



[Education](#)

A Guide for Working With Transgender and Gender Nonconforming Patients

Many health care professionals will likely provide services to at least one transgender and gender non-conforming (TGNC) patient during their career. TGNC individuals are now more accepted by society as overall awareness of this historically marginalized group increases. However, some health care professionals — including psychiatrists — do not think they are qualified to provide health care services to TGNC individuals, and thus shy away from doing so. To improve services and access to mental health care for TGNC individuals, it is critical more psychiatrists become familiar with the history and culture of this population and best practices for treatment.

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About the Guide

This introductory guide offers an array of topics that will be essential in understanding how to work with TGNC patients. It provides basic information to raise awareness of the needs of TGNC patients and how to incorporate gender-affirming care in psychiatric practices.

This toolkit does not represent official APA policy, but offers a perspective from physicians that work with this community on a regular basis. The objective of this toolkit is to help a broader range of psychiatrists become familiar with best practices for treating TGNC patients. Psychiatrists can consult [Resources & References](#) section for further reading.

Disclaimer

Although TGNC patients have been treated psychiatrically, medically, and surgically for the past 100 years, standards of care regarding this patient population are still in infancy. Thus, research is still needed to develop more effective treatment.

Many experts have studied gender and sexuality throughout their careers. This toolkit represents just one view of how to work with TGNC patients, based largely on the [WPATH Standards of Care](#). This toolkit aims to provide a progressive treatment approach that will allow clinicians to treat TGNC patients with respect and with a focus on preserving patient autonomy.

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Management of Transgenderism

Norman P. Spack, MD, Discussant

DR TESS: Ms L is a 54-year-old biological male who self-identifies as a woman and is considering surgical removal of her penis and construction of a vagina. Ms L lived her early life as a boy and as a heterosexual male adult.


Around age 10 years, Ms L realized that despite being a boy, he enjoyed dressing in women's underwear and clothing. As a young man, Ms L married and fathered a child. Ms L married again as a heterosexual male but sought psychotherapy to address relationship issues. After 3 years, Ms L's therapy was centered around issues of cross-dressing; he came to understand, with the help of a therapist and cross-dressing and transgender support groups, that she is actually a woman. She sought hormone treatment to begin to change her appearance and match gender identity. She is happy with the effects of hormone therapy but is considering surgical treatment.

Ms L's medical history is significant for benign prostatic hyperplasia, borderline hypertension, migraine headaches, and a vasectomy. Her current medications include intramuscular estradiol valerate, 10 mg every 2 weeks; oral spironolactone, 75 mg/d; oral estradiol, 1 mg twice a day; and oral finasteride, 5 mg/d. Her mother died of postmenopausal breast cancer and her father had prostate cancer and died at age 61 years of heart disease. Ms L's daughter has been diagnosed as having depression and attention-deficit/hyperactivity disorder.

Ms L has only had sexual intercourse with women (when she self-identified as a heterosexual male). Ms L has not had problems with drugs or alcohol. She is self-employed, and she does not have health insurance.

Ms L is white, is 70 in tall, and weighs 161 lb. She has male-pattern baldness with mild to moderate hair loss around the edges of her crown. Her breasts did not show any masses and she has no axillary lymphadenopathy. Her testicles are atrophied. Her prostate is very mildly and symmetrically enlarged.

With estrogen therapy, her free testosterone level is nearly undetectable, prolactin and thyrotropin levels are within normal limits, and estradiol level is 66 pg/mL (reference range for adult men, 8-43 pg/mL). Her total cholesterol is 117 mg/dL (3.03 mmol/L); low-density lipoprotein cholesterol, 51 mg/dL (1.32 mmol/L); and high-density lipoprotein cholesterol, 51 mg/dL (1.32 mmol/L).

 CME available online at www.jamaarchivescme.com and questions on p 493.

Gender identity disorder (transgenderism) is poorly understood from both mechanistic and clinical standpoints. Awareness of the condition appears to be increasing, probably because of greater societal acceptance and available hormonal treatment. Therapeutic options include hormone and surgical treatments but may be limited by insurance coverage because costs are high. For patients seeking male-to-female (MTF) change, hormone treatment includes estrogens, finasteride, spironolactone, and gonadotropin-releasing hormone (GnRH) analogs. Surgical options include feminizing genital and facial surgery, breast augmentation, and various fat transplantations. For patients seeking a female-to-male (FTM) gender change, medical therapy includes testosterone and GnRH analogs and surgical therapy includes mammary and phalloplasty. Medical therapy for both FTM and MTF can be started in early puberty, although long-term effects are not known. All patients considering treatment need counseling and medical monitoring.

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www.jama.com

MS L: HER VIEW

I actually had issues all my life around my gender identity. As a child, I wanted things a neighbor friend used to tell me were incorrect; I wanted to play house and wanted to have a baby when I got older.

I identified as a cross-dresser from an early age until my late 40s. While in therapy, I realized that I am not a cross-dresser but what I call "transgender." Before I started hormones, I realized, I don't really have 2 genders. I really have 1. I'm really female.

The first people I told were close friends; they were very understanding. There has been some rejection and loss, but the acceptance and the strengthening of relationships, certainly with women, has been tremendous. My social circle

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has increased. Within my own family, it has been a hard aspect for them to accept.

I started with spironolactone without estrogen. The effect for me was a lack of drive or energy. But when the estrogen started, it was wonderful; it just felt like it was more and more me. I'm extremely happy. A lot of wonderful feelings and changes accompany it, not just on the physical level, but emotionally and mentally.

My hopes are actually just to have the female genitalia, for both a social and a sexual life. I'm looking forward to that very much—being able to have identification that matches who I am. And I look forward to having a sexual relationship as a female.

I'm a little bit nervous about complications if I were to pursue surgery. My understanding is that it takes about 3 to 6 months to start to feel yourself, and anywhere from 6 months to a year to have a complete recovery. So those are things that I'm not really looking forward to.

AT THE CROSSROADS: QUESTIONS FOR DR SPACK

How often and when do patients seek to affirm an identity of the opposite gender? What is the current understanding of the mechanism by which patients identify with the opposite gender? What are the medical options for male-to-female (MTF) therapy in adolescence and adulthood? What are the medical options for female-to-male (FTM) therapy in adolescence and adulthood? What surgical options exist for transgender patients and what are the costs? What are the important unanswered questions about transgender individuals? What do you recommend for Ms L?

DR SPACK: Ms L's situation is similar to many but not all who have an adult presentation, having cross-dressed as a child, married as a man, and fathered a child while feeling uncomfortable *being* a man. She is taking customary high-dose estrogen to suppress testosterone production and using potentially high-risk estrogen injections despite a family history of early coronary artery disease and breast cancer. She is contemplating feminizing genitoplasty surgery, although she has no specific plan and uncertain resources. Although she began to seek counseling only in her 40s in spite of conflicts about her gender throughout her life, 3 years of psychotherapy facilitated her physical and social transition.

PATIENTS SEEKING GENDER IDENTITY CHANGE

The basic nomenclature around gender identity and patients' desire to affirm the identity of the opposite gender can be confusing (**BOX 1**). Transgenderism refers to an informal diagnosis that describes individuals like Ms L, whose gender identity (the inherent sense of being male or female) differs from their biologic sex.

An accurate assessment of the prevalence of transgenderism in the United States is limited by the lack of case registries or a single national health insurance plan. In the Netherlands, the prevalence of transsexualism is 1 in 11 900

Box 1. Definitions

Sex: Refers to the physical genotype and phenotype, without regard to the sense of self.

Gender identity: Inherent sense of being male or female regardless of genotypic, phenotypic, or biochemical sex. Also referred to as **affirmed gender**.

Transgender: An informal diagnosis to describe those whose gender identity is different from their biologic sex.

Transsexual: Term typically ascribed to adults committed to making their bodies congruent with their gender identity.

Gender identity disorder: Formal diagnosis for the above conditions, according to the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition). This is a psychiatric diagnosis, so medical/surgical treatment is often not covered by health insurance.

Cross-dresser (transvestite): An individual who derives pleasure from dressing in clothes of the opposite sex (usually a genotypic male wearing female attire). Cross-dressers usually retain a gender identity consistent with genotypic sex and have no wish for anatomical change.

Sexual orientation: The sex that a person is physically attracted to, without regard to gender identity. In their affirmed gender, transgender individuals may be straight, gay, bisexual, or asexual.

genotypic men and 1 in 30 400 women.¹ Former data in the United States were unfortunately based on prevalence of feminizing genitoplasty surgeries (sex reassignment surgery). These are expensive and not covered by insurance; many patients forgo it. Therefore, these studies may have underrepresented the true prevalence of transgenderism.

About 66% of adult transsexuals report an onset of gender dysphoria in childhood, as was the case for Ms L; for the remainder, dysphoria develops later in life.² Virtually every program for under-21-year-olds finds an equal MTF-FTM sex ratio, yet adult clinics typically record 3 to 1 in favor of MTF. Many circumstances, however, may bias the data.^{3,4} Male-to-female adolescents are at extreme risk of bullying and violence, which may delay "coming out." Because androgyny in females is more accepted in US society, younger patients may be less aware whether they are lesbian, androgynous, or truly FTM and eventually desirous of mastectomy and testosterone treatment.

There is a perceptible increase in the number of people in the United States coming forward as transgender, and at younger ages. Statistics are limited by variability in the services available that facilitate identification of transgender youth and by cultural factors that inhibit people in some subpopulations from being identified prior to adulthood.⁵ Some early school-aged children's parents insist that their offspring affirm the gender identity of their genetic sex from the very first gender-specific behaviors and preferences.⁶ Although 80% of such gender-nonconforming children may not be transgen-

Box 2. Current Recommendations for Treatment of Transgender Adults¹

Initial diagnosis: Mental health care professionals should follow the World Professionals Association for Transgender Health's standards of care⁹ to accurately diagnose gender identity disorder.

Psychotherapy: Individuals with gender identity disorder often have other psychosocial or psychiatric issues. Psychotherapy should assess the influence of these conditions on an individual's diagnosis as well as allocate appropriate treatment for all diagnoses.

Real-life experience: Individuals seeking medical treatment should first live in the desired gender role for 12 months before beginning medical, irreversible treatment.

Hormone therapy: Once the diagnostic criteria have been met, the treating endocrinologist can begin the proper cross-sex hormone treatment and/or hormone depletion. The endocrinologist should monitor the physical changes of the patient.

Surgery: Endocrine guidelines recommend that after 1 year of hormone treatment, the transsexual individual, the attending endocrinologist, and the mental health care professional may consider sex reassignment surgery.

der at the onset of puberty, many are homosexual or "gender2 queer" as adolescents and adults (gender queer individuals see themselves within a continuum between male and female; some reject the concept of gender identity as binary). The 20% who persist as transgender become increasingly gender-dysphoric at the onset of Tanner stage 2 puberty (in genetic girls, ages 10-12 years, with breast development; in genetic boys, ages 12-14 years, with doubling/tripling of testicular size) and almost never desist from being transgender.^{3,7} Greater openness to and acceptance of sexual orientation and gender variance and positive depictions of transgender people in the media contribute to patients expressing their gender identity and/or role at an earlier age. Parental and public awareness of medical treatments, such as gonadotropin-releasing hormone (GnRH) analog therapy to block the onset of genetic puberty, give the impression that the incidence of transgender children is increasing.⁸ Increasingly, colleges and universities are providing counseling and hormone therapy and a few offer the full array of surgeries with university health insurance. A list of websites relating to transgenderism education and treatment is given in the eBox (available at <http://www.jama.com>).

The diagnosis of gender identity disorder (according to the *Diagnostic and Statistical Manual of Mental Disorders* [Fourth Edition]) requires a series of evaluations by mental health care professionals (BOX 2). At the Gender Management Services Clinic at Boston Children's Hospital, patients must provide a letter of referral from a mental health care clinician who has seen the patient for at least 6 months and complete approximately 6 hours of psychological evalu-

ation, including family member participation, before beginning any hormone therapy.

Because the presentation of adults is idiosyncratic, academic psychologists have also developed subcategories for their diagnoses. These classifications may be extremely important to the therapists working with them, but the main relevance to their medical and surgical clinicians is whether a mental health care clinician has referred the patient as a candidate who meets the standards for hormone and/or surgical intervention.⁹

MECHANISMS BY WHICH PATIENTS IDENTIFY WITH THE OPPOSITE GENDER

Biologic mechanisms remain elusive. The phenomenon, like homosexuality, is not limited by geography or era; there are reports of people living in the opposite gender throughout history.

