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A Qualitative Study of Ex-Gay and Ex-Ex-Gay Experiences

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Some individuals attempt to change their sexual orientation to resolve conflict between sexual orientation and religious belief. The psychological and social experiences of individuals attempting such change are not well documented scientifically. This study used qualitative methodology to explore the psychological and social experiences of individuals as they attempt to change their orientation. The findings support and extend existing research and suggest that there may be important differences in religious outlook between those who persist in trying to change and those who go on to affirm a homosexual identity.

KEYWORDS conversion therapy, ex-gay, sexual orientation, religion

INTRODUCTION

It is a common perception that a nonheterosexual identity is necessarily incompatible with a strong religious identity (Lease, Horne, & Noffsinger-Frazier, 2005). This feeling is perpetuated by direct and indirect messages from religious organizations that gay, lesbian, bisexual, and transgender (GLBT) individuals are not welcome (Ritter & Terndrup, 2002). This type of negative spiritual experience can contribute to an individual's feelings of negativity toward his/her homosexual orientation (Lease, Horne, & Noffsinger-Frazier, 2005; Ream & Savin-Williams, 2005). In response to this incompatibility between spirituality and sexuality, many people opt to give either the religious identity or the sexual identity priority and deny the other (Bartoli

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& Gillem, 2008). One method of resolution that has drawn attention is that of sexual orientation conversion or "reparative therapy," which claims to help an individual attempt to change sexual orientation from homosexual to heterosexual.

The idea of changing orientation to comply with religious statutes that condemn homosexuality may seem appealing for reasons both religious and practical. Conservative religious organizations such as Exodus (2009) and Focus on the Family (2009) cite beliefs that God does not approve of homosexuality and that being gay is the result of psychological harm suffered early in life. In the nonreligious world, members of the GLBT community are still fighting for acceptance in mainstream society, are still victims of hate crimes and verbal abuse (Huebner, Rebchock, & Kegeles, 2004; Peters, 2003), and are largely unprotected by the legal system in matters of discrimination in housing and employment (Brown & Henriquez, 2008). The combination of religious and practical issues makes it relatively easy to persuade some individuals to attempt a change of orientation.

Using a variety of religious and pseudo-psychological techniques (Adams & Sturgis, 1977; Besen, 2003; Drescher, 2001b; Throckmorton, 1998; see Haldeman, 1994, for a review), participants in these programs may undertake years of expensive "therapy" that is usually unsuccessful (see APA, 2009; Bieber et al., 1962; Haldeman, 1991, 1994; Throckmorton, 1998; Tozer & McClanahan, 1999) and ill-advised by professionals (American Psychological Association, 2009; National Association of Social Workers, 2009; Whitman, Kocet, & Vilia, 2006). Scientific estimates of effectiveness of conversion therapy are essentially nonexistent because of difficulties obtaining samples, following individuals after they exit therapy, defining "success" and obtaining objective measurements of behavioral and psychological change (Drescher, 1999; Haldeman, 1991, 1994; Isay, 1988; Tozer & McClanahan, 1999). Existing evidence on reorientation attempts suggests that, while behavior change is possible in some cases, actual alteration of one's underlying sexual orientation is not possible (Ritter & Terndrup, 2002).

Even if one were to accept the highest estimates of how many people change their orientation, we are left with the vast majority of people who try to change their sexual orientation being unsuccessful. Individual accounts, anthropological studies, popular media publications, anecdotal literature, and available empirical research cite numerous negative outcomes of the "conversion" process, including depression, anxiety, sexual difficulties with partners of both sexes, problems expressing affection, professional difficulties, and feelings of inadequacy, religious and spiritual crises, and significant life losses (marriage, family, church, community, etc.) (Beckstead, 2001; Bennett, 1998; Drescher, 2001a; Human Rights Campaign, 2000; Isay, 2001; Shidlo & Schroeder, 2002; Wolkomir, 2004).

The combination of the "failure" rate of conversion therapies and the potential negative effects of participating in conversion therapy makes this an

important area for research. However, scientific research on the entire topic of changing one's sexual orientation has been limited and, in many cases, seriously methodologically flawed (Spitzer, 2003; see Drescher & Zucker, 2006, for a review). Attempts to shed light on the subject have been marred by sampling bias, difficulties defining outcome measures, and disagreement or ambiguity regarding what constitutes "reparative therapy" (Beckstead, 2006; Cohen & Savin-Williams, 2006; Diamond, 2006).

Shidlo and Schroeder (2002) completed one of the more comprehensive studies on experience in reparative therapy to date, interviewing 202 participants in anonymous 90-minute interviews. They interviewed people who had formerly participated in sexual orientation conversion therapy under the guidance of a therapist or therapy-oriented group (either religious or secular). The majority of participants were recruited through e-mail lists and newspaper advertisements. Based on qualitative analysis of their interview transcripts, they propose a model of progress through conversion programs that involves a common start and then a deviation onto one of two paths. All participants begin in the "honeymoon" period, during which they are hopeful and positive about the prospect of changing their orientation. From there, participants diverge onto either the "self-perceived failure" or "self-perceived success" path. People who perceive themselves as a failure pass through a period in which they question the process of conversion and the ideas behind it, and may eventually return to a gay identity in a healthy or unhealthy way. People who perceive themselves as successes may identify as successful but still struggling or successful without struggling.

While Shidlo and Schroeder's (2002) study helped to increase understanding of the reparative therapy process, there is still much to learn about how people experience reparative therapy and its aftermath. The present study has two main goals: to use a novel research method to support the growing base of knowledge on orientation change and to explore differences between people in the "self-perceived success" and "self-perceived failure" categories. Using a grounded theory-based approach (Glaser & Strauss, 1967; Strauss & Corbin, 1997), we analyzed publicly available posts on Internet message boards related to attempting orientation change.

This Internet-based methodology helps to address two methodological criticisms of the existing research on reparative therapy (see Bieschke, Paul, & Blasko, 2007; Tozer & McClanahan, 1999, for methodological criticisms). First, participants are often recruited directly from conversion therapy groups or conferences (i.e., Ponticelli, 1999; Schaeffer et al., 1999, 2000). Our Internet sample is less susceptible to response bias that may result from referral by a conversion group; the anonymous nature of the Internet may provide a great deal more candor in participant dialogue than has been achieved in previous studies. A second criticism of existing research is that samples are disproportionately male, Caucasian, and North American (Bieschke, Paul, & Blasko, 2007). The wide reach of the Internet will enable us to access

information from a much larger set of respondents than previous researchers and may help to provide information about the experiences of groups that are underrepresented in existing work.

METHODS

Participants

"Participants" in this study were individuals who posted to Internet message boards related to changing one's sexual orientation from gay to straight. We analyzed messages from two groups of boards. The first was for individuals trying to change their sexual orientation, curious about the process or potential of changing their orientation, or who perceive themselves as having already changed. These participants identify themselves as "ex-gays." The second group of message boards was for individuals who had previously tried to change their orientation and were unsuccessful. These boards were designed to provide support for people as they try to move past the "ex-gay" experience. These participants identify themselves as "ex-ex-gays."

Message boards were located by conducting searches in major search engines for groups addressing ex- or ex-ex-gay issues. In order to be included in the study, a message board had to have a publicly available archive and had to have activity relevant to the stated topic of the board. This search resulted in three message boards for ex-gays and two for ex-ex-gays, all hosted by the same major Web site.

Ethical Considerations

Although the Internet has been around for some time, research using Internet information as a primary data source is still relatively new. Internet-based research brings with it some attendant ethical concerns, the most prominent of which is concern for privacy (Stanton & Rogelberg, 2001). Research that uses Web-based archival data is particularly worthy of ethical consideration because of concerns for consent and privacy violation (King, 1996; Marx, 1998; Thomas, 1996a, b).

As we conducted this research, we paid special attention to these ethical dilemmas. We took several steps to ensure participant privacy and to respect boundaries of expected privacy in Internet interactions. First, we limited our data collection to forum archives that were specifically designated as public. The venue that hosted the groups we examined requires group moderators to select whether their archives are public or private, and the archive status is known to members. We considered the fact that the groups in our study had public archives, indicating that posters did not expect their information would be secure.

We also focused on ethical considerations when reporting our results (King, 1996). We report no identifying information in any of our research-related materials (though most posters use anonymous "handles" anyway) and do not identify the specific groups that we assessed. All of the posts that we examined were posted at some point in the past, so we minimized the controversy associated with observing live interactions. At no point did any of the researchers create accounts on any of the boards, post, or contact any members of any of the groups. Demographics are not given for individual posters and are not reported in a sufficient level of detail that individual posters could be identified.

We submitted our research protocol for Institutional Review Board (IRB) consideration before beginning work. Given the public designation of the archives, this research was deemed exempt from IRB oversight. At every point in our work, we attempted to abide by Marx's (1998) suggestions for considering the ethics of research practices involving online "surveillance."

Group Characteristics

The two ex-gay message boards with fewer than 500 messages in the archive were coded in their entirety. We used a stratified approach to select messages to code for the remaining boards. Subsets of at least 200 messages were sampled beginning at regular intervals (i.e., 1, 5,000, 10,000, 15,000, etc.). This methodology helped to ensure that we got data representing the life of the board and helped to reduce the likelihood of social climate or individual posters affecting results. Posts that were not relevant to the project were not coded. These most often included accidental duplicate postings, re-postings of articles and material from print outlets, and other social posts (e.g., recipes, birthday and holiday greetings, off-topic conversations).

The three ex-gay boards varied widely in terms of membership and message count, from 21 members and 344 messages at the smallest to 830 members and 23,613 messages at the largest. Posts on the ex-gay boards were made between May 2001 and September 2009. We examined 2,867 posts and coded 728 posts from 267 individual posters on the ex-gay boards.

The two ex-ex-gay boards were more uniform in their membership/message load. One board had 345 members and 4,226 messages; the other had 306 members and 5,831 messages. Posts on the ex-ex-gay boards were made between 1999 and the September 2009. We examined 1,887 posts and coded 213 posts from 71 posters on the ex-ex-gay boards.

Coding

Our goal in examining message boards was to determine what kinds of experiences people have when trying to change their sexual orientation. Since existing research is limited in scope and has been qualitative in nature,

we felt that an open-ended, flexible methodology would best suit our needs. In order to allow for thematic elements or patterns in experience that had not previously been identified in research, we used grounded theory to evaluate our data. Grounded theory is a qualitative methodology that focuses on identifying themes in textual or verbal material (Glaser & Strauss, 1967; Strauss & Corbin, 1997), with the goal of building scientific theory from real-world information. Coding is an iterative process designed to yield a broad picture of concepts, trends, and ideas in the data. Five coders were involved in the coding completed for this project. Ex-gay boards and ex-ex-gay boards were coded separately, due to the difference in content of material, but the process was the same for both groups.

Coding was accomplished in several iterations. In the first iteration, open coding, we read approximately 1,000 posts and created codes for any idea or expression that seemed relevant to our area of inquiry. At the end of the open coding phase, we identified core themes and grouped codes according to these larger thematic units, thereby creating code families. Any discrepancies between coders with regard to appropriate application of codes were resolved at this point, and a final code book was established. All coders returned to the beginning of this initial data and recoded using the finalized code book. Additional data were selected using theoretical sampling, which means that only posts relevant to our area of inquiry were included in analysis from this point forward.

RESULTS

Demographics

While traditional demographic information was not available for this data, many posters willingly shared demographic information in their postings. Information here is provided only for participants who gave information and is not necessarily representative of the population under study. More detailed demographic information can be found in Table 1.

Demographics were similar between the two samples. Of the 240 ex-gays who reported their gender, 190 (79.17%) were male. In the ex-ex-gay sample, 49 people reported their gender, and 40 (81.63%) were male. The proportion of males and females did not differ between the two samples ($\chi^2_{3df} = 7.74$, $p > .05$). The average age of the 80 ex-gays who reported their age was 31.61 (SD = 9.48), and ages ranged from 18 to 60 years. The average age of the 22 ex-ex-gays who reported an age was 38.14 (SD = 10.17), with a range of 20–61 years. Ex-ex-gays were significantly older than ex-gays ($t(97) = -2.75$, $p < .01$). Of the 74 individuals who reported their location in the ex-gay sample, 51 (68.92%) lived in North America. Of the 22 who reported their location in the ex-ex-gay sample, 12 (54.55%) lived in North America.

TABLE 1 Demographics of Ex-Gay and Ex-Ex-Gay Samples

	Ex-Gay Boards		Ex-Ex-Gay Boards	
Category	n	% of total n	n	% of total n
Total N	267	100%	71	100%
# married previously	54	20.22%	15	21.13%
Location				
North America	51	68.92%	12	54.55%
Australia	5	6.76%	4	18.18%
Central/South America	5	6.76%	0	0%
Europe	5	6.76%	2	9.09%
Africa	4	5.41%	0	0%
Middle East	2	2.70%	0	0%
Asia	2	2.70%	4	18.18%
Total reporting location	74	27.72%	22	30.99%
Sex				
Male	190	79.17%	40	81.63%
Female	47	19.58%	9	18%
Transgender	3	1.3%	0	0%
Total reporting sex	240	89.89%	49	69%
Age of poster	M = 31.61, SD = 9.48 Range = 18 to 60		M = 38.14, SD = 10.171 Range = 20–61	
Total reporting age	80	29.96%	22	30.99%

Ex-Gay Message Boards

Seven code families were used to code data for the ex-gay boards. Code families, individual codes within the families, and frequency of application for the ex-gay group are shown in Table 2. Demographic codes indicate descriptive characteristics of the posters as they are available. Pre-entry motivation codes describe participants' reasons for attempting change of orientation and for visiting the discussion board. Psychological well-being codes include positive and negative psychological experiences reported in posts. Social well-being codes include positive and negative social experiences. Process codes are codes used to characterize the change process. These include strategies tried previously, types of advice given to new members, perceptions of the change process, and descriptions of specific struggles. Success codes indicate participants' feelings of being successful in the change process and questions/concerns related to success.

Ex-Ex-Gay Message Boards

Four code families were used to code data for the ex-ex-gay boards. Code families, individual codes within the families, and frequency of application for the ex-gay group are shown in Table 3. Demographic codes indicate descriptive characteristics of the posters as they were available. Examples of demographic codes include duration of struggle to change, time out of

TABLE 2 Codes and Application Rates for Ex-Gay Boards

Code Family	Code	Freq
Pre-entry motivations	Marriage-related concerns	9
	Spiritual revelation/experience	7
	Belief that being gay is wrong/not content being gay	7
Roots	Parental treatment—family dynamics	31
	Sexual Abuse	9
	Developmental experiences with sexuality/sexualized needs for affection	4
	Bullying	2
Reasons for coming to the board	Looking for support/accountability	54
	Support others and maintain change	8
	Desperate/last hope	4
	Process codes	
Previous religious strategies tried	Support Group	19
	Therapy	16
	Prayer	7
	Accountability partner	4
	Reading ex-gay books	3
	Residential treatment	2
	Confession	2
Previous secular strategies tried	Therapy	2
	Psychoactive meds	2
Advice given to newcomers		
Social 59	Don't go it alone	22
	Find hetero Christian friends	17
	Find an accountability partner	15
	Cut ties to the gay world	3
	Focus on your spouse	2
Religious 45	Read scripture	19
	Seek God first and healing will follow	11
	Read general Christian literature	7
	Speak in tongues	5
	Fast to cast out demons	3
Practical 32	Avoid sources of temptation	14
	Don't give into desires	8
	Get therapy	5
	Stay busy	5
Perceptions of process	Healing takes time	22
	Always struggle/daily struggle	19
	Continued struggle brings you closer to God	8
	May get worse before getting better	4
	Easier the earlier you start	3
Specific struggles	Pornography	27
	Masturbation	20
	Fantasy/thinking about gay contact	12
	Actual sex with same-sex partner	10
	Gay chat rooms/cybersex	10
	Contact with potential or ex-ss partners	6
	Gay bars/clubs	3

(Continued on next page)

TABLE 2 Codes and Application Rates for Ex-Gay Boards *(Continued)*

Code Family	Code	Freq
	Psychological Well-Being	
Negative psychological states	Depression—explicit (13)/implicit (5)	18
	Suicide—active (13)/passive (2)	15
	Guilt	10
	Confusion over identity	9
	Shame	8
	Anger	6
	Hopelessness	5
	Fear/Afraid	5
	Disgust	5
	Self-hatred	4
Negative social states	Loneliness	28
	Severed old social ties to try conversion	6
	Family of origin concerns	5
Positive feelings	Feels supported	15
	Hopeful	14
	Relief/happiness at finding the board	5
Perceived Successes	Felt attraction for the opposite sex	6
	Lost some attraction for the same sex	5
	Got married	2
	Celibacy	2
	Concerns about marrying	
Finding a marriage partner	Seek God first–marriage will follow	6
	Make friends with Christian women	6
	Frustration finding marriage partner	6
	Personal ad	3
	Find an ex-lesbian to date	3
Practical matters	Timing of disclosure in relationships	3
	Concerned about hetero performance	2
	Concern for well-being of potential partner	2

Note. Only codes that were applied more than once are reported in this table.

ex-gay movement, relationship status, background in the GLBT community, and stated gender. Religious status codes characterize the poster's current religious belief system (i.e., Fundamentalist Christian, spiritual but not Christian) and his/her stated feelings about spirituality and sexuality. Ex-gay experience codes fall into several subcategories that mirror codes from the ex-gay boards: pre-entry motivations, psychological well-being, and strategies used to try to change. Codes for positive outcomes of the process, negative outcomes of the process, and attitudes toward the ex-gay movement were also categorized. Current state codes contained codes for current positive and negative psychological states and perceptions of the poster's current role relative to the ex-gay movement (i.e., educating others about GLBT issues, supporting others coming to terms with sexuality).

TABLE 3 Codes and Application Rates for Ex-Ex-Gay Boards

Code Family	Code	Freq
Reasons for trying to change	Religious	2
	Ex-gay experiences	
Strategies tried	Marriage	5
	Therapy	4
	Ex-gay internet group	3
	Structured ex-gay program	3
Psychological experiences	Depression	4
	Guilt	4
	Confusion over identity	3
	Fear	3
	Suicidal ideation or attempt	2
Ex-gay leftovers	Guilt	5
	Self-doubt	3
	Confusion over identity—Still unsure whether being gay is a sin	2
	Difficulty forming relationships	2
Attitudes toward ex-gays	Resistance to other views/information	4
	Avoid thinking about spiritual journey	4
	Problems of ex-gays are unrelated to orientation	4
	Supports good intent of ex-gay therapists	2
	Ex-gays are motivated by fear	2
	Ex-gay movement "preys" on people	2
	Current State	
Positive religious experiences/thoughts	Orientation is irrelevant to God	3
	Feels closer to God than when ex-gay	5
Positive outcome of experiences	Feels stronger in faith	5
	Identity development	5
Perceptions of current role	Educate about GLBT issues	5
	Support others coming to terms with their sexuality	4
Current psychological states	At peace with their sexuality	8
	Values the journey	7

Note. Only codes that were applied more than once are reported in this table.

Qualitative Results

Results are presented in time order according to place in the process, and are grouped into code families. Results for the ex- and ex-ex-gay groups are presented side by side when applicable, and similarities and differences are noted as appropriate. Where necessary, we have corrected grammar or spelling in the posts to improve readability.

Why Do People Try to Change Their Sexual Orientation?

Motivation to Change

Motivation to change focuses on factors that moved the participant to attempt to change his/her sexual orientation. The most commonly reported

motivators for change among ex-gays were trying to save a heterosexual marriage (9 of 23 who reported a reason) and having a religious experience (7 of 23 who reported a reason). Participants who had an opposite-sex partner and children seemed most likely to be motivated by the desire to keep their family intact:

> I'm still not complete because I still sin with my homosexual desires. I want freedom from them and am willing to do whatever it takes because at this point my marriage is in trouble and I do not want to lose my wife and children. (Ex-gay)

Many participants who were motivated by a religious experience reported having been religious at some previous point in their life, leaving the religious life, and returning, at which point they felt that a change in orientation was needed:

> Well, some friends of mine who I have known for a while, asked me to church. I went and God came back in my life. That was Sunday, on that Thursday night I was born again. Since all of this, my mouth has cleaned up like crazy. I have had no sexual urges; I have quit smoking, and so much more. I know it sounds a lil [sic] crazy but this is true. (Ex-gay)

Others reported having no religious affiliation previously, and then had an experience that motivated them to include religion in their life:

> I basically became Agnostic/Atheist for a LOOOOONG time. Yesterday, I attended a Baptist church, and have found a new-found spirituality inside of me. Another thing. I'm gay. or . . . was?. . . . I've made up my mind to change, and become straight . . . or AT LEAST abstinent. (Ex-gay)

We also coded participants' reasons for coming to the board specifically. By far, the most common reason given was to find support and/or accountability:

> I am new to this site and am recently struggling with other chat rooms and engaging in sinful behavior there. I was wondering if anyone here would be available to help keep me accountable and just good old fashioned friendship? Thanks.:) (Ex-gay)
>
> I'm looking for some guys to talk with and be accountable to concerning my struggles. I'm early 20s and would like to chat with somebody about that age range who understands what guys like us are going through. (Ex-gay)

Ex-ex gay participants who gave a reason for attempting to change overwhelmingly cited religious reasons for doing so, but their reasons were not as specific or varied as they ex-gays.

How Did We Get This Way, Anyway?

Many posters on the ex-gay boards discussed their perceptions of the causes for their sexual orientation. By far, the most commonly reported reason was parental treatment and/or family dynamics (31 of 46 who reported a reason). Most often, this took the form of some failed bonding with the same-sex parent.

> One of the roots, for me, were I needed physical and emotional intimacy from men. I NEVER receive this from my father or any male during my childhood. I didn't understand until recently why I was drawn to homosexual men. (Ex-gay)

> Often I have heard that in the case of lesbians, that as young girls they watched a weak mom allow the husband to abuse her or allowed the father to abuse them without stopping it. . . . I read that as a young girl seeing this and being abused subconsciously begins to think, "If this is what it's like to be a woman, I want no part of it. They vow to never have a man hurt them again and often become very masculine and strong in order to protect themselves. (Ex-gay)

What Is the Conversion Process Itself Like?

We examined multiple parts of the process of trying to change one's orientation. Results have been subdivided into four categories: past conversion attempts, advice for newcomers, perceptions of the process, and specific struggles.

Past Conversion Attempts

The most common strategies already used by participants differed between the ex-gay and ex-ex-gay groups. For ex-gays, the most common strategies used to try and change orientation prior to coming to the board were support groups (19 of 53 who reported a reason) and religious therapy (16 of 53 who reported a reason). Often, posters reported having tried multiple strategies, as seen in this post:

> I have been to many biblical counselors, psychologists, psychiatrists, and support groups seeking change from my behaviors, and relief from severe

> loneliness and depression. Unfortunately, I certainly seem much worse off than before. (Ex-gay)

Ex-ex-gays reported getting married (5 of 18 who reported a reason) and attending therapy (4 of 18 who reported a reason) as the most common strategies they tried when they were attempting to change. Like the ex-gays, many ex-ex-gays reported having tried multiple strategies in order to change their orientation.

> In the eyes of the ex-gay community, I guess you can call me a "failure," because all the prayers, counseling, therapies and deliverance sessions didn't "take." (Ex-ex-gay)

> I tried everything to try to get rid of my homosexuality. Psychologist, Marriage, I tried to have demons what I thought was demons casted out of me, had hands laid on me, I ran from gay people like a plague, went to church almost every time the church door opened and many times after church services and everybody from church was gone, I was at the altar begging God to heal me, and I did these things all of my life and none of it helped. (Ex-ex-gay)

Advice for New Would-be Changers

Newcomers to the ex-gay boards got a variety of pieces of advice from established members on how to manage their same-sex desires. Finding local support and praying were suggestions that were offered nearly every time someone came to the board asking for advice. As a result, we did not count the individual posts. Aside from these universal suggestions, advice fell into three categories: social, religious, and practical. Social advice was most frequently given (59 of 136 pieces of advice) and focused on the newcomer finding social support, locally and in person if possible. New posters were advised: Don't go it alone (22 of 59 pieces of advice), find heterosexual Christian friends (17 of 59 pieces of advice), and find an accountability partner (15 out of 59 pieces of advice). An accountability partner is someone to whom one is accountable for behavior and who can be called in case of a need for support.

> Seems like there should be some kind of support group or at least someone who could encourage you face to face. Just don't go it alone. That's the most difficult place. (Ex-gay)

> But needing to resolve the root issues that contributed to the lack of bonding with the same sex parent will help in restoring the balance you need in your male gender identity. Making same sex friendships nonsexual male connections with Christians will help you in learning boundaries among other things. (Ex-gay)

> For any of the newcomers out there—that is a word that has worked wonders—ACCOUNTABILITY!! In essence, find someone that you can trust and confess your sins/failures/successes to. Someone that will hold you to your goals and help you to achieve realistic ones. Someone that will pray for and with you. (Ex-gay)

The next most common advice category involved strategies that were specifically religious (45 of 136 pieces of advice). Posters were most commonly advised to read scripture (19 of 45 pieces of advice) and seek God first and trust that healing will follow (11 of 45 pieces of advice).

> Meanwhile, quit worrying about it all and concentrate on living a life that is glorifying to God. (Ex-gay)

> I recently learned from someone that by obsessing over our SSA struggles would not get us anywhere except more frustrations and heartbreak. So we have to focus more on God and being in holiness. It would end up helping us think less about being ex-gay while considering ourselves more in His image as true heterosexuals. (Ex-gay)

> Let God renew your mind as you take to heart His word- just be willing and submit even your body to the Lord because that is His temple- where He lives by his Spirit. Your own thoughts will come under His Lordship this way. (Ex-gay)

Finally, new posters were given practical advice for managing their homosexual urges (32 of 136 pieces of advice). The most commonly offered strategies were to avoid sources of temptation (usually this referred to the computer) (14 of 32 pieces of advice) and to resist giving in to desires (8 of 32 pieces of advice).

> You have to get yourself away from the situations that give you access to sex. Are you meeting the sex partners on the internet, cruising spots or where? You have to do something to distance you from your weakness. For example: an alcoholic is not going to go to a bar, if they have just gotten sober. (Ex-gay)

Perceptions of the Process Itself

General perceptions of the process given by members of the ex-gay boards varied greatly in terms of their positivity and/or negativity. The most commonly mentioned perceptions of the process dealt with the time involved (41 of 56 perceptions). Many new posters were hoping for a "quick fix," but veterans quickly informed them that their attraction to the same sex will probably always be something they struggle with, and that healing takes time:

> It took a lifetime of dysfunction to get us where we are now, so it will take time for our minds to be transformed, for our desires to come into alignment with His. (Ex-gay)

> I know the lonely feeling that you get for a man, but remember that Jesus is a man too and he can help you sort out your feelings. It is a daily struggle and you need to call on him every day he is the only one who can help us. (Ex-gay)

> I promise you, the struggle you're in will NOT just 'go away.' Even if you take up the weapons of your warfare that are mighty through God for the pulling down of strongholds and persevere to freedom from homosexual lust, the flesh and all the evil, . . ., will still wage an unrelenting battle in this area as long as you're alive. (Ex-gay)

People in our ex-gay sample overwhelmingly reported having ongoing struggles with many types of sexual behavior. Pornography (27 of 88 struggles), masturbation (20 of 88 struggles), and fantasizing (12 of 88 struggles) were all commonly noted struggles.

> I have never acted out with another man but struggle with Internet pornography and masturbation. (Ex-gay)

> I now have come full circle and let my gay feeling come back into my life when I should have been calling on Jesus to help I did not. I have fallen back into sin. Since I have had access to the net it has been VERY easy to go into the Web and check out all the sites that are full of the gay sex, chats rooms etc. . . . (Ex-gay)

Psychological Well-Being During Conversion

Codes in this family were divided into positive and negative states. In both samples, statements of negative feelings during the process were far more common than those of positive feelings. The most common negative feelings reported in the ex-gay group were depression (18 of 85 reasons), suicidal ideation or attempt (15 of 85 reasons), and guilt (10 of 85 reasons). Ex-ex-gays most commonly recalled feeling depression (4 of 16 reasons), guilt (4 of 16 reasons), confusion about identity (3 of 16 reasons), and fear (3 of 16 reasons) while they were trying to change their orientation. In both groups, negative feelings were often reported in groups:

> I guess I have some anger for turning out like this. I certainly don't even accept myself. I believe had I known what my life would be like the past 20 years I certainly would have ended my life. I probably shouldn't feel that way because I have been greatly blessed in many areas. But the issues of being so alone seem to overwhelm those blessings and rob me of joy. The emptiness, sadness, and loneliness that I feel is indescribable at times. (Ex-gay)

> I was bad, a failure and condemned. That belief system caused me to live in fear, confusion, pain and guilt. (Ex-ex-gay)

Ex-gay individuals who reported suicidal thoughts divided along two primary dimensions. The first was the timing of the suicidal thoughts. The majority of respondents that reported being suicidal stated that it was the prospect of being gay led that led them to thoughts of suicide, rather than the struggle of trying not to be gay:

> I came to the place of trying to kill myself because I didn't want to be labeled a homosexual. (Ex-gay)

Another subset of individuals reporting suicidal thoughts were classified as "passive suicide." In these cases, the poster expressed a desire to die but did not want to actually commit suicide:

> We struggle with a sin that society embraces and much the church doesn't know how to deal with. I've prayed more times than I can remember that God would let me die in my sleep, but to date it hasn't worked. (Ex-gay)

The most commonly reported negative social experience among ex-gays was loneliness (28 of 39 who reported). Participants reported being lonely for a variety of reasons. Some reported being unable to discuss their sexuality and related issues because people do not understand:

> My story is likely not unique, but I have been prevented from knowing that because it is so difficult to share. Male friends I've had who have not faced this issue personally seem to be inevitably alienated by it in various ways and to varying degrees, despite their well-meaning assurances to me that they can handle my talking about it with them. (Ex-gay)

> Since moving here five years ago, I've had no one to share my struggles with. I have been reluctant to mention it to anyone because almost all of the previous times I mentioned my struggles to other guys in church were a disaster. I realize part of the problem was that I had unreal expectations, but that doesn't soothe the pain. (Ex-gay)

Others are socially isolated because they were previously in the gay community and left that support network in their quest to attain heterosexuality (6 of 39 who reported):

> Can you help me? I am trying to turn my life around and in doing so I have separated myself from all my friends. My friends don't believe the same way I do and were giving me a hard time. (Ex-gay)

Posters to the ex-gay boards also reported positive feelings related to their experience in the ex-gay movement. Most commonly, they reported feeling supported (15 of 34 statements) and hopeful about their potential to become heterosexual (14 of 34 statements).

> When I have spent those countless nights crying out to God to help me rid myself of these thoughts and actions which would lead to nothing but heartache— … the unintentional personal Hell I have gone through has been so worth it. I have never received so much support for ANYTHING in my life … I'm spellbound. And, I cry … yes … I cry after reading every email, even just when somebody else adds me to their chat list … because I finally know there's others like me. (Ex-gay)

> I have already started some of the suggestions and plan on making use of the remaining suggestions or contacts. I know this is not going to be an easy road, but one that will make my life a lot richer. (Ex-gay)

> Anyway … I am getting to like this group … and the first thing I got used to doing when I use the Internet is open my e-mail eager for any new e-mails … filled with hope, advice and showing me a new bright future waiting for me. (Ex-gay)

What Is Considered a "Success"?

