EXHIBIT 183
REDACTED

Assessment, Support and Therapeutic Approaches for Adolescents with Gender Variance/Dysphoria

SOC 8 – Draft 7/20/21

INTRODUCTION

Historical Context and Changes Since Previous Guidelines

Compared to the longer-established care models for transgender adults, specialized healthcare for transgender adolescents is a relatively new field of practice. Until recently, there were few specialized gender clinics for youth globally, and the handful of clinics served generally small numbers of children and adolescents. In more recent years there has been a sharp increase in the number of adolescents requesting gender care (Arnoldussen et al. , 2019, Kaltiala et al., 2019). New clinics have been founded, but clinical services in many places do not keep pace with the increasing number of youth seeking care. Hence, there are often long waitlists for services and barriers to care still exist for many transgender youth around the world.

For a long time, there was limited information regarding the prevalence of gender diversity among adolescents. Studies from high school samples give much higher current estimates than earlier expected of 1.2% identifying as transgender (Clark et al., 2014) and up to 2.7% or more (e.g., 7-9%) experiencing some level of self-reported gender diversity (Eisenberg et al., 2017, Wang et al., 2020, Kidds et al., 2021). These studies suggest that gender diversity should no longer be viewed as rare. Additionally, a pattern of uneven ratios by assigned sex has been reported in gender clinics, with adolescents assigned female at birth initiating care 2.5-7.1 times more frequently as compared to adolescents who are assigned males at birth (Arnoldussen et al., 2019, Kaltiala et al., 2015 Kaltiala et al., 2019, Aitken et al., 2015, de Graaf et al., 2018).

A specific WPATH standards of care section dedicated to the needs of children and adolescents was first included in the WPATH Standards of Care in its 5th version from 1988. Youth age 16 or older were deemed potentially eligible for gender affirming medical care, but only in select cases. The subsequent 6th (2005) and 7th (2011) versions divided medical affirming treatment for adolescents into three categories and formulated eligibility criteria regarding age/puberty stage: fully reversible puberty delaying blockers as soon as puberty had started; partially reversible “masculinizing” or “feminizing”

hormone therapy for adolescents of age of majority, which was age 16 in certain European countries; and fully irreversible surgeries at age 18 or older, except for chest "masculinizing" mastectomy, which had an age minimum of 16 years of age. Other eligibility criteria for gender-related medical care were: persistent long (childhood) history of gender "non-conformity"/dysphoria; emerging or worsening at the onset of puberty; absence or management of co-existing psychological, medical or social problems that interfere with treatment; provision of support for moving forward with the intervention by the parents or other caregivers; and provision of informed consent. A specific chapter dedicated to transgender and gender diverse adolescents has been created for this 8th edition of the Standards of care, distinct from the child chapter, due to: (1) the exponential growth in adolescent referral rates, (2) research findings specific to adolescent gender diversity-related care, and (3) the special developmental and gender affirming care issues specific to this age group.

Methodology

For the current 8th revision of the Standards of Care, our multidisciplinary workgroup started by reviewing the recommendations in former editions. As there are now two separate chapters for childhood and adolescence, to ensure consistency between both chapters, some authors were part of both chapters. For a similar reason, when applicable, we collaborated with other chapters on topics shared between the chapters (i.e., Assessment of Adults, Hormone Therapy, Surgery and Reproductive Health).

Draft statements were refinements of earlier versions of the SOC and also draw from the more recent Endocrine Society Clinical Practice Guideline (Hembree et al., 2017). Statements were rephrased or adapted and several new statements were added. This led to the formulation of the final 12 statements that were prepared for the Delphi process. In two rounds they all reached consensus endorsement from the larger Standards of Care revision committee.

Adolescence Overview

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation that bridges between childhood and adulthood (Sanders, 2013). Multiple developmental processes occur simultaneously, including pubertal-signaled changes, cognitive, emotional, and social development, and related psychosocial development. These processes do not all begin and end at the same time for a given individual, nor do they occur at the same age for all persons. Therefore, the lower and upper borders of adolescence are imprecise and cannot be defined exclusively by age, despite the fact that brain development occurs well into the mid-20's and also the fact that different countries and States define age of majority (legal decision-making status) at different ages (Dick et al., 2014). While a majority of municipalities define the age of majority at 18 years, in some countries it is as low as 15 years (e.g. Indonesia and Myanmar), whereas in others it is as high as 21 years (e.g. Mississippi and Singapore).

Given the simultaneous, overlapping and interrelated adolescent developmental processes, including the common drive for independence from caregivers (Steinberg, 2004). Cognitive development in adolescence often involves moves towards increased abstract thinking, advanced reasoning, and meta-cognition (i.e., a young person's ability to think about their own feelings in relation to how others perceive them; Sanders, 2013). The ability to reason hypothetical situations allows an individual to conceptualize numerous possibilities for a particular decision. Additionally, adolescents often experience a sense of urgency with a decreased threshold for experiencing reward in a hyperresponsive brain circuitry, as their sense of time has been found to be profoundly different than that of older individuals (Van Leijenhorst et al., 2010). Therefore, this period is also often associated with more risk-taking behaviors. Along with these notable developments in the adolescent brain, it is also a period known for individuation from parents and the development of autonomy, with a heightened focus on peer relationships, which can be both positive and detrimental (Gardner & Steinberg, 2005). Social-emotional development also advances during this period, with great variability among young people regarding level of maturity as it relates to inter and intra-personal communication and insight (Grootens-Wiegers et al., 2017). For transgender and gender diverse adolescents making decisions about gender affirming treatments that potentially have lifelong consequences, it is important to understand how all of these aspects of development impact the decision-making capacity for a given young person within their specific cultural context.

Gender Identity Development in Adolescence

The research and understanding of gender identity development in adolescence is evolving. It is important to understand what is known and that what is *not known* about gender identity development in adolescents when providing clinical care to young people and families (Berenbaum, 2018). When considering sought after treatments, families may often have questions related to the development of their adolescent's gender identity and whether or not the adolescent's declared gender will remain the same over time. For some adolescents, a declared gender identity that differs from the assigned sex at birth comes as no surprise to their parents as their history of gender diverse expression dates back to childhood (Leibowitz & de Vries, 2016). For others, the declaration does not happen until the emergence of pubertal changes, or even well into adolescence (McCallion et al., 2021, Sorbara et al., 2020).

Historically, social learning and cognitive developmental research on *gender development* was done on youth who were not necessarily gender diverse in identity or expression, under the assumption that sex correlated with a specific gender, and therefore little attention was given to *gender identity development.* In addition to biological factors influencing gender development, this line of research demonstrates that there is a role for psychological and social factors as well (Perry & Pauletti, 2011). While there has been less focus on *gender identity development* in transgender and gender diverse youth, there is ample reason to suppose that apart from biological factors, psychosocial factors are also involved. For some youth, gender identity development appears fixed, often expressed from a young

age, while for others there may be a developmental process that contributes to gender identity development over time. Families often have questions about this very issue and so it is important to note that it is not possible to distinguish between those where gender identity may seem fixed from birth from those where gender identity development appears to be a developmental process. Future research would shed more light on gender identity development if done across many different environments over long periods of time with diverse cohort groups. Trends in the conceptualization of gender identity, shifting from dichotomous, or binary, categories of male and female to one that is a dimensional spectrum along a continuum (APA, 2013), would also need to be accounted for.

Neuroimaging studies, genetic studies, and other hormone studies on individuals born with a difference of sex development (DSD) demonstrate a biological contribution to the development of gender identity for individuals whose gender identity does not match their assigned sex at birth (Steensma et al., 2013). However, parsing out the role of the environment on gender identity development is very difficult, even for young people whose parents did not raise them with rigid stereotypical gender role expectations, given the fact that the environment remains highly binary regarding gender identity and expression in most cultures.

Adolescence is considered a crucial period for the development of gender identity development for gender diverse young people (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). Longitudinal research on Dutch clinical follow-up studies on adolescents receiving puberty suppression and/or gender affirming hormones after comprehensive assessment demonstrated that none of them refrained from pursuing gender affirming surgery years later, suggesting that adolescents seeking treatment demonstrate stability with their gender identity over time (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014; van Goozen, Kuiper, & Cohen-Kettenis, 2005a).