No studies have documented a relationship between transgenderism and maternal-fetal hormonal milieu. Female infants with congenital adrenal hyperplasia who are exposed to the highest continuous fetal androgen concentrations may be profoundly genitally affected, yet the overwhelming majority retain a female gender identity throughout life.¹⁰ Some infant genetic males with disorders of sex development with hormonally functional testes in utero have undergone gonadectomy and sex reversal shortly after birth because of a lack of genital anlage to form male genitals. Many of these children remain in their female identity, suggesting that gender identity may be malleable in some cases and for a finite time.¹¹

Recent pathologic and nuclear magnetic resonance imaging studies suggest that transgenderism may be linked to alterations in the brain. A sexually dimorphic area in the hypothalamic bed nucleus of the stria terminalis is typically twice as large in biological males. In stained autopsy slices from 30- to 40-year-old MTF transsexuals, the nucleus is female sized. Change in size may not be attributable to estrogen use—in nontranssexual men taking estrogen for years who died of prostate cancer, similar slides showed no change. Similar concordance with genetic sex rather than environmental hormone exposure has been seen in virilized women who died of adrenal cancer.¹² A recent nuclear magnetic resonance imaging study described 4 sex-specific areas of the human brain. Transgender individuals studied before the administration of any hormones had brain regions consistent with their affirmed gender, not their genotypic sex.¹³ Studies of identical twins, who share the transgender diagnosis far more than fraternal twins or siblings, suggest that genetics play a major role in the etiology of transgenderism.¹⁴

MEDICAL OPTIONS FOR MTF THERAPY IN ADOLESCENCE AND ADULTHOOD

Transgender patients choose a variety of approaches to feel comfortable with their outward appearance. Some adult pa-

Table. Hormone Therapy and Hormone-Blocking Drugs in Transgender Patients

Hormone	Dosage	Approximate Cost	Comment
Male to female			
Estrogen			
Oral estradiol	2.0-8.0 mg/d	\$1 per 2-mg tablet	
Transdermal estradiol patch	0.1-0.4 mg twice weekly	\$39 per eight 24-h patches	
Parenteral estradiol valerate	5-30 mg intramuscularly every 2 wk	\$200 per 15-mL vial	40 mg/mL
Antiandrogens			
Spironolactone	100-200 mg/d	\$56 per one hundred 100-mg tablets	
Gonadotropin-releasing hormone agonist	3.75 mg intramuscularly monthly	\$150-\$250 per injection	Both analogs are used off label
Leuprolide	7.5 mg intramuscularly monthly	\$350-\$550 per injection	
Histrelin implant	Subcutaneous implant	\$2800-\$5500 per implant	Implant releases 50 µg/d; each implant lasts 24-30 mo
Progesterone	20-60 mg/d	Minimal	Decreased bone density, altered lipid profile, obesity
Finasteride	1 mg/d	Variable	For balding
Female to male			
Parenteral testosterone			
Testosterone enanthate or cypionate	100-200 mg intramuscularly every 2 wk or 50-100 mg subcutaneously or intramuscularly weekly	\$53-\$87 per 200-mg/mL for 10-mL vial	10-mL vial
Testosterone gel, 1%	2.5-10 mg/d	\$330 per thirty 5-mg tubes	Patients using patches/gels tend to experience more breakthrough bleeding. Four pumps/d.
Testosterone patch	2.5-7.5 mg/d	\$2-\$10 per patch	Usual dosage is 5 mg/d and each patch is changed daily. Often an irritant.

tients are content or feel coerced to remain in the gender role of their natal sex because of family or social circumstances. Others, such as genotypic males with a slim frame, a height less than 73 in, soft facial features and vocal pitch, a relatively nonprominent “Adam’s apple,” relatively sparse and light facial hair, and no male-pattern balding have major cosmetic advantages. Some may only take cross-gender sex steroids but dress in a natal or androgynous style. For those who desire medical therapy, options include estrogens, finasteride, spironolactone, and GnRH analogs for MTF patients. Hormone therapy for adults has permanent effects and should be preceded by at least 1 year of counseling and living full-time in the gender role of the affirmed sex.¹⁵ Results of use of hormone agents are highly variable for fully mature genetic male adults. The overall goal is to achieve phenotypic feminization and decrease the virilizing effects of endogenous testosterone. Endocrinologists should continuously monitor the health effects of these therapies (TABLE and BOX 3).

Estrogen is used to achieve feminization (eg, breast development, softening of skin, a more female fat distribution and alteration in mood) via negative feedback on the hypothalamus; estrogen also down-regulates gonadotrophins to lower serum testosterone levels. This reduces the rate of growth of male-pattern hair, erections, and libido while enhancing the effect of estrogen on breast growth. In an MTF patient who has not had the testes removed, the dosage of estrogen required to suppress testosterone levels to the negligible range and to maximize feminization is 4 to 8 times greater than any nontransgender woman would be given. The risk of thromboembolism at these high dosages is a concern. To achieve these high levels, intramuscular estrogen

can be given, as in the case of Ms L, as 10 mg weekly of estradiol valerate. This formulation results in serum levels of estrogen of more than 1800 pg/mL. Intramuscular injections spare the patient’s liver a “first-pass” exposure via the enterohepatic circulation that could otherwise stimulate hepatic clotting factors. However, the high serum levels can overexpose the liver via the systemic circulation and the hepatic artery and lead to potentially carcinogenic liver neoplasia and growth.¹⁶ Many laboratories cannot reliably measure estradiol levels other than 17β-estradiol. Because of increased risk of venous thrombosis and cardiovascular risk compared with 17β-beta estradiol, oral ethinyl estradiol and conjugated estrogens should be avoided.¹⁶⁻¹⁹ There are very infrequent reports of prolactinomas (estrogen treatment routinely doubles or triples the baseline prolactin level), breast cancer, and even prostate cancer in MTF patients. In the latter case, the cancer was probably in situ at the initiation of estrogen therapy.²⁰

The main purpose of spironolactone is to inhibit androgen binding to its receptor to diminish the rate of growth and thickness of male-pattern hair; this reduces the heavy financial burden of electrolysis, which can cost \$120/week (Table).

Finasteride blocks the enzyme 5α-reductase, inhibiting the conversion of testosterone to dihydrotestosterone (DHT) and is usually given to reduce prostatic size from benign prostatic hypertrophy. Lower dosages have been shown to reduce the involvement of dihydrotestosterone in early male-pattern balding. Interestingly, treating Ms L’s benign prostatic hypertrophy may not be necessary because it may be partially treated by the estrogen-induced suppression of serum testosterone and dihydrotestosterone (Table).

Box 3. Monitoring of Hormone Treatment in Male-to-Female and Female-to-Male Transsexual Adults¹⁵**Male-to-Female Treatment^a**

1. Evaluate patient every 2 to 3 months in the first year and then 1 to 2 times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol levels every 3 months. Serum testosterone levels should be less than 55 ng/dL. Serum estradiol level should not exceed the peak physiologic range for young, healthy females, with ideal levels of approximately 100 to 200 pg/mL. Dosages of estrogen should be adjusted according to the serum levels of estradiol.
3. For individuals taking spironolactone, serum electrolytes, particularly potassium, should be monitored every 2 to 3 months in the first year.
4. Routine cancer screening (eg, breast, colon, prostate) is recommended as for nontranssexual individuals.

Female-to-Male Treatment^a

1. Evaluate patient every 2 to 3 months in the first year and then 1 to 2 times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 2 to 3 months until levels are in the normal physiologic range for males. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. If level is higher than 800 ng/dL or lower than 320 ng/dL, adjust dosage accordingly. For transdermal testosterone, the testosterone level can be measured at any time after 1 week. During the first 3 to 9 months of testosterone treatment, total levels may be high although free testosterone levels are normal because of high sex hormone binding globulin 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 less than 50 pg/mL.
4. Make complete blood count and liver function measurements at baseline and every 3 months for the first year and then 1 to 2 times a year. Monitor weight, blood pressure, lipids, fasting blood glucose (if there is a family history of diabetes), and hemoglobin A_{1c} (if patient has diabetes) at regular visits.
5. If cervical tissue is present, an annual Papanicolaou test is recommended by the American Congress of Obstetricians and Gynecologists.
6. If mastectomy is not performed, consider mammograms as recommended by the American Cancer Society.

^aConsider bone mineral density testing at baseline if risk factors for osteoporotic fracture are present (eg, previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not adherent to hormone therapy.

Gonadotrophin-releasing hormone analog is used frequently in MTF individuals in Europe who have not undergone gonadectomy and following at least 6 months of counseling. In adolescents, extensive psychological evaluation is also required. These drugs are available in the United States as leuprolide, nafarelin, or histrelin. They inhibit the release of gonadotrophins and thereby the stimulus for secretion of testosterone from the testes. The suppression of testosterone that is achieved rivals that of a bilateral gonadectomy and only 1 to 2 mg of daily oral estradiol is required for feminization. The rate of male-pattern hair growth slows, breasts increase, and erections virtually cease. Libido is also suppressed. The Dutch have made this treatment the core of their adolescent program, blocking puberty at its onset and providing several years of continuing counseling until a definitive decision can be made regarding taking estrogen at about age 16 years.²¹⁻²⁴ The results are dramatic: gender dysphoria is reduced and social and academic performance improves.^{7,25,26} Estrogen reduces stature to a more appropriate female height, voice never deepens, facial hair never grows, facial bone structure is less male-angular, and breast development is normal. Unfortunately,

these drugs are prohibitively expensive regardless of age at use and are rarely covered by insurance in the United States for transgenderism (Table).

Although Ms L started hormone therapy late, she does have the advantage of a relatively thin frame, normal height for a woman, and light hair, which minimizes facial hair removal. Her regimen of high-dose estrogen and spironolactone can certainly suppress erections, diminish libido, and improve mood. Breast development in an adult of this build is highly variable and may not be adequate to the patient despite use of estrogen (Table).

MEDICAL OPTIONS FOR FTM THERAPY IN ADOLESCENCE AND ADULTHOOD

Hormone treatments for FTM patients include testosterone, GnRH analogs, and progestin. The best option and order in which to treat depends on the age of the patient at presentation.

Treating FTM individuals hormonally is relatively easy when they are aged 14 to 16 years. Young FTM individuals who are at Tanner stage 2 and experiencing an increase in gender dysphoria should be counseled and treated with a GnRH analog. Pubertal suppression via a GnRH analog pre-

vents full biological puberty and, specifically, menses. Around age 16 years, the patient may begin cross-hormone therapy. Testosterone cypionate or enanthate given subcutaneously or intramuscularly weekly (50-75 mg per dose) suppresses menses and virilizes the body, face, and hair. Reversible pubertal suppression prevents changes such as breast development that would later need surgical removal.

For adults, parenteral or transdermal preparations are used to achieve normal male testosterone value ranges (320-800 ng/dL). Despite the differences in treatment, both adolescents and adults must have 6 months of experience living in the desired gender role before beginning hormone treatment.⁹ As with MTF patients, endocrinologists should continuously monitor for normal and adverse health effects (Box 3).⁹

SURGICAL OPTIONS AND THEIR COSTS

Because most insurance companies in the United States consider surgical therapy cosmetic and typically do not cover costs, the exact number of patients seeking surgical therapy is unknown.

Male-to-female transgender individuals who have not had pubertal suppression early in life may seek facial feminizing surgery, breast augmentation, and various fat transplants as either adults or adolescents. Male-to-female surgical techniques include penile inversion or creation of a vagina from sections of the colon.²⁷ Depilated scrotal skin is used to create the labia. Two decades ago, much of the literature on postoperative MTF patients described considerable dissatisfaction concerning sensation and orgasm in the genitoplasty. More recent nerve-sparing techniques have rendered remarkable improvements.²⁷⁻²⁹ In Thailand, where the price is lower than in the United States, these types of procedures can range between \$9000 and \$20 000. The estimated cost of vaginoplasty surgery (1 stage with penile inversion, clitoroplasty, and labioplasty) plus hospital stay in a Philadelphia, Pennsylvania, transgender center is \$19 500. Breast implants are approximately \$8100 and additional facial and body augmentation surgeries range from \$3500 to \$10 600 (Philadelphia).

Female-to-male adolescents or adults who have not had pubertal suppression may seek mammoplasty surgery as soon as it can be done, usually around age 16 years. A small-breasted individual can have an excellent, nearly scar-free result with a simple subareolar incision and excision of breast tissue. For those with an inframammary fold, the procedure is similar to a reduction mammoplasty except that a flat chest is the ultimate goal, so the subcostal scars are obvious.^{30,31} The prices of subcutaneous mastectomies/mammoplasty range from just under \$5000 to \$7900 (Philadelphia).³²

FUTURE DIRECTIONS

Definitively determining the mechanism by which some individuals are transgender will be a major future achievement. In addition to validating transgender patients' experiences, their conditions will no longer be regarded as primarily psychiatric disorders. It will enable social adjustment and suppression of the natal undesired puberty. Treatment as a primary medical condition would result in insurance coverage, including surgery.

Follow-up studies of transgender youth whose puberty was suppressed are needed to assess long-term effects. Areas for research include bone mineral density, other unexpected medical effects, and long-term psychological and social functioning.³³ Issues of long-term reproductive health and preservation of ova and sperm for patients even if their puberty is suppressed should be investigated.³⁴

How to manage this population of patients as they mature and expand within our health care system is yet to be determined. Primary care physicians need to make their own "transitions" to care for transgender patients, as many have done in caring for those who are gay or lesbian. Training needs to be enhanced to manage the psychological issues, medications, and associated risks.³⁵ Medical schools need to include the care of gender variance in all of its forms in their curricula, and training programs for mental health clinicians need to incorporate such information.

