No. 19-2064

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CHRISTOPHER DOYLE, LPC, LCPC, individually and on behalf of his clients,
Plaintiff – Appellant,
v.
LAWRENCE J. HOGAN, JR., Governor of the State of Maryland,
in his official capacity;
BRIAN E. FROSH, Attorney General of the State of Maryland,
in his official capacity,
Defendants - Appellees

On Appeal from the United States District Court
for the District of Maryland
In Case No. 1:19-cv-00190-DKC before the Honorable Deborah K. Chasanow

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, Individually and on behalf of his clients

v. : Civil Action No. DKC 19-0190

LAWRENCE JOSEPH HOGAN, JR., et al.

MEMORANDUM OPINION

Plaintiff Christopher Doyle ("Plaintiff") initiated the instant action against Defendants Lawrence J. Hogan, Jr. in his official capacity as Governor of the State of Maryland and Brian E. Frosh in his official capacity as the Attorney General of the State of Maryland (collectively, "Defendants") on January 18, 2019.

The complaint alleges that § 1-212.1 of the Health Occupations Article of the Maryland Code violates Plaintiff's: (1) right to freedom of speech under the First Amendment (ECF No. 1 ¶¶ 144-163); (2) clients' First Amendment rights to receive information (*id.* ¶¶ 164-172); (3) right to free exercise of religion under the First Amendment (*id.* ¶¶ 173-189); (4) "right to liberty of speech under Articles 10 and 40 of the Declaration of Rights of the Constitution of Maryland" (*id.* ¶¶ 190-210); and (5) "right to free exercise and enjoyment of religion under Article 36 of the Declaration of Rights of the Constitution of

Maryland" (*id.* ¶¶ 211-227). Plaintiff seeks (1) "a preliminary injunction enjoining Defendants and Defendants' officers, agents, servants, employees, and attorneys, and all other persons who are in active concert or participation with them . . . from enforcing [§ 1-212.1][;]" (2) "a permanent injunction enjoining enforce[ement] of [§ 1-212.1;]" (3) "a declaratory judgment declaring unconstitutional [§ 1-212.1] and Defendants' actions in applying [§ 1-212.1] under the United States Constitution and Constitution of Maryland[;]" (4) "nominal damages for the violation of [his] constitutional rights[;]" (5) "actual damages in an amount to be awarded at trial[;]" (6) a declaration that "the rights and other legal relations with subject matter here are in controversy so that such declaration shall have the force and effect of final judgment[;]" (7) the court's continued jurisdiction after finding in Plaintiff's favor "for the purpose of enforcing th[e] [c]ourt's order[;]" and (8) "reasonable costs and expenses of this action, including attorney's fees, in accordance with 42 U.S.C. § 1988[.]" (ECF No. 1, at 42-45). Presently pending are: (1) Plaintiff's January 18, 2019 motion for preliminary injunction (ECF No. 2); (2) Defendants' March 8, 2019 motion to dismiss for failure to state a claim (ECF No. 26); (3) a motion for leave to file an amicus curiae brief in support of Defendants' motion to dismiss and opposition to Plaintiff's motion for preliminary injunction (ECF

No. 28) filed by FreeState Justice, Inc. ("FreeState") on March 15, 2019; (4) a motion for leave to file an amicus curiae brief in support of Defendants' opposition to Plaintiff's motion for preliminary injunction (ECF No. 31) filed by The Trevor Project on March 15, 2019; (4) Plaintiff's April 11, 2019 motion to compel (ECF No. 44); and (5) Plaintiff's May 16, 2019 motion for leave to file surreply in opposition to Defendant's motion to dismiss (ECF No. 58).

A hearing is scheduled for August 5-6 and will focus on some aspects of the motion to dismiss, and the motion for a preliminary injunction. Some of the other pending motions, preliminary issues, and some of the arguments raised in the motion to dismiss will be resolved in this memorandum opinion, without a hearing. For the following reasons, FreeState's motion for leave to file amicus curiae will be granted, The Trevor Project's motion for leave to file amicus curiae will be granted, Plaintiff's motion for leave to file surreply will be granted, and Plaintiff's motion to compel will be denied without prejudice.

I. Background

Defendant Hogan signed Senate Bill ("Senate Bill or SB") 1028 on May 15, 2018. The law was codified as § 1-212.1 of the Health Occupations Article of the Maryland Code and took effect on October 1, 2018. (ECF No. 1-1, at 1, 6). § 1-212.1(b)

prohibits mental health or child care practitioners from engaging in conversion therapy, defined by § 1-212.1(a)(2)(i) as "a practice or treatment . . . that seeks to change an individual's sexual orientation or gender identity[,]" with minor clients. § 1-212.1(a)(1)(2)(ii) states that "'conversion therapy' includes any effort to change the behavioral expression of an individual's sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender."

Under § 1-212.1, mental health and child care practitioners may practice therapy with minors that "provides acceptance, support, and understanding, or the facilitation of coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices." However, such therapy may not "seek to change sexual orientation or gender identity." MD. CODE, Conversion Therapy, § 1-212.1(a)(1)(2)(iii). § 1-212.1(c) states that practitioners in violation of the statute "shall be considered to have engaged in unprofessional conduct and shall be subject to discipline by a certain licensing or certifying board."

§ 1-212.1(a)(3) defines "mental health or child care practitioner[s]" as physicians, professional counselors or therapists, psychologists, social workers or residential child

care program professionals licensed or certified in the State of Maryland, and "[a]ny other practitioner licensed or certified under [the Health Occupations Article of the Code of Maryland] who is authorized to provide counseling by the practitioners licensing or certifying board." According to Defendants, § 1-212.1 permits practitioners to (1) communicate with the public about conversion therapy; (2) express their views about conversion therapy to any person, including minor and adult clients; (3) recommend conversion therapy to any person, including minor and adult clients; (4) administer conversion therapy to clients over the age of 18; and (5) refer minor clients to unlicensed counselors and religious leaders for the purposes of undergoing conversion therapy. (ECF No. 26-1, at 3).

To conclude that sexual orientation change efforts ("SOCE") threaten the physical and psychological well-being of minors, the Maryland legislature relied on research, conclusions and statements by the American Psychological Association, American Psychiatric Association, American Medical Association Council on Scientific Affairs, National Association of Social Workers, American Counseling Association Governing Council, American School Counselor Association, American Psychoanalytic Association, American Academy of Child and Adolescent Psychiatry, American Association of Sexuality Educators,

Counselors, and Therapists, Pan American Health Organization, American College of Physicians, and the Pediatrics journal. (ECF No. 1-1, at 4). Much of the information that the legislature relied on discusses the efficacy, or lack thereof, of conversion therapy and explains that the practice may lead to depression or even suicide. For example, the American Psychological Association's 2009 report on sexual orientation change efforts defines SOCE as "methods that aim to change a same-sex sexual orientation (*e.g.*, behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) to hetereosexual[,]" (ECF No. 1-2, at 20 n.5) and concludes that:

> sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people, including confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidal ideations, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviors, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources.

(ECF No. 1-1, at 1). Concerned about the negative effects conversion therapy may have on children during and after receiving the treatment, the "Maryland General Assembly passed,

and the Governor signed, SB 1028 to protect Maryland children from harm[.]" (ECF No. 53, at 1).

Plaintiff is a "psychotherapist who is licensed to practice mental health counseling in Maryland." (ECF No. 1, at 5). Plaintiff currently acts as a mental health therapist for Patrick Henry College in Purcelville, VA, executive director for the Institute for Healthy Families in the Washington, D.C. area (the "Institute"), and clinical director and licensed counselor for Northern Virginia Christian Counseling. (ECF Nos. 53-2, at 2, p. 9 & 1, at 20). Plaintiff asserts that he "has devoted most of his professional life to providing counseling to young people and their parents who are seeking help for unwanted same-sex attractions[.]" (ECF No. 1, at 21).

II. Motions for Leave to File Briefs as Amici Curiae

FreeState is a legal advocacy organization that seeks to improve the lives of low-income lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people in Maryland. (ECF No. 28, at 1). FreeState contends that it "has demonstrated a special interest in the outcome of the suit" and "represents large constituencies of individuals which have a vested interest" because it "played an integral role in advocating for the passage and subsequent enactment" of § 1-212.1. (*Id.*, at 2) (internal quotations omitted). Similarly, The Trevor Project states that it is the nation's largest LGBTQ youth crisis

intervention and suicide prevention organization. Some of the individuals The Trevor Project serves were treated with conversion therapy or belong to families interested in compelling them to undergo conversion therapy. (ECF No. 31, at 2). The Trevor Project contends that it "has a special interest in this litigation and can offer . . . an additional, unique perspective on the relevant facts and law[] based on what it has learned firsthand from the LGBTQ youth it serves." (ECF No. 31, at 1). Both parties also point out that several other district courts analyzing the constitutionality of similar laws that ban conversion therapy have "liberally granted leave to file amicus *curiae* briefs[.]" (ECF Nos. 28, at 2 & 31, at 5).

Plaintiff opposes the proposed amici curiae, arguing that their proposed briefs are neither useful nor timely. (ECF No. 37, at 2). As for usefulness, Plaintiff disputes the relevance of a study article appended to FreeState's proposed brief and argues that, based on a 2014 public statement by a FreeState's predecessor organization Equality Maryland, the organization actually believes § 1-212.1 is unnecessary. (*Id.*, at 3-5). Plaintiff adds that The Trevor Project's discussion about the negative effects conversion therapy may have on parent-child relationships is discredited by Defendants' response to Plaintiff's request for admissions. As for timeliness, Plaintiff states that the amici curiae "proffer information

months after the counseling ban" and believes acceptance of the amicus briefs "will disrupt the current preliminary injunction proceedings." Finally, Plaintiff argues that the factual material included in The Trevor Project's proposed brief creates an "*ex post facto* evidentiary record to bolster Maryland's counseling ban enactment." (*Id.*, at 8).

There is no Federal Rule of Civil Procedure that applies to motions for leave to appear as amicus curiae in a federal district court. District courts therefore have discretion whether to grant or deny such leave and often look for guidance to Rule 29 of the Federal Rules of Appellate Procedure, which applies to amicus briefs at the federal appeals level. *See, e.g.*, *Jin v. Ministry of State Sec.*, 557 F.Supp.2d 131, 136 (D.D.C. 2008); *Tafas v. Dudas*, 511 F.Supp.2d 652, 660 (E.D.Va. 2007); *Bryant v. Better Bus. Bureau of Greater Md., Inc.*, 923 F.Supp. 720, 728 (D.Md. 1996); *Washington Gas Light Co. v. Prince George's County Council*, Civ. Action No. 08-cv-0967-DKC, 2012 WL 832756, at *3 (D.Md. Mar. 9, 2012). Rule 29 indicates that amici should state "the reason why an amicus brief is desirable and why the matters asserted are relevant to the disposition of the case." Fed.R.App.P. 29(b)(2). As noted by Judge Davis in Bryant, "[t]he aid of amici curiae has been allowed at the trial level where they provide helpful analysis of the law, they have a special interest in the subject matter of the suit, or existing

counsel is in need of assistance." *Bryant*, 923 F.Supp. at 728 (citing *Waste Mgmt. of Pa., Inc. v. City of York*, 162 F.R.D. 34, 36 (M.D.Pa. 1995)). "A motion for leave to file an amicus curiae brief, however, should not be granted unless the court 'deems the proffered information timely and useful.'" *Id.* (quoting *Yip v. Pagano*, 606 F.Supp. 1566, 1568 (D.N.J. 1985), *aff'd*, 782 F.2d 1033 (3d Cir. 1986), *and aff'd sub nom. Appeal of Yip*, 782 F.2d 1033 (3d Cir. 1986)).

FreeState and The Trevor Project have each demonstrated a special interest in the outcome of the suit. The Trevor Project's memorandum provides a separate, experiential perspective of conversion therapy and the issues surrounding it and FreeState's memorandum provides a helpful analysis of § 1-212.1 as a reasonable regulation of a particular mental health treatment. Additionally, Plaintiff's arguments in opposition to the proposed amici curiae are without merit. Plaintiff's argument that FreeState actually agrees with Plaintiff's position on § 1-212.1 is speculative and, therefore, unpersuasive. To the extent that The Trevor Project's brief is undermined by Defendants' admissions, a single discrepancy fails to frustrate The Trevor Project's proposed amicus brief in its entirety. Furthermore, both proposed amici filed their briefs shortly after Defendants filed their motion to dismiss and opposition to Plaintiff's motion for preliminary injunction,

providing ample time for their review and consideration. Thus, Plaintiff's timeliness objections are similarly unconvincing. The proposed amicus briefs also comply with the requirements of United States District Court for the District of Maryland Standing Order 2018-07. Accordingly, the motions for leave to file brief as amicus curiae will be granted and the amicus briefs will be considered.

III. Motion to Compel

Plaintiff argues that, "when [he] attempted to take Defendants' Rule 30(b)(6) deposition on March 28, 2019, Defendants either refused to answer dozens of questions on the basis of 'legislative privilege,' or their designated witness was unprepared and could not answer any of numerous specific questions as to how Defendants interpret, apply or enforce [§ 1-212.1]." (ECF No. 38, at 1). Thus, under Fed.R.Civ.P. 37(a)(1), Plaintiff requests "an order compelling Defendants to provide a Rule 30(b)(6) deposition witness properly prepared and able to answer [his] questions concerning Defendants' positions, interpretations, understanding, application, and enforcement of [§ 1-212.1]." (ECF No. 44, at 1). Plaintiff also requests "an order compelling Defendants to produce a properly prepared Rule 30(b)(6) designee to answer Plaintiffs' deposition questions concerning Defendants' consideration of less speech-restrictive alternatives to [§ 1-212.1]." (*Id.*).

In response, Defendants explain that, after receiving Plaintiff's notice of deposition, they arranged a designee to attend the deposition and fully answer Plaintiff's questions. (ECF No. 52, at 1-2). Defendants argue that the designee spent ample time preparing for the deposition and answered Plaintiff's questions "on allegations of harm related to conversion therapy, possible amendments to the bill that were considered and adopted by the legislature, testimony presented at the committee hearings on the bill, and the public conclusions made by the legislature." (*Id.*, at 4-10). Finally, Defendants assert that the designee was entitled to assert legislative privilege when Plaintiff's "deposition questions inquired into legislative intent[.]" (*Id.*, at 12).

Rule 30(b)(6) provides that persons designated to represent an organization "must testify as to matters known or reasonably available to the organization." The rule "requires a good faith effort . . . to find out the relevant facts—to collect information, review documents and interview employees with personal knowledge[.]" *Wilson v. Lakner*, 228 F.R.D. 524, 528 (D.Md. 2005). "As a corollary, depending on the nature and extent of the obfuscation, the testimony given by [a] nonresponsive deponent (*e.g.*, 'I don't know') may be deemed binding on the corporation so as to prohibit it from offering

contrary evidence at trial." *Dorsey v. TGT Consulting, LLC*, 888 F.Supp.2d 670, 685 (D.Md. 2012).

Here, the arguments advanced in support of Plaintiff's request are unpersuasive. Defendants provided a designee, the Director of Health Occupations Boards and Commissions, with knowledge about § 1-212.1. In preparation for the deposition, the designee spent about 7 hours reviewing documents and speaking with lawyers in the Maryland Attorney General's office. (ECF No. 45-1, at 23-24). Finally, Plaintiff's frustration with the designee's invocation of legislative privilege here does not demonstrate noncompliance with Rule 30(b)(6). The designee's testimony indicates that she made "good faith efforts to prepare" and "rendered substantial testimony concerning the subject area of [her] designation[.]" *Wilson*, 228 F.R.D. at 530 (internal quotations removed). Thus, Plaintiff's arguments do not indicate that additional designees are necessary at this time. Accordingly, Plaintiff's motion to compel will be denied.

IV. Motion for Leave to File Surreply

Plaintiff argues that his proposed surreply to Defendants' motion to dismiss must be accepted because he must be provided with and have an opportunity to address the discovery evidence Defendants rely on in their reply. (ECF No. 58, at 1). According to Plaintiff, Defendants' reply "argue[s], for the first time, that discovery evidence supports dismissal of Plaintiff's claims

for lack of standing" and relies on "passages of Plaintiff's deposition testimony that w[ere] not available when Defendants' Motion to Dismiss was filed." (*Id.*) Thus, Plaintiff's surreply requests permission "to argue from discovery evidence, including all of [his] deposition testimony[.]" (*Id.* (emphasis omitted)).

Under Local Rule 105.2(a), "[u]nless otherwise ordered by the Court, surreply memoranda are not permitted to be filed." A surreply may be permitted "when the moving party would be unable to contest matters presented to the court for the first time in the opposing party's reply." *Khoury v. Meserve*, 268 F.Supp.2d 600, 605 (D.Md. 2003) (citation omitted). By contrast, "[a] motion for leave to file a surreply may be denied when the matter addressed in the reply is not new." *Marshall v. Capital View Mut. Homes*, No. 12-cv-3109-RWT, 2013 WL 3353752, at *3 (D.Md. July 2, 2013) (citation omitted).

By way of background, Defendants' motion to dismiss argues that Plaintiff lacks standing. Specifically, Defendants state that Plaintiff does not allege an injury-in-fact, or "'[] intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by statute' and that 'there exists a credible threat of prosecution thereunder.'" (ECF No. 26-1, at 7) (quoting *Davison v. Randall*, 912 F.3d 666, 678 (4th Cir. 2019)). Plaintiff's opposition to Defendants' motion to dismiss argues that Plaintiff has standing

because, due to § 1-212.1, he may have to halt counseling with five Maryland minor clients he is treating for "unwanted same-sex attractions and/or gender identity conflicts." (ECF No. 47, at 3) (internal quotation omitted). Defendants' reply repeats and elaborates on their original standing argument, adding that Plaintiff's deposition and other discovery documents further demonstrate Plaintiff's lack of standing. (ECF No. 53, at 1-5). Attached to Defendants' reply are excerpts of Plaintiff's deposition, Plaintiff's answers to interrogatories, and copies of informed consent forms used by Plaintiff at the Institute for Healthy Living. (ECF Nos. 53-2; 53-3; 53-4; 53-5; 53-6).

Although the standing argument in Defendants' reply is not novel, Defendants do augment their argument with new evidence by relying on Plaintiff's discovery responses. As a result, Plaintiff's deposition and the standing arguments in Plaintiff's proposed surreply that advance new conclusions based on the deposition will be considered in determining whether Plaintiff has standing and the motion for leave to file surreply will be granted.

V. Motion to Dismiss

A. Defendants' Incorporation by Reference

Defendants filed an opposition in response to Plaintiff's motion for preliminary injunction on March 8, 2019. (ECF No. 25). In their motion to dismiss, Defendants rely on and

incorporate by reference some of the arguments they advanced in their opposition to Plaintiff's motion for preliminary injunction, which assert that Plaintiff "has not state[d] a claim for violation of his free speech rights as a matter of law." (ECF No. 26-1, at 2 n.1). As a preliminary matter, Plaintiff disputes Defendants' incorporation by reference. (ECF No. 47, at 10-11). Plaintiff's response to Defendants' motion to dismiss and motion for leave to file surreply conclude that Defendants' incorporation indicates waiver of their defense because Defendants "only perfunctorily and cursorily referenced their defense of failure to state a claim as to [Plaintiff]'s [f]ree [s]peech claim[.]" (*Id.*; *see also* ECF No. 58, at 11). Defendants' reply argues instead that Federal Rule of Civil Procedure 10(c) allows them to incorporate by reference their arguments that Plaintiff cannot establish a violation of his free speech rights. (ECF No. 53, at 9).

Rule 10(c) provides that "[a] statement in a pleading may be adopted by reference elsewhere in the same pleading or in any other pleading or motion." Although Rule 10 instructs the form of pleadings, "[a] few federal courts have allowed defendants to incorporate by reference to prior motions made in the action." 5A Charles Alan Wright & Arthur R. Miller, Fed. Prac. & Proc. Civ. § 1326 (4th ed. 2019). This court and other federal district courts have allowed incorporation by reference under similar

circumstances. *See, e.g., NVR, Inc. v. Harry A. Poole, Sr. Contractor, Inc.*, No. 14-cv-241-ELH, 2015 WL 1137739, at *2 n.5 (D.Md. Mar. 13, 2015) (considering arguments incorporated from defendant's previous motion to dismiss into defendant's newly filed reply to plaintiff's response to defendant's motion to dismiss or, in the alternative, motion for more definite statement); *Levy v. Wexford Health Sources, Inc.*, No. 14-cv-3678-TDC, 2016 WL 865364, at *6 (D.Md. Mar. 7, 2016) (permitting parties to "incorporate by reference arguments made in their original briefs" if plaintiff was required to re-file her motion for partial summary judgment); *Lowden v. William M. Mercer, Inc.*, 903 F.Supp. 212, 216 (D.Mass. 1995) (stating that "it is appropriate to incorporate by reference an argument made in a motion to dismiss an original complaint despite the subsequent amendment of the complaint."). Because Plaintiff's arguments in favor of prohibiting incorporation are without merit, the free speech arguments advanced in Defendants' opposition to Plaintiff's motion for preliminary injunction will be evaluated as part and parcel of Defendants' motion to dismiss.