The ultimate goal of most posters on the ex-gay boards was to get married to a member of the opposite sex. Most perceived successes had to do with feeling attraction for members of the opposite sex or losing some measure of attraction to members of the same sex (11 of 15 perceived successes):

> One thing I can say is I have seen potential in women. I NEVER did that before. I thought of them as friends but there is more to it now. I am actually hoping for more. (Ex-gay)

For some, celibacy or abstinence are considered positive outcomes, or at least better outcomes than being an active homosexual (2 of 15 successes):

> Celibacy isn't delightful in every respect—if I have been "given the gift of celibacy," it's not what I would necessarily have chosen. However, it is the path I believe I must follow. (Ex-gay)

In spite of the general "goal" of heterosexual marriage, many ex-gay posters expressed concern about marrying. Most commonly noted was frustration finding a marriage partner (24 of 31 concerns). Posters also noted concern for their potential partners, reporting worries about their ability to perform sexually in a heterosexual marriage or about their partner's well-being, in that they might not be able to love someone of the opposite sex as fully as they deserve (7 of 31 concerns).

> . . . I feel that it is unfair for any exgay ministry to preach that marriage is the only solution for an ex-gay. Do I have to prove myself in some way? Isn't that being a little self-obsessed? And how about the girl? Do I have the right to offer myself to her when I know that she would be much better off with a man that can love her totally body and soul. That would be very selfish. (Ex-gay)

What Happens After Leaving the Ex-Gay Movement?

The vast majority of people who posted to the ex-ex-gay boards specifically stated that they had abandoned the ex-gay movement and any hope of changing their orientation. A very few (one or two across all of the coded posts) people who were still actively trying to change visited the ex-ex-gay boards to look for some different perspectives, but they were the exception rather than the norm. Thirty-six of the 39 people who stated their sexual orientation on the board identified as gay, and the other three identified as bisexual. None of them identified as straight. Information provided by these posters may offer us some insight into what it is like to be what Shidlo and Schroeder (2002) termed a "self-perceived failure."

While we do not have "before and after" data regarding participants' religious identities, some posters gave good insight into their spiritual standing while in the ex-gay movement as compared to their current standing, having left the movement. Twenty-seven of the 30 individuals who mentioned their past religious identity were Christian of some sort. Twelve of these individuals reported being in a self-described fundamentalist branch of Christianity, and four reported having been ministers or leaders in their churches. Thirty-one individuals reported their current religious identity. Of those, 22 were still practicing Christianity of some sort, but only one reported being fundamentalist. One person identified as a Unitarian Universalist, three described themselves as spiritual but not Christian, and four indicated specific other spiritual paths, such as Buddhism.

Most of the posters to the ex-ex-gay boards report currently being in overall good psychological health. The most common statements about how they were feeling relative to their time in the ex-gay movement were that they valued their journey through the process (7 of 15 statements) and that they were currently at peace with their sexuality (8 of 15 statements).

> I have come to recognize my ex-gay experience as simply part of my coming out process. Although there are many things I regret about my ex-gay experience, I have to admit that it was a good way of facing many of my doubts about homosexuality. (Ex-ex-gay)

> My evolution as a gay, in order to discover who I really am, has been interesting to say the least. I have actually got to the place where I am

> completely happy being gay with no regrets or desire to be anything else but gay. It's a very peaceful place. (Ex-ex-gay)

By and large, ex-ex-gay posters view their experience in the ex-gay movement as having yielded positive results in the long run, despite their negative experiences while in the programs. Most commonly reported positive outcomes were being stronger in their faith (5 of 10 outcomes) and having a more solid identity for having gone through the program (5 of 10 outcomes).

> However, it was through the ex-gay experience itself that I was forced to face the hard questions about the meaning of life and the will of God. In fact, as I continue to 'unlearn' my ex-gay teachings, I am beginning to appreciate what it means to be a "child of God", or to have a "spirit filled life." (Ex-ex-gay)

Some posters reported residual effects from their time in the ex-gay movement. Most common among these were guilt and self-doubt.

> It has been over two years since I decided the ex-gay life was not for me. I have re-established my faith and have dealt with most of the philosophical issues. However, I still sometimes feel guilt and shame about my attractions. I can't honestly say that all of the old ex-gay messages have been erased. Does anybody relate? (Ex-ex-gay)

Many posters arrived at a place of resolving their sexuality with their religious identity. Several mentioned the view that they believe sexuality to be irrelevant to God (3 of 8 comments), and that their relationship with God is stronger than it was while they were ex-gay (5 of 8 comments).

> We are not condemned by God because of it. He loves us equally along with heterosexuals. In fact God does not view any of us as heterosexuals or homosexuals. Rather, He relates to us as His sons and daughters on a level equal to Christ. That is difficult for some to grasp, but it is biblical. (Ex-ex-gay)

> I have no regrets not being actively involved in any church any more. I have a stronger faith now than I have ever had and continue to minister to others as God leads by sharing His love and grace with anyone who seems interested. It has been quite rewarding and fulfilling to me. (Ex-ex-gay)

Despite making gains from their journey through the ex-gay movement, ex-ex-gays' views about the ex-gay movement are mixed. A large number of posters view ex-gays as being resistant to new information or other viewpoints (4 of 18 views) and believe that ex-gays avoid thinking about their spiritual journey (4 of 18 views).

> Ex-gay groups want to make it clear that their clients are voluntary participants. However, at the same time ex-gay groups tend to strongly discourage participants from seriously considering alternatives. (Ex-ex-gay)

> However, the recurring motto I was often advised was, "Pray for more faith"—which basically amounted to "Stop asking questions and get with the program." (Ex-ex-gay)

Another common viewpoint about the ex-gay movement was that its members' problems were the result of other sexual or psychological issues and did not relate much (if at all) to being gay (4 of 18 views).

> That's what I was thinking when I first got involved. . . . I saw so much time being spent on sexual thoughts that I began to think of them as not having a problem with gay . . . but actually sex problems . . . ya know like compulsive disorders and such . . . I as a gay man just didn't think about that aspect as much as they seemed to base it on . . . sex this and masturbation that and the guilt and shame all the time . . . finally I saw as you did . . . that it was sex problems that caused such misery . . . not the fact they were gay. (post edited for readability) (Ex-ex-gay)

Members of the ex-ex-gay groups view their current roles to be ones of service to others, either educating about GLB issues (5 of 9 roles) or supporting others who are struggling to reconcile their religion with their sexuality (4 of 9 roles).

> While much has already been done, we cannot afford to sit back and take it for granted that things will continue to improve if we do not try to inform as many as we can with the facts and truth about homosexuality and homosexuality and the Bible. (Ex-ex-gay)

> I understand more and more that my mission, if you will, is to educate fundamentalist/conservatives about homosexuality and God's unconditional love. (Ex-ex-gay)

Differences Between Ex-Gays and Ex-Ex-Gays (or Self-Perceived Successes and Self-Perceived Failures)

One area in which ex-gays and ex-ex-gays seemed to differ is their approach to religion. Ex-gays seem to relate to their religion as an end in itself and as central to their identity. This way of viewing religion has been known as "intrinsic religiosity" and is described as "deep and primary" (Allport & Ross, 1967). As in this quote, religious solutions are often the first and only line of defense for ex-gays:

> Confess your sins to God because he is the only one who can change your heart and fill it with the pure water of his word. You have been drinking the polluted water from this relationship and your judgment is clouded. . . . The need that is being filled through this [gay] relationship can only be met through knowing God personally and let him become your lover, friend and partner. Men will only let you down and leave you angry, lonely and depressed. Go to God. (Ex-gay)

Ex-ex-gays seem to view their religion or spirituality as more of an evolving attribute of themselves or as a journey. This religious orientation is termed a "quest" orientation (Batson, 1976). Quest-oriented individuals see questioning and doubting as parts of a mature spirituality (Maltby, 1999). Those who identify as ex-ex-gays appear to engage in more questioning of their spirituality and to be comfortable with a greater degree of uncertainty about their beliefs:

> You are a very wise man to realize that no one man can have "the absolute answer to anyone else's life or spiritual journey but by sharing, we may see similarities that may help each other." That statement of yours is so true! It's interesting to note that even in a counselor's office (which is by and large not run by the church) the counselor realizes he cannot tell a man exactly what to do, he can only lead and suggest. It's amazing how even an institution that is not "spiritual" per se sees that we all are so very unique! (Ex-ex-gay)

DISCUSSION

It is important that we gain a more comprehensive understanding of what motivates people to attempt change their sexual orientation, how they experience the change process, and what the outcomes of reparative therapy are (Schuck & Liddle, 2001). The ability to successfully embrace a positive spirituality that is compatible with one's sexual orientation has been linked to better psychological well-being (Lease, Horne, & Noffsinger-Frazier, 2005; Ream & Savin-Williams, 2005; Wagner, Serafini, Rabkin, Remien, & Williams, 1994), and a better understanding of the motivation to prioritize religion over sexuality will help practitioners facilitate positive resolution of these two identities. We add support to existing theories about the process of attempting to change one's orientation, suggest some areas that warrant additional research, explain limitations of the current project, and offer preliminary recommendations for practitioners working with clients experiencing religion/sexuality conflict.

Support for Existing Theories

Our observations about the nature of the conversion process are largely consistent with Shidlo and Schroeder (2002). The participants in Shidlo and

Schroeder's (2002) study and the participants in the present study were motivated to undergo conversion because of religious beliefs or to save their heterosexual marriage. Some of Shidlo and Schroeder's (2002) participants also indicated the desire for community connections as a motivator for joining the ex-gay movement, though that theme was not expressed by participants in our sample. It is possible that their participants, having joined in-person groups or sought in-person therapy, are more socially oriented or have a higher need for affiliation than those in our Internet sample.

Many of the psychological, sociological, and interpersonal harms and helps reported in Shidlo and Schroeder (2002) were echoed by our participants. Participants in both studies reported depression, suicidal ideation, and deficits in self-esteem. Socially, both participant groups reported loneliness, social isolation, and lack of social supports while beginning or ending conversion therapy. Participants in both studies reported valuing the social support provided by ex-gay groups. This consistency supports the idea that, for many people, reparative therapy is related to negative experiences and feelings, but that participants also report positive experiences during the reparative therapy process.

Participants in the two studies also offered similar reports of advice given to would-be changers. Avoiding temptations, using accountability partners, forming platonic friendships with heterosexual same-sex people, reading scripture, and praying were all strategies offered to both groups of participants. This suggests consistency in the message that is given to ex-gays, regardless of how they come into contact with members of the movement.

In both Shidlo and Schroeder (2002) and the present study, even people who purport to have changed their orientation from homosexual to heterosexual still report significant struggles with homosexual urges. Many have developed coping mechanisms for these urges, but nearly all posters who reported that their orientation had changed noted that the "struggle" is likely to continue throughout their entire life. This finding reinforces the idea that there is some percentage of people who are able to achieve sustained behavior change, but it seems that an actual change in one's root sexual orientation is not a reasonable expectation (Beischke, Paul, & Blasko, 2007).

Suggestions for Further Research

Our observation that there may be differences between those who persist with orientation change and those who move on to recover their gay identity in terms of their religious orientation merits further research. Given the connections between religious orientation and attitudes toward sexuality in general (Cowden & Bradshaw, 2007; Reed & Myers, 1991), it is reasonable to expect that there is a demonstrable connection between religious orientation and mode of resolution in the religion/sexuality conflict. We hypothesize that individuals with an intrinsic religious orientation will be more likely to

prioritize their religious identity over their sexual identity, and will persist at achieving orientation change. In terms of Shidlo and Schroeder's (2002) model, this means that intrinsically oriented individuals will be more likely to identify as successful, even if they are still struggling with homosexual urges.

In contrast, individuals with a quest orientation will be more likely to respond to doubts or frustrations experienced while they are in the ex-gay movement by investigating possibilities beyond their current set of religious beliefs, and may consider a wider body of information in choosing their resolution strategy. Since their view of religion/spirituality is evolving and malleable, this will provide more possibilities for them to find a good fit between their spiritual and sexual identities. Thus, they will be more likely to identify as "failures" and follow the path to some recovery of their gay identity.

Religious orientation may have additional connections to individuals' resolution process. Quest orientation is associated with greater cognitive complexity and an intrinsic orientation is associated with simpler cognitive complexity (Batson & Raynor-Prince, 1983). It might be reasonable to expect, then, that individuals with an intrinsic orientation would persist in a single resolution strategy longer than those with quest orientations. A quest orientation, with its greater cognitive complexity, may result in an individual's ability to see their problem from multiple perspectives, integrate those multiple perspectives, and apply them to his/her situation (Batson & Raynor-Prince, 1983).

Future research on the relationship between religious orientation and ex-gay experiences would be beneficial for understanding individual differences in enrollment in and response to these programs. Given that religious orientation has been linked to other personality dimensions (Henningsgaard & Arnau, 2008; Saroglou, 2002), understanding more about this link can provide better information about providing effective mental health and social services to individuals with experience in the ex-gay movement.

Another significant topic for further study has to do with the role of marriage and family in attempting to change one's sexual orientation. A common motivator for attempting change was to save an existing heterosexual marriage, and a significant portion of individuals in both ex-gay and ex-ex-gay samples indicated that they either had been or were currently in a heterosexual marriage. Wolkomir (2004) did one of the only studies in the literature on the experience of wives of men who are attempting orientation change. The women in her study reported that their husbands' struggle left them feeling unsure about their marriage and their femininity, and reported making significant shifts in how they viewed their marriage and their role in it. These women were all in a support group for wives of strugglers and were committed to making their marriages work. It would be worthwhile to further examine the emotional and relational experiences of women married

to (ex)gay men, and the ways in which the nature of spousal interaction affects both parties' senses of well-being.

Several participants reported feeling angry or resentful at their parents for their difficulties with homosexuality. Much of the information provided by ex-gay groups cites parents and family dynamics as reasons for same-sex attraction. It would seem logical that this attribution would strain the relationship between individuals and their parents. It would be interesting to know what changes occur in the family dynamic when an adult child attempts to change his/her orientation.

Limitations of This Research

Though this study addresses some limitations of past research by expanding the sampling base and reducing response bias, it suffers from several limits of its own. First, though our sample has more breadth than some previous samples, it is more limited in other ways. Since our data were obtained via the Internet, this means that all of our participants had to be in an area where Internet service is available, be able to access Internet service, and be technically savvy enough to find the message board and post to it. This could bias our sample to people who are relatively more well-off and educated, and to those who live in more developed countries.

Another potential sample-related limitation is that, while we expect that anonymity breeds candor, it could also be argued that it has the potential to breed dishonesty or skewed reporting of events in a participants' life. In the context of an in-person support group of people from one geographical area, truth in disclosure is made necessary to some extent by the potential to be found out if one is untruthful. In contrast, online support seekers may feel more at liberty to gloss over difficulties or distort experiences in other ways since the likelihood of discovery is much less.

Next, it may be that individuals who are seeking support from an Internet source are concerned about anonymity, and so are not seeking in-person support. This could mean that Internet support-seekers are predisposed to be more ashamed, depressed, etc., about their situation. As noted previously, individuals in Shidlo and Schroeder's (2002) sample cited community concerns as a motivation for change, while our sample did not mention that factor. There may be important differences between people who seek help via an Internet format and those who seek in-person help.

Another possible characteristic of Internet support-seekers is that they have more access to competing viewpoints on homosexuality. They may be more likely to have evaluated other options for dealing with their sexual orientation (such as embracing their sexual identity or attending an affirming church) and still have chosen to try conversion. This could mean that people on this message board are more religiously conservative and/or more

committed to changing their orientation than the larger population of people in the ex-gay movement.

Finally, because of the anonymous nature of the Internet, users can choose to simply stop posting at any point. This makes following through the entire change process with any single person nearly impossible. We do not have the ability to find out if there are differences in outcomes for people who exhibit varying levels of distress or satisfaction while they are posting to the board.

Preliminary Recommendations for Practice

Though this research is part of a relatively young area of study, it does allow us to suggest some potentially useful strategies for professionals who work with individuals dealing with sexuality/religion conflict. In their handbook on affirmative therapy with lesbian and gay clients, Ritter and Terndrup (2002) offer some guiding principles for therapeutic contact with individuals struggling with religious issues. These principles are easily extended to applications involving clients with religion/sexuality conflicts who are considering or recovering from reorientation therapy. First among these is a recommendation that therapists understand the possibility that LGBT clients may view their religious tradition as an important part of their identity even if that tradition is not supportive of LGBT individuals, relationships, or behaviors. They may experience their religion/sexuality conflict as being "caught between cultures" (p. 273). Thus, strategies applied to other cases of identity conflict may be applicable to this situation. Therapists are also advised to be mindful of and respectful of a client's religious beliefs.

Ritter and Terndrup (2002) incorporate a thorough discussion of the philosophical foundations for religious belief, indicating that for religious beliefs to be viable to a person, they must be philosophically reasonable, morally helpful, spiritually illuminating, and communally supportive. Some conflict may arise in GLBT individuals as they realize that their current spiritual path does not meet these criteria. The therapist's role, then, may be one of encouraging critical thinking and evaluation of both one's beliefs and of the community in which they express those beliefs.

Part of developing a viable religious belief may be exploring alternative and/or affirming faith groups. Many mainstream faith traditions now have affirming groups (though not always sanctioned by the official branch of the tradition). Protestant denominations, Catholics, and several Jewish traditions have affirming groups (see Ritter & Terndrup, 2002, for more detailed information). Outside of the more mainstream Judeo-Christian traditions lay other spiritual paths that may be particularly affirming for GLBT individuals. Goddess religions, pagan traditions, earth-centered spiritual paths, and shamanic traditions all offer substantial support for variations in sexual

orientation and gender expression, and may be positive options for the client (Ritter & Terndrup, 2002). Therapists and/or clients should explore affirming options available in their area.

Clients who are seeking guidance about whether or not to attempt conversion therapy may benefit from a discussion about the specifics of the personnel and methods used in conversion therapy programs. Many practitioners of conversion therapy are not licensed professionals (Ritter & Terndrup, 2002) but rather are religious leaders or lay people with an interest in the issues at hand. Part of the American Psychological Association's ethical code (2002) centers around ensuring that clients receive informed consent before beginning therapeutic activity. While it is important to maintain objectivity with regard to a client's religious beliefs, it would be advisable to ensure that the client understands the circumstances under which reparative therapy occurs. Knowing that the conversion process is not recommended by professional organizations and is not staffed by licensed professionals may aid the client in making a more informed choice regarding his/her entry into reparative therapy.

This study provides corroboration of the existing research findings on the psychological and social aspects of trying to change one's orientation. We also suggest that there may be important differences in the way people approach religion that help to determine the length and outcome of their time in conversion therapy. An interesting area of research would be to investigate the possibility of religious orientation as a contributor to one's feeling of success in conversion therapy and as a contributor to the quality of the resolution between religion and sexuality. Further research on the family networks around members of the ex-gay movement may help to provide better supports for both strugglers and their families as they attempt to resolve the conflict between their religion and their sexuality.

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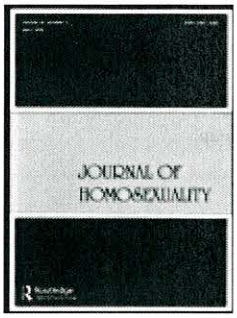

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Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification

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Therapy meant to change someone's sexual orientation, or reorientation therapy, is still in practice despite statements from the major mental health organizations of its potential for harm. This qualitative study used an inductive content analysis strategy (Patton, 2002) to examine the experiences of thirty-eight individuals (31 males and seven females) who have been through a total of 113 episodes of reorientation therapy and currently identify as gay or lesbian. Religious beliefs were frequently cited as the reason for seeking reorientation therapy. Frequently endorsed themes of helpful components of reorientation therapy included connecting with others and feeling accepted. Harmful aspects of reorientation therapy included experiences of shame and negative impacts on mental health. Common reasons for identifying as LGB after the therapy included self-acceptance and coming to believe that sexual orientation change was not possible. The findings of this study were consistent with recommendations by the American Psychological

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Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009), which concluded that helpful aspects of reorientation therapy could be achieved through affirmative treatment methods while avoiding potential harms that may be associated with reorientation therapy. Limitations of the findings, including a small, self-selected sample, are discussed.

KEYWORDS LGBT, conversion therapy, reorientation therapy, reparative therapy

Sexual reorientation therapy, or interventions that are designed to change someone's sexual orientation from lesbian, gay, or bisexual (LGB) to heterosexual, continues despite the fact that homosexuality and bisexuality are not mental disorders. These interventions are controversial and possibly iatrogenic, as most major mental health organizations have noted while criticizing the practice.

Position papers on reorientation therapy from major mental health organizations clearly object to its use. For example, the American Psychiatric Association has identified reorientation therapy as potentially harmful and lacking in scientific evidence (American Psychiatric Association, 2006). The National Association of Social Workers (2007) said in a position statement that reorientation therapy "cannot and will not change sexual orientation" (paragraph 5) and encouraged social workers to refrain from reorientation practices. The Ethics Committee of the American Counseling Association has said that reorientation therapy does not meet professional standards and that counselors must not offer reorientation therapy in their occupations as counselors but may offer it only in other roles, such as pastoral counseling (Whitman, Glosoff, Kocet, & Tarvydas, 2006). The American Psychological Association conducted a review of the relevant research on reorientation therapy and adopted a resolution stating that there is not enough research evidence to support the use of reorientation therapy, that available research indicates it is unlikely that patterns of sexual attractions will be changed by reorientation therapy, and it recommends the use of "affirmative multiculturally competent treatment" approaches (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009, p. 121). The resolution further states that the potential benefits of reorientation therapy can be achieved by therapeutic interventions that are not focused on changing sexual orientation (American Psychological Association, 2009). Despite these directives from the major mental health associations in the United States, reorientation therapy continues to be practiced by both mental health professionals and religious organizations (Exodus International, 2005).

REORIENTATION THERAPY AND SEXUAL ORIENTATION

The terms *sexual reorientation therapy, reorientation therapy, conversion therapy*, and *reparative therapy* are used to describe interventions that are meant to change someone's sexual orientation. Sexual orientation is a complex, multidimensional construct that encompasses an array of human sexual attractions, behaviors, emotions, and identities (American Psychological Association, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Sell, 1997). Thus a single individual's sexual identity comprises that person's sexual attractions (i.e., to persons of the same sex or gender, opposite sex or gender, or more than one gender), sexual behaviors, and social connection with others who share similar sexual attractions and engage in similar behaviors. In turn, reorientation therapy is intended to alter one or more of these domains in such a way that an individual may stop (1) identifying as LGB; (2) engaging in sexual behaviors with partners of the same sex; (3) finding individuals of the same sex attractive; and/or (4) associating with people who have same-sex attractions and engage in same-sex sexual behaviors. A number of interventions, some of which may be tied to behavioral, cognitive, psychoanalytic/psychodynamic, and/or religious counseling principles, may be used during a course of reorientation therapy (Flentje, Heck, & Cochran, 2013).

To understand the emergence of reorientation therapy as a therapeutic intervention, the historical persecution and criminalization of individuals on the basis of sexual orientation must be considered as part of the context (Mogul, Ritchie, & Whitlock, 2011). One's motivation for sexual orientation change might include avoiding the real threat of prosecution for same-sex behavior, as well as other forms of societal discrimination. In addition, many major religions have historically identified same-sex behavior as a "sin," resulting in conflict for people who experience same-sex desires and a simultaneous commitment to a religious organization that decries same-sex behavior. Family pressures and internalized homophobia may also play a role in the motivation for sexual orientation change interventions. Finally, because the LGBT civil rights movement has a relatively recent history and is still ongoing, individual experiences of what it means to be gay, lesbian, bisexual, or transgender vary tremendously based on the individual's context. With all of these factors considered, the development and persistence of sexual reorientation interventions is not surprising.

Furthermore, the history of the mental health establishment's perspectives toward homosexuality also helps to explain the development of reorientation therapy. These therapies developed under the now-refuted perspective that homosexuality was a mental illness, and continued to exist through the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (DSM-II). In the third edition of the DSM, a new diagnosis of ego-dystonic homosexuality was created

(American Psychiatric Association, 1980); with this diagnosis, an individual could be diagnosed if he or she was experiencing conflict with his or her same-sex sexual attraction or behavior. When homosexuality was considered a mental illness, researchers examined potential treatments for homosexuality (e.g., Cautela, 1967; Conrad & Wincze, 1976; Feldman & MacCulloch, 1965; Tanner, 1974; for a review, see Haldeman, 1991, 1994). In a revision of the third edition of the DSM, ego-dystonic homosexuality was removed (American Psychiatric Association, 1987).

Despite the shift away from clinical interventions designed to change sexual orientation after homosexuality was depathologized, Zucker (2003) described a movement that began in the early 1990s that advocated for the existence of sexual reorientation therapy, with the position that clients' wishes to change their sexual orientation should be honored by their therapists. Zucker notes that this movement was led by Socarides, a psychoanalyst, and Nicolosi, a psychologist, and coincided with the creation of the National Association for Research and Therapy of Homosexuality (NARTH) in 1992. The organized ex-gay movement began a visible media campaign in 1998 when advertisements in major newspapers began emerging, claiming that sexual orientation change was possible (Lund & Renna, 2003).

Reorientation therapy is a political, emotional, and controversial topic, and perhaps as a result of this, there is little methodologically sound empirical research on this type of therapy. Arguments have been made that reorientation therapy should be offered, if the client requests it, to honor the client's autonomy (Benoit, 2005). Individuals may seek reorientation therapy for many different reasons, including religious or cultural beliefs. This is particularly clear in a controversial study by Spitzer (2003), who studied 200 individuals who had experienced some kind of reorientation therapy and, after the therapy, maintained gains in their efforts to secure aspects of a heterosexual identity. In his study, 79% of the participants identified conflict between religious beliefs and same-sex behaviors as reasons that they wanted to change their sexual orientation. Spitzer's sample was predominantly religious, with 93% reporting that religion was very or extremely important in their lives. Spitzer concluded that sexual orientation change was possible in areas including behaviors, identity, attraction, content of fantasies, and the extent to which individuals were bothered by same-sex sexual feelings. Additionally, Spitzer reported that participants reported less depression as a result of the therapy and increased masculinity and femininity for the respective sexes. Within Spitzer's sample, 78% had spoken publicly about their sexual orientation change, and 19% directed ex-gay ministries or worked as mental health counselors.

Beckstead (2003) suggested that the widespread interpretation of Spitzer's study as proof that people can change their sexual orientation is inaccurate—that Spitzer's study, instead, shows that in rare cases people who are attracted to individuals of the same sex may be able to function

in relationships with individuals of the opposite sex. Additionally, Bancroft (2003) criticized the study in many different areas, including the lack of representativeness of the sample, the strong religious beliefs of the sample, the large percentage (78%) of the sample that had spoken publicly about their orientation change, recall bias, lack of clarity about the therapy provided, and the unfounded claims of sexual orientation change. Recently, Spitzer made a public apology for his study and indicated that the claims he made in his study were inappropriate (Besen, 2012). Nevertheless, Spitzer's (2003) study stands as one of the empirical underpinnings cited by the ex-gay movement.

Scholars have considered ways of coping with the conflict that can exist between religious beliefs and sexual orientation. Diamond (2003) suggested that individuals consider modifying, if possible, or leaving practices and relationships that are not supportive of LGB identification. She also acknowledged that, relative to a person's sexual orientation, these anti-LGB practices and relationships may comprise a large and important portion of the person's overall identity. In other words, the prioritization of LGB affirmation over other important aspects of a person's identity (e.g., religious identity; relationships with family members) may be inappropriate or invalidating, even if these practices and relationships are homophobic.

As noted earlier, reorientation therapy has also received criticism for its potential harmfulness. Bancroft (2003) suggested that the individual may experience "considerable conflict and unhappiness" (p. 421) as a result of feeling that he or she needs to change his or her sexual orientation. Bancroft thoughtfully considered the potential harmfulness of his early research on behavioral reorientation techniques as potentially reinforcing homophobic beliefs. Other researchers have argued that reorientation therapy should not be practiced because there is no pathological condition that needs treatment (Tozer & McClanahan, 1999). Yarhouse and Throckmorton (2002) rebut this type of argument by pointing out that treatment is often given for nonpathological conditions, and they state that not all reorientation programs reinforce the idea that same-sex attraction is pathological.

RESEARCH ON EXPERIENCES OF INDIVIDUALS IN AND AFTER REORIENTATION THERAPY

There is a relatively limited body of research on individuals who have sought out reorientation therapy. Most of this research has focused on factors leading to the decision of individuals to enter this therapy or on the experiences of clients post-treatment. The extant literature on reorientation is summarized below.

Beckstead (2001) analyzed qualitative data from 20 Mormon proponents of reorientation therapy who reported that they had benefited from the

treatment. The participants reported that being LGB was similar to having a disease and meant that their lives would consist of having multiple sexual partners, a high likelihood of contracting a sexually transmitted disease, and isolation (Beckstead, 2001). Several of the participants reported being told that they would be excommunicated from their religious communities if they were to continue to have same-sex relationships (Beckstead, 2001). Benefits of reorientation therapy included emotional relationships with persons of the same sex, increased identification with their own gender, which was a focus of treatment for many of the participants, and reduced same-sex sexual behaviors or desire; however, none of the participants reported increased sexual attraction to the opposite sex (Beckstead, 2001).

Beckstead and Morrow (2004) combined data from the 20 proponents with data from 22 individuals who had undergone reorientation therapy and reported negative outcomes to develop a model to capture the experiences of Mormon individuals who had experienced reorientation therapy. A preliminary model was subjected to a confirmatory process whereby eight additional participants with varied conversion therapy experiences and perspectives discussed the model in focus groups (Beckstead & Morrow, 2004). Beckstead and Morrow's final model, which is placed in the context of societal homophobia and heterosexism, provides a detailed overview of (1) factors and processes that may lead people to seek reorientation therapy; (2) positive and negative sexual reorientation therapy experiences; (3) post-treatment experiences and personal (identity) development; and (4) possible outcomes. Furthermore, the model specifies experiences that are unique to proponents or opponents of reorientation therapy and experiences that are shared by both groups.

According to Beckstead and Morrow's (2004) model, experiencing dissonance between same-sex attractions and religious beliefs, which can lead to disparaging self-labeling (e.g., fag, dyke, pervert), negative emotionality, and unhealthy coping behaviors, is often an impetus for seeking help from religious leaders or therapists and entering reorientation therapy. The model then suggests that both proponents and opponents of reorientation therapy experienced benefits, including finding and connecting with individuals in similar situations, having a framework by which to understand why they experienced same-sex attraction (same-sex attractions were primarily explained as occurring due to unmet same-sex emotional needs), and experiencing increased identification with their gender (Beckstead & Morrow, 2004). The model also specifies negative reorientation therapy experiences (e.g., disappointment; depression and suicidality; increased emotional distress; interpersonal and relational challenges; loss of faith), primarily voiced by opponents of the therapy, but with proponents and opponents alike indicating that they felt increasingly suicidal after feeling disappointed about "failing to sexually reorient" (p. 671, Beckstead & Morrow, 2004). Notably, eight participants (19% of the sample; four proponents and four opponents)

attempted suicide after the therapy, and many participants reported having known others who had completed suicides after reorientation therapy (Beckstead & Morrow, 2004). After therapy, the model highlights a number of possible experiences that may include vacillating between different identities, disillusionment, developing or solidifying values, and eventually finding self-acceptance. Finally, the model specifies a number of possible outcomes that range from adopting a positive sexual identity (e.g., LGB, same-sex attracted, heterosexual) to finding peace, congruence, and authenticity, to continuing to experience sexual orientation–related challenges. Based on the findings, Beckstead and Morrow (2004) conclude that the potential harms of reorientation therapy are considerable and outweigh the benefits, which could be obtained in other types of therapy.