Transgender people are among the last patients to be excluded from the US health care system and universal protection from discrimination. Yet we have much to learn from them about the neurobiology and social psychology of gender. These patients strain our usual constructs about nature and nurture. Yet we also learn, as we did when homosexuality was removed from being listed as a mental illness in 1973, about the negative effects on patients of describing a condition as a mental illness when it appears to be secondary to medical treatment delayed or denied. There is no greater gift to patients than to respect them for who they believe they are and to enable them to refashion their bodies to match their affirmed gender.

RECOMMENDATIONS FOR MS L

Ms L has some unique risks from the current treatment as a middle-aged MTF person and her options may unfortunately be limited by insurance issues.

She has a worrisome family history of early cardiovascular disease and breast cancer. Based on the high dose of estrogen being taken and the thromboembolic risk of taking so much estradiol via injection, she should consider doing whatever she can to lower her estrogen dose to a normative level.³⁶ Optimal treatment would be a feminizing genitoplasty because only 1 to 2 mg of estradiol would be needed. However, surgery may not yield patient satisfaction and is a \$25 000 undertaking not covered by insurance. Other surgical options include feminizing surgery to the facial bones, tracheal shaves to remove the Adam's apple, brow plastic surgery to bring the hairline forward, and augmentation mammoplasties.³⁷ For patients whose bodies cannot align with their gender, physicians should not underestimate the influence of circulating hormones that do match the patient's gender. Ms L does require reevaluation and potential counseling from a mental health gender specialist to reassess her candidacy for genitoplasty surgery and to provide support regardless of her decision, even if it is based solely on financial grounds.

The next best option, especially if genitoplasty is not likely to occur, would be bilateral gonadectomies, which would be

CLINICAL CROSSROADS

affordable and have the same hormonal benefits. Postoperatively, spironolactone can usually be reduced but not necessarily discontinued because male-pattern hair loss often continues. If surgical gonadectomy is not possible, a “medical gonadectomy” could be possible with a GnRH analog via 1- or 3-month depot injection, daily nasal spray, or small subcutaneous implant in the underside of the upper arm that releases drug for up to 2 years. She also would need to take 1 to 2 mg of estradiol.³⁶

To minimize her long-term risks, she requires annual mammograms as would any estrogen-taking MTF individual her age.³⁶ She needs to be mindful of all risk factors for cardiovascular disease and receive prompt and proper treatment should she develop hyperlipidemia, hypertension, or diabetes.

QUESTIONS AND DISCUSSION

QUESTION: What do you see is the role of psychiatry and mental health clinicians in managing these patients?

DR SPACK: The role of mental health clinicians in managing these patients through their self-discovery and treatment is critical. In my practice, patients need to be in counseling for at least 6 months to be treated. They need to remain in counseling throughout treatment and transition. In my practice, families benefit too. Mental health intervention should persist for the long term, even after surgery, as patients continue to be at mental health risk, including for suicide.³⁶ While the causes of suicide are multifactorial, the possibility cannot be ruled out that some patients unrealistically believe that surgery(ies) solves their psychological distress. Early intervention in young adolescents, including pubertal suppression, has been initiated only in the past 10 to 15 years; long-term follow-up is awaited to determine whether the outcomes are more favorable.^{21,25}

QUESTION: To what extent is gender dysphoria universal? Can you tell us if it is worldwide and if it is cross-cultural?

DR SPACK: The degree to which patients express themselves has to do with cultural acceptance. The data about the actual incidence is very difficult to obtain. Initial studies in the United States, based on surgical data, are likely to be inaccurate.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Online-Only Material: The eBox (list of websites) is available at <http://www.jama.com>.

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Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples

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Abstract

Historically, many gender variant individuals have lived in a chronic state of conflict between self-understanding and physical being, one in which there was a continual misalignment between others' perceptions of them and their internal self-perception of gender. Only recently have professionals from mental health and medical realms come together to provide services to these youth. This paper describes an innovative program: the first mental health and medical multidisciplinary clinic housed in a pediatric academic center in North America to serve the needs of gender variant youth. We describe our model of care, focusing on the psychologist's role within a multidisciplinary team and the mental health needs of the youth and families assisted. We highlight clinical challenges and provide practice clinical vignettes to illuminate the psychologist's critical role.

Keywords

transgender; gender dysphoria; gender non-conforming; youth; adolescent

Introduction

Historically, many gender variant individuals have lived in a chronic state of conflict between self-understanding and physical being, with a continual misalignment between others' perceptions of them and their internal self-perception of gender. Only recently have professionals from mental health and medical realms come together to provide services to youth and, hopefully, some validation. As with other newly evolving fields of study, initial interventions were applied without the benefit of much research or precedent for guidance, and at times in an atmosphere of professional division (see Drescher & Byne, 2012, for a summary of continued controversies).

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The Gender Management Services-Disorders of Sexual Development Program (GeMS-DSD) evolved due to the dearth of available services for two distinct populations: a) youth with Disorders of Sexual Development (DSD) and b) gender variant youth. DSD refer to biological conditions in which anatomic sexual development is atypical (Houk, Hughes, Ahmed, & Lee, 2006) whereas gender variance refers to gender expression and/or identity inconsistent with prevailing societal expectations and norms (Kulick, 1999). The term transgender typically refers to those individuals for whom genotype and phenotype are mismatched. Therefore, biologically male children may self-identify as female and vice versa, or youth may not fit neatly into either category. This paper will focus on the gender variant group served by GeMS-DSD. We highlight clinical challenges, and provide clinical vignettes to illuminate the psychologist's critical role. Please refer to the online supplemental materials for further description of terms relevant to gender, sex and sexuality, and a summary of suggested psychosocial evaluation recommendations.

The development of the GeMS-DSD Program was made possible because the initiative of an endocrinologist with prior expertise treating transgender adults, and a strong passion to assist gender variant youth without access to care. As with any novel program, a vision and a sense of possibility are essential aspects of effective action. With a strong belief in the need for such a program in a multidisciplinary hospital setting, the GeMS-DSD service was developed, partially dependent upon the persuasive abilities of the founding physicians, but also within the structure of an institution that encouraged care for underserved youth and with clinic directors and hospital administrators who fostered innovation. The GeMS-DSD program became the first multidisciplinary mental health and medical program housed in a pediatric academic center in North America to serve youth with DSD or gender variance, and has forged a path for the development of other clinics in the United States. Many mental health professionals, medical students, pediatric house officers, endocrine fellows, and staff endocrinologists have participated in our program.

Program Development

The development of GeMS-DSD was a shared effort, requiring extensive multidisciplinary collaboration. Consultation was sought from urology, endocrinology, medical ethics, genetics, neonatology, gynecology, psychology, and hospital administration. When the program opened, it was co-directed by a pediatric urologist with expertise treating children with DSD and a pediatric endocrinologist, working in tandem with a psychologist to provide evaluations and services for gender variant youth and their families. The remainder of the discussion will focus on the gender variant group in the GeMS program, with an emphasis on the crucial role of psychologists within this multidisciplinary team.

In order to develop our mental health protocols, our hospital supported the GeMS psychologist receiving training in Amsterdam from Peggy Cohen-Kettenis, PhD and her team, pioneers in assessing and treating transgender youth. The purpose of the trip was to learn and adapt the Dutch protocol for use in the United States. The Amsterdam group opened the first specialized gender identity clinic for children and adolescents in 1987 (deVries & Cohen-Kettenis, 2012) and have published numerous studies based on their protocol and interventions (e.g., Delemarre-van de Waal & Cohen-Kettenis, 2006; deVries,

Steensma, Doreleijers, & Cohen-Kettenis, 2011; Wallien & Cohen-Kettenis, 2008; deVries & Cohen-Kettenis, 2012). During the training trip, the GeMS psychologist and endocrinologist participated in the first international Adolescent Gender Identity Research Group Meeting. Psychological measures were selected collaboratively for clinics to use in the evaluation of transgender youth, based on shared experience with this population, while each clinic adapted and added measures as needed for individual sites.

When opened, the GeMS clinic was flooded with inquiries from families, not only from the local region, but also from across the nation and internationally. Notably, before the GeMS program existed, the demand for services was largely invisible. In addition, children and families struggled to identify resources (many of which were predominantly non-existent) without the aid of trained professionals, while sometimes coping with significant and multifaceted psychosocial challenges. These could include a range of issues such as managing family responses, including anxieties and discord related to atypical gender expressions and/or disclosures of children; managing peer, school and other social circumstances in contexts that were often less than accepting; and managing mental health issues. Numerous articles have been published outlining similar multifaceted issues gender nonconforming children and families may face (e.g., Dreger, 2009; Ehrensaft, 2007; Malpas, 2011; Menvielle, 2012). In response to the increasing volume of cases a social worker joined the team to conduct pre-screening telephone intakes, aid families in finding resources, and to help develop written clinic protocols in collaboration with the psychologist.

Clinic Practice

The GeMS program, based on the model of care first developed and shaped in Amsterdam, continues to be adapted over time in response to new developments in the field and service demands. Our protocol relies on existing guidelines and standards for working with transgender individuals developed by various disciplines. For example, the World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al., 2011), the Endocrine Society Guidelines (Hembree et al., 2009), the Report of the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (2009; <http://www.apa.org/pubs/info/reports/gender-identity.aspx>), and the American Counseling Association Competencies for Counseling with Transgendered Clients (2010) each offer valuable recommendations for working with the transgender population. Generally, these guidelines and standards are similar in that they all recommend supporting transgender individuals in their affirmed gender identity, which often includes assisting in medical interventions that will help make the individual's body congruent with their affirmed gender. The APA Task Force report (APA, 2009) states support for the "efficacy, benefit, and medical necessity of gender-transition treatments for appropriately evaluated individuals..." (p.67), a statement consistent with the goals of the GeMS team.

Nevertheless, many of these guidelines do not focus on issues specific to transgender youth. The Society for Adolescent Health and Medicine (2013) has issued recommendations for promoting the health and well-being of lesbian, gay, bisexual and transgender adolescents, and the American Academy of Child and Adolescent Psychiatry (2012) has published practice parameters addressing gay, lesbian, bisexual, gender nonconforming and gender

discordant children and adolescents. The APA also published a helpful and accessible pamphlet regarding gender identity and gender expression, with some information about transgender youth (<http://www.apa.org/topics/sexuality/transgender.pdf>). They note that “it may be helpful to consult with mental health and medical professionals familiar with gender issues in children” (p. 3), while also emphasizing that “identifying as transgender does not constitute a mental disorder” (p. 3) and that “it is not helpful to force the child to act in a more gender-conforming way” (p. 3). This position is aligned with our gender affirming approach to care (see Hidalgo et al., 2013 for an elaboration of a gender affirming model) which views gender variations as part of an expected diversity, and not pathology. Mental health challenges may emerge related to cultural and social responses to a child or co-exist with gender non-conformity. Consistent with much literature (e.g., Hidalgo et al., 2013; Steensma, McGuire, Kreukels, Beelman & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008) we view gender as sometimes fluid over time, recognizing that not all gender non-conforming children fit neatly into male or female identities, and that gender identity (internal sense of self) and gender expression (outward expression of gender) may modify over time. Members of the GeMS team have played a role in the development of standards and guidelines, including as a member of the active APA Task Force to develop guidelines for psychological practice with transgender and gender non-conforming clients.

As time has elapsed, and our clinical expertise has developed, we have advanced to a more flexible, individualized approach to care than was utilized at the clinic’s inception, which may evolve further with increasing research to inform best practices. Within our current model we continue to prioritize evaluation and treatment, mental health and readiness for medical treatment, but allow for a variable structure and account for the unique circumstances of the youth and family. Therefore, the model set forth below is adaptable, serving as a guide for care as opposed to an inelastic protocol. Clinical discretion and family needs are prioritized, as deemed appropriate by the psychologist working within a multidisciplinary team. In addition, as the field evolves, our future practices may vary from those delineated. However, we anticipate that our fundamental approach will endure, and can be described as the intertwining of mental health and medical expertise, each informing the other to best assist families and youth.

Intake

The initial telephone intake, conducted by a GeMS clinical social worker, includes gathering a substantial amount of information and allows the parent and/or guardian the opportunity to tell their story to a knowledgeable professional, often for the first time. The information includes reasons for concerns about gender variance, current crises, and developmental, medical, and mental health history. Other services include support, psycho-education, explanation of protocols, outside referrals and scheduling a clinic appointment when appropriate. We believe that it is imperative for a qualified and experienced clinician to be the first point of clinical contact to set the roadmap for future care, and to act as an identified trusted individual to whom the family can turn. The intake frequently plants the seeds of hope, providing relief for families who have been enduring the stress of a situation for which they have had little preparation, often within a context of isolation. A description of the patient population presenting in GeMS through the year 2010 indicated that the mean age at

intake was approximately 14, with a slight preponderance of genotypic female to male patients, many of whom (approximately 44%) presented with a significant psychiatric history (Spack et al, 2012).

It is important to note that the earliest we medically treat children is when puberty has just begun, medically defined as Tanner Stage 2 (Marshall and Tanner, 1969, 1970). A youth's chronological age is less relevant than their biological development and a cognitive level necessary to adequately assent to treatment. However, we do not accept new patients for treatment older than eighteen.