B. Standing

The issue of standing may be challenged on a motion to dismiss for lack of subject matter jurisdiction under Fed.R.Civ.P. 12(b)(1). "The plaintiff has the burden of proving that subject matter jurisdiction exists." *Evans v. B.F. Perkins*

Co., 166 F.3d 642, 647 (4th Cir. 1999). When deciding Rule 12(b)(1) motion, the court "may consider evidence outside the pleadings" to help determine whether it has jurisdiction over the case before it. *Richmond, Fredericksburg & Potomac R.R. Co. v. United States*, 945 F.2d 765, 768 (4th Cir. 1991); *see also Evans*, 166 F.3d at 647. The court should grant a Rule 12(b)(1) motion "only if the material jurisdictional facts are not in dispute and the moving party is entitled to prevail as a matter of law." *Richmond*, 945 F.2d at 768 (citing *Trentacosta v. Frontier P. Aircraft Indus.*, 813 F.2d 1553, 1558 (9th Cir. 1987)).

Any plaintiff seeking to invoke the jurisdiction of a federal court must establish standing. *See, e.g.*, *Allen v. Wright*, 468 U.S. 737, 750—51 (1984); *S. Walk at Broadlands Homeowner's Ass'n Inc. v. Openband at Broadlands, LLC,* 713 F.3d 175, 185 (4th Cir. 2013). The doctrine of standing consists of two distinct "strands": constitutional standing pursuant to Article III and prudential standing. *See Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11 (2004). The requirements for constitutional standing reflect that Article III "confines the federal courts to adjudicating actual 'cases' and 'controversies.'" *Allen*, 468 U.S. at 750; *see also Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1993) ("[S]tanding is an essential and unchanging part of the case-or-controversy requirement of Article III[.]"). "[A plaintiff] must, in other

words, show that the facts alleged present the court with a 'case or controversy' in the constitutional sense and that [he] is a proper plaintiff to raise the issues sought to be litigated." *Linda R.S. v. Richard D.*, 410 U.S. 614, 616 (1973). To establish Article III standing, a plaintiff must demonstrate that:

> (1) [she] has suffered an "injury in fact" that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Doe v. Obama, 631 F.3d 157, 160 (4th Cir. 2011) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 180-81 (2000)). A plaintiff can show injury-in-fact in two ways:

> First, there is a sufficiently imminent injury in fact if plaintiff[] allege[s] "an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder." *Babbitt v. Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979). "[I]t is not necessary that [a plaintiff] first expose himself to actual arrest or prosecution to be entitled to challenge a statute that he claims deters the exercise of his constitutional rights." *Steffel v. Thompson*, 415 U.S. 452, 459 (1974). Separately, there is an ongoing injury in fact if plaintiff[] make[s] a "sufficient showing of self-censorship, which occurs when a claimant is chilled from exercising his right to free expression." *Cooksey v. Futrell*, 721 F.3d 226, 235 (4th

> Cir. 2013) (internal quotation marks omitted).

Kenny v. Wilson, 885 F.3d 280, 288 (4th Cir. 2018).

Defendants argue that Plaintiff cannot demonstrate injury-in-fact because he has minimal connections to the state of Maryland and "fails to allege that he performs or intends to perform conversion therapy on minor clients in Maryland." (ECF No. 26-1, at 8). Although Defendants accurately point out that Plaintiff's complaint and motion for preliminary injunction do "not specifically allege that he has *any* [client]s in Maryland" (*id.*), Plaintiff's answers to Defendants' interrogatories clarify that Plaintiff provides therapy to at least two minors who reside in Maryland and formerly provided counseling to at least three other minor clients who reside in Maryland (ECF No. 53-3, at 3).[1] Additionally, Plaintiff testified that he has used his Maryland therapeutic license (ECF No. 58-1, at 137) to treat minor clients in Maryland over the past three years (*id.*, at

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[1] Plaintiff's interrogatory responses indicate that he uses audio visual equipment to conduct much of the individual counseling with these clients. However, Plaintiff is still subject to Maryland law even if Plaintiff himself is not physically located in Maryland when treating his Maryland clients. *See* Craig P. Tanio et al., Maryland Telemedicine Task Force: Final Report, Appendix R: Physician Licensing in Maryland http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/tlmd/tlmd_ttf_rpt_102014.pdf ("Physicians and other practitioners delivering telemedicine services must abide by state licensure and scope of practice laws and requirements in the state where the patient receives services.").

133) and wishes to continue this practice (*id.*). Thus, Plaintiff has demonstrated that he is a "mental health or child care practitioner" actively treating clients in Maryland. §1-212.1.

Defendants next argue that, even if Plaintiff demonstrates that he counsels clients in Maryland, he is not injured by § 1-212.1 because he does not actually perform conversion therapy. (ECF No. 53, at 2). Defendants rely on Plaintiff's testimony about his counseling practice, interrogatory answers and the consent forms he uses when practicing at the Institute for Healthy Families. (ECF Nos. 53-2; 53-3; 53-4; 53-5; 53-6). The forms state that "[Plaintiff] and the Institute for Healthy Families do[] not practice reparative therapy, reorientation therapy, conversion therapy, or any type of sexual orientation change effort (SOCE) therapy." (ECF No. 53-6, at 2). The forms further state that clients seeking treatment for sexual or gender identity conflicts will receive "sexual/gender identity-affirming therapy/coaching." (*Id.*). Plaintiff's deposition testimony states, in relevant part, that he "define[s] conversion therapy as a practice that is expressly trying to change a client from gay to straight" and affirms that he does not "engage in that particular kind of therapy." (ECF No. 53-2, at 5, p. 20). Plaintiff explained:

> Essentially, the work that I do, I describe it as sexual and gender identity affirming therapy, and what I explain to clients is

> that they're in the driver's seat, that I'm not imposing a goal on their work. I have a duty and a right to my clients to work with what they want to work on, and clients that may be open to sexual fluidity or change, I'm open to that client's goal.

(*Id.*, at 6, p. 22). Finally, Defendants argue that Plaintiff has not shown a credible threat of prosecution because "[h]e has not been the subject of complaints to the Maryland Board of Professional Counselors and Therapists . . . and his only communications with the Board occurred in connection with renewing his license." (ECF No. 53, at 5).

Plaintiff responds that relevant portions of his complaint demonstrate how he is injured by § 1-212.1, including:

> As a psychotherapist licensed in Maryland who engages in counseling to eliminate, reduce, or resolve unwanted same-sex attractions, behaviors, or identity, Plaintiff is subject to potential professional discipline under [§ 1-212.1].
>
> [§ 1-212.1] prohibits Plaintiff from engaging in counseling to eliminate, reduce, or resolve unwanted same-sex attractions, behaviors, or identity with his minor clients, and requires Plaintiff to discontinue ongoing counseling despite the clients' and their parents' consent and requests to continue, or face penalties under the statute.

(ECF No. 47, at 3) (quoting ECF No. 1, at 26). According to Plaintiff, "'[a]ccepting as true all of the factual allegations contained in the complaint and drawing all reasonable inferences in favor of the plaintiff,' . . . it is clear that [he] is

challenging [§ 1-212.1] because it bans his Maryland counseling with Maryland clients." (ECF No. 47, at 4) (quoting *Hall v. DIRECTV, LLC*, 846 F.3d 757, 765 (4th Cir. 2017), *cert. denied*, 138 S.Ct. 635 (2018) (internal marks omitted)). Plaintiff's surreply adds that, although Plaintiff testified that he does not engage in conversion therapy, he also testified that he currently treats minors with "gender identity confusion" who "sometimes identify a goal that they have for themselves to change or reduce or eliminate the unwanted attraction or confusion." (ECF No. 58-1, at 134-35). Where clients manifest this intent, Plaintiff "wish[es] to provide them with the counseling that they seek in order to accomplish their self-chosen goals." (*Id.*, at 135-36). In conclusion, Plaintiff stated that § 1-212.1 "determines that the work that [he] do[es] is called conversion therapy[.]" (*Id.*, at 136). Finally, Plaintiff adds that his practice of conversion therapy qualifies as prohibited behavior under § 1-212.1 even when the "change goal" originates with his minor client. (ECF No. 58, at 6).

Although portions of Plaintiff's testimony undermine whether Plaintiff practices conversion therapy as defined by § 1-212.1, Plaintiff has demonstrated standing. Plaintiff testified, after reading the definition of conversion therapy provided in the senate bill that preceded § 1-212.1, that he does not engage in conversion therapy. (ECF No. 58-1, at 70).

Plaintiff added that he "affirm[s] [the client's] identity as they state[.]" (*Id.*, at 73). However, Plaintiff explained that the treatments used to affirm a client's identity include "practices and techniques . . . that may have an effect on a client's sexual identity, gender identity, attractions, [and] behaviors[.]" (*Id.*, at 71-72). Plaintiff's treatment methods may simultaneously affirm a client's identity while "help[ing] them understand or resolve certain unwanted attractions and behaviors" (*id.*, at 74) because "a [client]'s sexual or gender identity may not be the same as their attractions [and] behaviors" (*id.*, at 72). Plaintiff "has experienced a non-speculative and objectively reasonable chilling effect" due to § 1-212.1 and, thus, has demonstrated standing. *Cooksey v. Futrell*, 721 F.3d 226, 236 (4th Cir. 2013).

C. Third-Party Standing

Plaintiff's complaint, filed "individually and on behalf of his clients[,]" alleges that § 1-212.1 harms his clients because the law "prevents [them] from receiving counseling to eliminate, reduce, or resolve unwanted same-sex attractions, behaviors, or identity and deprives them of the opportunity even to obtain information about such counseling from [licensed mental health professionals]." (ECF No. 1, at 33). Defendants argue that Plaintiff does not have third-party standing because his minor

clients "are not hindered in their ability to represent their own interests." (ECF No. 26-1, at 9).

Generally, a plaintiff "must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Warth v. Seldin*, 422 U.S. 490, 499 (1975). However, "there may be circumstances where it is necessary to grant a third party standing to assert the rights of another." *Kowalski v. Tesmer*, 543 U.S. 125, 129-30 (2004). The United States Court of Appeals for the Fourth Circuit summarized the test for third-party standing in *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 215 (4th Cir. 2002):

> Even if a plaintiff satisfies Article III standing requirements, "[f]ederal courts must hesitate before resolving a controversy, even one within their constitutional power to resolve, on the basis of the rights of third persons not parties to the litigation." *Singleton v. Wulff*, 428 U.S. 106, 113 (1976). To overcome the prudential limitation on third-party standing, a plaintiff must demonstrate: (1) an injury-in-fact; (2) a close relationship between [him]self and the person whose right [ ]he seeks to assert; and (3) a hindrance to the third party's ability to protect his or her own interests. *Powers v. Ohio*, 499 U.S. 400, 410–11 (1991).

There is little doubt that, if Plaintiff's minor clients would like Plaintiff to treat them using conversion therapy, they are injured by § 1-212.1. Likewise, Plaintiff's close

relationship with his minor clients is evidenced by his ongoing provision of counseling services. However, Plaintiff fails to show how his clients are unable to protect their own interests by independently bringing suit. Plaintiff asserts that his minor clients cannot file suit because they face "embarrassment, stigmatization, and opprobrium[.]" (ECF No. 47, at 6) (quoting ECF No. 1, at 29). However, the court "cannot simply assume that every" potentially embarrassed and stigmatized minor client "is incapable of asserting his or her own claims." *Freilich,* 313 F.3d at 215. "[T]hird parties themselves usually will be the best proponents of their own rights," and Plaintiff has provided no concrete evidence that these alleged factors prevent his minor clients from bringing their claims. *Singleton*, 428 U.S. at 114. Additionally, Plaintiff's minor clients may file pseudonymously to ensure their information remains private while proceeding on their own behalf. *See, e.g., Otto v. City of Boca Raton, Fla.,* 353 F.Supp.3d 1237, 1247 (S.D.Fla. 2019) ("Further, the Court notes . . . that minor clients have been able to file suit pseudonymously in other cases challenging bans on SOCE.") (internal quotations and citation omitted); *Doe v. Christie,* 33 F.Supp.3d 518, 520 (D.N.J. 2014), *aff'd sub nom. Doe ex rel. Doe v. Governor of N.J.*, 783 F.3d 150 (3d Cir. 2015); *Pickup v. Brown*, 42 F.Supp.3d 1347, 1349 (E.D.Cal. 2012), *aff'd*, 728 F.3d 1042 (9th Cir. 2013), and *aff'd*, 740 F.3d 1208 (9th Cir. 2014).

Accordingly, Plaintiff does not possess third party standing to bring claims on behalf of his minor clients. As a result, Plaintiff's claim that § 1-212.1 violates his clients' First Amendment right to receive information, asserted only on behalf of his minor clients, will be dismissed.

D. Eleventh Amendment Immunity

Defendants argue that, under the Eleventh Amendment, "the Governor and Attorney General, the only two [D]efendants, are immune from this suit and should be dismissed as defendants." (ECF No. 25, at 14). Defendants recognize that private individuals may sue "[s]tate officials for prospective or declaratory relief for ongoing violations of federal law[,]" (ECF No. 26-1, at 11) (quoting *Weigel v. Maryland,* 950 F.Supp.2d 811, 831 (D.Md. 2013)) (internal quotation marks omitted) but add that Defendants are not included under this Eleventh Amendment exception because they are not specifically responsible for enforcing § 1-212.1. (*Id.*, at 12). Plaintiff responds that Defendants are excepted from Eleventh Amendment immunity because § 1-212.1 "suggests department- or board-level officials are among the class of state officials who may be the proper defendants by virtue of explicit authority in" the law. (ECF No. 47, at 9).

Defendants' argument will be reviewed under Rule 12(b)(1). The Fourth Circuit has not decided whether sovereign immunity is

grounds for dismissal for failure to state a claim under Rule 12(b)(6) or for lack of subject matter jurisdiction under Rule 12(b)(1). Judges in this district favor analysis under Rule 12(b)(1) because immunity functions "as a block on the exercise of that jurisdiction[.]" *Gross v. Morgan State Univ.*, 308 F.Supp.3d 861, 865 (D.Md. 2018) (quoting *Biggs v. Meadows*, 66 F.3d 56, 60 (4th Cir. 1995)) (internal quotation marks omitted). "A motion to dismiss based on lack of subject matter jurisdiction pursuant to [] Rule . . . 12(b)(1) raises the question of whether the court has the competence or authority to hear the case." *Davis v. Thompson*, 367 F.Supp.2d 792, 799 (D.Md. 2005). The plaintiff bears the burden of establishing subject matter jurisdiction. *Adams v. Bain*, 697 F.2d 1213, 1219 (4th Cir. 1982); *see also Kerns v. United States*, 585 F.3d 187, 192 (4th Cir. 2009) (noting challenge may be either facial, *i.e.*, "a complaint fails to allege facts upon which subject matter jurisdiction can be based[,]" or factual, *i.e.*, "the jurisdictional allegations of the complaint [are] not true") (alteration in original) (internal citations and quotation marks omitted). Where defendants raise the defense of sovereign immunity, they make a facial challenge to the complaint. *See, e.g.*, *Weiss v. Price*, No. 17-cv-1127-ELH, 2018 WL 1156770, at *2 (D.Md. Mar. 5, 2018); *Downing v. Balt. City Bd. of School Comm'rs*, No. 12-cv-1047-RDB, 2012 WL 6615017, at *3 (D.Md. Dec. 18, 2012). In a facial

challenge, "the facts alleged in the complaint are taken as true, and the motion must be denied if the complaint alleges sufficient facts to invoke subject matter jurisdiction." *Kerns*, 585 F.3d at 192.

As noted by the Fourth Circuit in *Lee-Thomas v. Prince George's County Public Schools*, 666 F.3d 244, 248-49 (4th Cir. 2012):

> Pursuant to the Eleventh Amendment, "[t]he Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State." U.S. Const. amend. XI. The Supreme Court "has drawn on principles of sovereign immunity to construe the Amendment to establish that an unconsenting State is immune from suits brought in federal courts by her own citizens as well as by citizens of another State." *Port Auth. Trans-Hudson Corp. v. Feeney*, 495 U.S. 299, 304 (1990) (internal quotation marks omitted). The States' immunity also extends to "state agents and state instrumentalities." *Regents of the Univ. of Cal. v. Doe*, 519 U.S. 425, 429 (1997). "The Eleventh Amendment bar to suit is not absolute," however. *Feeney*, 495 U.S. at 304. There are three exceptions to that constitutional bar.
>
> First, "Congress may abrogate the States' Eleventh Amendment immunity when it both unequivocally intends to do so and acts pursuant to a valid grant of constitutional authority." *Bd. of Trustees of Univ. of Ala. v. Garrett*, 531 U.S. 356, 363 (2001) (internal quotation marks and alterations omitted). . . . Second, "the Eleventh Amendment permits suits for prospective injunctive relief against state officials

> acting in violation of federal law." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 437 (2004). . . . Third, "[a] State remains free to waive its Eleventh Amendment immunity from suit in a federal court." *Lapides v. Bd. of Regents of Univ. Sys. of Ga.*, 535 U.S. 613, 618 (2002).

To the extent that Plaintiff seeks damages for violation of his constitutional rights, Defendants are entitled to Eleventh Amendment immunity.

However, the second exception is also relevant here based on Plaintiff's request for injunctive relief. The exception, originally detailed in *Ex parte Young*, 209 U.S. 123, 155-56 (1908), applies to "officers of the state[] [who] are clothed with some duty in regard to the enforcement of the laws of the state[.]" Excluded from the exception are "officers who have only a general obligation to enforce all laws of the state and who lack a 'special relation' to the specific law or action being challenged." *Stinnie v. Holcomb*, 734 F.App'x 858, 874 (4th Cir. 2018) (citation omitted). "This requirement 'protects a state's Eleventh Amendment immunity while, at the same time, ensuring that, in the event a plaintiff sues a state official in his individual capacity to enjoin unconstitutional action, any federal injunction will be effective with respect to the underlying claim.'" *Kobe v. Haley*, 666 F.App'x 281, 299 (4th Cir. 2016) (quoting *McBurney v. Cuccinelli*, 616 F.3d 393, 399 (4th Cir. 2010).

§ 1-212.1(c) itself states that practitioners in violation of the statute "shall be subject to discipline by the mental health or child care practitioner's licensing or certifying board." § 1-212.1(e) adds that "The [Maryland] Department [of Health] shall adopt regulations necessary to implement this section." As Defendants highlight, the text of § 1-212.1 awards the statute's disciplinary and regulatory maintenance to specific bodies. However, the statute does not explicitly prohibit oversight by the Maryland governor and attorney general. Additionally, the governor "supervise[s] and direct[s] the officers and units" in the State of Maryland Executive Branch, including the Maryland Department of Health. MD. CODE, State Government, § 3-302. Similarly, the attorney general "is the legal adviser of and shall represent and otherwise perform all of the legal work for each officer and unit of the State government." *Id.* § 6-106; *see also Bostick v. Smoot Sand & Gravel Corp.*, 154 F.Supp. 744, 756 (D.Md. 1957), *judgment rev'd on other grounds*, 260 F.2d 534 (4th Cir. 1958) ("[I]t has not been unusual for the Maryland Attorney General to render legal opinions to agencies of the Federal government, and to include them in his official reports."). "The requirement is not a stringent one, as the officer being sued need only "'have some connection with the enforcement of the act.'" *Stinnie*, 734 F.App'x at 875 (quoting *Young*, 209 U.S. at 157). "[I]t is not

even 'necessary that such duty of enforcement be declared in the same act which is to be enforced.'" *Id.* (quoting *Young*, 209 U.S. at 157). Thus, Defendants have failed to demonstrate that issuing an injunction against them would be ineffective at prohibiting enforcement of § 1-212.1.

V. Conclusion

For the foregoing reasons, FreeState's motion for leave to file amicus curiae will be granted, The Trevor Project's motion for leave to file amicus curiae will be granted, Plaintiff's motion for leave to file surreply will be granted, and Plaintiff's motion to compel will be denied without prejudice. A separate order will follow.

/s/
DEBORAH K. CHASANOW
United States District Judge

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

American Psychological Association

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

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

Purpose

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

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

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

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

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

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

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

Documentation of Need

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

Users

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

Distinction Between Standards and Guidelines

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

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

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

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Compatibility

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

Practice Guidelines Development Process

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

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

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

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

Selection of Evidence

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

Foundational Knowledge and Awareness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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societal stigma particular to African American men. An Asian American/Pacific Islander trans woman may experience the benefit of being perceived as a cisgender woman, but may also experience sexism, misogyny, and objectification particular to Asian American/Pacific Islander cisgender women.

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

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

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

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

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

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

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

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

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making, given the historical disenfranchisement and disempowerment of TGNC people in health care.

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

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

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

Stigma, Discrimination, and Barriers to Care

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

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

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

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

Issues of employment discrimination and workplace harassment are particularly salient for TGNC military personnel and veterans. Currently, TGNC people cannot serve openly in the U.S. military. Military regulations cite "transsexualism" as a medical exclusion from service (Department of Defense, 2011; Elders & Steinman, 2014). When

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Life Span Development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assessment, Therapy, and Intervention

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

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

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

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

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

Application. Because of the increased risk of stress-related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC people (Coleman et al., 2012). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC person is experiencing, nor erroneously

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assume that those mental health problems are a result of the person's gender identity or gender expression. Psychologists are strongly encouraged to be cautious before determining that gender nonconformity or dysphoria is due to an underlying psychotic process, as this type of causal relationship is rare.