Shidlo and Schroeder (2002) interviewed 202 individuals who had undergone some kind of reorientation therapy and were recruited through advertisements in newspapers, online, and through e-mail Listservs. As with previous research, women were largely underrepresented, comprising only 10% of their sample. Unlike other samples, there was a representation of nonreligious individuals, with 24% of the sample identifying as nonreligious. Participants had spent an average of 26 months in reorientation treatment, ending the last treatment episode an average of 12 years before their interview (Shidlo & Schroeder, 2002). Shidlo and Schroeder reported that many of the individuals that they interviewed said that at one point in time they would have identified themselves as reoriented, but that with time they realized that this was not the case. Shidlo and Schroeder found that persons who had gone through reorientation therapy had mixed experiences with the therapy, with many reporting that they had been both harmed and helped from the same episode of therapy.

Shidlo and Schroeder (2002) developed a model for a pathway to perceived treatment failure or success. The model begins with the preentry period, which was the time during which the participant became motivated to enter treatment. Strong motivators that were reported were a search for a social group where he or she felt comfortable, religious reasons, desire to hold together a marriage and family, threatened expulsion from a religious academic institution if treatment was refused, and mood or anxiety symptoms. For the latter group that sought therapy for mood or anxiety symptoms, they reported that their therapists suggested reorientation therapy in response to their symptoms. Overall, reorientation therapy was suggested to the client by the therapist in 26% of the interventions reported.

The next phase of Shidlo and Schroeder's (2002) model was identified as the "honeymoon period," in that participants reported a sense of hope and relief at entering therapy. The model then puts forth division into two groups: persons who perceive themselves as successful and persons who perceive themselves as failing, 13% and 87%, respectively, within the sample. The authors further divide the successful group into three subgroups:

"successful and struggling," which was defined by repeated same-sex sexual behaviors; "successful and not struggling," which was defined by using strategies to manage same-sex sexual urges; and "successful heterosexual shift," defined by individuals who were living actively heterosexual lives. Notably, of the eight individuals in the successful heterosexual shift phase, seven were providers of counseling to individuals who were reorienting or reoriented (Shidlo & Schroeder, 2002).

For individuals who saw themselves as not having reoriented, the honeymoon phase was followed by a time of disillusionment (Shidlo & Schroeder, 2002). At this time, the authors state that participants experienced a deadening of sexual desire, or they experienced strong feelings of same-sex sexual desire and felt disappointed in their treatment progress. The latter group often engaged in dangerous impulsive behaviors including substance use, suicidality, or unsafe sexual behaviors. From this point, Shidlo and Schroeder saw the participants as reestablishing a gay or lesbian identity with considerable residual reorientation therapy harm ($n = 155$) or with considerable renewal and strength ($n = 21$).

PURPOSE OF THIS STUDY

The present study is a departure from previous research on reorientation therapy for several reasons. First, in contrast to the controversial Spitzer (2003) study, the present study involved recruiting individuals who went through reorientation therapy and did not report a change in sexual orientation. To date, no studies have specifically focused on ex-ex-gay individuals, or those who have entered reorientation therapy at one point, then later reclaimed a gay or lesbian identity. Second, this study differs from the studies conducted by Beckstead and Morrow (Beckstead, 2001; Beckstead & Morrow, 2004) in that participants in the present study were not recruited on the basis of one particular religious identity, and therefore may represent a broader group of individuals who went through reorientation interventions. Finally, in contrast to the model-building approach of Shidlo and Schroeder (2002), the recruitment strategy of the present study was designed to capture individuals who perceived themselves as successful, not in having achieved sexual orientation conversion, but in having reclaimed a new identity as gay or lesbian.

The purpose of this study is to thematically examine the experiences of people who have undergone reorientation therapy and have determined that an ex-gay life is not for them: ex-ex-gay (or ex-ex-lesbian) individuals. This study seeks to identify the reasons that led these individuals to seek reorientation therapy and the reasons that they later chose to claim a gay or lesbian identity. Additionally, this study aims to determine how reorientation therapy was perceived to be beneficial or harmful to the individual.

METHODS

Recruitment of Participants

Participants met inclusion criteria if they had been through any type of intervention designed to change their sexual orientation from LGB to heterosexual and currently identified as LGB. Recruitment efforts targeted several online sources over a period of approximately 12 months in 2008 and 2009. First, a notice describing the study was included in an e-mail newsletter to individuals who had registered with an ex-ex-gay Web site. The notice suggested that information about the study could be passed on to others, which created a snowball effect that resulted in additional postings about the study on at least seven other Listservs or Web sites (according to participant reports when they were asked where they heard about the study), including a Listserv for people who identify as both gay and Christian. Additionally, a description of the study was sent out to a Listserv of psychologists who are interested in lesbian, gay, bisexual, and transgender (LGBT) issues. It was anticipated that it would be difficult to find participants for this study due to low base rates of individuals who met the criteria for study participation. In addition, previous researchers had also reported difficulty in recruitment. For instance, Throckmorton and Welton (2005) spent one year recruiting participants who considered themselves reoriented or reorienting and were able to find 28 participants who met their study criteria during that time. Similarly, Spitzer (2003) spent 2 years of intensive searching to locate 200 participants and ultimately ended up recruiting many activist ex-gays. A number of factors influence the decision of an optimal sample size for reaching saturation, or the point at which additional data collection would not offer new insights or themes; however, a general recommendation for sample sizes for interview data in sexuality research was recently offered as 25–30 participants (Dworkin, 2012). Considering the uniqueness of this population, recruitment difficulties in previous research, and the goal of identifying relevant themes regarding reorientation experiences, a target goal of 30 participants was set for the present investigation.

Measures

Demographic questions

Respondents were queried about their demographic characteristics, including age, gender (including queries for male, female, transgender male to female, transgender female to male, and other), education level, income, and relationship status.

Sexual orientation

Two items were used to measure sexual orientation. One question asked the participant if he or she identifies as gay, lesbian, heterosexual, or bisexual.

The Kinsey Scale (Kinsey, Pomeroy, & Martin, 1948) was also used to measure sexual orientation both because of its simplicity and because it is a scale with which persons who go through sexual reorientation therapy may be familiar. The Kinsey Scale is a 7-point scale where responses range from 0, indicating exclusively heterosexual, to 6, indicating exclusively homosexual (Kinsey et al., 1948). Because the focus of this investigation was on the shifts in identity that accompany an individual's self-definition as gay, ex-gay, or ex-ex-gay, the measures of sexual orientation in this study reflected LGB identity, rather than attraction or behavior.

Questions about therapy experiences

Several items queried the participants' experiences with reorientation therapy. These questions included number of episodes of therapy, the length of therapy, the modality of therapy, the designation of the person(s) who provided the therapy, and the setting of the therapy. If the participant had experienced more than one episode of reorientation therapy, these questions were asked for each episode.

Furthermore, participants were asked about reorientation experiences via the following questions: "What were your reasons for seeking reorientation therapy?"; "How did this therapy episode help you in the short term?"; and "How did this therapy harm you in the short term?" Similarly worded items were used to assess the long-term helpfulness and harmfulness of each therapy episode. Participants' reasons for LGB identification following therapy were assessed by asking: "What were your reasons for identifying as gay, lesbian, or bisexual after reorientation therapy?"

Procedure

Due to concerns that the data could be compromised if an open survey was offered to anonymous parties, participants were asked to contact the principal investigator via e-mail or telephone to participate in the study. After contact was made, the investigator mailed the individual a paper survey and a separate form and envelope to request an incentive of $15. This method was meant to prevent the same individual from completing the survey multiple times, with contact with the principal investigator being the deterrent.

Analyses

An inductive content analysis strategy (Patton, 2002) was used to analyze participants' responses to the open-ended survey questions. Verbatim responses were printed for the research assistants (research assistants were either advanced undergraduate students [$n = 5$] or graduate students who had

obtained MA degrees [$n = 2$]), who collaborated with the principal investigator to identify core themes in the responses and develop an open coding system (Strauss & Corbin, 1998) serving as both developers and coders. During this process, the developers were instructed to read all responses one or more times and to mentally note any themes that began to emerge. The code developers were then instructed to reread all responses and identify specific themes that could be captured using a short phrase or sentence. The developers were not limited in the number of potential themes they could identify. Once complete, the developers met to share their themes. Generally speaking, the most prominent themes were discussed first, and often the principal investigator would ask the theme developers to specify portions of responses that would be included under each theme category.

This process continued until a consensus had been reached about the themes that were present in the responses. Once a consensus had been reached either three research assistants (one of whom had a MA degree) or two research assistants and the principal investigator coded each of the responses. Responses were counted as resonating with a particular theme if at least two out of the three coders identified the theme as present in the specific response. Frequencies of responses that were classified as a particular theme were then tallied, and themes that occurred at least twice are reported. Fleiss's Kappa was calculated as a measure of agreement among raters. Kappa coefficients within this study ranged from .53–.71, in the *moderate* to *substantial* agreement range (as defined by Landis & Koch, 1977).

RESULTS

Participants

Relevant sample characteristics are reported here for convenience; sample characteristics are also reported in Flentje, Heck, and Cochran (2013). Thirty-eight people participated in the study; their demographic information is reported in Table 1. Participants indicated that they had continually identified as lesbian or gay for between 13 months and 23 years ($M = 7.09$ years, $SD = 5.62$) since their last episode of reorientation therapy. When asked about their current religious identification, respondents indicated that they identified with Protestantism ($n = 26$), no religion ($n = 4$), Judaism ($n = 2$), Greek/Eastern Orthodoxy ($n = 2$), Catholicism ($n = 1$), Buddhism ($n = 1$), or were undecided ($n = 1$). The group who identified as Protestant further identified with the following churches or denominations: nondenominational ($n = 5$), Methodist ($n = 5$), United Church of Christ ($n = 2$), Baptist ($n = 2$), Episcopal ($n = 2$), Quaker ($n = 2$), Lutheran ($n = 2$), Metropolitan Community Church ($n = 1$), Evangelical ($n = 1$), Presbyterian ($n = 1$), Christianity "emergent" ($n = 1$), Golden Rule Christian ($n = 1$), and the Reformed Church of America ($n = 1$).

TABLE 1 Demographic Information ($N = 38$)

Demographic variable	n, % (or M, SD, if applicable)
Age M (SD, range)	37.37 (11.98, 20 – 66)
Sex (n, %)	
Male	38 (81.6%)
Female	7 (18.4%)
Sexual orientation	
Gay	38 (81.6%)
Lesbian	7 (18.4%)
Sexual orientation: Kinsey scale[a]	
Predominantly homosexual, only incidentally heterosexual	16 (42.1%)
Exclusively homosexual	22 (57.9%)
Race (n, %)	
Caucasian	33 (86.8%)
African American	1 (2.6%)
Latino/Latina	1 (2.6%)
Asian/Pacific Islander	1 (2.6%)
Multi Racial	2 (5.3%)
Education (n, %)	
Some college	1 (2.7%)
4-year college degree	11 (29.7%)
Some graduate school	6 (16.2%)
Graduate/professional degree	19 (51.4%)

[a]Participants only endorsed these two categories for sexual orientation.

Reorientation Experiences

Participants provided information about multiple episodes of reorientation therapy when applicable, with 38 participants providing information on 113 episodes. Participants reported that 7.1% of episodes were inpatient, 50.4% were outpatient, and 42.5% were classified as "other." Responses to what was meant by "other" varied considerably and included things such as telephone or e-mail therapy, online support groups, conferences, and retreats. Characteristics of reorientation episodes are summarized briefly in Table 2. In-depth details of reorientation experiences are reported in Flentje, Heck, and Cochran (2013).

Reasons for Seeking Reorientation Therapy

A total of 36 participants provided responses regarding their reasons for seeking reorientation therapy, and eight distinct themes emerged. The theme "religious beliefs" was the most frequently identified theme within the responses ($n = 29$, 80.6%). The "religious beliefs" theme represented answers about specific religious beliefs (e.g., "I had been taught that God would punish me as a gay man") that led participants to see an LGB identity as incompatible with their religious belief system. Consistent with this

TABLE 2 Characteristics of Reorientation Therapy Episodes

Participant intervention experiences	Range	*M (SD)*	*Mdn*
Age at first reorientation intervention	11–52	23.18 (8.62)	20
Total number of hours in reorientation interventions	12–3000	487.20 (639.72)	200
Number of different reorientation episodes	1–9	3 (2.10)	2.5
Length of intervention episodes in weeks[a]	1–240	40.54 (42.64)	26
Professional designation of intervention provider[b]	*n*	%	
Religious leader	50	22.1%	
Religious individual without leadership duties	48	21.2%	
Licensed counselor	38	16.8%	
Pastoral counselor	29	12.8%	
Peer counselor	21	9.3%	
Marriage and family therapist	18	8.0%	
Psychologist	11	4.9%	
Social worker	6	2.7%	
Psychiatrist	5	2.2%	

[a]This and the following categories are calculated for all reorientation episodes (participants reported on multiple episodes), 113 total for the study.
[b]Participants could endorse multiple professional designations for providers, resulting in 226 total responses to this question.

theme, 100% of participants reported that they had been part of a religious or spiritual community that held negative beliefs about LGB people. Additionally, there was a "desire for a 'normal' heterosexual life" ($n = 14$, 38.9%). Responses that were coded for this theme indicated that the participants wanted to be married and have children and families, and again saw these desires as incompatible with being LGB. A complete listing of the themes that emerged and the frequency of their occurrences can be found in Table 3.

Perceived Helpfulness of Therapy

All of the participants ($N = 38$) provided responses regarding short-term and long-term helpfulness for each of the reorientation therapy episodes that they experienced, and 16 themes emerged from those responses (percentages are reported according to the percent of the total of the 113 therapy episodes that they were reporting). The most commonly occurring themes for short-term helpfulness of reorientation therapy included providing a "sense of connectedness, support" (21 occurrences, 18.6%) and that the participants "felt accepted, not alone" (15 occurrences, 13.3%). For both of these themes, it appeared that there was a benefit to the social aspect of being able to share experiences with people who felt similarly conflicted about same-sex attractions. After these two themes, the third most frequently occurring theme was that the therapy was not helpful in the short term (14 occurrences, 12.4%). It should be noted that although this seems to be a counterintuitive response

TABLE 3 Reasons for Seeking Reorientation Therapy: Themes That Emerged

Theme	Frequency	Example
Religious beliefs	29 (80.6%)	"Being gay was a sin and I couldn't be a Christian and gay."
Desire for a "normal" heterosexual life	14 (38.9%)	". . . I wanted to live a "normal" life, married with children- it was my dream."
Family acceptance/rejection	14 (38.9%)	"Wanted to be 'normal' so that my family and parents would love me again."
Religious community acceptance/rejection	11 (30.6%)	"I wished to continue actively in my church which I could not continue to do in that church as a gay man."
Mental health (depression, guilt, fear)	10 (27.8%)	"I felt defective, abnormal, depressed, and self-hatred toward myself and wanted to change."
Social stigma	7 (19.4%)	". . . social stigma of being perceived as queer, deviate, effeminate"
In a straight marriage or family	4 (11.1%)	"I was married with 4 kids."
Being gay associated with negative or risky health behaviors	3 (8.3%)	". . . fear of the 'gay lifestyle' (i.e., disease, promiscuity, loneliness, drug/alcohol abuse)."

(e.g., participants indicated that a "helpful" aspect of the therapy was that it was "not helpful"), the statements here reflect the participants' responses to the question and were coded accordingly. Suicide was explicitly mentioned in six responses (5.3%). In these cases, participants indicated that their therapists or being in therapy had helped them to deal with suicidal feelings or encouraged them to not act on suicidal impulses. When considering long-term helpfulness, the most frequent theme was that the episode of therapy did not provide long-term help (35 occurrences, 31.0%). The next most frequently occurring themes were that the therapy "solidified gay identity" (13 occurrences, 11.5%) and provided a "sense of connectedness, support" (12 occurrences, 10.6%). The complete list of themes that emerged regarding ways in which participants had found reorientation interventions to be helpful and the frequency of the occurrences of these themes are noted in Table 4.

TABLE 4 Themes in the Helpfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this episode of therapy help you in the short term?		
Sense of connectedness, support	21 (18.6%)	"I found peers, support, love, and friendship. I had a free place to discuss my struggles. They helped me get through crisis situations."
Felt accepted, not alone	15 (13.3%)	"It helped me realize I wasn't alone in my 'struggle.'"

(*Continued*)

TABLE 4 (Continued)

Theme	Frequency	Example
Didn't help	14 (12.4%)	"This therapy did not aid me in the short term."
Hope (explicitly stated or implicit)	12 (10.6%)	"Therapy made me feel empowered over my own life, both in regards to my sexual orientation and the rest of my life in general. I would almost always leave each therapy session feeling great about myself and optimistic . . . It made me feel good in the short term."
Family or relationship issues	10 (8.8%)	"Gave me skills/tools and increased my self evaluation of areas in my life that could perhaps be improved—e.g., mother/father–son relationships, relationships/friendships with male peers, self esteem issues."
Mental health or other health issues addressed	9 (8.0%)	"Again, by providing a place where I didn't feel alone in my struggles, thereby staving off suicide and deeper depression."
Safe place to talk, be honest	6 (5.3%)	"Gave me an opportunity to talk about being homosexual for the first time in my life."
Helped to talk about same-sex attractions with family or community	5 (4.4%)	"It helped me to finally admit to others, including my parents, that I had same sex attractions."
Strengthening or reconciliation of faith	4 (3.5%)	"It helped to establish that I was a person of worth and to focus on God partnering with me."
Aided the coming out process	3 (2.7%)	"In settling the upset emotions of the coming out process."
Solidified a gay identity	2 (1.8%)	"Helped me to accept I was not straight"
Trauma issues dealt with	2 (1.8%)	"I was elated and felt my childhood memories of trauma were healed."
How did this therapy help you in the long term?		
Didn't help	35 (31.0%)	"This therapy has not aided me in the long term."
Solidified gay identity	13 (11.5%)	"It reinforced the fact that I was made gay and that it was not a lifestyle or a circumstances choice."
Sense of connectedness, support	12 (10.6%)	"I had a group of friends/acquaintances that I could talk to openly and honestly without fear of judgment. They understood me."
Strengthening or reconciliation of faith	7 (6.2%)	"I realized God's love was bigger than my homosexuality. I was His, and no power could negate that fact."
Felt dissatisfaction with reparative therapy	6 (5.3%)	"Showed me that ex-gay ministries/mentality was cult-like and destructive, overall, by proffering false hopes and promoting further/more rigid thinking and self condemnation."
Mental health or other health issues addressed	5 (4.4%)	"He recognized I was really depressed and connected me with medical professionals who diagnosed my depression and supplied antidepressants—possibly saving my life."

(*Continued*)

TABLE 4 (Continued)

Theme	Frequency	Example
Family or relationship issues	4 (3.5%)	"Opened up some opportunities for growth with my dad and family. Built the relationship levels with my parents to share about my homosexuality later in life. Allowed me to stop blaming my parents for my situation."
Safe place to talk, be honest	4 (3.5%)	"She is, to this day, the only therapist I've felt safe being honest with."
Aided with the coming out process	3 (2.7%)	"Started me on the road to come out."
Learned repressive techniques	3 (2.7%)	"It taught me a certain measure of self-control and made me aware of my abilities to deny sexual desires."
Met a partner or lover there	3 (2.7%)	"Met my future first gay lover."
Gained skills	2 (1.8%)	"Gave me skills"
Helped to talk about same-sex attractions with family or community	2 (1.8%)	"It began the ongoing journey of accepting my sexual orientation and sharing this with friends or family when I have a certain comfort level with them."
Trauma issues dealt with	2 (1.8%)	"I learned a lot about myself and was able to come to terms with some abuse and neglect from my past."

Perceived Harmfulness of Therapy

All of the participants responded to questions regarding short- and long-term harms for each therapy episode they experienced, and 17 themes emerged (percentages are representative of the percent of the total number of episodes experienced among the sample, $N = 113$). The most frequently identified short-term harms resonated with themes that represented "mental health (depression, anxiety)" and "shame, guilt, self-hatred," each with 17 occurrences (15.0%). Additionally, 17 episodes (15.0%) were identified as not being harmful in the short term. In the long term, participants identified that 24 episodes (21.2%) were not harmful. As with the question on helpfulness, these seemingly counterintuitive responses were the participants' verbatim answers to the question about harmfulness. The next most frequently cited long-term harm was "shame, guilt, and self-hatred" (21 occurrences, 18.6%). Suicide was specifically mentioned as a harmful aspect of reorientation episodes (four occurrences in both the short and long term, 3.5%). Identified themes and the number of occurrences of these themes are in Table 5.

Reasons for Identifying as LGB

Thirty-six participants provided responses when queried about their reasons for identifying as LGB after reorientation therapy, and eight distinct themes

TABLE 5 Themes in the Harmfulness of Each Reorientation Episode

Theme	Frequency	Example
How did this therapy episode harm you in the short term?		
Mental health (depression, anxiety)[a]	17 (15.0%)	"It was fear inducing—horrible. Almost like an exorcism performed on me. I had panic attacks and anxiety."
Shame, guilt, self-hatred	17 (15.0%)	"I felt shame about my urges/attractions."
Didn't harm	17 (15.0%)	"It probably did no harm in the short term. Finally getting to talk to someone was very calming."
False hope	13 (11.5%)	"It complied with my errant thinking that it was okay for me to get married, even though this was going on, that it would all work itself out and the situation would improve somehow—it fostered false hope."
Suppressing, not being honest, secrecy	10 (8.8%)	"Didn't face the problem. Tried to suppress to please the counselor."
Isolation, distance or loss of relationships	8 (7.1%)	"Isolation from family and friends."
Inaccurate or bad view of LGBT people	7 (6.2%)	"I was told many incorrect and untrue things about LGBT people . . . reinforced the idea that LGBT people are sick and evil."
Blamed parents, damage in relationship with parents	6 (5.3%)	"It also caused me to attempt to fit my past experiences into a reparative therapy model of attractions, which led me to begin blaming my parents for things they were not responsible for."
Delayed coming out or pursuing relationships	6 (5.3%)	"Also in the short term my experience with therapy delayed my ultimate coming out by about 2–3 years, which I view as short term in the grand scheme of things."
Financial cost	5 (4.4%)	"I didn't make much money and it was difficult to afford."
Can't change, failure, worthlessness	4 (3.5%)	"Also made me feel inadequate because my faith was too weak for me to change."
Distrust	2 (1.8%)	"The pastor counseled me in private and later told the whole church all we had spoken in private. It was a painful breach of trust."
Fear of going to hell	2 (1.8%)	"Constantly second guessing myself thinking I was going to hell."
Loss of faith in God or spirituality	2 (1.8%)	"Caused me to stop believing in God for a time."
Loss of time	2 (1.8%)	"The summer after I concluded ex-gay therapy was when I had my first relationship. However, the entire school year after that summer was a social black hole—I literally recall nothing of what transpired that year. To some degree I don't think I was ready to come out as gay, yet I knew I wasn't going back to therapy. It was a very strange year, I don't remember pursuing anyone of either gender romantically and it almost feels like my 'lost year.'"

(*Continued*)

TABLE 5 (Continued)

Theme	Frequency	Example
How did this therapy episode harm you in the long term?		
Didn't harm	24 (21.2%)	"Didn't. Was able to see what a load of crap it was."
Shame, guilt, self-hatred	21 (18.6%)	"It led me to more introspection and greater self-loathing. Every activity I performed had to be scrutinized for possible demonic overtures."
Loss of faith in God or spirituality	12 (10.6%)	"It caused me to feel separated from God and condemned to hell."
Mental health (depression, anxiety)[a]	10 (8.8%)	"In spite of the therapist's efforts, my depression grew worse under his care rather than growing better. I began cutting, secured a gun license in my state, and almost killed myself."
Blamed parents, damage in relationships	8 (7.1%)	"Based on this man's advice and others in his organization, I spent a lot of money and told my father that our relationship made me gay—I regret these things."
Isolation, distance or loss of friendships	8 (7.1%)	"I was not comfortable with myself and that was making people around me uncomfortable too. As a result, I was left behind by almost everyone, except my family."
Financial cost	6 (5.3%)	"Expense/debt of treatment."
Delayed coming out or pursuing relationships	5 (4.4%)	"Delayed accepting myself."
False hope	5 (4.4%)	"It created in me the false image that I could change my sexuality. I was kept in this lie for more than 12 years, trying to change it."
Career or academic consequences	4 (3.5%)	". . . it distracted me from my true course, i.e., from continuing in college (which I eventually went back to) pursuing my career and hobbies, friends through these interests, etc."
Distrust	4 (3.5%)	"Made me distrust sharing this with other counselors."
Inaccurate or bad view of LGBT people	4 (3.5%)	"Exposed me to a lot of very miserable gay people who I thought were representative of all gays."
Can't change, failure, worthlessness	3 (2.7%)	"Contributed to shame and self-hatred because my orientation never changed—not even a little. I felt like a failure."
Suppressing, not being honest, secrecy	3 (2.7%)	"I learned things that fed my anonymous sexual behavior. This ended up creating a cycle of shame and secrecy that would become very hard to break."
Fear of going to hell	2 (1.8%)	"I still struggle with the fact that I am not going to hell."

[a]Suicide was mentioned specifically regarding four (3.5%) episodes of therapy in reference to short-term harm and four (3.5%) episodes of therapy in reference to long-term harm; these responses were given by two different participants in the study.

TABLE 6 Reasons for Identifying as LGB After Reorientation Therapy

Theme	Frequency	Example
Acceptance of and being honest about being gay or lesbian	15 (41.7%)	". . . I decided that the change I needed to experience was accepting myself."
I couldn't change my sexual orientation	14 (38.9%)	"The realization that therapy did not get rid of sexual orientation; it only 'treated the symptoms.'"
Religious integration with LGB identity	9 (25.0%)	"This is how I was made—and God made me—so I was okay as is, in His image."
Desire for or finding intimacy or a relationship	7 (19.4%)	"I fell in love with another Christian woman."
Deterioration of mental health	6 (16.7%)	"The chaos in my life since the therapy, my life had become something close to hell."
Exhausting to be ex-gay, gave up	5 (13.9%)	". . . it was because I was simply exhausted from 13 years of suppressing my natural urges."
Ex-gay example falling from grace	2 (5.6%)	"A prominent ex-gay individual was caught using a restroom in a gay bar and made a lame excuse for being there."
Being gay or lesbian is not associated with negative, risky, or stigmatized health behaviors	2 (5.6%)	". . . I decided it would be OK to 'try out' a same-sex relationship provided it wasn't all the horrible things my church and my therapist said it would be."

emerged. These themes and their frequency of occurrence are reported in Table 6. The most frequently occurring themes included "acceptance of and being honest about being gay or lesbian" ($n = 15$, 41.7%), "I couldn't change my sexual orientation" ($n = 14$, 38.9%), and the experience of a "religious integration with LGB" ($n = 9$, 25.0%). When considering the theme of "religious integration with LGB" it is important to note that 100% ($n = 37$, 1 participant declined to answer this series of questions) of participants had been part of a religious community that held negative beliefs about LGB people, and 97.3% ($n = 36$) of participants had left these religious communities. Of the participants who had left their religious communities, 61.1% ($n = 22$) did so after reorientation therapy.

DISCUSSION

Sexual reorientation therapy remains a controversial area of practice; there are widespread concerns that reorientation therapy is harmful, and recent studies (e.g., Spitzer, 2003) that are cited to support the effectiveness of reorientation therapy have been heavily criticized on methodological grounds. The results of this study are not intended to resolve this controversy; rather, the results illuminate the experiences of individuals who have undergone reorientation therapy and identify as LGB.

The results of this study are consistent with previous research in several ways. First, the sample comprised mainly Caucasian and male individuals, which was similar to participant demographics from other studies (Schaeffer et al., 1999; Schroeder & Shidlo, 2001; Shidlo & Schroeder, 2002; Throckmorton & Welton, 2005). Second, participants' motivations for seeking reorientation therapy and the delivery of therapy were driven by religious and heteronormative beliefs. Specifically, religious beliefs and desires to have or maintain a heterosexual lifestyle, which includes marriage and children, were the most commonly cited reasons for entering reorientation therapy, a finding that is consistent with previous research (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002; Spitzer, 2003; Tozer & Hayes, 2004). Although previous research suggests that mental health professionals (e.g., psychologists, pastoral counselors) are often identified as the most common providers of reorientation therapy (Shidlo & Schroeder, 2002; Spitzer, 2003), the most frequent providers reported by participants were individuals with a religious affiliation, while very few psychologists, psychiatrists, and social workers were identified as the participants' providers of reorientation therapy. On the other hand, the fact that any mental health professionals were identified as providers of reorientation therapy is inconsistent with the statements made by virtually all major mental health organizations that such practices are ineffective and possibly unethical.

With respect to perceived helpfulness of reorientation therapy, participants endorsed feelings of acceptance, connection, hope, and support. Beckstead and Morrow (2004) reported that most of their participants derived a sense of belonging and were provided with hope as a result of treatment, and as Shidlo and Schroeder (2002) pointed out, conversion therapy "may offer a powerful social component as part of the treatment" (p. 252). In the long run, many participants acknowledged that treatment would not help them to become heterosexual; rather, treatment helped to solidify aspects of their sexual identity and integrate (or reconcile) this identity with their religious beliefs. Furthermore, 97.3% of participants reported that they had left religious communities that held negative beliefs about LGB individuals, with 61.1% of these individuals doing so after reorientation therapy.

Once again, acceptance of one's sexual orientation and a realization that sexual orientation could not be changed were the most frequent themes identified in participants' reasons for leaving reorientation therapy and identifying as gay or lesbian. In sum, these findings echo the results of Shidlo and Schroeder (2002) and suggest that for some, reorientation therapy was very much part of the process by which they came to accept their own sexual orientation and to feel freed to identify as gay or lesbian.

There are many reasons that individuals who have undergone reorientation therapy might be motivated to identify beneficial aspects of the experience. Studies of psychotherapy outcome have repeatedly identified "common factors" of all forms of therapy that are beneficial components

of the experience, and one of the most consistent of these factors is the therapeutic alliance (Wampold, 2010). Even though participants in our study later reclaimed an identity that was opposite of the intended goal of reorientation therapy, many of these individuals were likely to have experienced a good working relationship, or alliance, with treatment providers they encountered in the process. The psychological theory of cognitive dissonance (Festinger, 1957), in which individuals are motivated to justify their decisions through modifying their interpretation of the outcome, may also apply to reorientation therapy. Individuals who have invested a great deal of time, money, and effort into the process of reorientation therapy may be motivated to find benefits of the experience to explain such an investment of resources. Finally, an individual undergoing reorientation therapy may experience a mitigation of shame or internalized homophobia by attempting to overcome unwanted aspects of his or her identity. Although the ultimate result of reorientation therapy could be an increase in shame through the process, as some of the participants in this study noted, temporary amelioration of shame may occur while one is attempting to become heterosexual.