When extrapolating these conclusions to present-day gender diverse adolescents seeking care, one must contextualize the societal changes that have evolved over time as it pertains to transgender people. Given the increase in visibility for transgender and gender diverse people, it is important to address current influences on social development for young people (Kornienko et al., 2016). One trend is that more young people are presenting to gender clinics with gender diverse and gender nonbinary presentations (Twist & de Graaf, 2019). Another phenomenon refers to adolescents seeking care who have not seemingly expressed gender diversity in their childhood years. One researcher attempted to study and describe this phenomenon (Littman, 2019), however the significant methodological challenges that exist in the research provide context for the findings: 1) the survey included only parents and not the youths' experiences; and 2) the recruitment of parents was drawn from a setting that conceptualized treatments for gender dysphoria as inherently pathological. In truth, some who have changed their thoughts about their own gender identity have described how social influence was relevant in their self-experience of gender during adolescence (Strang et al., 2018; Vandenbussche, 2021). For a select subgroup of young people, in the context of exploration, social influence may be a relevant issue for them. This is neither a new nor surprising concept for clinicians working with

adolescents, however we emphasize the harms that can arise when these phenomena are prematurely labeled based on datasets with substantial sample bias (WPATH, 2018).

Regardless of what is known about adolescent gender identity development, an individualized approach to clinical care is both ethical and necessary. As is the case in all areas of medicine, each study has methodological limitations and conclusions drawn from the research cannot *and should not* be universally applied to all adolescents when answering the common parental question about the stability of a particular young person's gender identity development. Future research will help advance scientific understanding of gender identity development, however there will always be some gaps and these gaps should not leave the TGD adolescent without important and necessary care.

Research evidence

A key issue in adolescent transgender care is the quality of evidence for effectiveness of gender affirming medical treatments. Given the lifelong implications of medical treatment and the young age at which they may be started, adolescents, their parents, and care providers should be informed about the evidence base. It seems reasonable that decisions to move forward with medical treatments should be made carefully. Despite the slowly growing body of evidence on effectiveness of early medical intervention, the number of studies is still low compared to outcome studies in adults. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible and we provide a short narrative review instead.

When writing this chapter, there were several longer term (into young adulthood) longitudinal cohort follow-up studies that show positive results of early (adolescent) medical treatment, all stemming from one Dutch clinic. The findings demonstrate improved psychological functioning and body image satisfaction associated with the resolution of gender dysphoria. Most of these studies followed a pre-post methodological design and compared baseline psychological functioning to outcomes after the provision of medical gender-affirming treatments. Different studies evaluated different aspects or combinations of treatment interventions: 1) gender-affirming hormones and surgeries (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001; Smith et al., 2005), 2) puberty suppression (de Vries et al., 2011) or 3) puberty suppression, affirming hormones and surgeries (de Vries et al., 2014). The 2014 long term follow-up study is the only study that followed youth from early adolescence (pre-treatment mean age of 13.6) until young adulthood (post treatment mean age of 20.7) and was the first study to show that gender-affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender, contributing to a satisfactory objective and subjective well-being' (de Vries et al., 2014). These were convincing results. However, the question of generalizability remains, as it included a select, socially-supported small sample (n=55), all of whom experienced childhood gender nonconformity. The participants came from a clinic that uses a multidisciplinary approach and provides comprehensive, ongoing assessment and support for gender dysphoria and emotional well-being.

Several more recently published longitudinal studies followed a cross sequential study design; after baseline measurement, evaluations were conducted at fixed follow up times (e.g. 6/12/24 months after baseline). This design results in the evaluation of participants at different stages of their gender affirming treatments. Some participants may not have started gender-affirming medical treatments; others have been treated with puberty suppression; while others have started gender affirming hormones or even had their gender affirming surgeries (Costa et al., 2015, Becker-Hebly et al., 2020, Kuper et al., 2020, Achille et al., 2020, Carmichael et al., 2021). This design makes interpreting the outcomes more challenging. Regardless, the data all demonstrate improved or stable psychological functioning and body image or treatment satisfaction. Another recent study compared psychological functioning of transgender adolescents at baseline and while on puberty suppression with cisgender high school peers at two different time point. At baseline the transgender youth demonstrated lower psychological functioning than their cisgender peers, while on puberty suppression they demonstrated better functioning than their same age peers (van der Miesen et al., 2020).

Two additional studies investigated how initial mental health treatment is related to post-treatment outcomes. In a retrospective chart study Kaltiala et al. (2020) showed that transgender adolescents who did well in terms of psychiatric symptoms and functioning before affirming hormones were provided, mainly did well during the treatment, while adolescents with more problems at baseline had high continued to have these problems. Nieder et al., (2021) demonstrated that transgender adolescents who progressed further with desired medical affirming treatments (puberty suppression, affirming hormones, affirming surgeries) were more satisfied with their overall treatment (including the mental health treatment initially) after a mean duration of two years after baseline. The conclusion is that timely gender affirming medical care is important for transgender youth, who represented a subgroup of young people that were not excluded from the study due to higher psychiatric acuity.

Providers may have concern around the possibility that adolescents regret certain decisions they make during this period or detransition in the future. There are two studies that report low rates of adolescents (1.9% and 3.5%) deciding to stop puberty suppression (Wiepjes et al., 2018, Brik et al., 2019). These low percentages come again from Dutch clinics that follow a protocol including careful assessment before affirming medical treatment was started and show that it was likely only started in those for whom gender incongruence is considered to last into adulthood. At present, no clinical cohort studies have yet reported on adolescents who regret or detransition after *ir*reversible affirming treatment. Case studies report that there are adolescents who detransition but do not regret initiating treatment as they experience the start of treatment as a part of their gender exploration and consolidation (Turban, 2018), however this is not substantiated with any longitudinal research. There are adolescents who may regret the steps they have taken (Dyer, 2020). Therefore, it is important to consider all narratives and patient experiences when assisting families make sense of the existing research evidence. So far, very little is known about how many and which adolescents may eventually detransition, and providers are advised to discuss this in a collaborative and trusting manner as a possible future experience with adolescents and their parents during the planning stages before gender

affirming medical treatments are started. Also, providers should be prepared to support adolescents who detransition. In an internet convenience sample survey of 237 self-identified detransitioners, 25% had medically transitioned before age 18. Many of them expressed strong difficulties finding the help that they needed during their detransition process and reported that their detransition was a very isolating experience, during which they did not receive enough support (Vandenbussche, 2021).

So, in conclusion, although the samples are relatively small (n = 22-101) and the time to follow-up is varied (6-months – 7 years), the existing research studies all demonstrate improvement in the lives of transgender adolescents who receive some form of gender affirming medical treatment and rates of regret are very low. The data show that early medical intervention as part of a broader combined assessment and treatment approach focusing on gender dysphoria as well as broader general well-being, can be effective and helpful for transgender adolescents. These positive findings also justify why randomized control trials are deemed unethical since withholding puberty suppression or hormones is not without negative effects, apart from being impossible to conduct in a fully blinded way because blockers and sex hormones have clear visible effects.

Ethics and human rights perspective

Because research evidence on medical affirming treatment for adolescents should not be the only leading principle while providing such care, a medical ethics and human rights perspective was also considered while formulating the statements. After all, allowing irreversible puberty to progress in adolescents who experience gender incongruence is without any question *not* a neutral act given that it may have immediate and lifelong harmful effects for a transgender young person (Giordano, 2009; Giordano & Holm, 2020; Kreukels & Cohen-Kettenis, 2011). From a human rights perspective, considering gender diversity is a normal variation of human diversity, it is an adolescent's right to participate in their own decision-making process about their health and lives with access to gender health services (Amnesty International, https://www.amnesty.org.uk/press-releases/amnesty-international-uk-and-liberty-joint-statement-puberty-blockers).

Short Summary of Statements and Unique Issues in Adolescence

These guidelines are designed to account for what is known and what is not known about gender identity development in adolescence, the evidence for gender affirming care in adolescence, and the unique aspects that distinguish adolescence from other developmental stages.

