gay, Queer | Master's | United Methodist |
| Allison | 19 | Caucasian | F | Lesbian | High School | Southern Baptist |
| Luke | 28 | Filipino American | M | Gay | Master's | Catholic |
| Hannah | 23 | Caucasian | F | Lesbian | Bachelor's | Southern Baptist |
| Melanie | 20 | Biracial | F | Lesbian | High School | Catholic |
| Laura | 30 | Caucasian | F | Lesbian | Bachelor's | Various Christian |
| Trey | 23 | Caucasian | M | Gay | High School | Catholic |
| Deborah | 31 | Caucasian | F | Lesbian | Bachelor's | Lutheran (ELCA) |
| Chad | 36 | Biracial | M | Gay | Bachelor's | Free Will Baptist |

taped and transcribed verbatim, and transcripts were coded using grounded theory methods of open, focused, and axial coding. In particular, this study adhered to Charmaz's (2006) constructivist grounded theory, recognizing that data and analysis should be understood in the context of time, place, situation, and culture.

In qualitative research, reliability and validity are synonymous with the concept of trustworthiness (Merriam, 2009). This study utilized the following techniques to ensure rigor: triangulation, peer examinations, member checks, rich description, and maximum-variation sampling (Bogdan & Biklen, 2007; Maxwell, 2005; Merriam, 2009).

## FINDINGS

In grounded theory research, analysis leads to "a substantive-level theory, written by a researcher close to a specific problem or population of people" (Creswell, 2007, p. 67). According to Glaser and Strauss (1967), the founders of the grounded theory approach, substantive theories are those that describe a "substantive, or empirical, area of sociological inquiry" (p. 32). The substantive theory in this study is a five-stage process by which gay, lesbian, and queer individuals with a Christian upbringing resolve the conflict between sexual identity and religious beliefs (see Figure 1).

### Five-Stage Process

This five-stage process includes an awareness of the conflict, an initial response to the conflict, a catalyst of new knowledge propelling participants

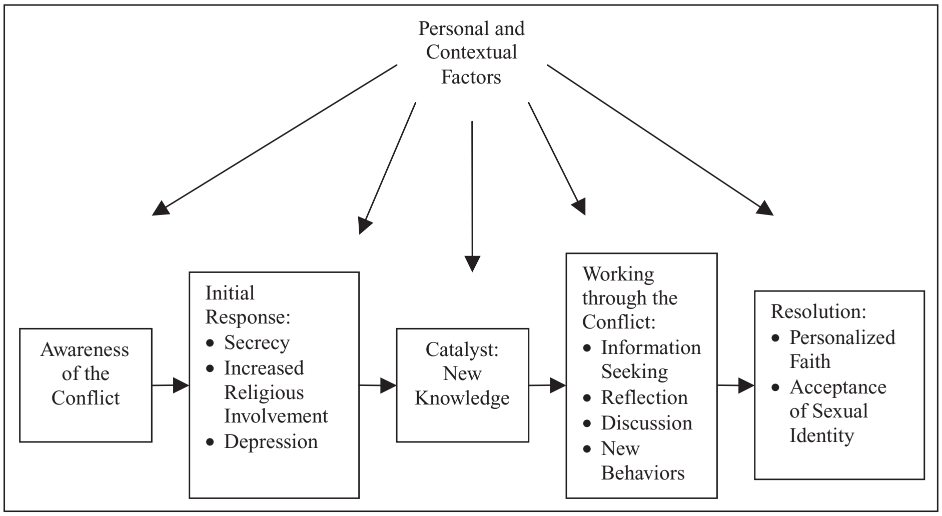

**FIGURE 1** Model of internal conflict resolution.

forward, steps of working through the conflict, and resolution of the conflict. The entire process of conflict resolution was affected by two core categories: personal factors (reflective abilities, strength and resiliency, anger, creativity, and humor) and contextual factors (family, community resources, and church doctrine).

### AWARENESS OF THE CONFLICT

Participants spoke at length about conflict between church doctrine regarding sexual orientation and their personal experiences with same-sex attraction. All 15 described messages from pastors and religious figures that both implicitly and explicitly condemned "homosexuality." Several individuals, such as Logan, 29, who was the only participant to grow up attending a Methodist church, stated that the official church doctrine was to "hate the sin [and] love the sinner." Jake, 31, who grew up in the Church of Christ, once heard a sermon characterizing "homosexuality as being a ticket to hell." Similarly, Chad, 36, remembered his Free Will Baptist pastor saying "you could not be gay and go to church. You cannot be a Christian. You cannot inherit the Kingdom of God and be a homosexual. You will burn forever in hell." Some churches, like Jennifer's Catholic congregation, did not explicitly address the taboo topic of sexuality. Still, in her church "it was generally established that homosexuality was wrong and that's about all you need to know. . . . It wasn't really talked about much. It was assumed that you knew that it was wrong."

Awareness of the conflict between church doctrine and same-sex attraction often left participants confused and fearful. Mark slowly and thoughtfully described his experience:

> I was horrified at first because it [same-sex attraction] flew in the face of everything I believed a good Christian man should be and experience and feel. And, at first it didn't make sense at all and then as soon as I realized it, I wanted it to go away so badly.

### INITIAL RESPONSE TO THE CONFLICT

After participants became aware of conflict between same-sex attraction and church doctrine, they had several initial responses or reactions. All worked tirelessly to keep their sexual desires a secret. Jake, who now calls himself a clairvoyant, described how being more involved in his church helped him stay in the closet:

> I felt really safe in the youth group because who was going to be gay in a church youth group? That's where I felt safe. And it was ironic that I felt like I could hide out in this youth group and no one would pick on me or call me out or see me as being queer because I'm attending church and

> I'm attending this Christ-driven event. And it worked. It worked. It was like perfect stealth in the youth group and no one ever picked on me.

Mark, who grew up as a Jehovah's Witness, had a similar reaction: "I didn't really seek help about it [same-sex attraction] because there is such a deep stigma to it, and so I was very ashamed. I would not talk about it with anyone." Several participants used the term "compartmentalization" to describe their efforts to keep sexual desires a secret. Trey, for example, explained that he "somehow compartmentalized my faith and my sexuality in my own mind."

As participants kept secret their same-sex attraction, involvement in religious activities increased. Eleven spent time in prayer, hoping that their desires would dissipate. Mark described his prayers in this way: "I prayed that I would be changed. I prayed that I would get married. I prayed that I would meet a nice girl. I prayed that this part of me would just go away." Hannah, 23, whose mother took her to a Love Won Out seminar with ex-gay speakers, also "prayed a lot that God would just take it [same-sex desires] away." In addition to intense prayer, many participants studied their bibles and spent more time at church. Melanie, for example, threw herself "more into church thinking that maybe it would help me, that I would find some sorts of tools to make it go away, and I started trying to pray it away. I did so many rosaries."

Becoming more involved in religious activities, however, did not eliminate participants' same-sex desires, and many experienced depression. William, who no longer calls himself a Christian but follows the teachings of Christ, started seeing a therapist because he "had a lot of depression as a result" of the conflict. Allen, a minister's son, also became depressed; he explained that "at night, it all came crashing in. There was a lot of crying, a lot of depression." Allison, raised a Southern Baptist and at 19 the youngest participant in this study, recalled a similar low point in her life:

> I got really depressed and my brain was kind of in turmoil about what was going on because of this girl that came into my life. . . . I couldn't eat, or I couldn't not eat, and I just got the shakes. It was really crazy for a couple weeks, just trying to process everything that happened because it felt like it was so life-changing, because it was. It was just scary to think this might be who I am.

For Deborah, who went to a women's college, religion failed her when she was depressed and needed it most:

> I went into a huge depression, and some of that was because of my sexuality. My mother died when I was 19, too, so it kind of coincided. But it came at a really bad time. So, when I felt like I needed the church the most, I didn't have that.

Like Deborah, Mark lost one of his parents. During the period in which he was experiencing same-sex attraction his father died, and Mark was "at times, suicidal."

### CATALYST: NEW KNOWLEDGE

Participants were able to break the cycle of increased religious involvement, secrecy, and depression when they encountered some type of new knowledge. This new information challenged church doctrine on sexuality ingrained since childhood and, in so doing, became a turning point or catalyst for change. William, the oldest participant at 43, described a "turning point" that "took time" to really sink in. It involved talking with a traveling preacher who had been instrumental in helping William's parents deal with his sexual identity. Hannah, raised Southern Baptist, had her "aha" moment when the "light bulb" went off at her Christian college as she "met people who were involved with the church who *did* accept people who were gay." She was intrigued, and consequently decided to major in religion. Like Hannah, Allison also made new friends who became "the catalyst [she needed] for getting out" of the "Christian bubble."

In discussing various catalysts, participants also mentioned inconsistencies in church doctrine regarding issues other than homosexuality, such as divorce, birth control, and suicide.

Jake recounted his church's harsh stance on divorce, and how this strict doctrine made him reconsider his own beliefs and learn about the imperfections inherent in the institution of religion. Laura experienced doubt in her faith when a non-Christian friend committed suicide. She described her predicament this way:

> This very wonderful person that I've known who loved everyone and who was so tortured took his own life. My religion is telling me that he is in hell. That's probably the first time I really started drawing lines in the sand from what people told me and what I allowed myself to believe. So that was pretty pivotal.

Summing up this type of catalyst, Logan said, "there's a disconnect to what we're talking about and what we're doing." This "disconnect" between church doctrine and participants' experiences of the world caused them to question their faith and to begin working through the conflict between sexual identity and religious beliefs.

### WORKING THROUGH THE CONFLICT

Once driven forward by the catalyst of new knowledge, participants began the process of resolving the conflict between sexual identity and religious upbringing. Because new knowledge was the catalyst for this process, it is not surprising that they reacted to it by seeking out additional information. Allen explained that this searching was necessary because otherwise it was too hard to "see outside of" the faith in which he was raised. He stated, "There's one doctrine and that's all you're shown. You really have to search and find" other information. Through information seeking, participants investigated various Christian beliefs about sexual orientation, other religious philosophies, and the topic of sexuality in general.

In addition to seeking information, respondents took time to reflect on what they were learning, hearing, and experiencing. Although Allison "over-analyzed everything" and was "very skeptical" about religion, after reflection she eventually "came back around to it." She attributed this change in attitude to the need to "believe in something." Hannah also wanted to be able to define her beliefs concretely. She "just had so many questions" and wanted to learn about "the psychology of religion and religion itself." Like Hannah, Laura "asked the hard questions" about theology at an early age. Regardless of the issues that participants pondered, reflection proved to be an important way in which they dealt with the conflict between sexual identity and religious beliefs.

Although some participants preferred personal reflection to talking with other people, all found it helpful to discuss new ideas and information with others. Luke described the importance of these experiences: "I talked about them [my new ideas]. I did that in order to make sure what I was thinking and feeling were truly in the core of my own belief system." Interaction with others was both formal, with therapists or support groups, and informal, with mentors and friends, and served to both challenge and support participants as they worked through this conflict.

Participants also tried out new behaviors. They visited different Christian and non-Christian churches, experimented with same-sex behaviors, and formed same-sex relationships. For example, Deborah, who grew up in the Lutheran Church, "went on a quest trying to figure out what it was that did fit" her idea of a spiritual place. She was introduced to Wicca by a friend, and went on to practice it. Similarly, Laura was introduced to a new spirituality in her visits to a Native American community. She said, "the great thing was that, within that community. . . there was a place for me as a gay person." Interestingly, some respondents described new sexual behaviors as well. Allen, laughing when he recounted his first sexual experience, commented:

> Oddly, my first real sexual experience was at a Christian college, in the dorm of a Christian college. There was a lot of turmoil. I'm supposed to be here strengthening my faith, finding my faith, becoming a minister or whatever I was going to do with my life, but homosexuality followed me to school.

### RESOLUTION

Working through the conflict between sexual identity and religious beliefs led participants to a point where they identified a resolution to this conflict. The first aspect of resolution was acceptance of their sexual identities as gay, lesbian, or queer. For Deborah, acceptance was a "huge life lesson." She was able to acknowledge that "this is who I am and I need to trust it because it's not going to change." In addition to accepting their sexual identity, participants moved away from organized religion to embrace a more personalized faith. Mark eloquently explained why these changes in faith were necessary:

> It's difficult to emphasize how often gay people need to realign our spiritual identities. Many of us keep them, but they have to be altered because, otherwise, there's no way that we could conceive of ourselves in a positive way.

Respondents described their personalized faith as either religious or non-religious; religious faith was defined as Christian for some and non-Christian for others. Hannah admitted that her version of Christianity today is "a lot different than what it was" before, when "it was very constricted." Now, she is "very open to other religions" as opposed to adhering to "the straight and narrow" path like she was taught. And even though Chad "found the church, and it's a great place to go to worship on Sunday," he also discovered that "really, truly what Christianity is about is fully being the person that you are, that God made you." Jennifer, who grew up Catholic, is focusing on deepening her faith and her relationship with her Catholic girlfriend.

Although some participants identified as non-religious, they also discussed having a more personalized faith. This faith, however, was in humanity rather than in God or a Higher Power. Jake, for one, believes in "karma" and tries "to be careful with other people." Allen, an agnostic, described losing his religious faith and replacing it with faith in people. Similarly, Sarah, an atheist who identifies as queer, said:

> I'm happier now and I believe in a better humanity than I ever did as a religious person. I'm more hopeful for the future than I ever was then. I push myself harder to be a good person in day-to-day life and to do a lot more service than I ever did when I believed in God.

It is important to note that participants described the process of resolving conflict between sexual identity and religious beliefs as ongoing. Mark commented, "I don't think that we're static individuals." Similarly, William remarked: "Life is a journey. . . . So, I just feel like that's part of what I'm here for, and I'm going to be open to the journey." Luke also captured the notion of a journey in the following remark:

> It's more of a process, more of a moving target rather than [going] from having these unresolved issues to having this resolution. So it's somewhere in between, and you're always moving, hopefully, more towards a resolution. So I recognize that in my life there's parts of that conflict that I'm more at peace with and there's still other parts of it that are not as comfortable for me.

### Personal and Contextual Factors

Each stage of the process of resolving the conflict between sexual identity and religious beliefs was influenced by the core categories of personal and contextual factors. Participants specifically described five personal factors: reflective abilities, strength and resiliency, anger, creativity, and humor. Reflective abilities allowed them to think critically through information regarding homosexuality and Christianity whereas strength and resiliency were important as they dealt with resistance from others. Expressing anger at organized religion and God helped them work through their emotions, and creative outlets, such as art and poetry, provided means for expression. Finally, humor enabled many to cope with the conflict.

Participants also identified three contextual factors that influenced the resolution process: family, community resources, and church doctrine. For those whose families were accepting of their sexual orientation, it was somewhat easier to resolve the conflict between sexual identity and religious beliefs. Moreover, those who lived in communities with resources for gay, lesbian, and queer individuals had less difficulty resolving conflict. Some participants even relocated to these communities so they could live as openly gay, lesbian, and queer individuals. Finally, because church doctrine can fall along a spectrum from condemning to accepting homosexuality, participants' religious upbringing impacted the resolution process. For example, those who grew up attending churches that were very condemning had more difficulty resolving the conflict between sexual identity and religious beliefs than those attending more accepting churches.

## DISCUSSION AND IMPLICATIONS

The findings of this grounded theory study led to three conclusions. First, resolving the conflict between sexual identity and religious beliefs is a five-stage process of internal conflict resolution. These five stages are an awareness of the conflict, an initial response to the conflict, a catalyst of new knowledge propelling participants forward, steps of working through the conflict, and resolution of the conflict. Second, personal and contextual factors affect every aspect of the resolution process. Finally, as discussed below, faith development and sexual identity development are intertwined and fluid constructions.

This grounded theory study contributes to the literature first and foremost by providing a substantive theory of the process of internal conflict resolution. Existing theories of conflict resolution focus on conflict among individuals, groups, and countries rather than internal, personal conflict. Furthermore, this research has multidisciplinary implications in that it adds to the growing body of literature on faith development, sexual identity development, and transformational learning, as well as conflict resolution.

The second conclusion that personal and contextual factors affect every aspect of the process of resolving conflict reinforces their centrality in a life span perspective of human development. That these factors were so influential is not surprising, given that behavior is considered to be a product of both the person and the environment (Chuang, Liao, & Tai, 2005; Vermunt, 2005). Social workers have long taken a holistic view of development, acknowledging the dynamic and reciprocal relationships between personal and contextual factors. Ecological systems theory, a foundational theory in the social work profession, reflects a synthesis of the ecological perspective and general systems theory (Rothery, 2001). Further, the existence of these personal and contextual factors in the conflict resolution process emphasizes a central notion in grounded theory, that a core category, or "story around which the analysis focuses" (Ezzy, 2002, p. 92) will emerge from the data.

The third and final conclusion is that faith development and sexual identity development are intertwined and fluid constructions for gay, lesbian, and queer individuals with a Christian upbringing. The participants in this study moved through Fowler's (1981) stages of faith development more rapidly than is usually the case because of the conflict they experienced between sexual identity and religious beliefs. However, having a Christian upbringing prolonged sexual identity development. Although the model of the internal conflict resolution process, at first glance, appears to be linear and concrete (see Figure 1), the process of resolving conflict between sexual identity and religious beliefs is fluid and interactive.

## Practice Implications

In addition to the three conclusions noted above, this study has several practice implications for social work and faith communities. First and foremost, it contributes to social work practice with gay, lesbian, and queer populations by providing a substantive theory by which individuals with a Christian upbringing resolve conflict between sexual identity and religious beliefs. According to Merriam (2009), a "grounded theory study seeks not just to understand, but also to build a substantive theory about the phenomenon of interest" (p. 23). Because substantive theories are grounded in data and have real-world applications (Glaser & Strauss, 1967; Merriam, 2009), this type of theory is especially useful for social workers. Understanding the process of conflict resolution will help practitioners who serve individuals coping with this particular circumstance. Professionals who are familiar with the process can begin by normalizing their clients' experiences, and, if they are able to identify where their clients are in the resolution process, they can introduce pertinent resources and information.

In recent years, the profession of social work has rekindled a focus on spirituality, faith, and religion. To this end, practitioners often include the spiritual dimension along with biological, psychological, and social dimensions in their multifaceted understanding of development. Understanding the interconnectedness of faith and sexuality in identity development is crucial for social workers serving this population. The participants in this study experienced depression as part of the process of dealing with the conflict between sexual identity and religious beliefs—an understandable psychological response considering the position communicated by many churches. The Jehovah's Witness organization, for example, disfellowships individuals who identify as gay, lesbian, or queer. In some circumstances, as with one participant in this study (Mark), individuals lose regular contact with their family members and friends who are part of the church. This type of isolation does not have the intended consequence of bringing individuals back into the fold, as many churches hope, but instead fosters even greater spiritual disenfranchisement.