Participants' perceptions of how reorientation therapy was harmful in this study were consistent with the results of Shidlo and Schroeder (2002). These include increased psychological distress that centered on depressed mood, increased anxiety, and suicidality. Many of the responses resonated with a theme of "shame, guilt, and self-hatred." While client deterioration as a result of treatment is considered harmful (Lilienfeld, 2007), additional themes (e.g., "not harmful," "financial costs," "loss of time") that emerged from the participants' responses reflect opportunity costs, or the harm that is derived from receiving ineffective or suboptimal treatments (Lilienfeld, 2002). The varying responses to questions of helpfulness and harmfulness could indicate that a person's unique background, psychosocial history, and preconceived notions about reorientation therapy may affect his or her perceptions of helpfulness and harmfulness. Additionally, the variability in interventions that exists among providers of sexual reorientation therapies (see Flentje et al., 2013) further complicates matters when attempting to discern how and why differences in perceptions of helpfulness and harmfulness might arise.

Implications

The results reported herein are not only consistent with previous research but also have important practical implications that warrant attention. Perhaps the largest implication of this study involves the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009). The results of this study support the report's conclusions, which indicate that the helpful components of reorientation therapy could be obtained through other treatments, while minimizing the potential

for harm that appears in the reports of participants who have undergone reorientation therapy.

Specifically, the most frequently identified helpful components of reorientation therapy (a sense of connectedness with others or acceptance) could be achieved through other, less stigmatizing, treatment methods. Within this vein, it is important to increase the availability of alternatives to reorientation therapy, especially in communities and treatment centers that may offer or promote reorientation therapies. Silverstein (2003) pointed out that ex-gay organizations have attractive and easy-to-use Web sites, and that other therapy options are not well publicized. This means that persons who are concerned about their sexual orientation, or family who are concerned about the sexual orientation of their children or teens, may find these Web sites and see them as a viable, and perhaps the only, option. On this front, mental health organizations should continue to work to increase the visibility of therapy options that are affirming of LGB identities.

It is also important to consider this study's clinical implications. Phillips (2004) raised the importance of appreciating the complexity of sexuality when working with clients who experience both same-sex attraction and religious promotion of non–gay friendly values. It may be tempting to suggest that a client change or leave religious communities that are anti-LGB; however, this suggestion may be harmful to both the client and the therapeutic relationship. Alternatively, affirmative and client-centered interventions may help clients come to this conclusion on their own or help clients develop positive coping skills to navigate homophobic environments and relationships (American Psychological Association, 2009). Miville and Ferguson (2004) noted that for some individuals, religion may not be optional, and in respecting client diversity and autonomy, it is important to value both the client's religious and sexual identity (Haldeman, 2004), even if these may seem to be in conflict with one another.

Haldeman (2004) recommended a therapeutic approach that focuses on the client; such an approach may not necessarily advocate for openness about one's sexual orientation, nor would it advocate for a change in sexual orientation, but instead it would integrate the client's own values into his or her sexual orientation, thereby finding some resolution between the conflicted aspects of the client's identity. Haldeman's recommendation is supported in the findings of this study, in that a frequently cited reason for identifying as gay or lesbian was an integration of religious beliefs and sexual orientation.

The results indicate that the "desire for a 'normal' heterosexual life," including children, marriage, and families, is a common reason for seeking reorientation therapy. A therapist who is approached by a client who wishes to change his or her sexual orientation may want to be aware of this motivation and should attempt to find a way to explore alternatives to traditional marriage and family structures with his or her clients. The results also

suggest that suicidal ideation was addressed in the context of reorientation therapy, and some participants found this to be beneficial. Even if suicidality is not a result of participation in reorientation therapy, this helpful component of the therapy could be addressed within the context of an affirmative approach to sexual orientation. In their review of the literature, Haas et al. (2010) concluded that there is a large body of literature indicating LGB individuals have increased rates of suicide risk. Two participants within this study perceived a link between reorientation interventions and an increase in suicidal ideation or behaviors. If suicidality is caused or exacerbated by participating in reorientation therapy, the case for abandoning the therapy and adopting an affirmative, client-centered approach is strengthened. This is particularly important given that LGB people are presumed to already be at higher risk for suicidal ideation (Haas et al., 2010). Therapists should inquire about current and past suicidality, especially when treating clients who have been through reorientation therapy. When confronted with a client who is expressing interest in changing his or her sexual orientation, a treatment provider should be keenly aware of the potential for suicidality, as this theme occurred both in the helpful and harmful components of reorientation therapy episodes.

Future Directions

This study also points to the need for future research. There were several instances of participants reporting reorientation episodes that were helpful because these episodes involved participants' feeling supported, accepted, or hopeful or because these episodes helped to resolve family or relationship challenges and mental health issues. Future research could assess the psychological health and wellbeing of individuals with varying levels of motivation for seeking reorientation therapy in an effort to approximate the prevalence of psychological disorders and suicidality among individuals who are highly motivated to seek this form of treatment. Next, future research could examine the helpfulness of non-reorientation-focused therapies in persons who are presenting for treatment wanting to change their sexual orientation. This could evaluate whether or not the helpful components of reorientation therapy could be achieved through other means with this population and could help determine the effectiveness of affirmative, client-centered interventions in treating individuals who are highly motivated to change their sexual orientation.

Similarly, future research could build on other findings regarding the perceived harmfulness of reorientation therapy episodes. Areas of perceived harmfulness of reorientation therapy that warrant future research include the consequences of the shaming or suppression aspects of reorientation therapy, the loss of or damage to important relationships, and the delays experienced prior to coming out.

Limitations

This study has several limitations that should be noted in the interpretation of the results. First, due to the design of this study, no conclusions can be made regarding causality, and causal inferences regarding the potential benefits and potential harm experienced by persons who undergo reorientation therapy cannot be made. Longitudinal research would be required to examine the relationship between reorientation therapy and psychological functioning in a scientifically rigorous way. However, longitudinal research or a randomized controlled trial may be unethical and difficult or impossible to conduct, given that a review of the scientific evidence for sexual orientation change efforts (SOCE), which includes reorientation therapies, concluded that "enduring change to an individual's sexual orientation as a result of SOCE was unlikely. Furthermore, some participants were harmed by the interventions" (American Psychological Association, 2009, p. 54).

A second important limitation of this study involves the reliance on participants' retrospective self-reports, which may not accurately reflect behavior or experience. For some participants, reorientation therapy episodes were more than a decade prior to this study; thus, it is possible that some information that was provided was incorrect or distorted. Next, the participants for this study were self-selected volunteers, and there is no way to know if the results would generalize to individuals who were exposed to the recruitment information and decided not to participate. In addition, the measures of sexual orientation used in the study focused primarily on identity and did not include the dimensions of attraction and behavior emphasized in the definition of sexual orientation provided by Sell (1997). Given that some recent research has identified different findings when measuring sexual orientation identity, attraction, and behavior, future research with this population could incorporate a more multidimensional conceptualization of sexual orientation.

Finally, the inductive/open coding analysis (Patton, 2002) that was used to analyze the results represents a preliminary step toward developing or replicating a theoretical model meant to capture the reorientation experiences of ex-ex-gay and lesbian people. However, the results of the inductive/open coding analysis are promising, given their similarity to the results of Shidlo and Schroeder (2002) and Beckstead and Morrow (2004). Despite these limitations, this study has provided important information about the motivation for seeking reorientation therapy, the perceived helpfulness and harmfulness of reorientation therapy, and the reasoning behind identifying as LGB after treatment.

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Sexual Orientation Change Efforts Among Current or Former LDS Church Members

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This study examined sexual orientation change efforts (SOCE) by 1,612 individuals who are current or former members of the Church of Jesus Christ of Latter-day Saints (LDS). Data were obtained through a comprehensive online survey from both quantitative items and open-ended written responses. A minimum of 73% of men and 43% of women in this sample attempted sexual orientation change, usually through multiple methods and across many years (on average). Developmental factors associated with attempts at sexual orientation change included higher levels of early religious orthodoxy (for all) and less supportive families and communities (for men only). Among women, those who identified as lesbian and who reported higher Kinsey attraction scores were more likely to have sought change. Of the 9 different methods surveyed, private and religious change methods (compared with therapist-led or group-based efforts) were the most common, started earlier, exercised for longer periods, and reported to be the most damaging and least effective. When sexual orientation change was identified as a goal, reported effectiveness was lower for almost all of the methods. While some beneficial SOCE outcomes (such as acceptance of same-sex attractions and reduction in depression and anxiety) were reported, the overall results support the conclusion that sexual orientation is highly resistant to explicit attempts at change and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants.

Keywords: LGBTQ, SOCE, psychotherapy, religion, Mormon

Many twenty-first-century, traditional world religions continue to denounce both same-sex attractions (SSA) and same-sex sexual activity as immoral, despite a growing social and professional consensus that views both as positive variants of human sexuality (Fontenot, 2013). As a result of this conflict, many traditional religious individuals who experience SSA engage in sexual orientation change efforts (SOCE) in an attempt to conform to religious teachings and social pressure (Beckstead, 2012; Jones & Yarhouse, 2011; Maccio, 2010). Despite a recent increase in public discourse regarding SSA, SOCE studies have been limited in quantity, scope, and methodology, and ultimately have failed to demonstrate either the effectiveness or benefit/harm of SOCE (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation [APA], 2009). Even with the APA's (2009) extensive report and recommendations regarding SOCE, considerable questions remain regarding SOCE demographics, prevalence, and intervention types. Consequently, the purpose of this study was to document and evaluate the prevalence, variety, duration, demographics, effectiveness, benefits, and harm of SOCE within one particular faith tradition—the Church of Jesus Christ of Latter-day Saints (LDS, Mormon). We built upon the APA (2009) recommendations for improving SOCE research by using (a) more representative sampling methods, (b) more precise measures of sexual orientation and identity, (c) references to life histories and mental health concerns, and (d) increased inquiry regarding efficacy and safety.

Brief History of SOCE Research

Some early studies purported to demonstrate SOCE effectiveness (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, Armstrong, & Blaszczynski, 1981; Tanner, 1975). While not claiming the elimination of a same-sex orientation, some of these authors reported limited success in decreasing same-sex attraction and behavior, usually without a reciprocal increase in opposite-sex attraction or sexual behavior (cf. APA, 2009). However, this work suffered from major methodological flaws, including the absence of control groups, biased samples, very small treatment groups (< 15 subjects per treatment group), and internally inconsistent methods of data collection. In many recent

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studies, researchers have attempted to gain a deeper understanding of SOCE through surveys, case studies, clinical observations, and descriptive reports with convenience-sampled populations from religiously affiliated organizations, where conflict and distress remain high despite increasing social acceptance of LGBTQ individuals (e.g., Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Silverstein, 2003; Spitzer, 2003). A recent review of this literature by an APA (2009) task force on SOCE efforts showed that individuals reported varied rationale for SOCE (also see Morrow & Beckstead, 2004). For example, telephone interviews with 200 self-selected individuals claiming success in sexual orientation change cited personal, emotional, religious, and/or marriage-related issues as reasons for seeking change (Spitzer, 2003).

The APA (2009) also reported widely varied SOCE strategies. A survey of 206 licensed mental health professionals who practice sexual orientation change therapy reported providing individual psychotherapy, psychiatry, group therapy, or a combination of individual and group therapies to address clients' reported desire to change sexual orientation (Nicolosi et al., 2000). Many individuals have attempted sexual orientation change with the help of nonprofessional individuals or organizations, which are often religiously or politically motivated (e.g., Evergreen International, Exodus International, Focus on the Family, Jews Offering New Alternatives for Healing; cf. Besen, 2012; Drescher, 2009). Such efforts range from one-on-one pastoral counseling to group conferences or retreats and can include such practices as confession, repentance, and self-control, as well as cognitive behavioral approaches (Ponticelli, 1999). Individuals may also engage in personal efforts to change sexual orientation. One recent qualitative study of sexual and religious identity conflict among late adolescents and young adults reported heightened efforts to be faithful, bargains with God, prayer, fasting, and increased church involvement as commonly self-reported individual efforts to "overcome" SSA (Dahl & Galliher, 2012). The outcomes of these private and religious efforts, however, remain almost completely unstudied.

Finally, qualitative reports have suggested that individuals who engaged in SOCE reported a variety of perceived benefits and harms (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Shidlo & Schroeder, 2002). Based on a comprehensive review of this work, the APA (2009) SOCE task force concluded that no study to date has demonstrated adequate scientific rigor to provide a clear picture of the prevalence or frequency of either beneficial or harmful outcomes. More recent studies claiming benefits and/or harm have done little to ameliorate this concern (e.g., Jones & Yarhouse, 2011; Karten & Wade, 2010).

Limitations of Previous Work

Experimental, quasi-experimental, correlational, and qualitative SOCE studies are limited in scope, methodological rigor, and comprehensiveness (APA, 2009). Previous studies have employed problematic sampling procedures, including biased subjects, small samples sizes, and a lack of female participants (e.g., McCrady, 1973; Mintz, 1966; Nicolosi et al., 2000; Spitzer, 2003). Virtually all studies to date have relied on convenience sampling, without any attempt to draw from nonbiased sources (Silverstein, 2003). Many researchers have drawn directly from those who were previously enrolled in therapeutic religious programs intended to change sexual orientation—participants who may be under cultural, religious, or personal pressure to make a positive self-report (e.g., Maccio, 2011; Nicolosi et al., 2000; Spitzer, 2003). Furthermore, previous studies have lacked consistency in the definitions of sexual orientation and sexual orientation change, making it difficult to compare across studies (Savin-Williams, 2006).

The frequency and rate of SOCE in SSA populations remain unknown (see Morrow & Beckstead, 2004, for a discussion). No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those who have attempted SOCE. Furthermore, no known study to date has provided a comprehensive assessment of basic demographic information, psychosocial well-being, and religiosity, which would be required to understand the effectiveness, benefits, and/or harm caused by SOCE. Most studies have focused on the outcome of interventions led by licensed mental health professionals, while neglecting to directly assess the effectiveness or potential harm of self-help, religious, or nonlicensed efforts to change, understand, or accept sexual orientation. Finally, in spite of the APA's 2009 report on SOCE, considerable debate continues about the meaning of the report (cf. Hancock, Gock, & Haldeman, 2012; Rosik, Jones, & Byrd, 2012), focusing specifically around the lack of more conclusive SOCE-related outcome research.

The LDS Church and Same-Sex Attraction

The Church of Jesus Christ of Latter-day Saints is a U.S.-based Christian religious denomination claiming more than 14 million members worldwide (Church of Jesus Christ of Latter-day Saints, 2013). The LDS church claims the Holy Bible as scripture and, through traditional Biblical interpretations, has historically both condemned same-sex sexuality as sinful (cf. Kimball, 1969; O'Donovan, 1994) and explicitly encouraged its lesbian, gay, bisexual, transgender, and queer (LGBTQ) members to attempt sexual orientation change (Byrd, 1999; Faust, 1995; Packer, 2003; Pyrah, 2010). While the LDS church has somewhat softened its stance toward LGBTQ individuals in recent years (Church of Jesus Christ of Latter-day Saints Church, 2012), it continues to communicate to its LGBTQ members that sexual orientation change is possible through various means including prayer, personal righteousness, faith in Jesus Christ, psychotherapy, group therapy, and group retreats (e.g., Holland, 2007; Mansfield, 2011). In these respects, the LDS church's approach to SSA has closely paralleled other religious traditions including Orthodox Judaism, evangelical Christianity, and Roman Catholicism (Michaelson, 2012).

The Present Study

In the current study, we aimed to build on previous work to present a comprehensive analysis of the (a) prevalence of SOCE in a sample of SSA Mormons, (b) most commonly pursued SOCE methods, (c) demographic and developmental factors associated with increased likelihood to engage in SOCE, (d) effectiveness of SOCE, and (e) extent to which SOCE treatments have led to reported positive or iatrogenic effects. Our sample included sufficient numbers of men and women so that gender can be included as a factor in analyses, allowing for a more nuanced assessment of gendered SOCE processes. We sought to overcome many of the limitations of previous work by reporting from a large, interna-

tional, demographically diverse sample and by employing a large battery of qualitative and quantitative measures of demographic information, psychosocial well-being, mental health, sexuality, and religiosity. We also believed that the LDS church's long-standing opposition to same-sex sexuality, along with its continued support of SOCE in various forms, made the LDS SSA population ideal for a deeper study of these issues—one that could also inform our understanding of SOCE within other religious traditions.

Method

Research Team

Given the controversial nature of SOCE research, we feel it is important to engage transparently in our research dissemination. All authors self-identify as LGBTQ allies and also affirm the position of the American Psychological Association on the importance of affirming and supporting religious beliefs and practices (American Psychological Association, 2010). All authors have been active in supporting the LGBTQ community through campus, community, online, and national/international engagement. Four of the five authors were raised LDS, and two remain active LDS church participants. All authors work closely with LGBTQ Mormons in their professional and/or personal roles.

Participants

Participants were recruited for a web-based survey entitled "Exploration of Experiences of and Resources for Same-Sex-Attracted Latter-day Saints." Inclusion criteria were as follows: Participants had to (a) be 18 years of age or older, (b) have experienced SSA at some point in their life, (c) have been baptized a member of the LDS church, and (d) have completed at least a majority of survey items (i.e., the basic demographics, relevant sexual history, and psychosocial measures sections).

Data management. The LimeSurvey online survey software (Schmitz & LimeSurvey Project Team, 2011) marked 1,588 responses as "completed." Of these responses, 40 were excluded because the respondents failed to meeting participation criteria in the following ways: underage ($n = 8$), no indication of LDS membership ($n = 3$), no indication of ever experiencing same-sex attraction ($n = 17$), and leaving the majority of the survey blank (i.e., nothing beyond the demographic information, $n = 12$). Data for one participant was lost during downloading and data cleaning. Of the records designated as "not completed" by Limesurvey, 65 were included because they met the aforementioned inclusion criteria. This process left 1,612 respondents in the final data set.

Demographic information. Seventy-six percent of the sample reported to be biologically male and 24% reported to be biologically female. Regarding gender, the following responses were reported: "male" (74.5%), "female" (22.2%), "female to male" (0.3%), "male to female" (0.6%), "neither male nor female" (0.5%), and "both male and female" (1.9%). The mean sample age was 36.9 years ($SD = 12.58$). Approximately 94% reported residing in the United States, with 6% residing in one of 22 other countries (Canada being the next most common, at 2.8%). Of those residing in the United States, 44.7% reported residing in Utah, with the remainder residing across 47 other states and the District of Columbia. Regarding race/ethnicity, 91.1% identified as exclusively White, 4.5% as multiracial, 2.2% as Latino/a, and the remainder as either Asian, Black, Native American, Pacific Islander, or other.

Regarding educational status, 97.2% reported at least some college education, with 63.7% reporting to be college graduates. Sexual orientation self-labeling indicated that 75.5% identified as gay or lesbian, 14.5% as bisexual, and 4.9% as heterosexual, with the remaining 5.1% identifying as queer, pansexual, asexual, same-sex or same-gender attracted, or other. Relationship status was reported as 40.8% single, 22.7% unmarried but committed to a same-sex partner, 16.9% married or committed to heterosexual relationships, 12.6% in a marriage, civil union, or domestic partnership with a same-sex partner, and 5.8% divorced, separated, or widowed. Regarding LDS church affiliation, participants described themselves as follows: 28.8% as active (i.e., attending the LDS church at least once per month), 36.3% as inactive (i.e., attending the LDS church less than once per month), 25.2% as having resigned their LDS church membership, 6.7% as having been excommunicated from the LDS church, and 3.0% as having been disfellowshipped (i.e., placed on probationary status) from the LDS church.

Measures

The survey included items developed specifically for this study and a number of pre-existing measures assessing psychosocial health and sexual identity development. Major survey sections included demographics; sexual identity development history; measures of psychosocial functioning; an exploration of various methods to accept, cope with, or change sexual orientation; and religiosity. The larger study yielded data for a number of research questions; only measures relevant for the current study are described in the following sections. Specifically, measures for this study focus on methods related to SOCE and on a number of outcome variables related to sexual identity development (i.e., sexual identity distress) and positive psychosocial functioning (self-esteem and quality of life) that allowed us to assess SOCE correlates related to general well-being.

Sexual orientation identity, history, and religiosity. Participants answered several questions about their sexual orientation identity, history, sexual development milestones, disclosure experiences, and religiosity. Participants rated levels of family and community support for LGBTQ identities via a 6-point Likert-type scale from 0 (*closed or nonsupportive*) to 5 (*very open or supportive*). Participants rated their sexual behavior/experience, feelings of sexual attraction, and self-declared sexual identity on a 7-point Likert-type scale (modeled after the one-item Kinsey scale), ranging from 0 (*exclusively opposite sex*) to 6 (*exclusively same sex*), with the additional option of asexual also provided (Kinsey, Pomeroy, & Martin, 1948). Participants rated early and current religious orthodoxy on a 6-point Likert-type scale from 0 (*orthodox*—a traditional, conservative believer) to 5 (*unorthodox*—more liberal and questioning).

Attempts to cope with same-sex attraction. Participants were asked which of several activities they had engaged in to "understand, cope with, or change" their sexual orientation. Options included: (a) individual effort (e.g., introspection, private study, mental suppression, dating the opposite sex, viewing

opposite-sex pornography), (b) personal righteousness (e.g., fasting, prayer, scripture study), (c) psychotherapy, (d) psychiatry (medication for depression, anxiety, sleep problems, somatic complaints, and so forth), (e) group therapy, (f) group retreats, (g) support groups, (h) church counseling (e.g., LDS bishops), and (i) family therapy. These options were developed by the research team based on several sources, including direct clinical practice with LDS LGBTQ individuals, familiarity with LDS culture/practice and doctrine (Holland, 2007; Mansfield, 2011), and the psychology LGBTQ literature (APA, 2009). For each option, participants were asked to provide their ages when the effort began, the duration (in years), and a rating of the perceived effectiveness of each method (effort: 1 = *highly effective*, 2 = *moderately effective*, 3 = *not effective*, 4 = *moderately harmful*, 5 = *severely harmful*). These variables were later reversed scored to ease interpretation, such that 1 = *severely harmful*, 2 = *moderately harmful*, 3 = *not effective*, 4 = *moderately effective*, and 5 = *highly effective*. Participants were also provided an open-ended field to describe each effort in their own words.

Participants were asked to indicate their original goals for each effort, along with what was actually worked on (e.g., "desire to change same-sex attraction," "desire to accept same-sex attraction"). Participants were grouped into two categories: "SOCE reported" and "SOCE not reported." The participants in the SOCE-reported group consisted of those who checked the "desire to change same-sex attraction" box for at least one method or who responded affirmatively to one of the following two questions: (a) "My therapist(s) actively worked with me to reconsider my same-sex sexual behavior and thought patterns in order to alter or change my same-sex attraction," and/or (b) "My therapist(s) used aversive conditioning approaches (i.e., exposure to same-sex romantic or sexual material while simultaneously being subjected to some form of discomfort) in attempts to alter my attraction to members of my same-sex." All other participants were categorized as SOCE not reported.

Sexual Identity Distress Scale. The Sexual Identity Distress Scale (SID; Wright & Perry, 2006) is a seven-item measure assessing sexual-orientation-related identity distress. SID scores are obtained by reverse scoring the negative items and summing the scores. Higher scores indicate greater identity distress. According to its authors, the SID has demonstrated high internal consistency (α = .83), test–retest reliability, and strong criterion validity (Wright & Perry, 2006). Cronbach's alpha for the current sample was .91.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item measure of self-esteem developed for adolescents but used with samples across the developmental spectrum. The RSES uses a Likert-type scale (1–4), with higher scores indicating higher self-esteem (reverse scoring required). The RSES demonstrated test–retest reliability of .85 and has demonstrated good validity. Cronbach's alpha for the current sample was .92. Total scores are calculated as the average across items.

Quality of Life Scale (QOLS). The QOLS (Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument measuring six domains of quality of life: material and physical well-being; relationships with other people; social, community and civic activities; personal development and fulfillment; recreation; and independence. The average total score for "healthy populations" is about 90. Average scores for various less-healthy groups range between Israeli patients with posttraumatic stress disorder (61) and young adults with juvenile rheumatoid arthritis (92). Evaluations from various studies indicate that the QOLS has demonstrated internal consistency (αs = from .82 to .92) and high test–retest reliability (*r*s = from .78 to .84; Anderson, 1995; Wahl, Burckhardt, Wiklund, & Hanestad, 1998). Cronbach's alpha for the current sample was .90.

Procedures

Data collection and recruitment. This study was approved by the institutional review board at Utah State University. It was released as an online web survey from July 12 through September 29, 2011, and required both informed consent and confirmation that the respondents had only completed the survey once. Participants were given the option of providing their names, e-mail addresses, and phone numbers in order to receive study results and/or be contacted for future studies; approximately 70% of the respondents voluntarily provided this information.

Since past SOCE outcome studies have been criticized for either small or biased samples, considerable efforts were made to obtain a large and diverse sample, especially with regard to ideological positions toward SOCE. Journalists in the online and print media were contacted about this study as it was released. Because of feature coverage by the Associated Press, articles about this study appeared in over 100 online and print publications worldwide, including the Huffington Post, ReligionDispatches.org, *Salt Lake Tribune*, *San Francisco Chronicle*, *Houston Chronicle*, *Q-Salt Lake*, and KSL.com. In all, 21% of respondents indicated that they heard about the study directly through one of these sources or through direct Internet search.

Leaders of major LDS-affiliated LGBTQ support groups were also contacted and asked to advertise this study within their respective organizations (e.g., Affirmation, Cor Invictus, Disciples, Evergreen International, LDS Family Fellowship, Gay Mormon Fathers, North Star, and Understanding Same-Gender Attraction). In total, 21% of respondents indicated learning about the survey from one of these groups. Careful attention was paid to include all known groups and to ensure inclusion across the spectrum of varying LDS belief and orthodoxy (to avoid claims of selection/recruitment bias). Special emphasis was made to reach out directly and in multiple ways to conservative LDS LGBTQ support groups such as Evergreen and North Star. Only Evergreen International refused to advertise, although many among our respondents acknowledged either current or past Evergreen affiliation.

Nonreligiously affiliated LGBTQ support organizations (e.g., Equality Utah, Salt Lake City Pride Center) were also helpful in promoting awareness about this survey. In total, 5% of respondents indicated learning about the survey from one of these sources. Once the survey was promoted through the previously described venues, a sizable portion of survey respondents (47%) indicated learning about the survey through word of mouth, including e-mail, Facebook, blogs, online forums, or other web sites.

Missing data. An analysis of missing data for the variables hypothesized to be associated with SOCE (family and community support, early religious orthodoxy, Kinsey scores, and the SID, RSES, and QOLS measures) revealed that 373 of the 1,612 cases (23.1%) contained at least some missing data across these vari-

ables, with 693 of the 62,175 fields overall (1.1%) being left blank. To account for potential bias in our statistical analyses arising from these missing data, we conducted a multiple imputation analysis using SPSS Statistics Version 20 to test the robustness of our findings with respect to the group comparisons using these measures. In SPSS, the imputation method was set to "automatic," and the number of imputations was set to five. When comparing the pooled imputed results with the original analyses, we found significance levels remained unchanged (with one exception noted in a later discussion), and *t* values changed minimally. Consequently, all statistical analyses reported are based on the original, nonimputed data.

Results

SOCE Prevalence, Methods, and Effectiveness

SOCE prevalence. Overall, 73% of men ($n = 894$) and 43% of women ($n = 166$) reported engaging in at least one form of SOCE, $\chi^2(1, n = 1{,}610) = 120.81$, $\Phi = .274$, $p < .001$. Of those who did attempt sexual orientation change, participants averaged 2.62 ($SD = 1.60$) different SOCE methods (maximum of eight, and minimum of one). Men reported utilizing a higher number of different SOCE types ($M = 2.76$, $SD = 1.63$) than did women ($M = 1.93$, $SD = 1.22$), t (adjusted $df = 286$) $= -7.58$, $p < .001$, $d = 0.58$.

Most common SOCE methods. Personal righteousness was reported by both men and women as the most commonly used SOCE method with the longest average duration, followed by individual effort, church counseling, and psychotherapy. Some of the most common personal righteousness methods mentioned included increased prayer, fasting, scripture study, focus on improving relationship with Jesus Christ, and temple attendance. Some of the most common individual effort methods mentioned included cognitive efforts (e.g., introspection, personal study, journaling), avoidance (e.g., suppression, self-punishment), seeking advice from others, seeking to eliminate or reverse same-sex erotic feelings (e.g., date the opposite sex, view opposite-sex pornography, emphasize gender-conforming appearance or behavior), and exploration in the LGBTQ community. A full list of prevalence rates, average durations, and effectiveness ratings for the nine SOCE methods is provided in Table 1. As a group, religious and private efforts (personal righteousness, ecclesiastical counseling, and individual efforts) were by far the most commonly used change methods (use exceeding 85% by those attempting change), with

Table 1
Sexual Orientation Change Efforts (SOCE) Method Prevalence, Starting Age, Duration, and Effectiveness Ratings by Sex

	Count/%		Age began SOCE method (yrs.)		Method duration (yrs.)		SOCE method effectiveness		Method effectiveness w/out SOCE			Effect size
SOCE method	*n*	%	*M*	*SD*	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*d*
Personal righteousness												
Men	688	77	16.65	6.91	12.40	9.73	2.57	1.21	218	3.39	1.26	−0.66
Women	114	68.7	17.55	6.75	8.18	8.14	2.37	1.09	91	3.33	1.15	−0.86
Individual effort												
Men	520	58.2	17.45	6.78	11.24	9.25	2.88	1.18	376	3.93	0.98	−0.97
Women	62	37.3	19.28	6.33	8.07	6.88	2.97	1.12	176	4.09	0.93	−1.09
Church counseling												
Men	448	50.1	21.10	7.86	7.34	8.65	2.58	1.15	161	3.06	1.22	−0.41
Women	54	32.5	21.61	7.25	6.34	6.89	2.59	1.11	33	2.45	1.20	0.12
Psychotherapy												
Men	330	36.9	24.29	9.06	4.70	5.76	3.23	1.20	335	3.96	0.91	−0.68
Women	37	22.3	23.11	6.75	6.27	6.79	3.22	1.16	155	4.11	0.82	−0.89
Support Groups												
Men	138	15.4	28.34	10.16	3.61	4.65	3.24	1.06	202	4.22	0.81	−1.04
Women	7	4.2	26.29	6.55	4.86	6.50	3.71	0.95	50	4.14	0.97	−0.45
Group therapy												
Men	126	14.1	27.93	10.44	2.71	3.38	3.16	1.18	111	4.04	0.85	−0.85
Women	6	3.6	32.00	9.10	1.58	0.80	3.00	1.79	31	3.90	0.98	−0.62
Group Retreats												
Males	56	6.3	29.88	11.18	2.45	3.84	3.45	1.24	53	4.36	0.83	−0.86
Females	3	1.8	26.33	3.51	0.70	0.52	2.67	1.53	4	4.50	1.00	−1.42
Psychiatry												
Men	33	3.7	25.52	10.73	8.38	9.42	3.06	1.30	276	3.91	0.90	−0.76
Women	2	1.2	25.50	3.54	17.00	5.66	4.50	0.71	115	3.95	0.98	0.64
Family therapy												
Men	34	3.8	24.42	9.21	4.37	6.40	2.88	1.07	65	3.65	1.02	−0.74
Women	1	0.6	21.00	N/A	0.25	N/A	N/A	N/A	12	3.58	0.67	N/A

Note. The % column indicates, out of the total number (by sex) who attempted to change, the percentage who used each method. Method effectiveness: ratings: 1 = *severely harmful,* 2 = *moderately harmful,* 3 = *not effective,* 4 = *moderately effective*, 5 = *highly effective*. The "method effectiveness w/out SOCE" columns represent those who engaged in the respective method without attempting to change their sexual orientation. Regarding comparisons of method effectiveness with and without SOCE, *t* values ranged from −0.5 to 14.5; *p* values ranged from .59 to < .001. Effect size (*d*) reflects differences between SOCE-focused methods and non-SOCE-focused methods.

therapist-led (40.4%) and group-involved (20.8%) change efforts trailing significantly in prevalence. Finally, 31.1% of participants reported engaging exclusively in private forms of SOCE, not indicating any effort that involved external support.