Identity Exploration: A defining feature of adolescence is the solidifying of different aspects of identity, including gender identity. Statement 2 addresses identity exploration in the context of gender identity development. Statement 12B accounts for the length of time that a young person experiences and/or expresses a gender diverse identity in order to make a meaningful decision regarding gender affirming care.

Consent and Decision-Making: In adolescence, consent and decision-making require assessing the individual aspects of emotional, cognitive, and psychosocial development that occur. Statement 12C directly addresses emotional and cognitive maturity and describes the necessary components to assessing decision-making capacity within an individual context.
Caregivers/Parent involvement: Adolescents are typically dependent on their caregivers/parents in numerous ways, including treatment decisions and consent. Statement 11 addresses the importance of involving caregivers/parents and the role they play in treatment. No set of guidelines can account for every set of individual circumstances on a global scale.

This chapter should be used in coordination with other relevant chapters throughout the Standards of Care. These guidelines are meant to provide a gold standard based on the available evidence at this moment in time. While the available evidence for the assessment and treatment of gender diverse and transgender adolescents is relatively new (compared to adults), when factoring in the collective clinical experience of those working with this population as well as a perspective that respects the rights and dignity of transgender adolescents, we believe that these statements provide an ethical set of guidelines to assist families in collaborative decision-making.

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Summary of Statements

	Statement
1	We advise that clinicians working with gender diverse adolescents: 1. Must be licensed by their statutory body, and hold a Postgraduate degree or its equivalent in a relevant clinical field to this role granted by a nationally accredited statutory institution. 2. should receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum. 3. should receive training and have expertise in gender identity development, gender diversity in children and adolescents, the ability to assess capacity to assent/consent, and general knowledge of gender diversity across the life span. 4. should receive training and develop expertise in autism spectrum disorders and other neurodiversity experiences or collaborate with a developmental disability expert when working with autistic/neuro-diverse, gender diverse adolescents. 5. should continue professional development on gender diverse children, adolescents and families
2	We advise that clinicians working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully such that no one particular identity is favored.
3	We advise that clinicians working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment for adolescents presenting with gender identity related concerns seeking medical/surgical transition-related care in a collaborative and supportive manner.
4	We advise that clinicians work with families, schools, and other relevant settings in order to promote acceptance of gender diverse expressions of behavior and identities of the adolescents.

5	We recommend against efforts aimed at trying to change an adolescent's gender identity and lived gender expression to become more congruent with sex assigned at birth, also referred to as reparative and conversion therapy .
6	We advise that clinicians should inform the gender diverse and transgender adolescents about the health implications and safety aspects of chest binding or genital tucking interventions.
7	We advise that providers should consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence from menses who may not be ready or desire to pursue other medical affirming treatments, as well as those who wish to have testosterone.
8	We advise that clinicians should maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers in order to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender related surgery until transition to adult care.
9	We advise that clinicians should involve relevant disciplines, including mental health and medical professionals, in order to reach a decision as to whether puberty suppression, hormone initiation and/or gender related surgery for gender diverse and transgender adolescents is appropriate, and remains indicated throughout the course of treatment until transition to adult care.
10	We advise that clinicians working with trans and gender diverse adolescents requesting gender affirming medical or surgical treatments inform of the reproductive effects that includes the potential loss of fertility and options to preserve fertility in the context of the youth's stage of pubertal development prior to the initiation of treatment
11	We advise that when gender affirming medical or surgical treatments are indicated for adolescents clinicians working with trans and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful or unnecessary to the adolescent.
	The following recommendations are made regarding the requirements for gender affirming medical and surgical treatment, including facial surgery
12	We advise that clinicians assessing trans and gender diverse adolescents should only recommend gender affirming medical or surgical treatments requested by the patient when:

Commented [REDACTED]: When this statement appears in the text, it is worded slightly differently, and I think more clearly than it is here in the "Summary of Statements". Here is the version in the subsequent text, which, I believe reads more clearly (with respect to testosterone): **We advise that providers should consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence from menses who may not desire or be ready to pursue other medical affirming treatments, including testosterone.¶**
Therefore, I suggest changing what is listed in the Summary so it matches what is subsequently listed in the text.

A	The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 where a diagnosis is necessary to access health care. In countries which have not implemented the latest ICD other taxonomies may be used but efforts should be undertaken to utilize the latest ICD as soon as is practicably possible.
B	There is well-documented (according to local context) evidence of persistent gender incongruence or gender nonconformity / diversity of several years.
C	The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
D	The adolescent mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent and/or gender affirmative medical treatment have been addressed.
E	The adolescent has been informed of the reproductive effects that includes the potential loss of fertility and options to preserve fertility have been discussed in the context of the adolescent's stage of pubertal development.
F	The adolescent has reached Tanner 2 stage of puberty for pubertal suppression.
G	The adolescent is: 14 years and above for hormone treatment (oestrogens or androgens), **unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.** 15 years and above for chest masculinization; **unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.** 16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; **unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.** 17 and above for metoidioplasty , orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment **unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.** 18 years or above for phalloplasty, **unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.**
H	**The adolescent had at least 12 months of gender affirming hormone therapy, or longer if required to achieve the desired surgical result for gender-affirming procedures including,** Breast augmentation, Orchiectomy, Vaginoplasty, Hysterectomy, Phalloplasty metoidioplasty and facial surgery as part of gender affirming treatment **unless hormone therapy is either not desired or is medically contraindicated.**

Commented [█]: From █ -While age restrictions are outlined for access to gender affirming care, the authors discuss the¶
imprecision defining the lower and upper borders of adolescence. There is also the interchangeable use¶
of youth and adolescent. This leaves interpretation wide open for the recommendations for 'careful' and¶
'comprehensive' assessments – will this be up to individual providers to interpret these¶
recommendations for their 23 year old patient (who some may consider in adolescence) or? How do we¶
know when to follow recommendations for adolescents vs adults? Your chapter also states that it is¶
designed to support families to make decisions. This can be used in court when a parent sues their legal¶
adult adolescent who made their own decisions. Thus, a clear statement to differentiate family based¶
and individual based decisions is necessary.

Commented █: I personally don't this there is a need for this.

Commented █4]: "at least 12 months of gender affirming hormone therapy or longer" seems quite vague when referring to "or longer". For example, recent studies suggest there can be continued breast enlargement after 3+ years of estrogen Rx, so it could be considered premature to recommend breast augmentation, e.g., after only 12 months of Rx.

STATEMENTS

Statement 1:
We recommend that clinicians working with gender diverse adolescents:

1. **Must be licensed by their statutory body, and hold a Postgraduate degree or its equivalent in a relevant clinical field to this role granted by a nationally accredited statutory institution.**
2. **should receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.**
3. **should receive training and have expertise in gender identity development, gender diversity in children and adolescents, the ability to assess capacity to assent/consent, and general knowledge of gender diversity across the life span.**
4. **should receive training and develop expertise in autism spectrum disorders and other neurodiversity experiences or collaborate with a developmental disability expert when working with autistic/neuro-diverse, gender diverse adolescents.**
5. **should continue professional development on gender diverse children, adolescents and families**

Youth who are transgender and gender diverse should be provided evidence-based gender care from mental health providers who are trained to work with adolescents and families. Other chapters in these standards of care describe these criteria for professionals for gender care in more detail (see Child Chapter; Adult Mental Health Chapter). Professionals working with adolescents should understand what is and is not known regarding adolescent gender identity development, and how this differs from that of adults and prepubertal children.

When access to professionals trained in child and adolescent development is not possible, clinicians should make a commitment to obtaining training on adolescent development, including gender identity development. Similarly, considering the degree to which autistic/neurodiverse transgender youth represent a substantial portion of youth served in gender clinics globally, clinicians should seek additional training on autism and the unique elements of care that autistic gender diverse youth may

Commented [REDACTED]: I understand why this is being said, but it is a bit weak—Making a commitment is not equivalent to actually accomplishing something. In current times, where there is easier access to needed care—e.g. evaluation by a qualified MHP by telehealth, I would hesitate to imply that simply making "a commitment" is any guarantee that the patient will be provided with appropriate and quality care.