In addition, social workers should be aware that welcoming Christian churches, such as MCC, Unitarian Universalist churches, and Episcopal churches, play an important role in the spiritual development of gay, lesbian, and queer individuals with a Christian upbringing. Participants in this study expressed heartfelt gratitude for congregations such as these; however, several said that their spiritual and religious needs were not met by churches that overly attended to sexual orientation. In other words, respondents explained that these churches focused more on sexual identity than on religious identity. Helping professionals can assist clients in exploring the varied messages they receive from faith communities as they develop faith and sexual identity.

## Limitations and Suggestions for Future Research

As in all research, this study had limitations. Because of the small, nonrandom sample, the findings cannot be generalized in the statistical sense. In addition, the participants are not representative of all gay, lesbian, and queer individuals with Christian backgrounds. Finally, despite efforts to seek a maximum-variation sample, the vast majority of participants were Caucasian individuals who identified as either gay or lesbian.

This study is the first step in exploring the process by which individuals resolve conflict between sexual identity and religious beliefs. Because only three individuals who identify as queer and three from underrepresented racial groups were included in this study's sample, it should be repeated with recruitment targeting these two populations. Furthermore, this study should be replicated with other populations in order to gain a more comprehensive understanding of the process of conflict resolution. For instance, the sample could comprise individuals who identify as bisexual and transgender as well as those with a Jewish or Muslim upbringing. Finally, future research should attempt to connect information learned about this process to practical interventions to be used in counseling gay, lesbian, and queer-identified individuals with a Christian upbringing.

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# Competing Selves: Negotiating the Intersection of Spiritual and Sexual Identities

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Psychotherapy has sometimes been seen as incongruent with religion and spirituality. This fact is even more pronounced when counseling lesbian, gay, and bisexual (LGB) clients, who feel as if their sexual orientation places them at odds with religious doctrine that is experienced as antigay. Postmodern theory provides a context for understanding socially constructed identities that may be in conflict with one another and may also provide some insight into how therapists may approach religious issues with LGB clients. The current study uses a mixed method design to investigate the relation between religious and sexuality variables in a sample of 422 LGB respondents. Quantitative results indicated that conservative religious beliefs were related to higher levels of shame, guilt, and internalized homophobia. Qualitative results appeared to highlight eight themes, the more dominant of which indicated that issues around sexual orientation were the catalyst for questioning or changing religious affiliation or beliefs.

*Keywords:* gay, lesbian, homosexual, religion, spirituality

The concept of socially constructed identities has been largely focused on single dimensions of identity such as racial identity (e.g., Cross, 1995; Helms, 1990, 1995), ethnic identity (e.g., Phinney, 1990, 1992), gender identity (e.g., Martin, Ruble, & Szkrybalo, 2002), and sexual identity (e.g., Cass, 1979; McCarn & Fassinger, 1996). These models, while substantial contributions to the scholarly literature, have generally not addressed *intersecting* social identities. Other models have attempted to integrate intersecting social aspects of the self (Jones & McEwen, 2000; Sue & Sue, 1990). However, these models rely on traditional views of the ideal self as unitary or integrated (Hoskins & Leseho, 1996). Such models cannot fully capture the dynamic that occurs when aspects of the self are in competition. Postmodern theory provides an alternative to the concept of the unitary or integrated self, providing a theoretical backdrop for instances where aspects of the self may be in competition. The postmodern position depicts the self as a "fluid, evolving character that is in a continual process of becoming" (Hoskins & Leseho, 1996, p. 245). This study explores the evolving postmodern self in an investigation of people who identify as lesbian, gay, or bisexual (LGB) and their evolving spiritual identities.

Understanding the intersection between sexual and spiritual identity has important treatment implications. LGB men and women are more likely than their heterosexual counterparts to present for mental health treatment (Cochran, Sullivan, & Mays, 2003). This may in part be due to findings that suggest that LGB people are significantly more likely to attempt suicide (McDaniel, Purcell, & D'Augelli, 2001) and are at increased risk for major depression, eating disorders, generalized anxiety disorder, panic disorder, poor self-esteem, alcohol dependency, drug dependency, and comorbid diagnoses (Cochran et al. 2003; Cole, Kemeny, Taylor, & Visscher, 1996; Diamant & Wold, 2003; Jacobs & Tedford, 1980; Matthews, Hughes, Johnson, Razzano, & Cassidy, 2002; Remafedi, French, Story, Resnick, & Blum, 1998; Russell & Joyner, 2001; van Heeringen & Vincke, 2000). This increased risk is often attributed to the stress stemming from social stigma and discrimination (Fife & Wright, 2000; Matthews et al., 2002; Mays & Cochran, 2001; Otis & Skinner, 1996) that are created in homophobic environments.

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Religious culture often creates homophobic environments resulting in a struggle to integrate spiritual and sexual identities for LGB. Individuals often leave or feel left by their faith in the process of securing an LGB identity (Lease, Horne, Noffsinger-Frazier, 2005; Davidson, 2000; Robinson, 1999), and conflict between religious and sexual identities has been associated with distress, including shame, internalized homophobia, depression, and suicidal ideation (Lease et al., 2005; Schuck & Liddle, 2001; Mahaffy, 1996). Most Protestant, Judaic, Islamic, and Catholic doctrines regard homosexuality as aberrant and view the expression of same-gender attraction as sinful or immoral. The Christian community is currently divided over issues like the acceptance of LGB worshippers and the affirmation of same-sex marriage (Higgins, 2002; Mahoney, 2001). This debate has been described as the most controversial issue facing the church today (Davis, 2001). Gay Jews find themselves left struggling to negotiate ethnoreligious and sexual identities not wanting to be considered "less-than" Jews (Schnoor, 2006; DuBowski, 2001). The Vatican of the Catholic church issued a statement by then Cardinal Ratzinger, now known as Pope Benedict the XVI, that homosexuals are objectively disordered and inclined towards evil (Ratzinger, 1986). Finally, literature found in American mosques urges followers of Islam "to rob and inflict violence on Muslims who engage in homosexual acts" (Douthat, Henry, & Poe, 2005). The psychological effect of antigay doctrine can be devastating to LGB people (Haldeman, 2002). Helminiak (1986, 1995) asserts that spiritual challenges are at the forefront of the gay and lesbian experience.

However, spiritual/religious involvement can also be among the most salient (Miranti, 1996). In fact, one survey suggested that 72% of those surveyed described religion as the most influential aspect of their lives. For some, its significance to the self takes place even before an awareness of gender (Bergin & Jensen, 1990). Sexual identity can develop while religious identity is also taking shape, and this codevelopment creates a potential conflict with competing claims about identity and behavior (Yarhouse & Tan, 2005). Conversely, Barret and Barzan (1996) suggest that rejecting traditional religious institutions allows LGB people the freedom to reflect and construct an individualized spiritual self. Developing a sense of spirituality separate from formal institutionalized religious experiences can mediate the effects of negative religious experiences on the psychological health of LGB individuals (Lease et al., 2005; Davidson, 2000). However, the dissonance between religious and LGB identities can be a catch-22 for some clients (Bartoli & Gillem, 2008). For these clients, the spiritual self serves as a central organizing aspect of identity, which cannot be relinquished or shifted, even if it means sacrificing an affirming, representative sexual identity (Haldeman, 1996). Some of the most prejudicial attitudes toward gay Christians are expressed within the LGB community (Maynard & Gorsuch, 2001). For these reasons, it can be easier for some LGB people to come out as gay in their religious communities than it can be to come out as religious in their gay communities (Haldeman, 2002). As a result, they may find themselves not only unwelcome in church because of their sexual orientation (Tubbs, 2001), but they are also viewed as antithetical to the gay movement because they are religious (Swanson, 2004).

Overall, the available survey research suggests that most LGB individuals place an importance on both their spiritual and sexual identities (Rodriguez & Ouellette, 2000). However, evidence suggests the relation between sexual identity and spiritual identity is not a linear process that easily captures how LGB people organize these potentially competing aspects of the self. While discussion continues about the impact of antigay sentiments in religious communities, the extent to which this conflict impacts LGB people negatively, particularly to the point of warranting mental health treatment, is less clear. Taken from a postmodern perspective, a mixed-method approach to inquiry is required. Because research is limited in this area, broad areas of religion/spirituality and its possible effects on LGB individuals were investigated in the quantitative portion of the study. How much religion was emphasized in one's childhood, one's level of spiritual and religious well-being, and how conservative or liberal one experienced their church of origin, were chosen as predictors of shame, guilt, and internalized homophobia. Qualitative inquiry was then used to put the quantitative findings into a broader context of personal narrative and individual experience.

## Method

### Participants

Participants were part of a nationwide sample who responded to requests posted on online LGBT list serves and Web sites. Online research participants have been shown to have greater sample diversity (Gosling, Vazire, Srivastava, & John, 2004) and greater likelihood of honest responding (Locke & Gilbert, 1995; Turner et al., 1998). A total of 373 respondents completed the quantitative measures, and 422 respondents completed the qualitative question. Both the quantitative and qualitative questions were provided in the same questionnaire posted online. The current study is a mixed-method study in which one method was not meant to be predictive of the other. Therefore, all data were preserved, even if there were more respondents opting to complete the qualitative question than the quantitative question. Forty-one percent were identified as male, 58.2% as female, and .8% as intersexed. Responding to the demographic of gender, 40.9% were identified as male, 57.25% as female, and 1.9% as transgender. The average age of the sample was 31.9 (*SD* = 12; range 16–83). The sample was predominately Euro-American (84.6%), followed by Latino/Latino-American (5.9%), Asian/Pacific Islander/Asian-American (3.8%), African/African American (2.7%), Native American (1.9%), and Middle Eastern/Middle Eastern American (1.1%). Participants were encouraged to identify their partner status as they defined it, regardless of whether the status was legally recognized by their state. As such, 43.7% identified as single, 15% married, 20.1% cohabitating, 15% not cohabitating but in a committed relationship, 2.1% in more than one relationship, 2.7% divorced, 1.1% widowed, and .3% separated.

### Instruments

**Demographic and qualitative information.** A number of demographic questions were of interest in this study. Participants were asked about their past and current religious practices and how accepting, tolerant, or hostile they perceived those religions to be. The same questions were asked of their current chosen religion, as well as several questions addressing if and why participants changed religions since becoming an adult. One question included in the analysis read: "Regarding the religion with which you were affiliated growing up, on a scale of 1 to 7, how conservative or liberal do you think it was?" This was scored on a 7-point Likert scale from 1 (*very conservative*) to 7 (*very liberal*). If participants did not have a childhood religion, this item was left blank. Finally, participants were asked to write a narrative answer to the question "Briefly describe your experience regarding religion and your sexual orientation."

**The Religious Emphasis Scale (RES; Altemeyer, 1988).** The RES is a 10-item measure intended to measure the extent to which one's parent emphasized the family religion as one was growing up. Reponses are made on a 6-point, Likert-type scale. An example question asks a respondent to rate how much emphasis was placed on "Praying before meals" or "Discussing moral "do's" and "don'ts" in religious terms." The internal consistency coefficient alpha estimate for the current sample was .94.

**Quest Scale (Batson & Schoenrade, 1991a, 1991b).** The Quest Scale is a 12-item measure intended to assess three distinct aspects of religious orientation: the readiness to face existential questions, the experience of self-criticism and religious doubts as positive, and an openness to change. Respondents rate each question on a 9-point Likert type scale. The internal consistency alpha coefficient estimates were .62 for the existential scale, .70 for the doubting as positive scale, and .20 for the openness to change scale. Due to the low alpha coefficient estimate for the openness scale, this scale was deleted from interpretation. Interestingly, the item reading, "There aren't many religious issues on which my views are still changing" was primarily responsible for the low alpha coefficient on this scale. It is possible that this scale does not measure the same construct in LGBT samples.

**Spiritual Well-Being Scale (SWBS; Ellison, 1983).** The 20-item SWBS asks people to rate on a 6-point scale (*strongly agree* to *strongly disagree*) both their religious and existential (nonreligious) well-being. All items are summed to form three scale scores: one score for religious well-being (RWB), one score for existential well-being (EWB), and one score for total spiritual well-being (SWB). Because existential well-being was assessed using the Quest, only the RWB subscale was used for the current analysis. This particular subscale assesses the degree to which an individual perceives the well-being of their spiritual life as it is expressed in relation to God. Higher scores are indicative of greater well-being. The internal consistency alpha coefficient estimate for the current sample was .94.

## Internalizing Outcomes

**Harder Personal Feelings Questionnaire (PFQ2; Harder & Zalma, 1990).** The PFQ2 is a 22-item instrument designed to assess proneness to shame and guilt. The scale consists of a list of feelings and respondents are asked to endorse how common the feeling is to them on a 5-point Likert-type scale. The internal consistency alpha coefficient estimate for the current sample on the shame scale was .86 and for the guilt scale was .84.

**Internalized Homophobia Scale (IHS; Ross & Rosser, 1996).** The IHS is a 26-item instrument designed to assess internalized homophobia in LGBT samples. Internalized homophobia is defined as the reaction to the stigmas associated with a LGBT sexual orientation. The IHS has four subscales as well as an overall scale. For the purposes of the current research, the overall mean score was used. Participants are asked to rate items on a 7-point Likert-type scale. Because the language of some of the items were outdated (use of the word "homosexual" rather than "gay" or "queer") and because some of the items were specific for men (i.e., I do not feel confident about making an advance to another man), some of the language was changed to more current queer-affirming language that also incorporated women's experiences. The internal consistency alpha coefficient estimate for the current sample was .75.

# Results

## Quantitative Results

Demographically, a total of 29.3% of respondents said they converted from a nonaffirming or affirming religion, 14.5% said their beliefs were already affirming, 10.5% said they rejected God/religion, and 12.4% said they continued their beliefs but felt shame/guilt. About 20% of participants stated concepts of God/religion were dealt with before coming out, 20% were always comfortable, and 10% said they still struggled although they were out.

From a statistical perspective the researchers were interested in the extent to which religious variables predicted internalized outcomes for LGBT participants. A canonical correlation analysis was conducted using the religion variables (Quest-existential, Quest-self-criticism, and religious doubts as positive, RWB, RES, and a single-item measure of whether the participants' childhood religion was rated as conservative or liberal on a 7-point scale) as predictors of the internalizing outcome variables (shame, guilt, internalized homophobia) in order to analyze the multivariate shared relationship between the two variable sets. Collectively, the full model across all functions was statistically significant using the Wilks' lambda ($\lambda$) criterion, $F(15, 839.61) = 2.84$, $p < .001$ yielding an effect size of .128. Model 2 to 3 was also statistically significant, $F(8, 610) = 2.30$, $p = .02$, yielding an effect size of .058.

Table 1 provides a list of the standardized canonical coefficients for functions 1 and 2. Results indicated that the more one experienced religious doubts as positive, viewed the church in which they were raised as liberal minded, and the less ready they were to face existential questions, the less shame and internalized homophobia those participants experienced. Additionally, the more participants experienced religious well-being and the more ready they were to face existential questions, the more shame and guilt they reported experiencing.

It should be noted that while both of these findings are interesting, functions 1 and 2 accounted for only 12.8% and 5.8% of the variance, respectively. In other words, while there was statistical significance, the practical or clinical significance of these findings is tentative at best. Therefore, a mixed method design sheds further light on the research questions of interest.

## Qualitative Results

One qualitative question was asked of participants: "Briefly describe your experience regarding religion and your sexual orientation." This was answered by 422 respondents. Because these were not interviews, the researchers were more interested in what stories people chose to tell with no prompts aside from the original

Table 1
*Canonical Solution for Religion Variables Predicting Internalizing Variables (N = 312 Cases)*

| | Function 1 | | | Function 2 | | |
|---|---|---|---|---|---|---|
| Variable | Coef. | $r_s$ | $r_s^2$ | Coef. | $r_s$ | $r_s^2$ |
| Existential | .351 | .079 | 00.62% | −.368 | −.405 | 16.40% |
| Doubting as positive | −.804 | −.730 | 53.29% | −.183 | −.357 | 12.75% |
| Religious emphasis | .008 | .199 | 03.96% | −.185 | −.010 | 00.01% |
| Religious well-being | .288 | .260 | 06.76% | −.872 | −.840 | 70.56% |
| Conservative/liberal | −.511 | −.604 | 36.48% | −.262 | −.191 | 03.65% |
| $R_c^2$ | | | 07.40% | | | 04.50% |
| Shame | .423 | .560 | 31.36% | −.798 | −.824 | 67.90% |
| Guilt | −.290 | .279 | 07.78% | −.340 | −.772 | 59.60% |
| Internalized homophobia | .876 | .963 | 92.74% | .563 | .142 | 02.02% |

*Note.* Coef. = Standardized canonical coefficients; $r_s$ = structure coefficient; $r_s^2$ = structure coefficient squared or variance explain.

question. Religious and spiritual orientations are closely linked to the totality of a person's identity, interpersonal experience, and cultural background. Briefly, it is important to define what is meant by the terms religion and spirituality for the purposes of the current study. The two terms are often used interchangeably, although they connote very different aspects of a person's relationship with the divine (Bartoli & Gillem, 2008). Spirituality has been described in more personal or experiential terms (Hill, Thompson, & Williams, 2000) where religion, in contrast, is now more often identified with both personal beliefs (God or higher power) and organizational or institutional beliefs (Zinnbauer et al., 1997).

Data was analyzed consistent with a postmodern, constructivist approach to inquiry using a consensual qualitative approach (Hill et al., 2000). Respondents were provided the open-ended question, three judges from three different religious and sexual orientation perspectives (Female/Lesbian/Spiritual; Female/Straight/Catholic; Male/Gay/Catholic-Jewish) read the data independently and coded for themes. Initially, 21 themes were identified. The team conducted further analysis and was able to reach consensus on eight final themes to capture the responses. These are as follows:

**Sexuality issues made me question my religious beliefs.** Sexual identity as the catalyst for questioning, and subsequently shifting, religious beliefs was indicated in 170 responses. Often, people cited Episcopal, Pagan, or more liberal sects of their own religion, as ways they were able to reconcile the desire to maintain a religious identity while also being in an affirming religious environment. Others rejected religion or became more spiritual without needing to be associated with an organized religion. In all of these responses, sexual identity was cited as the reason for the questioning or change in religion. One participant wrote about his religion's stance against homosexuality stating, "religion denies my own existence!" Another writes, "I started avoiding it and then looked for a gay and lesbian temple." Not all responses reflected total reconciliation with the process. Some reflected on the sense of loss they felt in the process. One participant wrote that although she and her partner attended LGBT-affirming Unitarian services she wrote, "I regret that I cannot experience group activities that I celebrated as a Jew." Finally, another wrote "I always told people that if I were straight, I never would have questioned what I believed, been a FANTASTIC Christian, and maybe even become a pastor." This supports previous research that indicated 69% of gay male participants said they had turned away from organized religion, choosing instead to accept their sexual identity (Wagner, Serafini, Rabkin, Remien, & Williams, 1994) and that this strategy of reorganization is often associated with grief and loss (Ritter & O'Neill, 1989; Bartoli & Gillem, 2008; Davidson, 2000; Haldeman, 2001).