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

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

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

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

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

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

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an important source of resilience (Glaser, 2008; Kidd & Witten, 2008; Porter et al., 2013).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TGNC people may present with a range of parenting and family-building concerns. Some will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to make decisions regarding potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. The medical and/or social transition of a TGNC parent may shift family dynamics, creating challenges and opportunities for partners, children, and other family members. One study of therapists' reflections on their experiences with TGNC clients suggested that family constellation and the parental relationship was more significant for children than the parent's social and/or medical

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transition itself (White & Ettner, 2004). Although research has not documented that the transitions of TGNC people have an effect on their parenting abilities, preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition (dickey et al., 2012). This may result in divorce or separation, which may affect the children in the family. A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children (Amato, 2001; White & Ettner, 2007). This seems to be the case especially when children are reminded of the parent's love and assured of the parent's continued presence in their life (White & Ettner, 2007). Based on a small body of literature available, it is generally the case that younger children are best able to incorporate the transition of a parent, followed by adult children, with adolescents generally having the most difficulty (White & Ettner, 2007). If separated or divorced from their partners or spouses, TGNC parents may be at risk for loss of custody or visitation rights because some courts presume that there is a nexus between their gender identity or gender expression and parental fitness (Flynn, 2006). This type of prejudice is especially common for TGNC people of color (Grant et al., 2011).

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

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

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

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

Depending on the timing and type of options selected, psychologists may explore the physical, social, and emotional implications should TGNC people choose to delay or

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

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

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

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

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

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

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

Research, Education, and Training

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

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

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

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

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

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

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

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

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

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

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

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Appendix A
Definitions

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

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

(*Appendices continue*)

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

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

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

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

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

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

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

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

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

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

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

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

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

(*Appendices continue*)

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

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

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

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

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

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

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

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

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

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

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

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

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

(*Appendices continue*)

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

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

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

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

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

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

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

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

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

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Appendix B

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

Foundational Knowledge and Awareness

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

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

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

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

Stigma, Discrimination, and Barriers to Care

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

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

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

(*Appendices continue*)

Life Span Development

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

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

Assessment, Therapy, and Intervention

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

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

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

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

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

Research, Education, and Training

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

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

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Gender Identity Disorder in Young Boys: A Parent- and Peer-Based Treatment Protocol

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ABSTRACT

Gender identity disorder (GID) as a psychiatric category is currently under debate. Because of the psychosocial consequences of childhood GID and the fact that childhood GID, in most cases, appears to have faded by the time of puberty, we think that a cost-effective treatment approach that speeds up the fading process would be beneficial. Our treatment approach is informed by the known psychosocial factors and mechanisms that contribute to gender identity development in general, and focuses on the interaction of the child with the parents and with the same-gender peer group. To minimize the child's stigmatization, only the parents come to treatment sessions. A review of a consecutive series of 11 families of young boys with GID so treated shows a high rate of success with a relatively low number of sessions. We conclude that this treatment approach holds considerable promise as a cost-effective procedure for families in which both parents are present.

KEYWORDS

assessment, childhood, gender identity disorder, peer relations, risk factors, therapy

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Gender identity disorder in childhood

GENDER IDENTITY DISORDER (GID) – according to DSM-IV (American Psychiatric Association [APA], 1994) a combination of a 'strong and persistent cross-gender identification' with 'persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that gender' – is an uncommon psychiatric condition. Systematic epidemiologic prevalence data are not yet available. Childhood GID occurs several times more frequently in boys than in girls, if judged by referral patterns to specialized clinics. As far fewer data are available on girls with GID, and hardly any on their treatment, this article is limited to boys. Co-morbidity with other psychiatric conditions, especially conditions with an internalizing character, have been reported (e.g. Coates & Person, 1985; Zucker, 1990; Zucker & Bradley, 1995). Such co-morbidity seems to be particularly characteristic of boys referred for the evaluation of a gender identity problem during middle childhood (Zucker, 1990; Zucker & Bradley, 1995).

In only a very small subgroup of such boys, will the GID continue into adolescence and adulthood (transsexualism). By adolescence, the cross-gender identity of *most* appears to have faded, although the process or the causes of such fading have not been systematically studied. The majority of boys with GID will apparently become homosexual, and a minority heterosexual (Green, 1987). The prognosis for girls with GID is not well known, but retrospective data indicate that a few of them also will become transsexual, and others homosexual.

Justification of treatment

In the transgender rights movement, the question of a clinical diagnosis of GID is currently under intense debate. Many transgender persons would like to avoid the stigma of 'mental disorder' and prefer a medical – for instance, neurological – diagnostic category. Such a designation would permit the provision of needed health services. However, this argument predominantly addresses GID in adulthood. In regard to childhood GID, many gay/lesbian activists interpret its statistical association with later homosexuality as an indication that childhood GID is really childhood homosexuality ('proto-gay', Corbett, 1998) and should not be labeled as pathology at all (e.g. Minter, 1999). The exchanges between Richardson (1996, 1999) and Zucker (1999a), and Isay (1997) and Zucker (1999b) present the major arguments. Similarly to Zucker, we see GI and its variants as conceptually different from sexual orientation. A subgroup of children who later develop a homosexual orientation may have an increased vulnerability for developing childhood GID, but that does not make GID synonymous with homosexuality, especially given the fact that the GID has typically vanished by puberty.

What is apparent if one works clinically with GID boys is that they often experience problems such as frequent and severe ostracism by peers and others, including family members. They may show depressive and anxious features, already in early and middle childhood, and develop suicidal ideation when older. Because of continuing peer pressure, if they still act noticeably feminine in early and mid-adolescence, they run the risk of dropping out from school and jeopardizing their education. Thus, childhood GID in boys certainly constitutes a risk factor for exposure to social pressures and adverse emotional consequences. These sequelae of GID are our primary reason for its treatment. We expect that we can diminish these problems if we are able to speed up the fading of the cross-gender identity which will typically happen in any case. At present, we do not know for certain whether childhood GID that fades by puberty and childhood

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GID that continues into adulthood are two different childhood conditions. Therefore, we cannot rule out the possibility that early successful treatment of childhood GID will diminish the risk of a continuation of GID into adulthood. If so, successful treatment would also reduce the need for the long and difficult process of sex reassignment which includes hormonal and surgical procedures with substantial medical risks and complications.

Note that the prevention of homosexual development is not a goal of this treatment approach. Homosexuality per se is not a psychiatric disorder and therefore not in need of treatment. In addition, the available follow-up data on boys with a history of therapy for GID (Green, 1987) do not provide us with evidence suggesting that a treatment program focused on GID in childhood will have any effect on the development of sexual orientation.

Existing treatment approaches

To date, no well-established standard treatment regimen for the reduction of childhood GID is available, either pharmacological or psychological (Zucker, 2001). The treatment literature is typically limited to case reports, and descriptions of treatment regimens mostly refer to two categories (Zucker, 2001; Zucker & Bradley, 1995): (i) psychodynamically oriented or psychoanalytic treatment (e.g., Coates, Friedman, & Wolfe, 1991; Di Ceglie, 1998; Meyer & Dupkin, 1985), (ii) behavior therapy (Rekers, 1977, 1985; Rekers, Kilgus, & Rosen, 1990). However, the latter's coercive flavor, especially when associated with a religious ideology, has been strongly criticized (Pleak, 1999). Many therapists do not adhere to one specific school, but use elements of these and other therapeutic approaches.

Successful outcome has been reported for both forms of therapy in diverse individual cases. Yet, the lack of systematically controlled treatment studies of larger samples of boys with GID makes any statement on the general efficiency of a specific treatment approach impossible. The case reports involving dynamic treatment approaches have the added disadvantage that they leave very unclear which of the many therapeutic activities and techniques employed over the years of treatment actually account for symptomatic change, or even whether the multi-year treatment adds anything at all to the long-term process of fading of the cross-gender identity.

Importantly, the two predominant treatment modes described in the literature require much time and effort and are, therefore, very expensive. The case reports of psychodynamic treatment typically include multiple sessions per week over long periods, often spanning several years. The behavioral approach advocated by Rekers includes many home visits, sometimes with several graduate students involved in one case, an arrangement that is difficult to transpose into routine clinical practice.

Thus, there is a need for an effective treatment program that is relatively short-term and accessible to families of a wide socio-economic range. The purpose of the current article is to present a treatment protocol developed in our unit and to document the treatment outcome in a consecutive series of 11 young boys so treated.

Rationale for a new treatment approach

How should one go about developing a treatment program for children with GID? One would expect that some guidance should be provided by what we know about factors that contribute to the development of GID and/or its maintenance. Unfortunately, our knowledge here is still rudimentary. Table 1 lists a number of factors that have been suspected or demonstrated to play a role (Blanchard, Zucker, Bradley, & Hume, 1995; Coates et al., 1991; Coates, Hahn-Burke, Wolfe, Shindledecker, & Nierenberg, 1994;

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Table 1. Putative Gender Risk Factors

Abnormalities of the prenatal sex hormone milieu
Abnormalities of sex hormone production or utilization
Exposure to exogenous sex hormones (e.g., progestogens, DES)
Exposure to drugs (e.g., barbiturates, opiates)
Maternal stress (physical, emotional)
Characteristics of the boy
Feminine physical appearance
Poor health
Temperament (e.g., inhibited and shy)
Early separations
Separation anxiety
Rivalry with sister
Birth order late
Number of male siblings increased
Sensory reactivity enhanced
Sexual abuse
Characteristics of the parents or other caretakers
Parental preference for girl
Inadequate parental sex-typing
Indifference to cross-gender behavior
Initiation/encouragement of cross-gender behavior
Maternal encouragement of extreme physical closeness with boy
Lack/inadequacy of adult male models
Maternal dominance
Parental psychiatric problems

Coates, Wolfe, & Hahn-Burke, 1994; Green, 1974, 1987; Marantz & Coates, 1991; Meyer-Bahlburg, 1993; Zucker, 1985, 1990; Zucker, Wild, Bradley, & Lowry, 1993). Yet the empirical evidence, where it exists at all, is usually limited to not more than one study and is correlational rather than causal in character, so that none of the factors can be considered fully established. That conclusion applies even to the recently documented neuroanatomic feature of a reduced-sized brain nucleus, the central subdivision of the bed nucleus of the stria terminalis (BSTc) in adult male-to-female transsexuals (Kruijver et al., 2000; Zhou, Hofman, Gooren, & Swaab, 1995). Their BSTc volume was comparable with that of women and had approximately half the volume found in heterosexual and homosexual men. Replication by independent laboratories is yet to be done, and we also do not know whether such findings in adults apply to childhood GID.

Note that none of the suspected pregnancy factors – all of which imply variations of the prenatal sex-hormone milieu – has definitively been shown to operate in boys with GID. Even if there were solid empirical evidence, it would not necessarily yield any specific and feasible treatment approach, because organizational effects of prenatal hormones on brain development are likely to be limited to specific periods of fetal ontogenesis. There is good reason to assume that gender problems as they occur in children born with ambiguous genitalia are not the same as those in GID (Meyer-Bahlburg, 1994). The fact that, in our clinic, children who fully meet DSM-IV criteria for GID typically display much more extreme cross-gender behavior (5–10 standard deviations apart from gender-typical behavior on global bipolar gender scales) than intersex children with known prenatal hormone abnormalities (Meyer-Bahlburg, unpublished data) also makes a primary role of prenatal hormones in the development of GID less likely. In

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addition, there is no evidence for any sex-hormone abnormalities in boys with GID during early or middle childhood. Thus, treatment with sex hormones – a question frequently brought up by parents – is not an option. However, many boys with GID, even after the gender identity problem is resolved, appear to show a 'temperamental syndrome' that includes low interest in rough-and-tumble play and sports, low aggressiveness with other boys, aesthetic sensibility, and high emotionality (Meyer-Bahlburg, 1999), supported by small-sample studies showing increased prevalence of separation anxiety and depressive features (Coates & Person, 1985) and of inhibited-child syndrome and increased sensory sensibility (Coates & Wolfe, 1995). If such a temperamental syndrome should be confirmed, it is likely to have a partly genetic basis, as shown for instance for the inhibited child syndrome, and the genetic basis may well be unrelated to prenatal sex hormone variations.

Additional presumed etiologic factors for childhood GID are on the psychosocial side. They frequently imply or are derived from known mechanisms of social learning that appear to operate in the establishment or maintenance of gender-role behavior in children without GID (Fagot, 1985; Fagot & Leinbach, 1989; Huston, 1983) and are also reflected in the usually (but not always) quite strong influence of older siblings on the development of gender-role behavior in younger children in general (McHale, Crouter, & Tucker, 1999; Rust, Golombok, Hines, & Johnston, 2000). That social-learning mechanisms are involved is also compatible with success of intensive behavior therapy shown in the case reports by Rekers and co-workers (Rekers et al., 1990). In addition, increased insecure attachment has been noted in boys with GID (Birkenfeld-Adams, quoted in Bradley & Zucker, 1997) which may implicate aspects of the parent–child relationship in the development of the gender problem.

Thus overall, in the context of contemporary developmental psychopathology (Johnson, Cohen, Kasen, Smailes, & Brook, in press; Sameroff, 1997; Zeanah, Boris, & Larrieu, 1997), the most likely developmental pathway to GID will involve temperamental features coupled with a variety of psychosocial risk factors which in aggregate determine how far the child moves into the cross-gender area. Psychosocial risk factors are more likely targets of psychosocial interventions than temperament.

From birth onward, the child is exposed to psychosocial influences of the family, especially parents and siblings. Often one sees an unusually strong attachment of the GID boy to one or more adolescent or adult women, whereas fathers may be little available or even avoid the child because they dislike the feminine behavior. Participation in or even encouragement of feminine play and demeanor, or discouragement of rough and tumble boyish activities by a parent, often the mother or another woman in the family, are quite frequent.

Additional psychosocial influences on gender development come from the peer group (Maccoby, 1998). Relations to the peer group are a crucial part of the GID diagnosis. For instance, the key symptoms described for young boys with GID include 'strong preference for playmates of the other sex', i.e. of girls, along with 'intense desire to participate in the stereotypical games and pastimes of the other sex', preferential adoption of cross-gender pretend play, and cross-dressing. Fear and avoidance of other boys can be striking. Fridell (2001) has documented in detail the difficulties boys with GID experience in relations to other boys. A likely consequence of their preference for girl playmates is the continuous rehearsal of female role skills and habits, and a lack of development of male role skills and habits. The avoidance of contact with boys also implies a lack of peer group reinforcement for male-typical behavior; such peer-group reinforcement has been documented from middle preschool age on (Fagot, 1985; Katz & Walsh, 1991; Maccoby & Jacklin, 1987). From the large body of evidence on childhood

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peer relations in general (Schneider, 2000), we can infer that poor relations to male peers also indicate poor social competence, at least with male peers, and an increased likelihood of peer victimization (Hawker & Boulton, 2000) and of various internalizing problems (Boivin, Hymel, & Bukowski, 1995). We have to take into consideration that a boy's peer cohort is the age group he will have to interact and compete with in all spheres of adolescent and adult life, so that significant problems in this area during childhood may constitute an important disadvantage later.

The treatment literature contains some other useful hints for treatment development. For instance, Zucker, Bradley, Doering, and Lozinski (1985), in a survey of treatment cases covering diverse treatment approaches, concluded that the 'degree of [gender-related] behavioral change at follow-up correlated positively with number of therapy sessions and the child therapists' emphasis on gender-identity issues'. We have to keep in mind, however, that even 3–4 weekly sessions with a psychodynamically oriented therapist represent a small amount of time in comparison with the multiple social influences operating at home and in school. In addition, there are the questions of stimulus and response specificity. An experimental study by Rekers (1975) clearly demonstrated that behavior therapy of gender-atypical behavior in boys with GID in a therapist's office generalizes poorly to the home environment, and Rekers has repeatedly demonstrated that behavior therapy directed at one specific gender-atypical behavior may not necessarily generalize to another (possibly because classical behavior modification neglects the mechanism of self-socialization originally described by Kohlberg, 1966).

Taken together, these diverse considerations led us to develop a treatment approach for young children with GID that is mediated by the parents and includes a strong emphasis on relationships with same-sex peers. The expectation is that markedly increased exposure to same-sex peers will lead to more typical sex-differentiated behavior, as it has been shown by Martin and Fabes (2001) in a longitudinal study of a convenience sample of 3–6-year-old children (presumably without GID). Our particular treatment program has been designed for the age group we see the most, 4–6-year-olds.

Assessment

Our involvement with the patient begins with a systematic evaluation which by itself influences already the parents' understanding of the situation. The evaluation protocol has been designed to establish if the child meets criteria for the DSM diagnosis of GID and to rule out somatic intersexuality, to assess the degree or severity of GID, to identify other behavioral problems that need attention, to screen for putative risk factors that may have facilitated the development of GID in this child, and to identify factors that are contributing to its maintenance or might constitute barriers to change. The evaluation involves at least five sessions: two sessions with the parents, two sessions with the child, and a wrap-up session with the parents. Where both parents live together, we require both to participate in all sessions except those with the child.

The *evaluation procedures with the parents* include a battery of questionnaires and interviews (Table 2). Prior to Session 1, preferably right before it, in a room in the clinic, the parents complete the set of questionnaires which cover general symptoms of psychopathology and gender-specific issues. The Child Behavior Checklist (CBCL; Achenbach, 1991) is a broad-band behavioral symptom questionnaire which yields a number of factor analytically derived symptom scales and several more global scales. The Child Game Participation Questionnaire (CGPQ) was originally developed by Bates and Bentler (1973) for the discrimination of gender-typical and gender-atypical boys. It was modified (Sandberg & Meyer-Bahlburg, 1994) and re-analyzed on new samples of both boys and girls. The new scales and quasi-norms now available permit the characterization of a

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Table 2. Assessment – Parents (2–3 sessions)

Written Questionnaires	
CBCL	Child Behavior Check List*
CGPQ	Child Game Participation Questionnaire*
CBAQ	Child Behavior and Attitude Questionnaire*
GRS	Gender Risk Scale
QCSB	Questionnaire for Childhood Sexual Behavior
Interviews	
General clinical interview [unstructured]	
M-GRAS-C	Gender-Role Assessment Schedule – Child, Mother Version
Diary	
Symptom diary as homework assignment (min. 2 weeks)	

*Completed by father and mother independently.

child's gender-role behavior with regard to both boys and girls his/her age (Meyer-Bahlburg, Sandberg, Dolezal, & Yager, 1994). The Child Behavior and Attitude Questionnaire (CBAQ) was originally developed by Bates, Bentler, and Thompson (1973) also for the discrimination of gender-typical and -atypical boys. The male form was modified and a new female form created (Sandberg, Meyer-Bahlburg, Ehrhardt, & Yager, 1993), and both re-analyzed on new samples, again permitting the comparison of a child's gender-role behavior with that of both boys and girls (Meyer-Bahlburg, Sandberg, Yager, Dolezal, & Ehrhardt, 1994). The Gender Risk Scale (GRS; Meyer-Bahlburg, 1984) is an un-normed checklist designed as a quick screen for many of the factors that have been hypothesized to be involved in the development of gender identity disorder (Table 1). The Questionnaire for Childhood Sexual Behavior (Becker & Meyer-Bahlburg, 1984) is another un-normed checklist and consists of items covering diverse sexual behaviors of childhood (collected from clinic charts) ranging from expression of sexual curiosity to sexual play to coitus. The first three questionnaires (CBCL, CGPQ, CBAQ) are completed independently by father and mother. This permits us a fast check on the degree of agreement between both regarding their child's behavior problems. Major disagreements may indicate significant discrepancies in the parents' attitude to the child which is important for treatment.

Session 1 begins with the inquiry about the referral reasons, current features of cross-gender behavior and a brief overview of its beginning and development, and ends with a clinical-developmental history aided by a review of the family's photo albums that cover the child's development. As a homework assignment the parents are given a structured diary form to complete for a minimum of two weeks. The diary is set up for each family individually to cover salient cross-gender and other problem behaviors of the child as reported by the parents on the written questionnaires and during the first evaluation session, along with time and activities spent with father, mother, brothers, sisters, other boys, other girls, and other men and women, as applicable. This diary can help answer several questions. It allows us to gauge how the parents can cooperate with such daily homework assignments in general, and what difficulties are presented by their lifestyle and work schedules. Are they able to perform the specific task of keeping such a diary which is used as an important monitoring tool during therapy, or will they need training? What cognitive or ideological difficulties do they have in discriminating gender-typical and -atypical activities, and do they need help in this area? How do the behaviors reported in the first session compare with those reported day by day? How do the parents cooperate with each other in such assignments?