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Commented [REDACTED]: From [REDACTED] Statement 1¶
This statement seems to be focused on mental health providers yet uses the word clinician in the first¶
sentence. Primary care pediatricians and family medicine providers can also receive this training and¶
should be included in this statement. Just because a person is transgender does not mean that they have¶
to be evaluated by a mental health provider – that's pathologization of an identity – however, if they¶
have significant mental health symptoms/stressors etc. (which many do), then of course refer to mental¶
health, just like with other youth. Also, I agree with Steve R's comment to make the 'commitment to¶
obtaining training' stronger.

Commented [REDACTED]: the world "clinicians" will be substituted by health professionals in all the chapter so this will be sorted

require (Strang et al., 2016). If these qualifications are not possible, then consultation and collaboration with a provider who specializes in autism and neurodiversity is advised.

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., ... & Pleak, R. R. (2016). Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *Journal of Clinical Child & Adolescent Psychology*, 1-11. doi:10.1080/15374416.2016.1228462

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Statement 2:
We advise that clinicians working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully such that no one particular identity is favored.

Adolescence is a developmental period that involves physical and psychological changes characterized by individuation and the transition to independence from caregivers (Berenbaum, Beltz, Corley, 2015; Steinberg, 2009). It is a period during which young people may explore different aspects of identity, including gender identity.

Adolescents differ regarding the degree to which they explore and commit to aspects of their identity (Meeus et al., 2012). For some adolescents, the pace to achieving consolidation of identity is fast, while for others it is slower. For some adolescents, physical, emotional, and psychological development occur on the same general timeline, while for others, there are certain gaps between these aspects of development. Similarly, there is variation in the timeline for gender identity development (Katz-Wise et al, 2017). For some young people, gender identity development is a clear process that starts in early childhood, while for others pubertal changes contribute to one's experience of themselves as a particular gender (Steensma et al., 2013), and for many others a process may begin well after pubertal changes finish. Given these variations, there is no *one particular pace, process, or outcome* that can be predicted for an individual adolescent seeking gender affirming care.

Therefore, clinicians working with adolescents should prioritize supportive environments that simultaneously respects an adolescent's affirmed gender identity and also allows the adolescent to openly explore evolving gender needs, should they change over time.

Berenbaum, S., Beltz, A., & Corley R. (2015). *The Importance of Puberty for Adolescent Development: Conceptualization and Measurement.* Advances in Child Development and Behavior, Volume 48, 53-92. http://dx.doi.org/10.1016/bs.acdb.2014.11.002

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Meeus, W., van de Schoot, R., Keijsers, L., Branje, S. (2012) Identity Statuses as Developmental Trajectories: A Five-Wave Longitudinal Study in Early-to-Middle and Middle-to-Late Adolescents. J Youth Adolescence. 41:1008-1021. DOI 10.1007/s10964-011-9730-y

Steensma TD, Kreukels BP, de Vries AL, Cohen-Kettenis PT. Gender identity development in adolescence. *Horm Behav*. Jul 2013;64(2):288-97. doi:10.1016/j.yhbeh.2013.02.020

Steinberg, L. (2009). Should the science of adolescent brain development inform public policy? American Psychologist, 64 (8), 739-750. doi.org/10.1037/0003-066x.64.8.739

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Statement 3:

We recommend that clinicians working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment for adolescents presenting with gender identity related concerns seeking medical/surgical transition-related care in a collaborative and supportive manner.

Given the many ways identity may unfold during adolescence, we recommend using a comprehensive assessment, conducted by a qualified mental health clinician, to guide treatment and optimize outcomes. The assessment process should be approached collaboratively with the adolescent and their caregiver(s), which is described in more detail in statement 11. An assessment should occur prior to any medical interventions being considered (e.g., puberty blocking medication, gender affirming hormones, surgeries).

There are many different gender identity trajectories that youth may experience. For example, some youth will realize they are transgender or more broadly gender diverse and pursue medical interventions to align their bodies with their identity. For others, their gender exploration will help them better understand themselves, but will not result in affirming a gender different from what was assigned at birth or involve the use of medical interventions. With the ongoing sociocultural developments regarding the definitions of gender, youth may increasingly present with a range of identities and ways of describing their experiences and gender related needs (Twist & de Graaf, 2019), which may change as they mature and develop. Utilizing a comprehensive assessment for each adolescent helps to better understand their unique needs and individualize their care.

Careful assessment was part of the most robust longitudinal study that exists thus far on gender diverse adolescents pursuing gender affirming medical interventions. In this study, which followed transgender youth into adulthood, positive psychological and quality of life outcomes were found for those who met the criteria to physically transition. However, it is critical to note that all of these youth experienced childhood gender dysphoria *and* were required to undergo a comprehensive assessment over time prior to each medical intervention to help determine whether they would likely benefit from the intervention (de Vries & Cohen-Kettenis, 2012; de Vries, McGuire, Steensma, Wagenaar, Doreleijers & Cohen-Kettenis, 2014). In other words, it was a very specific sample and cannot be generalized to all gender diverse adolescents seeking medical interventions. Furthermore, the assessment itself has not been part of any study, so we cannot conclude its unique effect on long-term outcomes.

Commented [REDACTED] We can agree that an assessment needs to be done, but it should not be a universal¶
requirement that all trans youth need a mental health clinician to assess them, that is the definition of¶
psychopathologization. Further, when discussing assessment throughout the chapter, the words cautious¶
and careful appear several times, but we are still lacking meaningful guidance on what constitutes¶
'cautious' and 'careful' which serves to make providers nervous and hesitant.

Commented [REDACTED] This is a good point, please be aware that the word "clinicians" will be change to "health professionals" in all the chapters. The recommendations that passed Delphi was for clinicians but the text starts here with mental health clinicians, can you please try to resolve this?

Commented [REDACTED]: I agree this is critically important and should be cross-referenced to similar text in the hormone chapter in the section pertaining to adolescent care.

Delivery of healthcare and access to specialists varies globally. Thus, adaptations to the assessment process and flexibility may be necessary, as long as all of the information needed to guide treatment, as outlined below, is obtained. In some cases, a more extended assessment process may be particularly useful for youth with more complex presentations (e.g., complicating mental health histories, co-occurring autism spectrum characteristics [Strang et al., 2018], absence of childhood gender incongruence). Given the unique cultural, financial, and geographical factors that exist for specific populations, providers should design assessment models that are flexible and which allow for appropriately timed care to as many young people as possible. At the same time, it is important to remember that treating youth outside of the assessment framework (e.g., with limited or no assessment) currently has no empirical support and therefore carries the risk that the decision to start gender affirming medical interventions *may* not be in the long-term best interest of the young person.

The assessment should include a thorough clinical interview with the adolescent alone, the caregiver(s) alone, and the adolescent and caregiver(s) together. Additionally, psychometrically validated psychosocial and gender measures can also be used to provide additional information.

We advise developing a positive and trusting working alliance with the adolescent and caregiver(s) that is collaborative and aims to support the young person in making a fully informed decision about their body and their health. A process that takes caregiver(s) viewpoints into account and recognizes the value of their input provides important information for understanding the adolescent and the context in which they live and function. Additionally, involving the young person's caregiver(s) in the assessment process often helps them come to better understand their adolescent's struggles and gender-related needs, thereby allowing them to be more affirming and supportive. Research shows that gender diverse youth do best when supported by their caregiver(s) (see statement 11/12; Ryan, Huebner, Diaz, & Sanchez, 2009).

The comprehensive assessment for gender diverse youth seeking gender affirming medical interventions should ensure that all requirements for the medical intervention being sought are fulfilled (see statements 12A-12G), including the following domains (obtained from both the youth and caregivers[s]).

Gender Identity Development (see 12 A, B): Assessment related to how the young person came to realize that their body and/or sense of self did not align with their assigned gender at birth is important, along with how this aspect of the young person's identity development intersects with their understanding of their life more broadly, including their sexuality and social context. Ensuring that the young person is able to distinguish these aspects of themself is important. Attention to social media/internet and peer influence related to a young person's declaration of a transgender identity and timing of gender dysphoria is also important to understand, as well as cognitive rigidity around gender roles and expression.