**Spiritual, but not religious.** The second largest group talked about being spiritual, rather than religious, and discussed God as a loving and accepting being. Some of these 75 responses discussed organized religion's stance on homosexuality. One participant wrote, "I have learned 'to believe' that God is very beautiful and wonderful. God cannot condemn or hate his children. At least, that is not the kind of God I was raised to believe in. No one will ever change my mind about that, even though my church may not see it that way." Finally, another wrote, "I feel it is very possible to be homosexual and have a healthy spiritual life. I personally do not identify as religious, but I do identify as spiritual."

**It was never an issue.** The third group indicated that the intersect of religion and sexual identity was never an issue for them. For these 71 responses, participants tended to fall into two different subgroups. The much larger subgroup had either never been exposed to religion or never felt dissonance between the two. One person wrote, "My father would never allow me to go to church. He did not want church members to 'brainwash' me and influence me in any way." Another simply wrote, "Religion, when I did take part in it as an adolescent, had nothing to do with sexual identity." A few people constituted a second subgroup who believed either their religion was affirming of their sexual identity from the beginning, or the issues were so small they were negligible. One person wrote, "They really didn't affect each other; religion was open to my sexual orientation." Another talked briefly about her church's stance on homosexuality and concluded, "Regardless of the church's official decisions, I am still totally convinced that it is possible to live as both a lesbian and a faithful Christian."

**Rejected religion for other reasons besides my sexual identity.** The fourth group of 48 participants indicated they rejected religion for other reasons. Other reasons often cited were hypocrisy, feeling religion-restricted growth, or they indicated they just never liked religion in general. For example, one person wrote, "I don't think I dumped religion because I was gay. I think it had more to do with getting educated in general and casting a more critical eye on religion in the process." A second wrote, "I really lost a lot of respect for my religion (Catholic) while in middle school/high school. Long before even recognizing my sexual orientation."

**Still searching or struggling.** These 43 respondents indicated they are still searching for a religious identity or spiritual belief system that feels congruent to them. These respondents noted feeling closeted by their religion and struggling with the decision to find an alternative. One wrote, "Continue to participate in weekly services but do not participate in social functions at church. There is nothing to attract gay or even single people. Do a few volunteer activities, but feel that if the others knew I am gay, that I would not be accepted and in fact thrown out and never invited back. We sing a song at church, which says, 'All are welcome in this place,' but I do not feel this applies to any who would come across as gay." Another wrote, "It's something I struggle with daily as religion had been my main support for the first 19 years of my life and I feel like my own personal foundation has been shattered because of the rejection."

**Oppression.** Forty-one participants indicated that the religion they had been most closely affiliated with in the past felt oppressive to women, used for political or minority oppression, and served only as a tool to control the masses. Feeling closeted and having a parent side with religion over their LGBT children were also common narratives in this theme. For most, this led to a decision to no longer affiliate with a specific religion. One respondent wrote, "But my disaffection with religion has less to do with their typically anti-homosexual bias than with its subtle efforts to gain inordinate power over people's freedom." Another wrote, "I had a 'falling out' with religion due to many factors, not one of which was sexual orientation. It bothered me that they were intolerant of gays and said that they would go to hell, but I was more concerned by the blatant sexist attitude and the way they all but condoned violence against women."

**Trauma and rejection.** A total of 25 responses had themes of trauma, blatant cruel rejection, sexual abuse by priests, being disowned by family, sent to conversion therapy, or otherwise banned from their church or childhood homes. One wrote, "The Catholic Church is full of perverted child molesters and sick abusive bastards." Another wrote, "My parents turned to our religion, South Baptist, for 'help' to 'fix' me after I came out to them. This led to therapy with Christian psychologists, false literature about homosexuals, and conferences on homosexuality put on by the Christian Coalition. This led me to hate my religion and all those associated with it, as my experiences were very negative and emotionally degrading."

**Themes for further exploration.** Three other themes were present in the data, but at relatively low numbers. However, these are worthy of discussion because they could represent important subsamples of the population that may present for treatment. The first is that one's culture, ethnicity, or nationality can intersect with sexual orientation to create an additional pressure. For example, one respondent wrote, "It wasn't religion that condemns me and makes me lie to my family, but rather cultural factors. Born and raised in Russia, homosexuality was condemned and persecuted, but not for religious reasons." The second theme dealt with suicidality. Four responses indicated suicidal thoughts or attempts as a direct result of an inability to reconcile the dissonance between religion and sexual identity. One man wrote, "When I realized that I was ultimately going to fail being heterosexual, and sleep with a man, I tried to kill myself by smashing my car into a bridge pylon. No one figured it was a suicide attempt I guess, because I was let right out of the hospital as soon as they decided I didn't have a concussion. I then decided I could not be homosexual AND Christian, and dropped out of all church services." This highlights the possibility that religion and sexuality may feel completely irreconcilable to some people. Considering that people who identify as LGBT are significantly more likely to attempt suicide than those who identify as straight, this highlights one potential reason. The third theme is the transgender experience. While only two responses alluded to being transgender, the overall impression was that this is a different experience than being gay, lesbian, or bisexual. One respondent wrote, "I would tell my mother that God made a mistake with me and that I should have been a boy not a girl. She would just laugh it off and say God doesn't make mistakes. Well, now that I'm a lesbian she accepts me for who I am even though I still feel that God has made a mistake." While many of the LGBT responses talked frankly about their struggles with God and religion, none of them believed that their sexual identity was a mistake.

## Discussion

The current study addresses the conflict between spiritual identity and LGB sexual identity. Using a mixed method design, results indicate that higher levels of shame, guilt, and internalized homophobia were associated with the view that doubting one's religion was not okay, an overall feeling of religious well-being, and a history of perceived conservatism in one's religion in childhood. Those with higher levels of shame and doubt also felt more ready to face existential questions, possibly because of this variable's positive relationship to variables that tended to measure more traditional beliefs in God and a grounding in religious doctrine.

While statistically significant, the practical significance is attenuated by the modest effect sizes. Qualitative data provided additional information and a context from which to interpret the quantitative findings. Responses indicated that most LGB individuals believed their sexuality was the catalyst for questioning their religious identity and making religious shifts. The demographic information supports this data where almost 40% of the respondents either rejected religion or God or converted to a religious view more affirming of their sexual orientation.

The small effect size plus the qualitative finding may suggest that most LGB individuals are able to resolve the conflict of these competing identities and reorganize these identities in ways that work for them. One way this occurs is by turning to places of worship that welcome them with open arms. Worthington (2004) notes that affirming religious organizations in some LGB communities surpass political action organizations and that almost all denominations have an LGB counterpart committed to reconciling faith traditions with a positive sense of LGB identity. Although these institutions are limited in number, their congregations are among the fastest growing in the nation (Lukenbill, 1998). Some organizations, such as the United Church of Christ or the Unitarian Universalists, are religious institutions which explicitly welcome people of all sexual orientations and honor their relationships. Other institutions such as the Metropolitan Community Church (MCC) were created by members of the gay community to fill this niche and are comprised of not only predominantly gay congregations, but are also presided over by LGB people. Finally, many LGB people have turned to ancient religious traditions, such as Native-American (Kaufman & Raphael, 1996) and Pagan (Palmer, 1994; Neitz, 2000; Griffin, 1999) faiths, as a source of spiritual comfort. The current study supports research suggesting that gay-affirming church involvement enables LGB people to alleviate the conflict between sexual and religious identities (Lukenbill, 1998; Perry, 1990; Piazza, 1994; White, 1994).

## Limitations

Like all self-report, point-in-time studies, causal relationships cannot be implied and participants' answers are vulnerable to response bias, reactivity, and random responding. This study intended to look at within-group constructs rather than using a straight comparison sample. The qualitative responses relied on one question rather than several and because the participants wrote responses independently, there was no opportunity for clarification by the examiner, potentially leading to error in the classification of qualitative responses. Finally, the current sample was largely White, Euro-American, and was limited to people with internet access and a desire to answer internet surveys. Participants may have self-selected somewhat, based on their interest in the research topic. Therefore, the generalizability to people who do not meet these criteria is limited.

## Implications for Treatment

Psychotherapy is too frequently at odds with religion and spirituality, especially where they intersect with sexual orientation, but their collisions need not be damaging for spiritual LGB clients. Some scholars have debated whether depolarizing the debate between spirituality and sexuality is even possible or appropriate (Morrow, Beckstead, Hayes, & Haldeman, 2004). There is a clear body of evidence showing that therapy is value-laden and that counselors and clients often share different value systems. This counselor-client value dissonance is nowhere more apparent than when dealing with issues of spirituality and sexuality (Zinnbauer & Pargament, 2000). Postmodern cognitive theory provides a theoretical basis for developing skill sets to negotiate these values by proposing that personal identities are relationally and socially constituted (Cox & Lyddon, 1997). In other words, the social constructs of what it means to be "gay" or what it means to be a "Christian" permeate the person construct of one's understanding of his or her sexual identity. Therapy then becomes a process of investigation into the meaning making behind social and person constructs of the self, couched in a highly affirming therapeutic relationship. Such a therapeutic stance relies less on disordered thinking and diagnosis (adjustment disorder, gender dysphoria, personality disorders) and more on understanding the individual meaning making process around social constructs that appear to be impeding adjustment.

For those whose spiritual self feels more salient, the renegotiation of one's sexual self may be considered. This is accomplished by either refraining from sexual behavior (acknowledging a LGBT orientation, but not acting on it) or by attempting to change one's sexual orientation through conversion therapy (Brooke, 1993; Malloy, 1981). Research suggests that conversion therapy is largely unsuccessful and has been shown to be detrimental to the mental health of clients (Shildo & Schroeder, 2002) due to increased feelings of guilt, depression, difficulties in forming relationships with other men, and a generalized sense of de-masculinazation (Haldeman, 2001). Although the American Psychological Association (APA, 1999) and other mainstream mental health organizations have issued policy statements affirming that homosexuality is not a mental disorder and disavowing treatments based on this premise, conversion therapy is still encouraged through some religious organizations.

This is particularly important since people from diverse backgrounds are routinely pathologized from a dominant-culture perspective. A clear practical implication is the development of psychotherapy approaches that do not pathologize or raise client spiritual or religious beliefs, or client sexual orientation without clear empirical or clinical justification (Zinnbauer & Pargament, 2000). The current data suggest that multiple selves do not necessarily become fragmented or overly conflicted. A therapist should not, as the authors initially did, make assumptions that a client who identifies as both spiritual or religious, as well as LGB is necessarily dealing with a conflict in negotiating their identities. As the current study has shown, many LGB people have successfully negotiated the integration of these two aspects of identity in a way that allows them to feel congruent and free from identity conflict. People are effectively able to adjust aspects of the self in useful and adaptive ways. Therefore, when LGB clients present for mental health treatment, therapists should discuss these identities with their client before dedicating time in therapy to deal with an issue that is not a problem for their client. However, it is likely that those who are unable to make these adaptive adjustments are the ones who come to psychotherapy for help.

However, for those individuals who are not able to reconcile their sexual and spiritual identities, the conflict is particularly strong. As noted in the current study, a significant number of respondents continued to report struggles in reconciling spiritual and sexual identity constructs. Since research suggests that the ability to integrate spirituality and sexuality increases one's mental health (Wagner et al, 1994), the ability of counselors to help clients negotiate such conflicts becomes an essential skill set. As discussed earlier, because LGB people are more susceptible to a number of psychological disorders due to exposure to discrimination, therapists should exercise more oversight over LGB clients dealing with this identity conflict, as they may be especially vulnerable. Therapists should assist these clients to find ways to continue to follow their chosen religion in a way that does not exacerbate psychological trauma, or to create meaningful spiritual communities that accept their dual identities. The ultimate goal is renegotiation through a dynamic and complex self-reorganization process, taking place in a safe environment that allows the client to explore the conflict (Bartoli & Gillem, 2008).

It is also necessary to address the practical implications for the therapist who will experience countertransference to the material presented by the client. The reality is that there are professionals who hold religious beliefs that are not affirming to the LGB orientation. Those responsible for culturally sensitive training may not always know when to intervene when the cultural diversity of one's mindset (i.e., conservative religious) impedes the cultural diversity of another's (i.e., LGB). Counselors who are informed by self-reflection, an understanding of a variety of spiritual and religious beliefs, and an awareness of their own feelings around the spectrum of sexual orientation are those best equipped to provide effective mental health services to religious and spiritual LGB clients. Anything less, and counselors risk acting as unethical and subversive moral agents (Zinnbauer & Pargament, 2000).

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-08)

Introduced by: Resident and Fellow Section, Massachusettes Medical Society, California Medical Association, Medical Society of the State of New York

Subject: Removing Financial Barriers to Care for Transgender Patients

Referred to: Reference Committee A

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Whereas, The American Medical Association opposes discrimination on the basis of gender identity[1] and

Whereas, Gender Identity Disorder (GID) is a serious medical condition recognized as such in both the Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text Revision) (DSM-IV-TR) and the International Classification of Diseases (10th Revision),[2] and is characterized in the DSM-IV-TR as a persistent discomfort with one's assigned sex and with one's primary and secondary sex characteristics, which causes intense emotional pain and suffering;[3] and

Whereas, GID, if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death;[4] and

Whereas, The World Professional Association For Transgender Health, Inc. ("WPATH") is the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders,[5] and has established internationally accepted Standards of Care [6] for providing medical treatment for people with GID, including mental health care, hormone therapy and sex reassignment surgery, which are designed to promote the health and welfare of persons with GID and are recognized within the medical community to be the standard of care for treating people with GID; and

Whereas, An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID; [7] and

Whereas, Health experts in GID, including WPATH, have rejected the myth that such treatments are "cosmetic" or "experimental" and have recognized that these treatments can provide safe and effective treatment for a serious health condition;[7] and

Whereas, Physicians treating persons with GID must be able to provide the correct treatment necessary for a patient in order to achieve genuine and lasting comfort with his or her gender, based on the person's individual needs and medical history;[8] and

Whereas, The AMA opposes limitations placed on patient care by third-party payers when such care is based upon sound scientific evidence and sound medical opinion;[9, 10] and

Whereas, Many health insurance plans categorically exclude coverage of mental health, medical, and surgical treatments for GID, even though many of these same treatments, such as psychotherapy, hormone therapy, breast augmentation and removal, hysterectomy, oophorectomy, orchiectomy, and salpingectomy, are often covered for other medical conditions; and

Whereas, The denial of these otherwise covered benefits for patients suffering from GID represents discrimination based solely on a patient's gender identity; and

Whereas, Delaying treatment for GID can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients' health and strain the health care system; therefore be it

RESOLVED, That the AMA support public and private health insurance coverage for treatment of gender identity disorder (Directive to Take Action); and be it further

RESOLVED, That the AMA oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician (Directive to Take Action).

Fiscal Note: No significant fiscal impact.

## References

1. AMA Policy H-65.983, H-65.992, and H-180.980
2. Diagnostic and Statistical Manual of Mental Disorders (4th ed.. Text revision) (2000) ("DSM-IV-TR"), 576-82, American Psychiatric Association; International Classification of Diseases (10th Revision) ("ICD-10"), F64, World Health Organization. The ICD further defines transsexualism as "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex." ICD-10, F64.0.
3. DSM-IV-TR, 575-79
4. Id. at 578-79.
5. World Professional Association for Transgender Health: http://www.wpath.org. Formerly known as The Harry Benjamin International Gender Dysphoria Association.
6. The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version (February, 2001). Available at http://wpath.org/Documents2/socv6.pdf.
7. Brown G R: A review of clinical approaches to gender dysphoria. J Clin Psychiatry. 51(2):57-64, 1990. Newfield E, Hart S, Dibble S, Kohler L. Female-to-male transgender quality of life. Qual Life Res. 15(9):1447-57, 2006. Best L, and Stein K. (1998) "Surgical gender reassignment for male to female transsexual people." Wessex Institute DEC report 88; Blanchard R, et al. "Gender dysphoria, gender reorientation, and the clinical management of transsexualism."J Consulting and Clinical Psychology. 53(3):295-304. 1985; Cole C, et al. "Treatment of gender

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8. The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, at 18.
9. Id.
10. AMA Policy H-120.988

## Relevant AMA policy

### H-65.983 Nondiscrimination Policy

The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur. (Res. 127, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CEJA Rep. 2, A-05)

### H-65.992 Continued Support of Human Rights and Freedom

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05)

### H-180.980 Sexual Orientation as Health Insurance Criteria

The AMA opposes the denial of health insurance on the basis of sexual orientation. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97)

### H-120.988 Patient Access to Treatments Prescribed by Their Physicians

The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-08)

Introduced by: Resident and Fellow Section

Subject: Physician Scientist Benefit Equity

Referred to: Reference Committee C

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Whereas, The importance of physician-scientists to modern medicine is well known as "Virtually everything now used in clinical medicine can trace its roots to investigations performed in a clinical or basic science department…;"[1] and

Whereas, The number of physician-scientists has been steadily declining and "There are nearly 25% fewer physician-scientists on medical school faculties today than two decades ago;"[2] and

Whereas, The reasons for the decline in the number of physician-scientists are numerous, they are known to include "the heavy accumulation of debt through many years of research training…" and "questions about earning a living from academic life:"[2] and

Whereas, A significant loss of benefits can occur when house staff work as physician-scientists and receive salary support from research training grants, such as provided by the National Institutes of Health (NIH) and other programs, including loss of health insurance, medical liability insurance, life insurance, disability insurance, and retirement benefits; and

Whereas, This loss of benefits can present a disincentive to resident physicians pursuing a research career and furthering medical knowledge to improve patient care; and

Whereas, This loss of benefits produces inequities between resident physicians serving in research versus clinical roles within the same institution; therefore be it

RESOLVED, That our AMA support the concept that all resident and fellow physicians who function in a role as physician scientists are provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships, to include disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience, and if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents.