Method effectiveness/harm ratings. As detailed in Table 1, when sexual orientation change was not reported as a method objective, participants rated all but one of the methods as at least moderately effective (scores between 3.0 and 4.0), with a few methods (support groups, group therapy, group retreats, psychotherapy, psychiatry, individual effort) approaching or exceeding highly effective status (4.0 and above). Conversely, when sexual orientation change was reported as a method objective, in almost all cases reported method effectiveness was significantly lower (i.e., more harmful), with medium to large Cohen's *d* effect sizes (see Table 1 for exact effect sizes). Several SOCE methods including personal righteousness, individual effort, church counseling, and family therapy received average effectiveness ratings below 3.0 (more harmful than helpful). As shown in Figure 1, the SOCE methods most frequently rated as either ineffective or harmful were individual effort, church counseling, personal righteousness, and family therapy. The SOCE methods most frequently rated as effective were support groups, group retreats, psychotherapy, psychiatry, and group therapy. Ironically, methods most frequently rated as "effective" tended to be used the least and for the shortest duration, while methods rated most often as "ineffective" or "harmful" tended to be used most frequently and for the longest duration.

Developmental Factors Linked to SOCE

As reported in Table 2, some developmental factors that appear to be associated with SOCE included less family and community support for LGBTQ identities (for men only) and high levels of religious orthodoxy prior to acknowledging SSA (for both men and women; highly significant with a Bonferroni corrected $\alpha = .008$). Those who reported growing up in a rural community were more likely to engage in SOCE (71.0%) than those who reported growing up in an urban (63.0%) or a suburban (64.4%) community, $\chi^2(2, n = 1{,}565) = 6.95, \Phi = .067, p = .03$.

Effectiveness of Change Efforts

Reported changes in sexual identity. With regard to self-reported sexual attraction and identity ratings, only one participant out of 1,019 (.1%) who engaged in SOCE reported both a heterosexual identity label and a Kinsey attraction score of zero (exclusively attracted to the opposite sex). As shown in Table 2, the mean Kinsey attraction, behavior, and identity scores of those reporting SOCE attempts were not statistically different from those who did not indicate an SOCE attempt. Multiple imputation procedures to account for missing data yielded only one significant change in outcome; the statistical difference in Kinsey attraction scores between women who reported engaging in SOCE versus those who did not was found to be significant for the pooled imputation results at $t = -2.0, p = .045$ (vs. $t = -1.75, p = .08$ in the original analysis)—indicating that women who reported

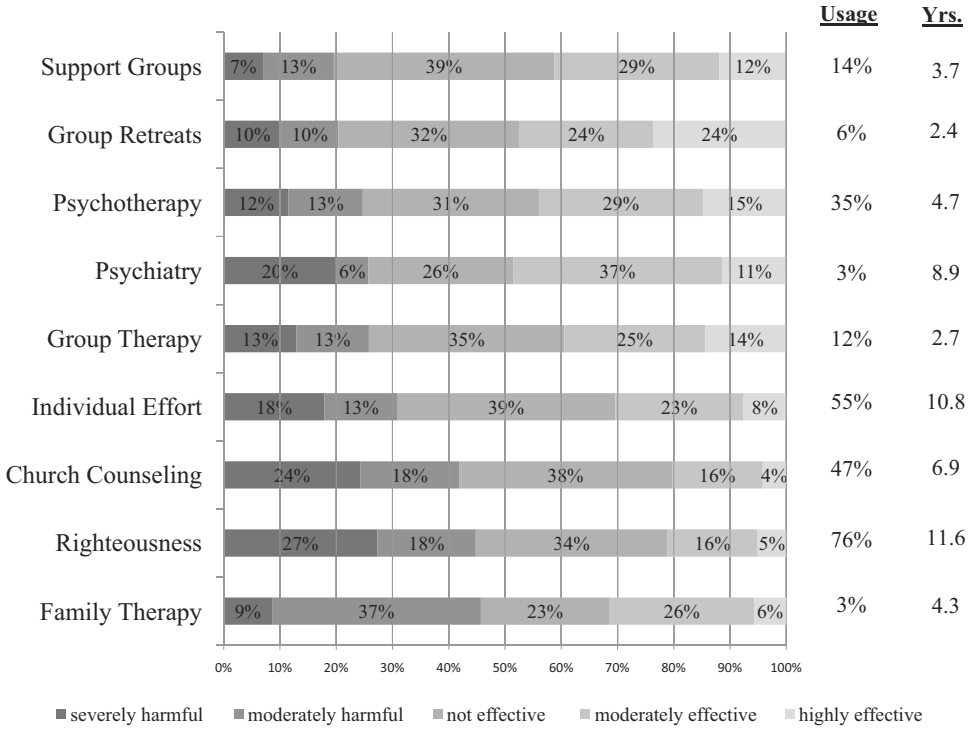

Figure 1. Graph displaying nine sexual orientation change effort (SOCE) methods, participant ratings of each method's effectiveness or harmfulness, percentages of participants who used each method, and the average number of years each method was employed.

Table 2
Developmental Factors, Kinsey Scores, and Psychosocial Health by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported			SOCE not reported						
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*df*	*p*	*d*
Developmental factors by sex										
Men										
Family LGBTQ support	879	0.89	1.31	323	1.33	1.63	4.4	483[a]	<.001	0.30
Community LGBTQ support	881	0.96	1.32	325	1.33	1.6	3.73	495[a]	<.001	0.25
Religious orthodoxy before acknowledging SSA	874	1.22	1.61	293	2.46	1.94	9.89	435[a]	<.001	0.70
Women										
Family supportive growing up	165	0.84	1.23	218	1.00	1.42	1.11	381	.268	0.12
Community supportive growing up	164	1.09	1.41	221	1.23	1.43	0.95	383	.343	0.10
Religious orthodoxy before acknowledging SSA	165	1.51	1.73	213	2.77	1.95	6.66	369[a]	<.001	0.68
Kinsey scores by sex										
Men										
Feelings of sexual attraction	858	5.12	1.28	315	4.93	1.62	−1.88	466[a]	.061	0.13
Sexual behavior/experience	849	4.49	2.00	306	4.72	1.89	1.71	1153	.088	0.12
Sexual identity	845	4.82	1.98	308	4.87	1.98	0.37	1151	.709	0.03
Women										
Feelings of sexual attraction[b]	161	4.45	1.57	209	4.15	1.62	−1.75	368	.08	0.19
Sexual behavior/experience	157	3.76	2.09	206	3.32	2.15	−1.97	361	.05	0.21
Sexual identity	154	4.47	2.02	204	4.09	2.04	−1.76	356	.08	0.19
Psychosocial health by sex										
Men										
Quality of life	894	82.28	14.3	326	82.48	14.74	0.21	1218	0.834	0.01
Sexual identity distress	894	10.16	7.61	325	7.01	6.23	−7.35	697[a]	<.001	0.45
Self-esteem	894	3.15	0.64	328	3.29	0.61	3.38	1220	0.001	0.22
Women										
Quality of life	166	81.9	13.2	222	83.01	13.81	0.79	386	0.428	0.08
Sexual identity distress	166	9.49	7	221	7.04	5.91	−3.65	320[a]	<.001	0.38
Self-esteem	166	3.13	0.64	222	3.21	0.66	1.22	386	0.220	0.12

Note. LGBTQ = lesbian, gay, bisexual, transgender, and queer; SSA = same-sex-attracted.
[a] Corrected degrees of freedom. [b] Multiple imputation analyses conducted to account for missing data found a statistical difference in Kinsey attraction scores (from 0, *exclusively opposite sex* to 6, *exclusively same sex*) between women who reported engaging in SOCE vs. those who did not at $t = -2.0$, $p = .045$. Also, those who self-rated as "asexual" (i.e., rating of 7) were not included in the Kinsey analyses so as to not alter the commonly accepted interpretations of Kinsey scores.

engaging in SOCE reported significantly higher Kinsey attraction scores than women who did not report engaging in SOCE.

With regard to sexual identity (Table 3), more than 95% of both men and women who engaged in some form of SOCE identified as nonheterosexual. Men who did and did not report engaging in SOCE did not differ from each other statistically in terms of current sexual identity labels. Women who reported engaging in SOCE were significantly more likely to self-identify as lesbian than were those who did not engage in SOCE. SOCE participants currently self-identifying as heterosexual reported a mean Kinsey attraction score of 3.02 ($SD = 1.42$), which is commonly associated with bisexuality.

Reports and explanations of successful change. Participants were provided the option to describe their various change efforts in their own words. A review of these narratives yielded 32 participants (3.1% of those attempting change) who indicated some type of SSA change. Of these 32 participants, 15 described a decrease in the frequency and/or intensity of their SSA, without mentioning a cessation of SSA. As an example, one participant wrote, "While the same-sex attraction is still stronger than heterosexual attractions, the frequency and intensity and duration of those attractions have lessened." Twelve of the 32 narratives did not mention attraction at all but instead mentioned either a decrease or a cessation of same-sex sexual behavior, as exemplified in this narrative: "I feel like I have been forgiven for my sexual behavior. I think of a same-sex relationship every day, but I don't act on it." Five of the narratives reported an increase in other-sex attractions, two of the narratives reported a reduction in anxiety about the SSA, and five indicated some sort of change that was unclear or vague (e.g., "I have felt so much strength from God to control myself"). Finally, it should be noted that some participants fit into more than one of these categories and that none of the 32 participants indicated an elimination of SSA.

Perceived Benefits and Harm Associated With SOCE

Perceived benefits. Open-ended narratives were also reviewed to provide further insight into the perceived effectiveness summarized in Table 1 and Figure 1. Based on this review, methods rated as effective did not appear to generally reflect any changes in sexual orientation but instead referred to several other benefits, such as ultimate acceptance of sexual orientation, a decrease in depressive or anxiety symptoms, and improved family relationships. One such example from the personal righteousness narratives illustrates this point: "Instead of meeting original goals, the direction of the goals changed as I learned to accept and love myself as I am—as God created me." Another participant who attempted SOCE through a psychotherapist added,

> My therapist wanted to treat what he called the "underlying factors" that could lead to my same-gender attraction. He wanted to help with

Table 3
Current Sexual Identity Status Differences by Sex and by Sexual Orientation Change Efforts (SOCE) Involvement

Variable	SOCE reported		SOCE not reported	
	n	%	*n*	%
Men[a]				
Gay	717	80.30	267	81.40
Bisexual	96	10.80	37	11.30
Heterosexual	41	4.60	14	4.30
Same-sex- or gender-attracted	20	2.20	0	0.00
Other	19	2.10	10	3.00
Subtotal	893		328	
Women[b]				
Lesbian	109	65.70	109	49.10
Bisexual	32	19.30	69	31.10
Heterosexual	7	4.20	17	7.70
Other	18	10.80	27	12.20
Subtotal	166		222	

[a] Male differences are not statistically significant. [b] Female differences are significant at $\chi^2(3, n = 388) = 11.68, \phi = .174, p < .01$.

> depression and other things he was qualified to do. It did help, and the therapy helped with coping but did not really treat the underlying cause. In fact, because of talking, I resolved to accept it.

Perceived harm. As shown in Table 2, comparisons of psychosocial health were made between those who reported SOCE attempts and those who did not. Overall, no significant difference (Bonferroni corrected $\alpha = .008$) in quality of life for men or women was found between the two groups, though participants who reported engaging in SOCE had significantly higher sexual identity distress (men and women) and lower self-esteem (men only).

A similar review of the open-ended narratives also provides additional insight into the harmful ratings assigned to the various methods. Reportedly damaging aspects of SOCE included decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality. One example from the personal righteousness narratives illustrates: "Therapy, meeting with the bishop, meeting with stake president, praying, fasting, etc. Nothing worked. I felt that God wasn't listening, or wanted me to suffer. I felt horrible until I changed my outlook."

A narrative from the ecclesiastical counseling narratives further illustrates:

> After first being told to go on a mission to be cleansed of these feelings (resulting in relationships that intensified my same-sex activity) and then being told to get married and have children, and the feelings would go away—I buried myself emotionally and spiritually.

Another participant wrote, "My Bishop gave me a blessing promising me that I could change. Every day I didn't change, I thought I was more a failure, more of a monster."

Discussion

The purpose of this study was to better understand the demographics, prevalence, variety, perceived effectiveness, and potential benefit/harm of sexual orientation change efforts (SOCE) among current and former LDS church members through the recruitment of a large, demographically diverse sample. Our findings suggest that the majority of participants engaged in SOCE via multiple avenues for over a decade (on average). Almost no evidence of SSA being eliminated via SOCE could be found in this sample, and minimal evidence supported successful change in sexual orientation. SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE, but psychosocial function was lower in those who had engaged in SOCE. Participants reported a number of positive and negative outcomes of change efforts; perceived effectiveness ratings varied substantially, depending on the particular method and the reported goals.

The Nature of SOCE

LDS SOCE demographics. Highly religious LDS men from unsupportive families and communities were most likely to report having engaged in SOCE, while LDS women were somewhat less likely to do so. These findings confirm previous research that SOCE efforts most often arise from religious and/or social pressure (APA, 2009). The finding that same-sex-attracted LDS women were less likely to engage in SOCE seems noteworthy, though the exact reasons for this are still unknown. Same-sex-attracted LDS women may feel less pressure to engage in SOCE because of the greater sexual fluidity afforded women within the constraints of socialized gender roles (Diamond, 2009); U.S. male culture tends to stigmatize male homosexuality more than female homosexuality or bisexuality (Herek, 2002). The role of LDS cultural factors, such as the church's historical emphasis on missionary service for 19-year-old men with an accompanying requirement for sexual worthiness also warrants investigation.

Prevalence of SOCE types. Although the psychology literature to date has focused almost exclusively on therapist-led SOCE (APA, 2009), religious and private forms of SOCE were far more prevalent in our sample. To illustrate, while more than 85% of SOCE participants reported engaging in either religious or individual SOCE efforts, only 44% reported some form of therapist or group-led SOCE. Personal righteousness (e.g., prayer, fasting, scripture study, improved relationship with Jesus Christ) as a form of SOCE was reported by our sample to be (a) by far the most prevalent method used to change sexual orientation (more than twice as common as psychotherapy), (b) initiated at the earliest average ages (16–18 years), and (c) utilized for the longest average duration of any SOCE method (more than12 years on average for men and eight years for women). Church counseling (e.g., with LDS bishops) and individual efforts also yielded significantly higher prevalence and duration rates than most other SOCE forms. These findings generally held true for both men and women, though LDS women reported engaging in church counseling, individual-based, and group-based SOCE at considerably lower rates than LDS men.

We recognize, from the age of onset and duration of effort data, that many of our participants were still actively engaged in efforts to understand, cope with, or change their orientation and that the efforts have been carried out across varying developmental stages and historical contexts (i.e., our participants ranged in age from 18–70 years). Thus, while our "snapshot in time" yields important information about the experiences of SOCE at a broad and com-

prehensive level, we look forward to more detailed assessment of the ways that SOCE are developmentally, historically, and culturally contextualized.

Effectiveness/Harm Rates of SOCE

The evidence from this study—based on multiple criteria including Kinsey-style self-ratings of attraction, sexual identity self-labels, method effectiveness ratings, and open-ended responses—suggests that for this sample, sexual orientation was minimally amenable to explicit change attempts. The literature supports these findings (APA, 2009; Beckstead, 2012). It is notable that zero open-ended narratives could be found indicating complete elimination of SSA via SOCE and that only a small percentage of our sample (3.2%) indicated even slight changes in sexual orientation. When survey participants did report experiencing sexual orientation change, the most common descriptions involved slight to moderate decreases in SSA, slight to moderate increases in other-sex attraction, and/or a reduction in same-sex sexual activity. As Beckstead (2012) noted, it is unclear if the decreased frequency and intensity of SSA are due to a reduction of sexual attraction or due to avoidance behaviors and/or a decrease of intense feelings, such as anxiety and shame, associated with SSA. Instead of fundamental changes in core sexual orientation, accommodation and acceptance of one's SSA were the most common themes. While these findings seem consistent with the larger literature and broad professional consensus, we are compelled by the fact that we have observed these patterns within a population that may be among the most likely to embrace and support change efforts.

We note that all nine methods utilized by participants to understand, cope with, or change SSA (with the exception of church counseling for women) were rated as effective (on average) when sexual orientation change was not listed as a goal. However, when sexual orientation change was listed as a goal, a majority of methods decreased in reported effectiveness—often with large effect sizes. Personal righteousness was rated as the most "severely harmful" of all SOCE methods for our sample, particularly noteworthy given that it was also rated as the most commonly used SOCE method (76%) for the longest average duration (12 years for men, eight years for women). Church counseling and individual efforts were rated as the next most "severely damaging" SOCE methods for our sample, with church counseling being rated as only slightly less damaging than personal righteousness. Significantly higher sexual identity distress (in men and women) and lower self-esteem (in men) were associated with prior participation in SOCE, although we do not know distress and self-esteem levels prior to SOCE participation, and thus cannot determine causality.

Additional study is warranted to provide better understanding of why religious methods were simultaneously used so frequently, yet rated as most ineffective/harmful. We theorize that the high prevalence of religious SOCE is due in large part to the LDS church's continued emphasis on prayer, fasting, scripture study, improved relationship with Jesus Christ, and consulting with church leaders (e.g., bishops) as primary ways to deal with SSA (Holland, 2007; Kimball, 1969; Mansfield, 2011). We also speculate that highly religious individuals in our sample were more likely keep their SSA private due to social stigma and thus more likely to favor/trust religious or private efforts over secular ones. In addition, most licensed therapists are likely to refuse to engage in SOCE—all of which could explain the increased prevalence of private and religious forms of SOCE in this sample.

Based on our review of the open-ended responses, we also speculate that when religious SOCE did not result in the desired outcomes, it may have damaged many of our participants' faith and confidence in God, prayer, the church, and its leaders. Consequently, failed SOCE often led to high levels of self-shame, feelings of unworthiness, rejection and abandonment by God, and self-loathing, as well as "spiritual struggles" for many of our respondents (Bradshaw, Dehlin, Galliher, Crowell, & Bradshaw, 2013; Dahl & Galliher, 2012; McConnell, Pargament, Ellison, & Flannelly, 2006). This pattern of findings does emphasize the importance of ensuring that LDS church leaders are adequately trained to deal with LGBTQ issues and addressing culturally inherited leadership beliefs and practices that might be contributing to these deleterious effects.

Effectiveness. In terms of effectiveness, group-related and therapist-led methods tended to be rated by participants as the most effective and least damaging. While therapist-led SOCE were reportedly used less frequently than individual and religious methods, they were surprisingly common, given the general denunciation of SOCE by all of the major mental health professional organizations. A review of the open-ended descriptions for the various methods indicated that for the majority of participants, a rating of "effective" for therapist-led methods did not signify successful change in sexual orientation but instead indicated other outcomes such as acceptance of sexual orientation (even when change was an original goal), a decrease in anxiety or depression, and/or improvements in family relationships. These findings appear to align with APA (2009) conclusions that the secondary benefits found in SOCE can be found in other approaches that do not attempt to change sexual orientation.

Implications for Counseling

Our results present several possible implications for therapist-led and church-affiliated LGBTQ counseling. First and most obvious, these findings lend additional support to the strong positions already taken by most mental health professional organizations that therapist-led SOCE treatments are not likely to be successful—although our data indicate that such interventions are ongoing among the LDS population. Consequently, LDS-affiliated therapists, support group/retreat leaders, and ecclesiastical leaders who encourage or facilitate SOCE (whether therapist-led, religious, or group-based) might consider amending their approaches in light of these findings. LDS therapists, group, and ecclesiastical leaders might also consider providing evidence-based psychoeducation about reported SOCE effectiveness rates to their LDS LGBTQ clients, family, and fellow congregants.

Given the high prevalence and reported ineffectiveness/harm rates of religious SOCE in particular, counselors and church leaders who work with LDS LGBTQ populations might consider explicitly assessing for and exploring histories of religious SOCE with LDS LGBTQ clients. In addition, group-based methods such as support groups, group therapy, and group retreats (that do not encourage SOCE) should potentially be recommended with increased frequency, along with psychiatry (where depression/anxiety is particularly notable)—based on their reported relative effectiveness compared with other methods. Finally, as noted in Bradshaw et al. (2013), LDS-affiliated

therapists should duly consider the finding that acceptance-based forms of therapy are likely to be rated as significantly more effective and less harmful by LDS LGBTQ individuals than are change-based forms of therapy. Ultimately, these suggestions align well with the therapeutic recommendations offered by the APA (2009).

Summary and Limitations

The major findings from this study are as follows: (a) the majority of same-sex-attracted current and former LDS church members reported engaging in SOCE for mean durations as long as 10–15 years, (b) religious and private SOCE were reported to be by far the most commonly used SOCE methods for the longest average durations and were rated as the most ineffective/damaging of all SOCE methods, and (c) most LDS SOCE participants reported little to no sexual orientation change as a result of these efforts and instead reported considerable harm.

Our reliance on convenience sampling limits our ability to generalize our findings to the entire population of same-sex-attracted current and former LDS church members. For example, our sample almost certainly overrepresents men, Whites, and U. S. residents, along with those who are more highly educated and affluent, and who either read the newspaper or are Internet-connected. Because of the highly distressing, stigmatizing, and/or controversial nature of being both same-sex-attracted and LDS, it is probable that a significant number of both highly devout and highly disaffected current and former LDS church members did not become aware of or feel comfortable participating in this study.

The extent to which these findings generalize to the broader, non-LDS LGBTQ religious population is uncertain. While we acknowledge that the LDS church is distinctive in many ways from other more LGBTQ-affirming religious institutions (e.g., Reform and Reconstructionist Judaism, Unitarian Universalism, and Episcopalian), there is some evidence to suggest that the societal and theological pressures experienced by LDS LGBTQ individuals are similar to those in other conservative religious traditions (e.g., Orthodox Judaism, Catholicism, evangelical Christianity, and Islam; APA, 2009; Michaelson, 2012). Though no known research has been conducted to compare SOCE experiences across religious denominations, the APA's report on SOCE seems to acknowledge several commonalities in LGBTQ/SOCE experiences between LDS church members and those of other religious traditions, which include (a) church-based doctrinal and administrative opposition toward same-sex sexuality, (b) no known role for same-sex relationships within church structure, (c) the possible threat of expulsion for assuming an open LGBTQ identity, (d) considerable church-related familial and social pressure to eschew an LGBTQ identity and to engage in SOCE, (e) ostracizing of LGBTQ individuals at church/temple/synagogue/mosque, and (f) considerable psychological distress for religious LGBTQ individuals due to identity conflict. In addition, several studies with samples drawn from Christian reparative therapy conferences (e.g., Exodus International) have explicitly noted the participation of LDS church members, suggesting possible similarities between LDS LGBTQ experiences and those of other religious traditions (Beckstead & Morrow, 2004; Morrow & Beckstead, 2004). We are hopeful that additional research will be conducted to further assess similarities and differences in SOCE experiences between religious traditions.

Because our survey relied heavily on both self-report and participant memory, responses are likely to be impacted accordingly. Also, while we are able to provide some correlational data relative to findings such as factors associated with the likelihood of SOCE participation, average Kinsey scores of those who did and did not engage in SOCE, and a relationship between SOCE and well-being, it is not possible to determine causality and directionality of these relationships without the use of methodologies such as randomized clinical trials or longitudinal studies. For example, regarding our finding that women who have engaged in SOCE were more likely to identify as lesbian than those who did not engage in SOCE, it is difficult to ascertain from our data whether women who are more likely to identify as lesbian are also more likely to engage in SOCE, or if the process of engaging in SOCE might make one's nonheterosexual identity more salient. Finally, it should be noted that participants were not always consistent and coherent in their reports. For example, a number of participants described SOCE in their open-ended responses, even though they had not indicated "change" as either a goal or as something worked on during the methods earlier in the survey. In order to retain a more parsimonious set of classification criteria, we elected to use more conservative inclusion criteria and did not include participants in the SOCE-reported group based on open-ended responses only. Consequently, it is likely that SOCE rates are underreported in our sample.

In summary, this study contributes to the literature by demonstrating significantly greater prevalence of religious and private SOCE versus therapist-led SOCE, no meaningful evidence of reported SOCE effectiveness, and considerable evidence of SOCE-related harm—all via a large, diverse sample. Despite our results being limited to one particular faith tradition, the observed motivations, correlates, and outcomes of SOCE are likely relevant in other conservative religious contexts, and we look forward to additional research on this topic.

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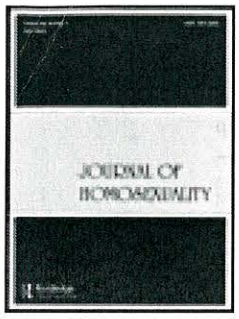

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Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment

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

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

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

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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).

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

Compatibility

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

Practice Guidelines Development Process

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

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

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

Funding for this project was provided by Division 44 (Society for the Psychological Study of LGBT Issues); the APA Office on Lesbian, Gay, Bisexual, and Transgender (LGBT) Concerns; a grant from the Committee on Division/APA Relations (CODAPAR); and donations from Randall Ehrbar and Pamela St. Amand. Some members of the Task Force have received compensation through presentations (e.g., honoraria) or royalties (e.g., book contracts) based in part on information contained in these *Guidelines.*

Selection of Evidence

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

Foundational Knowledge and Awareness

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

Rationale. Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender (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-

[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,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assessment, Therapy, and Intervention

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

Rationale. TGNC people may seek assistance from psychologists in addressing gender-related concerns, other mental health issues, or both. Mental health problems experienced by a TGNC person may or may not be related to that person's gender identity and/or may complicate assessment and intervention of gender-related concerns. In some cases, there may not be a relationship between a person's gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, having a TGNC identity may lead or contribute to a co-occurring mental health condition, either directly by way of gender dysphoria, or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; I. H. Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one's gender; Baltieri & De Andrade, 2009; Hepp, Kraemer, Schnyder, Miller, & 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 Cuyprere, 2008; Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013) as well as challenging (Brown, 2007; Iantaffi & Bockting, 2011). A study of successful relationships between TGNC men and cisgender women found that these couples attributed the success of their relationship to respect, honesty, trust, love, understanding, and open communication (Kins et al., 2008). Just as relationships between cisgender people can involve abuse, so can relationships between TGNC people and their partners (Brown, 2007), with some violent partners threatening to disclose a TGNC person's identity to exact control in the relationship (FORGE, n.d.).

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

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

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

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

Some TGNC people and their partners may fear the loss of mutual sexual attraction and other potential effects of shifting gender identities in the relationship. Lesbian-identified partners of trans men may struggle with the idea that being in a relationship with a man may cause others to perceive them as a heterosexual couple (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 in-

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

Research, Education, and Training

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

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

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

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

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

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

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

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

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

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

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

DAVID SCHWARTZ,

Plaintiff,

-v-

THE CITY OF NEW YORK, and LORELEI SALAS, in her official capacity as Commissioner of the New York City Department of Consumer Affairs,

Defendants.

Case No. 1:19 Civ. 00463 (RJD) (ST)

DECLARATION OF JUDITH M. GLASSGOLD IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

Judith M. Glassgold, Psy.D, a licensed psychologist, declares the truth of the following under penalty of perjury, pursuant to 28 U.S.C. § 1746:

1. I have been retained by counsel for Defendants as a consultant in connection with the above-referenced litigation. I have personal knowledge of the contents of this declaration, and if called upon to testify, I could and would testify competently to the contents of this declaration.

2. My background, experience, and scholarly publications are summarized in my curriculum vitae, which is attached as Exhibit A to this report.

3. I am a Lecturer and Clinical Supervisor at the Graduate School of Applied and Professional Psychology of Rutgers, the State University of New Jersey. I earned my Psy.D. in Clinical Psychology in 1989 from Rutgers, the State University of New Jersey. I have taught and supervised graduate students at Rutgers in psychology and psychotherapy, especially in the area

of sexual orientation and gender, as well as in the treatment of depression, anxiety, suicidality, and trauma.

4. I am a licensed psychologist in New Jersey. From 1991 to 2009, I maintained a clinical practice in New Jersey working with all ages on a broad range of psychological and mental health issues. I specialized in lesbian, gay, bisexual, and transgender (LGBT) issues working with children, adolescents, and adults. In that capacity, I worked with hundreds of individuals struggling with sexual orientation and gender identity and expression.

5. I have extensive experience in public policy, including on providing nonpartisan, expertise on health issues for Congress. In that capacity, I advised on health policy issues and provided policy consultations on sexual orientation, gender identity, and conversion therapy. I worked for the American Psychological Association as an Associate Executive Director in the Public Interest Directorate and developed public policies based on the science of psychology and represented the association to policy makers in Congress and federal agencies. One of the key areas I worked on were policies related to sexual orientation and gender identity. I am currently the Director of Professional Affairs at the New Jersey Psychological Association where I advise psychologists on clinical issues and the New Jersey Psychological Association on legal, regulatory and practice issues, including the New Jersey law banning conversion therapy.

6. In my writing and policy work, I focus on public policy, public health, psychology, and civil rights. I have authored a number of papers, presentations, and trainings related to the harmful effects of conversion therapy as well as appropriate approaches for those distressed by their sexual orientation or who face conflicts between their religious beliefs and sexual orientation. I have written extensively on these topics, as my curriculum vitae reflects,

including 20 professional articles, professional book chapters and books and presented over 60 trainings on psychotherapy of sexual orientation and gender identity.

7. I am member of the American Psychological Association (APA) and the New Jersey Psychological Association. I earned Fellow status of the American Psychological Association due to my expertise in sexual orientation and psychology of gender. I have received multiple professional honors and awards, including election to leadership positions in national associations, invitations to present at professional conferences, appointments to committees, the awarding of professional fellowships, and recognition of my scholarly achievement and public service.

8. My varied and successful professional experiences have allowed me to develop a broad expertise in sexual orientation, gender identity, professional ethics, and related topics.

9. I served as the Chair of the American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2007-2009) and co-wrote and edited the final report released in 2009 (the "APA Report"), attached as Exhibit B.[1] The APA Report was undertaken to answer fundamental questions about the benefits and harms of SOCE and was published with an accompanying Resolution to inform mental health providers, patients and their families, policy makers, community organizations, and faith-based organizations on the appropriate treatment for those distressed by their sexual orientation.