Social Development and Support; Intersectionality (4, 11): Assessment of family relationships and dynamics, including support or lack of support regarding the young person's gender identity, and how these dynamics influence an adolescent's understanding of self should occur. Exploration of one's social support outside of the family (friends, online community, school climate, etc.), including specific aspects of a young person's social development such as areas of support, rejection, and broad influence is also important. Understanding culture/religion-specific expectations around gender roles and gender expression, and how these intersect with the young person's gender identity should occur. Assessment of gender minority stress at home, school, and the larger community, along with the young person's resilience characteristics and strengths, including their communication and self-advocacy skills, is also important.

Diagnostic Assessment of Possible Co-Occurring Mental Health and/or Developmental Concerns (12 D): A diagnostic assessment for any co-existing mental health diagnoses and broad functioning, both past and present, will identify if any other experiences and characteristics might be impacting a young person's awareness of self and/or their decision-making capacity. Assessment should include consideration of the following: depression, anxiety, abuse/bullying/teasing history, trauma, autism spectrum disorder, eating disorder concerns, and other diagnoses that might interfere with obtaining developmentally-informed, informed consent.

Assessing Capacity for Decision Making (12C): A conversation about the medical intervention(s) desired, including an assessment of the adolescent's understanding of the effects of the intervention, helps to ensure the expectations are realistic and will minimize the possibility of later disappointment. It is important to assess a young person's understanding of the various potential gender pathways, including the possibility that the young person's gender identity and gender-related need might develop and change over time (e.g., shift from a binary to non-binary identity or vice-versa; de/retransition). This includes normalizing the possibility that all trajectories can happen for anyone, and discussing with the young person how they might hypothetically navigate a different trajectory later if their gender-related needs change in the future (e.g., regarding medical interventions, with impacts that cannot be undone).

Commented [REDACTED]: Are there more specific actions that can be taken (beyond a "conversation") to assess the ability of the adolescent to provide informed assent/consent? I see that this is presented in a more focused way in Statement 12C—Perhaps the reader should be directed to that statement here.

Commented [REDACTED]: or regret.

de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality, 59*(3), 301–320. doi:10.1080/00918369.2012.653300

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics, 134*(4), 1-9. doi:10.1542/peds.2013-2958

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Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352. doi:10.1542/peds.2007-3524

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., ... & Pleak, R. R. (2016). Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *Journal of Clinical Child & Adolescent Psychology*, 1-11. doi:10.1080/15374416.2016.1228462

Twist, J. & de Graaf, N. M. (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's national gender identity development service, *Clinical Child Psychology and Psychiatry, 24* (2), 193-198.

Statement 4:
We recommend that clinicians work with families, schools, and other relevant settings in order to promote acceptance of gender diverse expression of behavior and identities of the adolescent.

Multiple studies and related expert consensus support implementation of approaches that promote acceptance and affirmation of gender diverse youth across all settings, including families, schools, healthcare, and all other organizations and communities with which they interact (e.g, Pariseau et al., 2019; Russell et al., 2018; Simons et al., 2013; Toomey et al., 2010; Travers et al., 2012). Acceptance and affirmation are accomplished through a range of approaches, actions, and policies that we recommend be enacted across the various relationships and settings in which a young person exists and functions. Examples of acceptance and affirmation of gender diversity and exploration that can be implemented by family, staff, and organizations, as organized by Pariseau and colleagues (2019) and others include:

1. Actions that are supportive of youth drawn to engaging in gender-expansive (e.g., nonconforming) activities and interests,
2. Communications that are supportive when youth express their experiences about their gender and gender exploration,
3. Use of the youth's asserted name/pronouns,
4. Support for youth wearing clothing/uniforms, hairstyles, and items (e.g., jewelry, makeup) they feel affirm their gender,
5. Positive and supportive communication with youth about their gender and gender concerns,

Commented [REDACTED]: Perhaps I missed it, but the term "gender-affirming model of care" is increasingly being used in the context of adolescence and sounds very much like what I highlighted in yellow. Should this term be mentioned and discussed, given its increasing use in the professional literature and in the lay press—clarifying what is meant (and what is not meant) with the term "gender-affirming model of care"?

Commented [REDACTED]: -Agree with [REDACTED] suggestion to include the gender affirmative model of care, it is curious as to why¶
this model is left out of the chapter. The APA GAM book also has several nonbinary and trans authors¶
which are curiously not included in this chapter.¶
Keo-Meier, C. E., & Ehrensaft, D. E. (2018). The gender affirmative model: An interdisciplinary approach¶
to supporting transgender

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6. Education for people in the young person's life (e.g., family members, healthcare providers, social support networks), as needed, about gender diversity issues, including how to advocate for gender diverse youth in community, school, healthcare and other settings,
7. Support for gender diverse youth to connect with communities of support (e.g., LGBTQ groups, events, friends),
8. Provision of opportunities to discuss, consider, and explore medical treatment options when indicated,
9. Anti-bullying policies that are enforced.
10. Inclusion of nonbinary experiences in daily life, reading materials, and curricula (e.g., books, health and sex education classes, essay topics assigned moving beyond the binary, LGBTQ and ally groups),
11. Gender inclusive facilities which the youth can readily access without segregation from non-gender diverse peers (e.g., bathrooms, locker rooms).

We recommend healthcare professionals work with parents, schools, and other organizations/groups to promote acceptance and affirmation because acceptance and affirmation are associated with fewer negative mental health and behavioral symptoms and more positive mental health and behavioral functioning ((Day et al., 2015; de Vries et al., 2016; Greytak et al., 2013; Pariseau et al., 2019; Peng et al., 2019; Russell et al., 2018; Simons et al., 2013; Taliaferro et al, 2019; Toomey et al., 2010; Travers et al., 2012). Russell and colleagues (2018) found improvement increases with more acceptance and affirmation across more settings (e.g., home, school, work, and friends). Rejection by family, peers, and school staff (e.g., intentionally calling name and pronoun youth does not identify with, not acknowledging affirmed gender identity bullying, harassment, verbal and physical abuse, poor relationships, rejection for being trans/gender diverse, eviction) was strongly linked to negative outcomes such as anxiety, depression, suicidal ideation, suicide attempts, and substance use (Grossman et al., 2005; Klein and Golub; 2016; Pariseau et al., 2019; Peng et al., 2019; Reisner et al., 2015; Roberts et al., 2013). We recommend against behaviors that are considered rejecting towards a young person's affirmed gender or gender exploration from family members, peers, and other adults (e.g., school staff), because negative symptoms increase with increased levels of rejection and continue into adulthood (e.g., Roberts et al., 2013).

Commented [█████]: Again, this sounds very much like my understanding of the term "gender-affirming model of care", and I wonder if this term should be mentioned here and explained—see my comments, above.

Neutral or indifferent responses to a youth's gender diversity and exploration (e.g., letting a child tell others their chosen name but not using the name, not telling family or friends when the youth wants them to disclose, not advocating for the child about rejecting behavior from school staff or peers, not engaging or participating in other supports such as psychotherapists and support groups) have also been found to have negative consequences, such as increased depression symptoms (Pariseau et al., 2019). We recommend against ignoring a youth's gender questioning or delaying tending to the gender exploration. We also recommend professionals recognize the youth need individualized approaches,

support, and pacing of exploration over time and across domains and relationships. Youth may need help coping with the tension of tolerating others' processing/adjusting to an adolescent's identity exploration and changes (e.g., Kuper et al., 2019). We recommend collaborating with parents and others as they process their concerns and feelings and educate themselves about gender diversity as such processes may not be rejection or neutrality, but may be efforts to develop attitudes and gather information that foster acceptance (e.g., Katz-Wise et al., 2017).

Commented [redacted] Two other ideas that are left out of this chapter are trauma informed care - which is critical to¶
approaching this population – and the ethical imperative for providers to actively advocate for youth's¶
access to care and address misrepresentations of research and clinical care practices.