Fiscal Note: No significant fiscal impact

**References**

1. Neilson EG, Ausiello D, and Demer LL. J. Invest. Med. 1995, 43(6), 534-542
2. Neilson EG. J. Clin. Invest. 2003, 111(6),765-7.

## Relevant AMA-RFS Policy

**310.799R Benefit Packages for Resident Physicians**
Resolved 1) that the AMA-RFS seek to assure that all institutions be required to provide their resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and 2) if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents. However, this provision cannot be used to eliminate the benefit in question. (RFS Substitute Resolution 13, I-92: Reaffirmed: RFS Report C, I-02)

**310.992R Minimum Resident Benefits**
Asked that the AMA-RFS continue to monitor the revision of the "General Requirements" of the Essentials of Accredited Residencies in Graduate Medical Education for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (RFS Report I, I-89; Reaffirmed, RFS Report C, I-99)

## Relevant AMA Policy

**H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers**

Our AMA: (1) continues its strong support for the Medical Scientists Training Program’s stated mission goals;

(2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees;

(3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research;

(4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and

(5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00)

**H-310.999 Guidelines for Housestaff Contracts or Agreements**
The "Essentials of Approved Residencies, " approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.
Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical

Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.

It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to cover the more significant substantive provisions of a housestaff contract or agreement.

The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.

II. Proposed Terms and Conditions A. *Parties to the Contract or Agreement* (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.

B. *General Principles* (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.

C. *Obligation of the Housestaff* (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME "Essentials of Approved Residencies" and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject.

D. *Obligation of the Institution* (1) The institution agrees to provide an educational program that meets the standards of the ACGME "Essentials of Approved Residencies." (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME "Essentials of Approved Residencies."

E. *Salary for Housestaff* (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials.

F. *Hours of Work* There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of the housestaff, including the provision of adequate off-duty hours.

G. *Off-Duty Activities* The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.

H. *Vacation and Leave* The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefore, and educational conferences. Reimbursement for tuition and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.

I. *Insurance Benefits* Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.

J. *Professional Liability Insurance* The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.

K. *Committee Participation* Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.

L. *Grievance Procedures* The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance procedure, a prior agreement as to how these costs will be apportioned between the parties.

M. *Disciplinary Hearings and Procedure* With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.

N. *Description of the Educational Program* The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.

O. *Patient-Care Issues* The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.

P. *Other Provisions* The agreement should provide for adequate, comfortable, safe, and sanitary facilities.

The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings. (BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00)

**H-310.929 Principles for Graduate Medical Education**

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be

modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99)

**H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians**

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 1, I-934; Appended: Res. 311, I-98; Modified: Res. 306, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-08)

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| Introduced by: | Resident and Fellow Section |
| Subject: | Evaluation of Increasing Resident Review Committee (RRC) Requirements |
| Referred to: | Reference Committee C |

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Whereas, The creation of the Outcome Project and the development of the six core competencies from the Accreditation Council for Graduate Medical Education has lead to a novel and valuable shift in the focus of graduate medical education toward competency-based learning; and

Whereas, The shift in focus to competency-based learning has created a need for new assessment tools, structured curricula, and extensive documentation of resident performance data in an attempt to quantify a largely qualitative experience; and

Whereas, Excessive documentation requirements could detract from time available for residents and fellows to learn directly from patients during clinical encounters and less time for staff to teach residents, therefore be it

RESOLVED, That the AMA study residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement.

Fiscal Note: Estimated cost of $38,602 to visit between 10 to 20 GME sponsoring institutions and analyze work effort involved by a representative sample of program directors and Designated Institutional Officers to respond to ACGME accreditation requirements.

## Relevant AMA Policy

**H-315.982 CMS Documentation Guidelines for Teaching Physicians**
The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements: and (3) accept a statement of the teaching physician’s level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98)

**D-300.995 Reducing Burdens of CME Accreditation and Documentation**
Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-08)

Introduced by: Resident and Fellow Section

Subject: Loss of Status Following Family Medical Leave Act (FMLA) Qualified Leave During Residency Training

Referred to: Reference Committee C

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Whereas, Current AMA policy (H-420.967) states “Physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status”; and

Whereas, The Family Medical Leave Act (FMLA) guarantees that eligible employees be given “a minimum of twelve weeks of unpaid leave per year” for certain medical and family reasons (including pregnancy/childbirth) and be restored “to the same or an equivalent position” upon their return to work[1]; and

Whereas, Certain residency training programs require residents taking family medical leave (including maternity leave) for periods protected under the FMLA (up to 12 weeks) to repeat the entire year, citing this requirement as necessary to maintain board eligibility[2]; and

Whereas, Specialty board policies regarding board eligibility do not seem to explicitly require a resident taking family medical leave to repeat the entire year (rather than simply extend training) in the event of a resident taking a period of leave protected under the FMLA[3, 4]; and

Whereas, Residents who must repeat an entire year of training as a direct result of taking an FMLA-protected maternity leave suffer a “loss of status”, as well as lost potential income, as a result of taking maternity leave; and

Whereas, Perpetuation of policies that result in this kind of “loss of status” due to residents taking maternity leave lowers morale for many residents and may discourage women from entering the specialty of their choice [5, 6]; and

Whereas, Residency programs imposing such a requirement as a result of actual or falsely construed specialty board policy may unknowingly be committing a tort against those residents who suffered a “loss of status” and those who did not take desired leave as a result of the threat of “loss of status”; and

Whereas, The policies of the specialty boards regarding family medical leave and board eligibility requirements are extremely variable between specialties and confusing to residents and faculty alike; therefore be it

RESOLVED, That our AMA oppose requiring residents to repeat a year of training when returning to work following a leave that qualifies under the federal Family Medical Leave Act (New HOD Policy); and be it further

RESOLVED, That our AMA urge the American Board of Medical Specialties and its member boards to be in compliance with the Family Medical Leave Act and to retract any policies that do not comply (Directive to Take Action).

Fiscal Note: Less than $1000

**References**

1. U.S. Department of Labor: Compliance Assistance - Family and Medical Leave Act. http://www.dol.gov/esa/whd/fmla/
2. Jagsi R, Tarbell, NJ, and DF Weinstein. Supplement to "Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education." *New England Journal of Medicine*, 2007; 357(19): 1889-1891.
3. American Board of Orthopedic Surgery, Inc. 2008 Rules and Procedures for Residency Education. https://www.abos.org/documents/2008RP.doc
4. Rose, SH, Burkle CM, Elliott BA, et al. "The Impact of Parental Leave on Extending Training and Entering the Board Certification Examination Process." *Mayo Clinic Proceedings.* 2006; 81(11):1449-53.
5. Jagsi R, Tarbell, NJ, and DF Weinstein. "Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education." *New England Journal of Medicine*, 2007; 357(19): 1889-1891.

**Relevant AMA Policy:**

**H-420.967 Maternity Leave Policies**
Over the past decade, the medical community has made significant progress in responding to the unique needs of women medical students and physicians, including the issue of maternity leave. The continuation and enhancement of these efforts should be encouraged. Therefore,
(1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written maternity leave policies as part of the physician's standard benefit agreement.
(2) AMA policy regarding recommended components of maternity leave policies for physicians, as specified in Policy 420.987 is expanded to include physicians in practice, reading as follows: (a) Residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' work loads, particularly in residency programs; and (c) Physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status.
(3) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave. (BOT Rep. HH, I-90; Modified: Sunset Report, I-00)

**H-420.961 Education -- Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians**
AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity and Family Leave for Residency Programs and Employed Medical Staffs: (1) The AMA urges medical schools, residency training programs, medical specialty boards, and the

Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of written leave policies, including parental leave, family leave, and medical leave; (2) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (3) Physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (4) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (5) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (6) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; and (7) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification. Residency program directors must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility. (CME Rep. 6, A-98; Reaffirmation I-03)

**H-420.979 AMA Statement on Family and Medical Leave**
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98)

**H-420.987 Maternity Leave for Residents**
The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs. (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' work loads. (5) Residents should be able to return to their training program after disability leave without loss of training status. (BOT Rep. Z, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

**H-420.996 Maternity Leave for Housestaff**
Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant housestaff. (Sub. Res. 89, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

**D-310.970 Improving Parental Leave Policies for Residents**
Our AMA will study and encourage the Accreditation Council for Graduate Medical Education's participation in such study of (1) the feasibility of considering guaranteed paid maternity leave for residents of no less than six weeks duration, with the possibility of unpaid maternity leave of an additional six weeks; (2) written leave policies for residents for paternity and adoption; and (3) the effect of such maternity, paternity, and adoption leave policies on residency programs, with report back to the House of Delegates at the 2008 Annual Meeting. (Res. 303, A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-08)

Introduced by: Resident and Fellow Section

Subject: Telemedicine and Medical Licensure

Referred to: Reference Committee C

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Whereas, The advancement of telemedicine will allow patients both in the United States of America and worldwide to obtain excellence in healthcare; and

Whereas, Telemedicine promotes increased access to healthcare by eliminating travel expenses, aiding those with impediments to mobility, and connecting patients directly with the most highly trained physicians in the world; and

Whereas, Physicians who wish to obtain a U.S. state medical license must first successfully pass all three Steps of the United States Medical Licensing Examination, an examination sponsored by the National Board of Medical Examiners, not a state board medical examination; and

Whereas, Physicians wishing to be board certified in the U.S. must successfully pass their respective specialty board examination(s), usually a national board examination for each specialty, not a state specific specialty board exam; and

Whereas, Physicians nationwide should, to the best of their ability, practice medicine according to evidence-based medicine, regardless of where the physician was trained, the state in which the physician treats patients, or the state in which the patient is a permanent resident; and

Whereas, Currently each state has its own medical license which must be successfully applied for and maintained if a physician wishes to treat patients in that state (with limited consultative exceptions), and the application for and acquisition of a state medical license is typically a long process; and

Whereas, For physicians engaging in repetitive telemedicine activities, the maintenance of multiple active medical licenses is economically prohibitive as annual or semi-annual renewal fees accrue; and

Whereas, Physicians with a valid state license who practice in a Veterans Health Administration (VHA) Hospital are permitted to work in VHA hospitals beyond the state in which they are licensed, without being required to hold multiple licenses; and

Whereas, Our patients should be free to seek healthcare they deem most appropriate and the AMA should lead the charge for constant medical innovation by supporting increased access to excellent medical care; therefore be it

RESOLVED, That the AMA study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure (Directive to Take Action).

Fiscal Note: Estimated cost of $135,128 to develop instrument and conduct survey and follow up.

## Relevant AMA Policy:

### H-160.937 The Promotion of Quality Telemedicine

(1) The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: (a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. (b) Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. (c) Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. (d) The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. (e) Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. (f) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. (g) Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. (h) The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.
(2) The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.
(3) The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality. (4) The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Essentials and Standards of the Accreditation Council for Continuing Medical Education. (CME/CMS Rep., I-96; Reaffirmed: CMS Rep. 8, A-06)

### H-480.974The Evolving Impact of Telemedicine

Our AMA: (1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96)
(4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services;
(5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and

(7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01)

**H-480.969 The Promotion of Quality Telemedicine**
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99)

**H-480.961 Teleconsultations and Medicare Reimbursement**
Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

**H-480.968 Telemedicine**
AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to

meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

**H-480.984 Technology Assessment in Medicine**
(1) The AMA believes that technology assessment programs and coverage determinations should be based upon the following principles in order to assure sound clinical practice and equitable public policy: (a) The primary objective of health care technology assessment should be the development of accurate and complete information for physicians on safety, effectiveness, and clinical indications in order to enhance the appropriate utilization of health care technology. (b) The development of information on safety, effectiveness, and indications for use should be based upon a rigorous scientific methodology. (c) The primary responsibility for the conduct of technology assessment should rest with the medical profession, with participation from both the research and practice communities. Participation in such assessment by all appropriate medical specialties is important, particularly when use of the technology crosses specialties. (d) The pluralistic approach to technology assessment in both the public and private sectors should be strongly encouraged and continued. (e) The results of technology assessment must be communicated in an accurate and timely manner throughout the research and practice communities; specialty societies and other health care professional organizations should intensify efforts to disseminate such information. (f) Health care technologies should be re-evaluated on a continuing basis after their introduction, particularly if they are expensive or have the potential to cause serious harm if applied inappropriately. (g) Obsolete technologies should be identified and their further use should be discouraged. (h) Cost-effectiveness is an important consideration in technology assessment, but it should remain subordinate to considerations of safety and effectiveness. (i) Decisions as to the cost-effectiveness of technology can best be made by the physician on an individual patient basis, taking into consideration the needs of the individual and the results of cost-effectiveness analyses. Therefore, cost-effectiveness should not be used by payers to preclude or limit the availability of a safe and effective technology by either refusal to reimburse or by the provision of more limited reimbursement for such technology. (j) Payer determinations regarding coverage for health care technologies must be made with the involvement of the medical community and the public. Such determinations should be timely and responsive to the evolving information on safety and effectiveness. (k) Payer coverage policies for investigational technologies should be flexible and reviewed frequently so as to assure that the needs of individual patients are met. (l) Payers should integrate the concept of risk/benefit analysis into their decision-making and adapt their coverage policy accordingly. In serious and life-threatening illnesses, payers must recognize that patient and physician may agree upon a particular therapy, notwithstanding a lesser degree of certitude about that therapy's safety and effectiveness, if no other alternative therapies are available.
(2) The AMA should continue its efforts to educate the public about the contributions of innovations in health care technology to the health and well-being of all people and the prevention of disease.
(3) The AMA should emphasize access to effective technologies (and reimbursement for such technologies) which may be more appropriate for a subset of patients, even though other technologies may be more effective for the majority of patients for a given clinical condition, in order to protect physician judgment and patient preference in selection of therapy.
(4) When safety, effectiveness and availability have been established, cost should be a substantial determining factor in the choice of technology. (Joint CMS/CSA Rep., I-90; Reaffirmed: In Lieu of Res. 711, I-93; Amended: CSA Rep. 8, A-03)

**H-275.955 Physician Licensure Legislation**

Our AMA (1) reaffirms its policies opposing discrimination against physicians on the basis of being a graduate of a foreign medical school and supports state and territory responsibility for admitting physicians to practice; and (2) reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge. (CME Rep. B, A-90; Reaffirmation A-00)

**H-275.962 Proposed Single Examination for Licensure**

Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination, (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) urges that appointing graduates of LCME accredited medical schools to accredited residency training not be dependent on their passing Steps I and II or the single examination for licensure. (CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

**H-275.967 Licensure by Endorsement**

The AMA opposes national legislation which would mandate licensing reciprocity by all state licensing authorities. (Res. 42, A-88; Reaffirmed: Sunset Report, I-98)

**H-275.978 Medical Licensure**

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; and (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

**H-275.993 Examinations for Medical Licensure**
Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-08)

Introduced by: Resident and Fellow Section

Subject: Protecting Patients and Residents by Reducing Extended Work Shifts

Referred to: Reference Committee C

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Whereas, Five years have passed since both the American Medical Association (AMA) and the American Council on Graduate Medical Education (ACGME) adopted specific duty hour restrictions to protect residents, fellows, and patients[i,ii]; and

Whereas, The current duty hour restrictions continue to allow residents and fellows to work for up to 30 continuous hours with no dedicated time for sleep; and

Whereas, A growing body of literature published mostly in the past five years has shown that decreasing or eliminating extended work shifts (defined as shifts greater than 16 hours) may improve both resident quality of life and patient safety[iii,iv,v,vi,vii,viii,ix,x,xi,xii]; and

Whereas, This same body of literature also suggests that decreasing or eliminating extended shifts does not compromise resident education, even for residents in surgical programs[xiii,xiv,xv,xvi,xvii,xviii,xix,xx,xxi,xxii,xxiii]; and

Whereas, Despite the accumulated evidence, it would be premature to create a new mandate eliminating extended work shifts for residents and fellows at a time when many residency programs are still struggling to comply with the current duty hour restrictions; and

Whereas, Residency programs can instead be encouraged to voluntarily reduce or eliminate extended work shifts in order to improve resident quality of life and patient safety, allowing individual programs to move towards this goal at their own pace; and

Whereas, Decreasing or eliminating extended work shifts will require new team-based approaches to patient care as well as improvements in the way physicians communicate patient information to each other at the time of shift-change; therefore be it

RESOLVED, That our AMA reaffirm support of the current ACGME duty hour restrictions, and be it further

RESOLVED, That our AMA encourage the voluntary reduction or elimination of extended work shifts (>16 hours) for residents and fellows by academic medical centers and teaching hospitals while opposing a new ACGME mandate at this time, and be it further

RESOLVED, That our AMA continue to evaluate outcomes-based research on the impact of reductions in extended work shifts on (1) Patient Safety, (2) Resident Education, (3) Resident Safety, (4) Resident Quality of Life and (5) Professionalism in Transfer of Care, and be it further

RESOLVED, That our AMA develop specific prioritized research questions/objectives to further evaluate issues related to resident duty-hour reforms, such as best practices for signing out patients and organizing patient care teams.

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[ii] H-310.927

[ii] ACGME Duty Hours, 2007. Accessed at http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf on March 21, 2008.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-08)

Introduced by: Resident and Fellow Section

Subject: Pediatric Suspected Intentional Trauma

Referred to: Reference Committee D

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Whereas, More than 6,000,000 children were reported as maltreated and 899,000 were confirmed victims by child protective services in 2005,[1] and

Whereas, 62.8 percent of victims experienced neglect, 16.6 percent were physically abused, 9.3 percent were sexually abused, 7.1 percent were psychologically maltreated, and 2.0 percent were medically neglected,[1] and

Whereas, 1460 children died in 2005 from child abuse,[1] and

Whereas, Recent studies demonstrate that only 50-60% of abuse related deaths are reported making child abuse deaths as the least reported form of fatal maltreatment,[2] and

Whereas, Children who experience maltreatment are at increased risk for adverse health effects and behaviors as adults—including smoking, alcoholism, drug abuse, eating disorders, severe obesity, depression, suicide, sexual promiscuity, and certain chronic diseases,[3,4] and

Whereas, Maltreatment during infancy or early childhood can cause important regions of the brain to form improperly, leading to physical, mental, and emotional problems such as sleep disturbances, panic disorder, and attention-deficit/hyperactivity disorder,[5] and

Whereas, 25% to 30% of infant victims of shaken baby syndrome die from their injuries, and nonfatal consequences of shaken baby syndrome include varying degrees of visual impairment (e.g., blindness), motor impairment (e.g. cerebral palsy) and cognitive impairments,[6] and

Whereas, Victims of child maltreatment who were physically assaulted by caregivers are twice as likely to commit physical assault as adults, [7] and

Whereas, The direct costs (judicial, law enforcement, and health system responses to child maltreatment) are estimated at $24 billion each year. The indirect costs (long-term economic consequences of child maltreatment) exceed an estimated $69 billion annually, [8] and

Whereas, More than 53% of physicians do not report child abuse when they state they have a suspicion for abuse, [9] and

Whereas, Researchers found that 31% of traumatic head injuries were not recognized by the physicians who first evaluated these victims, [10] and

Whereas, Physicians serve on the front lines of detecting and diagnosing child abuse and yet less than 57% of physicians who are mandated reporters receive any training regarding child abuse reporting; therefore be it,[11]

RESOLVED, That our AMA support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and be it further

RESOLVED, That our AMA support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents.