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Table 3. GIDC Assessment: Child (2 sessions)

[WORD	Pseudo-vocabulary test]
CGPQ	Child Game Participation Questionnaire
DAP	Draw-A-Person Test (with gender inquiry)
PO-1	Play Observation 1. standard toy set
PO-2	Play Observation 2. standard dress-up set
GI-I-C	Gender Identity Interview for Children
GRAS-C	Gender-Role Assessment Schedule – Child
Physical exam	
Intersex status	
Pubertal status	
General health	

The second session with the parents begins with a brief review of the preceding week's diary, but is mostly devoted to the 'Mother' version of the Gender Role Assessment Schedule-Child (M-GRAS-C; Meyer-Bahlburg & Ehrhardt, 1988b; see also Cosentino, Meyer-Bahlburg, Alpert, & Gaines, 1993), a systematic and detailed semi-structured interview held with both parents that covers in detail many aspects of the child's gender-related behaviors, interests, affiliations, etc. This may be followed, as needed, by further clinical inquiry including a brief family history.

The *evaluation procedures with the child* – usually involving two sessions – include both structured and unstructured activities (Table 3). The first session begins with the observation of how the boy is able to separate from the parent(s) who bring(s) him in.

The session takes place in an office which in one corner displays a set of male-typical and female-typical toys. The first structured activity is a simple word list presented as a vocabulary 'test' in order to provide the child and his parents with an easily acceptable label for what he did at this visit. Children who are mature enough are then orally administered the CGPQ. It is followed by a GID-specific Draw-a-Person test with inquiry. Then we schedule a 'break' during which the clinician ostensibly completes some paper work while unobtrusively observing the boy for 15–20 minutes and recording his toy and activity choices and related behaviors after he has been instructed to play for a while by himself in the toy corner. Later the clinician administers selected sections of the child version of the GRAS-C (Meyer-Bahlburg & Ehrhardt, 1998a), after the child has been given a set of Lego blocks and encouraged to construct with it whatever he likes. Dependent on when the child appears comfortable enough during session 1 or 2, the clinician administers the Gender Identity Interview (Zucker et al., 1993), a semi-structured interview designed to elicit disclosure of cross-gender wishes and ambivalences.

For the second session with the child, the toy set has been replaced by a dress-up set with stereotypically male (black cape, face mask, sword) and female (high-heeled shoes, hat, boa) role-play outfits. The inquiry focuses on the remaining sections of the GRAS-C, while the boy is again given Lego to play with. The interview is interspersed with an unobtrusively observed pretend-play session in the dress-up corner, with arts and crafts activities done at a table, and possibly some ball play.

In addition to the sessions, parents are asked to have their family physician complete a general *physical examination* report complemented by a form covering potential physical symptoms of somatic intersexuality and of (precocious) pubertal development.

Session 5 (or 6, if we need more time for the evaluation), the *wrap-up*, is again limited to the parents. This session covers the rationale for our evaluation procedures, a review of our findings, the resulting psychiatric diagnoses and other significant problems, the

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prognosis of the GID and of other problem behaviors as appropriate, whether and why we recommend treatment, and what the treatment of GID and of other problems would require in terms of efforts, time and costs. The issue of homosexuality is of major concern to most parents who bring a child with a gender problem. We therefore make a special point of addressing the available prognostic data and emphasize that homosexuality is not a psychiatric disorder, that it is not the prevention of homosexuality, but the prevention of the psychosocial sequelae of GID that is the goal of treatment, and that no therapeutic approach to childhood GID is known to interfere with the development of homosexuality. As there is currently no professional consensus in regard to the status of childhood GID as a clinical entity in our society, it is very important to be open with the parents about this debate. Pleak (1999) provides useful ethical guidelines for handling this situation. At the end we let the parents decide whether they want to commit themselves to treatment now or want to think it over, and whether there are significant obstacles to treatment in the near future such as stressful periods at work or at home, travel plans, etc., which would make it desirable to postpone the onset of an intense and consistent period of treatment.

Treatment protocol

Overview On the basis of the considerations outlined in the earlier section on the rationale, we devised a protocol for the treatment of GID in boys (Table 4). The specific goals we have for the boy are to develop a positive relationship with the father (or a father figure), positive relationships with other boys, gender-typical skills and habits, to fit into the male peer group or at least into a part of it, and to feel good about being a boy. Our treatment protocol is oriented towards social learning theory and includes elements of behavior and milieu therapy, but requires the therapist to use eclectically whatever other specific techniques he or she can bring to bear on the specific gender-related and other problems a child and his family may present. The treatment sessions are conducted with the parents. If both parents live in the household, we require the consistent attendance of either at the weekly sessions. We explain to the parents that their boy's GID is not his personal problem but can be better understood as a result of the dynamic interrelationship of all members of the family unit and its interaction with the boy's temperament. Sometimes other significant caretakers are also asked to attend the wrap-up session. The boy himself is not included, because of the inefficiency of office treatment at this age and in order to minimize stigmatization that may be associated with visits to a mental-health facility, especially when gender and sex issues are discussed. During the initial intense period of treatment involving weekly sessions, the parents are asked to maintain the structured diary, with modifications as needed.

At the weekly visits, the diary serves as the basis for the weekly review of the child's

Table 4. Treatment – Overview

Goals for boy:	developing positive relationship with father (figure) developing positive relationships with male peers developing gender-typical skills and habits fitting into the male peer group feeling good about being a boy
Orientation:	eclectic – behavioral, milieu, etc.
Mode:	sessions with parents, caretakers (phone contact with school, etc.)
Monitoring:	by parental diary

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behavior problems, the parental responses to the problems, and the social changes introduced by the parents. We provide guidance to the parents on how to achieve the goals described earlier, help them develop their own ways of implementing the treatment plan at home, and deal with the side effects and their underlying dynamics when the social structure within the family as well as the relations between the family and outsiders undergo change. Although the major goals and some of the techniques proposed will be suggested to all parents of boys with GID, we want the parents to come up with their own ideas and solutions as much as possible.

As the child's GID is gradually ameliorated, the frequency of the office visits by the parents is reduced. Treatment is terminated when the boy regularly seeks the presence of male friends and his cross-gender behavior appears to be largely within normal limits. Treatment may be discontinued if the progress remains unsatisfactory.

Key components

Gender ideology and sensitization Significant components of the sessions with the parents are listed in Table 5. Where appropriate, the first treatment session deals with the parents' gender ideology. For parents who are specifically opposed to sex-typing or to some male-typical behaviors such as rough-and-tumble play we need to work out an ideological compromise because, for a while at least, a moderate degree of sex-typing (at a minimum, tolerance for some degree of sex-typing demands by the peer group) is required if the GID is to resolve. (Of course, the GID itself often represents an extreme degree of sex-typing by the child himself.) Some other parents seem to have difficulties in recognizing what gender-typical behaviors in their child's age group are, and may need some initial sensitization in this area.

Father–son relationship By the time of the evaluation, family interaction and attachment patterns are usually well established. The boy with GID is often particularly close to the mother or/and another woman, such as a grandmother, teenaged sister, a nanny or a neighbor. The father may be closer to another child or may be on the fringes of family

Table 5. Behavioral/Milieu Protocol

Focus: Parents/caretakers
- integrating treatment approach with parents' gender ideology;
- sensitization to gender-specific behavior;
- changing intrafamiliar alignments:
  - increased active time of father (figure) with boy,
  - letting go of boy by mother/female,
  - increased mother's support of male-role taking by boy,
  - managing sibling interaction;
- changing parental social life to facilitate boy's play dates, etc.;
- increased attention to gender-typical behavior;
- decreased attention to gender-atypical behavior;
- distraction from cross-gender behavior rather than prohibition;
- making it worthwhile to be a boy;

Focus: Peers
- identifying suitable male peers for play dates;
- increased play dates with male peers (5×/week),
  - initially one boy at a time, later more;
- decreased play dates with female peers;
- increased extracurricular activities with boys:
  - e.g., clubs, teams, scouts, camps.

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life altogether, because of an overloaded work schedule or for other reasons. Improving the GID boy's relationship with his father often requires a change of the established intrafamiliar alignments. Such changes can cause significant stress and anxiety for the parents, the boy with GID, and other children in the family, and may bring to the surface conflicts and issues that need to be dealt with by whatever treatment modality – dynamic or other – appears suited. Additional stress is created by the requirement of increased peer contacts (see later). In the 4–6 years age group, such peer contacts must usually be initiated and at least for a while maintained by contacts between the parents involved. If, as is typical, suitable playmates are not among the social circle of the GID boy's parents, the parents have to establish new contacts with other parents, which in most cases implies decreased time with their habitual circle of friends, especially when we also have to decrease play dates with girls of the boy's age group.

Responding to cross-gender behavior When they bring their child for evaluation, most parents of boys with GID have already started to interfere with their son's cross-gender behavior. Parents usually resort to blunt critique and prohibition which, in our experience, may make the child go underground and hide his cross-gender interests from view without genuinely changing his cross-gender identity. We have seen dramatic examples of a 'double gender life' in some adolescents that seemed to have developed on this basis. To prevent such developments we train the parents in using 'attention management' instead of prohibition, i.e. giving the child positive attention when he engages in gender-neutral or masculine activities and no attention, not positive and especially also not negative ('benign neglect'), when he resorts to cross-gender activities. In addition, once the parents have become aware of typical antecedent situations or contexts when the child is likely to get into cross-gender activities, we work out with the parents suitable ways of 'distracting' the boy from initiating cross-gender behavior.

Peer relations From the first or second treatment session on, we introduce the focus on the boy's peer relations. We set as a goal five play dates per week with other boys (including weekend days), to be attained within about six weeks. This does not include school and, at least initially, also not other organized group activities. To this end, the parents need to start with identifying suitable boys for such play dates, that is, boys who neither have a cross-gender problem of their own nor are too rough, and who are within about half a year of the GID boy's age. Also, the parents must be sufficiently comfortable with the social background of the potential playmates so that they can build relationships with the playmates' parents which is a prerequisite for play dates at this age.

Typical initial problems that arise with the introduction of play dates with other boys are the disinterest or resistance of the boy with GID, or his withdrawal to his sister if he has one, the tendency for male playmates to associate with other boys in the family rather than the boy with GID, and the preference of the boys with GID to associate with the sister of a male playmate if available. Such problems require patience, prudent selection of playmates, and careful arrangements of play dates, and many parents need help in this area.

Initially, only one boy at a time is invited to a play date. Later, the play dates can be enhanced by having two or more boys present – a much more difficult task to handle for the boy with GID. Initial play dates should take place in a setting that allows for spontaneous play and interaction between the boys – which in the beginning may require some help from the parents such as suggesting activities and, occasionally, smoothing conflict – rather than organized group activities. Thus, the family's home or yard is a better place than a sports team or a visit to the local mall with the parents. Once the GID

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boy has become comfortable with other boys, the peer dates can be expanded to include extracurricular group activities, preferably including his new friends.

Miscellaneous issues A recurrent problem is the maintenance of a boy's GID outside the family, for instance by a grandmother or an aunt the boy visits frequently. If the parents are unable to influence the situation in such cases, we invite the outside family members to join selected sessions with the parents. More frequently, it is the nursery school or kindergarten setting that contributes to the maintenance of GID by providing extensive opportunities for cross-gender behavior, especially in the ubiquitous dress-up corner. Interventions here can be delicate because of the need to avoid stigmatization of the boy or stimulation of the parents' fear of such stigmatization. Our management of this problem ranges from direct meetings or telephone conversations with the teachers to change of school.

Attendance at summer camp can be either detrimental to the treatment goals or very useful, depending on the circumstances. All-boys camps are rarely available for this age group. Among co-ed camps we prefer those that engage in some degree of segregation of boys and girls, and if there is a choice of activities, we suggest that boys with GID, while in treatment, are not signed up for group activities preferentially chosen by girls such as ballet dancing or gymnastics. However, signing GID boys up for activities preferentially chosen by boys, especially team sports, requires some skill acquisition by the GID boy well before the start of the summer camp; otherwise the experience may be totally negative and counterproductive to the goals of therapy.

Many boys with GID show special artistic interests and talents. The introduction of the male peer group is not meant to replace those interests by the development of more stereotypical masculine activities such as team sports. Thus, for boys with artistic talents, it is particularly important that the parents select playmates whose interests and talents overlap with those of their GID boy or who at least do not denigrate such activities.

A clinical treatment review

To gauge the effectiveness of this treatment approach, we conducted a clinic-chart review. In our clinic, the therapist dictates very detailed reports for each evaluation session as well as progress notes for each treatment session. The latter cover in detail the parents' reports of the child's behavior and their reactions to it (based on their diary notes during the preceding interval), the suggestions made by the therapist or elicited from the parents, and the evaluation of goal attainment and any other justification of decisions made jointly with the parents regarding the interval to the next visit, the termination of regular visits, and the termination of follow-up visits or phone calls. Attainment of the goals (Table 4) is based on parents' reports: joint activities of father and son and the boy's readiness to spend time with his father, joint activities of the boy with his male peers and his active pursuit of play dates by phone calls, etc., the boy's engagement in gender-typical activities, his apparent acceptance by male peers, and the absence of statements indicating gender dysphoria. Transcripts of these dictations and the parents' diary notes are kept in the chart. Review of these materials by the author are the basis for the findings below.

Sample

The sample consisted of a consecutive series of boys below age 7 years, who were referred to our unit for an evaluation of a gender identity problem. They were diagnosed as either having GID or GID Not Otherwise Specified (GID NOS) by DSM-IV criteria, did not have a problem of somatic intersexuality, and their parents decided for treatment

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at our clinic. In all cases, the clinic records were reviewed after termination of the treatment.

Results

The sample consisted of 11 boys, 10 non-Hispanic Caucasian and 1 Hispanic. Age at evaluation ranged from 3 years, 11 months to 6 years, 3 months, with a median at 4 years, 9 months. All families were middle-class. The mother was present in the household in all families, the father in 10 of the 11 families (although this was not a selection criterion for treatment). Eight boys were diagnosed as having GID of childhood, and three as GID NOS.

Treatment of the GID was terminated in most cases when the goals (Table 4) were fully reached. Ten of the 11 cases showed such marked improvement; only one did not and was, therefore, judged to be unsuccessful. The total number of treatment visits per family ranged from 4–19 (median 10). In some cases, treatment for other family problems such as marital conflict or individual psychiatric problems of the parents, continued after treatment of the child's GID was completed. Follow-up was done mostly by telephone. The duration of follow-up was left to the parents and varied, up to several years. There was no significant recurrence of GID or GID NOS in the 10 successful cases, although several parents reported *occasional* recurrence of some cross-gender activities, especially during the first winter following treatment when children are homebound and peer contacts diminished.

Discussion

As the chart review data showed, a relatively short-term parent-mediated peer-centered treatment approach to GID appears promising. The speed of GID fading was remarkable and supports our clinical impression that psychosocial factors play a major role in the development of GID in preschoolers. Note that fathers were present in all families but one, and it was the family without a father in which we were unsuccessful. (In the latter family which included, along with the boy, several adolescent and young adult daughters, the father had died about a year before his son's referral to us, and the mother had difficulties attending weekly clinic visits, setting up frequent play dates, and finding an alternative father figure.) One of the good effects of the treatment protocol was an increase of father–son involvement and an improvement of the father–son relationship in most families.

The way we think this treatment works can be conceptualized as follows. Joint activities with the father – suitably selected and gradually developed – will increase the GID boy's attachment to him which will then facilitate the boy's projection of himself into the future in a masculine (father-like) gender role. Once the boy's attachment to the father has increased, the boy will also be more responsive to the gender role reinforcements provided by his father. This is important because fathers are usually stronger sex typers than are mothers (Fagot, 1985). If mother or another woman who has previously supported the boy's feminine behavior can be brought to the point at which she is able to support the male gender-role behavior of her boy, it will further help with the boy's self-image development. Activities with other boys will help establish familiarity with boys and build up male gender skills and habits. They will also compete with the display of cross-gender behavior. The skill acquisition, in turn, will help to decrease the boy's discomfort with male peers. We usually see that with increasing exposure to male peers there is also a gradually increasing attachment to other boys. Being attached to other boys will make it easier for the GID boy to look towards his male peers as gender-role

models and to respond more strongly to their gender role reinforcements. Improvement of the GID boy's social competence with boys is another outcome. All of the above processes tend to strengthen the GID boy's identification as a male and to increase his self-socialization as a male.

The treatment rationale presented here left aside the more complex formulations of GID development as presented from a psychodynamic perspective, especially by Coates et al. (1991). We do not doubt that the internal processes involved in GID development and treatment are more complex than sketched out here, but they are difficult to validly document. However, the success of our treatment approach suggests that, at least for rather young boys with GID, intense and costly psychodynamic therapy may not be necessary. In any case, systematic controlled treatment studies are required to decide such questions.

The development of our treatment approach is still in its beginning, and further improvements are desirable. It is likely, for instance, that the program would profit from incorporating some of the techniques used elsewhere to facilitate children's peer relations (Schneider, 2000).

Based on our clinical experience, we think that this type of treatment is appropriate only for relatively young children of preschool age or early school age, and will become progressively more difficult to use, the older the child is at referral. Not only does the symptomatology at the older age seem more resistant to change, but also more of the older children with GID have additional behavior problems, as Zucker (1990) documented, and they appear to come from families with more mental-health problems. This treatment protocol is not at all suitable for children of pubertal age and older when management of GID through the parents is inappropriate.

The next step in the development of our treatment approach is its full manualization. On that basis, a formal randomized clinical trial should be conducted that includes evaluation of the outcome independent of the treating therapist. The challenge of such a clinical trial lies in finding a suitable placebo treatment condition. If that is not possible, the feasibility of employing waiting-list controls would have to be explored.

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University of Maryland Baltimore County

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303 connections

I oversee the State of Maryland's 22 health regulatory boards and commissions, serving as their intermediary with the offices of the Secretary and Governor, as well as assisting with the coordination of legislative proposals. These groups license and discipline approximately 450,000 health professionals. I also serve as a Maryland Charity Campaign Coordinator.

My previous experience in executive administration, state and federal governments, education, boards, and training make me an excellent team player. I have built upon my administrative experience to serve in a number of key positions.

kimberlylang@hotmail.com

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Experience

Director of Health Occupations Boards and Commissions
Maryland Department of Health - Health Occupations Boards and Commissions
2017 – Present · 2 yrs
Baltimore, Maryland

I serve as the Secretary of Health's liaison with the State of Maryland's 22 regulatory health boards and commissions. I also assist in coordinating legislative initiatives. These groups license and discipline approximately 450,000 health professionals. I additionally serve as a Maryland Charity Campaign Coordinator.

Deputy Director for the Office of Governmental Affairs
Maryland Department of Health
2017 · less than a year
Baltimore, Maryland

As a Deputy Director, I assisted and managed the overall legislative strategy for the Maryland Department of Health, working directly with the Secretary and Chief of Staff on a daily basis. This position also encompassed attending hearings and working with the press office. Additionally, I also responded to inquiries from legislators and their staff members.

The White House
14 yrs

People Also Viewed

Denis McDonough • 3rd
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I oversaw the Assistant to the President for Homeland Security and Counterterrorism's daily schedule, long range planning, and strategic interactions with other White House officials, Members of Congress, the press, and the public. This position included the responsibility of handling classified documents and insuring they were properly maintained as well as training new staff members/adult learners within our office to do the same through the use of training tools, direct interaction, and on-the-job training. I was the National Security Council's Combined Federal Campaign (CFC) Key Worker for the 2015 campaign. See less

See mor
Prom

Special Assistant to the Assistant to the President for Homeland Security and Counterterrorism
2014 – 2015 1 yr
Washington, DC

This position included coordinating the front office and overseeing the distribution of classified and non-classified material. I assisted in managing interactions between stakeholders within the West Wing, the greater White House, and throughout the interagency. When promoted to my next position, I served as the primary trainer for my replacement (adult learner), imparting knowledge about the organization and drawing upon my personal experiences. I also was the National Security Council's Combined Federal Campaign (CFC) Captain for the 2014 campaign. See less

Resource Management Specialist (National Security Council)
2013 – 2014 1 yr
Washington, DC

This position included coordinating placement, compliance, and reporting while assisting with recruiting, in-processing, and out-processing. I provided expert customer service in a timely manner to those both inside the organization and individuals interacting with the human resources department. Working with the NSC's Director for Training, I developed and facilitated adult learning for over one year. During this time, I adapted course content and trained approximately 190 new staff members. See less

Special Assistant to the Deputy/National Security Advisor
2005 – 2013 8 yrs
Washington, DC

As a special assistant, I coordinated the Deputy/National Security Advisor's schedule to include meetings with senior members of the White House, foreign dignitaries, and interagency colleagues. I continuously advised senior leadership on urgent workforce issues. I served as the office point-of-contact throughout the interagency. I provided instruction and trained front office staff (adult learners) and new employees throughout the NSC concerning the organization's culture, policies, and procedures through orientation as well as on-going interactions and encouragement to attend seminars held to improve the workforce. See less

Administrative Assistant to the National Security Advisor and Deputy National Security Advisor
2004 – 2005 1 yr
Washington, DC

This job entailed serving a multitude of administrative functions for the National Security Council's front office in the West Wing as well as being the primary interactive support for other Administrative Assistants. I evaluated incoming material and assisted others in implementing and accomplishing the goals of the organization. When I was promoted to my next position, I was the primary trainer for my replacement (adult learner), giving both formal instruction and on-the-job training. See less

Clearance Assistant to the Counsel s Office
2004 less than a year
Washington, DC

I coordinated all clearance and ethics paperwork within the Counsel's office. I served as the initial point of contact for prospective Senate- confirmed nominees who were undergoing their background process. I insured that procedures were followed within the office as well as conveyed this information to nominees. I managed the calendar of the Clearance and Ethics office. I also organized incoming correspondence, providing feedback and suggestions related to the questions relayed. See less

Staff Assistant to the Student Correspondence Department
2003 – 2004 1 yr
Washington, DC

As a staff assistant I reviewed, monitored, and tracked incoming student correspondence to the President. I utilized my on-the-job training to assist with data entry to ensure students received appropriate and timely responses to achieve excellent customer service. I assisted in the training of new office members and interns (adult learners), providing routine advice and guidance while familiarizing them with both office procedures and culture. See less

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2000 – 2003 3 yrs
Fort Meade, Maryland

I supervised and assisted approximately 25 first- and second-year teachers (adult learners) by providing training and expertise as well as creating and developing a new orientation program. This program's curriculum insured that these adult learners were familiar with the procedures utilized throughout the county. As an instructor of adults, this position included establishing and managing training standards, creating training material, and reconfiguring material as necessary for educating adult learners. I also insured that course information conformed to county standards. See less

Chairperson, Social Studies Department
1995 – 2000 5 yrs
Glen Burnie, Maryland

I supervised curriculum and training for a seven-member department, including serving as mentor for other educators (adult learners). I was the subject-matter expert for social sciences issues throughout the building, helping to provide instruction to both students and fellow educators (adult learners). I reviewed training/curriculum material, disseminating the best to my department. I served as a county-wide curriculum writer for the eight grade US History course and also taught the course at my school. See less

Social Studies Teacher
1993 – 1995 2 yrs
Fort Meade, Maryland

This position encompassed my teaching of 9th-12th grade US Government and US Law courses. I developed daily lesson plans which demonstrated and utilized qualitative and quantitative techniques to measure effective understanding of curriculum. I also worked closely with senior leadership, the administration, and other key stakeholders.