10. I served as one of the APA staff coordinators for the expert consensus panel that provided the basis of the final report of the 2015 US Substance Abuse and Mental Health Services Administration (SAMHSA) "Ending Conversion Therapy: Supporting and Affirming

[1] Am. Psychl. Ass'n, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009).

LGBT Youth" (Exhibit C).[2] I also contributed to the writing and editing of the final report. This report rejects the use of SOCE and provides the scientific basis for beneficial and effective alternative treatments.

11. Since the publication of both of these reports, I have provided extensive training at conferences for educators, mental health, medical and social service professionals on sexual orientation change efforts, conversion therapy and appropriate interventions for children, adolescents, and adults addressing distress or conflicts regarding sexual orientation and gender identity. *See* Exhibit A.

12. In the past 10 years, I have provided consultation on state legislation regarding sexual orientation and conversion therapy, advised interested parties on the risks and benefits of psychological interventions, and provided legal expert testimony by declaration in matters such as *King v. Christie* (2014). I was qualified as an expert in psychology in connection with proceedings in New Jersey Family Court, where I provided expert testimony on multiple occasions during the early 1990s.

I. Background and Definitions

13. Sexual orientation is a well-established concept in psychology. Sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions and behaviors directed to another person. Sexual orientation is an objective, human phenomenon that can be assessed and measured. Sexual orientation is usually discussed in terms of four categories: heterosexual, lesbian, gay, and bisexual.

[2] Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, HHS Publication No. (SMA) 15-4928 (2015).

14. Decades of scientific research has shown unequivocally that heterosexual, gay, lesbian, and bisexual sexual identities are part of the normal spectrum of human sexual orientation and are not a mental illness or developmental defect.

15. Gender identity is an established concept in psychology, referring to an internal, deeply-rooted sense of oneself as belonging to a particular gender; it is distinct from sexual orientation. Gender expression refers to how an individual expresses their internal sense of identity, including through their demeanor, dress, and behavior. Most people have a gender identity that is congruent with their assigned sex at birth. For a transgender person, however, their gender identity does not match their assigned sex at birth. In addition, many people are gender-nonconforming—that is, their gender expression does not conform to traditional gender role. Being gender nonconforming does not mean that a person is lesbian, gay, bisexual, or transgender. Gender identity is an objective, human phenomenon and can be assessed and measured.

16. Decades of scientific research has shown that variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder or developmental defect.

17. Conversion therapy, also called sexual orientation change efforts ("SOCE") or reparative therapy, refers to psychological interventions that seek to change the treatment recipient's sexual orientation from gay, lesbian, or bisexual to heterosexual, or to change a transgender gender identity or gender non-conforming identity to match the sex assigned at birth or reduce gender non-conforming behaviors and demeanor. Currently, SOCE is attempted primarily by talk therapies including role plays, behavior modification through non-aversive techniques, psychoanalytic techniques, cognitive therapies, medical approaches, family therapy,

and religious and spiritual efforts. SOCE can include non-aversive and aversive techniques, and is sometimes be engaged in by choice and sometimes imposed on the recipient.

18. SOCE aimed at changing sexual orientation and gender identity and expression is often based on the inaccurate and stereotyped notions that same-sex attractions and gender identity diversity are disordered and inferior to opposite-sex attractions and cisgender identification,[3] and that lesbian, bisexual, gay, and transgendered (LGBT) individuals are incapable of leading productive lives and engaging in stable sexual and family relationships. These assumptions are inconsistent with current psychological research and understanding of sexual orientation and gender identity.

19. Many psychotherapies are delivered though verbal interactions (talk, words, discussion, interpretation), though some are delivered through a combination of verbal discussion, emotional attachment, and actions, such as establishment of emotional safety and connection, activities such as play, neurological desensitization, rebutting of irrational beliefs and thoughts, and behavioral exposure and desensitization. Most often, therapy rebuts irrational and unscientific beliefs about oneself and others. Although therapies differ amongst themselves in the focus and the content of the verbal interactions, the focus of the verbal discussions are to deliver experiences that improve health.

II. Sexual Orientation Change Efforts Are Ineffective

20. The current practice in mental and behavioral healthcare emphasizes the delivery of empirically validated treatments where interventions are subject to careful evaluation to assess safety and effectiveness. These psychotherapies are treatments that have a valid scientific basis for their theoretical content and/or interventions. Not all approaches have equal validity;

[3] Cisgender means identifying with the gender that is the same as the biological sex identified at birth.

therapeutic claims and approaches are subject to empirical verification, which is a reason for their recognition as part of health care practice.

21. SOCE is rejected by mainstream mental health practitioners and professional association and guidelines because (1) it is unsupported by valid evidence of efficacy; and (2) significant valid evidence shows that it can pose harm to patients who receive it. *See infra* Part III. Research on SOCE does not have a valid scientific basis for its underlying theories or its interventions. The American Psychiatric Association has explicitly rejected the theoretical basis of SOCE due to significant evidence that sexual orientation and gender diversity are normal human variations. Exhibit D.[4] There is no valid scientific evidence verifying SOCE claims of change of sexual orientation or attractions. Rather, multiple reviews of the research literature, such as the APA Report, and empirical research, found that SOCE is ineffective and poses significant harms to individuals of all ages. *See* Exhibit B at 2-4; Exhibit E;[5] Exhibit F;[6] Exhibit G;[7] Exhibit H.[8] SOCE has been found to have no benefits and pose a risk of significant harm and thus cannot qualify as a valid mental health intervention. These points will be detailed in the following sections.

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[4] Am. Psychiatric Ass'n, Board of Trustees and Assembly, *Position Statement on Issues Related to Homosexuality* (2013).

[5] Dehlin, J. P. et al., *Sexual Orientation Change Efforts Among Current or Former LDS Church Members,* 62 Journal of Counseling Psychology 95 (2015).

[6] Kate Bradshaw et al., *Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated With the Church of Jesus Christ of Latter-day Saints*, 41:3 Journal of Sex & Marital Therapy 391 (2015).

[7] Flentje, A. et al., *Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification*, 61(9) Journal of Homosexuality 1242 (2014).

[8] Maccio, E.M., *Self-Reported Sexual Orientation and Identity Before and After Sexual Reorientation Therapy*, 15(3) Journal of Gay and Lesbian Psychotherapy 242 (2011).

22. All existing valid empirical research data show that SOCE is ineffective. There is no existing valid research that shows that sexual orientation can be changed by psychological interventions. In 2007, the APA formed a task force, which I chaired, to review the existing psychological evidence on SOCE and evaluate its benefits and harms. The resulting Report, "Appropriate Therapeutic Responses to Sexual Orientation," and the accompanying APA Resolution rejected SOCE as a valid treatment for patents. *See* Exhibit B; Exhibit I.[9] The conclusions of the Report have been confirmed by subsequent research. *See* Exhibits G, H, and I.

23. Claims of effectiveness made by SOCE providers and proponents have either been disproved by recent scientific research, failed to survive scientific scrutiny, or been retracted by their authors. SOCE claims of effectiveness are marred by serious methodological errors in research design and analysis, inappropriate claims of causality, or invalid generalizations from anecdotal claims based on single-case studies or select populations. The APA Task Force on SOCE found "serious methodological problems in this area of research," including that "only a few studies met the minimal standards for evaluating whether psychological treatments such as efforts to change sexual orientation are effective." *See* Exhibit B at 2.[10] Based on its review of the studies that met these standards, the APA Report reached the following conclusion:

> [E]nduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE and did not report significant change to other-sex attractions that

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[9] Am. Psychl. Ass'n, *Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (2009), *reprinted in* Anton, B.S., *Proceedings of the American Psychological Association for the Legislative Year 2009: Minutes of the Annual Meeting of the Council of Representatives and Minutes of the Meetings of the Board of Directors*, American Psychologist 385 (2010).

[10] The common limitations cited by the APA include composition and recruitment of test subjects; attrition; inadequate assessments of sexual orientation; inadequate description of interventions and procedures; unclear definitions for evaluating success; and problems with timing of the assessments.

> could be empirically validated, though some showed lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE.

See Exhibit B at 2-3. This review of the literature included both aversive methodologies and non-aversive talk therapies, and included instances where the treatments in question had been sought by the recipient.

24. After the release of the Task Force report, the APA Council of Representatives passed a resolution that stated, in part, "the APA concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation" and "the APA concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation." Exhibit I at 3.

25. There is limited research on SOCE that post-dates the APA's comprehensive review of psychological evidence through 2007, however all such research that is methodologically sound confirms the conclusions of the APA Task Force that SOCE is (1) ineffective and (2) harmful. No valid research conducted since 2007 supports the causal claim that individuals will be able to change their sexual orientation, eliminate same-sex sexual attractions and arousal, or achieve a heterosexual sexual orientation through SOCE.

26. Since 2007, three research teams have completed studies, using representative sample populations, that assessed participants' evaluations of their experiences with SOCE. These studies found that participants in SOCE do not report the elimination of same-sex arousal or sexual orientation change to heterosexual. *See* Exhibit E-H. This conclusion is all the more striking given that the studies assessed participants' self-reported, generally retrospective perceptions of their experiences, which were not independently measured or verified. These

types of studies cannot establish causal claims and often reflect positive client appraisals.[11] Many of these participants also reported significant harms.

27. One research group (Bradshaw, Dehlin, and colleagues) evaluated the experiences of 1600 members of the Church of the Latter Day Saints. One thousand sixty of the study's 1600 total participants reported going through SOCE, with 898 reporting that they had engaged in practices with a licensed mental health counselor. *See* Exhibits E-F. Only one individual of a subset of almost 1000 individuals who reported participating in SOCE perceived that their sexual orientation may have shifted significantly, and even this individual reported still experiencing same-sex attractions. Exhibit E at 6. The vast majority of participants of those who saw a licensed mental health provider reported that efforts were either ineffective or harmful. A few participants reported shifts in their perception of their sexual attractions, although these perceptions were not validated by independent measures, and reported coping strategies that accommodated their faith and same-sex orientation (e.g., reduction in sexual behavior or celibacy). One research participant in this group concluded "the feelings don't go away." Exhibit F at 408. The ineffective interventions received by participants in this study included both aversive therapies and non-aversive talk therapies, which were in some cases pursued by the participant.

III. Sexual Orientation Change Efforts Are Harmful To Patients

28. Evidence shows that SOCE interventions pose the risk of significant harm to participants.[12] Past studies described in the 2009 APA Report indicate that the risks of harm include reported feelings of distress, anxiety, depression, suicidal ideation, increase in substance

[11] See discussion of research adequacy in APA Report, chapter 3. Exhibit B at 26.

[12] The Task Force report provides a detailed discussion of this topic and an extensive review of relevant research published prior to 2007. *See* Exhibit B at 35-43.

abuse, self-blame, guilt, and loss of hope among other negative feelings, as well as disillusionment with religious faith, and harm to family relationships. Research published recently reported that 37% reported moderate and significant harms including those found in the APA Report, such increased risk of suicidality, depression, self-blame, and disillusionment with faith. Exhibit F at 408; *see also* Exhibit G at 1257.

29. Both aversive and non-aversive talk forms of SOCE pose a significant risk of harms; this includes even talk therapies pursued by the recipient. For example, research reviewed in the APA Report included evaluations of talk therapies pursued by the recipient, in which outcomes were not guaranteed. The APA report found that participants in talk therapies and religious efforts reported: (a) decreased self-esteem and authenticity to others; (b) increased self-hatred and negative perceptions of homosexuality; (c) confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, and suicidality; (d) anger at and a sense of betrayal by SOCE providers; (e) an increase in substance abuse and high-risk sexual behaviors; (f) a feeling of being dehumanized and untrue to self; (g) a loss of faith; and (h) a sense of having wasted time and resources. The risk of harm is particularly significant for those patients who fail to change their sexual orientation when they expect to be able to change. These patients are at risk for increased shame, guilt, depression, issues with intimacy, sexual dysfunction, and suicidality. *See* Exhibit J;[13] Exhibit K;[14] Exhibit F at 407. Further, Bradshaw, Dehlin and colleagues (2015) reported harms from both aversive and non-aversive treatments as well as voluntary, talk therapies. Exhibit F at 398, 407. The research conducted by Dehlin, Gallagher,

[13] Douglas Haldeman, *Therapeutic Antidotes: Helping Gay and Bisexual Men Recover from Conversion Therapies* (2001).

[14] Michael Schroeder et al., *Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers*, 5:3-4 Journal of Gay & Lesbian Psychotherapy 131 (2002).

et al. and Bradshaw, Dehlin and colleagues found similar mental health and emotional distress were reported by participants. Exhibit E at 7-8; Exhibit F at 398, 407-08.

30. Evaluations of SOCE since 2007 have focused almost exclusively on talk therapies and religious efforts. These studies on LDS SOCE participants found that 37% of participants in SOCE perceived they have experienced moderate or severe harm by these efforts. Exhibit F at 408. Valid psychotherapeutic practices do not harm patients. Clinicians expect that on occasion a patient may not respond to psychotherapy (i.e. their symptoms may not improve notwithstanding the appropriate use of valid therapies), however, it is not accepted in the clinical practice of psychology to use interventions that are reported to cause harm in a substantial portion of patients that receive them. The harms of SOCE resulted from ineffective treatment of mental health conditions as well as the harmful impact of treatment based on inaccurate and stereotyped information regarding sexual orientation and gender identity that increased distress.

31. Pursuing SOCE can prevent or delay other treatments that may be beneficial to patients that could lead to symptom reduction. That is, during the time a patient is undergoing SOCE, he or she is forgoing the opportunity to seek treatment from providers offering legitimate psychotherapy supported by in empirical evidence of efficacy. Thus, providing SOCE can potentially worsen mental health symptoms including depression, suicidal ideation, and substance abuse.

32. In contrast, participants in this recent research reported benefits when they received therapy that allowed them to explore their own sexual orientation without a pre-determined outcome and who received prompt mental health treatment for distress. Exhibit F at 398. This confirms the findings of the 2009 APA Report.

33. SOCE's ineffectiveness and potential risk for harm is settled science. SOCE is

rejected as a treatment by all the major mental health, counseling and health organizations in the United States, as well as many international health associations and government entities. SOCE is rejected by the American Psychological Association, American Psychiatric Association, American Medical Association, American Academy of Family Physicians, American Academy of Child and Adolescent Psychiatry, American Counseling Association, American Association of Pediatrics, American Psychoanalytic Association, Australian Psychological Society, British Psychological Association, Endocrine Society, National Association of Social Workers, Psychological Society of Ireland, Psychological Society of South Africa, and the World Professional Association for Transgender Health. *See* Exhibit I; Exhibit D; Exhibit L;[15] Exhibit M;[16] Exhibit N;[17] Exhibit O;[18] Exhibit P;[19] Exhibit Q;[20] Exhibit R;[21] Exhibit S;[22] Exhibit T;[23]

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[15] Am. Med. Ass'n, *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations* (2018).

[16] Am. Acad. of Family Physicians, *Reparative Therapy* (2016).

[17] Am. Acad. of Child & Adolescent Psychiatry, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, 51 J. Am. Acad. Child & Adolescent Psychiatry 957 (2012).

[18] Joy S. Whitman *et al.*, Am. Counseling Ass'n, *Ethical Issues Related to Conversion or Reparative Therapy* (2013).

[19] Am. Ass'n of Pediatrics, *Homosexuality and Adolescence*, 92 Pediatrics 631 (1993).

[20] Am. Psychoanalytical Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012).

[21] Austl. Psychological Soc'y, *APS Position Statement on Psychological Practices that Attempt to Change Sexual Orientation* (2015).

[22] British Psychological Soc'y *et al.*, *Memorandum of Understanding on Conversion Therapy in the UK* (2017).

[23] Wylie C. Hembree *et al.*, *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clinical Endocrinology & Metabolism 3132 (2009).

Exhibit U;[24] Exhibit V;[25] Exhibit W;[26] Exhibit X.[27]

34. The American Psychiatric Association reiterated its opposition to SOCE in November 2018, *see* Exhibit Y,[28] and re-endorsed the dangers associated with SOCE in its position statement of 2013:

> The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed.

Exhibit D.

35. The American Psychiatric Association Board of Trustees has also rejected the validity of the developmental theories underpinning SOCE, noting the absence of any rigorous scientific evidence supporting these approaches, and recommending that practitioners refrain from attempts to change individuals' sexual orientation. *See* Exhibit Z.[29]

36. SOCE is not only an inappropriate treatment for sexual orientation issues, but also not a scientifically valid treatment for sexual conflicts, sexual abuse or sexually compulsive (out of control or "addictive" sexual behaviors). Scientifically valid treatments for these conditions do not include efforts based on SOCE or changing sexual attractions, orientation and gender

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[24] Nat'l Ass'n of Soc. Workers, *Position Statement: Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons* (2015).

[25] Irish Council for Psychotherapy, *Position on Conversion Therapy, Reparative Therapy, Gay Cure and Transgender Conversion Therapy in Ireland* (2017).

[26] Psychological Soc'y of S. Africa, *Practice Guidelines for Psychology Professionals Working with Sexually and Gender-Diverse People* (2017).

[27] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (2012).

[28] Am. Psychiatric Ass'n, *APA Reiterates Strong Opposition to Conversion Therapy* (Nov. 15, 2018).

[29] Am. Psychiatric Ass'n, *Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): COPP Position Statement* (2000).

identity. In these cases, SOCE poses a significant risk to mental health by reinforcing damaging stereotypes and increasing shame related to sexuality.

IV. Appropriate Treatment For Those Distressed By Conflicts Surrounding Sexual Orientation

37. A prohibition on SOCE does not limit health professionals from providing competent care to those who are distressed by their sexual orientation or gender identity. There are both well-accepted therapeutic techniques as well as specialized approaches that help to resolve conflicts and distress, including conflicts between religion, on the one hand, and sexual orientation and gender identity, on the other. SOCE is not among these accepted approaches.

38. Decades of studies, including recent randomly-controlled evaluations of therapy, indicate that patients benefited from therapies that provide accurate information about sexual orientation and gender identity. Approaches that reduce the stigma, fear, and shame surrounding sexual orientation and gender diversity are effective at reducing mental health symptoms. *See, e.g.*, Exhibit AA.[30] These treatments are based on a significant body of research that indicate that anti-LGBT stigma, and the stress of anti-LGBT prejudice and discrimination (often termed "minority stress") can trigger chronic feelings of shame and/or guilt. Past and current exposure to negative social stereotypes; rejection or lack of support in family relationships, and discrimination at school, community organizations and work can trigger mental health symptoms and unhealthy coping behaviors.

39. The APA Report and subsequent research examined the issue of the appropriate treatment for those who are distressed by conflicts between religious beliefs and sexual orientation, many of whom appear to participate in SOCE. These patients appear to come from

[30] Pachankis, J. E., et al., *LGB- Affirmative Cognitive-Behavioral Therapy for Young Adult Gay and Bisexual Men: A Randomized Controlled Trial of a Transdiagnostic Minority Stress Approach*, 83(5) Journal of Consulting and Clinical Psychology 875, 886 (2015).

faiths that believe heterosexuality and other-sex relationships are perceived as part of the natural order and are morally superior to homosexuality. Research on SOCE suggests that individuals reject or fear their same-sex sexual attractions because of the internalization of the values and attitudes of their religion that characterize homosexuality negatively and as something to avoid. Such individuals feel tremendous isolation and loneliness due to the perceived rejection of their same-sex attractions by their faith. Many such individuals have limited access to accurate psychological research on LGBT lives.

40. These individuals are extremely vulnerable to claims of SOCE as they believe change is required by their faith and may keep trying to change their sexual orientation despite risks to their mental health. Most of these individuals participated in different forms of SOCE over the course of several years increasing the risk of harm due to lack of appropriate treatment as well as harmful interventions. There are unique risks of harms in such cases, such as disillusionment with faith and lack of effective treatment of chronic mental health disorders.

41. Based on this research and the unique risks of certain groups, the APA Report endorsed the position that enduring change in sexual orientation is unlikely from SOCE and that patients perceive a benefit when offered affirmative approaches that support, accept, and recognize important values, including religious concerns.

42. This APA Report recommendation is supported by the work of Bradshaw, Dehlin and colleagues (2015) showing that participants perceived efforts to be most helpful when they worked with a counselor to clarify their own values and goals without having a pre-set goal of sexual orientation change or acceptance. Exhibit F at 398.

43. There are numerous examples of research-based approaches for those with conflicts between faith and sexual orientation and gender identity. *See* Exhibit BB;[31] Exhibit CC.[32] Specifically, the APA Report recommended the appropriate application of therapeutic interventions for all adults who are distressed by their sexual orientation that have the following central elements: (a) acceptance and support, (b) a comprehensive assessment (including mental health concerns), (c) active coping, (d) social support, and (e) identity exploration and development without a pre-determined outcome. These interventions are helpful for those from all backgrounds, including conservative religious faiths. These well-accepted psychotherapy treatments provide these benefits without the risks of SOCE.

V. Gender Identity Change Efforts

44. SOCE often includes efforts to ensure that gender expression (actions and dress associated with gender roles) conform to traditional gender roles as well as that gender identity is consistent with the sex assigned at birth. These efforts are sometimes termed gender identity change efforts ("GICE").

45. GICE is fundamentally inconsistent with the consensus view of the medical, psychiatric, and psychological communities regarding the appropriate care of gender diverse and transgender individuals, and it poses a risk of significant harm.

46. The World Professional Association for Transgender Health (WPATH) promulgated Standards of Care (SOC) that are the internationally recognized guidelines and inform psychological and medical treatment throughout the world. *See* Exhibit X.[33] The

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[31] Levy, D.L. & Reeves, P., *Resolving identity conflict: Gay, Lesbian, and Queer Individuals with a Christian upbringing*, 23(1) Journal of Gay & Lesbian Social Services 53 (2011).

[32] Sherry, A., et al., *Competing Selves: Negotiating the Intersection of Spiritual and Sexual Identities*, 2 Professional Psychology: Research and Practice 112 (2010).

[33] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (2012).

WPATH SOC are formulated and revised over a period of nearly 30 years by the foremost experts in the care of transgender and gender diverse individuals, informed by the available clinical data. The American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, and the American College of Obstetrics and Gynecology, among others, all endorse protocols in accordance with the WPATH SOC. *See* Exhibit T; Exhibit DD;[34] Exhibit EE;[35] Exhibit FF;[36] Exhibit GG;[37] Exhibit HH;[38] Exhibit II;[39] Exhibit JJ;[40] Exhibit KK.[41] The WPATH SOC affirm gender diversity and call for practitioners treating those who experience distress related to their gender identity to practice a "gender affirming" approaches, meaning treatments facilitating the alignment of the individual's physical body, gender expression, and social identity (i.e., demeanor, dress) with their gender identity.

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[34] Am. Med. Ass'n, *Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients* (2008).

[35] Am. Psychological Ass'n, *Transgender, Gender Identity, & Gender Expression Non-Discrimination* (2008).

[36] Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832 (2015).

[37] Am. Psychiatric Ass'n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012).

[38] Madeline B. Deutsch *et al.*, Am. Acad. of Family Physicians, *Updated Recommendations from the World Professional Association for Transgender Health Standards of Care*, 87 Am. Family Physician 92 (2013).

[39] Emilia Lombardi, *Enhancing Transgender Health Care*, 91 Am. J. Pub. Health 869 (2001).

[40] *LGBT Practice Tools*, Nat'l Ass'n of Soc. Workers (last viewed Mar. 28, 2019).

[41] Am. College of Obstetricians and Gynecologists, Committee on Health Care for Underserved women, *Committee Opinion Number 512: Health Care for Transgender Individuals* (December 2011, reaffirmed 2019).

47. The harms caused by GICE included increase in suicidal ideation and attempts, self-mutilation, increased depression and anxiety, increased self-hatred, hopelessness, shame and an increase in substance abuse and high-risk sexual behaviors. *See* Exhibit KK; Exhibit LL.[42]

VI. Conclusion

48. Interventions aimed at changing an individual's sexual orientation and gender identity have not been empirically demonstrated to be effective or safe. SOCE and GICE are ineffective no matter the demographics of the participants (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, ability status, language, and socioeconomic status).

49. SOCE and GICE pose significant risk of harm whether they are aversive or non-aversive, are coerced or requested by the participant, or employ talk therapy methods or active interventions. SOCE and GICE are harmful no matter the demographics of the participants (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, ability status, language, and socioeconomic status).

50. Practitioners are entitled to their personal beliefs. But they should not be permitted to provide discredited and harmful services to patients, especially those in extreme distress due to distressing conflicts between sexual orientation, gender identity and faith beliefs, to an unacceptable risk of severe and life-long harm, including significantly increased risks of anxiety, depression, suicidality, and substance abuse. Doing so is unconscionable and unethical.

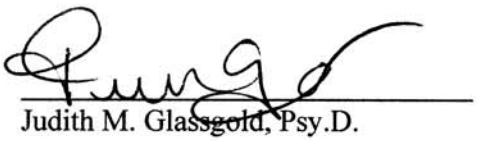
51. The major mental health professional organizations stand uniformly opposed to SOCE and GICE and instead recommend affirmative approaches that address the stigma surrounding same-sex orientation and gender diversity and emphasize acceptance, support, and

[42] Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts With LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, Journal of Homosexuality (2018).

recognition of important values, including religious faith. Alternatives that provide benefits without the risk of harm are available for all populations that are distressed.

52. These approaches are based on the scientific evidence that sexual orientation and gender identity diversity are normal and positive variants of human sexuality and are not indicators of mental or developmental disorders. Further, gay men, lesbians, bisexual, and transgender individuals can and do live satisfying lives and form stable, committed relationships and families; and no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation and gender diversity to family dysfunction or trauma.

Dated: March 28, 2019
Hillsborough, New Jersey



Judith M. Glassgold, Psy.D.

OUR WORK

Asylum & Immigration (http://www.nclrights.org/our-work/asylum-immigration/)

Born Perfect: The Campaign to End Conversion Therapy (http://www.nclrights.org/our-work/bornperfect/)

Elders (http://www.nclrights.org/our-work/elders/)

Employment (http://www.nclrights.org/our-work/employment/)

Family & Relationships (http://www.nclrights.org/our-work/family-relationships/)

Federal Legislation & Policy (http://www.nclrights.org/our-work/federal-legislation-policy/)

State Legislation & Policy (http://www.nclrights.org/our-work/state-legislation-policy/)

Healthcare (http://www.nclrights.org/our-work/healthcare/)

Housing (http://www.nclrights.org/our-work/housing/)

Low Income & Poverty (http://www.nclrights.org/our-work/low-income-poverty/)

Prisons (http://www.nclrights.org/our-work/prisons/)

Rural Communities (http://www.nclrights.org/our-work/rural-communities/)

Sports (http://www.nclrights.org/our-work/sports/)

Transgender Law (http://www.nclrights.org/our-work/transgender-law/)

BORN PERFECT

(http://www.nclrights.org/wp-content/uploads/2014/06/born-perfect163-whitw-black.png)

In June 2014, NCLR launched **Born Perfect: The Campaign to End Conversion Therapy** by passing laws across the country to protect LGBT children and young people, fighting in courtrooms to ensure their safety, and raising awareness about the serious harms caused by these dangerous practices.

Few practices hurt LGBT youth more than attempts to change their sexual orientation or gender identity through conversion therapy, which can cause depression, substance abuse, and even suicide.

But some mental health providers continue to subject young LGBT people to these practices—also known as "reparative therapy," "ex-gay therapy," or "sexual orientation change efforts"—even though they have been condemned by every major medical and mental health organization in the country.

NCLR has been working to protect LGBT youth from these practices for more than 20 years, securing legislation protecting youth from these dangerous practices in California in 2012; New Jersey in 2013; Washington, D.C. in 2014; Oregon and Illinois in 2015; Vermont in 2016; Connecticut, Nevada, New Mexico, Rhode Island in 2017; Washington state, Maryland, Hawaii, New Hampshire, and Delaware in 2018; and New York, Massachusetts, and Colorado in 2019. Today, we are working with legislators and LGBT leaders in dozens of other states and helping bring similar protections to the rest of the country. We believe that every LGBT child is born perfect and that any young person's identity as lesbian, gay, bisexual, or transgender should be honored, celebrated, and supported.

Text AA

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Search

RECENT POSTS

Why Raising the Minimum Wage Is a Critical LGBTQ Issue (http://www.nclrights.org/why-raising-the-minimum-wage-is-a-critical-lgbtq-issue/)

NCLR Legal Director Shannon Minter Awarded American Psychiatric Association Fryer Award (http://www.nclrights.org/nclr-legal-director-shannon-minter-wins-apa-fryer-award/)

Congratulations Kate Kendell Commitment to Justice Awardee, Lupita! (http://www.nclrights.org/conc kate-kendell-commitment-to-justice-awardee-lupita/)

We Belong At the Table (http://www.nclrights.org/we-belong-at-the-table/)

I survived eight years of conversion therapy. But I fought back. (http://www.nclrights.org/i-survived-eight-years-of-conversion-therapy-but-i-fought-back/)

LEARN MORE

Born Perfect: Home (http://www.nclrights.org/born

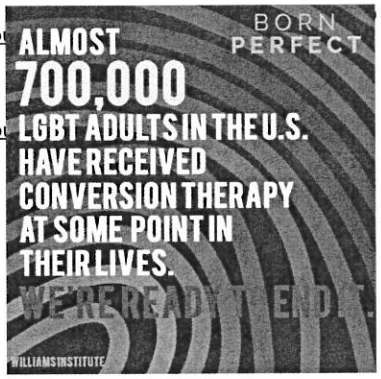
The Facts About Conversion Therapy (http://www.nclrights.org/born the-facts-about-conversion-therapy)

Laws & Legislation By State (http://www.nclrights.org/born laws-legislation-by-state)

Toolkit, Resources & Statements

Youth (http://www.nclrights.org/our-work/youth/)

Additional Civil Rights (http://www.nclrights.org/our-work/additional-civil-rights/)



content/uploads/2018/10/BP_SOCIAL_1-1.png)We are committed to ending these dangerous and stigmatizing practices across the country once and for all—relegating them to the dustbin of history, and ensuring every child knows they were #BornPerfect.

If you have been personally impacted by conversion therapy or are considering legislation in your state, connect with NCLR for help (mailto:bornperfect@nclrights.org).

LEARN MORE

(http://www.nclrights.org/wp-content/uploads/2018/10/BP_WEBSITE_STORIES.png)**SURVIVOR STORIES & SURVIVOR NETWORK**
While experts estimate that as many as 1 in 3 LGBT people have been subjected to some form of conversion therapy, trauma from these experiences can make it difficult to come forward. Read about the courageous survivors who have, and find the support to use your own voice for good.
Learn more. (http://www.nclrights.org/bornperfect-survivor-stories-and-survivor-network)

(http://www.nclrights.org/wp-content/uploads/2018/10/BP_WEBSITE_FACTS.png)**THE FACTS ABOUT CONVERSION THERAPY**
Find out more about the dangerous practice of conversion therapy, also known as "reparative therapy," "ex-gay therapy," or "sexual orientation change efforts."
Learn more. (http://www.nclrights.org/bornperfect-the-facts-about-conversion-therapy)

(http://www.nclrights.org/wp-content/uploads/2018/10/BP_WEBSITE_MAP.png)LAWS & LEGISLATION BY STATE

Get up-to-date information on which states are working with NCLR to pass laws protecting children and young people from conversion therapy.
Learn more.