Fiscal Note: Staff cost estimated at less than $500 to implement.

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## Relevant AMA Policy

### H-515.989 Evidence of Standards for Child Sexual Abuse

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a physician. (Res. 78, I-87; Reaffirmed: Sunset Report, I-97)

### H-60-990 Child Pornography

The AMA (1) supports reassembling an interdisciplinary panel of experts periodically to continue to address shared concerns and information relevant to the issue of child pornography; (2) encourages and promotes awareness of child pornography issues among physicians; (3) through physicians, encourages parents to use the educational textbook entitled, Sex Talk for a Safe Child; (4) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (5) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (6) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; and (7) cooperates with other national organizations and federal and local agencies in addressing the problem of child pornography. (BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98)

### H-60.961 HHS to Require the States to Repeal the Religious Exemption in the Child Abuse and Neglect Prevention Statutes

The AMA will petition the Secretary of HHS to remove the religious exemption in child abuse and neglect cases from the Code of Federal Regulations and to exercise administrative authority to urge state officials to repeal existing child abuse and neglect religious exemption provisions in state statutes, thereby restoring equal protection under the law for all children. (Sub. Res. 219, A-93; Reaffirmed by BOT Rep. 24, A-97)

### H-75.991 Requirements or Incentives by Government for the Use of Long-Acting Contraceptives

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved. (2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive. (3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk. (4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting

contraceptives should be covered by Medicaid and other health insurance programs, both public and private. (5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures. (BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04)

**H-60.992 Missing and Exploited Children**

To enhance physician involvement with issues related to missing and exploited children, the AMA supports the following statements and activities: (1) Child abductions and runaway behaviors are harmful and emotionally upsetting, divisive, and chaos-producing to victims and their families. Any disappearance of a child constitutes a family crisis with both victims and families at high risk for developing physical and emotional problems. Any child who is the object of a custody dispute is vulnerable to parental snatching, running away and/or being abused. (2) Medical interventions, including family therapy, should occur immediately after a child is reported missing; if the child returns home or is found dead, physicians and other health care professionals should continue to monitor the victim patient and/or the patient's family. (3) Children abducted by family members or strangers should be considered victims of child abuse and such occurrences should be designated as reportable instances of child abuse under state statutes. (4) Prevention efforts should focus on reducing family stress, combatting alcoholism and drug abuse, dealing with poor marital relationships including divorce mediation and counseling, and providing supportive services for families at risk. (5) All shelter services that are presently available to runaways and homeless youths should contain a high quality health care component. Comprehensive standards of health care should be developed for the national network of runaway centers. Physicians should be consultants to and work with governing boards of these agencies. (6) Children's medical records should be intelligible and include a complete medical history, distinguishing physical characteristics and detailed information, as outlined in the Child Identification Form developed by the AMA. The AMA encourages physicians to utilize this form in their practice settings. Pediatricians and family physicians should encourage parents to arrange for the speedy transfer of the child's previous medical records and physicians should respond promptly to such requests. The parent's refusal to comply with this request should warrant further questioning of the parents or a report of a possible missing child. (7) At prevention, diagnostic and treatment levels, physicians should attempt to identify troubled children and their families early and ensure that appropriate treatment takes place or that referrals are made to the other medical specialists or community resources. (8) The primary care physician, medical examiner and dentist are key members of the missing child identification team, and should be knowledgeable about the steps to be taken (completing the NCIC forms) immediately after a child is reported missing. (9) Physicians should actively promote the practice of obtaining clear and readable fingerprints and footprints as a technically useful way to document these unique physical characteristics of children. (10) State medical societies should consider establishing committees on child abuse and neglect, with the topic of missing and exploited children included in the charge of responsibilities. (11) The AMA supports continued research on abducted children (both parent and stranger abductions), runaways, homeless youth and their families, and how physicians can help them. (12) All levels of medical education should emphasize the diagnosis, comprehensive treatment and prevention of problems associated with families that suffer from stress and that may be related to problems of alcoholism, drug abuse, domestic violence and marital dysfunction. Educational programs should address the reactions of physicians to these complex and frustrating social problems. (13) The AMA supports cooperating with the American Academy of Pediatrics, the American Psychiatric Association, the American College of Obstetricians and Gynecologists, and the College of American Pathologists in developing and disseminating information about the health care needs of missing children and effective prevention strategies. (14) The AMA supports cooperating with the American Bar Association, the American Psychiatric Association, law enforcement agencies and the National Center for Missing and Exploited Children in considering the problem of identifying and tracking perpetrators of child abductions. (BOT Rep. O, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

**H-245.984 Treatment Decisions for Seriously Ill Newborns**
Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03)

**H-515.988 Repeal of Religious Exemptions in Child Abuse and medical Practice statutes**
Our AMA (1) reaffirms existing policy supporting repeal of the religious exemption from state child abuse statutes; (2) recognizes that constitutional barriers may exist with regard to elimination of the religious exemption from state medical practice acts; and (3) encourages state medical associations that are aware of problems with respect to spiritual healing practitioners in their areas to investigate such situations and pursue all solutions, including legislation where appropriate, to address such matters. (BOT Rep. H, A-90; Reaffirmed: Sunset Report, I-00)

**H-515.983 Physicians and Family Violence**
Ethical Considerations: (1) The medical profession must demonstrate a greater commitment to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, day care, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers.
(2) Informed consent for interventions should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents. Physicians can obtain authorization for further interventions from a court order or a court-appointed guardian. (3) Physicians should inform parents of a child-abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. The safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims physicians must not disclose an abuse diagnosis to caregivers, spouses, or any other third party without the consent of the patient. (CEJA Rep. B, I-91; Reaffirmed: CSA Rep. 7, I-00; Modified and Reaffirmed: CEJA Rep. 1, A-03)

**H-525.980 Expansion of AMA Policy on Female Genital Mutilation**
The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; and (4) supports that physicians who are requested to perform female genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores. (CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

**D-60.982 Long Term Effects of Early Abuse/Neglect on Brain Development**

Our AMA will: (1) work with national organizations, e.g., American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American College of Obstetricians and Gynecologists, and others involved with early brain research, child abuse and neglect and public education to make educational materials available to hospital infant and pediatric personnel, physicians, parents, other child care providers and educators and the public at large; (2) urge state and local medical societies to work with their legislators to put in place educational, and where appropriate, support programs for those involved with infants and young children, i.e., parents, students in junior and senior high school, child care providers, and early childhood educators; and (3) work with the federal government and pertinent agencies to make this issue--prevention of early abuse and brain damage with its devastating long term effects for individuals and society--a priority of our nation. (BOT Action in response to referred for decision Res. 526, A-02)

**D-515-993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse**

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will: (1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation’s health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5) invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-08)

Introduced by: Resident and Fellow Section

Subject: Accuracy of Internet Physician Profiles

Referred to: Reference Committee A

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Whereas, Various internet sites such as WebMD, VIMO and HealthGrades provide physician provider information such as education/training, practice type, location, board certification status, and disciplinary actions [1] ; and

Whereas, Information provided in internet physician profiles is often obtained from third party sources and may contain erroneous information such as inaccurate listing of specialty or practice location, and these sites do not claim accuracy of the provided information [2, 3, 4] ; and

Whereas, Physicians are not always notified that their provider information is being posted or provided open access to their full information profile, and may even be required to pay to see their full profile, and there is no mechanism for oversight of the physician profile information; and

Whereas, Patients are increasingly using the internet to review the credentials of their physicians [5], and may receive misinformation from these internet sites, therefore be it

RESOLVED, That the AMA investigate the publication of physician information on internet websites; and be it further

RESOLVED, That the AMA investigate potential solutions to erroneous physician information contained on Internet websites with report back at I-08.

Fiscal Note: Implement accordingly at estimated staff cost of $4,752.

## References

1. WebMD Find a Doctor page: http://www.webmd.com/healthcare_services/default.htm; VIMO Search for a Doctor page: http://www.vimo.com/doctor/; HealthGrades http://www.healthgrades.com/.
2. WebMD Legal disclaimer: “WebMD, its licensors, and its suppliers make no representations or warranties about the following: The accuracy, reliability, completeness, currentness, or timeliness of the Content, software, text, graphics, links, or communications provided on or through the use of the WebMD Site or WebMD” Accessed March 2, 2008 from http://www.webmd.com/policies/about-terms-and-conditions-of-use#part4.
3. VIMO legal disclaimer: “Vimo gathers data from a variety of different sources, public and private. While we strive to provide the most accurate, up-to-date information possible, we can't guarantee that our listings are completely without error” accessed March 2, 2008 from http://www.vimo.com/html/copyright.php.
4. HealthGrades legal disclaimer “HealthGrades obtains its information from sources it believes to be reliable. However, because of the possibility of human and mechanical error as well as other factors, HealthGrades makes no representations or warranties, express or implied, as to the accuracy or

timeliness of its information, and cannot be responsible or liable for any errors or omissions in its information or the results obtained from the use of such information." Accessed March 2, 2008 from http://www.healthgrades.com/consumer/index.cfm?fuseaction=modnw&modtype=content&modact=legal_disclaimer&tv_eng=home&tv=home.

5. Kaiser Family Foundation *Online Health Information Poised to Become Important Resource For Seniors, But Not There Yet* (January 12, 2005). Accessed March 2, 2008 from http://www.kff.org/entmedia/entmedia011205nr.cfm.

## **Relevant AMA Policy**

### H-406.996 Use and Release of Physician-Specific Health Care Data

(1) Our AMA advocates that third party payers, government entities and others that use and release physician-specific health care data adhere to the following principles: (a) Physicians under review and relevant physician organizations shall be provided with an adequate opportunity to review and respond to proposed physician-specific health care data interpretations and disclosures prior to their publication or release. (b) Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate or subjective physician-specific health care data shall be established. (c) Reliable administrative, technical, and physical safeguards to prevent the unauthorized use or disclosure of physician-specific health care data shall be developed. (d) Such safeguards shall treat all underlying physician-specific health care data and all analyses, proceedings, records, and minutes from quality review activities on physician-specific health care data as confidential, and provide that none of these documents shall be subject to discovery, or admitted into evidence in any judicial or administrative proceeding. (2) Our AMA supports release of severity-adjusted physician-specific health care data from carefully selected pilot projects where the data may be deemed accurate, reliable, and meaningful to physicians, consumers, and purchaser; (3) Our AMA urges that any published physician-specific health care data be limited to appropriate data concerning the quality of health care, access to health care, and the cost of health care; (4) Our AMA opposes the publication of physician-specific health care data collected outside of carefully selected pilot studies or where the data are not deemed accurate, reliable, or meaningful; (5) Our AMA urges that a copy of the information in any such profile be forwarded to the subject physician, and that the physician be given the right to review and certify adequacy of the information prior to any profile being distributed, including being placed on the Internet; and (6) Our AMA urges that the costs associated with creation of any such profiling system should not be paid for by physicians licensure fees. (BOT Rep. Q, I-92; BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; CMS Rep. 10, A-96; Appended: Res. 316, I-97; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)

### E-5.027 Use of Health-Related Online Sites

As Internet prevalence and access rapidly increases, individuals turn to the Internet to find health-related information quickly and efficiently. Online users can access innumerable informational or interactive online sites, many of which are maintained by physicians or rely on their services. Physician involvement should be guided by the following considerations: (1) Physicians responsible for the health-related content of an online site should ensure that the information is accurate, timely, reliable, and scientifically sound, and includes appropriate scientific references. (2) The provision of diagnostic or therapeutic services through interactive online sites, including advice to online users with whom the physician does not have a pre-existing relationship or the use of decision-support programs that generate personalized information directly transmitted to users, should be consistent with general and specialty-specific standards. General standards include truthfulness, protection of privacy, principles of informed consent, and disclosures such as limitations inherent in the technology. (3) When participating in interactive online sites that offer email communication, physicians should follow guidelines established in Opinion 5.026, "The Use of Electronic Mail." (4) Physicians who establish or are involved in health-related online sites must minimize conflicts of interest and commercial biases. This can be achieved through safeguards for disclosure and honesty in funding and advertising. It also requires that physicians not place commercial interests ahead of patient health; therefore, physicians must not use health-related online sites to promote unnecessary services, refer patients to entities in which they have ownership interests, or sell products outside of established ethical guidelines. (See Opinions 2.19, "Unnecessary Services;" 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician;" 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices;" and 8.063, "Sale of Health-Related Products from Physicians' Offices"). Promotional claims on online sites must conform to Opinion 5.02, "Advertising and Publicity." (5) Physicians who establish or are involved in health-related online sites that use patient-specific information must provide high-level security protections, as well as privacy and confidentiality safeguards. (I, II, IV, V, VI) Issued December 2003 based on the report "Use of Health-Related Online Sites," adopted June 2003, (AJOB 2003; 3(3)).

**H-478.999 An International Code of Ethics for Internet Health Sites**
Our AMA supports of a universal code of ethics for Internet health sites. (Res. 615, A-00)

**H-375.969 Physician Access to Performance Profile Data**
AMA policy is that every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (Res. 827, A-98)

AMERICAN PSYCHOLOGICAL ASSOCIATION

# Transgender, Gender Identity, & Gender Expression Non-Discrimination

*Adopted by the American Psychological Association Council of Representatives August, 2008.*

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

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

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

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

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

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

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

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

**Whereas** transgender and gender variant people may be at increased risk in institutional environments and facilities for harassment, physical and sexual assault (Edney, 2004; Minter, 2003; Peterson et al., 1996; Witten & Eyler, 2007) and inadequate medical care including denial of gender transition treatments such as hormone therapy (Edney, 2004; Peterson et al., 1996; Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Riser et al., 2005; Rodriquez-Madera &Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

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

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

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

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

**Therefore be it resolved** that APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

**Therefore be it further resolved** that APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

**Therefore be it further resolved** that APA supports full access to employment, housing, and education regardless of gender identity and expression;

**Therefore be it further resolved** that APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals;

**Therefore be it further resolved** that APA encourages legal and social recognition of transgender individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression which do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

**Therefore be it further resolved** that APA supports access to civil marriage and all its attendant benefits, rights, privileges and responsibilities, regardless of gender identity or expression;

**Therefore be it further resolved** that APA supports efforts to provide fair and safe environments for gender variant and transgender people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

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

**Therefore be it further resolved** that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals;

**Therefore be it further resolved** that APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

**Therefore be it further resolved** that APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender transition therapies;

**Therefore be it further resolved** that APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender;

**Therefore be it further resolved** that APA supports the funding of basic and applied research concerning gender expression and gender identity;

**Therefore be it further resolved** that APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development, and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals regardless of gender identity or gender expression;

**Therefore be it further resolved** that APA supports cooperation with other organizations in efforts to accomplish these ends.

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# Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

American Psychological Association

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

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

## Purpose

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

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

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

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

Given the added complexity of working with TGNC and gender-questioning youth[2] and the limitations of the available research, the *Guidelines* focus primarily, though not exclusively, on TGNC adults. Future revisions of the *Guidelines* will deepen a focus on TGNC and gender-questioning children and adolescents. The *Guidelines* address the strengths of TGNC people, the challenges they face, ethical and legal issues, life span considerations, research, education, training, and health care. Because issues of gender identity are often conflated with issues of gender expression or sexual orientation, psychological practice with the TGNC population warrants the acquisition of specific knowledge about concerns unique to TGNC people that are not addressed by other practice guidelines (APA, 2012). It is important to note that these *Guidelines* are not intended to address some of the conflicts that cisgender people may experience due to societal expectations regarding gender roles (Butler, 1990), nor are they intended to address intersex people (Dreger, 1999; Preves, 2003).

## Documentation of Need

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

## Users

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

## Distinction Between Standards and Guidelines

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

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

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[2] For the purposes of these guidelines, "youth" refers to both children and adolescents under the age of 18.

## Compatibility

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

## Practice Guidelines Development Process

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

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

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

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## Selection of Evidence

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

## Foundational Knowledge and Awareness

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

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

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

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

As early as the 1950s, research found variability in how an individual described their[3] gender, with some participants reporting a gender identity different from the culturally defined, mutually exclusive categories of "man" or "woman" (Benjamin, 1966). In several recent large online studies of the TGNC population in the United States, 30% to 40% of participants identified their gender identity as other than man or woman (Harrison et al., 2012; Kuper et al., 2012). Although some studies have cultivated a broader understanding of gender (Conron, Scout, & Austin, 2008), the majority of research has required a forced choice between man and woman, thus failing to represent or depict those with different gender identities (IOM, 2011). Research over the last two decades has demonstrated the existence of a wide spectrum of gender identity and gender expression (Bockting, 2008; Harrison et al., 2012; Kuper et al., 2012), which includes people who identify as either man or woman, neither man nor woman, a blend of man and woman, or a unique gender identity. A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological (Coleman et al., 2012). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth, as well as societal stigma and discrimination (Coleman et al., 2012).

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

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

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

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

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

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

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

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

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

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

***Application.*** Psychologists may assist people in differentiating gender identity and sexual orientation. As clients become aware of previously hidden or constrained aspects of their gender identity or sexuality, psychologists may provide acceptance, support, and understanding without making assumptions or imposing a specific sexual orientation or gender identity outcome (APA TFGIGV, 2009). Because of their roles in assessment, treatment, and prevention, psychologists are in a unique position to help TGNC people better understand and integrate the various aspects of their identities. Psychologists may assist TGNC people by introducing and normalizing differences in gender identity and expression. As a TGNC person finds a comfortable way to actualize and express their gender identity, psychologists may notice that previously incongruent aspects of their sexual orientation may become more salient, better integrated, or increasingly egosyntonic (Bockting et al., 2009; H. Devor, 1993; Schleifer, 2006). This process may allow TGNC people the comfort and opportunity to explore attractions or aspects of their sexual orientation that previously had been repressed, hidden, or in conflict with their identity. TGNC people may experience a renewed exploration of their sexual orientation, a widened spectrum of attraction, or a shift in how they identify their sexual orientation in the context of a developing TGNC identity (Coleman, Bockting, & Gooren, 1993; Meier, Pardo, Labuski, & Babcock, 2013; Samons, 2008).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Stigma, Discrimination, and Barriers to Care

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

***Rationale.*** Many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Bazargan & Galvan, 2012; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011). Discrimination can include assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression (Nadal, Rivera, & Corpus, 2010; Nadal, Skolnik, & Wong, 2012). Discrimination may also include refusing access to housing or employment or extreme acts of violence (e.g., sexual assault, murder). TGNC people who hold multiple marginalized identities are more vulnerable to discrimination and violence. TGNC women and people of color disproportionately experience severe forms of violence and discrimination, including police violence, and are less likely to receive help from law enforcement (Edelman, 2011; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011).