Show fewer roles

Member Board Of Trustees, Board Vice Chairperson, Chairperson of Human Resources Committee
Anne Arundel Community College
1997 – 2003 6 yrs
Arnold, Maryland

As a trustee, I oversaw a wide variety of governance issues. I served as the Board's Vice Chairperson (2002-2003) and Chairperson of the Human Resources Committee (2001-2003).

Education

University of Maryland Baltimore County
Doctor of Philosophy - PhD, Policy Sciences (Public Administration)
1998 2002

Dissertation: Student board members at two- and four-year institutions.

Loyola University Maryland
M.Ed., Administration-Supervision
1994 – 1997

Towson State University
Bachelor of Science - BS, Social Sciences (Secondary Education)
1989 – 1993

Interests

Loyola University Maryland
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University of Maryland Baltimore C...
71,290 followers

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UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

CHRISTOPHER DOYLE, LPC, LCPC, individually and on behalf of his clients, Plaintiff, v. LAWRENCE J. HOGAN, JR., Governor of the State of Maryland, in his official capacity, and BRIAN E. FROSH, Attorney General of the State of Maryland, in his official capacity, Defendants.	Civil Action No. 1:19-cv-00190-DKC **INJUNCTIVE RELIEF SOUGHT**

PLAINTIFF'S NOTICE OF TAKING DEPOSITION OF STATE OF MARYLAND

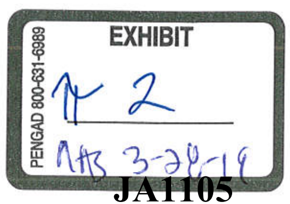
PLEASE TAKE NOTICE that, pursuant to Rule 30, Federal Rules of Civil Procedure, Plaintiff will take the following deposition(s) upon oral examination before a court reporter or some other officer duly authorized by law to take depositions, at the date(s), time(s), and location(s) shown for the witness(es) (or at such other date(s), time(s), and location(s) as to which the parties may mutually agree), for the purpose of discovery or as evidence in this action, which depositions will be recorded by stenographic means:

WITNESS	DATE, TIME	LOCATION
STATE OF MARYLAND (Rule 30(b)(6), Fed. R. Civ. P.)	TBD (on or before April 1, 2019)	TBD

Each deposition will commence on the date and time specified and continue thereafter until the deposition has been completed.

DESCRIPTION OF MATTERS FOR EXAMINATION

Defendants, pursuant to Rule 30(b)(6), Federal Rules of Civil Procedure, will designate one or more officers, directors, or managing agents of the State of Maryland, or designate other



persons who consent to testify on behalf of the State of Maryland, regarding the matters for examination set forth below, subject to the definitions also set forth below.

DEFINITIONS

The following definitions apply to the matters for examination below:

A. The "**Legislative Record**" of a bill means all information, documents, or actions reviewed, considered, discussed, or debated in any meeting, hearing, reading, or other public proceeding on the bill in the Senate of Maryland or House of Delegates of Maryland, or any committee thereof, or any conference committee of Senators and Delegates, and any transcript or audio or video recording of any such proceeding, including without limitation all pre-filed, draft, amended, failed, passed, enrolled, or enacted versions of the bill, and all testimony, letters, correspondence, communications, data, statistics, analyses, research, position papers, investigations, reports, studies, memoranda, notes, motions, special orders, roll calls, votes, vetoes, and veto overrides.

B. "**Minor**" means an individual under eighteen (18) years of age.

C. "**SB 1028**" means Maryland Senate Bill 1028 and/or the cross-filed House Bill 0902, as enacted by the General Assembly and signed into law by Defendant Governor Larry Hogan on May 15, 2018, becoming effective October 1, 2018, and codified at Md. Code Ann., Health Occ. § 1-212.1 (West).

D. "**SOCE**" means sexual orientation change efforts, including without limitation any counseling, practice, or treatment that assists an individual in changing his or her sexual orientation or gender identity, and further including without limitation any efforts to change the behavioral expression of an individual's sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex or gender.

MATTERS FOR EXAMINATION

1. The State of Maryland's purported interest in banning SOCE counseling for minors, including without limitation any complaint or other evidence of alleged harm in the Legislative Record of SB 1028.

2. Any evidence in the Legislative Record of SB 1028 that any minor within the State of Maryland was subjected to SOCE counseling against his or her will.

3. Any evidence in the Legislative Record of SB 1028 of alleged harm posed by voluntary SOCE counseling for minors who desire, request, or willingly consent to SOCE counseling.

4. Any evidence in the Legislative Record of SB 1028 of alleged harm caused by voluntary SOCE counseling for minors within the State of Maryland who desired, requested, or willingly consented to SOCE counseling.

5. Any evidence in the Legislative Record of SB 1028 that minors lack the ability to consent to voluntary SOCE counseling, or have the ability to consent to other treatments or procedures such as abortions, gender transition/reassignment, or same-sex relationship-affirming counseling.

6. The State of Maryland's efforts to narrowly tailor SB 1028, including without limitation any alternative to SB 1028 which Defendant considered prior to enactment of SB 1028, and all reasons for rejecting any such alternative.

7. All communications and coordination, between the State of Maryland and any advocacy group, regarding SB 1028 or any other effort to ban SOCE for minors.

8. Any study or research the State of Maryland conducted, commissioned, reviewed or relied upon to enact SB 1028.

9. The drafting, consideration, discussion, debate, and enactment of SB 1028 by the General Assembly and Governor of the State of Maryland.

10. The interpretation, application, and enforcement of SB 1028 by the Government of the State of Maryland.

11. The factual matters disclosed in any declaration or affidavit filed by Defendants in opposition to Plaintiff's Motion for Preliminary Injunction (Doc. 2).

12. The factual matters disclosed in any written responses, or documents produced in response, to Plaintiff's written Discovery Requests served February 16, 2019, and Defendants' disclosure efforts and sources.

13. Defendants' document production efforts and sources, for any document production pursuant to Rule 26(a)(1) or in response to Plaintiff's written Discovery Requests served February 16, 2019, including without limitation—

a. the physical or digital/electronic locations of the documents produced;

b. the time period(s) covered by the documents produced;

c. the search terms used to locate potentially responsive, electronically stored documents; and

d. the document custodian(s) consulted for responsive documents or from whom the documents were obtained for production.

Respectfully submitted,

/s/ Roger K. Gannam

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this February 16, 2019, I caused a true and correct copy of the foregoing to be served by e-mail on the following counsel of record:

Kathleen A. Ellis
Assistant Attorney General
Maryland Department of Health
Suite 302, 300 West Preston Street
Baltimore, Maryland 21201
kathleen.ellis@maryland.gov
Attorney for Defendants

/s/ Roger K. Gannam
Attorney for Plaintiff

UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

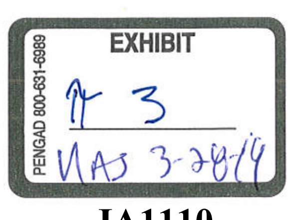
CHRISTOPHER DOYLE, LPC, LCPC,	)	
Plaintiff,	)	Civil Action No. 1:19-cv-00190-DKC
v.	)	
LAWRENCE J. HOGAN, JR., *et al.*,	)	
Defendants.	)	

DEFENDANTS' RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

Pursuant to the Federal Rules of Civil Procedure and this Court's Local Rules and Discovery Guidelines, the defendants, the Governor of Maryland and the Attorney General of Maryland, respond to the plaintiff's interrogatories. The information supplied in these answers is not based solely on the knowledge of the executing individual, but also includes the knowledge of that individual's agents, representatives, and attorneys, unless privileged. The language, word usage, and sentence structure is that of the attorneys assisting in the preparation of these answers and does not purport to be the precise language of the executing individual. The defendants' responses are subject to the following general objections, incorporated as indicated in each response.

Objections to Definitions and Instructions

1. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Definition No. 7 as overly broad. The Governor and Attorney General will respond to these requests for admission based on information within their control to obtain. Neither has the authority to compel the legislative or judicial branch of the State of Maryland's government to provide information for these discovery responses. *See* Md. Declaration of Rights, Article 8.



2. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Definition No. 11 as overly broad. The Governor and the Attorney General construe the term "Legislative Record" to include only materials that are publicly available, all of which are listed below, and they will respond to these requests for admission based on these materials:

a. MD0001 – MD0096 – HB 902 Bill File
b. MD0097 – MD0164 – SB 1028 Bill File
c. MD0165 – HB 902 Summary
d. MD0166 – HB 902 Documents
e. MD0167 – MD0170 – HB 902 Fiscal and Policy Note
f. MD0171 – MD0176 – HB 902 First Reader
g. MD0177 – HB 902 Voting Record
h. MD0178 – HB 902 History
i. MD0179 – SB 1028 Summary
j. MD0180 – SB 1028 Documents
k. MD0181 – MD0184 – Proposed Amendments to SB 1028 First Reader
l. MD0185 – MD0187 – Proposed Amendments to SB 1028 Third Reader
m. MD0188 – MD0191 – SB 1028 Fiscal and Policy Note
n. MD0192 – MD0197 – SB 1028 First Reader
o. MD0198 – MD0203 – SB 1028 Third Reader
p. MD0204 – MD0209 – Ch. 685, 2018 Laws of Maryland
q. MD0210 – MD0220 – SB 1028 Voting Record
r. Recording of Health and Government Operations Committee Hearing on HB 902
s. Recording of Education, Health and Environmental Affairs Committee Hearing on SB 1028
t. Recordings of floor proceedings in House of Delegates and Senate

3. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 2 because it purports to obligate the defendants to obtain and disclose information protected by the legislative privilege, the attorney client privilege, and the attorney work product doctrine. The term "SB 1028 Proponents" is defined to mean those individuals involved in legislative activities related to SB 1028 (2018), HB 902 (2018), and Ch. 685, 2018 Laws of Maryland, all of whom are protected by a legislative privilege from having to provide information in discovery. *See, e.g., 2BD Associates Ltd.*

Partnership v. County Commissioners for Queen Anne's County, 896 F. Supp. 528, 533 (D. Md. 1995). To the extent that either or both of the defendants were involved in the activities listed in the definition of "SB Proponents," they were engaged in legislative activities and are thus, protected by the legislative privilege. *See Bogan v. Scott-Harris*, 523 U.S. 44, 54 (1998) (determine scope of legislative privilege by the nature of the act); *Baraka v. McGreevey*, 481 F.3d 187, 196 (3d Cir. 2007) (Governor's advocacy for a bill in the legislature and Governor's signing of bill "squarely within the sphere of legitimate, legislative activity"); *Mandel v. O'Hara*, 322 Md. 103, 122-34 (1990) (Governor's deciding whether to veto or sign a bill is legislative act). Furthermore, the Governor and the Attorney General have no authority to require members of the General Assembly or their staffs to provide information or documents for discovery in this matter. *See* Md. Declaration of Rights, Article 8.

4. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 8 regarding the provision of a Privilege Log. With respect to the legislative privilege, no privilege log is necessary. *See North Carolina State Conference v. McCrory*, 2015 WL 12683665, at *7 (M.D.N.C. Feb. 4, 2015). Furthermore, the defendants object to Instruction No. 8 to the extent that it purports to require a privilege log of communications and documents created after the filing of the complaint. *See Interstate Indemnity Co. v. Black*, 2003 WL 23269342, at *1 (M.D.N.C. Oct. 24, 2003).

5. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 12 regarding the date range applicable to these discovery requests. There is no basis for requiring the production of information or documents for any time before the start of the legislative session in 2018 – January 10, 2018 – or for any time after the lawsuit was filed on January 22, 2019.

INTERROGATORY 1:

[If your response to RFA 1 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 1 is anything other than an unqualified admission, then for each Complaint in the Legislative Record of SB 1028 that a Minor was harmed by any SOCE counseling provided within the State of Maryland, Identify (per Definition # 9): the Person(s) making the Complaint, the date of the Complaint, the nature of the conduct and harm alleged in the Complaint, the Person(s) receiving the Complaint, the Person(s) allegedly providing the SOCE counseling, the location(s) of the SOCE counseling, the date(s) of the SOCE counseling, the nature of the SOCE counseling, and the Person(s) allegedly harmed.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 1 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Without waiving these objections, *see* MDOO11, MD0057, MD0063, MD0138, MD0152-MD0153 for information responsive to this interrogatory. *See also* Statement of Megan Simonaire made during the floor proceedings on April 4, 2018 in the House of Delegates from time stamp 2:55:07 to time stamp 3:02:24.

INTERROGATORY 2:

[If your response to RFA 2 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 2 is anything other than an unqualified admission, then for each Complaint in the Legislative Record of SB 1028 that a Minor was harmed by any SOCE counseling provided within the State of Maryland against that Minor's wishes or without that Minor's consent, Identify (per Definition # 9): the Person(s) making the Complaint, the date of the Complaint, the nature of the conduct and harm alleged in the Complaint, the Person(s) receiving the Complaint, the Person(s) allegedly providing the SOCE counseling, the location(s)

of the SOCE counseling, the date(s) of the SOCE counseling, the nature of the SOCE counseling, and the Person(s) allegedly subjected involuntarily to SOCE counseling.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 1 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, *see* MDOO11, MD0057, MD0063, MD0138, MD0152-MD0153 for information responsive to this interrogatory. *See also* Statement of Megan Simonaire made during the floor proceedings on April 4, 2018 in the House of Delegates from time stamp 2:55:07 to time stamp 3:02:24.

INTERROGATORY 3:

[If your response to RFA 3 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 3 is anything other than an unqualified admission, then for each study, research effort, or investigation conducted or commissioned by the State prior to enacting SB 1028 to determine whether any Minor within the State of Maryland had been harmed by any SOCE counseling or had been subjected to any SOCE counseling against the Minor's wishes or without the Minor's consent, Identify (per Definition # 9): the Person(s) who conducted the study, research, or investigation; the date(s) when the study, research, or investigation was conducted; the nature of that study, research, or investigation; the results of that study, research,

or investigation; and any Person(s) allegedly found to have been harmed by, or involuntarily subjected to, SOCE counseling.

[For the sake of clarity, this Interrogatory is limited to empirical studies, research, or investigations that the State itself conducted or commissioned, as opposed to studies, research, or investigations conducted by third parties which the State may have reviewed, considered, discussed, or debated.]

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 3 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this interrogatory is necessary.

INTERROGATORY 4:

[If your response to RFA 4 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 4 is anything other than an unqualified admission, then for each study, research effort, or investigation conducted or commissioned by the State prior to enacting SB 1028 to determine whether voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive, is harmful to that Minor, Identify (per Definition # 9): the Person(s) who conducted the study, research, or investigation; the date(s) when the study, research, or investigation was conducted; the nature of that study, research, or investigation; the results of that study, research,

or investigation; and any Person(s) allegedly found to have been harmed by any voluntary SOCE counseling.

[For the sake of clarity, this Interrogatory is limited to empirical studies, research, or investigations that the State itself conducted or commissioned, as opposed to studies, research, or investigations conducted by third parties which the State may have reviewed, considered, discussed, or debated.]

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 4 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this interrogatory is necessary.

INTERROGATORY 5:

[If your response to RFA 5 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 5 is anything other than an unqualified admission, then for each third-party study, research report, investigation, resolution, or position paper in the Legislative Record of SB 1028 that identified or provided causal evidence of harm from, or a causal attribution of harm to, voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive, Identify: the specific conclusion which you contend to have been made therein regarding voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion

requests, consents to, and/or wishes to receive; the specific page(s) where you contend that conclusion to exist; and the specific portion(s) of the Legislative Record of SB 1028 reflecting the State's review, consideration, discussion, or debate of that specific conclusion.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 5 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that the following documents, identified in the Legislative Record as construed by the defendants at MD0022-MD0023, MD0024-MD0025, MD0049-MD0050, MD0099, MD0104-MD0105, MD 0107-0112, MD0120-MD0123, and MD0204-209, and attached as exhibits to the plaintiff's complaint as ECF Document 1-2 and to the defendants' memorandum in opposition to the plaintiff's request for a preliminary injunction as ECF Documents 25-2, 25-9, 25-10, 25-11, 25-14, 25-17, and 25-18, contain information responsive to this interrogatory:

- Substance Abuse and Mental Health Services Administration, "Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth," HHS Publication No. (SMA) 15-4928, Rockville, MD: SAMHSA, 2015 at 2-3, 11, 20, 25, 26.

- Christy Mallory, Taylor N.T. Brown, and Keith J. Conron, "Conversion Therapy and LGBT Youth," The Williams Institute UCLA School of Law (Jan. 2018)

- 1993 American Academy of Pediatrics Position Statement
- 2000 American Psychiatric Association Position Statement
- 2012 American Academy of Child and Adolescent Psychiatry Practice Parameter
- 2015 American College of Physicians Position Paper
- Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults, PEDIATRICS Volume 123, Number 1, January 2009
- American Psychological Association, Report of Task Force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (2009) at v, 3, 4, 71-80
- Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults, PEDIATRICS Volume 123, Number 1, January 2009

The defendants also note that ECF document 25-2 at 2 notes that "[c]hildren are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers."

INTERROGATORY 6:

[If your response to RFA 6 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 6 is anything other than an unqualified admission, then for each third-party study, research report, investigation, resolution, or position paper in the Legislative Record of SB 1028 that identified or provided causal evidence of family rejection from, or a causal attribution of family rejection to, voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive, Identify: the specific conclusion which you contend to have been made therein regarding voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive; the specific page(s) where you contend that conclusion to exist; and the specific portion(s) of the Legislative Record of SB 1028 reflecting the State's review, consideration, discussion, or debate of that specific conclusion.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 6 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. Under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this interrogatory is necessary.

INTERROGATORY 7:

[If your response to RFA 6 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 6 is anything other than an unqualified admission, then Identify: each study, research report, investigation, resolution, or position paper in the Legislative Record of SB 1028 which You contend to have analyzed the ability or inability of Minors to consent to SOCE counseling; the specific page(s) where you contend that analysis to exist; and the specific portion(s) of the Legislative Record of SB 1028 reflecting the State's review, consideration, discussion, or debate of that specific analysis.

RESPONSE:

The defendants assume that the reference to RFA 6 is an error and that the interrogatory should refer to RFA 7. Based on that assumption, the defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Interrogatory No. 7 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. Under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that ECF Document 1-2 at page 82, identified throughout the Legislative Record

as construed by the defendants and, specifically in the Preamble to Chapter 685, 2018 Laws of Maryland, MD0204-MD0209, has information responsive to this interrogatory.

INTERROGATORY 8:

[If your response to RFA 8 is solely an unqualified admission, you may state so in response here and skip the remainder of this Interrogatory].