In the case of younger children who are not yet approaching puberty, guidance is often sought for gender related challenges, in which case we provide psycho-education, and offer referrals for families to receive supportive mental health counseling. These services may assist the youth in clarifying their gender identity, and help youth and families navigate the many anticipated and unanticipated issues they may confront, including whether or not to initiate a social transition (presenting in social settings as the affirmed gender). Children may experience anxiety and depression, often secondary to the social and familial ramifications of their gender questioning and/or atypical presentation, and a mental health professional with relevant expertise can be tremendously helpful.

When a child is seeking services closer to puberty, our current model typically recommends three to six months of psychotherapy. For some children who feel a compelling sense of urgency in light of impending physiological changes, this recommendation may be modified, especially when complicating factors are absent and the child is well supported. This aspect of the model reflects our recognition that many youth and/or parents seeking services in our clinic are in the early stages of gender exploration and consideration of medical intervention options, and need a safe forum in which to learn more about the issues involved, and treatment available. Further, we have found psychotherapy exceedingly helpful for treating co-occurring mental health issues and for exploring the child and/or adolescents' thought processes, family functioning, strengths and support systems. In addition, psychotherapy enables a deeper exploration of the child's Gender Dysphoria (GD), the range of gender expression and gender identity questioning, and whether the subjective experience fits more into a model of binary identity (e.g., male/female) versus a fluidity of gender and gender nonconformity. Mental health intervention can also support problem-solving regarding the medical and social challenges that lie ahead. It helps facilitate discussion between families and other support systems (schools, extended family, religious/sectarian community affiliates) as next steps are contemplated. Many authors also have noted the importance of mental health services (e.g., Bernal & Coolhart, 2011; Menvielle, 2012; Turek, 2011). Drescher & Byne (2012) emphasize that "the majority of adolescent persisters do well when they receive family and professional support for early interventions" (p. 504). Therefore, GeMS patients are asked to continue working with their outside mental health provider during the course of medical treatment in our clinic.

One of the purposes of the puberty blocking medical intervention (described below) is to buy time for the adolescent to continue exploring gender identity issues without the added stress of a puberty that is inconsistent with their self-identity. In our view, it is often

unrealistic to expect an adolescent to sort through the myriad of issues related to gender variance without the help of a professional. Many of the challenges adolescents face regard the reactions of others to their gender identity and/or expression, but can also include gender-related questioning and confusion (see Cohen-Kettenis, Steensma & de Vries, 2011, for an interesting discussion of psychological interventions for adolescents with GD).

Psychological Evaluation

The goals of evaluation, conducted by a licensed psychologist, are to further understand the child and family's needs, and to inform medical treatment interventions. Before initiating the evaluation, we typically request a letter from the child's outside community therapist composed with the aid of a guide we provide. The therapist is asked to address their understanding of the patient's gender identity history, including length of time the patient has had gender questioning feelings, how long he/she has been living in the role of a different gender (if at all), and how persistent his/her identification with a different gender has been, if ever, over the course of time. The letter includes the therapist's impression of the patient's supports, the therapist's perception of other mental health issues or developmental concerns, and finally, the therapist's perception of benefits/drawbacks related to medical intervention.

Assuming that the therapist's letter is generally supportive of medical intervention, following review by our mental health clinicians, we move forward with an on-site psychological evaluation. This evaluation consists of extensive interviews of youth and families, and measures of anxiety, depression, self-concept, behavioral and social functioning, autism spectrum disorder (ASD), and gender identity. With consent, outreach is often made to collateral informants, and we review relevant documents (e.g., neuropsychological evaluations), as appropriate.

In the clinical interview, we address what the youth and parents hope to accomplish from the evaluation, family and developmental history, school and academic history, mental health and medical history, substance use, and trauma history. We gather an extensive gender history including the youth's subjective experience of gender across time, gender presentation, gender role expression, and sexual orientation. Considerable attention is paid to factors that make these cases more complicated, such as patients presenting with features of ASD, severe psychiatric concerns (e.g., suicidality, self-harming behaviors, psychosis, violence and aggression, and history of abuse/trauma), and/or complicated family factors (e.g., divorced parents, unsupportive family members). We assess support structures and strengths, familial attitudes about non-traditional gender roles and sexual orientation preferences, religious, cultural and ethnic background, and additional individual and family stressors. The youth's age at first signs of GD or disclosures is always noted; families may be caught off guard when their children first disclose gender questioning close to adolescence or after the onset of puberty, and often the evaluations of these youth and families are particularly complex.

Consistent with psychological evaluations in general, the rationale for numerous measures and methods of information gathering is to obtain the most authentic and comprehensive clinical picture possible. This is particularly critical, given that the results and clinical

formulation play the primary role in deciding whether to move forward with a potentially life-changing medical intervention for the adolescent. We synthesize and interpret the information obtained, and use the evaluation as a way to understand the youth and family's state of mind, ambivalences, and overt and covert pressures. We also want to ensure that, to the extent possible, a youth's cultural and social environment will support their chosen gender identity and provide a safety net as they move forward. A full clinical report is written that integrates the information, and provides a formulation and recommendations. The team psychologist then meets with the family to review this information. Medical interventions that often follow are either in the form of puberty blockers, and/or cross-sex hormone therapy, described below.

As noted above, continuing psychotherapy for youth is typically recommended by our protocol. At times we recommend family treatment and/or support groups to help with the family's adjustment to their child's transition. The GeMS team then remains in contact with community providers as clinical care dictates. In addition, youth treated in our program return for regular clinic visits, meeting with both mental health and medical team members, in order to provide continuity of care and further assist adolescents and family members as needed.

Medical Intervention

Medical intervention with transgender youth in GeMS occurs under the auspices of a subdivision within the Endocrine Department. In brief, as alluded to above, with children who have recently begun puberty, puberty-blocking hormones are often prescribed. These are administered in the form of subcutaneous implants in the upper arm, which last two to three years, or monthly injections. These treatments are not routinely covered by health insurance in the United States and may range in cost from \$120 to over \$1,000 per month. Other medical services, laboratory tests, and sometimes cross-sex hormones may be covered by insurance.

In the absence of pubertal blockers, biological males with affirmed female identities may experience significant growth, permanent facial hair and vocal changes, and intolerable erections. A voice that has deepened cannot be raised through hormone therapy, and requires difficult and expensive speech therapy, in order to affect a higher voice. Similarly, without such intervention, biological females who identify as male may experience menstruation and breast development; the latter can only be modified through surgery. Nevertheless, an adolescent who has initiated puberty blockers can decide to terminate the intervention and allow physiological changes to occur as they would have, had the medical intervention never been initiated.

Only with an older adolescent, typically around age sixteen, are irreversible interventions initiated, and only after psychotherapy and a careful psychological evaluation has taken place. In this way, we try to ensure that an adolescent is not ambivalent, and that these interventions are well thought through and understood without coercion from others, and with full consent. When these conditions are met, an adolescent may be placed on cross-sex hormones (estrogen for genetic males and testosterone for genetic females), to facilitate a more complete transition into that individual's affirmed gender. When natal puberty has

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been previously blocked, the cross-sex hormones are even more effective in rendering a more gender consonant, “typical” presentation. For male-to-female (MTF) patients, treating with pubertal suppression in early puberty followed by estrogen in later adolescence causes enhanced breast development, vocal quality consistent with the affirmed gender, no development of a protruding larynx or “Adam’s Apple”, absence of male-typical facial or body hair, and diminished masculinization of the body frame and facial bones. For female-to-male (FTM) patients, pubertal suppression in early puberty followed by treatment with testosterone later in adolescence leads to development of facial and body hair, deepening of the voice, masculinization of the body frame and facial bones, no need for mastectomies, and no menarche (see Delmarre-van de Waal & Cohen-Kettenis, 2006 and Shumer & Spack, 2013 for further information).

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A common scenario is for GeMS to recommend puberty blockers, when the youth and/or the parent may feel that it would be best to start cross-sex hormone therapy instead. The delay of puberty, rather than the immediate onset of the puberty of choice (utilizing cross-sex hormones) is sometimes difficult for the youth or family to accept. This is an area where we currently have little research to guide us, and the decision of whether to block puberty, or instead move forward with an affirmed gender (i.e., cross-sex hormones) must be weighed carefully. Aside from the irreversible nature of cross-sex hormone initiation, this intervention has significant ramifications for fertility, while puberty blockers do not (Lazar, L, Meyerovitch,, de Vries,, Phillip & Lebanthal, 2014).

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Anecdotally, we have found that the GeMS evaluation has been invaluable by providing information to guide subsequent psychosocial and medical decision-making. In general, adolescence is marked by a search for identity and personal transformation, and at times impetuous decision-making. Given the implications of social transition and medical intervention, coupled with the developmental challenges of identity consolidation, we feel the need to progress with care and forethought, to ensure that all interventions proceed safely, to minimize medical and psychosocial contraindications or complications, and to make sure it is the appropriate timeframe for intervention. We also want to ensure that the child/adolescent who may be gender variant does not feel compelled to choose a gender (male/female), when in actuality they may not fit into a typically recognized gender identity. Nevertheless, these considerations always need to be balanced by the very real physiological ticking clock, especially for the younger child on the verge of a puberty that they deeply want to avoid.

Challenges and Dilemmas of Psychosocial Practice

Child and Family Expectations

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When confronted by a gender variant child, a parent may be caught very much off guard, with no ability to rehearse the best response to such an unanticipated circumstance. In addition, for a parent, it may feel like a loss of the daughter or son to whom they became so bonded. Moreover, some families are aware of their child’s GD in early childhood while others are surprised to learn about it when their child is in their teens. Both instances carry particular emotional impact for families. Many parents are resilient and loving in the face of these challenges, but may experience an understandable drive for rapid certainty and

solutions. We have also encountered parents who are resistant to accepting this diagnostic picture, and believe their child's gender variance is a phase, or a manifestation of some other psychological issue that can be resolved, thus resolving the gender variance. Unfortunately, the problems and issues that often exist for gender variant children and their families are nuanced and indeterminate, and the resolutions may evolve through a time consuming process without a known end. This can add to the stress and consequent pressure to "solve" the issues (see Bernal & Coolhart, 2012, Dreger, 2009, Menvielle, 2012 and Turek, 2011 for further discussion of family issues).

It can be particularly challenging when two parents or guardians with legal custody are in dissent about how to proceed, especially in contentious divorce situations when communication is minimal or hostile, yet medical consensus needs to be reached. Typically, our program requires consent of both parents before medical treatment can go forward and mental health and/or medical clinicians may need to be proactive in trying to resolve disputes with sensitivity.

Psychosocial Considerations

Any number of psychological, social and cultural factors can impinge upon youth and their family, and influence decision-making, expectations and emotional reactions. The Report of the APA Task Force on Gender Identity and Gender Variance (2009) summarizes some of these factors, including general behavior problems, peer related problems and other mental health issues. Below we outline some of the common issues we have encountered in our work.

Not infrequently, children and adolescents are involved in meaningful activities, which will be likely impacted by a gender transition. Prominent among these are youth sports teams, which are typically grouped by gender. Adolescents are often loath to lose these areas of gratification, along with the opportunity for social bonding. Other hobbies and interests that are often impacted include dancing, theatre, cheer leading and sleep-away camp, and children and families may be unable to forecast how they will weather these transitions. Therefore, a child may face the dilemma of losing the opportunity to sustain an ability or talent they value in order to live in a gender they embrace.

A youth's environment and culture is essential to consider when evaluating treatment options. Ideally, the family and community should provide every child safety, love and solace, and the support a gender questioning child and/or adolescent needs (as any youth does) to thrive into a healthy maturity. However, such youth often struggle for acceptance within their families and communities. We know from prior research (Dean, et al., 2000; Fitzpatrick, Jones, & Schmidt, 2005; Gibson & Catlin, 2011; Grossman & D'Augelli, 2007; Hass, et. al., 2010; Spack et al., 2012) that many children with GD become deeply anxious and depressed, and resort to suicide attempts. Others are at risk of leaving home and living a life with high costs and risks, including of exploitation, abuse, and as victims of violence, while obtaining hormones illicitly without the oversight of a qualified medical professional.

Even when families and children seek professional service and care, external factors beyond their control can impede access. Many geographic areas still lack basic services for children

with GD, and traveling for access to medical care is not always an option for families living within modest means. Furthermore, schools and religious institutions vary in level of comfort dealing with transgender children, and may not have the understanding or training to navigate the complexities of their transgender student or member's needs. Learning to deal with social issues such as bullying and isolation, and practical issues such as bathroom and locker use, requires open and honest dialogue with experts familiar with gender issues; not all communities are able or willing to avail themselves to this kind of discussion.

One positive outgrowth of the Internet and widespread coverage of transgender issues is mainstream access to information about gender variance and dysphoria. Families can become much less isolated by accessing on-line social networks and organizations such as Parents, Families, and Friends of Lesbians and Gays (PFLAG), even when there is not a chapter in their vicinity. However, the increased availability of differing professional standards and practices can sometimes also confuse families, who may specifically seek out professionals who seem open to providing services desired by the patient or parents, even if they are inconsistent with typical practice standards. This could result in circumventing the input of mental health professionals, or providing irreversible intervention for a young or ambivalent child.