(http://www.nclrights.org/bornperfect-laws-legislation-by-state)

(http://www.nclrights.org/wp-

(http://www.nclrights.org/born-Toolkit-resources-statement)

Legal Cases (http://www.nclrights.org/born-legal-cases)

Survivor Stories & Survivor Network (http://www.nclrights.org/born-survivor-stories-and-survivor-network)

Campaign Supporters (http://www.nclrights.org/born-campaign-supporters)

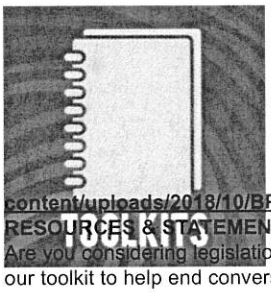
Advisory Committee (http://www.nclrights.org/born-advisory-committee/)

What You Can Do (http://www.nclrights.org/born-what-you-can-do)

READ MORE

NCLR Urges U.N. Committee Against Torture to End Conversion Therapy (http://www.nclrights.org/nclr-urges-un-committee-against-torture-to-end-conversion-therapy/)

Former Ex-Gay Leaders Unite in Opposition to Conversion Therapy and in Support of #BornPerfect (http://www.nclrights.org/form-ex-gay-leaders-unite-in-opposition-to-conversion-therapy/)



content/uploads/2018/10/BP_WEBSITE_TOOLKITS.png)**TOOLKITS, RESOURCES & STATEMENTS**
Are you considering legislation? We're here to help. Connect with NCLR, request our toolkit to help end conversion therapy, and explore the many articles, research papers, and policy statements finding that these practices are ineffective and harmful.
Learn more. (http://www.nclrights.org/bornperfect-Toolkit-resources-statement)

(http://www.nclrights.org/wp-

content/uploads/2018/10/BP_WEBSITE_LEGAL.png)LEGAL CASES
NCLR is working to defend existing state laws from legal challenges by anti-LGBT organization and representing the interests of survivors of these dangerous and discredited practices.
Learn more. (http://WWW.nclrights.org/bornperfect-legal-cases)

(http://www.nclrights.org/wp-

content/uploads/2018/10/BP_WEBSITE_supporters.png)CAMPAIGN SUPPORTERS
A broad range of supporters—including mental health, faith, civil rights, youth advocacy, and reproductive justice organizations—support an end to conversion therapy. Read the national open letters here, and find out how to sign your organization on.
Learn more (http://www.nclrights.org/bornperfect-campaign-supporters).

(http://www.nclrights.org/wp-

content/uploads/2018/10/BP_WEBSITE_ADVISORY.png)**ADVISORY COMMITTEE**
While experts estimate that as many as 1 in 3 LGBT people have been subjected to some form of conversion therapy, trauma from these experiences can make it difficult to come forward. Read about the courageous survivors who have, and find the support to use your own voice for good.
Learn more. (http://www.nclrights.org/bornperfect-advisory-committee/)

WHAT YOU CAN DO

Are you considering legislation in your state? Are you a survivor of these practices?
Do you want to get involved with ending these dangerous practice once and for all?
Find out what you can do to support the effort to end conversion therapy.
Learn more. (http://www.nclrights.org/bornperfect-what-you-can-do)

NATIONAL HEADQUARTERS
870 Market Street, Suite 370
San Francisco, CA 94102
Phone: 415.392.6257
Fax: 415.392.8442

WASHINGTON, DC OFFICE
1776 K Street, NW
Suite 852
Washington, DC 20006
Phone: 202.734.3545

LEGAL HELP LINE
1.800.528.6257 or
415.392.6257

RESOURCES
Resources (http://www.nclrights.org/legal-help-resources/)
Legal Help (http://www.nclrights.org/legal-help/)
Our Blogs (http://www.nclrights.org/our-blogs/)

SEARCH
Search Cases & Policy (http://www.nclrights.org/cases-and-policy/)

PRESS ROOM (HTTP://WWW.NCLRIGHTS.ORG/PRESS-ROOM/)
Press Releases & Statements (http://www.nclrights.org/press-room/)
About Us (http://www.nclrights.org/about-us/)

CONTACT US
Complete Contact List (http://www.nclrights.org/about-us/staff/)

SUPPORT THE FIGHT FOR JUSTICE
Give (http://www.nclrights.org/give/)

NCLR is a 501(c)(3) non-profit organization, and our federal tax identification number is 94-3086885.

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc. et. al.,

Plaintiffs,

v. CASE NO: 8:17-cv-02896-T-02AAS

CITY OF TAMPA, FLORIDA,

Defendant.
_____/

DECLARATION OF NORMAN SPACK, M.D.

I, **Norman Spack, M.D.**, a licensed medical doctor declares the truth of the following under penalty of perjury:

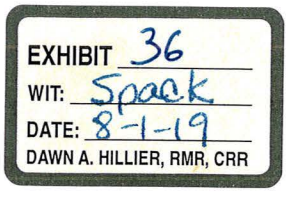
I. QUALIFICATIONS

1. I have personal knowledge of the facts in this Declaration, which are true and correct, if called upon to testify I would do so competently. I have not received payment for preparing this Declaration.

2. I have read the Ordinance No. 2017-47, An Ordinance of the City of Tampa, Florida Relating to Conversion Therapy on Patients Who are Minors and in my opinion the Ordinance is based upon the evidence-based medical consensus regarding appropriate treatment of transgender and gender non-conforming youth, and the Ordinance is necessary to effectuate the City of Tampa's interest in protecting vulnerable minors from the serious harms caused by conversion therapy.

3. I am a licensed medical doctor and earned my medical degree from University of Rochester School of Medicine and Dentistry in 1969 and undergraduate degree from Williams College in 1965. I hold licensures and certifications from the National Board of Medical Examiners, American Board of Pediatrics, and Society for Adolescent Medicine, and I am Board Certified in Endocrinology. A copy of my curriculum vitae is attached as Exhibit A.

4. I have held numerous leadership positions, and notably served as the co-founder and co-director of Gender Management (GeMS-DSD) and Clinical Director for the Endocrine Division of Children's Hospital in Boston, Massachusetts, and course director for Pediatric Endocrinology for Harvard Medical School.



5. I have held faculty academic appointments at Harvard Medical School since 1977 and most recently served as the Associate Clinical Professor of Pediatrics. I have taught numerous courses at Harvard Medical School involving gender identity and transsexuals. I have published peer-reviewed articles on the treatment of transgender people, with a particular emphasis on gender identity and youth.[*] I have been invited at numerous conferences both nationally and internationally to speak on the topic of gender management, transgenderism, and transgender youth, including the proper protocols for treatment of transgender adolescents.

6. In 2009, I was selected to serve on a task force for the Endocrine Society. The Endocrine Society worked in tandem with committees and members of the European Society of Endocrinology, the European Society for Paediatric Endocrinology, the Lawson Wilkins Pediatric Endocrine Society, and the World Professional Association for Transgender Health, with the express objective of formulating practice guidelines for endocrine treatment of transsexual persons. The clinical practice guideline, titled Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline, was published in the Journal of Clinical Endocrinology and Metabolism. A copy of the clinical practice guideline is attached as Exhibit B.

7. The method of development of evidence-based clinical practice guidelines for the treatment of transsexual individuals followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) group, an international group with expertise in development and implementation of evidence-based guidelines. The Task Force used the best available research evidence that Task Force members identified, and two commissioned systematic reviews to develop some of the recommendations.

8. The Endocrine Society Guidelines have been adopted by the American Academy of Pediatrics and the American Psychiatric Association.

9. Since 1978, I have treated more than 140 transgender children and adolescents.

[*] Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. H., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology: Research and Practice, 46,* 37–45. http://dx.doi.org/10.1037/a0037490; Spack, NP, Clinical Crossroads, Management of Transgenderism. JAMA 2013.209 (5): 478-484; Laura Edwards-Leeper PhD & Norman P. Spack MD (2012) Psychological Evaluation and Medical Treatment of Transgender Youth in an Interdisciplinary "Gender Management Service" (GeMS) in a Major Pediatric Center, Journal of Homosexuality, 59:3, 321-336, DOI: 10.1080/00918369.2012.653302; Spack NP, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, Vance SR. *Characteristics of children and adolescents with gender identity disorder referred to a pediatric medical center*. Pediatrics 2012; 129(3): 418-425; 1. Perrin E, Smith N, Davis C, Spack N, Stein MT. *Gender variant and gender dysphoria in two young children*. J Dev Behav Pediatr. 2010. 31(2):161-4.

II. ANALYSIS AND OPINIONS

A. Conversion Therapy Deviates from the Standards of Care for Treating Transgender and Gender Nonconforming Children

1. I have reviewed the Declaration submitted by Dr. Bernard Hudson. From that review, it is my professional opinion that the Declaration significantly misstates current medical knowledge and practice regarding the standard of care of treatment for transgender and gender nonconforming children and adolescents.

2. For decades, the medical profession has recognized that transgender people have a gender identity that differs from their sex at birth. Gender identity is a person's internal psychological identification as male, female, or something in between.

3. Current medical research strongly indicates that a person's gender identity has a biological component.

4. There is no scientific evidence that any type of therapy or treatment can change a person's gender identity, and attempts to do so put patients at risk of serious harms, including suicidality and depression.

5. Transgender and gender nonconforming minors are a vulnerable population who often experience significant distress, negative self-esteem, and suicidal or self-harm ideations. Because these young people are already psychologically vulnerable, subjecting them to attempts to change their gender identity or gender expression are particularly harmful and put them at risk of increased suicidality and depression, among other serious long term negative health impacts.

6. Subjecting minors to conversion therapy deviates from the standard of care for treating transgender and gender nonconforming children and adolescents.

B. The Standards of Care for Treatment of Transgender And Gender Nonconforming Minors Are Evidence-Based.

7. Multiple professional organizations have issued evidence-based guidelines and standards of care for treating transgender and gender nonconforming children and adolescents. I am familiar with these guidelines and standards which include: the World Professional Association for Transgender Health; the American Psychological Association the American Psychiatric Association; the American Medical Association; and the Endocrine Society.

8. These guidelines and standards of care are based upon decades of research and clinical experience and reflect the best available science and professional consensus.

9. There is no evidence-based support for treatments that attempt to change a young person's gender identity or gender expression. Conversion therapy deviates from the standards of care and guidelines promulgated for the psychological and medical treatment of gender diverse adolescents.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this June 12, 2019.

Norman Spack

Norman Spack, M.D.

EXHIBIT A

Harvard Medical School Curriculum Vitae

Date Prepared: January 15, 2015
Name: Norman P. Spack
Office Address: Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115.
Home Address: 474 Revere Beach Boulevard, Revere MA 02151
Work Phone: 617 355 4367
Work E:Mail: norman.spack@childrens.harvard.edu
Work FAX: **Place of Birth:** Brookline, MA

Education:

Year	*Degree*	*Institution*
1965	BA (Biology Honors Program)	Williams College
1969	MD	University of Rochester School of Medicine and Dentistry
2002	Honorary Doctorate in Humane Letters	Hebrew College Boston

Postdoctoral Training:

Year(s)	*Title*	*Discipline*	*Place of Training*
1969-70	Intern	Pediatrics	Boston City Hospital
1970-71	Junior Asst Resident	Pediatrics	Boston City Hospital
1971-72	Senior Asst Resident	Pediatrics	Children's Hospital Boston
1974-75	Fellow	Adolescent Medicine	Children's Hospital Boston
1975-77	Fellow	Diabetes	Children's Hospital Boston
1992-93	Fellow	Endocrinology	Children's Hospital Boston

Licensure and Certification:

1970	National Board of Medical Examiners
1975	American Board of Pediatrics (Fellow)
1987	Fellow, Society for Adolescent Medicine
1995	Certified in Endocrinology, American Board of Pediatrics
2002	Recertified in Endocrinology, American Board of Pediatrics

Faculty Academic Appointments:

Year	*Academic Title*	*Institution*
1977-78	Instructor in Pediatrics	Harvard Medical School
1978-96	Clinical Instructor in Pediatrics	Harvard Medical School
1997-12	Assistant Professor of Pediatrics	Harvard Medical School
2013-	Associate Clinical Professor of Pediatrics	Harvard Medical School

Appointments at Hospital/Affiliated Institutions:

Year	*Title*	*Hospital/Affiliated Institution*
1974-98	Courtesy Staff	Saints Memorial Medical Center, Lowell, MA
1976-80	Assistant in Medicine	Children's Hospital Boston
1978-98	Active Staff	Newton-Wellesley Hospital, Newton, MA
1981-	Associate in Medicine	Boston Children's Hospital
1983-95	Medical Staff	N.E. Deaconess Hospital, Boston, MA
1990-95	Medical Staff	Waltham-Weston Hospital, Waltham, MA
1999-01	Active Staff	Lowell General Hospital, Lowell, MA
1999-01	Consulting Staff	St. Elizabeth's Hospital, Boston, MA
1999-10	Consulting Staff	Caritas Norwood Hospital, Norwood, MA

Other Professional Positions:

Year	*Position/Title*	*Institution*
1974-84	Liaison to Children's Hospital	Bridge Over Troubled Waters, Boston, MA
1980-85	Medical Advisory Board	Bridge Over Troubled Waters, Boston, MA
1985-89	Medical Consultant	Multi-Service Center of Newton, MA
1987-92	Coordinator, Prospective Study of Vascular Complications in Adolescent Diabetics	Eye Research Institute Boston and Baylor University School of Medicine
1993-99	Director	Diabetes & Endocrine Youth Program, Saints Memorial Med Center, Lowell, MA
1999-01	Director	Pediatric Endocrine Clinic, Lowell General Hospital, Lowell, MA

Major Administrative Leadership Positions:

Local:

Year	*Position/Title*	*Institution*
1990-2002	Board of Trustees	Hebrew College of Greater Boston
1990-2009	Board Member (active)	National Executive Board, American Physicians' Fellowship for Medicine in Israel and reviewer of applications for research grants in No. America for Israeli and Palestinian MDs

1998-06	Clinical Director, John F. Crigler, Jr Endocrine Division	Children's Hospital Boston
1998-06	Course Director, Pediatric Endocrinology (PD507M.7) HMS 4th Year Elective	Harvard Medical School
2000-2002	Board Chair	Hebrew College of Greater Boston
2005-	Board of Governors	Combined Jewish Philanthropies of Greater Boston
2006-	Co-Founder and Co-Director, Gender Management (GeMS-DSD) Service	Boston Children's Hospital
2012-	Board of Directors	Bridge Over Troubled Waters, Boston, MA
2013-	Board of Directors	Piers Park Sailing Center & Adaptive Sailing Program East Boston

National:

Year	*Position/Title*	*Institution*
1973-74	Senior Staff Pediatrician, Major, USAF	Malcolm Grow USAF Medical Center, Washington, DC

International:

Year	*Position/Title*	*Institution*
1972-73	Capt, USAir Force, Chief of Pediatrics	USAF Regional Hospital Incirlik Turkey
2005	Subcommittee member on "structural issues in intersex management"	International Consensus Task Force between Lawson Wilkins/Pediatrics Endocrine Society of North America and European Society of Pediatric Endocrinology (ESPE)

Committee Service:

Year	*Name of Committee*	*Role*	*Institution*

Local:

1978-87	Committee of Tutors, HMS First Year Tutorial Program	Tutor	Harvard Medical School
1980-83	Curriculum Development Committee, Ambulatory Rotation, Introduction to Clinical Medicine Course	Coordinator	Dept of Medicine, Children's Hospital Boston
1986-87	Maternal and Child Health Clerkship Course Development Committee for New Pathway Curriculum	Member	Harvard Medical School
1986-87	Committee for Physician Fundraising Capital Campaign	Member	Children's Hospital Boston
1986-89	Committee of Professors, Dept of Medicine	Representative for Community Pediatricians	Children's Hospital Boston
1987-92	Subcommittee on Physician Privileges, Dept of Medicine	Member	Children's Hospital Boston
1994-98	Committee on Clinical Practice Guidelines for Treatment of Diabetes Mellitus	Member	Children's Hospital Boston
1994-11	Committee of House Staff Advisors	Advisor	Children's Hospital Boston
1997-99	Steering Comm for Clinical Ambulatory Reorganization, Dept of Medicine	Member	Children's Hospital Boston
1998-10	Joint Endocrine-Urology & Endocrine-Surgery Conferences	Coordinator	Children's Hospital Boston
1998-02	Alumni Council	Member	Children's Hospital Boston
1998-02	Janeway Inpatient Service Committee on Quality Improvement	Member	Children's Hospital Boston
2000-02	Alumni Association	President	Children's Hospital Boston
2000-02	Physicians Leadership Council	Representative	Children's Hospital Boston
2001	Steering Committee 50th Anniversary Celebration, Div of Adolescent/Young Adult Medicine	Member	Children's Hospital Boston
2002	Minority Clerkship Program	Mentor	Harvard Medical School
2003-04	Staff Executive Committee	Representative	Children's Hospital Boston
2006-08	Committee on Admissions	Member, Subcomm 4	Harvard Med School

2007-	Peer Review Subcommittee of Hospital Executive Committee	Member	Children's Hospital Boston
2008-	Task Force on Treatment of Transgendered Enrollees in Harvard University Health Services (appointed by Director of HUHS)	Member	Harvard University
2009-	Employees' LGBT Leadership Committee	Member	Children's Hospital, Boston

Professional Societies:

Year	*Society*	*Role*
1975-2002	American Academy of Pediatrics	Member
1975-	Society for Adolescent Medicine	Writer, Endocrine Section, First Board Examination
1978-	Massachusetts Medical Society	Member
1993-	Project Hope Medical Alumni	Member
1996-	Harry Benjamin International Gender Dysphoria Association (WPATH)	Member& Abstract Reviewer for Biennial International meeting
1996-	Lawson Wilkins Pediatrics Endocrine Society	Member
1997	The Endocrine Society	Member
2005	International Task Force on Treatment of Children with Disorders of Sex Development	Member
2005	Standing committee on Disorders of Sex Development, Pediatric Endocrine Society	Member
2008-09	Endocrine Society International Task Force on Clinical Management of Transsexual Persons and co-author of the resulting published Guidelines	Member

Editorial Activities:

Year	*Role*	*Name of Journal*
2002-10	Ad hoc reviewer	New England Journal of Medicine
2002-05	Ad hoc reviewer	Pediatrics
2007	Ad hoc reviewer	British Medical Journal
2009-12	Ad hoc reviewer	Journal of Sexual Medicine
2013	Ad hoc reviewer	Journal of Pediatrics

Honors and Prizes:

Year	*Name of Award*	*Awarding Organization*	*Achievement for which awarded*
1964	Lehman Scholar	Williams College	undergraduate service to college

1985	Anne Woolf Award Juv. Diabetes Assoc of Greater Boston For service to Children with Diabetes		
1987 1994	Mead Johnson Clinical Scholar Employee Recognition Award	Dept of Medicine Children's Hospital	Teaching Service
1996	Janeway Service Award	Dept of Medicine	Inpatient Teaching
2012	David Weiner Award to GeMS from Children's Board of Trustees for Leadership Innovation in Child Health		
2012	Annual lecturer in honor of John F. Crigler, Jr. MD, Dept of Medicine Grand Rounds , Sponsored by Endocrine Division		

Report of Funded and Unfunded Projects:

Year(s)	*Role*	*Grant Type*	*Title*
2002-03	Local Chief Investigator	Corporate (AstraZeneca Corp) drug trial (received no funding)	"Trial of Tamoxifen to Suppress Peripheral Precocious Puberty in 28 Girls with McCune-Albright Syndrome"- a multicenter clinical trial; Provided 4 of the national cohort of 28 patients studied and made all the observations and obtained all the clinical data

Report of Local Teaching and Training:

Teaching of Students in Courses:

Year(s)	*Type of responsibility*	*Institution*	*Effort*
1976-86	Tutor for 1st yr Tutorial Program	Harvard Medical School	1 hr/wk
2001	"Symposium on Gender Ambiguity/Gender Identity" Patient-Doctor III Course,	Harvard Medical School	2 hours
2003- 08	Mentor for minority Clerkship	Harvard Medical School	Summer
2007-09	"Transgenderism" HMS-I Human Sexuality Elective; 2 hour lecture Course(ME735.0)	Harvard Medical School	1 evening session/yr.
2007-12	"Sexual Differentiation/Gender Identity. Annual lecture Human Physiology Course, 1st yr	UMass Medical School, Worcester	2 hours

2010-	HMS-II Human Systems: Endocrine Reproductive Course (IN757.0j)	Harvard Medical School	1 Hour
2010-	Mentor, "Introduction to the Profession" for HMS-1 student in first week	Harvard Medical School	2 hours
	Evaluator, Comprehensive Physical Exam by HMS-II and IV students using patient surrogates	Harvard Medical School	2 4-hour sessions
2009-2010	Mentor to Harvard Undergrad and summer fellowship sponsor for research project. Mentor to HMS-IV minority student function in preceptorship in GeMS program	Harvard University and Harvard Medical School	2 Summers
2011-	Mentor, HMS-I Clinical Casebook Project	1 student	2 academic year

Education of Peers

Years	*Topic*	*Audience*	*Institution*
1978, 1982, 1989, 1999, 2002, 2009	"Growth and Gender Identity Formation"	Post-grad Community pediatricians affiliated with Children's Hospital	Children's Hospital Boston

Formal Teaching of Residents, Clinical Fellows and Research Fellows Children's Hospital and Harvard Medical School:

Years	*Topic*	*Audience*	*Institution*
1976-2005	"Pubertal Issues"	House Officers and HMS students in Peds Clerkships/Electives Annual lecture	Children's Hospital Boston
1978-2009	Puberty, Genital Ambiguity or Gender Identity	Depts of Urology and Radiology Residents and attendings Annual lecture	Children's Hospital Boston
1990-2002	"Growth In Children"	Pedodontic and Orthodontic trainees Harvard Dental School Annual lectures	Harvard Dental School
1978-2000	"Adolescent Growth and Pubertal Maturation"	Postgraduate Course in Adolescent Medicine Annual Lecture to postgrad MD's	Adolescent/Young Adult Division, Children's Hospital Boston

- **Clinical Supervisory and Training Responsibilities**
- Supervise 12 Endocrine fellows, 2-4 medical students per month, and Endocrine and Reproductive/Gyn fellows from Harvard hospitals who rotate through Endocrine clinics.
- Supervisor to 9 Endocrine Nurses

Year		*Institution*
1976-92	Daily preceptor in Adolescent Clinic for HMS students, Residents and Fellows	Children's Hospital
1978-92	Inpatient attending physician, Teen medical service one month/year	Children's Hospital
1993-12	Preceptor for HMS students, Residents, Fellows from Children's and other HMS hospitals; General Endocrine Clinic ½ day per week and Gender Clinic ½ day per month	Endocrine Clinic, Children's Hospital Boston
1993-12	Inpatient attending, Endocrine Service precepting HMS and other students, Children's Hosp Residents and Fellows Fulltime responsibility 2-4 weeks/yr	Endocrine Clinic, Children's Hospital Boston
2000-10	Preceptor to Boston University Med Students doing their 3rd year Peds clerkship during a weekly 4 hr endocrine satellite clinic of Children's Hospital	Boston University Medical School
2002-03	Mentor for minority clerkship program	Harvard Medical School each summer
2004	Mentor, Pediatric Resident from Costa Rica	Ped Endocrinology Clinic, International Health Central American Institute Foundation
2007-08	Mentor to HMS minority student who is recipient of a Point Foundation Award and a Fulbright to study transgender care in Amsterdam	Harvard Medical School

2008	Mentor to Brown U. Med School minority student in 6 month weekly Elective in longitudinal care	Brown University Medical School
2010-11	Mentor to 2 Harvard undergraduates doing senior theses on gender studies	Harvard University
	Mentor to PhD Candidate from Columbia U. (from Teheran) studying transgender youth	Columbia University

Formally supervised trainees and faculty

2007-10 Stanley Vance, HMS '10, A Point Scholarship recipient (extremely competitive national award to a GLBT Scholar), has worked with me throughout medical school, has maintained a relationship with our Gender Management Service, and received a Fulbright (between HMS III and IV) with the Gender Program in Amsterdam, the Netherlands. I assisted him in developing contacts with my Dutch colleagues. He worked with me on a senior project and co-authored our paper in Pediatrics published in March 2012 (ref 5) reviewing the demographics of our GeMS Clinic. Dr. Vance began Pediatric Residency at UCSF in 2010 where he helped inaugurate a clinic for transgender youth modeled after the Amsterdam clinic and our own GeMS program. He began Adolescent Medicine Fellowship at UCSF in '13.

2007 Sandy Salsberg MD, fellow in Endocrinology at Boston Children's. Co-authored a chapter on "Galactorrhea" (ref 10) with me during fellowship.

2007 Liz Rosolowski MD and Ari Wassner MD each co-authored updated chapters with me on "Genital Ambiguity" for the Manual of Neonatal Care published by the Children's Hosp Dept of Neonatology (ref 9)

2009-2011: Laura Edwards-Leeper, PhD, former psychologist in our GeMS Program and, (since August
2011, a child psychologist at Seattle Children's Hospital and since August 2012, psychologist at major medical center in Portland OR), in transgender medical management. We co-authored book chapters in the Zuckerman-Parker Handbook of Developmental and Behavioral Pediatrics in 2010 (ref 12)and the American Academy of Pediatrics Textbook of Adolescent Health Care published in June, 2011 (ref 13) and the major article published in Pediatrics. (ref 5)

2012- Dan Shumer MD, current first year fellow in Endocrinology at Children's, co-authored an invited review article on transgender youth for "Current Opinion in Endocrinology and Metabolism", edited by Lynne Levitsky MD (ref 13). Dr. Shumer has been inspired by the work in the GeMS clinic, plans to do his research in his second and third years of fellowship, and I will be one of his mentors. Should he continue to maintain such interest in gender issues in

endocrinology, it is my hope that I will be mentoring him towards becoming Co-Director of GeMS-related clinical activities.

Local invited presentations:
(No presentations sponsored by outside entities)

Year	*Title*	*Institution*
2001	"Short Stature"	Children's Hospital Pediatric Post-Grad Course
2002	"Growth in Teen-age Years"	Plenary Symposium-PriMed Conference, HMS
2002	"Pubertal Delay and Growth Attenuation'	Post-Graduate Course, Children's Hospital
2003	"Pubertal Variability"	Lecture, Beth Israel Deaconess Hospital Reproductive Endocrine Lecture, Boston, MA
2004	" Gender Ambiguity to Gender Identity"	Lecture, Surgical Grand Rounds, Children's Hospital
2003	"Short Stature in Children – implications of recent FDA approval of Recombinant Growth Hormone"	Lecture, Pediatric Staff of Cambridge/Mount Auburn Hospital, Cambridge, MA
2004	"The Gender-Variant Child-Lecture, an Endocrinologist's Perspective"	Psychiatry Grand Rounds, Children's Hospital
2006	"Gender Identity Disorder in a Prepubertal Middle School Child"	Lecture, Developmental and Behavioral Pediatrics Program, Harvard Medical School
2006	"Gender Identity in Children and Adolescents"	Lecture, Dept of Medicine Grand Rounds, Children's Hospital
2006	"Treatment of Transgenderism"	Invited talk, Pediatric Endocrine & Reproductive Dept, Mass General Hospital, Boston, MA
2007	"Sexual Differentiation"	Lecture, Advanced Fetal Care Course, Children's and HMS
2007	"Ethics of Transgender Care"	Lecture, Swartz Rounds, Children's Hospital
2008	"Gender Identity in Children & Adolescents"	Lecture, Pediatric Grand Rounds, Mass. General Hospital, Boston, MA
2008	"Care of Transgendered"	Plenary speaker, Annual GLBT Luncheon, Beth Israel Deaconess Medical Center, Boston MA

2008	"Transgenderism"	Lecture, Firm Rounds, Dept of Medicine, Beth Israel Deaconess Medical Center, Boston, MA
2008	"Gender Identity in Children & Adolescents"	Lecture, Pediatric Grand Rounds, Mass. General Hospital, Boston, MA
2008	"Transgenderism"	Invited Lecture, Grand Rounds, Lowell General Hospital, Lowell, MA
2008	Symposium on Transgenderism	Invited Lecture, Mass Medical Society & Medical Student Section, Waltham, MA Should be under Sponsored Talks (lecture)
2009	"Complex Decision-Making in Patients With Disorders of Sex Development"	Lecture, Radiology Grand Rounds, Children's Hospital
2009	"Preventing Psychiatric and Physical Morbidity in Transgender Youth"	Invited Lecture, MIT Health Service, Cambridge, MA
2010	"Transgenderism"	Invited presentation, "Abnormal Psychology Course" for Upper-class students and Graduate Students, Dept. of Psychology, Harvard University, Cambridge, MA
2010	"Treatment of Transgenderism"	Lecture, Lunch-talk for HMS LGBT Association
2011	"A Case of Transgenderism"	Discussant, Longwood Psychiatry Grand Rounds "Clinical Crossroads" Presentation for publication in JAMA
2011	"Needs of Transgender Youth"	LGBT Organization, Harvard School of Public Health
2011	Panel Member on Trans Care	LGBT/Kinsey Organization Orientation Harvard Medical School
2012	"Evolution of the GeMS Program"	John F. Crigler Jr, MD Annual Lecture, Pediatric Grand Rounds, Children's Hospital, Boston, Boston, MA
2012	Transgender Care	Hospital staff Franciscan Children's Hospital, Brighton, MA
2014	Transgender Care	Regional Meeting, American Academy Clinical Endocrinology, Princeton NJ
2014	Transgender Youth	Pediatric Grand Rounds, St Francis Children's Hospital, Paterson NJ
2015	Transgender Youth	Wellesley College Seminar

Report of Regional, National, and International Invited Teaching and Presentations
(*no presentations below were sponsored by outside entities, e.g. industry)*
Local presentations:

2002	"Abnormal Growth in Adolescence"	Workshop, Society for Adolescent Medicine National Annual Meeting, Boston, MA
2006	"Transgender Adolescents"	Workshop, Society for Adolescent Medicine, Boston, MA
2009	"The Gender-Dysphoric Child and His/Her Family"	Invited Lecture, Annual Course on Child Development for Primary Care, Boston University, Boston, MA
2009	"Gender Identity in Children"	Invited Lecture, National Association of Nurse Practitioners Annual Meeting, Boston, MA

Regional presentations:

Year	*Title*	*Institution*
2000	"Transgenderism"	Ethics Grand Rounds, Lahey Clinic, Burlington, MA
2001	"Gender Identity Formation/Disorders"	Invited lecture, Demetriou Memorial Plenary address Annual meeting, New England Chapter, Society for Adolescent Medicine Boxborough, MA
2001	"From Gender Ambiguity to Transgenderism"	Invited Lecture, Pediatric and Medicine Combined Grand Rounds and Full-day Visiting Professorship, Maine Medical Center, Portland, ME
2001	"Gender Identity Formation: From Intersex to Transgenderism	Invited Lecture, Brown University Medical School/Rhode Island Hospital, Providence, RI
2002	"Klinefelter's Syndrome & Adolescence"	Lecture, New England Chapter, Klinefelter's Association
2007	"Transgender Youth"	Invited Lecturer, Hasbro Children's Hospital Brown Medical School, Providence RI
2011	"2 Day Visiting Professorship"	Pediatric Grand Rounds and Conferences, Dept of Pediatrics, University of Vermont Medical School, Burlington, VT
2011	"Transgender Youth"	Featured Speaker, Danbury Hospital Annual Pediatrics Course, Danbury, CT
April 2013	"Transgenderism, Medical Perspective"	Endowed All-Campus lecture, Williams College, Williamstown, MA
2012, 2013	Visiting Lectureship	School of Medicine, University of New England, Biddeford, ME
2014	Visiting Professorship Ped. and Adult Endocrinology	Maine Medical Center, Portland
2014	Visiting Plenary lecturer	Dartmouth Medical School