If your response to RFA 8 is anything other than an unqualified admission, then for each less restrictive alternative to SB 1028 reflected in the Legislative Record of SB 1028, Identify: the alternative measure; all efforts undertaken by the State to determine the feasibility or efficacy of that alternative measure; all reasons for rejecting that alternative measure; and the specific portion(s) of the Legislative Record of SB 1028 reflecting review, consideration, discussion, or debate of the alternative measure.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to this interrogatory to the extent that it seeks information protected by the legislative privilege. *See, e.g., 2BD Associates Ltd. Partnership v. County Commissioners of Queen Anne's County*, 896 F. Supp. 528, 533 (D. Md. 1995). Without waiving these objections, the defendants state that the Legislative Record, as they construe it, reflects that alternatives to SB 1028 were identified in MD0042, MD0061, MD0117, MD0181, MD0184, MD0185, and MD0186, and, as reflected in the text of Chapter 685, 2018 Laws of Maryland, were not adopted. The recordings of the House and Senate floor proceedings also have information responsive to this interrogatory.

INTERROGATORY 9:

Identify (per Definition # 9) all SB 1028 Proponents and describe the nature of each such Person's involvement in the drafting, sponsoring, consideration, debate, and passage of SB 1028.

RESPONSE:

The defendants object to this interrogatory because it seeks information protected by the legislative privilege. *See, e.g., 2BD Associates Ltd. Partnership v. County Commissioners of Queen Anne's County*, 896 F. Supp. 528, 533 (D. Md. 1995).

INTERROGATORY 10:

Identify (per Definition # 9) all Persons (including organizations) with which any of the SB 1028 Proponents consulted, collaborated, or otherwise communicated Concerning the drafting, consideration, debate, amendment, or passage of SB 1028, and describe the nature of each such Person's involvement.

RESPONSE:

The defendants object to this interrogatory because it seeks information protected by the legislative privilege. *See, e.g., 2BD Associates Ltd. Partnership v. County Commissioners of Queen Anne's County*, 896 F. Supp. 528, 533 (D. Md. 1995).

INTERROGATORY 11:

Identify (per Definition # 9) each Documents in the Legislative Record of SB 1028, including its location within the Legislative Record of SB 1028, that You contend to conclude or demonstrate that—

(a) it is impossible for a therapist to successfully assist a Minor in changing or reducing his or her unwanted same-sex romantic attractions, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(b) it is impossible for a therapist to successfully assist a Minor in changing or reducing unwanted same-sex sexual behaviors, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(c) it is impossible for a therapist to successfully assist a gender confused Minor in re-gaining confidence and peace with his or her anatomical sex, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(d) it is safe and effective to affirm a Minor in his or her belief that he or she is of a sex or gender that is different from his or her anatomical sex, and/or that there are no short- or long-term negative effects of doing so, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(e) it is psychologically, emotionally, or physically safe and effective to assist a Minor in transitioning to a sex or gender different from his or her anatomical sex, and/or that there are no short- or long-term negative effects of doing so, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(f) it is safe and effective to withhold therapy from a Minor who is distressed about his or her unwanted same-sex attractions, and who desires to receive therapy to reduce those unwanted attractions, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(g) it is safe and effective to offer only therapy that affirms and supports the unwanted same-sex attractions or gender confusion of a distressed Minor who is seeking to change the unwanted same-sex attractions or gender confusion, rather than helping that Minor to make the changes he or she is seeking, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028];

(h) it is safer to wait until a Minor attains 18 years of age before providing therapy for unwanted same-sex attractions or gender confusion, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028]; and

(i) it is safer, better, or more desirable for a Minor who desires change and seeks counseling regarding unwanted same-sex attractions or gender confusion to receive that counseling from a non-licensed provider rather than a licensed provider, and state the applicable page(s) of the document [and state if no such document is in the Legislative Record of SB 1028].

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to this interrogatory because it seeks information about contentions that the defendants have not made and the language of SB 1028 does not support. The defendants also object to this interrogatory as seeking information that is irrelevant and unlikely to lead to the discovery of admissible evidence. Without waiving any of these objections, the Preamble to Chapter 685, 2018 Laws of Maryland quotes from studies and statements regarding the efficacy and safety of conversion therapy and the appropriate types of assistance that should be offered to youth questioning their sexual orientation or gender identity. *See* MD0204-

MD0209. Several of those studies are attached as exhibits to both the plaintiff's and the defendants' filings in this case as well as identified in the written submissions to the legislative committees contained in the Legislative Record, as defined by the defendants. The burden of deriving or ascertaining whether any of these documents contain support for the statements listed above, all of which misconstrue the provisions of SB 1028, is substantially the same for the plaintiff as it would be for the defendant.

Respectfully Submitted:
Brian E. Frosh
Attorney General of Maryland

Kathleen A. Ellis

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March 21, 2019

Attorneys for Defendants

I, Kimberly C. Lang, PhD, am duly authorized to execute these answers to interrogatories under oath on behalf of the defendants, the Governor of Maryland and the Attorney General of Maryland, in their official capacities. The information set forth in these answers was collected by others, and such information is not necessarily within my personal knowledge. However, on behalf of the Governor of Maryland and the Attorney General of Maryland, in their official capacities, I solemnly affirm under the penalties of perjury that the foregoing answers to interrogatories are true to the best of my knowledge, information, and belief.

Date: 03/21/19

Kimberly C. Lang, PhD

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of March, 2019, I caused a true and correct copy of the foregoing to be served by e-mail on the following:

Roger K. Gannam
Rgannam@lc.org

Horatio Mihet
hmihet@lc.org

John Garza
jgarza@lc.org

Kathleen A. Ellis

UNITED STATES DISTRICT COURT
DISTRICT OF MARYLAND

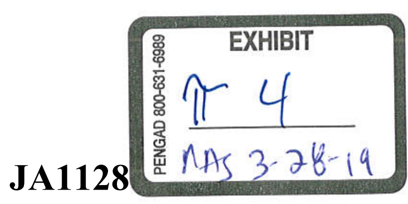
CHRISTOPHER DOYLE, LPC, LCPC,	)	
Plaintiff,	)	Civil Action No. 1:19-cv-00190-DKC
v.	)	
LAWRENCE J. HOGAN, JR., *et al.*,	)	
Defendants.	)	

DEFENDANTS' RESPONSE TO PLAINTIFF'S REQUESTS FOR PRODUCTION OF DOCUMENTS

Pursuant to the Federal Rules of Civil Procedure and this Court's Local Rules and Discovery Guidelines, the defendants, the Governor of Maryland and the Attorney General of Maryland, respond to the plaintiff's requests for production of documents. The defendants' responses are subject to the following general objections, incorporated as indicated in each response. To the extent feasible, responsive documents are attached to the electronic mail message transmitting this response or links to those documents in Google Drive are included in the electronic mail message. A flash drive containing copies of the available recordings of the Maryland General Assembly's committee hearings and floor proceedings with respect to House Bill 902 and SB 1028 have been sent via overnight delivery to Roger Gannam and Horatio Mihet.

Objections to Definitions and Instructions

1. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Definition No. 7 as overly broad. The Governor and Attorney General will respond to these requests for admission based on information within their control to obtain. Neither has the authority to compel the legislative or judicial branch of the



State of Maryland's government to provide information for these discovery responses. *See* Md. Declaration of Rights, Article 8.

2. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Definition No. 11 as overly broad. The Governor and the Attorney General construe the term "Legislative Record" to include only materials that are publicly available, all of which are listed below, and they will respond to these requests for admission based on those materials:

a. MD0001 – MD0096 - HB 902 Bill File
b. MD0097 – MD0164 – SB 1028 Bill File
c. MD0165 – HB 902 Summary
d. MD0166 – HB 902 Documents
e. MD0167 – MD0170 – HB 902 Fiscal and Policy Note
f. MD0171 – MD0176 – HB 902 First Reader
g. MD0177 – HB 902 Voting Record
h. MD0178 – HB 902 History
i. MD0179 – SB 1028 Summary
j. MD0180 – SB 1028 Documents
k. MD0181 - MD0184 – Proposed Amendments to SB 1028 First Reader
l. MD0185 – MD0187 – Proposed Amendments to SB 1028 Third Reader
m. MD0188 – MD0191 – SB 1028 Fiscal and Policy Note
n. MD0192 – MD0197 – SB 1028 First Reader
o. MD0198 – MD0203 – SB 1028 Third Reader
p. MD0204 – MD0209 – Ch. 685, 2018 Laws of Maryland
q. MD0210 – MD0220 – SB 1028 Voting Record
r. Recording of Health and Government Operations Committee Hearing on HB 902
s. Recording of Education, Health and Environmental Affairs Committee Hearing on SB 1028
t. Recordings of floor proceedings in House of Delegates and Senate

3. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 2 because it purports to obligate the defendants to obtain and disclose information protected by the legislative privilege, the attorney client privilege, and the attorney work product doctrine. The term "SB 1028 Proponents" is defined to mean those individuals involved in legislative activities related to SB 1028 (2018),

HB 902 (2018), and Ch. 685, 2018 Laws of Maryland, all of whom are protected by a legislative privilege from having to provide information in discovery. *See, e.g., 2BD Associates Ltd. Partnership v. County Commissioners for Queen Anne's County*, 896 F. Supp. 528, 533 (D. Md. 1995). Furthermore, the Governor and the Attorney General have no authority to require members of the General Assembly or their staffs to provide information or documents for discovery in this matter. *See* Md. Declaration of Rights, Article 8.

4. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 8 regarding the provision of a Privilege Log. With respect to the legislative privilege, no privilege log is necessary. *See North Carolina State Conference v. McCrory*, 2015 WL 12683665, at *7 (M.D.N.C. Feb. 4, 2015). Furthermore, the defendants object to Instruction No. 8 to the extent that it purports to require a privilege log of communications and documents created after the filing of the complaint. *See Interstate Indemnity Co. v. Black,* 2003 WL 23269342, at *1 (M.D.N.C. Oct. 24, 2003).

5. The defendants, the Governor of Maryland and the Attorney General of Maryland in their official capacities, object to Instruction No. 12 regarding the date range applicable to these discovery requests. There is no basis for requiring the production of information or documents for any time before the start of the legislative session in 2018 – January 10, 2018 – or for any time after the lawsuit was filed on January 22, 2019.

REQUEST FOR PRODUCTION 1:

[If your response to RFA 1 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 1 is anything other than an unqualified admission, then for each Complaint in the Legislative Record of SB 1028 that a Minor was harmed by any SOCE counseling provided within the State of Maryland, produce:

(a) all Documents Concerning that Complaint;

(b) all Documents Concerning how that Complaint was processed, handled, investigated, prosecuted, and/or resolved;

(c) all Documents Concerning any interview, investigation, or report conducted by the State in connection with that Complaint;

(d) all internal Communications of State personnel regarding that Complaint; and

(e) all Communications of State personnel with any Person(s) not employed by the State regarding that Complaint.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 1 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Without waiving these objections, MDOO11, MD0057, MD0063, MD0138, and MD0152-MD0153 are responsive to this request as is the statement of Megan Simonaire made during the floor proceedings on April 4, 2018 in the House of Delegates from time stamp 2:55:07 to time stamp 3:02:24.

REQUEST FOR PRODUCTION 2:

[If your response to RFA 2 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 2 is anything other than an unqualified admission, then for each Complaint in the Legislative Record of SB 1028 that a Minor was harmed by any SOCE counseling provided within the State of Maryland against that Minor's wishes or without that Minor's consent, produce:

(a) all Documents Concerning that Complaint;

(b) all Documents Concerning how that Complaint was processed, handled, investigated, prosecuted, and/or resolved by the State;

(c) all Documents Concerning any interview, investigation, or report conducted by the State in connection with that Complaint;

(d) all internal Communications of State personnel regarding that Complaint; and

(e) all Communications of State personnel with any Person(s) not employed by the State regarding that Complaint.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 1 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Without waiving these objections, MDOO11, MD0057, MD0063, MD0138, and MD0152-MD0153 are responsive to this request as is the statement of Megan Simonaire made during the floor proceedings on April 4, 2018 in the House of Delegates from time stamp 2:55:07 to time stamp 3:02:24.

REQUEST FOR PRODUCTION 3:

[If your response to RFA 3 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 3 is anything other than an unqualified admission, then for each study, research effort, or investigation conducted by the State prior to enacting SB 1028 to determine whether any Minor within the State of Maryland had been harmed by any SOCE counseling or had been subjected to any SOCE counseling against the Minor's wishes or without the Minor's consent, produce:

(a) all Documents Concerning that study, research, or investigation;

(b) all internal Communications of State personnel regarding that study, research, or investigation; and

(c) all Communications of State personnel with any Person(s) not employed by the State regarding that study, research, or investigation.

[For the sake of clarity, this RFP is limited to empirical studies, research, or investigations that the State itself conducted or commissioned, as opposed to studies, research, or investigations conducted by third parties which the State may have reviewed, considered, discussed, or debated.]

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 3 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this interrogatory is necessary.

REQUEST FOR PRODUCTION 4:

[If your response to RFA 4 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 4 is anything other than an unqualified admission, then for each study, research effort, or investigation conducted by the State prior to enacting SB 1028 to determine whether voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive, is harmful to that Minor, produce:

(a) all Documents Concerning that study, research, or investigation;

(b) all internal Communications of State personnel regarding that study, research, or investigation; and

(c) all Communications of State personnel with any Person(s) not employed by the State regarding that study, research, or investigation.

[For the sake of clarity, this RFP is limited to empirical studies, research, or investigations that the State itself conducted or commissioned, as opposed to studies, research, or investigations conducted by third parties which the State may have reviewed, considered, discussed, or debated.]

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 4 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this interrogatory is necessary.

REQUEST FOR PRODUCTION 5:

[If your response to RFA 5 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 5 is anything other than an unqualified admission, then produce each third-party study, research report, investigation, resolution, or position paper in the Legislative Record of SB 1028 which you contend to have identified or provided causal evidence of harm from, or a causal attribution of harm to, voluntary SOCE counseling, which a Minor

who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 5 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. There is no requirement that a legislature wait until it has evidence of actual harm before taking action to protect minors. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 519 (2009); *King v. Governor of State of New Jersey*, 767 F.3d 216, 239 (3d Cir. 2014); *Otto v. City of Boca Raton, Florida*, 2019 WL 588645, *20 (S.D. Fla. Feb. 14, 2019). Furthermore, under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that documents identified in the Legislative Record as construed by the defendants at MD0022-MD0023, MD0024-MD0025, MD0049-MD0050, MD0099, MD0104-MD0105, MD 0107-0112, MD0120-MD0123, and MD0204-209, and attached as exhibits to the plaintiff's complaint as ECF Document 1-2 and to the defendants' memorandum in opposition to the plaintiff's request for a preliminary injunction as ECF Documents 25-2, 25-9, 25-10, 25-11, 25-14, 25-17, and 25-18, are responsive to this request.

REQUEST FOR PRODUCTION 6:

[If your response to RFA 6 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 6 is anything other than an unqualified admission, then produce each third-party study, research report, investigation, resolution, or position paper in the

Legislative Record of SB 1028 which you contend to have identified or provided causal evidence of family rejection from, or a causal attribution of family rejection to, voluntary SOCE counseling, which a Minor who experiences unwanted same-sex attraction or gender confusion requests, consents to, and/or wishes to receive.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 6 as seeking information that is irrelevant and not likely to lead to the discovery of admissible evidence. Under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor 16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that, according to the plaintiff's instructions, no response to this request for production is necessary.

REQUEST FOR PRODUCTION 7:

[If your response to RFA 6 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 6 is anything other than an unqualified admission, then produce each study, research report, investigation, resolution, or position paper in the Legislative Record of SB 1028 which you contend to have analyzed the ability or inability of Minors to consent to SOCE counseling.

RESPONSE:

The defendants assume that the reference to RFA 6 is an error and that the request for production should refer to RFA 7. Based on that assumption, the defendants incorporate by reference their objections to Definition Nos. 7 and 11. The defendants further object to Request for Production No. 7 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. Under Maryland law, a minor under 16 years of age does not have the capacity to consent to medical treatment, including mental health treatment, and a minor

16 or 17 years of age does not have the ability to refuse treatment to which his or her parent or guardian has consented. *See* Md. Code Ann., Health-Gen'l § 20-104. Without waiving these objections, the defendants state that ECF Document 1-2 is responsive to this request for production.

REQUEST FOR PRODUCTION 8:

[If your response to RFA 8 is solely an unqualified admission, you may state so in response here and skip the remainder of this RFP].

If your response to RFA 8 is anything other than an unqualified admission, then produce all Documents Concerning each less restrictive alternative to SB 1028 reviewed, considered, discussed, or debated by the State, including but not limited to all Documents Concerning any effort conducted by the State to determine the feasibility or efficacy of any less restrictive alternative, and all Documents showing the specific portion(s) of the Legislative Record of SB 1028 where that alternative measure was reviewed, considered, discussed, or debated.

RESPONSE:

The defendants incorporate by reference their objections to Definition Nos. 7 and 11 and Instruction No. 8. The defendants further object to Request for Production No. 8 to the extent that it seeks documents protected by the legislative privilege. *See, e.g., 2BD Associates Ltd. Partnership v. County Commissioners of Queen Anne's County*, 896 F. Supp. 528, 533 (D. Md. 1995). Without waiving these objections, the defendants state that the Legislative Record, as they construe it, reflects that alternatives to SB 1028 were identified in MD0042, MD0061, MD0117, MD0181, MD0184, MD0185, and MD0186, and, as reflected in the text of Chapter 685, 2018 Laws of Maryland, were not adopted. The recordings of the House and Senate floor proceedings also are responsive to this interrogatory.

REQUEST FOR PRODUCTION 9:

All Documents Concerning the Legislative Record of SB 1028 to the extent not produced in response to any of the foregoing RFP.

RESPONSE:

The defendants incorporate by reference their objection to Definition No. 11 and Instruction No. 8 and further object to this request to the extent that it seek documents beyond the Legislative Record as construed by the defendants or documents protected by the legislative privilege. Documents numbered MD0001 to MD0220, and a flash drive with the recordings of the House and Senate proceedings regarding SB 1028 and HB 902 constitute the Legislative Record as construed by the defendants.

REQUEST FOR PRODUCTION 10:

All Communications between or among the SB 1028 Proponents and any other Persons regarding the drafting, introduction, sponsoring, consideration, amendment, debate, or passage of SB 1028 or any vote thereon.

RESPONSE:

The defendants incorporate by reference their objection to Instruction No. 8 and further object to Request for Production No. 10 as seeking documents protected by the legislative privilege.

REQUEST FOR PRODUCTION 11:

All Documents Concerning any lobbying or attempt of any advocacy group or other Person to influence the State to adopt or reject SB 1028 or any other ban on any form of SOCE counseling.

RESPONSE:

The defendants incorporate by reference their objection to Definition No. 7 and Instruction No. 8. The defendants further object to the request for documents unrelated to SB 1028 as defined in Definition No. 14 as seeking documents that are irrelevant and not likely to lead to the discovery of admissible evidence. The defendants also object to this request to the extent that it seeks documents protected by the legislative privilege. Without waiving any of

these objections, the defendants state that documents numbered MD0001 through MD0164 are responsive to this request.

REQUEST FOR PRODUCTION 12:

All Documents Concerning the State's interpretation, application, or enforcement of SB 1028, including but not limited to any proposed or enacted regulations, and any enforcement memoranda or guidelines provided to enforcement officials. [This RFP is not limited to the SB 1028 Proponents.]

RESPONSE:

The defendants incorporate by reference their objection to Definition No. 7. Without waiving that objection, the defendants state that the documents numbered MD0004-MD0005 and MD0210-MD403 are responsive to this request. The defendants state further that a letter dated March 12, 2018 and an email dated March 14, 2018 from Kathryn M. Rowe, Assistant Attorney General in the Office of Counsel to the General Assembly, to Senator Bryan W. Simonaire regarding SB 1028 are withheld as protected by the attorney-client privilege.

REQUEST FOR PRODUCTION 13:

All Documents Concerning the State's enforcement of, or any attempt to enforce, SB 1028 against any Person, including without limitation, all notices of violation, fines, warnings, citations, court documents, or Communications. [This RFP is not limited to the SB 1028 Proponents.]

RESPONSE:

The defendants incorporate by reference their objection to Definition No. 7. The defendants further object to this request as seeking documents protected by the medical review committee privilege in section 1-401 of the Health Occupations Article. Without waiving these objections, the defendants state that they have no responsive documents.

REQUEST FOR PRODUCTION 14:

All Communications between or among any of the SB 1028 Proponents and any advocacy group Concerning this lawsuit, the Plaintiff, SOCE counseling, SB 1028, or any other actual or proposed ban on any form of SOCE counseling. [For the sake of clarity and without limitation, as with all other requests, this Request is intended to encompass Communications between any attorneys for the State and any attorneys for advocacy groups regarding the enumerated subjects.]

RESPONSE:

The defendants incorporate by reference their objection to Definition No. 7 and Instructions No. 2 and No. 12. Without waiving those objections, the defendants are still working to determine whether they have any non-privileged documents responsive to this request. This response will be supplemented promptly when the defendants make that determination.

REQUEST FOR PRODUCTION 15:

All Documents Concerning Plaintiff's engagement in, provision of, or discussion of any SOCE counseling.

RESPONSE:

The defendants incorporate by reference their objections to Definition No. 7 and Instructions No. 2 and 12. Without waiving those objections, the defendants state that documents numbered MD0034, MD0036, and MD0059 to MD0062 are responsive to this request.