Mental health

Sadly, we know that transgender youth are at risk for anxiety, depression, self-harm, suicidal ideation, psychiatric hospitalizations, homelessness, exploitation, and abuse (Dean, et al., 2000; Fitzpatrick, Jones, & Schmidt, 2005; Gibson & Catlin, 2011; Grossman & D'Augelli, 2007; Hass, et. al., 2010; Grossman & D'Augelli, 2007; Spack et al., 2012). In addition, the spectrum of issues that can present in any child or adolescent can present in gender variant youth, including history of trauma, oppositional defiant disorder/conduct disorder, and learning disabilities. These youth may do poorly in school, and/or have difficulty with socializing, and negotiating the normal developmental challenges of adolescence. Optimally, a pubescent child and adolescent should be stable, safe, and supported in advance of receiving medical interventions such as puberty blockers or cross-sex hormones. Yet, for many, medical intervention is an antidote for some of their mental health problems. This poses a dilemma for the clinician, who may be averse to going forward with medical intervention, but feel compelled to do so in case that is the critical step needed to jump start a child's recovery. Such intervention should only take place once the crisis of active suicidal ideation, behavior and/or self-harm has receded, and following a full psychosocial evaluation if it had not taken place already, as well as with close monitoring to ensure that the child is safe and that the dangers continue to remit. Delays can be particularly difficult and contribute to a child's distress because of the limited physiological time frame. At the very least, psychological services should help to ensure adequate support systems before any medical intervention occurs, and puberty blockers can buy time and allow for a child to make thoughtful decisions about his or her gender.

Finally, there appears to be a higher than expected incidence of co-occurring GD with ASDs based on clinical experience as well as research, although more empirical study needs to be completed (e.g. deVries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers,

2010; Drescher, 2012; Spack et al, 2012). Very often adolescents on the autism spectrum know they are different from peers, but have only recently identified gender identity as a factor contributing to this divergence. Sometimes they and their families believe that a gender transition will solve all problems, and/or latch on to gender as the sole reason they are unlike their peers. Similarly, parents may believe that the GD is a manifestation of the ASD, and resist treatment. Parents of youth on the autism spectrum may be concerned that their child's intense focus on gender is a fleeting concern, particularly if their child has a history of transitory preoccupations. When children with an ASD are evaluated, it is often more difficult to discern the degree of gender variance given the relatively concrete and binary thought processes and communication patterns that typify this population. A child with an ASD already has challenges in social realms and is faced with an additional unique and complex set of social circumstances. A comprehensive evaluation should help sort through these issues and it may be necessary to move forward cautiously. However, it is our opinion that treatment not be withheld indefinitely as these youth experience the same biological time constraints characteristic of all pubescent individuals, and therefore need to receive optimally timed interventions to the extent possible.

Service Gaps and Evolution of Practice

Watching clinical services grow is rewarding, especially when they translate into more contented and peaceful lives for youth and their families. Nevertheless, evidence-based practices are aspirational when a new field emerges with no guiding clinical precedent. Controversies among providers in the mental health and medical fields are abundant. Drescher & Byne (2012) and Stein (2012) provide excellent discussions of issues of consensus versus continued controversies. These include differing assumptions regarding whether early intervention with gender variant youth can encourage desistance, and whether that is an appropriate practice. Other areas of debate include the age at which children (or adolescents) should be encouraged or permitted to socially transition; whether cross-sex hormones and surgery should be offered to youth, and if so, at what age; whether parental consent be required for these medical interventions; and whether mental health involvement be required, including psychological evaluation, prior to each stage of medical intervention. These issues are complex and providers in the field continue to be at odds in their efforts to work in the best interest of the youth they serve. Addressing each of these controversies goes beyond the scope of this paper; however, the GeMS team continues to stay abreast of these issues and actively participates in ongoing discussion and research (see Schwartz, D., 2012; Ehrensaft, D., Minter, S.P., 2012; Zucker, K.J., Wood, H., Singh, D., & Bradley, S.J., 2012; and Shwartz, D., 2012 for discussions of some of the issues and differing viewpoints).

An important priority going forward is to develop research to enhance our understanding of what typifies this population of children, and their developmental course and patterns, and to examine the long-term outcomes of treatment. The field needs to better comprehend which children are most likely to have a life-long and persistent identification with a different gender than the one they were assigned versus those who cease to self-identify as transgender over the course of time. Although some information is available (e.g., American Psychiatric Association, 2013; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Zucker, Wood, Singh, & Bradley, 2012) much more research in this area is needed.

Other high priority areas for systematic examination include the effects and side effects of various medical interventions, especially given that they are initiated with youth who may be on a lifetime course of hormone treatment, and psychosocial outcomes for youth who receive medical intervention during adolescence.

Finally, we can only report on children with access to services; youth may not have access because of geography and lack of availability, lack of financial means, and/or because of social structures that do not support them. As noted earlier, these children are at risk to be exploited, to be runaways, street youth and sex workers, and to self-medicate and self-harm. Prevention and outreach, to shelter at-risk youth from damaging and avoidable traumas, and to improve access to mental health services, should be one of the highest priorities for health care providers.

Clinical Case-Composites

The following represent composites, not actual cases, to serve as examples of how GeMS has addressed common clinical scenarios

Case Scenario # 1: Early Puberty

Referral Information: M. is a 10 year old Black natal female who identifies as male. He and his parents came to the clinic stating a desire to initiate puberty blockers to avoid feminizing.

History: Although only 10, M's pediatrician had put his pubertal development as Tanner Stage 2 (pubertal), and he was developing breasts. He had been living as a boy at school and elsewhere for two years, and was quite concerned that his pubertal changes might alert others to his natal gender, and was very also very assertive about his desire to avoid the onset of menstruation. He had been in therapy for two years, and was also being treated by a psychiatrist for anxiety symptoms. His therapist had written a letter in support of M living in his affirmed gender.

Psychological Evaluation: The formal psychological evaluation indicated that M had a longstanding identification as male, which emerged in his early preschool years, as well as ongoing GD, which predominantly took the form of anxiety. His anxiety diminished, according to him and his family, as well as his therapist and psychiatrist, as he transitioned socially and began to live and be treated as a male at home and at school. Information from school revealed that he was viewed as normal and high functioning in all areas. As an example of a response to gender-related questions, M stated that he was not a transgender boy, but just a regular boy. M did report significant anxieties related to social situations, as well as to bathing and bathroom situations. M resides with two biological parents who were both supportive and in accord with pursuing medical treatment, although they reported that it initially had been difficult for them to accept his social transition.

Recommendations: Given his long-standing history of GD, positive adjustment at school, the consistency of data obtained from the his psychiatrist, psychologist, both parents and himself, the GeMS team recommended puberty blockers as well as continued psychological treatment to help diminish his anxiety and problem-solve social situations as they may arise.

Continuing follow-up with the GeMS psychologist indicated that his anxiety diminished as his impending puberty was forestalled, with strong acceptance for his affirmed gender from his family and others.

2. Case Scenario # 2: Parent: Adolescent Conflict

Referral Information: E. is a 17 year old Hispanic natal male who came to the clinic with her parents, who immigrated to the United States soon after E's birth. E was hoping to be able to be treated with puberty blockers and female hormones, while her parents were unified in believing that psychotherapy could resolve her GD, and were hoping to have this confirmed by a psychological evaluation.

History: E's parents were invested in her remaining male, partially due to the elevation of male status in their traditional culture. Reportedly, E. had been interested in receiving care for her gender dysphoria for several years prior to the current appointment, to avoid the onset of pubertal changes she was already experiencing. However, her parents had been resistant. She had been in therapy with a psychologist for many years, and her therapist was instrumental in helping to persuade her parents to bring her to the clinic.

Psychological Evaluation: The evaluation revealed that E had identified as female since the age of 5, including using female pronouns, attempting to wear female underwear, playing with traditionally female toys, and identifying with female characters during pretend play. At present, E wore female clothing and had grown her hair, but appeared androgynous due to a deep voice and some light facial hair. She was generally assumed to be male at school and elsewhere, although her closest friends used her female name and pronouns at her request. The psychological evaluation revealed a strong cross-sex identification as female, and mild depression.

Recommendation: Puberty blockers were recommended, with possible cross-sex hormones in about six months. The psychologist spent considerable time with E's parents and with E, reviewing the results of the evaluation, and the basis for the recommendations. E's parents were distressed during discussion to learn that there was some urgency to proceed quickly, believing incorrectly that medical intervention could reverse pubertal changes. The treatment recommendations also included family therapy, to facilitate positive communication within the family and provide support and psycho-education for E's parents. We also recommended a continuation of psychotherapy for E., to help her adjust to personal and social changes, provide support, and to help her cope with family discord. E. continues to be seen by the psychologist in our clinic for consultation, and is adjusting well to the initiation of hormone treatment.

Case # 3. Ambivalence and Mental Health Complexity

Referral Information: L. is a 16 year old White European American natal female who presents as male, and has chosen a male name and male pronouns. He has been in therapy since the age of 8, and was initially evaluated and put on pubertal blockers in our clinic at age 13. His mother called the clinic requesting that L. be considered for cross-sex hormones.

L. was not seen for a full evaluation as he is an ongoing patient in our service, but for a screening related to his mother's request that cross-sex hormonal treatment be initiated.

History: L. was adopted at the age of 1, and his early history is not known. He has been diagnosed with depression, anxiety, and Conduct Disorder. He has a history of self-harm related to depression, academic pressure, and of being bullied in school. His social, academic, and emotional functioning tends to be poor, and he is emotionally and behaviorally dysregulated, with periods of rage at school and at home, and some known drug use. He was recently suspended at school for cheating and for provoking physical altercations. His mother believes that cross-sex hormones would alleviate his distress and dysregulation,

Psychological Screening: L's therapist, when contacted with the family's consent, indicated that L. appears ambivalent about his affirmed gender, and therefore did not believe that cross-sex hormones should be initiated. Other aspects of our evaluation also suggested ambivalence on L's part. Although he ultimately agreed with his mother that he should start testosterone, he began the evaluation by suggesting it was "too early" to start them. In addition L. reported that he binds his breasts on occasion (1 × per week) to present convincingly as male, but mostly does not, and that he has been involved in an ongoing heterosexual romantic relationship as a male. He stated that this relationship has been very gratifying, and indicated concern about losing his girlfriend when he started testosterone. Although he stated that he wants to be viewed as male, L also stated that he did not look forward to the changes that testosterone would cause.

Recommendations: Given that L was initially resistant to the initiation of cross-sex hormones, and that his mother initiated the consultation, along with L's ambivalence about the changes that testosterone would precipitate, cross-sex hormones were not recommended at this juncture. Instead, we recommended that L. continue to sort out his desires in his therapy relationship, while also addressing some of his other concerning behavioral and mental health issues. We also recommended family therapy, as it appeared that parental anxieties and pressures may have been impacting L's choices. We agreed to consult with L and his family again in 3 to 6 months.

Case #4.: Autistic Spectrum Disorder

Referral Information: B. is a 12 year old White European American natal male, Tanner stage 1, who has been increasingly presenting as female for approximately six months to one year. She and her parents presented in our clinic seeking an evaluation and recommendations for treatment.

History: B. was diagnosed with high functioning ASD at the age of 7, after experiencing social difficulties for several years. Although intellectually bright, B. has not done well in school. B. spends much of her spare time on the computer, investigating various subjects and reporting the details to her parents. Her parents worry about her poor academic progress and her socialization, and she has been in treatment since her initial diagnosis. B. disclosed

that she was a girl to her therapist and her parents 6 months earlier, after increasing depression and suicidal feelings.

Psychological Evaluation: The evaluation revealed that B. strongly identified as female. B. stated that this feeling had begun within the past year at the start of the school year. Her parents indicated that they would support her if she were truly transgender, but expressed concern that B. may be unhappy socially and using a transgender diagnosis as a means to attempt to resolve her social isolation, and as a result of self-hatred. They also expressed concern that B.'s identification as female is a passing phase, similar to other passing phases/obsessions she experienced throughout her life, rather than an enduring identification, and that B had limited understanding of the impact of changing genders. B.'s therapist was unsure of whether B. should be treated with hormones yet, expressing similar concerns to her parents. School reports indicated that B. was sometimes taunted by peers, apathetic about schoolwork, often inattentive, and increasingly isolated. All data consistently indicated depression and anxiety.

Recommendations: Because of the complexities of B.'s situation, including a relatively recent identification as female, and limited social understanding, we recommended continued psychotherapy and monitoring of her GD, with treatment addressing her depression and anxiety, without immediate medical intervention. We also recommended that her therapist consult with her school to problem-solve solutions to isolation and bullying, and interventions to increase gratifying activities for B. outside the home. We recommended a psychiatric consultation for possible psychopharmacological intervention as well, and a return visit in 3 months to monitor B's progress and her gender identification in light of the new interventions.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents

Children and adolescents who are growing up gay, lesbian, bisexual, gender nonconforming, or gender discordant experience unique developmental challenges. They are at risk for certain mental health problems, many of which are significantly correlated with stigma and prejudice. Mental health professionals have an important role to play in fostering healthy development in this population. Influences on sexual orientation, gender nonconformity, and gender discordance, and their developmental relationships to each other, are reviewed. Practice principles and related issues of cultural competence, research needs, and ethics are discussed. *J. Am. Acad. Child Adolesc. Psychiatry*, 2012;51(9):957-974. **Key Words:** sexual orientation, homosexuality, bisexuality, gender identity disorder, gender discordant.