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

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

Issues of employment discrimination and workplace harassment are particularly salient for TGNC military personnel and veterans. Currently, TGNC people cannot serve openly in the U.S. military. Military regulations cite "transsexualism" as a medical exclusion from service (Department of Defense, 2011; Elders & Steinman, 2014). When enlisted, TGNC military personnel are faced with very difficult decisions related to coming out, transition, and seeking appropriate medical and mental health care, which may significantly impact or end their military careers. Not surprisingly, research documents very high rates of suicidal ideation and behavior among TGNC military and veteran populations (Blosnich et al., 2013; Matarazzo et al., 2014). Being open about their TGNC identity with health care providers can carry risk for TGNC military personnel (OutServe-Servicemembers Legal Defense Network, n.d.). Barriers to accessing health care noted by TGNC veterans include viewing the VA health care system as an extension of the military, perceiving the VA as an unwelcoming environment, and fearing providers' negative reactions to their identity (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd, Mizock, Maguen, & Green, 2012). A recent study shows 28% of LGBT veterans perceived their VA as welcoming and one third as unwelcoming (Sherman et al., 2014). Multiple initiatives are underway throughout the VA system to improve the quality and sensitivity of services to LGBT veterans.

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

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

TGNC people have difficulty accessing necessary health care (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012) and often feel unsafe sharing their gender identity or their experiences of antitrans prejudice and discrimination due to historical and current discrimination from health care providers (Grant et al., 2011; Lurie, 2005; Singh & McKleroy, 2011). Even when TGNC people have health insurance, plans may explicitly exclude coverage related to gender transition (e.g., hormone therapy, surgery). TGNC people may also have difficulty accessing trans-affirmative primary health care if coverage for procedures is denied based on gender. For example, trans men may be excluded from necessary gynecological care based on the assumption that men do not need these services. These barriers often lead to a lack of preventive health care for TGNC people (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012). Although the landscape is beginning to change with the recent revision of Medicare policy (National Center for Transgender Equality, 2014) and changes to state laws (Transgender Law Center, n.d.), many TGNC people are still likely to have little to no access to TGNC-related health care as a result of the exclusions in their insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Life Span Development

### Guideline 8. Psychologists working with gender-questioning[4] and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.

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

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

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

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

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

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

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

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

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

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

When working with adolescents, psychologists are encouraged to recognize that some TGNC adolescents will not have a strong history of childhood gender role nonconformity or gender dysphoria either by self-report or family observation (Edwards-Leeper & Spack, 2012). Some of these adolescents may have withheld their feelings of gender nonconformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as TGNC. Parents of these adolescents may need additional assistance in understanding and supporting their youth, given that late-onset gender dysphoria and TGNC identification may come as a significant surprise. Moving more slowly and cautiously in these cases is often advisable (Edwards-Leeper & Spack, 2012). Given the possibility of adolescents' intense focus on immediate desires and strong reactions to perceived delays or barriers, psychologists are encouraged to validate these concerns and the desire to move through the process quickly while also remaining thoughtful and deliberate in treatment. Adolescents and their families may need support in tolerating ambiguity and uncertainty with regard to gender identity and its development (Brill & Pepper, 2008). It is encouraged that care should be taken not to foreclose this process.

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

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

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

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

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

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

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

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

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

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

***Application.*** Psychologists are encouraged to seek information about the biopsychosocial needs of TGNC elders to inform case conceptualization and treatment planning to address psychological, social, and medical concerns. Many TGNC elders are socially isolated. Isolation can occur as a result of a loss of social networks through death or through disclosure of a TGNC identity. Psychologists may assist TGNC elders in establishing new social networks that support and value their TGNC identity, while also working to strengthen existing family and friend networks after a TGNC identity has been disclosed. TGNC elders may find special value in relationships with others in their generational cohort or those who may have similar coming-out experiences. Psychologists may encourage TGNC elders to identify ways they can mentor and improve the resilience of younger TGNC generations, creating a sense of generativity (Erikson, 1968) and contribution while building new supportive relationships. Psychologists working with TGNC elders may help them recognize the sources of their resilience and encourage them to connect with and be active in their communities (Fuhrmann & Craffey, 2014).

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

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

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

## Assessment, Therapy, and Intervention

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

***Rationale.*** TGNC people may seek assistance from psychologists in addressing gender-related concerns, other mental health issues, or both. Mental health problems experienced by a TGNC person may or may not be related to that person's gender identity and/or may complicate assessment and intervention of gender-related concerns. In some cases, there may not be a relationship between a person's gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, having a TGNC identity may lead or contribute to a co-occurring mental health condition, either directly by way of gender dysphoria, or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; I. H. Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one's gender; Baltieri & De Andrade, 2009; Hepp, Kraemer, Schnyder, Miller, & Delsignore, 2004).

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

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

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

***Application.*** Because of the increased risk of stress-related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC people (Coleman et al., 2012). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC person is experiencing, nor erroneously assume that those mental health problems are a result of the person's gender identity or gender expression. Psychologists are strongly encouraged to be cautious before determining that gender nonconformity or dysphoria is due to an underlying psychotic process, as this type of causal relationship is rare.

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

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

Feminizing or masculinizing hormone therapy can positively or negatively affect existing mood disorders (Coleman et al., 2012). Psychologists may also help TGNC people who are in the initial stages of hormone therapy adjust to normal changes in how they experience emotions. For example, trans women who begin estrogens and antiandrogens may experience a broader range of emotions than they are accustomed to, or trans men beginning testosterone might be faced with adjusting to a higher libido and feeling more emotionally reactive in stressful situations. These changes can be normalized as similar to the emotional adjustments that cisgender women and men experience during puberty. Some TGNC people will be able to adapt existing coping strategies, whereas others may need help developing additional skills (e.g., emotional regulation or assertiveness). Readers are encouraged to refer to the World Professional Association for Transgender Health Standards of Care for discussion of the possible effects of hormone therapy on a TGNC person's mood, affect, and behavior (Coleman et al., 2012).

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

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

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

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

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

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

Psychologists working with TGNC people in rural settings may provide clients with resources to connect with other TGNC people online or provide information about in-person support groups in which they can explore the unique challenges of being TGNC in these geographic areas (Walinsky & Whitcomb, 2010). Psychologists serving TGNC military and veteran populations are encouraged to be sensitive to the barriers these individuals face, especially for people who are on active duty in the U.S. military (OutServe-Servicemembers Legal Defense Network, n.d.). Psychologists may help TGNC military members and veterans establish specific systems of support that create a safe and affirming space to reduce isolation and to create a network of peers with a shared military experience. Psychologists who work with veterans are encouraged to educate themselves on recent changes to VA policy that support equal access to VA medical and mental health services (Department of Veterans Affairs, Veterans' Health Administration, 2013).

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

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

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

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

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

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

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

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

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

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

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

TGNC people may present with a range of parenting and family-building concerns. Some will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to make decisions regarding potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. The medical and/or social transition of a TGNC parent may shift family dynamics, creating challenges and opportunities for partners, children, and other family members. One study of therapists' reflections on their experiences with TGNC clients suggested that family constellation and the parental relationship was more significant for children than the parent's social and/or medical transition itself (White & Ettner, 2004). Although research has not documented that the transitions of TGNC people have an effect on their parenting abilities, preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition (dickey et al., 2012). This may result in divorce or separation, which may affect the children in the family. A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children (Amato, 2001; White & Ettner, 2007). This seems to be the case especially when children are reminded of the parent's love and assured of the parent's continued presence in their life (White & Ettner, 2007). Based on a small body of literature available, it is generally the case that younger children are best able to incorporate the transition of a parent, followed by adult children, with adolescents generally having the most difficulty (White & Ettner, 2007). If separated or divorced from their partners or spouses, TGNC parents may be at risk for loss of custody or visitation rights because some courts presume that there is a nexus between their gender identity or gender expression and parental fitness (Flynn, 2006). This type of prejudice is especially common for TGNC people of color (Grant et al., 2011).

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

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

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

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

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

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

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

***Application.*** Psychologists' collaboration with colleagues in medical and associated health disciplines involved in TGNC clients' care (e.g., hormonal and surgical treatment, primary health care; Coleman et al., 2012; Lev, 2009) may take many forms and should occur in a timely manner that does not complicate access to needed services (e.g., considerations of wait time). For example, a psychologist working with a trans man who has a diagnosis of bipolar disorder may need to coordinate with his primary care provider and psychiatrist to adjust his hormone levels and psychiatric medications, given that testosterone can have an activating effect, in addition to treating gender dysphoria. At a basic level, collaboration may entail the creation of required documentation that TGNC people present to surgeons or medical providers to access gender-affirming medical interventions (e.g., surgery, hormone therapy; Coleman et al., 2012). Psychologists may offer support, information, and education to interdisciplinary colleagues who are unfamiliar with issues of gender identity and gender expression to assist TGNC people in obtaining TGNC-affirmative care (Holman & Goldberg, 2006; Lev, 2009). For example, a psychologist who is assisting a trans woman with obtaining gender-affirming surgery may, with her consent, contact her new gynecologist in preparation for her first medical visit. This contact could include sharing general information about her gender history and discussing how both providers could most affirmatively support appropriate health checks to ensure her best physical health (Holman & Goldberg, 2006).

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

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

## Research, Education, and Training

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

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

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

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

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

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

***Rationale.*** The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010) include gender identity as one factor for which psychologists may need to obtain training, experience, consultation, or supervision in order to ensure their competence (APA, 2010). In addition, when APA-accredited programs are required to demonstrate a commitment to cultural and individual diversity, gender identity is specifically included (APA, 2015). Yet surveys of TGNC people suggest that many mental health care providers lack even basic knowledge and skills required to offer trans-affirmative care (Bradford et al., 2007; O'Hara, Dispenza, Brack, & Blood, 2013; Xavier et al., 2005). The APA Task Force on Gender Identity and Gender Variance (2009) projected that many, if not most, psychologists and graduate psychology students will at some point encounter TGNC people among their clients, colleagues, and trainees. Yet professional education and training in psychology includes little or no preparation for working with TGNC people (Anton, 2009; APA TFGIGV, 2009), and continuing professional education available to practicing mental health clinicians is also scant (Lurie, 2005). Only 52% percent of psychologists and graduate students who responded to a survey conducted by an APA Task Force reported having had the opportunity to learn about TGNC issues in school; of those respondents, only 27% reported feeling adequately familiar with gender concerns ($n$ = 294; APA TFGIGV, 2009).

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

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

Because of the high level of societal ignorance and stigma associated with TGNC people, ensuring that psychological education, training, and supervision is affirmative, and does not sensationalize (Namaste, 2000), exploit, or pathologize TGNC people (Lev, 2004), will require care on the part of educators. Students will benefit from support from their educators in developing a professional, nonjudgmental attitude toward people who may have a different experience of gender identity and gender expression from their own. A number of training resources have been published that may be helpful to psychologists in integrating information about TGNC people into the training they offer (e.g., Catalano, McCarthy, & Shlasko, 2007; Stryker, 2008; Wentling, Schilt, Windsor, & Lucal, 2008). Because most psychologists have had little or no training on TGNC populations and do not perceive themselves as having sufficient understanding of issues related to gender identity and gender expression (APA TFGIGV, 2009), psychologists with relevant expertise are encouraged to develop and distribute continuing education and training to help to address these gaps. Psychologists providing education can incorporate activities that increase awareness of cisgender privilege, antitrans prejudice and discrimination, host a panel of TGNC people to offer personal perspectives, or include narratives of TGNC people in course readings (ACA, 2010). When engaging these approaches, it is important to include a wide variety of TGNC experiences to reflect the inherent diversity within the TGNC community.

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## Appendix A
## Definitions

Terminology within the health care field and transgender and gender nonconforming (TGNC) communities is constantly evolving (Coleman et al., 2012). The evolution of terminology has been especially rapid in the last decade, as the profession's awareness of gender diversity has increased, as more literature and research in this area has been published, and as voices of the TGNC community have strengthened. Some terms or definitions are not universally accepted, and there is some disagreement among professionals and communities as to the "correct" words or definitions, depending on theoretical orientation, geographic region, generation, or culture, with some terms seen as affirming and others as outdated or demeaning. American Psychological Association (APA) Task Force for *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* developed the definitions below by reviewing existing definitions put forward by professional organizations (e.g., APA Task Force on Gender Identity and Gender Variance, 2009; the Institute of Medicine, 2011; and the World Professional Association for Transgender Health [Coleman et al., 2012]), health care agencies serving TGNC clients (e.g., Fenway Health Center), TGNC community resources (Gender Equity Resource Center, National Center for Transgender Equality), and professional literature. Psychologists are encouraged to refresh their knowledge and familiarity with evolving terminology on a regular basis as changes emerge in the community and/or the professional literature. The definitions below include terms frequently used within the *Guidelines*, by the TGNC community, and within professional literature.

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

(*Appendices continue*)

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

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

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

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

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

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

**Drag:** the act of adopting a gender expression, often as part of a performance. Drag may be enacted as a political comment on gender, as parody, or as entertainment, and is not necessarily reflective of gender identity.

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

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

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

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

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

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

(*Appendices continue*)

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

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

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

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

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

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

**Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy):** the use of hormones to masculinize or feminize a person's body to better align that person's physical characteristics with their gender identity. People wishing to feminize their body receive antiandrogens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

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

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

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

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

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

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

(*Appendices continue*)

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

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

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

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

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

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

**Transition:** a process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to each person's life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

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

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

# Appendix B

# Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

## Foundational Knowledge and Awareness

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

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

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

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

## Stigma, Discrimination, and Barriers to Care

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

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

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

(*Appendices continue*)

## Life Span Development

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

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

## Assessment, Therapy, and Intervention

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

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

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

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

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

## Research, Education, and Training

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

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

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APA Official Actions

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

Approved by the Board of Trustees, July 2012
Approved by the Assembly, May 2012

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

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

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

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

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

## APA Position:

**Therefore, the American Psychiatric Association:**

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

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

# Background to the Position Statement

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

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

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

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# Editorials

## Updated Recommendations from the World Professional Association for Transgender Health Standards of Care

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The transgender population is a diverse group that crosses or transcends culturally defined categories of gender. The gender identity of these persons differs to varying degrees from the physical or genital sex they were assigned at birth. “Transgender” does not imply any specific form of sexual orientation; transgender persons display a range of sexual orientations similar to those who are not transgender. Transgender persons self-identify in a variety of ways, but common terms include transwoman (male to female) and transman (female to male).[1]

Transgender persons often seek a combination of medical, surgical, mental health, and other related treatments and services. Common treatments include cross-sex hormone therapy; genital reassignment surgery; nongenital surgical procedures of the face, breast, or body; speech and voice therapy; and facial hair removal.[2] Transgender persons require ongoing primary and preventive care, in addition to transgender-specific care. Preventive care approaches are similar to those of nontransgender persons, with adjustments based on hormonal and anatomical differences, such as the need for cervical screening in transmen and breast cancer screening in transwomen.[3]

The World Professional Association for Transgender Health (WPATH) is an international multidisciplinary professional association that publishes recognized standards for the care of transgender and gender-variant persons. In September 2011, WPATH published the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version, (SOC7).[4] The SOC7 is more comprehensive than the prior version,[5] and contains numerous updates that address changes in both the transgender community and in the practices of physicians who care for them. Although the SOC7 contains an evidence-based discussion of treatment options, adverse effects, and outcomes, specific treatment regimens (e.g., hormone dosing) are published elsewhere.[3,6-9] As such, they are not presented in this guideline. *Table 1* provides selected resources for transgender medical, surgical, and mental health care and cultural awareness.

The SOC7 states that primary care is an ideal setting for transgender health care, given that primary care physicians are knowledgeable of and often experienced with the administration of estrogens (for menopausal care and contraception), testosterone (for androgen deficient states such as with human immunodeficiency virus), and testosterone-blocking medications (for hirsutism and prostatic disease), and are aware of important mental and social health issues.[10] This recommendation is also in line with the position statement recently released by the American College of Obstetricians and ▶

**Table 1. Selected Resources on Transgender Medical, Surgical, and Mental Health Care and Cultural Awareness**

| *Source* | *Comment* |
|---|---|
| Alegria CA. Transgender identity and health care: implications for psychosocial and physical evaluation. *J Am Acad Nurse Pract.* 2011;23(4):175-182. | Basic review of primary and hormonal care, cultural awareness |
| Ettner R, Monstrey S, Eyler AE, eds. *Principles of Transgender Medicine and Surgery.* New York, NY: Haworth Press; 2007. | Textbook covering a wide range of transgender health subjects, including primary care, hormones, surgery, and mental health |
| Feldman J, Safer J. Hormone therapy in adults: suggested revisions to the sixth version of the standards of care. *Int J Transgenderism.* 2009;11(3):146-182. | In-depth review of hormonal care |
| Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2009;94(9):3132-3154. | In-depth, endocrinologist-oriented review; contains some outdated recommendations based on the sixth version of the World Professional Association for Transgender Health Standards of Care |
| University of California, San Francisco Center of Excellence for Transgender Health. Primary care protocol for transgender patient care. http://transhealth.ucsf.edu/protocols. | Peer-reviewed, evidence-based consensus recommendations on a range of care topics; Web-based; continuously updated |

Gynecologists directing physicians to prepare themselves for the care of transgender persons.[11]

Primary care physicians may see patients referred from a specialist who has initiated cross-sex hormone therapy. Conversely, a primary care physician inexperienced in the care of transgender persons may be approached by a patient seeking cross-sex hormone therapy. If the physician is not able to offer this therapy, the patient should be referred. WPATH maintains a database of health care professionals who provide transgender care, which is available at http://www.wpath.org/find_a_provider.cfm.

## Accessing Cross-Sex Hormone Therapy

The SOC7 allows physicians to tailor their practices based on individual patient issues, special physician skills or knowledge, cultural variations, lack of resources, and the need for harm reduction strategies. In addition, the SOC7 notes that non–mental health physicians with experience in gender variance and training in general behavioral or mental health may evaluate patients for eligibility to receive cross-sex hormone therapy and make referrals themselves. Ultimately, primary care physicians will determine their own comfort levels with conducting such assessments.