Day, J. K., Perez-Brumer, A., & Russell, S. T. (2018). Safe Schools? Transgender Youth's School Experiences and Perceptions of School Climate. *Journal of youth and adolescence*, *47*(8), 1731–1742. https://doi.org/10.1007/s10964-018-0866-x

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Klein A, Golub SA. Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults. LGBT Health. 2016 Jun;3(3):193-9. doi: 10.1089/lgbt.2015.0111.

Kuper, L, Lindley, L., & Lopez, X. (2019) Exploring the Gender Development Histories of Children and Adolescents Presenting for Gender Affirming Medical Care. Clinical Practice in Pediatric Psychology. 7, 3, 217–228. http://dx.doi.org/10.1037/cpp0000290

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Peng K, Zhu X, Gillespie A, et al. Self-reported Rates of Abuse, Neglect, and Bullying Experienced by Transgender and Gender-Nonbinary Adolescents in China. *JAMA Netw Open.* 2019;2(9):e1911058. doi:10.1001/jamanetworkopen.2019.11058

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Roberts AL, Rosario M, Slopen N, Calzo JP, Austin SB. Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. Journal of the American Academy of Child & Adolescent Psychiatry. 2013 Feb;52(2):143-52. doi: 10.1016/j.jaac.2012.11.006.

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Taliaferro, L., Mcmorris, B., Rider, G. N., & Eisenberg, M. (2019). Risk and Protective Factors for Self-Harm in a Population-Based Sample of Transgender Youth, Archives of Suicide Research 23(2) DOI:10.1080/13811118.2018.1430639

Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papadimitriou, M. (2012). Impacts of Strong Parental Support for Trans Youth: A Report Prepared for Children's Aid Society of Toronto and Delisle Youth Services. Trans Pulse Project. https://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf.

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Toomey, R., Ryan, C., Diaz, R. M., Card, N. A., & Russell, S. T. (2010). Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment. Developmental Psychology. 46. 1580-9. 10.1037/a0020705.

Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth:
School Victimization and Young Adult Psychosocial Adjustment
Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth:
School Victimization and Young Adult Psychosocial Adjustment

Statement 5:
We recommend against efforts aimed at trying to change an adolescent's gender identity and lived gender expression to become more congruent with sex assigned at birth, also referred to as reparative and conversion therapy.

Some healthcare providers, secular or religious organizations, and/or rejecting families may make efforts to thwart gender identity exploration and expression, such as choosing not to use the youth's identified name and pronouns or restricting self-expression in clothing and hairstyles. These disaffirming behaviors typically aim to reinforce views that a young person's gender identity/expression must match the gender associated with the sex assigned at birth. Activities and approaches (sometimes referred to as "treatments") aimed at trying to change a person's gender identity and expression to become more congruent with the sex assigned at birth have been attempted, but these approaches have not resulted in changes in gender identity (Craig et al., 2017; Green et al., 2020). We recommend against such efforts because they have been found ineffective and are associated with increases in mental illness and poorer psychological functioning (Craig et al., 2017; Green et al., 2020; Turban et al., 2020; SOC8 Adolescent Statement 4).

Much of the research on "conversion therapy" and "reparative therapy" has actually studied efforts to change gender expression (masculinity or femininity), conflating sexual orientation with Gender identity (APA, 2009; Burnes et al., 2016; Craig et al., 2017). Some of these efforts have targeted both gender identity and expression (AACAP, 2018). Conversion/reparative therapy efforts have been linked to increased anxiety, depression, suicidal ideation, suicide attempts, and healthcare avoidance (Craig et al., 2017; Green et al., 2020; Turban et al., 2020). Some of these studies have been criticized for the methodologies used and conclusions reached (e.g., D'Angelo et al., 2020), however this should not detract from the importance of emphasizing that a priori efforts to change a person's identity is ethically not sound. As both secular and religion-based gender identity/expression change efforts have been associated with negative psychological functioning that endures into adulthood (Turban et al., 2020), in addition to the larger ethical reasons that should drive the respect of gender diverse identities, we recommend against any type of conversion or change efforts.

Commented [REDACTED]: -In the section on gender identity development, I notice a very relevant paper on this topic – written by¶
nonbinary and trans psychologists is missing.¶
Kuper, L. E., Lindley, L., & Lopez, X. (2019). Exploring the gender development histories of children and¶
adolescents presenting for gender affirming medical care. Clinical Practice in Pediatric Psychology, 7(3),¶
217.¶
In this same section there is a reference to the extremely problematic ROGD study which should be 2018¶
not 2019, making it seem like there are two sides to this debate and it is possible for ROGD to be a real¶
thing, listing only 2 of the many major critiques. The reference to the relevant WPATH's clear position¶
statement about the ROGD idea is obscured in the last sentence – and the position is not clearly¶
presented. This creates a wishy-washy picture that will easily be misinterpreted. Also, the sentence that¶
begins with 'in truth' is odd, I don't understand why you would need to include that as an opening¶
phrase – as if we are hiding something and now here's the truth? Lastly, very well-done references from¶
trans authors are left out:¶
Restar, A. J. (2020). Methodological critique of Littman's (2018) parental-respondents accounts of¶
"rapid-onset gender dysphoria". Archives of Sexual Behavior, 49(1), 61-66.¶
Ashley, F. (2020). A critical commentary on 'rapid-onset gender dysphoria'. The Sociological¶
Review, 68(4), 779-799.

It is important to note that therapeutic exploration of gender diversity, and potential factors driving a young person's experience and report of gender incongruence, is not considered a reparative therapy effort in the context of supporting an adolescent with self-discovery, so long as there is no a priori goal to change or promote one particular gender identity or expression (AACAP, 2018; see SOC8 Adolescent Statement 2). To ensure these explorations are therapeutic, we recommend employing affirmative responses to gender exploration, such as those identified in SOC8 Adolescent Statement 4.

In summary, efforts to change a person's gender identity or gender expression or to thwart their gender exploration, are harmful and do not result in changes in gender identity. Efforts to change or thwart gender identity and/or expression are considered conversion therapy and are unethical as a practice. We strongly recommend against use of any type of conversion therapy.

American Academy of Child and Adolescent Psychiatry (AACAP) Sexual Orientation and Gender Identity Issues Committee. (2018). Conversion Therapy Policy Statement. Retrieved from: https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

American Psychological Association (2009). Report of the American Psychological Association Task Force on Appropriate Affirmative Responses to Sexual Orientation. Retrieved from: https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

American Psychological Association (2021). Resolution on Gender Identity Change Efforts. https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf

Burnes, T. R., Dexter, M. M., Richmond, K., Singh, A. A., & Cherrington, A. (2016). The experiences of transgender survivors of trauma who undergo social and medical transition. Traumatology, 22(1), 75-84.

Craig, S., Austin, A., Rashidi, M., Adama, M. (2017). Fighting for Survival: The experiences of lesbian, gay, bisexual, transgender, and questioning students in religious colleges and universities. Journal of Gay & Lesbian Social Services. Doi:10.1080/10538720.2016.1260512

D'Angelo, R., Syrulnik2, E., Ayad, S., Marchiano, L., Kenny, D.T., & Clarke, P. (2020). One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria. Archives of Sexual Behavior, 50:7–16 https://doi.org/10.1007/s10508-020-01844-2

Green, A. E., Price-Feeney, M., Dorison, S. H., & Pick, C. J. (2020). Self-reported conversion efforts and suicidality among US LGBTQ youths and young adults, 2018. American journal of public health, 110(8), 1221- 1227.

Substance Abuse and Mental Health Services Administration. (2015). Ending conversion therapy: Supporting and affirming LGBTQ youth. HHS Publication No.(SMA) 15-4928.

Turban, J.L., Beckwith, N., Reisner, S.L., Keuroghlian, A.S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, 77(1), 68–76. doi:10.1001/jamapsychiatry.2019.2285

Statement 6
We suggest that clinicians should inform the gender diverse and transgender adolescents about the health implications and safety aspects of chest binding or genital tucking interventions.