Scientific studies demonstrating the healthy, adaptive functioning of the great majority of gay and lesbian adults paved the way toward removal of homosexuality as an illness from the *DSM* in 1973.¹ Homosexuality is now recognized as a nonpathological variant of human sexuality. Although the great majority of gay and lesbian individuals have normal mental health, as a group they experience unique stressors and developmental challenges. Perhaps in part as a consequence of these challenges, adult and adolescent members of sexual minorities (defined below) develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with those in the general population.^{2,3} Thus, psychosocial distress may account for the different rates in depression, hopelessness, and current suicidality seen between gay, lesbian, and bisexual adolescents and their heterosexual peers.⁴ Studies in the U.S. and the Netherlands document this problem continuing into adulthood, and show a significant association among stigma, prejudice, discrimination, and poor mental health.^{2,5,6}

Sexual development comprises biological, psychological, and social aspects of experience. Extensive scientific research, described below, has been conducted on the influence of these factors on sexual orientation and gender in recent years.

Much of what has been learned scientifically about sexual orientation and gender development in the last generation has occurred in parallel with societal changes in attitudes toward sexual orientation and gender roles. While bias against sexual minorities is declining in many segments of society, intolerance is still widespread. Children and adolescents are exposed to these negative attitudes and are affected by them. This Practice Parameter is intended to foster clinical competence in those caring for children and adolescents who are growing up to be gay, lesbian, bisexual, gender variant, or transgender, reflecting what is currently known about best clinical practices for these youth.

METHODOLOGY

The list of references for this Practice Parameter was developed by online searches of Medline and PsycINFO. A search of PsycINFO articles published since 1806 and Medline articles published from 1950 through April 27, 2010, of key-word terms "sexual orientation," "gay," "homosexuality," "male homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender variant," "gender atypical," "gender identity disorder," and "homosexuality, attitudes toward" limited to English language, hu-

man subjects, and ages 0–17 years (PsycINFO) or 0–18 years (Medline) produced 7,825 unique and 967 duplicate references.

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

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

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

⁷ This winnowing process yielded 1,889 references.

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

An updated Medline search of articles through March 3, 2011, of the MeSH database using the same Subject Headings and limits used in the previous search produced 138 references. An updated PsycINFO search of articles through March 3, 2011, of the Thesaurus database using the same Terms (Descriptors) and limits used in the previous search produced 107 references.

Throughout the search, the bibliographies of source materials including books,^{8–10} book chapters,¹¹ and review articles,^{12–14} were consulted for additional references that were not produced by the online searches. Bibliographies of publications by the following experts were also examined to find additional pertinent articles not produced by online searches: Jennifer I. Downey, M.D., Jack Drescher, M.D., Richard C. Friedman, M.D., Gilbert Herdt, Ph.D., Richard Isay, M.D., Ellen Perrin, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., Gary Remafedi, M.D., M.P.H., and Kenneth Zucker, Ph.D. Recent studies and discussions at scientific meetings in the past decade were considered for inclusion.

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

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citations illustrating a representative sample of multiple viewpoints were selected.

DEFINITIONS

Many terms related to sexual development are being continually updated. The following definitions reflect current terminology, and are used in this Practice Parameter.

- *Sex*, in the sense of being male or female, refers to a person's anatomical sex. (Although usually considered dichotomously male or female, disorders of sex development can lead to intersex conditions, which are beyond the scope of this Practice Parameter).
- *Gender* refers to the perception of a person's sex on the part of society as male or female.
- *Gender role behavior* refers to activities, interests, use of symbols, styles, or other personal and social attributes that are recognized as masculine or feminine.
- *Gender identity* refers to an individual's personal sense of self as male or female. It usually develops by age 3, is concordant with a person's sex and gender, and remains stable over the lifetime. For a small number of individuals, it can change later in life.
- *Identity* refers to one's abstract sense of self within a cultural and social matrix. This broader meaning (equivalent to ego identity) is distinct from gender identity, and usually consolidated in adolescence.
- *Sexual orientation* refers to the sex of the person to whom an individual is erotically attracted. It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role.
 - *Homosexual* people are attracted erotically to people of the same sex, and are commonly referred to as gay in the case of males, and gay or lesbian in the case of females.
 - *Heterosexual* people are attracted erotically to people of the other sex.
 - *Bisexual* people are attracted erotically to people of both sexes.
- *Sexual minority* refers to homosexual and bisexual youth and adults.
- *Sexual prejudice* (or more archaically, *homophobia*) refers to bias against homosexual people. "Homophobia" is technically not a phobia; like other prejudices, it is characterized by hostility and is thus a misnomer, but the term is used colloquially.¹⁵
- *Internalized sexual prejudice* (or colloquially, *internalized homophobia*) is a syndrome of self-loathing based upon the adoption of anti-homosexual attitudes by homosexual people themselves.
- *Heterosexism* refers to individual and societal assumptions—sometimes not explicitly recognized—promoting heterosexuality to the disadvantage of other sexual orientations.
- *Childhood gender nonconformity* refers to variation from norms in gender role behavior such as toy preferences, rough-and-tumble play, aggression, or playmate gender. The terms *gender variance* and *gender atypicality* have been used equivalently in the literature.
- *Gender discordance* refers to a discrepancy between anatomical sex and gender identity. The term *gender identity variance* has been used to denote a spectrum of gender-discordant phenomena in the literature.
 - *Transgender* people have a gender identity that is discordant with their anatomical sex.
 - *Transsexuals* are transgender people who make their perceived gender and/or anatomical sex conform with their gender identity through strategies such as dress, grooming, hormone use and/or surgery (known as *sex reassignment*).
- *Gender minority* refers to gender nonconforming and gender-discordant children, adolescents, and adults.

HOMOSEXUALITY

Homosexuality comprises multiple components, and can refer to several aspects of same-sex attraction, including physiological arousability, erotic fantasy, sexual behavior, psychological identity, or social role. These facets of homosexuality can be congruent or incongruent in any given person.^{9,16} Many men and women with homosexual desire suppress their feelings or behavior, agonize over sexual orientation, or have homosexual relationships they keep secret while maintaining a heterosexual public identity.

Not surprisingly, rates of homosexuality vary depending upon definition and study method. In one study, adult males reported same-sex experience rates of 2.7% for the past year, 4.9% since age 18 years, and approximately 7–9% since puberty; for women, rates were 1.3%, 4.1%, and approximately 4%, respectively.¹⁶ Homosexual-

ity was correlated with higher education and urban residence. In another study, rates of lifetime same-sex experience were 6.7% for men and 14.2% for women, and 3% of men and 4% of women reported a same-sex partner in the preceding 12 months.¹⁷

One large sample of predominantly white but geographically and socioeconomically diverse junior and senior high school students found that 10.1% of males and 11.3% of females were “unsure” of their sexual orientation, and 1.5% of males and 1.1% of females said they were “bisexual or predominantly homosexual.” Same-sex attractions were reported by 4.5% of males and 5.7% of females, same-sex fantasies by 2.2% of males and 3.1% of females, and same-sex sexual behavior by 1.6% of males and 0.9% of females. Of youth with homosexual experience, only 27.1% identified themselves as gay, consistent with a struggle with identity and group affiliation.¹⁸

Influences on Sexual Orientation

There is evidence that biological factors influence sexual orientation.¹⁹ Evidence from a variety of animal and human studies indicate that prenatal neuroendocrine factors, including levels of sex hormones, influence sexual organization of the brain in utero when neuronal patterns are laid down, and activate their sexual function beginning in puberty.

Neuroendocrine Factors. The *neurohormonal theory* of sexual orientation posits that prenatal sex hormone levels influence development of gender role behavior in childhood and sexual orientation in adulthood.²⁰ However, evidence of the organizing effects of sex hormones in females, and of the degree to which animal studies may be relevant to humans is limited.²¹ Although sex hormone levels during fetal brain development may influence childhood gender variance and adult sexual orientation, neither homosexuality nor gender variance is an indication for endocrine, genetic, or any other special medical evaluation.

Genetic Factors. There is evidence of a genetic influence on gender role behavior in childhood and sexual orientation in adulthood from family, twin, and molecular studies.¹⁹ One study found that, among gay adult males, 52% of monozygotic co-twins were homosexual, whereas only 22% of dizygotic co-twins and 11% of adoptive

brothers were homosexual.²² Another study found that, among adult lesbians, 48% of monozygotic co-twins, 16% of dizygotic co-twins, and 6% of adoptive sisters were also lesbian.²³ These data suggest a substantial heritable influence on sexual orientation.

Neuroanatomy. Limited evidence suggests that the size of certain neuroanatomical features may correlate with sexual orientation. In males, these may include the third anterior interstitial nucleus of the hypothalamus (INAH-3)²⁴ and the supra-chiasmatic nucleus (SCN).¹⁹ Further research is needed to confirm these results and to establish their significance. When used appropriately, information about biological influences on sexual orientation can be relevant to patients, families, and clinicians. However, such influences do not constitute an illness.

Psychological and Social Factors. Before the shift to empirically based psychiatry following the publication of *DSM-III*, prevailing psychiatric theory ascribed homosexuality to character pathology.¹ However, this view was revised because of a lack of empirical evidence. Although homosexuality is associated with somewhat elevated rates of certain psychiatric disorders such as depression and anxiety, there is no evidence from any controlled scientific study that most gay and lesbian people suffer from character pathology, or from any other mental illness; on the contrary, the vast majority do not.^{2,3} In addition, studies of character profiles and defense mechanisms have found no differences between nonheterosexuals and the general population.^{25,26} Another theory, that male homosexuality resulted from overly close mothers and hostile or distant fathers, was similarly not supported by empirical study of nonclinical populations.²⁷ Rather, nonclinical groups of gay adults, especially males, appear to have childhood histories of gender nonconformity; their family relationships may be the result rather than the cause of gender nonconformity, and may possibly be subject to a degree of recall bias.^{28,29}

Social learning does not appear to influence sexual orientation at the level of erotic fantasy or physiological arousal, although it can influence identity and social role in both positive and negative ways. Knowledge of other homosexual people is not necessary for the development of a homosexual orientation.⁹ The effect of parents'

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sexual orientation on their children's own gender development and sexual orientation has been investigated in longitudinal studies of community samples in the U.S. and the United Kingdom.³⁰⁻³³ Parents' sexual orientation had no effect on gender development in general. This was true even though tolerance for gender nonconformity was more common among lesbian parents than among heterosexual ones. Boys raised by lesbian couples demonstrated greater gender role flexibility such as helping with housework, on average, a social strength that was also observed in some heterosexual-parent families, and that appears to be influenced more by parental attitudes than by parental sexual orientation. Regarding sexual orientation in adolescents who were raised by same-sex parents (including same-sex attraction, same-sex relationships, and gay identity), compared with the general population, no differences in sexual attraction are found; the large majority of adolescents raised by lesbian couples identify as heterosexual. However, in the minority of cases, when they do experience same-sex attractions, adolescent girls raised by lesbian parents appear to experience less stigma about acting on those feelings than those raised by heterosexual parents, and are accordingly slightly more likely to identify as bisexual.³³ Data on children raised by gay male couples is relatively lacking, but preliminary evidence appears to be consistent with the findings in children raised by lesbian couples.³⁰

Exposure to anti-homosexual attitudes can induce shame and guilt in those growing up gay, leading them to suppress a gay identity or same-sex behavior; conversely, well-adjusted gay or lesbian adults can provide positive role models for youth.⁷ There is no rational basis for depriving gay youth of such role models, as stereotyped views of homosexual adults as being more likely to commit sexual abuse of minors is not supported by evidence.^{34,35}

Psychosexual Development and Homosexual Orientation

Children display aspects of sexuality from infancy, and develop sexual feelings almost universally by adolescence or earlier. Although most people are predominantly heterosexual, some develop predominantly same-sex attractions and fantasies in or before adolescence. Most boys, whether heterosexual or homosexual, experience

a surge in testosterone levels and sexual feelings in puberty, and almost all begin to masturbate then.³⁶ Most girls experience more gradually increasing sexual desires. A majority of girls, although a smaller majority than among boys, also begin to masturbate, and they do so over a broader age range. Erotic fantasizing often accompanies masturbation, and may crystallize sexual orientation.³⁷ Whether heterosexual or homosexual, most men experience more frequent interest in sex and fantasies involving explicit sexual imagery, whereas women's sexual fantasies more often involve romantic imagery.³⁸ Sexual behavior with others typically begins in or after mid-to-late adolescence, although the age of onset of activity, number of partners, and practices vary greatly among individuals.¹⁶

One possible developmental pathway of male homosexuality proceeds from same-sex erotic fantasy to same-sex experience, then homosexual identity (self-labeling as gay), and finally a homosexual social role (identifying oneself as gay to others).³⁹ In comparison with those who first identify as gay in adulthood, those who identify as gay in adolescence may be somewhat more likely to self-label as gay before same-sex experience, and to achieve the foregoing gay developmental milestones earlier. This developmental path appears to be more common in recent cohorts than it once was,⁴⁰ perhaps reflecting the consolidation of a gay identity earlier in recent generations as the result of the increasing visibility of gay role models for adolescents. Developmental pathways may be more variable in females, whose sexuality is generally more fluid than that of males.⁴¹ Compared with men, women are more likely to experience homosexual as well as heterosexual attraction across the lifespan.¹² This may occur only in youth, may emerge in adulthood, or may be stable through life.⁴²

Certainty about sexual orientation and identity—both gay and straight—increases with age, suggesting “an unfolding of sexual identity during adolescence, influenced by sexual experience and demographic factors.”¹⁸ Although it may be difficult to tell which developmental path a particular adolescent is on at a given moment, a consistently homosexual pattern of fantasy, arousal, and attraction suggests a developmental path toward adult homosexuality. Retrospectively, many gay men and lesbians report same-sex erotic attraction from youth onward.²⁸

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Development of Gender Role Behavior. Boys and girls generally exhibit different patterns of gender role behavior. These are quite distinct from erotic feelings, instead involving such areas as toy preferences, play patterns, social roles, same-sex or opposite-sex peer preferences, gesture, speech, grooming, dress, and whether aggression is expressed physically or through social strategies.^{43,44} For example, most boys are more likely than girls to engage in rough-and-tumble play. Most boys exhibit aggression physically, whereas most girls do so through verbal and social means. When given a choice, most boys are more likely to select conventionally masculine toys such as cars, trains, and adventure or fighting games, whereas most girls more frequently select conventionally feminine toys such as dolls, jewelry, and nurturing games. Most children exhibit a preference in middle childhood for same-sex playmates, or “sex-segregated play.”