The SOC7 criteria for hormone therapy are the presence of persistent and well-documented gender dysphoria, the patient having the capacity to make a fully informed decision and consent to treatment, and the patient being at the age of majority in a given country (a separate process exists within SOC7 for minors). The *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., criteria for gender identity disorder in adults can be used as a guide for evaluating for gender dysphoria; however, the manual does not provide a clear definition of the condition, and a revision of terminology and criteria is expected for the upcoming fifth edition.[12,13]

Any significant medical or mental health concerns must be reasonably well controlled before initiating cross-sex hormone therapy. Each physician should make an assessment based on the nature and severity of the comorbidity and the needs of the patient. For example, poorly controlled dyslipidemia should not prevent initiation of the therapy, whereas it may be delayed in a patient who has brittle diabetes or a poorly controlled psychotic disorder. The decision should be made on a case-by-case basis, and informed patient consent is crucial.

## Statements of Medical Necessity and Individuality

In a 2008 statement, the WPATH Board of Directors defined all medical, surgical, and mental health care services related to gender dysphoria as medically necessary.[14] The SOC7 reiterates this statement, and calls for universal insurance coverage of such services. This statement, as well as SOC7, affirms that each gender-variant person will have his or her own individual desires with respect to timing, the use of hormones and surgery, and the type of social transition being made. The health care of transgender persons has begun moving out of the shadows and into the spotlight; as transgender health care moves into the mainstream, primary care physicians will be increasingly called upon to provide compassionate and individualized care to this diverse community.

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# Enhancing Transgender Health Care

*Emilia Lombardi, PhD*

## ABSTRACT

As awareness of transgender men and women grows among health care educators, researchers, policymakers, and clinicians of all types, the need to create more inclusive settings also grows.

Greater sensitivity and relevant information and services are required in dealing with transgender men and women. These individuals need their identities to be recognized as authentic, they need better access to health care resources, and they need education and prevention material appropriate to their experience.

In addition, a need exists for activities designed to enhance understanding of transgender health issues and to spur innovation. (*Am J Public Health.* 2001;91:869–872)

Transgender health issues are beginning to come to the attention of many health practitioners and researchers. In fact, the desire to improve the treatment experienced by transgender individuals led the American Public Health Association to pass a resolution on transgender health issues during its 1999 annual meeting.[1] Acknowledging health care discrepancies is only a start, however. To provide much-needed services to this population, researchers, educators, and health care professionals of all types need concrete, comprehensible information about transgender individuals.

Gender variations have been documented for many years. Generally, female-to-male gender transgression has been described as resulting from the inequality found between women and men and women's desire for status and resources, whereas male-to-female transgression has been explained as resulting from the need to express an inner desire or has been eroticized.[2] More recent explanations have been based on the medical model.

The term *transvestite* was used early in the 20th century to describe people (primarily men) who dress in women's clothing for their own interests (usually erotic).[3] Later, *transsexualism* (listed as gender identity disorder in the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*[4]) was used to describe a population of individuals whose feelings concerning their gender involved more than a desire to dress in a particular set of clothes and a stronger identification with gender values contrary to societal expectations.[5]

*Transgender* was originally used to differentiate those who seek medical intervention in changing their gender from those who do not; however, this term later changed to encompass a range of possible identities and behaviors, including transvestitism and transsexualism (the way in which *transgender* evolved in usage has not been examined fully). Currently, *transgender*, *transvestite*, and *transsexual* are at times used interchangeably to describe individuals whose identities and social lives are very similar. It is likely, however, that many people will not fit into traditional conceptions of transvestite, transsexual, or transgender.

The use of terminology has not been consistent across time and among writers. The meaning of such terms varies among individuals as well, and as a result there is little understanding of what people mean when they say they are transgender or transsexual. For the sake of uniformity within this commentary, however, the label *transgender* is used in a global sense, encompassing transvestites, transsexuals, and self-identified transgender individuals.

Generally, people can be categorized across 4 characteristics: biological sex, legal–institutional sex, social gender, and psychologic gender. *Biological sex* is usually determined by people's genitals but can encompass other factors such as chromosomes, hormonal makeup, secondary sex characteristics, and other physiologic variations. Furthermore, there are intersexed conditions that can create problems in regard to categorizing infants as male or female (e.g., children born with ambiguous genitalia, androgen sensitivity syndrome). These children may undergo surgical intervention so that their genitals more clearly resemble those found on traditionally male or female children.

*Legal–institutional sex* refers to people's designation on identification, forms, and even questionnaires. There may be ways for people to change their legal–institutional sex; frequently this requires some sort of professional intervention (i.e., needing to submit a letter from one's surgeon to change one's birth certificate). However, different areas of the country (and across the world) have different regulations allowing for such changes.

*Social gender* refers to how people present themselves in public: the clothing they wear, their hairstyle, their physical characteristics, even how they act and talk. Different cultures have different ways of explaining and dealing with gender variance; some Native American cultures refer to *two-spirit people* (aspects of both genders), and Hindu cultures include *hidras* (neither man nor woman). Social gender can also be influenced by medical interventions used to change aspects of people's appearance. Many people go to great lengths to change aspects of their appearance (some of which is necessary to change their legal sex). In addition, individuals may be consistent or inconsistent in their gender presentation. People may have an inconsistent social gender because one aspect of their gender is used for performances, fun, or even sexual behavior.

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# LGBT Practice Tools

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## Navigating Gender: Holiday Resources for Families, Youth and Professionals

Gender Spectrum

Dec 19, 2018

Get tips to help transgender individuals navigate conversations when gender comes up at holiday gatherings. Resources include practical strategies, questions to make discussions more meaningful, and videos to help youth discuss gender with grandparents, and more.

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## TransFamily Support Services

Dec 18, 2018

TransFamily Support Services guides transgender/non-binary youth and their families through the gender transitioning process to help make it the most positive experience possible. They provide family coaching, assistance with healthcare and insurance issues, help navigating the legal system, and support at schools.

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LGBT Health & Development Program, Northwestern University

Dec 10, 2018

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World Professional Association for Transgender Health

Dec 03, 2018

The World Professional Association for Transgender Health promotes 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.

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Page 1 of 3 First Previous [1] 2 3 Next Last

# Practice

- Aging
- Behavioral Health
- Child Welfare
- Clinical Social Work
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- Health
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**The American College of Obstetricians and Gynecologists**
*Women's Health Care Physicians*

# COMMITTEE OPINION

Number 512 • December 2011
(Reaffirmed 2019)

**Committee on Health Care for Underserved Women**

# Health Care for Transgender Individuals

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

## The Spectrum of Transgender Identity

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

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

The social and economic marginalization of transgender individuals is widespread. Harassment, discrimination, and rejection occur frequently within an individual's own family and affect educational, employment, and housing opportunities.

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

## Barriers to Health Care

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

### Box 1. Transgender Definitions

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

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

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

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

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

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

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

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

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

### Box 2. Sexual Identity and Gender Identity Definitions

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

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

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

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

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

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

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

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

The consequences of inadequate treatment are staggering. Fifty-four percent of transgender youth have attempted suicide and 21% resort to self-mutilation. More than 50% of persons identified as transgender have used injected hormones that were obtained illegally or used outside of conventional medical settings. Additionally, such individuals frequently resort to the illegal and dangerous use of self-administered silicone injections to spur masculine or feminine physiologic changes (5). The American College of Obstetricians and Gynecologists, therefore, urges public and private health insurance plans to cover the treatment of gender identity disorder.

## Caring for Transgender Individuals

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

## Creating a Welcoming Environment

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

## Gender Transition: World Professional Association for Transgender Health Guidelines

The World Professional Association for Transgender Health is a multidisciplinary professional society representing the specialties of medicine, psychology, social sciences, and law. Their published clinical guidelines about the psychiatric, psychologic, medical, and surgical management of gender identity disorders are widely used by specialists in transgender health care (11), but are not universally accepted by all members of the transgender health community because critics consider them to be overly restrictive and inflexible.

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

### Female-to-Male Transgender Individuals

#### *Hormones*

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

#### *Surgery*

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

#### *Screening*

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

### Male-to-Female Transgender Individuals

#### *Hormones*

Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications. After surgery, doses of estradiol, 2–4 mg/d, or conjugated equine estrogen, 2.5 mg/d, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Nonoral therapy also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma (13).

### Surgery

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

### Screening

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

## Conclusion

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

## Resources

Select clinics with expertise in treating transgender individuals:

Fenway Community Health
www.fenwayhealth.org

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

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

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

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# Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment

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**ABSTRACT**
Studies of adults who experienced sexual orientation change efforts (SOCE) have documented a range of health risks. To date, there is little research on SOCE among adolescents and no known studies of parents' role related to SOCE with adolescents. In a cross-sectional study of 245 LGBT White and Latino young adults (ages 21–25), we measured parent-initiated SOCE during adolescence and its relationship to mental health and adjustment in young adulthood. Measures include being sent to therapists and religious leaders for conversion interventions as well as parental/caregiver efforts to change their child's sexual orientation during adolescence. Attempts by parents/caregivers and being sent to therapists and religious leaders for conversion interventions were associated with depression, suicidal thoughts, suicidal attempts, less educational attainment, and less weekly income. Associations between SOCE, health, and adjustment were much stronger and more frequent for those reporting both attempts by parents and being sent to therapists and religious leaders, underscoring the need for parental education and guidance.

**KEYWORDS**
Sexual orientation; LGBT youth; reparative therapy; conversion therapy; sexual orientation change efforts; suicidality; depression

The American Psychiatric Association removed homosexuality from its diagnostic manual as a mental disorder more than four decades ago, yet efforts to change sexual orientation, often referred to as "conversion" or "reparative" therapy, continue to be practiced by some mental health providers, clergy, and religious leaders (APA Task Force on Appropriate Therapeutic Reponses to Sexual Orientation, 2009; Substance Abuse, Mental Health Services Administration, 2015). Although research on adult populations has documented harmful effects of sexual orientation change efforts (SOCE), no studies have examined SOCE among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Yet

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because some people believe that homosexuality can be changed or "cured," some parents engage in efforts to change their child's sexual orientation, and some may seek professional therapies for a child's same-sex sexual orientation. In this study we consider the health and adjustment of a sample of lesbian, gay, bisexual, and transgender (LGBT)[1] young adults in association with retrospective reports of efforts by their parents to change their sexual orientation during adolescence.

### *Existing research and field consensus*

SOCE continues to be practiced despite a lack of credible evidence of effectiveness, reported harm from a range of studies on SOCE with adults (see APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; SAMHSA, 2015), and increased adoption of practice guidance from major professional associations that caution against SOCE.[2] In one controversial study, 200 individuals who reported some change from homosexual to heterosexual following therapy were examined (Spitzer, 2003). The majority reported some minimal change from a homosexual to a heterosexual orientation; complete sexual orientation change was rare. The study received a great deal of attention and criticism for methodological limitations that included sample recruitment bias and problems in measurement and statistical reporting (see Drescher & Zucker, 2006 for a comprehensive review of the critiques of this study; the author later retracted the study). A review of 28 empirically based studies that have examined the use of these therapies strongly criticized the body of literature for multiple significant methodological flaws (see Serovich et al., 2008).

By the 1990s a wide range of major professional associations in the United States adopted position statements that supported affirmative care for lesbian, gay, and bisexual (LGB) clients and patients, and in the same time period several of them published statements that opposed efforts to change an individual's sexual orientation (e.g., American Academy of Pediatrics, 1993; American Psychiatric Association, 1994; American Psychological Association, 1998; National Association of Social Workers, 1992). Despite these professional statements, some providers have continued to engage in SOCE with adults and adolescents, and the American Psychological Association (APA) convened a task force in 2007 to conduct a systematic review of peer-reviewed studies related to SOCE. The task force report concluded that published studies making claims that sexual orientation had been changed were methodologically unsound (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Moreover, the report noted that SOCE were unlikely to be successful and involved risk of harm. Specifically, studies of SOCE with adults (e.g., Shidlo & Schroeder, 2002) have reported a range of negative outcomes, including depression, anxiety, self-hatred, low self-esteem, isolation, and suicidality (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

## *Adolescents, parents, and SOCE*

At the time of the APA report, no studies were identified that focused on sexual orientation change efforts among adolescents (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009); nevertheless, several organizations continued to market the effectiveness of sexual orientation change efforts for youth (see Ryan & Rivers, 2003). As the Group for the Advancement of Psychiatry—a policy organization that provides guidance for the psychiatric profession—has noted, "Despite … changes in scientific thinking in the last two decades, social and religious conservatives have advanced their own illness/behavior model of homosexuality [which] maintains that homosexuality is not inborn and that variations of long disproven theories of homosexuality's etiology can serve as a basis for offering conversion therapies" (Drescher et al., 2016, p. 8).

Understanding adolescent experiences is especially important, particularly since SOCE with minors raises distinct ethical concerns (Hicks, 1999; Substance Abuse and Mental Health Services Administration, 2015). These include determining what constitutes appropriate consent, the potential for pressure from parents and other authority figures, the minor's dependence on adults for emotional and financial support, and the lack of information regarding the impact of SOCE on their future health and wellbeing.

Concerned parents who believe that being lesbian, gay, or bisexual (LGB) is wrong and that an individual's sexual orientation can be changed may engage in rejecting behaviors, such as trying to change their child's sexual orientation; excluding them from family events and activities to discourage, deny, or minimize their identity; or using religion to prevent or change their sexual orientation (e.g., Ryan, Huebner, Diaz, & Sanchez, 2009). These parental behaviors are typically motivated by concern and represent efforts to try to help their child "fit in," to be accepted by others, to conform with religious values and beliefs, and to meet parental expectations (Morrow & Beckstead, 2004; Ryan et al., 2009; Ryan & Rees, 2012; SAMHSA, 2014). Moreover, such efforts are based on a belief that homosexuality is a mental illness or developmental disorder that needs to be corrected or cured. Yet SOCE are at odds with mainstream understandings of human development and professional standards of care, which hold that LGB identities are normative and that social stigma and minority stress contribute to negative health outcomes and self-hate (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Substance Abuse and Mental Health Services Administration, 2015).

There is growing concern that SOCE has continued to be practiced despite serious ethical conflicts and potentially harmful effects (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). An analysis by the Williams Institute estimated that nearly 700,000 U.S. LGBT adults have received SOCE conversion therapy interventions, including 350,000 LGBT adults who received SOCE interventions as adolescents (Mallory, Brown & Conron, 2018). This concern led legal advocates in the United States to introduce legislation to prevent SOCE among licensed practitioners, an approach that has been adopted in 10 U.S. states and a growing number of jurisdictions and that has sought to inform families, the public, practitioners and religious leaders of the impact of such practices (Drescher, 2013; Movement Advancement Project, 2018). Although these laws appear to have raised awareness and informed public perceptions and responses (Ames, 2015), they do not prevent SOCE in families or by unlicensed practitioners, clergy, and others.

The U.S. Substance Abuse and Mental Health Services Administration asked the APA to convene a scientific advisory panel of researchers and practitioners who were experts in the field to review existing research, professional policies, and clinical guidelines to develop consensus recommendations related to the ethical and scientific foundations of conversion therapy with minors (Substance Abuse and Mental Health Services Administration, 2015). Concurrently, the Obama administration called for an end to conversion therapy of minors, citing, in particular, the importance of family support for LGBT young people (Jarrett, 2015). Most recently, in March 2018 the European parliament passed a resolution condemning the practice and urging member nations to ban SOCE.

### The current study

Historically, SOCE research has focused on adults. Decades ago, Gonsiorek theorized that the experience of SOCE during adolescence can “contribute to negative self-esteem and mental health problems” (Gonsiorek, 1988, p. 116), yet there are no known studies of the link between such interventions and the health and wellbeing of lesbian, gay, bisexual, and transgender (LGBT) young people, particularly SOCE efforts carried out both by parents and caregivers, as well as by practitioners and religious leaders.

To our knowledge, we present the first study to examine young adults’ retrospective reports of parent-initiated efforts to change their sexual orientation during adolescence, and the associations between these experiences and young adult mental health and adjustment. The two goals of this study include: (1) to identify demographic and family characteristics that are associated with parent-initiated attempts to change a child’s sexual orientation during adolescence, and (2) to examine associations among these parent-initiated attempts in adolescence with a range of indicators of young adult health and adjustment.

## Method

The sample included 245 participants who self-identified as LGBT. Participants were recruited from local bars, clubs, and community agencies that serve this population in a 100-mile radius of the research center. Screening procedures were used to select participants into the study based on the following criteria: age (21–25); ethnicity (White, Latino, or Latino mixed); self-identification as LGBT during adolescence; being open about LGBT status to at least one parent or guardian during adolescence; and having lived with at least one parent or guardian during adolescence at least part-time. The survey was administered in both English and Spanish, and it was available in either computer-assisted or paper-and-pencil format. The study protocol was approved by the university's institutional review board.

### *Sample*

Of the 245 participants, 46.5% were male, 44.9% were female, and 8.6% were transgender. The majority of participants identified as gay (42.5%), 27.8% as lesbian, 13.1% as bisexual, and 16.7% as other (e.g., queer, dyke, homosexual). Approximately one half of the sample identified as Latino (51.4%), and the other 48.6% identified as White, non-Latino. In addition, 18.78% of the respondents were immigrants to the United States. The age of the participants ranged from 21 to 25 years (*M* = 22.8, *SD* = 1.4). Family of origin socioeconomic status was assessed retrospectively (1 = *both parents in unskilled positions or unemployed* to 16 = *both parents in professional positions; M* = 6.75, *SD* = 4.77).

### *Measures*

#### *Parent-initiated efforts to change youths' sexual orientation*

Participants responded to two items that assessed past parental and caregiver-initiated efforts to change the youths' sexual orientation. The first item asked: "Between ages 13 and 19, how often did any of your parents/caregivers try to change your sexual orientation (i.e., to make you straight)?" (0 = never [49.64%]; 1 = ever [53.06%]). A second item asked: "Between ages 13 and 19, how often did any of your parents/caregivers take you to a therapist or religious leader to cure, treat, or change your sexual orientation?" (0 = never [65.71%]; 1 = ever [34.29%]). We created a single measure with three categories that identifies the severity of parent-initiated attempts to change youths' sexual orientation. The three categories include: (1) no attempt to change sexual orientation ($n$ = 109; 41.63%), (2) parent and caregiver-initiated attempt to change sexual orientation without external conversion efforts ($n$ = 52; 21.22%), and (3) parent and caregiver-initiated attempt to change sexual orientation with external conversion efforts ($n$ = 78; 31.84%). Six participants who reported conversion efforts but not parental attempts to change sexual orientation were dropped from the current study, for a total analytic sample of 239 participants.