Commented [redacted] Another wonderful statement, although I find it odd to refer to our community's embodiment practices¶
as interventions as if the field of medicine created them for us, that's doesn't hit quite right. One¶
important typo to change: "Genital tucking is the practice of positioning the penis and testes so that they¶
are not visible under clothing." I would say they will certainly be visible under clothing so you may¶
consider rewording to "...practice of positioning the penis and testes to reduce the outward appearance¶
of a genital bulge."

Gender diverse and transgender youth may experience distress related to chest and genital anatomy. Practices such as chest binding, chest padding, genital tucking and genital packing are reversible, non-medical interventions that may help alleviate this distress (Olson-Kennedy, 2018; Deutsch 2016; Transcare BC; Callen-Lorde). It is important to assess distress related to physical development or anatomy, educate youth about potential non-medical interventions to address this distress, and address use and safety of these interventions.

Chest binding involves the compression of the breast tissue to create a flatter appearance of the chest. Studies suggest that up to 87% of transmasculine patients report a history of binding (Peitzmeier, 2017; Jones, 2015). Binding methods may include the use of commercial binders, sports bras, layering of shirts, layering of sports bras, or using elastics or other bandages (Peitzmeier, 2017). Currently most youth report learning about binding practices from online communities comprised of peers (Julian, 2019). Providers can play an important role in ensuring that youth receive accurate and reliable information about the potential benefits and risks of chest binding. Additionally, providers can counsel patients on safe binding practices and monitor for potential negative health effects. While there are potential negative physical impacts of binding, youth who bind report many benefits including increased comfort, improved safety, and lower rates of misgendering (Julian, 2019). Common negative health impacts of chest binding in youth include back/chest pain, shortness of breath, and overheating (Julian, 2019). More serious negative health impacts such as skin infections, respiratory infections, and rib fractures are uncommon, but have been associated with chest binding in adults (Peitzmeier, 2017). If binding, youth should be advised to use only those methods that are considered safe for binding—such as binders specifically designed for the gender diverse population—to reduce the risk of serious negative health effects. Methods that are considered unsafe for binding include the use of duct tape, ace wraps, and plastic wrap as these can cause restriction in blood flow, skin damage, and restricted breathing. If youth report negative health impacts of chest binding these should ideally be addressed by a gender

affirming medical provider with experience working with transgender and gender diverse youth. Many youth who bind may desire chest masculinization surgery in the future (Olson-Kennedy, 2018).

Genital tucking is the practice of positioning the penis and testes so that they are not visible under clothing. Methods of tucking include tucking the penis and testes between the legs or, tucking the testes inside the inguinal canal and pulling the penis back between the legs. Typically, genitals are held in place by underwear or a gaff, a garment that may be made or purchased. Limited studies are available on the specific risks and benefits of tucking in adults, and none in youth. Previous studies that have demonstrated that tight undergarments are associated with decreased sperm concentration and motility; elevated scrotal temperatures can be associated with poor sperm characteristics and theoretically genital tucking could affect spermatogenesis and fertility (Marsh 2019) though no definitive studies exist. Further research is needed on specific benefits and risks of tucking in youth.

UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. (https://transcare.ucsf.edu/guidelines) Last Accessed April 2021

Callen Lorde Safer Tucking:http://callen-lorde.org/graphics/2018/09/HOTT-Safer-Tucking_Final.pdf. Last accessed December 2020

Callen Lorde Safer Binding: http://callen-lorde.org/graphics/2018/09/Safer-Binding_2018_FINAL.pdf. Last accessed December 2020

TransCare BC:http://www.phsa.ca/transcarebc/care-support/transitioning/bind-pack-tuck-pad Last accessed December 2020

Jones, T., A. D. P. de Bolger, T. Dune, A. Lykins, and G. Hawkes. 2015. Female-to-Male (FtM) Transgender People's Experiences in Australia: A National Study. Cham: Springer International Publishing.

Peitzmeier S, Gardner I, Weinand J, Corbet A, Acevedo K. Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study. Cult Health Sex. 2017 Jan;19(1):64-75. doi: 10.1080/13691058.2016.1191675. Epub 2016 Jun 14. PMID: 27300085.

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts.

JAMA Pediatr. 2018 May 1;172(5):431-436. doi: 10.1001/jamapediatrics.2017.5440. PMID: 29507933; PMCID: PMC5875384.

Jarrett BA, Corbet AL, Gardner IH, Weinand JD, Peitzmeier SM. Chest Binding and Care Seeking Among Transmasculine Adults: A Cross-Sectional Study. Transgend Health. 2018 Dec 14;3(1):170-178. doi: 10.1089/trgh.2018.0017. PMID: 30564633; PMCID: PMC6298447.

Julian JM, Salvetti B, Held JI, Murray PM, Lara-Rojas L, Olson-Kennedy J. The Impact of Chest Binding in Transgender and Gender Diverse Youth and Young Adults. J Adolesc Health. 2020 Oct 26:S1054-139X(20)30582-6. doi: 10.1016/j.jadohealth.2020.09.029. Epub ahead of print. PMID: 33121901.

Marsh C, McCracken M, Gray M, Nangia A, Gay J, Roby KF. Low total motile sperm in transgender women seeking hormone therapy. *J Assist Reprod Genet.* 2019;36(8):1639-1648. doi:10.1007/s10815-019-01504-y

Statement 7: We advise that providers should consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence from menses who may not desire or be ready to pursue other medical affirming treatments, including testosterone.

When discussing options with gender diverse youth around menstrual-suppressing medications, providers should engage in shared decision making, use gender-inclusive language (e.g. asking patients which terms they utilize to refer to their menses, reproductive organs, and genitalia) and perform physical exams that are approached in a sensitive, gender-affirmative manner (Bonnington et al., 2020; Krempasky et al., 2020). There is no formal research on how menstrual suppression may impact gender dysphoria. However, the use of menstrual suppression can be an initial intervention to allow for further exploration of gender-related goals of care and/or prioritization of other mental health care, especially for those who experience a worsening of gender dysphoria from unwanted uterine bleeding (see Statement 12D, (Mehringer & Dowshen, 2019)). A detailed menstrual history and evaluation for any underlying menstrual disorders should be performed prior to implementing menstrual-suppressing therapy (Carswell & Roberts, 2017). As part of the discussion of menstrual-suppressing medications, consideration for desire for contraception and how effective menstrual-suppressing medications are as methods of contraception also needs to be considered (Bonnington et al., 2020). A variety of menstrual suppression options, such as combined estrogen-progestin medications, oral progestins, depot progestin and IUDs should be offered to allow for individualized treatment plans within the context of availability, cost and insurance coverage, contraindications and side effect profile (Kanj et al., 2019).

Options for combined oral contraception include different combinations of ethinyl estradiol, with ranging doses, and different generations of progestins (Pradhan & Gomez-Lobo, 2019). Lower-dose ethinyl estradiol components of combined oral contraceptive pills are associated with increased breakthrough uterine bleeding. Continuous combined oral contraceptives may be used to allow for continuous menstrual suppression, as can delivered as transdermal or vaginal ring options. Progestin-only hormonal medication options may be desired, especially in transmasculine or non-binary youth who do not desire estrogen-containing medical therapies, are actively growing, and/or in patients at risk for thromboembolic events or other contraindications to receiving estrogen (Carswell & Roberts, 2017). Progestin-only hormonal medications include oral progestins, depo-medroxyprogesterone injection, etonogestrel implant and levonorgestrel intrauterine device (Schwartz et al., 2019). Progestin-only hormonal options vary in terms of efficacy in achieving menstrual suppression and have lower rates of achieving amenorrhea than combined oral contraception options (Pradhan & Gomez-Lobo, 2019). Clinicians should not make assumptions regarding the method of administration as some transmasculine youth may desire vaginal rings or IUD implants (Akgul et al., 2019). Hormonal medications require monitoring for potential mood lability and/or depressive effects; however, the benefits and risks of untreated menstrual suppression in the setting of gender dysphoria should be evaluated on an individual basis.