Social, psychological, and biological factors, including genetic and environmental ones, interactively influence childhood gender role behavior and gender identity.^{45,46} Sex differences exist at multiple levels of brain organization, and there is evidence of neuroanatomic differences between gender-typical and gender-atypical individuals. At the same time, part of a developing child’s cognitive understanding of gender—for example, whether competitiveness and aggression can be feminine, or whether empathic, nurturing activities can be masculine—is related to societal norms.⁴⁷ As science has progressed, the complexity of the way in which factors related to gender role behavior such as genes, hormones, and the environment (including the social environment) interact have come to be better appreciated. Psychological experience is presumably reflected in brain structure or function, and each may influence the other. Previous questions about the roles of nature and nurture in causing childhood gender role differences have come to be understood as overly simplistic, and have been replaced by models showing biological and environmental factors influencing one another bidirectionally during critical periods in neurodevelopmental processes that are sometimes modifiable and sometimes fixed.

Gender Nonconformity and Its Developmental Relationship to Homosexuality. Most boys and girls display some variability in gender role behavior.

However, some children display toy, play, and peer preferences that are typical of the other gender. They have been referred to as “gender atypical,” “gender variant,” or, increasingly, “gender nonconforming” in scholarly literature. Childhood gender nonconformity often is a developmental precursor of homosexuality in males, and sometimes in females.⁴⁸

Although childhood gender nonconformity does not predict adult homosexuality with certainty, many gay men recall boyhood aversion to rough-and-tumble play, aggressive behavior, and competitive athletics.⁴⁹ In females, gender nonconformity (e.g., being a “tomboy”) is sometimes associated with adult homosexual orientation, although less consistently than in males.⁵⁰ Many gay people report having felt “different” from others long before the development of erotic feelings as such due to childhood gender nonconformity, which can elicit teasing, low peer status, and poor self-esteem; boys, who may particularly value adherence to gender norms, may be especially distressed.⁵¹

Although gender nonconforming children may experience discomfort or marked anxiety if forced to participate in gender-typical behaviors, their gender identity is entirely congruent with their sex. They do not express a wish to be, or belief they are, the other sex. On the contrary, gender nonconforming boys in particular may be upset by feelings they are insufficiently masculine, especially in contexts in which gender norms are highly valued.⁹

Adolescence, Sexual Orientation, and Identity Formation. Adolescence normally brings increased sexual and aggressive drives, social role experimentation, and separation and individuation for all youth. For those who are developing as gay, lesbian, bisexual, or transgender, the challenge of establishing one’s ego identity—including a sense of one’s sexual identity—is uniquely complex. Although most heterosexual youth take social acceptance of their sexual orientation for granted, sexual and gender minority youth usually cannot.⁹ They must cope with feeling different, ostracism, and dilemmas about revealing a sexual identity that is discrepant from family and social expectations (“coming out”).¹³ These adolescents are at somewhat elevated risk for having suicidal thoughts⁵²⁻⁵⁴; however, only a minority actually do, indicating a capacity for resilient coping in most.

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Increasing social acceptance may encourage gay, lesbian, or bisexual adolescents to come out more frequently and at younger ages. However, some youth who become aware that they have homosexual feelings may be unprepared to cope with possible negative attitudes that they may encounter among their own family or peers.⁵⁵

Clinical Issues in Homosexuality

Effects of Stigma, Peer Rejection, Bias, and Bullying. Despite increasing tolerance, gender and sexual minority youth may experience criticism, ostracism, harassment, bullying, or rejection by peers, family, or others, even in relatively tolerant, cosmopolitan settings.⁵⁶ These can be associated with significant social problems, distress, and psychological symptoms.⁵⁷ They may be shunned or disparaged when they long for peer acceptance. A poor developmental fit between children's gender nonconformity or sexual orientation and parents' expectations can result in distress for both parent and child.¹¹

Internalized Sexual Prejudice. Even when not personally threatened, homosexual youths may be indirectly or overtly disparaged by family or peers. They may observe other gay people experiencing disrespect, humiliation, lower social status, or fewer civil rights. This experience may create difficulty reconciling the simultaneous developmental needs to form a sexual identity on the one hand and to feel socially acceptable on the other, typically a painful developmental conflict for gay youth.¹³ They may identify with others who are emotionally important to them but sexually prejudiced, leading to a syndrome of self-loathing (internalized sexual prejudice, or "internalized homophobia"). This may adversely affect self-esteem, lead to denial of same-sex attractions, cause difficulty identifying with other gay people, and prevent formation of healthy relationships.⁸

Revealing a Homosexual Orientation to Others. Many gay and lesbian youth hide their identity from others.⁵⁵ The dilemma over whether to reveal a homosexual orientation—to "come out of the closet" or "come out"—is a unique aspect of the psychological development of sexual and gender minority youth. They must decide whether to hide their sexual orientation (remain "in the closet," or "closeted") or risk rejection. Coming out is usually a highly significant event that may

be anticipated with dread. There is no single answer to the question whether a particular gay youth should come out, or to whom. This requires judgment about the youth's maturity and coping, as well as the social context. For some, coming out brings great relief. Others in hostile environments may come out with bravado before it is safe; for them, remaining closeted or in denial may be adaptive.

GENDER IDENTITY AND GENDER DISCORDANCE

For the vast majority of people, gender identity is established in toddlerhood, is consistent with biological sex, and remains fixed. This holds true for many children with gender-nonconformity in toy, play, and playmate preferences. However, some children experience not only gender nonconformity, but also discomfort with their biological sex. They derive comfort from being perceived as, or a wish to be, the other sex. The desire leads to discordance between gender identity and phenotypic sex, a core feature of gender identity disorder (GID) as conceptualized in the *DSM-IV*.⁵⁸ The diagnosis of GID in children is controversial, and the degree to which *DSM-IV* criteria reflect an illness or social bias against gender nonconformity has been debated.^{59,60}

Several different categories of gender discordance, each characterized by a unique developmental trajectory, have been described.⁶¹ They differ in regard to whether gender discordance emerges in childhood, adolescence or adulthood; whether the gender discordance is persistent or transient; and whether there is a post-transition homosexual or heterosexual orientation. These heterogeneous developmental trajectories may subsume different causes of gender discordance.

In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2%⁶² to 11.9%⁶³ continuing to experience gender discordance. Rather, 75% become homosexual or bisexual in fantasy and 80% in behavior by age 19; some gender-variant behavior may persist.⁶³ The desistence of gender discordance may reflect the resolution of a "cognitive confusion factor,"⁶⁴ with increasing flexibility as children mature in thinking about gender identity and realize that one

can be a boy or girl despite variation from conventional gender roles and norms.

In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood.⁶⁵ This gender discordance may lead to life-long efforts to pass socially as the other sex through cross-dressing and grooming, or to seek sex reassignment through hormones or surgery.

Many of the clinical issues pertaining to gay and lesbian youth doubtlessly affect youth with gender discordance as well. In addition, children and especially adolescents with gender discordance have been found to have behavior problems and anxiety.^{66,67} Proposed causes include family and social opprobrium, the discrepancy between psychological and anatomic gender, and maternal and family psychopathology.^{65,68}

Factors Influencing Development of Gender Discordance

Causes of gender discordance may include biological factors.⁵⁹ Genetic males with gender discordance tend to have a later birth order, more male siblings, and lower birth weight, suggesting an influence of prenatal events that is poorly understood. Individuals with gender discordance may differ in central nervous system lateralization from the general population. Consistent with this hypothesis, they are more likely to be non-righthanded, to have abnormal EEG findings, and to have lateral otoacoustic processing consistent with their gender identity compared to a non-gender discordant population.⁵⁹ As with sexual orientation, variations in prenatal sex hormones may influence later gender identity, but do not appear to fully determine it.⁶⁹ There is evidence that the central bed nucleus of the stria terminalis (BSTc), a hypothalamic structure implicated in sexual behavior, is small in male to female transsexuals, similar to most females.⁷⁰

A hypothesis that inappropriately close maternal and overly distant paternal relationships causes gender discordance in boys was not borne out by empirical study, which found both mothers and fathers to be distant from sons with gender discordance, possibly a result, rather than the cause, of gender discordance.⁶² A theory that predisposing biological factors, temperamental anxiety, and parental tolerance for gender nonconformity interact to cause gender discordance has not been empirically tested.⁷¹ A controlled study found in-

creased rates of psychopathology in mothers of boys with gender discordance, but was not designed to assess a causal relationship.⁶⁸

PRINCIPLES

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

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

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

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

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

Clinicians should bear in mind potential risks to patients of premature disclosure of sexual

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orientation, such as family rejection or alienation from support systems, which might precipitate a crisis. They should be familiar with standard confidentiality practices for minors, and should protect confidentiality when possible to preserve the clinical alliance. This is particularly true when using media such as electronic health records, in which sensitive information can be easily disseminated. It is often helpful to emphasize reasonable expectations of privacy in the clinical relationship with sexual and gender minority youth—not to express shame, but to permit the exploration of sexual identity free from fear and with a sense of control over disclosure. As the development of sexual identity is variable, it is often desirable to allow youth to set the pace of self-discovery.

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

Families of sexual or gender minority youth may consult mental health professionals for a variety of reasons, for example, to ask whether a disclosure of being gay represents a temporary stage, to request support for an adolescent, or to address problems such as bullying, anxiety, or depression. Just as some adults try to alter their sexual orientation,⁷² some parents may similarly hope to prevent their children from being gay. Difficulty coping with prejudice and stigma are often the appropriate focus of treatment.

Families treat gay or gender-discordant children with considerable variation. Whereas some accept their children, others explicitly or implicitly disparage or reject them, evoking shame and guilt; some force them to leave home. Although some are surprised by a child's coming out, others are not, and some are supportive. Families may have to fundamentally alter their ideas about a child who comes out, confront misconceptions, and grieve over lost hopes and/or expectations. Most parents experience distress following a child's coming out, frequently experiencing cognitive dissonance or feelings of anxiety, anger, loss, shame, or guilt; despite this, over time the majority become affirming and are not distressed.⁷³ Children frequently predict their parents' reactions poorly. Ideally, families will support their child as the same person they

have known and loved, although doing so may require time.

Youth who are rejected by their parents can experience profound isolation that adversely affects their identity formation, self-esteem, and capacity for intimacy; stigmatized teens are often vulnerable to dropping out of school, homelessness (which may lead to exploitation or heightened sexual risk), substance abuse, depression and suicide.⁵³ Clinicians should aim to alleviate any irrational feelings of shame and guilt, and preserve empathic and supportive family relationships where possible. They should assess parents' ideas about what constitutes normal, acceptable behavior, their cultural background, and any misconceptions or distorted expectations about homosexuality. These may include fears that their child will have only casual relationships, is fated to contract HIV/AIDS, cannot become a parent if desired, or will be ostracized. Stereotyped views of gay males as engaging only in numerous, indiscriminate sexual encounters are not supported by empirical research except in rare cases.¹² If such behavior is present and cannot be explained as part of normal adolescent sexual drive or identity formation, factors known to be associated with excessive sexuality in youth, such as a history of sexual abuse, family dysfunction, a pattern of conduct problems, or mood disorder such as bipolar disorder or depression, should be considered. Clinicians should screen for all forms of abuse or neglect (as in any evaluation), with careful attention to adverse family reactions to a youth's sexual or gender development. If these are suspected, they should involve child protective services as clinical appropriateness and ethical and legal mandates warrant. Support groups may be helpful for families in distress. In cases of protracted turmoil or family pathology, referrals to family therapy, individual or couples therapy may be appropriate.

Sexual and gender minority youth may experience unique developmental challenges relating to the values and norms of their ethnic group.⁷⁴ Various groups may place different emphasis on ideals of masculinity or femininity, on family loyalty, or on social conformity; some with authoritarian parenting ideals may sanction youth who reject traditional mores.