### Young adult health and adjustment

Indicators of mental health and adjustment assessed included suicidal ideation, lifetime suicidal attempts, depression, self-esteem, and life satisfaction. Suicidal ideation was assessed by one item: "During the past six months, did you have any thoughts of ending your life?" (0 = no, 3 = many times). Lifetime suicidal attempts were assessed by one item: "Have you ever, at any point in your life, attempted taking your own life?" (0 = no, 1 = yes). Depression was measured by the 20-item CES-D (Radloff, 1977, 1991). Two dichotomized cut-off scores were also used: a clinical cut-off score (≥16) and a prescription intervention cut-off score (≥22). Self-esteem was measured by Rosenberg's 6-item self-esteem scale (Rosenberg, 1979). Life satisfaction was measured by an 8-item scale (e.g., "At the present time, how satisfied are you with your living situation?"). Social support was measured by the 12-item Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988).

Behavioral health risk indicators included substance use and abuse and engagement in risky sexual activities. Binge drinking (or heavy alcohol use) was assessed by two items that measured the frequency of drinking and the number of drinks per occasion (0 = less than 1–2 times per week and less than 3 drinks per occasion; 1 = 1–2 times per week or more and more than 3 drinks per occasion). Substance abuse problems were assessed by four items (e.g., "In the past five years, have you had problems with the law because of your alcohol or drug use?") and were dichotomized to represent ever having problems versus never having problems. Risky sexual behavior was assessed in six ways: unprotected sex during the last 6 months (0 = no, 1 = yes), unprotected sex with a casual or HIV positive partner during the last 6 months (0 = no, 1 = yes), unprotected sex during last sexual encounter (0 = no, 1 = yes), unprotected casual sex during last sexual encounter (0 = no, 1 = yes), ever been diagnosed with a sexually transmitted disease (0 = never, 1 = ever), and one item that assessed HIV risk ("In the last six months, were you ever at risk for being infected with or transmitting HIV?"; 0 = no, 1 = yes).

Finally, two indicators of young adult socioeconomic status were assessed: current monthly income and educational attainment. Current weekly income as assessed by one item: "What is your personal weekly income (after taxes, unemployment, social security, etc.)?" (1 = less than \$100, 7 = more than \$2000). Educational attainment was assessed by one item: "What is the highest level of education you have completed?" (1 = *less than elementary school*, 7 = *postgraduate*).

### *Demographic and family characteristics*

Adolescent gender nonconformity and family religiosity were included as possible characteristics that may predict whether or not parents/caregivers attempted to change the participant's sexual orientation during adolescence. Adolescent gender nonconformity was measured by one item: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself when you were a teenager (age 13–19)?" This item was reverse coded for males such that a higher score is representative of more nonconformity to gender norms ($M = 4.40$, $SD = 1.87$). Family religiosity was measured by one item: "How religious or spiritual was your family while you were growing up?" (0 = *not at all*, 3 = *extremely;* $M = 1.35$, $SD = 0.91$).

## *Plan of analysis*

First, demographic and family characteristics were included in a multinomial logistic regression to predict the likelihood of a participant experiencing parent-initiated attempts to change their sexual orientation during adolescence without external conversion intervention efforts (= 1) and parental attempts to change sexual orientation with external conversion efforts (= 2) compared to no attempts (= 0). Second, to understand the associations among parent-initiated attempts to change the participant's sexual orientation during adolescence with young adult health and wellbeing, we used logistic regressions for dichotomous outcomes and multiple linear regression for continuous outcomes, including known covariates for the outcomes of interest (Ryan et al., 2009). To minimize exclusion of participants due to missing data and to maximize statistical power, we used PRELIS, a component of LISREL, to impute missing data (total <5%; Graham, Cumsille, & Elek-Fisk, 2003) using all numeric variables in an expectation maximization algorithm for imputation. All continuous variables were checked for assumptions of normality; the depression measure was significantly skewed, but after a square-root transformation the items met assumptions of normality. Finally, we conducted linear trend analyses for study outcomes across the three groups of participants based on no attempts, parent-initiated attempts, and parent-initiated attempts with external conversion efforts.

## Results

Similar background characteristics predicted both types of parent-initiated SOCE (see Table 1). Notably, there were no differences in reports of SOCE

**Table 1.** Demographic and family characteristics predicting parent/caregiver-initiated sexual orientation change efforts.

| | Parent-initiated SOCE | Parent-initiated SOCE with external conversion efforts |
|---|---|---|
| Female (Ref = male) | 1.62 (0.76–3.46) | 0.94 (0.46–1.92) |
| Transgender (Ref = male) | 2.30 (0.40–13.14) | 1.93 (0.44–8.47) |
| Bisexual (Ref = gay/lesbian) | 0.80 (0.30–2.17) | 0.40 (0.13–1.23) |
| Queer (Ref = gay/lesbian) | 0.49 (0.14–1.74) | 1.24 (0.46–3.34) |
| White, non-Latino (Ref = Latino) | 0.86 (0.39–1.90) | 1.51 (0.70–3.23) |
| Immigrant (Ref = U.S. native) | 1.98 (0.67–5.90) | 6.47 (2.43–17.23)*** |
| Family of origin SES | 0.85 (0.78–0.93)*** | 0.88 (0.81–0.95)*** |
| Adolescent gender nonconformity | 1.18 (0.96–1.45) | 1.27 (1.05–1.54)* |
| Family religiosity | 1.72 (1.13–2.61)* | 1.88 (1.28–2.76)** |

*N* = 239. Ref = reference group. Adjusted odds ratios and 95% confidence intervals from a multinomial logistic regression are shown. The reference category for the model was "neither change efforts nor conversion efforts." ****p* < .001. ***p* < .01. **p* < .05.

based on gender, sexual identity (bisexual or queer), or ethnicity. However, adolescents who grew up in religious families were more likely to experience SOCE (with and without external conversion efforts). Higher family of origin socioeconomic status was also associated with fewer parent-initiated SOCE (with and without conversion efforts). Additionally, participants who were not born in the United States and who reported more gender nonconformity during adolescence were more likely to experience parent-initiated attempts to change with external conversion efforts.

Table 2 displays the results of logistic and linear regressions predicting young adult health and adjustment based on reports of parent-initiated SOCE during adolescence (both with and without external conversion efforts). Both levels of parent-initiated attempts to change participant's sexual orientation during adolescence were associated with more negative mental health problems for young adults. Specifically, those who experienced SOCE were more likely to have suicidal thoughts (although only for those who reported SOCE with external conversion efforts) and to report suicidal attempts and higher levels of depression. Participants who experienced SOCE had lower life satisfaction and less social support in young adulthood. Parental-initiated SOCE in adolescence were not associated with self-esteem, substance use or abuse, or risky sexual behavior. Finally, parent-initiated SOCE during adolescence were associated with lower young adult socioeconomic status: less educational attainment and less weekly income (although only for those who experienced attempts to change with external conversion efforts).

Differences across the three groups defined by parent-initiated SOCE are presented in Table 3. Trend analyses confirmed that parental attempts to change adolescents' sexual orientation are significantly associated with negative health outcomes in young adulthood, and that those problems are worse

**Table 2.** Parent/caregiver-initiated sexual orientation change efforts predicting young adult outcomes.

| | Parent-initiated SOCE | Parent-initiated SOCE with external conversion efforts |
|---|---|---|
| **Mental Health** | | |
| Suicidal ideation (continuous) | 0.13 | 0.27*** |
| Suicidal attempt (1 = ever) | 3.08 (1.39–6.83)** | 5.07 (2.38–10.79)*** |
| Depression – Clinical cut-off score (≥16) | 2.20 (1.02–4.73)* | 3.92 (1.92–8.00)*** |
| Depression – Prescription intervention cut-off score (≥22) | 1.94 (0.82–4.57) | 3.63 (1.67–7.87)** |
| Depression (continuous) | 0.15* | 0.30*** |
| Self-esteem (continuous) | −0.13 | −0.13 |
| Life satisfaction (continuous) | −0.19** | −0.34*** |
| Social support (continuous) | −0.26*** | −0.45*** |
| **Substance Use/Abuse** | | |
| Binge drinking (1 = yes) | 0.90 (0.42–1.93) | 1.01 (0.50–2.03) |
| Substance abuse problems (1 = yes) | 0.87 (0.42–1.82) | 1.70 (0.84–3.44) |
| **Sexual Risk Behavior** | | |
| Unprotected sex during last 6 months (1 = yes) | 1.61 (0.70–3.72) | 2.05 (0.91–4.59) |
| Unprotected sex with casual or HIV + partner last 6 months (1 = yes) | 0.91 (0.36–2.30) | 2.09 (0.91–4.78) |
| Unprotected sex at last intercourse (1 = yes) | 0.90 (0.43–1.87) | 1.23 (0.62–2.45) |
| Unprotected casual sex at last intercourse (1 = yes) | 1.01 (0.41–2.49) | 1.11 (0.48–2.58) |
| STD diagnosis (1 = ever) | 0.79 (0.33–1.91) | 1.36 (0.62–2.99) |
| HIV risk in last 6 months (1 = yes) | 0.74 (0.31–1.74) | 1.06 (0.50–2.26) |
| **Current Socioeconomic Status** | | |
| Educational attainment (continuous) | −0.15* | −0.32*** |
| Current weekly income (continuous) | −0.12 | −0.27*** |

*N* = 239. Adjusted odds ratios and 95% confidence intervals are shown for dichotomous outcomes and standardized beta coefficients are shown for continuous outcomes. All analyses controlled for gender, sexual orientation, ethnicity, immigrant status, family of origin socioeconomic status, adolescent gender nonconformity, and family of origin religiosity. $^{***}p < .001$. $^{**}p < .01$. $^{*}p < .05$.

for young adults who experienced SOCE that included external conversion efforts during adolescence. This pattern of results emerged as statistically significant for 12 of the 18 outcomes tested, including significant findings for all outcomes related to mental health and socioeconomic status.

## Discussion

Results from this study clearly document that parent/caregiver efforts to change an adolescent's sexual orientation are associated with multiple indicators of poor health and adjustment in young adulthood. The negative associations were markedly stronger for participants who experienced both parental attempts to change their sexual orientation, coupled with efforts to send the adolescent to a therapist or religious leader to change their sexual orientation (strategies often called "conversion" or "reparative" therapy). In this sample of LGBT young adults, more than half reported some form of

**Table 3.** Trend effects related to parent/caregiver-initiated sexual orientation change efforts predicting young adult health outcomes.

| | No SOCE (*n* = 109) | Parent-Initiated SOCE (*n* = 52) | Parent-Initiated SOCE with External Conversion Efforts (*n* = 78) | Group difference ($\chi^2$; *F*) |
|---|---|---|---|---|
| **Mental Health** | | | | |
| Suicidal ideation (continuous) | .17 | .38 | .57 | *** |
| Suicidal attempt (1 = ever) | 22.0 % | 48.1 % | 62.8 % | *** |
| Depression – Clinical cut-off score (≥16) | 26.6 % | 46.2 % | 65.4 % | *** |
| Depression – Prescription intervention cut-off score (≥22) | 15.6 % | 32.7 % | 52.3 % | *** |
| Depression (continuous) | 9.21 | 12.99 | 16.10 | *** |
| Self-esteem (continuous) | 2.88 | 2.74 | 2.72 | ** |
| Life satisfaction (continuous) | 3.05 | 2.78 | 2.61 | *** |
| Social support (continuous) | 4.18 | 3.66 | 3.31 | *** |
| **Substance Use/Abuse** | | | | |
| Binge drinking (1 = yes) | 42.2 % | 36.5 % | 41.3 % | NS |
| Substance abuse problems (1 = yes) | 49.5 % | 50.0 % | 66.7 % | * |
| **Sexual Risk Behavior** | | | | |
| Unprotected sex during last 6 months (1 = yes) | 28.4 % | 36.5 % | 42.3 % | * |
| Unprotected sex with casual or HIV + partner last 6 months (1 = yes) | 22.0 % | 21.2 % | 38.5 % | * |
| Unprotected sex at last intercourse (1 = yes) | 49.5 % | 53.9 % | 59.0 % | NS |
| Unprotected casual sex at last intercourse (1 = yes) | 15.6 % | 23.1 % | 25.6 % | NS |
| STD diagnosis (1 = ever) | 24.8 % | 21.2 % | 30.8 % | NS |
| HIV risk in last 6 months (1 = yes) | 28.4 % | 25.0 % | 37.2 % | NS |
| **Current Socioeconomic Status** | | | | |
| Educational attainment (continuous) | 5.19 | 4.65 | 4.26 | *** |
| Current weekly income (continuous) | 2.73 | 2.31 | 2.03 | *** |

Six participants who reported conversion efforts but not parent attempts are excluded. Percentages are shown for dichotomous outcomes with chi-square significance levels, and average scores are shown for continues outcomes with ANOVA *F* significance levels.
***$p < .001$. **$p < .01$. *$p < .05$.

attempt by their parents and caregivers to change their sexual orientation during adolescence. With the exception of high-risk sexual behavior and substance abuse, attempts to change sexual orientation during adolescence were associated with elevated young adult depressive symptoms and suicidal behavior, and with lower levels of young adult life satisfaction, social support, and socioeconomic status. Thus SOCE is associated with multiple domains of functioning that affect self-care, wellbeing, and adjustment.

The results of this study point to a number of factors that impact practice and provision of appropriate care. Family religiosity was strongly linked to parental attempts to change sexual orientation. In a related study, families that were highly religious were least likely to accept their LGBT children (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Religiously conservative families often have misinformation about sexual orientation and gender identity and need accurate information to help support their LGBT children in the context of their values and beliefs (for guidance see Ryan & Rees, 2012; Substance Abuse Mental Health & Services Administration, 2014). Moreover, parents and caregivers often conflate sexual orientation with gender expression. Discomfort with gender nonconformity may be at the root of much of parents' and caregivers' motivations for SOCE: in the current study, gender nonconforming youth were more likely to experience attempts to change their sexual orientation through conversion therapy with therapists and religious leaders. Further, our results show that immigrant parents are more likely to try to change their children's sexual orientation by sending them for clinical or religious intervention.

Related research has found that SOCE typically happens in the context of other family rejecting behaviors that contribute to health risks in young adulthood (Ryan et al., 2009). Parents, caregivers and others who provide support for LGBT children and adolescents need to understand that family rejection encompasses a wide range of behaviors, and education is critical for families, providers, and religious leaders on the relationship between family rejection and acceptance with health and wellbeing for LGBT young people (Ryan, 2009; Ryan & Chen-Hayes, 2013; Ryan et al., 2010; Substance Abuse and Mental Health Services Administration, 2015; Substance Abuse Mental Health & Services Administration, 2014).

Studies on responses of parents and caregivers with LGBT children indicate that parents' reactions are motivated by a number of concerns, which include helping their child "fit in" to their family and cultural world, responding to religious and cultural values, keeping their families together, and trying to protect their LGBT child from harm (Maslowe & Yarhouse, 2015; Ryan, 2009; Substance Abuse Mental Health & Services Administration, 2014). In other words, parents are typically motivated by doing what they think is best for their child. Nonetheless, our study did not directly examine the motives of the parents of study participants. However, these findings reinforce the critical need for culturally appropriate family education and guidance on sexual orientation and gender identity and expression, the harmful effects of family rejecting behaviors, including SOCE, and the need for supporting their LGBT children, even in the context of parental and familial discomfort and religious conflict.

There are several limitations of this study. First, study inclusion criteria called for current identification as LGBT; it is likely that this inclusion criterion excludes persons who are dissatisfied with their LGBT identity, or persons who had identified as LGBT during adolescence but not at the time of the study. Thus we acknowledge that we did not include young people whose sexual orientation may be more fluid (e.g., sexual orientation in adolescence not consistent with sexual orientation in young adulthood). Second, although the study included a measure of family religiosity, there is no measure of specific religious affiliation, a factor that might be a further predictor of the role of parents in SOCE of their children. Third, the design is retrospective, and thus causal claims cannot be made. We cannot rule out the possibility that those who were most maladjusted as young adults retrospectively attribute parental behaviors during adolescence as attempts at changing their sexual orientation; we also cannot rule out the possibility that well-adjusted LGBT young adults may be less likely to recall experiences related SOCE. However, we note that the face validity of the specific measures is compelling: the alternatives are less plausible than the explanation that sexual orientation change attempts would likely undermine health and wellbeing.

Most attention to SOCE has focused on the ethics of professional practice and recent efforts to end such practice through legislation. This study highlights the crucial role parents play in SOCE—either directly themselves or through sending their children to therapists or religious leaders. Results point to the need for multicultural and faith-based family education resources and approaches to help parents and caregivers learn how to support their LGBT children in the context of their family, cultural, and religious values (see, for example, Kleiman & Ryan, 2013; Ryan, 2009; Ryan & Rees, 2012). In addition to supporting families and educating religious leaders and congregations, legislative and professional regulatory efforts to end SOCE therapies are important for raising awareness about and preventing a contraindicated practice that contributes to health risks, and for changing negative attitudes and bias regarding LGBT people.

Taken together, these findings provide a needed empirical framework for understanding the scope of SOCE in and outside of the home and the costs of sexual orientation change efforts directly from those individuals who are most affected—LGBT young people themselves. Historically, research and strategies to prevent SOCE have focused on mental health practitioners and much less on religious leaders, with limited awareness of the role of families in pressuring LGBT young people to change core identities. As indicated by this study, more attention is needed on family-based efforts to change a child's sexual orientation and gender expression. Because LGBT youth cannot escape family rejecting behaviors (see, for example, Ryan, 2009; Ryan & Rees, 2012), approaches to prevent and ameliorate efforts to change a child's sexual orientation and gender identity must include the broader social context that includes the home and social, cultural, and religious influences on families and caregivers to change or suppress a child's sexual orientation and gender expression.

## Notes

1. The sampling frame for the study included youth who identified as LGBT during adolescence. Of note, all transgender youth in this sample also identified as lesbian/gay, bisexual, homosexual, or queer.
2. Policy statements cautioning against SOCE have been issued across disciplines ranging from counseling (American Counseling Association, 2013) to medicine (Society for Adolescent Health and Medicine, 2013), nursing (International Society of Psychiatric-Mental Health Nurses, 2008), psychiatry (American Psychiatric Association, 2000; World Psychiatric Association, 2016), psychology (American Psychological Association, 2009), and social work (National Association of Social Workers, 2015).

## Disclosure statement

No potential conflict of interest was reported by the authors.

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