REQUEST FOR PRODUCTION 16:

All Documents Concerning the provision of any SOCE counseling by any provider within the State of Maryland.

RESPONSE:

The defendants object to this request as unduly burdensome. There are more than 50,000 licensed and certified individuals who may provide counseling to patients or clients regarding sexual orientation or gender identity. Nothing in the practice acts governing these individuals require them to specify an area of practice like SOCE counseling or conversion therapy. To determine whether any of the licensing or certifying boards has any documents responsive to this

request would require review of the files for the more than 50,000 licensees and certificate holders. The defendants further object to this request as seeking documents that are irrelevant and unlikely to lead to the discovery of admissible evidence. Documents concerning providers of SCOE counseling have nothing to do with the constitutionality of SB 1028.

REQUEST FOR PRODUCTION 17:

Each Document You reviewed or referenced to obtain Your answer to any of these Discovery Requests, which was not already provided in response to any foregoing RFP.

RESPONSE:

The defendants incorporate by reference their objections to Definition No. 2. The defendants further object to this request because it seeks information protected by the attorney work product doctrine about the documents selected for review by the defendants' counsel. Disclosure of the information required by Instruction No. 8 for a privilege log would cause disclosure of the privileged information.

Respectfully Submitted:
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Kathleen . Elli

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March 21, 2019

Attorneys for Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of March, 2019, I caused a true and correct copy of the foregoing to be served by e-mail on the following:

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John Garza
jgarza@lc.org

Kathleen A. Ellis

SB1028 (CH0685)

2018 Regular Session

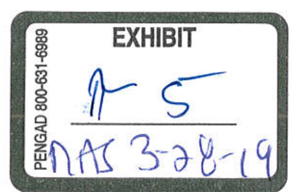
Entitled: Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)

Sponsored by: Senator Madaleno

Status: Approved by the Governor - Chapter 685

Synopsis:	Prohibiting certain mental health or child care practitioners from engaging in conversion therapy with individuals who are minors; providing that a certain mental health or child care practitioner who engages in conversion therapy with a minor shall be considered to have engaged in unprofessional conduct subject to disciplinary action; defining "conversion therapy" as a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation or gender identity; etc.
Analysis:	Fiscal and Policy Note
All Sponsors:	Senators Madaleno, Ferguson, Guzzone, Kagan, Lee, Manno, Pinsky, Smith, Zucker, and Young
Additional Facts:	Cross-filed with: HB0902 Bill File Type: Regular Effective Date(s): October 1, 2018
Committee(s):	Education, Health, and Environmental Affairs; Health and Government Operations
Broad Subject(s):	Health Occupations Public Health
Narrow Subject(s):	Counselors -see also- Guidance Counselors; Social Workers Ethics Gender -see also- Women Health Occupations -see also- specific health occupations Mental and Behavioral Health Psychiatrists Psychologists Sexual Orientation Youth -see also- Minors
Statutes:	Article - Health Occupations (1-212.1)

May 18, 2018 4:09 P.M.



SB1028 (CH0685)

2018 Regular Session

Entitled: Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)

Sponsored by: Senator Madaleno

Status: Approved by the Governor - Chapter 685

Document Name	
Amendments	Senate - (Senator Salling) {263124/01 Rejected
Amendments	Senate - (Senator Simonaire) {453624/01 Rejected
Amendments	Senate - (Education, Health, and Environmental Affairs) {664932/01 Adopted
Amendments	Senate - (Senator Simonaire) {893529/02 Rejected
Amendments	House - (Delegate Parrott) {133826/02 Rejected
Amendments	House - (Delegate Parrott) {353422/01 Rejected
Amendments	House - (Delegate Parrott) {353825/01 Rejected
Analysis	- Fiscal and Policy Note
Text	- First - Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)
Text	- Third - Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)
Text	- Chapter - Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)
Vote - Senate - Committee	- Education, Health, and Environmental Affairs
Vote - House - Committee	- Health and Government Operations
Vote - Senate Floor	- Favorable with Amendments Adopted (32-14) - 03/23/18
Vote - Senate Floor	- Floor Amendment {893529/2 (Senator Simonaire) Rejected (13-33) - 03/23/18
Vote - Senate Floor	- Third Reading Passed (34-12) - 03/24/18
Vote - House Floor	- Floor Amendment {353422/1 (Delegate Parrott) Rejected (39-81) - 03/26/18
Vote - House Floor	- Floor Amendment {133826/2 (Delegate Parrott) Rejected (37-88) - 03/26/18
Vote - House Floor	- Floor Amendment {353825/1 (Delegate Parrott) Rejected (36-86) - 03/26/18
Vote - House Floor	- Third Reading Passed (95-27) - 03/26/18

May 18, 2018 4:09 P.M.

SB1028/263124/1

BY: Senator Salling

AMENDMENT TO SENATE BILL 1028
(First Reading File Bill)

On page 5, in line 19, strike "A" and substitute "**:**

1. **A**";

in lines 21 and 26, strike "**1.**" and "**2.**", respectively, and substitute "**A.**" and "**B.**", respectively; and in line 27, after "**IDENTITY**" insert "**; OR**

2. **COMMUNICATION BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER:**

A. **DISCUSSING SEXUAL ORIENTATION, GENDER IDENTITY, OR TREATMENT THAT SEEKS TO CHANGE AN INDIVIDUAL'S SEXUAL ORIENTATION OR GENDER IDENTITY;**

B. **EXPRESSING THE MENTAL HEALTH OR CHILD CARE PRACTITIONER'S VIEWPOINT REGARDING SEXUAL ORIENTATION, GENDER IDENTITY, OR TREATMENT THAT SEEKS TO CHANGE AN INDIVIDUAL'S SEXUAL ORIENTATION OR GENDER IDENTITY; OR**

C. **RECOMMENDING TREATMENT THAT SEEKS TO CHANGE AN INDIVIDUAL'S SEXUAL ORIENTATION OR GENDER IDENTITY TO PATIENTS OR REFERRING PATIENTS TO UNLICENSED INDIVIDUALS, SUCH AS RELIGIOUS LEADERS**".

SB1028/453624/1

BY: Senator Simonaire

AMENDMENT TO SENATE BILL 1028
(First Reading File Bill)

On page 2, after line 12, insert:

"WHEREAS, In 2009, the American Psychological Association convened a Task Force on Appropriate Therapeutic Responses to Sexual Orientation that urged the seeking of areas where collaboration with religious leaders, institutions, and organizations could promote the well–being of sexual minorities through the use of accurate scientific data regarding sexual orientation and gender identity; and

WHEREAS, The 2009 Task Force also urged the encouragement of the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns to prioritize initiatives that address religious and spiritual concerns and the concerns of sexual minorities from conservative faiths; and

WHEREAS, The American Psychological Association in its report on the Appropriate Therapeutic Responses to Sexual Orientation, which was published in 1998, stated that "psychologists...respect the rights of individuals to privacy, confidentiality, self–determination, and autonomy"; and".

SB1028/664932/1

BY: Education, Health, and Environmental Affairs Committee

AMENDMENT TO SENATE BILL 1028
(First Reading File Bill)

On page 1, in the sponsor line, strike "and Zucker" and substitute "Zucker, and Young".

SB1028/893529/2

BY: Senator Simonaire

AMENDMENT TO SENATE BILL 1028
(First Reading File Bill)

On page 5, in line 13, strike "**SEEKS**" and substitute "**:**

1. SEEKS";

and in line 14, after "**IDENTITY**" insert "**; AND**

2. IS ABUSE AS DEFINED IN § 3–601 OF THE CRIMINAL LAW ARTICLE OR IS COERCIVE".

SB1028/133826/2

BY: Delegate Parrott

AMENDMENT TO SENATE BILL 1028
(Third Reading File Bill)

On page 5, in line 24, strike "A" and substitute "**:**

1. **A**";

in lines 26 and 31, strike "**1.**" and "**2.**", respectively, and substitute "**A.**" and "**B.**", respectively; and in line 32, after "**IDENTITY**" insert "**; OR**

2. **A PRACTICE OR TREATMENT BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER WHO REPRESENTS TO THE PUBLIC THAT THE PRACTICES AND TREATMENTS PROVIDED BY THE MENTAL HEALTH OR CHILD CARE PRACTITIONER ARE BASED IN RELIGION**".

SB1028/353422/1

BY: Delegate Parrott

AMENDMENT TO SENATE BILL 1028
(Third Reading File Bill)

On page 5, in line 17, strike "**PRACTICE OR**" and substitute "**PHYSICAL**"; and in line 20, strike "**EFFORT**" and substitute "**PHYSICAL TREATMENT THAT SEEKS**".

SB1028/353825/1

BY: Delegate Parrott

AMENDMENT TO SENATE BILL 1028
(Third Reading File Bill)

On page 6, in line 15, after the semicolon insert "OR"; and strike beginning with the semicolon in line 16 down through "**THERAPY**" in line 18.

SB 1028

Department of Legislative Services
Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Third Reader

Senate Bill 1028 (Senator Madaleno, *et al.*)

Education, Health, and Environmental Affairs Health and Government Operations

Health Occupations - Conversion Therapy for Minors - Prohibition (Youth Mental Health Protection Act)

This bill prohibits specified mental health or child care practitioners from engaging in "conversion therapy" with a minor. A violation of this prohibition is considered unprofessional conduct and must be subject to discipline by the appropriate licensing or certifying board. Additionally, the bill prohibits the use of State funds to (1) conduct or refer an individual to receive conversion therapy; (2) provide health coverage for conversion therapy; or (3) provide a grant to, or contract with, any entity that conducts or refers an individual to receive conversion therapy. The Maryland Department of Health (MDH) must adopt implementing regulations.

Fiscal Summary

State Effect: The bill is not expected to materially affect State finances or operations, as discussed below.

Local Effect: The bill is not expected to materially affect local finances or operations, as discussed below.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Conversion therapy" means a practice or treatment by a mental health or child care practitioner that seeks to change an individual's sexual orientation or gender identity, and includes any effort to change the behavioral expression of an individual's sexual orientation; change gender expression; or eliminate or reduce sexual or

romantic attractions or feelings toward individuals of the same gender. The definition does not include specified practices, including sexual-orientation neutral interventions to prevent or address unlawful conduct or unsafe sexual practices and that do not seek to change sexual orientation or gender identity.

"Mental health or child care practitioner" means a practitioner licensed or certified by the State Board of Physicians; the State Board of Professional Counselors and Therapists; the State Board of Examiners of Psychologists; the State Board of Social Work Examiners; and the State Board for Certification of Residential Child Care Program Professionals. The definition also includes any other practitioner who is licensed or certified to provide counseling by the practitioner's board.

Current Law/Background: According to a January 2018 report from The Williams Institute at the University of California Los Angeles School of Law, approximately 698,000 lesbian, gay, bisexual, or transgender (LGBT) adults have received conversion therapy in the United States, including about 350,000 LGBT adults who received treatment as adolescents. Additionally, approximately 20,000 LGBT youth (ages 13 to 17) are estimated to receive conversion therapy from a licensed health care professional before the age of 18.

According to The Williams Institute, conversion therapy has been practiced in the United States for over a century. Conversion therapy involves a range of techniques; talk therapy is the most common technique, but other more physical treatments are also used (*e.g.*, aversion treatments). Several professional associations, including the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics, have issued statements opposing the use of conversion therapy.

A federal bill, the Therapeutic Fraud Prevention Act, was introduced in April 2017. The bill prohibits conversion therapy from being provided in exchange for monetary compensation and prohibits associated advertisements.

According to the Movement Advancement Project, as of February 2018, nine states (California, Connecticut, Illinois, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, and Vermont) and the District of Columbia have banned conversion therapy for minors.

State Fiscal Effect: The Department of Budget and Management advises that the State Employee and Retiree Health and Welfare Benefits Program does not cover conversion therapy services. Medicaid also does not cover these services.

The State Board of Physicians advises that it has not received complaints regarding conversion therapy, but that if such a complaint was received, the board would investigate

the complaint as a possible standard of care violation through the board's disciplinary proceedings (which includes peer review procedures). The State Board of Professional Counselors and Therapists also advises that the board has not received complaints regarding this practice, although it is not specifically prohibited by the Maryland Professional Counselors and Therapists Act or board regulations.

Several health occupations boards, including the State Board of Physicians, the State Board of Professional Counselors and Therapists, the State Board of Examiners of Psychologists, and the State Board of Social Work Examiners, are authorized to impose disciplinary fines in addition to or in lieu of certain disciplinary action. Such fines are remitted to the general fund. Thus, to the extent these health occupations boards receive complaints and impose disciplinary fines against licensees as a result of the bill, general fund revenues may increase minimally. Any additional disciplinary proceedings can likely be handled with existing resources.

MDH can adopt implementing regulations with existing resources.

Local Fiscal Effect: The Maryland Association of County Health Officers advises that local health departments (LHDs) do not provide conversion therapy as it is not a recommended or accepted practice. Thus, the bill does not affect LHD finances or operations.

Small Business Effect: Potential meaningful for mental health or child care practitioners that offer conversion therapy. The bill explicitly prohibits the practice of conversion therapy with minors under State law and subjects specified practitioners to discipline for the practice by the appropriate licensing or certifying board. The bill also prohibits the award of State funds or contracts to entities that provide or refer individuals for such services.

Additional Information

Prior Introductions: None.

Cross File: HB 902 (Delegate Cullison, *et al.*) - Health and Government Operations.

Information Source(s): Maryland Association of County Health Officers; Maryland Commission on Civil Rights; Maryland State Department of Education; Department of Budget and Management; Maryland Department of Health; Department of Juvenile Services; The Williams Institute; The Movement Advancement Project; Department of Legislative Services

Fiscal Note History: First Reader - February 27, 2018
md/jc Third Reader - March 30, 2018

Analysis by: Sasika Subramaniam

Direct Inquiries to:
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SENATE BILL 1028

J2, J1 8lr1806
CF HB 902

By: **Senators Madaleno, Ferguson, Guzzone, Kagan, Lee, Manno, Pinsky, Smith, and Zucker**
Introduced and read first time: February 5, 2018
Assigned to: Education, Health, and Environmental Affairs

A BILL ENTITLED

1 AN ACT concerning

2 **Health Occupations – Conversion Therapy for Minors – Prohibition**
3 **(Youth Mental Health Protection Act)**

4 FOR the purpose of prohibiting certain mental health or child care practitioners from
5 engaging in conversion therapy with individuals who are minors; providing that a
6 certain mental health or child care practitioner who engages in conversion therapy
7 with an individual who is a minor shall be considered to have engaged in
8 unprofessional conduct and shall be subject to discipline by a certain licensing or
9 certifying board; prohibiting the use of State funds for certain purposes; requiring
10 the Maryland Department of Health to adopt certain regulations; defining certain
11 terms; making this Act severable; and generally relating to conversion therapy.

12 BY adding to
13 Article – Health Occupations
14 Section 1–212.1
15 Annotated Code of Maryland
16 (2014 Replacement Volume and 2017 Supplement)

17 Preamble

18 WHEREAS, Contemporary science recognizes that being lesbian, gay, bisexual, or
19 transgender (LGBT) is part of the natural spectrum of human identity and is not a disease,
20 a disorder, or an illness; and

21 WHEREAS, The American Psychological Association convened a Task Force on
22 Appropriate Therapeutic Responses to Sexual Orientation that conducted a systematic
23 review of peer–reviewed journal literature on sexual orientation change efforts and
24 concluded in its 2009 report that sexual orientation change efforts can pose critical health
25 risks to lesbian, gay, and bisexual people, including confusion, depression, guilt,
26 helplessness, hopelessness, shame, social withdrawal, suicidal intentions, substance abuse,

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.

1 stress, disappointment, self–blame, decreased self–esteem and authenticity to others,
2 increased self–hatred, hostility and blame toward parents, feelings of anger and betrayal,
3 loss of friends and potential romantic partners, problems in sexual and emotional intimacy,
4 sexual dysfunction, high–risk sexual behaviors, a feeling of being dehumanized and untrue
5 to self, a loss of faith, and a sense of having wasted time and resources; and

6 WHEREAS, The American Psychological Association issued a resolution on
7 Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in
8 2009 stating that it "advises parents, guardians, young people, and their families to avoid
9 sexual orientation change efforts that portray homosexuality as a mental illness or
10 developmental disorder and to seek psychotherapy, social support, and educational services
11 that provide accurate information on sexual orientation and sexuality, increase family and
12 school support, and reduce rejection of sexual minority youth"; and

13 WHEREAS, The American Psychiatric Association stated in 2000 that
14 "psychotherapeutic modalities to convert or 'repair' homosexuality are based on
15 developmental theories whose scientific validity is questionable. Furthermore, anecdotal
16 reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last
17 four decades, 'reparative' therapists have not produced any rigorous scientific research to
18 substantiate their claims of cure. Until there is such research available, the American
19 Psychiatric Association recommends that ethical practitioners refrain from attempts to
20 change individuals' sexual orientation, keeping in mind the medical dictum to first, do no
21 harm"; and

22 WHEREAS, The American Psychiatric Association also stated in 2000 that "the
23 potential risks of reparative therapy are great, including depression, anxiety, and
24 self–destructive behavior, since therapist alignment with societal prejudices against
25 homosexuality may reinforce self–hatred already experienced by the patient. Many
26 patients who have undergone reparative therapy relate that they were inaccurately told
27 that homosexuals are lonely, unhappy individuals who never achieve acceptance or
28 satisfaction. The possibility that the person might achieve happiness and satisfying
29 interpersonal relationships as a gay man or lesbian is not presented, nor are alternative
30 approaches to dealing with the effects of societal stigmatization discussed"; and

31 WHEREAS, The American Psychiatric Association further stated in 2000 that it
32 "opposes any psychiatric treatment such as reparative or conversion therapy which is based
33 upon the assumption that homosexuality per se is a mental disorder or based upon the a
34 priori assumption that a patient should change his/her sexual homosexual orientation"; and

35 WHEREAS, The American Academy of Pediatrics in 1993 published an article in its
36 journal "Pediatrics" stating "[t]herapy directed at specifically changing sexual orientation
37 is contraindicated, since it can provoke guilt and anxiety while having little or no potential
38 for achieving changes in orientation"; and

39 WHEREAS, The American Medical Association Council on Scientific Affairs
40 prepared a report in 1994 in which it stated "[a]version therapy (a behavioral or medical
41 intervention which pairs unwanted behavior, in this case, homosexual behavior, with

1 unpleasant sensations or aversive consequences) is no longer recommended for gay men
2 and lesbians"; and

3 WHEREAS, The American Medical Association Council on Scientific Affairs further
4 stated in its 1994 report that "[t]hrough psychotherapy, gay men and lesbians can become
5 comfortable with their sexual orientation and understand the societal response to it"; and

6 WHEREAS, The National Association of Social Workers prepared a 1997 policy
7 statement in which it stated "[s]ocial stigmatization of lesbian, gay, and bisexual people is
8 widespread and is a primary motivating factor in leading some people to seek sexual
9 orientation changes. Sexual orientation conversion therapies assume that homosexual
10 orientation is both pathological and freely chosen. No data demonstrates that reparative or
11 conversion therapies are effective, and, in fact, they may be harmful"; and

12 WHEREAS, The American Counseling Association Governing Council issued a
13 position statement in April 1999 that stated it opposed the promotion of reparative therapy
14 as a "cure" for homosexual individuals; and

15 WHEREAS, The American School Counselor Association issued a position paper in
16 2014 in which it stated that "[i]t is not the role of the professional school counselor to
17 attempt to change a student's sexual orientation or gender identity" and that "[p]rofessional
18 school counselors do not support efforts by licensed mental health professionals to change
19 a student's sexual orientation or gender as these practices have been proven ineffective and
20 harmful"; and

21 WHEREAS, The American Psychoanalytic Association issued a position statement
22 in June 2012 regarding attempts to change sexual orientation, gender identity, or gender
23 expression, and in the position statement the Association states "as with any societal
24 prejudice, bias against individuals based on actual or perceived sexual orientation, gender
25 identity or gender expression negatively affects mental health, contributing to an enduring
26 sense of stigma and pervasive self–criticism through the internalization of such prejudice";
27 and

28 WHEREAS, The American Psychoanalytic Association also stated in June 2012 that
29 "psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,'
30 change or shift an individual's sexual orientation, gender identity or gender expression.
31 Such directed efforts are against fundamental principles of psychoanalytic treatment and
32 often result in substantial psychological pain by reinforcing damaging internalized
33 attitudes"; and

34 WHEREAS, The American Academy of Child and Adolescent Psychiatry published
35 in 2012 an article in its journal entitled "The Journal of the American Academy of Child
36 and Adolescent Psychiatry", stating "[c]linicians should be aware that there is no evidence
37 that sexual orientation can be altered through therapy, and that attempts to do so may be
38 harmful. There is no empirical evidence adult homosexuality can be prevented if gender
39 nonconforming children are influenced to be more gender conforming. Indeed, there is no
40 medically valid basis for attempting to prevent homosexuality, which is not an illness. On

1 the contrary, such efforts may encourage family rejection and undermine self–esteem,
2 connectedness and caring, important protective factors against suicidal ideation and
3 attempts. Given that there is no evidence that efforts to alter sexual orientation are
4 effective, beneficial, or necessary, and the possibility that they carry the risk of significant
5 harm, such interventions are contraindicated"; and