For gay and lesbian adolescents who are also members of ethnic minorities, the deleterious effect of anti-homosexual bias may be compounded by the effect of racial prejudice. In

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response to unique pressures to gain group acceptance, they may give particular weight to negative group stereotyping of gay people. Gay and lesbian youth who are also members of ethnic minorities may be less likely than nonminority youth to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity.⁷⁵ In caring for youth who are members of both ethnic and sexual minorities, mental health professionals should take into account the unique complexities of identity formation for these groups.

Religion, often a valued aspect of identity, can vary widely regarding tolerance for sexual minorities. Membership in relatively more liberal or conservative religious groups is a significant influence on one's "sexual script," or social pattern in the expression of sexuality.¹⁶ Some minority denominations hold strong religious injunctions against homosexuality and stricter views about gender roles. As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. However, many religious groups are reconciling their traditions with more inclusive values. This remains an area of active social and cultural debate and change. Clinicians should respect the religious values of their patients, and should be aware of ongoing developments in religious thinking that may provide opportunities to integrate the religious and sexual aspects of identity.

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

Bullying. Gay, lesbian, bisexual, and gender non-conforming youth are regularly exposed to hostile peers. Victims of peer harassment experience serious adverse mental health consequences including chronic depression, anxiety, and suicidal thoughts.⁷⁶⁻⁷⁸ Sexual and gender minority youth may benefit from support for coping with peer harassment. School programs including no-tolerance policies for bullying have proved effective.⁷⁹ Family treatment may be useful when sexual and gender minority youth are harassed in their families. Psychotherapy may help to avert or alleviate self-loathing related to identification with the aggressor. Clinicians should consider environmental interventions such as consultation or advocacy

with schools, police, or other agencies and institutions advocating enforcement of zero tolerance policies to protect youth who may be victims of harassment or bullying.

Suicide. Rates of suicidal thoughts and suicide attempts among gay, lesbian, and gender-variant youth are elevated in comparison with the general population.⁵²⁻⁵⁴ The developmental interval following same-sex experience but before self-acceptance as gay may be one of especially elevated risk.⁵⁴ Suicidal thoughts, depression, and anxiety are especially elevated among gay males who were gender-variant as children.^{80,81} Family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts.⁸²

High-Risk Behaviors. Unique factors promoting risk-taking among gay and lesbian youth include maladaptive coping with peer, social and family ostracism, emotional and physical abuse, and neglect.⁸³ Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution. Positive coping skills and intact support systems can act as protective factors. Lesbian youth have higher rates of unintended pregnancy than heterosexual female youth, perhaps due to anxiety about their same-sex attractions and a desire to "fit in," an assumption birth control is unnecessary, or high-risk behavior rooted in psychological conflict.⁸⁴ Clinicians should monitor for these risks or provide anticipatory guidance for them when appropriate.

Substance Abuse. Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used. These youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs. Lesbian and bisexual girls and boys describing themselves as "mostly heterosexual" (as opposed to unambiguously hetero- or homosexual) are at increased risk for alcohol use.⁸⁵ A subgroup of gay youth displays higher rates of use of alcohol and drugs including marijuana, cocaine, inhalants, designer, and injectable drugs.⁵² They may use drugs and alcohol to achieve a sense of belonging or to relieve painful affects such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings.

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HIV/AIDS and Other Sexually Transmitted Illnesses. Adolescents are at risk for acquiring sexually transmitted illnesses included HIV infection through sexual risk taking, especially those who feel invulnerable or fatalistic, or who lack mature judgment, self-confidence, or the mature interpersonal skills needed to negotiate safe sexual experiences. Programs aimed at reducing adolescent sexual risk taking that are successful not only increase information about how HIV and sexually transmitted diseases are acquired and prevented, but also provide emotionally relevant and practical help in having safe sexual experiences that are developmentally relevant to youth.⁸⁶ Adolescent gay males may be at particular risk of acquiring HIV sexually because of its high prevalence among men who have sex with men. Factors such as substance abuse or internalized homophobia associated with shame, guilt, or low self-esteem may interfere with an individual's motivation to use knowledge effectively about how to protect oneself from acquiring HIV infection. If present, these issues should be addressed clinically. Special HIV-prevention programs have been developed for and tested in gay youth and have demonstrated promising results.^{87,88}

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

Protecting the opportunity to achieve full developmental potential is an important clinical goal in working with sexual and gender minority youth. The psychological acceptability of homosexual feelings to an individual and his or her family, and the individual's capacity to incorporate them into healthy relationships, can change with therapeutic intervention, and are an appropriate focus of clinical attention.⁹ Clinicians should strive to support healthy development and honest self-discovery as youth navigate family, peer, and social environments that may be hostile. Family rejection and bullying are often the proper focus of psychiatric treatment rather than current or future sexual orientation.

Sometimes questions about a youth's future sexual orientation come to psychiatric attention. When they do, it may be most useful to explore what this issue means to the adolescent and significant persons in his/her life. It may be

preferable to indicate that it is too early to know an adolescent's sexual orientation rather than to refer to such feelings as a "phase," which may have connotations of disapproval.

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

The availability of role models for sexual and gender minority youth varies greatly. The increasing visibility of gay people in society may decrease the isolation and loneliness of some gay youth, but others may be confronted with information that forces self-labeling before they are able to cope with irrational bias and feeling different. Some have access to positive role models or opportunities to form an affirming sexual identity among family, friends, the media, or through school programs such as gay-straight alliances. Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

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

There is no established evidence that change in a predominant, enduring homosexual pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter homosexuality.⁸⁹ Psychiatric efforts to alter sexual orientation through "reparative therapy" in adults have found little or no change in sexual orientation, while causing significant risk of harm to self-esteem.⁷ A study of efforts to do so in adults⁷¹ has been criticized for failure to adequately consider risks such as increased anguish, self-loathing, depression, anxiety, sub-

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stance abuse and suicidality, and for failure to support appropriate coping with prejudice and stigma.⁹⁰

There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts.⁸² As bullies typically identify their targets on the basis of adult attitudes and cues,⁷⁶ adult efforts to prevent homosexuality by discouraging gender variant traits in “pre-homosexual children” may risk fomenting bullying. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.^{7,91}

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

A majority of children display gender role behavior that adult caregivers regard as departing from gender role norms in toy preferences at least some of the time (demonstrating a difference between that which is culturally expected and that which is actually statistically normal).⁹² However, a smaller group of children demonstrate a consistent difference in gender role behavior from social norms. In different children, this may be true to varying degrees. In some, it may involve only a few areas—for example, an aversion to rough-and-tumble sports in boys, or tomboyishness in girls. In others, it may involve several areas, including dress, speech, and use of social styles and mannerisms. It is important to distinguish those who display only variation in gender role behavior (gender nonconformity, which is not a *DSM* diagnosis) from those who also display a gender identity discordant from their socially assigned birth gender and biological sex (gender discordance, reflected in the *DSM-IV* diagnosis Gender Identity Disorder when accompanied by marked gender nonconformity).⁹³

A clinical interview using *DSM* criteria is the gold standard for making a *DSM* diagnosis. In

some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-sex wishes. To assist clinicians in determining whether gender discordance is present, in addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children,⁹⁴ the Gender Identity Questionnaire for Children,⁹⁵ and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults.⁹⁶ In using such instruments, clinicians should bear in mind that the American Psychiatric Association’s Gender Identity Disorder subworkgroup for *DSM-5* is currently debating areas of controversy in the diagnostic criteria for GID, including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.⁹⁵

Disorders of sex development are an important differential diagnosis in gender discordant children and adolescents, for which endocrinological treatment may be indicated.⁹⁷ When the clinical history suggests that a somatic intersex condition may be present, clinicians should consider consultation with a pediatric endocrinologist or other specialist familiar with these conditions.

Children. Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity.¹⁴ There have been no randomized controlled trials of any treatment. Early treatments for gender discordance developed in the 1970s included behavioral paradigms⁹⁸; their long-term risks and benefits have not been followed up in controlled trials, and have been rejected on ethical grounds as having an inappropriately punitive and coercive basis.⁹⁹ Psychodynamically based psychotherapy for gender discordance in boys has been proposed based on a psychodynamic hypothesis that gender discordance is a defense in fantasy against profound, early separation anxiety⁷¹; like other treatment strategies, this has not been empirically tested in controlled trials.

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Recent treatment strategies based upon uncontrolled case series have been described that focus on parent guidance and peer group interaction. One seeks to hasten desistence of gender discordance in boys through eclectic interventions such as behavioral and milieu techniques, parent guidance and school consultation aimed at encouraging positive relationships with father and male peers, gender-typical skills, and increased maternal support for male role-taking and independence.¹⁰⁰ Another approach encourages tolerance of gender discordance, while setting limits on expression of gender-discordant behavior that may place the child at risk for peer or community harassment.¹⁰¹ Desistence of gender discordance has been described in both treatment approaches, as it is in untreated children.

As an ethical guide to treatment, "the clinician has an obligation to inform parents about the state of the empiric database,"¹⁴ including information about both effectiveness and potential risks. As children may experience imperatives to shape their communications about gender discordant wishes in response to social norms, a true change in gender discordance must be distinguished from simply teaching children to hide or suppress their feelings. Similarly, the possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth,⁵⁷ the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.

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

There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender-discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential

risks and benefits of doing so. Social gender assignment appears to exert partial influence on the gender identity of infants with disorders of sex development.⁶⁹ At the same time, countervailing biological factors may override social gender assignment and contribute significantly to gender discordance in many cases. Therefore, the possibility that sending a child to school in his/her desired gender may consolidate gender discordance or expose the child to bullying should be weighed against risks of not doing so, such as distress, social isolation, depression, or suicide due to lack of social support. Further research is needed to guide clinical decision making in this area.

Adolescents. For some individuals, discordance between gender and phenotypic sex presents in adolescence or adulthood.¹⁰² Sometimes it emerges in parallel with puberty and secondary sex characteristics, causing distress leading to a developmental crisis. Transgender adolescents and adults often wish to bring their biological sex into conformity with their gender identity through strategies that include hormones, gender correction surgery, or both, and may use illicitly obtained sex hormones or other medications with hormonal activity to this end. They may be at risk from side effects of unsupervised medication or sex hormone use.

One goal of treatment for adolescents in whom a desire to be the other sex is persistent is to help them make developmentally appropriate decisions about sex reassignment, with the aim of reducing risks of reassignment and managing associated comorbidity.¹⁴ In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent. Transgender youth may face special risks associated with hormone misuse, such as short- and long-term side effects, improper dosing, impure or counterfeit medications, and infection from shared syringes.

For situations in which deferral of sex-reassignment decisions until adulthood is not clinically feasible, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues that reversibly delay the

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development of secondary sexual characteristics.¹⁰² The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex. Prospective, case-controlled study of such treatment to delay puberty has shown some beneficial effects on behavioral and emotional problems, depressive symptoms, and general functioning (although not on anxiety or anger), and appears to be well tolerated acutely.¹⁰³ In addition, gender discordance is associated with lower rates of mental health problems when it is treated in adolescence than when it is treated in adulthood.¹⁰⁴ Therefore, such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.

Treatment approaches for GID using guidelines based on the developmental trajectories of gender-discordant adolescents have been described.¹⁰⁵⁻¹⁰⁷ In one approach, puberty suppression is considered beginning at age 12, cross-sex hormone treatment is considered beginning at age 16, and gender reassignment surgery at age 18.¹⁰⁵ Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and treatment of associated mental health problems. In another approach based on stage of physical development rather than age, pubertal suppression has been described at Tanner stage 2 in adolescents with persistent GID; risks requiring management include effects on growth, future fertility, uterine bleeding, and options for subsequent genital surgery and cross-sex hormone use.¹⁰⁷ For families of transgender adolescents, a therapeutic group approach has been described that encourages parental acceptance.¹⁰⁸ This approach may help to mitigate psychopathology and other deleterious effects of environmental nonacceptance. Further research is needed to definitively establish the effectiveness and acceptability of these treatment approaches.

Principle 8. Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care provid-

ers, advocating for the unique needs of sexual and gender minority youth and their families.

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

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

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

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

There are many books and Internet resources for youth and families on issues such as discovering whether one is gay or lesbian. Clinicians should consider exploring what youth and families read, and help them to identify useful resources. Organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN) provide support and resources for families, youth, and educators. These organizations have programs in a number of communities. Clinicians can obtain information through professional channels such

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as the AACAP Sexual Orientation and Gender Identity Issues Committee (www.aacap.org), the American Psychiatric Association (www.psych.org), the Lesbian and Gay Child and Adolescent Psychiatric Association (www.lagcapa.org), and the Association for Gay and Lesbian Psychiatrists (www.aglp.org).

The Model Standards Project, published by the Child Welfare League of America, is a practice tool related to the needs of LGBT youth in foster care or juvenile justice systems available at www.cwla.org.¹⁰⁹ The *Standards of Care for Gender Identity Disorders*, including psychiatric and medical care, are published by the World Professional Association for Transgender Health (www.wpath.org).¹¹⁰

PARAMETER LIMITATIONS

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

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

accessed on the AACAP website. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

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

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

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