2015	Visiting Professor	U. of Miami Medical Center

Sponsored Talks

2008	Symposium on Transgenderism	Invited Lecture, Mass. Medical Society & medical Student section, Waltham, MA . Sponsor: Mass. Medical Society and by Student Chapter of Mass. Med Society
2012	"Bullies and Victims"	Panelist, Webinar Symposium Massachusetts Medical Society, Waltham, MA. Sponsor: Mass Med Society
2012	"Transgender for Primary Care"	Harvard "Pri-Med" lecture, Boston Sponsor: HMS Dept of Continuing Education

National invited presentations:

Year	*Title*	*Institution*
2007	"The Gender Management Service"	Workshop, Ped. Endocrinologists and Parents of Transgender Children, Oakland Children's Hospital, Oakland, CA
2007	"The Transgender Child"	Invited Lecturer, Pediatric Grand Rounds, Winthrop Hospital, Mineola, NY
2007	Symposium on Transgender Youth	Panelist, Biennial Conference of World Professional Association for Transgender Health, Chicago, IL
2008	Visiting Scholar and First Dan Gunther Memorial Endowed Annual Speaker	Department of Pediatric Endocrinology, Seattle Children's Hospital, Seattle, WA
2008	"Symposium on Gender Identity"	Invited Lecturer, Annual National American Academy of Child & Adolescent Psychiatry, Chicago, IL
2008	"Symposium on Transgender Youth"	Invited Lecture, Annual Meeting American Society for Adolescent Psychiatry, Boston, MA
2009	"Symposium on Neurobiology of Transgenderism"	Invited Lecturer, American Psychiatric Association, San Francisco, CA
2009	Presentation of the Endocrine Society Clinical Practice Guidelines on Endocrine Management of Transsexual Adolescents and Adults"	Invited symposium speaker, Endocrine Society Annual Meeting, Washington, D.C.
2009	"Treatment of the Transgendered"	Invited Plenary speaker, National Annual Meeting Gay and Lesbian Medical Association, Washington, D.C.
2009	"Transgender Care"	Visiting Lecturer at Dept of Pediatric Endocrinology & Dept of Human

		Resources, University of CA San Francisco, CA
2009	Combined Endocrine, Pediatric & Psychiatry Grand Rounds on "Transgender Youth"	University of Rochester School of Medicine on occasion of 40th Reunion of Class of '69, Rochester, NY
2010	"Meet the Expert"	Annual Meeting, American Assoc of Clinical Endocrinologists, Boston, MA
2013	"Transgender College Students"	Plenary Address, National Annual Meeting of American College Health Association, Boston
2013	"Transgender Youth" , Visiting Professor	Washington U Dept of Pediatrics and Cardinal Glennon Children's Hospital, St. Louis
2013 Conference	"Transgenderism"	Great Plains 2-day Ped Endocrine Kansas City, MO.
2013	Visiting Professorship	Morristown Medical Ctr, New Jersey
2014	Visiting Professorship	Dept Peds, UT Southwestern Med Ctr Dallas
2014	Pediatric Grand Rounds	St. Francis Children's Hospital Paterson NJ
2015	Panelist on Transgender Students	Barnard College Board of Trustees, NY
2015	Pediatric Grand Rounds	Maimonides Med. Ctr, Brooklyn NY
2015	Visiting Professorship	U. Miami Med Ctr, Dept of Peds

International invited presentations:

Year	*Title*	*Institution*
1993	"Update on Management of Type 1 Diabetes Mellitus in Children & Adolescents"	Invited Lecturer and Volunteer, Project Hope, Kiev, Ukraine
2003	"From Genital Ambiguity/intersex to Gender Dysphoria in Children & Adolescents – A Pediatric Endocrinologist's Perspective"	Platform presentation, Harry Benjamin International Gender Dysphoria Assoc. Bi-annual Meeting, Ghent, Belgium
2005	"An Approach to the Transgender"	Platform presentation, Consensus conference on Transgender Youth, Institute for Child Health, Great Ormond Street Hospital, London, England
2006	"How should we properly treat Transgender adolescents medically?"	Lecturer, International Conference on Transgenderism, 23rd International Lesbian and Gay Assoc. conference in Geneva, Switzerland
2006	"Potential Use of an Implantable long-lasting GnRH Analogue as an Adjunct to Treatment of the	Conference address, Research Symposium Free University of Amsterdam, The Netherlands

	Early Pubertal Transgender Adolescents	
2007	"Lessons from the Demographics of our Gender Management Service"	Featured speaker, Symposium on Medical Treatment of the Transgender Adolescent Imperial College, London, England
2009	"Rights of Transgender Youth"	Invited symposium speaker, 5th World Congress on Family Health and Children's Rights Halifax, Nova Scotia, Canada
2009	"Treatment of Transgender Youth"	Invited speaker, "Meet the Expert Section," Combined Meeting of Lawson-Wilkins Pediatric Endocrine Society (PES) & European Society for Pediatric Endocrinology (ESPE) New York City, NY
2010	"Gender Dysphoria in Youth: Diagnosis, Management, and Follow-up Data A Developmental Perspective"	Invited speaker on 3-person panel with Peggy Cohen-Kettenis, PhD (Amsterdam) and Kenneth Zucker, PhD (Toronto) Plenary Symposium sponsored by Lawson Wilkins Pediatric Endocrine Society at Pediatric Academic Societies' Annual Meeting, Vancouver, British Columbia
2011	"Treatment of Transgender Youth" (first time that transgender youth have been discussed at Endocrine Society "Meet the Professor" topic)	"Meet the Professor" Program Endocrine Society Annual Meeting, Boston, MA
2011	3-lecture speaking tour in Israel	1. Lecture to Pediatric staff of Tel Hashomer Children's Hospital, Tel Aviv 2. Lecture to Pediatric Endocrine Faculty, Hadassah Medical Center, Jerusalem 3. Keynote speaker, Annual meeting, Israeli Society for Pediatric and Adolescent Gynecology, Tel Aviv
2012	"Transgender Youth"	Society for Pediatric Urology State of the Art Plenary Atlanta, GA
2013	Hormonal action	Androgen Insensitivity Syndrome Organization International meeting, Boston
2013	Visiting Professorship Hosp for Sick Children Dept of Ped Endocrinology	Toronto, Canada
2014	Speaker, Symposium on Trans-Genderism, Endocrine Society	Annual Scientific Meeting, Chicago

2015	Symposium on Transgender	Pediatric Endocrine Society and Pediatric Academic Societies, San Diego

Clinical Activities:

Year (s)	Type of Activity	Name and location of practice	Level of activity
1978-1992	Attending Physician	Adolescent Medicine, Children's Hospital Boston	Half time
1978-98	Private Practice in Adolescent Medicine	Adolescent-Young Adult Medical Associates, Chestnut Hill, MA	Half time
1981-89	Staff Physician, Teen Pregnancy Program	Healthworks of Merrimack Valley	Half time
1993-1998	Attending Physician	Endocrinology, Children's Hospital Boston	Half time
1998-09	Private practice	Clinic for Adult Transsexuals, Chestnut Hill, MA	Monthly weekend sessions
1998-2006	Clinical Director	Endocrinology, Children's Hospital Boston	Full time
2007-2015	Co-Directorship	Gender Management Service (GeMS), Boston Children's Hospital	Full time

Current Licensure and Certification:

1975	Massachusetts Medical License, renewed 2014

Practice Activities:

Years	*Type of Activity*	*Name/location of practice*	*Level of Activity*
1978-95	Ambulatory Care	Adolescents Unit, Children's	4 sessions/week
1978-95	Ambulatory Care	Diabetes Clinic, Children's	1 session/week
1978-98	Ambulatory Care	Private Adolescent Practice	4 sessions/week
1995-11	Ambulatory Care	Endocrine Clinic, Children's	3-4 sessions/wk
2007-	Ambulatory Care	Gender Management Clinic Boston Children's Hospital	1 session/month

Clinical Innovations:

Innovation	*Description*

1976 First use of A1c test in a pediatric diabetes clinic	As a fellow with Kenneth Gabbay's Diabetes Program at Children's Hosp., I was member of 4-person team to analyze this test of diabetes control.
1977 Initiated first evening clinic at Children's Hospital Adolescent Unit	Enabled HMS IV students who had taken the 1 month elective course in Adolescent Med to follow their patients by attending clinical weekly.
1977 Initiated first formal relationship between Adolescent Unit and Bridge Over Troubled Waters, social service for street youth van	These street teens were medically disenfranchised, having broken ties with their families and health insurance. As a volunteer on their medical van, I arranged follow-up at Children's for medical problems beyond scope until ~ 1998 when Bridge established its own medical clinic
1978 Co-founded first free-standing Adolescent Medicine practice in New England with Dr. Estherann Grace	We undertook this novel venture, while maintaining a ½ time teaching commitment to Children's Hospital Adolescent Unit, with the support of Dr. Robert Masland, Chief of Adol Med. Patients were 11-25 years of age, many offspring of Harvard Med faculty. The Spack-Grace partnership lasted 20 years.
1985 First pediatrician in USA to publicly treat transgender adolescents and young adults	First contact with transgender patients was in the above private adolescent medicine practice.
1992-93 At age 50	Invited by Endocrine Chief, Dr. Joseph Majzoub, to join his Division half-time. I needed to retrain to complete requirements for PedEndo subspecialty Board exam (completed 1995)
1992 Became the first pediatrician in USA to develop a large practice of transgender *adults*	With the retirement of practitioners providing care, treating psychotherapists needed an MD a person to refer adult patients for hormonal/medical intervention. I was encouraged by Drs. Joseph Majzoub and John Crigler, to gain new insight into the field. I made it a monthly teaching clinic in my private office, bringing fellows in adult endocrinology from BIDMC and BWH who now see trans adults in Boston academic endocrine clinics.
2007 Co-Founded first combined clinic, GeMS (Gender Management Service), at a pediatric academic center, seeing transgender youth and infants, children and adolescents with Disorders of Sex Development	1-2 centers were seeing trans older adolescents and many had clinics for DSD children, but none in either hemisphere had combined them before
Developed first interdisciplinary team in a pediatric center in the USA to provide	We started with 35 patients; have treated 140 via various methods. Our protocols are being

comprehensive interdisciplinary evaluation and care for gender non-conforming children and transgender youth. We were the first to utilize the Amsterdam protocol using GnRH analogues to suppress puberty in highly selected subjects (2007)	copied by new programs in 8 major cities in US and Canada, with our consultation (see reference March Pediatrics 2012) Currently developing multicenter collaborative longitudinal outcome research with 3 other centers.
2008 Member of 8-person international Task Force appointed by the Endocrine Society President to write a manual of are of transsexual persons, including adolescents.	The Endocrine Society had previously shunned this topic. The monograph received the endorsement of most international endocrine societies. I received an award for my involvement from the Gender Identify Research and Education Society of the U.K. (GIRES)
2008 Member of 6-person Task Force, appointed by Director of Harvard University Health Services (HUHS), under mandate from the University President, to develop standards of care for transgender utilizers of the HUHS.(2008-12)	Previously, psychological counseling and hormonal Rx had already been provided. We utilized an evidence- based methodology to write guidelines under which HUHS would pay for mammoplastic and/or genitoplastic surgery. I still travel to HUHS to consult on individual cases.

Education of Patients and Service to the Community:

Year	*Title*	*Institution*
1975 – 85	Volunteer Physician	Bridge Over Troubled Waters, Boston, MA
1975	Lecturer	Various support groups on Adolescence, Diabetes Mellitus, Klinefelter's Syndrome, Genital Ambiguity and Gender Dysphoria
1980-85	Medical Advisory Board	Bridge Over Troubled Waters, Boston, MA
2003	"Medical Ethics in the BioTech Era" , Speaker	Jointly sponsored by Hebrew College & the Wilstein Institute for Jewish Public Policy Hebrew College, Newton, MA
2006	"Transgender Youth"	Regional TransHealth Conference Sponsored by PFLAG (Parents and Friends of Lesbians and Gays), Worcester, MA
2006	"Treatment of the Transgendered Adolescent"	Invited Lecturer, True Colors State-Wide Meeting on a Gender Variant Youth,

		New Britain, CT
2007	"Transgendered Youth"	Invited Lecturer, Grand Rounds, TransHealth National Conference, Philadelphia, PA
2008	"A Novel Approach to Transgender Youth" Invited Lecture,	Pride Day Sponsored by Project Aware, Bridgewater State College, Bridgewater, MA
2009	"The Gender Management Service" Invited Lecture,	Seminar with Laura Edwards-Leeper, PhD for students and faculty, Wheelock College, Boston, MA
2009	Testified in favor of anti-discrimination bill protecting rights of the transgendered before joint legislative committee, Massachusetts House and Senate, Boston, MA	
2009	Testified against an amendment to restrict public accommodation to transgendered before joint committee of Maine House and Senate, Augusta, ME	
2010	"The Transgender Student" Invited Lecture	Lesley University, Cambridge, MA
2010	Presentation to spouses/partners "Transgenderism in Youth"	American Assoc Clinical Endocrinologists, Boston, MA
2010	"The Biblical Mandate to Heal: A Guide to Treatment of Transsexuals" Lecture	Harvard Law School Jewish Students Association, Cambridge, MA
2010	Advisory Board	Camp Aranu'tiq for Transgender Youth
2011	"Your Transgender Child"	Maine Families with Transgender Children, Portland, ME
2011	"Transgender Youth" "Matters of Taste" guest speaker	Benefit for Jewish Community Day School, Watertown, MA
2011	"Medical Needs of Transgender Youth"	Panelist during 2-day symposium on GLBT Issues, Lambda Society, Harvard Law School, Cambridge, MA
2011	Sermon, Annual Reunion Service, "Not Standing Idly By"	Williams College, Willamstown, MA
2012	Discussant on film "Ma Vie en Rose"	Coolidge Corner Theatre "Science in Film" monthly series, Brookline, MA
2012	Keynote address on "Transgender Youth"	National Pathways to Adulthood Convening under auspices of the Children's Bureau, U.S. Dept of Health and Human Services, New Orleans, Louisiana
2012	Advisory Committee	Liaison between Boston Children's Hospital and Piers Park Sailing Center for disabled sailors, East Boston

2014	Consultant to Barnard College	Panel on the Transgender Undergraduate or applicant

Recognition:

2007 Millender Award, Combined Jewish Philanthropies "for service to medicine and to the Jewish Community of Greater Boston"
2007 AGA Vision for Change Award "For outstanding contributions to the care of those with variations in gender identity and sexual development," New Brunswick, NJ
2009 Authors' Award GIRES (Gender Society) of UK for co- authorship of Endocrine Society Guidelines
2009 Levi Award Boston Alliance for Gay/Trans Youth for leadership in transgender care
2010 "Prism" Award Children's Hospital Boston GLBT and Friends Committee service to Trans youth
2011 Selected by Williams College Chaplain and Alumni Leadership to deliver sermon at memorial service concluding annual reunion
2012 Bicentennial Medal from Williams College to 5 alumni/year for lifetime achievement in a field of endeavor (transgender care/advocacy)
2012 Honoree, Jewish Alliance for Law and Social Action (JALSA) of New England, Boston Advocacy for transgender advocacy
2015 Honoree, Keshet (Rainbow) annual gala, Combined Jewish Philanthropies of Greater Boston's outreach to the GLBT community

Media Acknowledgement:

2002, 06, 2008-12 Listed among "Best Doctors in Boston" by Boston Magazine

2007 Consultant National Public Radio "On Point" show. Subject: local physician who gender-transitioned

2007 Interviewee/consultant ABC 20/20 Barbara Walters' Program on Transgendered Children

2008 Consultant and interviewee National Public Radio "All things Considered" Subject transgender children. Selected by NPR staff for compilation CD of best segments aired in past 5 yrs.

2008 Subject/interviewee Boston Globe, Time, Phila Inquirer, The Guardian (UK), London Times, The Atlantic and NY Times

2008 Interviewee New Scientist (UK) Magazine article on Controversies in care of transgender adolescents
2009 Interviewee Philadelphia Inquirer feature on Transgender Adults

2009 Interviewee BBC World Service, on Transgender Youth

2010 Interviewee WBUR-FM, Boston NPR affiliate, on summer camp for Transgender Youth

2010 Interviewee WCVB-TV (Boston) "Chronicle," nightly magazine show on Transgenderism

2010 Principal Subject "Different," article on Transgender youth Dream Magazine, Children's Hospital Publication

2011 Transgenderism Speaker, dinner program, Jewish Community Day School of Greater Boston
2011 Transgender youth Interviewee, Maclean's, Canada's national weekly Magazine
2011 Principal subject Front page story by Bella English, Boston Globe
2011 Interviewee National Public Radio by Emily Rooney, concerning Globe article
2012 Principal subject Column for international distribution to Jewish press Jewish Telegraphic Agency
2012 Interviewee "Dateline NBC" on gender non-conforming 10 yr old

2012 Principal interviewee Washington Post article on Transgender youth
2012 Principal subject "The Metamorphosist", Boston Phoenix
2012 Principal subject Article, Boston's Jewish Advocate weekly newspaper
2012 Interviewee Cover Story on "Transgender Youth and Pubertal Suppression", Endocrine News (Endocrine Society monthly), Jan 2013 2
2013 Interviewee Article on transgender youth in The Economist magazine
2014 Speaker TedTalk International Presentation on Transgender Youth (over 1 million views)
2015 Featured interviewee Diane Sawyer ABC-TV 2 hour interview of Bruce/Caitlyn Jenner
2015 Panelist Charlie Rose PBS show co-hosted by Eric Kandel MD, Nobel Laureate in Medicine Physiology, on subject of Gender and the Brain. 4 other panelists were basic scientists.

Report of Scholarship

Peer-Reviewed Publications in print or other media.

Research investigations:

1. Gabbay KH, **Spack NP**, Loo S. Hirsch HF and Ackil A. Aldose Reductase Inhibition: Studies with Alrestratin. Metabolism 1979; 28 (4): 471 – 6.
2. Feke GT, Buzney SM, Ogasawara H, Fujio N, **Spack NP** and Gabbay KH. Retinal circulatory abnormalities in type 1 diabetes. Investigative Ophthalmology & Visual Science 1994; 35: 2968-75
3. Poussaint TY, Barnes PD, Anthony DC, **Spack NP**, Scott RM, Tarbell NJ. Hemorrhagic

pituitary adenomas of adolescence. American Journal of Neuro-radiology 1996; 17: 1907-12.

4. Goddard DS, Liang MG, Chamlin SL, Svoren BM, **Spack NP**, Mulliken JB. Hypopituitarism in PHACES Association. Pediatric Dermatology,2006; Sept-Oct;23(5):476-80
5. **Spack NP**, Edwards-Leeper L, Feldman HA, Leibowitz S, Mandel F, Diamond DA, Vance SR.
   Characteristics of children and adolescents with gender identity disorder referred to a pediatric medical center. Pediatrics 2012; 129(3): 418-425.

Other peer-reviewed publications:.

1. Perrin E, Smith N, Davis C, **Spack N**, Stein MT. Gender variant and gender dysphoria in two young children. J Dev Behav Pediatr. 2010. 31(2):161-4.

2. **Spack, NP**, Clinical Crossroads, Management of Transgenderism. JAMA 2013.209 (5): 478-484.

Clinical Guidelines:

1. Lee PA, Houk CT, Ahmed SF, Hughes IM in collaboration with participants* in the International Consensus Conference on Intersex organized by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. Consensus statement on management of intersex disorders. Pediatrics 2006; 118 (2): e488-500 (*participant cited in Acknowledgements section of paper)
2. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ, **Spack, NP**, Tangpricha V, and Montori VM. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. J Clinical Endocr Metab, 2009. 94 (9): 3132-54.

Reviews, Chapters, Monographs, and Editorials

Chapters and review articles

1. Grace E, **Spack N**. Teaching teenagers to cope. Internist. 1979. (20)8:6-8.
2. **Spack NP**. Recent advances in the care of children with diabetes mellitus. Pediatrics in Review 1980; 1: 259.
3. **Spack, NP**. Diabetes in adolescence. In: Kulig JW (ed.) Acute and chronic medical disorders, adolescent medical disorders. Adolescent Medicine: State of the Art Reviews. 1991: 523 – 538.
4. **Spack NP**. Medical problems of the exercising child: asthma, diabetes and epilepsy. In: Micheli L, (ed.) Pediatric and Adolescent Sports Medicine. Boston, Little, Brown and Company, pp. 124-133, 1984.
5. **Spack NP**. Juvenile diabetes mellitus. In Manual of Pediatric Therapeutics. In: Graef J and Cone TEC (eds.) Boston, Little, Brown and Company, 1985.

6. **Spack NP.** Medical aspects of anorexia nervosa and bulimia. In: Emmett SW (ed.) Eating Disorders. New York: Brunner/Mazel, 1988.

7. **Spack NP**, Neinstein LS. Galactorrhea. In: Neinstein LS (ed.) Adolescent Health Care: A Practical Guide (4th Edition). Philadelphia, Lippincott Williams & Wilkins Co, pp. 1043-1050, 2002.

8. **Spack NP**. Transgendered Youth. In: Perrin E, Sexual Orientation in Child and Adolescent Health Care. New York, Kluwer Academic/Plenum Publishers, 2002.

9. Rosolowski E and **Spack NP**. Disorders of Sex Differentiation. In: Cloherty JP et al (eds) Manual of Neonatal Care. 2008 Wassner A and **Spack NP**. Disorders of Sex Differentiation. (revision of Rosolowski and Spack chapter): In: Cloherty JP and Stark A et al (eds) Manual of Neonatal Care Philadelphia, Lippincott Williams & Wilkins, 2011, Philadelphia, Lippincott Williams & Wilkins,

10. Salsberg SL and **Spack NP**. Galactorrhea. In Neinstein LS et al (eds.) Adolescent Health Care. (5th Edition). Philadelphia, Lippincott Williams & Wilkins Co., 2008

11. **Spack NP**. An endocrine perspective on the care of transgender adolescents. Journal of Gay & Lesbian Mental Health.2009; 13:309-319.

12. Edwards-Leeper L and **Spack NP**. Gender Identity Disorder. In Augustyn M et al (eds.). The Zuckerman Parker Handbook of Developmental and Behavioral Pediatrics for Primary Care, 3rd edition. Philadelphia, Lippincott Williams & Wilkins, 2010.

13. **Spack NP** and Edwards-Leeper, L. Medical Treatment of the Transgender Adolescent. In Fisher M, et al (eds,) Textbook of Adolescent Health Care , American Academy of Pediatrics, 2011,

14. Leibowitz S and **Spack N**. The development of a gender identity psychosocial clinic: treatment issues, logistical considerations, interdisciplinary cooperation, and future initiatives. Child and Adolescent Psychiatric Clinics of North America. 2011. 20(4): 701-24

15. Edwards-Leeper L and **Spack N**. Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service-(GeMS)" in a major pediatric center. J. Homosexuality. 2012; 59:321-336.

16. Shumer D and **Spack N.** The Approach to Transgender Youth. Levitsky, Lynne (Ed.) Current Opinion in Endocrinology, Diabetes and Obesity. Wolters Kluwer/Lippincott Williams and Wilkins 2013. 20:69-73.

Monographs:

1. **Spack NP**. Transgenderism. Lahey Clinic Medical Ethics. 2005. 12(3). Fall issue. D. Steinberg, editor. Biomedical Ethics-A Multidisciplinary Approach to Moral Issues in Medicine and Biology. Hanover, University Press of New England 2007.

Educational Materials:

1. Masland RP, **Spack NP**, Grace EM. The Challenge of Adolescent Medicine (videotape). Network for Continuing Medical Education, 1978.
2. **Spack NP**. Chronic Illness in Adolescents (videotape). Network for Continuing Medical education, 1979.
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Narrative report of Research, Teaching, and Clinical Contributions.

Since 2000, I have been developing standards of care for transgender teens and young adults. I was the first USA pediatric endocrinologist to adopt Dutch protocols for pubertal suppression. In 2007 I co-founded the novel Gender Management Service (GeMS) at Children's for Disorders of Sex Development (DSD) and Gender Identity Disorders (GID).

These interests developed from 1974-1998 as a Fellow/Attending in Adolescent Medicine and Endocrinology. From 1978-1998, I managed a private practice in Adolescent Medicine while half-time at Children's. 1998-2006, I was the Endocrine Division's Clinical Director. I spent 60% of time in clinical care, 20% in teaching, 10% in administration, 5% in clinical research, and 5% in other professional roles. I was course director of an HMS elective in Pediatric Endocrinology for nine years, and a member of the HMS Admissions Committee, 2006-09. In 2011 I forged links with Fenway Health for training and collaborative regional conferences.

I have contributed to task forces, meetings, and workshops: The 2005 international Task Force on Intersex Disorders of the North American and European Pediatric Endocrine Societies, whose guidelines were published in *Pediatrics* and *Archives of Disease in Childhood in 2006*, and the Endocrine Society's international Task Force in 2007, whose guidelines on treatment of transsexuals were published in *J Endocrin & Metab* September, 2009. I was appointed to a Task Force on care of transgender members of Harvard University Health Service. I have been keynote/plenary speaker at regional, national, and international meetings. I have published on transgenderism, including an award-winning publication for a collection of articles from the *Lahey Clinic Medical Ethics Journal*. I am first-author of the first article about transgender youth published in *Pediatrics* in March, 2012. I have been featured in national and international major newspapers and magazines, *NPR,* and local and national television; a 2008 interview received a national award from the NPR staff.

I introduced Gender Identity into the HMS curriculum in the Reproductive-Endocrine Physiology 2nd year course, receiving the highest ratings. HMS students attend the GeMS clinic. One mentee did a Fulbright with my Amsterdam colleagues and is now modeling our program at UCSF.I teach transgenderism at other medical schools and was "visiting professor" at five pediatric academic centers. I have helped new transgender programs at HUHS (Harvard), Hasbro Children's, NYU Pediatrics, DC Children's, CHOP, Chicago Memorial, Vancouver Children's, Seattle Children's, UCSF, L.A. Children's, Maine Medical Center, and Hospital for Sick Children, Toronto.

I was trained at Rochester in behavioral medicine by George Engel, MD and in endocrinology by Seymour Reichlin, MD. At Children's I was taught adolescent medicine by Robert Masland, MD and pediatric endocrinology by John Crigler, MD. I learned about Gender Identity Disorders from Dan Federman, MD. My career has progressed from local, regional, and national acknowledgment to international recognition as a leading expert in transgender medicine. I have relinquished my administrative duties in the Endocrine Division to devote all of my energies to care of transgender youth in Boston and nationally. We will soon begin a 4-site consortium longitudinal study of transgender youth supported by an NIH 5-year R-01 and I will be local PI.

EXHIBIT

B

SPECIAL FEATURE

Clinical Practice Guideline

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

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

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

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

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

Summary of Recommendations

1.0 Diagnostic procedure

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

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

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

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

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

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

2.0 Treatment of adolescents

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

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

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

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

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

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

3.0 Hormonal therapy for transsexual adults

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

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

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

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

4.0 Adverse outcome prevention and long-term care

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

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

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

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

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

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

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

5.0 Surgery for sex reassignment

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

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

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

Introduction

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

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

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

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

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

TABLE 1. Definitions of terms used in this guideline

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

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

Etiology of Gender Identity Disorders

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

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

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

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

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

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

Method of Development of Evidence-based Clinical Practice Guidelines

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

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

1.0 Diagnostic procedure

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

Diagnostic assessment and psychotherapy

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

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

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

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

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

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

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

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

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

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

Codes based on current age:
   302.6 GID in children
   302.85 GID in adolescents or adults
Specify whether (for sexually mature individuals):
   Sexually attracted to males
   Sexually attracted to females
   Sexually attracted to both
   Sexually attracted to neither

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

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

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

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

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

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

The real-life experience

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

Eligibility and readiness criteria

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

TABLE 4. Hormone therapy for adults

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

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

TABLE 5. Hormone therapy for adolescents

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

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

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

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

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

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

1.1 Recommendation

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

1.1 Evidence

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

1.1 Values and Preferences

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

1.2 Recommendation

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

1.2 Evidence

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

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

1.2 Values and Preferences

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

1.3 Recommendation

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

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

1.3 Remarks

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

1.4 Recommendation

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

1.4 Remarks

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

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

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

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

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

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

2.0 Treatment of adolescents

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

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

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

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

2.1–2.2 Recommendations

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

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

2.1–2.2 Evidence

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

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

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

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

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

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

2.1–2.2 Values and Preferences

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

2.1–2.2 Remarks

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

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

2.3 Recommendation

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

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

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

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

Adapted from Ref. 62.

2.3 Evidence

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

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

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

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

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

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

[a] Adapted from Ref. 63.

[b] Adapted from Ref. 59.

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

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

2.3 Values and Preferences

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

2.3 Remarks

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

TABLE 8. Follow-up protocol during suppression of puberty

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

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

2.4 Recommendation

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

2.4 Evidence

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

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

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

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

TABLE 9. Protocol induction of puberty

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

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

2.4 Values and Preferences

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

2.4 Remarks

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

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

TABLE 10. Follow-up protocol during induction of puberty

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

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

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

2.5–2.6 Recommendations

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

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

2.5–2.6 Evidence

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

3.0 Hormonal therapy for transsexual adults

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

3.1–3.3 Recommendations

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

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

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

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

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

3.1–3.3 Evidence

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

FTM transsexual persons

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

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

TABLE 12. Hormone regimens in the transsexual persons

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

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

[b] Not available in the United States.

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

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

MTF transsexual persons

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

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

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

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

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

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

3.1–3.3 Values and Preferences

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

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

3.1–3.3 Remarks

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

3.4 Recommendation

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

3.4 Evidence

FTM transsexual persons

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

MTF transsexual persons

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

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

TABLE 13. Masculinizing effects in FTM transsexual persons

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

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

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

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

TABLE 14. Feminizing effects in MTF transsexual persons

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

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

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

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

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

3.4 Values and Preferences

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

4.0 Adverse outcome prevention and long-term care

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

4.1 Recommendation

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

4.1 Evidence

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

FTM transsexual persons

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

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

MTF transsexual persons

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

4.2 Recommendation

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

4.2 Evidence

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

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

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

4.3 Recommendation

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

4.3 Evidence

FTM transsexual persons

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

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

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

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

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

[a] Adapted from Refs. 83 and 85.

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

MTF transsexual persons

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

4.4 Recommendation

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

4.4 Evidence

FTM transsexual persons

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

MTF transsexual persons

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

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

4.5–4.6 Recommendations

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

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

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

4.5–4.6 Evidence

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

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

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

4.7 Recommendation

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

4.7 Evidence

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

4.7 Values and Preferences

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

4.7 Remarks

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

5.0 Surgery for sex reassignment

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

TABLE 17. Sex reassignment surgery eligibility and readiness criteria

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

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

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

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

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

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

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

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

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

5.1–5.3 Recommendations

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

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

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

5.1–5.3 Evidence

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

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

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

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

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