6 WHEREAS, The Pan American Health Organization, a regional office of the World
7 Health Organization, issued a statement in May 2012 that states "[t]hese supposed
8 conversion therapies constitute a violation of the ethical principles of health care and
9 violate human rights that are protected by international and regional agreements"; and

10 WHEREAS, The Pan American Health Organization also noted that reparative
11 therapies "lack medical justification and represent a serious threat to the health and
12 well–being of affected people"; and

13 WHEREAS, The American Association of Sexuality Educators, Counselors, and
14 Therapists issued a statement in 2014 that states "same sex orientation is not a mental
15 disorder and that [it] opposes any 'reparative' or conversion therapy that seeks to 'change'
16 or 'fix' a person's sexual orientation"; and

17 WHEREAS, The American Association of Sexuality Educators, Counselors, and
18 Therapists further stated in 2014 its belief that sexual orientation is not "something that
19 needs to be 'fixed' or 'changed'" and provided as its rationale for this position that
20 "[r]eparative therapy (for minors, in particular) is often forced or nonconsensual[,]", has
21 "been proven harmful to minors[,]", and that "[t]here is no scientific evidence supporting
22 the success of these interventions"; and

23 WHEREAS, The American Association of Sexuality Educators, Counselors, and
24 Therapists also stated in 2014 that "[r]eparative therapy is grounded in the idea that
25 non–heterosexual orientation is 'disordered'" and that "[r]eparative therapy has been
26 shown to be a negative predictor of psychotherapeutic benefit"; and

27 WHEREAS, The American College of Physicians wrote a position paper in 2015
28 stating that it "opposes the use of 'conversion,' 'reorientation,' or 'reparative' therapy for the
29 treatment of LGBT persons[,]", that "[a]vailable research does not support the use of
30 reparative therapy as an effective model in the treatment of LGBT persons[,]", and that
31 "[e]vidence shows that the practice may actually cause emotional or physical harm to LGBT
32 individuals, particularly adolescents or young persons"; and

33 WHEREAS, Minors who experience family rejection based on their sexual
34 orientation face especially serious health risks; and

35 WHEREAS, In a study published in 2009 in the journal "Pediatrics", lesbian, gay,
36 and bisexual young adults who reported higher levels of family rejection during adolescence
37 were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to
38 report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times
39 more likely to report having engaged in unprotected sexual intercourse when compared

1 with peers from families that reported no or low levels of family rejection; and

2 WHEREAS, Maryland has a compelling interest in protecting the physical and
3 psychological well–being of minors, including LGBT youth, and in protecting minors
4 against exposure to serious harm caused by sexual orientation change efforts; now,
5 therefore,

6 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
7 That the Laws of Maryland read as follows:

8 **Article – Health Occupations**

9 **1–212.1.**

10 **(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS**
11 **INDICATED.**

12 **(2) (I) "CONVERSION THERAPY" MEANS A PRACTICE OR**
13 **TREATMENT BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER THAT SEEKS TO**
14 **CHANGE AN INDIVIDUAL'S SEXUAL ORIENTATION OR GENDER IDENTITY.**

15 **(II) "CONVERSION THERAPY" INCLUDES ANY EFFORT TO**
16 **CHANGE THE BEHAVIORAL EXPRESSION OF AN INDIVIDUAL'S SEXUAL ORIENTATION,**
17 **CHANGE GENDER EXPRESSION, OR ELIMINATE OR REDUCE SEXUAL OR ROMANTIC**
18 **ATTRACTIONS OR FEELINGS TOWARD INDIVIDUALS OF THE SAME GENDER.**

19 **(III) "CONVERSION THERAPY" DOES NOT INCLUDE A PRACTICE**
20 **BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER THAT:**

21 **1. PROVIDES ACCEPTANCE, SUPPORT, AND**
22 **UNDERSTANDING, OR THE FACILITATION OF COPING, SOCIAL SUPPORT, AND**
23 **IDENTITY EXPLORATION AND DEVELOPMENT, INCLUDING SEXUAL**
24 **ORIENTATION–NEUTRAL INTERVENTIONS TO PREVENT OR ADDRESS UNLAWFUL**
25 **CONDUCT OR UNSAFE SEXUAL PRACTICES; AND**

26 **2. DOES NOT SEEK TO CHANGE SEXUAL ORIENTATION**
27 **OR GENDER IDENTITY.**

28 **(3) "MENTAL HEALTH OR CHILD CARE PRACTITIONER" MEANS:**

29 **(I) A PRACTITIONER LICENSED OR CERTIFIED UNDER TITLE**
30 **14, TITLE 17, TITLE 18, TITLE 19, OR TITLE 20 OF THIS ARTICLE; OR**

31 **(II) ANY OTHER PRACTITIONER LICENSED OR CERTIFIED**

1 UNDER THIS ARTICLE WHO IS AUTHORIZED TO PROVIDE COUNSELING BY THE
2 PRACTITIONER'S LICENSING OR CERTIFYING BOARD.

3 (B) A MENTAL HEALTH OR CHILD CARE PRACTITIONER MAY NOT ENGAGE IN
4 CONVERSION THERAPY WITH AN INDIVIDUAL WHO IS A MINOR.

5 (C) A MENTAL HEALTH OR CHILD CARE PRACTITIONER WHO ENGAGED IN
6 CONVERSION THERAPY WITH AN INDIVIDUAL WHO IS A MINOR SHALL BE
7 CONSIDERED TO HAVE ENGAGED IN UNPROFESSIONAL CONDUCT AND SHALL BE
8 SUBJECT TO DISCIPLINE BY THE MENTAL HEALTH OR CHILD CARE PRACTITIONER'S
9 LICENSING OR CERTIFYING BOARD.

10 (D) NO STATE FUNDS MAY BE USED FOR THE PURPOSE OF:

11 (1) CONDUCTING, OR REFERRING AN INDIVIDUAL TO RECEIVE,
12 CONVERSION THERAPY;

13 (2) PROVIDING HEALTH COVERAGE FOR CONVERSION THERAPY; OR

14 (3) PROVIDING A GRANT TO OR CONTRACTING WITH ANY ENTITY
15 THAT CONDUCTS OR REFERS AN INDIVIDUAL TO RECEIVE CONVERSION THERAPY.

16 (E) THE DEPARTMENT SHALL ADOPT REGULATIONS NECESSARY TO
17 IMPLEMENT THIS SECTION.

18 SECTION 2. AND BE IT FURTHER ENACTED, That, if any provision of this Act or
19 the application thereof to any person or circumstance is held invalid for any reason in a
20 court of competent jurisdiction, the invalidity does not affect other provisions or any other
21 application of this Act that can be given effect without the invalid provision or application,
22 and for this purpose the provisions of this Act are declared severable.

23 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
24 October 1, 2018.

SENATE BILL 1028

J2, J1 8lr1806
CF HB 902

By: **Senators Madaleno, Ferguson, Guzzone, Kagan, Lee, Manno, Pinsky, Smith, ~~and Zucker~~ Zucker, and Young**
Introduced and read first time: February 5, 2018
Assigned to: Education, Health, and Environmental Affairs

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 23, 2018

CHAPTER ______

1 AN ACT concerning

2 **Health Occupations – Conversion Therapy for Minors – Prohibition**
3 **(Youth Mental Health Protection Act)**

4 FOR the purpose of prohibiting certain mental health or child care practitioners from
5 engaging in conversion therapy with individuals who are minors; providing that a
6 certain mental health or child care practitioner who engages in conversion therapy
7 with an individual who is a minor shall be considered to have engaged in
8 unprofessional conduct and shall be subject to discipline by a certain licensing or
9 certifying board; prohibiting the use of State funds for certain purposes; requiring
10 the Maryland Department of Health to adopt certain regulations; defining certain
11 terms; making this Act severable; and generally relating to conversion therapy.

12 BY adding to
13 Article – Health Occupations
14 Section 1–212.1
15 Annotated Code of Maryland
16 (2014 Replacement Volume and 2017 Supplement)

17 Preamble

18 WHEREAS, Contemporary science recognizes that being lesbian, gay, bisexual, or
19 transgender (LGBT) is part of the natural spectrum of human identity and is not a disease,
20 a disorder, or an illness; and

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

EXHIBIT
PENGAD 800-631-6989
7
3-28-19

1 WHEREAS, The American Psychological Association convened a Task Force on
2 Appropriate Therapeutic Responses to Sexual Orientation that conducted a systematic
3 review of peer–reviewed journal literature on sexual orientation change efforts and
4 concluded in its 2009 report that sexual orientation change efforts can pose critical health
5 risks to lesbian, gay, and bisexual people, including confusion, depression, guilt,
6 helplessness, hopelessness, shame, social withdrawal, suicidal intentions, substance abuse,
7 stress, disappointment, self–blame, decreased self–esteem and authenticity to others,
8 increased self–hatred, hostility and blame toward parents, feelings of anger and betrayal,
9 loss of friends and potential romantic partners, problems in sexual and emotional intimacy,
10 sexual dysfunction, high–risk sexual behaviors, a feeling of being dehumanized and untrue
11 to self, a loss of faith, and a sense of having wasted time and resources; and

12 WHEREAS, The American Psychological Association issued a resolution on
13 Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts in
14 2009 stating that it "advises parents, guardians, young people, and their families to avoid
15 sexual orientation change efforts that portray homosexuality as a mental illness or
16 developmental disorder and to seek psychotherapy, social support, and educational services
17 that provide accurate information on sexual orientation and sexuality, increase family and
18 school support, and reduce rejection of sexual minority youth"; and

19 WHEREAS, The American Psychiatric Association stated in 2000 that
20 "psychotherapeutic modalities to convert or 'repair' homosexuality are based on
21 developmental theories whose scientific validity is questionable. Furthermore, anecdotal
22 reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last
23 four decades, 'reparative' therapists have not produced any rigorous scientific research to
24 substantiate their claims of cure. Until there is such research available, the American
25 Psychiatric Association recommends that ethical practitioners refrain from attempts to
26 change individuals' sexual orientation, keeping in mind the medical dictum to first, do no
27 harm"; and

28 WHEREAS, The American Psychiatric Association also stated in 2000 that "the
29 potential risks of reparative therapy are great, including depression, anxiety, and
30 self–destructive behavior, since therapist alignment with societal prejudices against
31 homosexuality may reinforce self–hatred already experienced by the patient. Many
32 patients who have undergone reparative therapy relate that they were inaccurately told
33 that homosexuals are lonely, unhappy individuals who never achieve acceptance or
34 satisfaction. The possibility that the person might achieve happiness and satisfying
35 interpersonal relationships as a gay man or lesbian is not presented, nor are alternative
36 approaches to dealing with the effects of societal stigmatization discussed"; and

37 WHEREAS, The American Psychiatric Association further stated in 2000 that it
38 "opposes any psychiatric treatment such as reparative or conversion therapy which is based
39 upon the assumption that homosexuality per se is a mental disorder or based upon the a
40 priori assumption that a patient should change his/her sexual homosexual orientation"; and

41 WHEREAS, The American Academy of Pediatrics in 1993 published an article in its
42 journal "Pediatrics" stating "[t]herapy directed at specifically changing sexual orientation

1 is contraindicated, since it can provoke guilt and anxiety while having little or no potential
2 for achieving changes in orientation"; and

3 WHEREAS, The American Medical Association Council on Scientific Affairs
4 prepared a report in 1994 in which it stated "[a]version therapy (a behavioral or medical
5 intervention which pairs unwanted behavior, in this case, homosexual behavior, with
6 unpleasant sensations or aversive consequences) is no longer recommended for gay men
7 and lesbians"; and

8 WHEREAS, The American Medical Association Council on Scientific Affairs further
9 stated in its 1994 report that "[t]hrough psychotherapy, gay men and lesbians can become
10 comfortable with their sexual orientation and understand the societal response to it"; and

11 WHEREAS, The National Association of Social Workers prepared a 1997 policy
12 statement in which it stated "[s]ocial stigmatization of lesbian, gay, and bisexual people is
13 widespread and is a primary motivating factor in leading some people to seek sexual
14 orientation changes. Sexual orientation conversion therapies assume that homosexual
15 orientation is both pathological and freely chosen. No data demonstrates that reparative or
16 conversion therapies are effective, and, in fact, they may be harmful"; and

17 WHEREAS, The American Counseling Association Governing Council issued a
18 position statement in April 1999 that stated it opposed the promotion of reparative therapy
19 as a "cure" for homosexual individuals; and

20 WHEREAS, The American School Counselor Association issued a position paper in
21 2014 in which it stated that "[i]t is not the role of the professional school counselor to
22 attempt to change a student's sexual orientation or gender identity" and that "[p]rofessional
23 school counselors do not support efforts by licensed mental health professionals to change
24 a student's sexual orientation or gender as these practices have been proven ineffective and
25 harmful"; and

26 WHEREAS, The American Psychoanalytic Association issued a position statement
27 in June 2012 regarding attempts to change sexual orientation, gender identity, or gender
28 expression, and in the position statement the Association states "as with any societal
29 prejudice, bias against individuals based on actual or perceived sexual orientation, gender
30 identity or gender expression negatively affects mental health, contributing to an enduring
31 sense of stigma and pervasive self–criticism through the internalization of such prejudice";
32 and

33 WHEREAS, The American Psychoanalytic Association also stated in June 2012 that
34 "psychoanalytic technique does not encompass purposeful attempts to 'convert,' 'repair,'
35 change or shift an individual's sexual orientation, gender identity or gender expression.
36 Such directed efforts are against fundamental principles of psychoanalytic treatment and
37 often result in substantial psychological pain by reinforcing damaging internalized
38 attitudes"; and

39 WHEREAS, The American Academy of Child and Adolescent Psychiatry published

1 in 2012 an article in its journal entitled "The Journal of the American Academy of Child
2 and Adolescent Psychiatry", stating "[c]linicians should be aware that there is no evidence
3 that sexual orientation can be altered through therapy, and that attempts to do so may be
4 harmful. There is no empirical evidence adult homosexuality can be prevented if gender
5 nonconforming children are influenced to be more gender conforming. Indeed, there is no
6 medically valid basis for attempting to prevent homosexuality, which is not an illness. On
7 the contrary, such efforts may encourage family rejection and undermine self–esteem,
8 connectedness and caring, important protective factors against suicidal ideation and
9 attempts. Given that there is no evidence that efforts to alter sexual orientation are
10 effective, beneficial, or necessary, and the possibility that they carry the risk of significant
11 harm, such interventions are contraindicated"; and

12 WHEREAS, The Pan American Health Organization, a regional office of the World
13 Health Organization, issued a statement in May 2012 that states "[t]hese supposed
14 conversion therapies constitute a violation of the ethical principles of health care and
15 violate human rights that are protected by international and regional agreements"; and

16 WHEREAS, The Pan American Health Organization also noted that reparative
17 therapies "lack medical justification and represent a serious threat to the health and
18 well–being of affected people"; and

19 WHEREAS, The American Association of Sexuality Educators, Counselors, and
20 Therapists issued a statement in 2014 that states "same sex orientation is not a mental
21 disorder and that [it] opposes any 'reparative' or conversion therapy that seeks to 'change'
22 or 'fix' a person's sexual orientation"; and

23 WHEREAS, The American Association of Sexuality Educators, Counselors, and
24 Therapists further stated in 2014 its belief that sexual orientation is not "something that
25 needs to be 'fixed' or 'changed'" and provided as its rationale for this position that
26 "[r]eparative therapy (for minors, in particular) is often forced or nonconsensual[,]", has
27 "been proven harmful to minors[,]", and that "[t]here is no scientific evidence supporting
28 the success of these interventions"; and

29 WHEREAS, The American Association of Sexuality Educators, Counselors, and
30 Therapists also stated in 2014 that "[r]eparative therapy is grounded in the idea that
31 non–heterosexual orientation is 'disordered'" and that "[r]eparative therapy has been
32 shown to be a negative predictor of psychotherapeutic benefit"; and

33 WHEREAS, The American College of Physicians wrote a position paper in 2015
34 stating that it "opposes the use of 'conversion,' 'reorientation,' or 'reparative' therapy for the
35 treatment of LGBT persons[,]", that "[a]vailable research does not support the use of
36 reparative therapy as an effective model in the treatment of LGBT persons[,]", and that
37 "[e]vidence shows that the practice may actually cause emotional or physical harm to LGBT
38 individuals, particularly adolescents or young persons"; and

39 WHEREAS, Minors who experience family rejection based on their sexual
40 orientation face especially serious health risks; and

1 WHEREAS, In a study published in 2009 in the journal "Pediatrics", lesbian, gay,
2 and bisexual young adults who reported higher levels of family rejection during adolescence
3 were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to
4 report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times
5 more likely to report having engaged in unprotected sexual intercourse when compared
6 with peers from families that reported no or low levels of family rejection; and

7 WHEREAS, Maryland has a compelling interest in protecting the physical and
8 psychological well–being of minors, including LGBT youth, and in protecting minors
9 against exposure to serious harm caused by sexual orientation change efforts; now,
10 therefore,

11 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
12 That the Laws of Maryland read as follows:

13 **Article – Health Occupations**

14 **1–212.1.**

15 **(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS**
16 **INDICATED.**

17 **(2) (I) "CONVERSION THERAPY" MEANS A PRACTICE OR**
18 **TREATMENT BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER THAT SEEKS TO**
19 **CHANGE AN INDIVIDUAL'S SEXUAL ORIENTATION OR GENDER IDENTITY.**

20 **(II) "CONVERSION THERAPY" INCLUDES ANY EFFORT TO**
21 **CHANGE THE BEHAVIORAL EXPRESSION OF AN INDIVIDUAL'S SEXUAL ORIENTATION,**
22 **CHANGE GENDER EXPRESSION, OR ELIMINATE OR REDUCE SEXUAL OR ROMANTIC**
23 **ATTRACTIONS OR FEELINGS TOWARD INDIVIDUALS OF THE SAME GENDER.**

24 **(III) "CONVERSION THERAPY" DOES NOT INCLUDE A PRACTICE**
25 **BY A MENTAL HEALTH OR CHILD CARE PRACTITIONER THAT:**

26 **1. PROVIDES ACCEPTANCE, SUPPORT, AND**
27 **UNDERSTANDING, OR THE FACILITATION OF COPING, SOCIAL SUPPORT, AND**
28 **IDENTITY EXPLORATION AND DEVELOPMENT, INCLUDING SEXUAL**
29 **ORIENTATION–NEUTRAL INTERVENTIONS TO PREVENT OR ADDRESS UNLAWFUL**
30 **CONDUCT OR UNSAFE SEXUAL PRACTICES; AND**

31 **2. DOES NOT SEEK TO CHANGE SEXUAL ORIENTATION**
32 **OR GENDER IDENTITY.**

33 **(3) "MENTAL HEALTH OR CHILD CARE PRACTITIONER" MEANS:**

1 (I) A PRACTITIONER LICENSED OR CERTIFIED UNDER TITLE
2 14, TITLE 17, TITLE 18, TITLE 19, OR TITLE 20 OF THIS ARTICLE; OR

3 (II) ANY OTHER PRACTITIONER LICENSED OR CERTIFIED
4 UNDER THIS ARTICLE WHO IS AUTHORIZED TO PROVIDE COUNSELING BY THE
5 PRACTITIONER'S LICENSING OR CERTIFYING BOARD.

6 (B) A MENTAL HEALTH OR CHILD CARE PRACTITIONER MAY NOT ENGAGE IN
7 CONVERSION THERAPY WITH AN INDIVIDUAL WHO IS A MINOR.

8 (C) A MENTAL HEALTH OR CHILD CARE PRACTITIONER WHO ENGAGED IN
9 CONVERSION THERAPY WITH AN INDIVIDUAL WHO IS A MINOR SHALL BE
10 CONSIDERED TO HAVE ENGAGED IN UNPROFESSIONAL CONDUCT AND SHALL BE
11 SUBJECT TO DISCIPLINE BY THE MENTAL HEALTH OR CHILD CARE PRACTITIONER'S
12 LICENSING OR CERTIFYING BOARD.

13 (D) NO STATE FUNDS MAY BE USED FOR THE PURPOSE OF:

14 (1) CONDUCTING, OR REFERRING AN INDIVIDUAL TO RECEIVE,
15 CONVERSION THERAPY;

16 (2) PROVIDING HEALTH COVERAGE FOR CONVERSION THERAPY; OR

17 (3) PROVIDING A GRANT TO OR CONTRACTING WITH ANY ENTITY
18 THAT CONDUCTS OR REFERS AN INDIVIDUAL TO RECEIVE CONVERSION THERAPY.

19 (E) THE DEPARTMENT SHALL ADOPT REGULATIONS NECESSARY TO
20 IMPLEMENT THIS SECTION.

21 SECTION 2. AND BE IT FURTHER ENACTED, That, if any provision of this Act or
22 the application thereof to any person or circumstance is held invalid for any reason in a
23 court of competent jurisdiction, the invalidity does not affect other provisions or any other
24 application of this Act that can be given effect without the invalid provision or application,
25 and for this purpose the provisions of this Act are declared severable.

26 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
27 October 1, 2018.