The use of GnRH analogue may also result in menstrual suppression however it is recommended that gender diverse youth meet the eligibility criteria (as outlined in Statement 12) before consideration of this medication solely for this purpose (Carswell & Roberts, 2017; Pradhan & Gomez-Lobo, 2019). Finally, menstrual-suppression medications may be indicated as an adjunctive therapy for breakthrough uterine bleeding that may occur while on exogenous testosterone or as a bridging medication with awaiting menstrual suppression with testosterone therapy. With the use of exogenous testosterone as a gender-affirming hormone, menstrual suppression is typically achieved in the first six months of therapy (Ahmad & Leinung, 2017). However, it is vital that adolescents be counseled that ovulation and therefore, pregnancy, is still possible, even in the setting of amenorrhea as this is a common misconception (Gomez et al., 2020; Kanj et al., 2019).

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Commented [redacted]: These are statement based on review articles. I would suggest to cross ref to the endo chapter for the clinical studies in transgender youth.

Commented [redacted]: This is confusing since the statement focuses on the use of medication in youth not ready /not wishing testosterone

Ahmad, S., & Leinung, M. (2017). The Response of the Menstrual Cycle to Initiation of Hormonal Therapy in Transgender Men. *Transgender Health*, *2*(1), 176–179. https://doi.org/10.1089/trgh.2017.0023

Akgul, S., Bonny, A. E., Ford, N., Holland-Hall, C., & Chelvakumar, G. (2019). Experiences of Gender Minority Youth With the Intrauterine System. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *65*(1), 32–38. https://doi.org/10.1016/j.jadohealth.2018.11.010

Bonnington, A., Dianat, S., Kerns, J., Hastings, J., Hawkins, M., De Haan, G., & Obedin-Maliver, J. (2020). Society of Family Planning clinical recommendations: Contraceptive counseling for transgender and gender diverse people who were female sex assigned at birth. *Contraception*, *102*(2), 70–82. https://doi.org/10.1016/j.contraception.2020.04.001

Carswell, J. M., & Roberts, S. A. (2017). Induction and Maintenance of Amenorrhea in Transmasculine and Nonbinary Adolescents. *Transgender Health*, *2*(1), 195–201. https://doi.org/10.1089/trgh.2017.0021

Gomez, A. M., Đỗ, L., Ratliff, G. A., Crego, P. I., & Hastings, J. (2020). Contraceptive Beliefs, Needs, and Care Experiences Among Transgender and Nonbinary Young Adults. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *67*(4), 597–602. https://doi.org/10.1016/j.jadohealth.2020.03.003

Kanj, R. V., Conard, L. A. E., Corathers, S. D., & Trotman, G. E. (2019). Hormonal contraceptive choices in a clinic-based series of transgender adolescents and young adults. *The International Journal of Transgenderism*, *20*(4), 413–420. https://doi.org/10.1080/15532739.2019.1631929

Krempasky, C., Harris, M., Abern, L., & Grimstad, F. (2020). Contraception across the transmasculine spectrum. *American Journal of Obstetrics and Gynecology*, *222*(2), 134–143. https://doi.org/10.1016/j.ajog.2019.07.043

Mehringer, J., & Dowshen, N. L. (2019). Sexual and reproductive health considerations among transgender and gender-expansive youth. *Current Problems in Pediatric and Adolescent Health Care*, *49*(9), 100684. https://doi.org/10.1016/j.cppeds.2019.100684

Pradhan, S., & Gomez-Lobo, V. (2019). Hormonal Contraceptives, Intrauterine Devices, Gonadotropin-releasing Hormone Analogues and Testosterone: Menstrual Suppression in Special Adolescent Populations. *Journal of Pediatric and Adolescent Gynecology*, *32*(5S), S23–S29. https://doi.org/10.1016/j.jpag.2019.04.007

Schwartz, A. R., Russell, K., & Gray, B. A. (2019). Approaches to Vaginal Bleeding and Contraceptive Counseling in Transgender and Gender Nonbinary Patients. *Obstetrics and Gynecology*, *134*(1), 81–90. https://doi.org/10.1097/AOG.0000000000003308

Statement 8:

We advise that clinicians should maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers in order to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender related surgery until transition to adult care.

Youth who receive gender affirming medical interventions should maintain an ongoing relationship with their multidisciplinary team for the duration of treatment, ideally through their transition to adult care. Treatment typically involves providers from multiple disciplines through the adolescent years, as specific needs often change over time. The adolescent and their families/caregivers can greatly benefit from an ongoing relationship with a supportive multidisciplinary team who approaches the young person's care individually and with a developmental lens. This ongoing supportive relationship can assist with not only gender specific topics, but also other aspects of psychosocial development that may be more complex to navigate due to the young person's gender diversity.

Gender-specialized mental health professionals, in particular, play an important role in continuity of care for young people through their gender transition (see statement 1). These providers typically have the skills and longer appointment times, compared to their medical colleagues, to address the range of topics related to care that often arise for gender diverse youth. There are several reasons why ongoing involvement with a mental health professional is important. First, gender specialized mental health providers often assist adolescents during a time that is characterized by many changes (emotional development, social development, brain development) (Steinberg, 2009). Therefore, decisions related to interventions should be approached with an appropriate developmental framework, which is well understood by child/adolescent mental health providers. Second, many of these youth experience mental health struggles (Sorbara et. al, 2020), which may or may not be directly tied to their gender dysphoria, yet may impact upcoming treatment decisions (see statement 12D). Third, work with mental health clinicians may assist adolescents in considering fertility implications of starting hormone treatment (Chen, et al., 2018; see statements 10 and 12E). Fourth, mental health providers can help adolescents navigate family dynamics, relationship difficulties, and peer social situations (e.g., losing friends when coming out, challenges in romantic relationships) that may arise (see statements 4 and 11). Fifth, exploring how youth understand a variety of gender trajectories (e.g., non-binary gender identity with or without gender affirming medical treatments) may be helpful to discuss in the context of an ongoing relationship with a mental health provider (see statement 2).

Interventions should be individualized and aim to increase resiliency in the adolescent by strengthening social-emotional skills, addressing the impact of minority stress, assisting with rigidity in thinking that may increase the young person's distress, and providing a safe space for the adolescent to continue exploring their identity should they so desire. Along these lines, it is critical that the adolescent feels comfortable within the therapeutic relationship to voice a desire to change or stop the transition process should this become the adolescent's preference.

Commented [redacted] on the issue of the statement using the more broad 'clinician' and then the text using¶
the more specific 'mental health professional' plus lack of empirical support for the text of this¶
statement.

We advise that the adolescent's caregiver(s) be included in the therapy and assessment process so they are kept abreast of the adolescent's desires, have the opportunity to share their thoughts and feelings about the transition steps and overall mental health of the adolescent, and learn ways to be supportive of their adolescent through the transition process (see statement 11). Caregiver(s) may benefit from their own therapy to process their experiences and reactions to their adolescent's gender transition, as this often brings up feelings of grief, loss, and fear for caregiver(s), which should not be minimized or dismissed. By validating these concerns and helping caregiver(s) process their feelings, they will be better able to support their adolescent, which will likely result in better mental health outcomes (Ryan, Huebner, Diaz, & Sanches, 2009).

Commented [22]: I cant find from the text as to what the evidence is for the recommendation. the statement says "clinician" but the text says "mental health professional", i can understand that for some (those who have poor family support or need to work in resilience or have severe mental health problems) this is necessary, but for everyone? the text should support the statement "clinician" and not provide a new recommendation by the need for a mental health worker.

Chen, D., Matson, M., Macapagal, K., Johnson, E. K., Rosoklija, I., Finlayson, C., Fisher, C., & Mustanski, B. (2018). Attitudes toward fertility and reproductive health among transgender and gender non-conforming adolescents. *Journal of Adolescent Health, 63* (1), 62-68.

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics, 123(1), 346-352. doi:10.1542/peds.2007-3524

Sorbara JC, Chiniara, LN, Thompson S, Palmert, M. (2020). Mental Health and Timing of Gender Affirming Care. *Pediatrics* ;146(4) :e20193600.

Steinberg, L. (2009). Should the science of adolescent brain development inform public policy? American Psychologist, 64 (8), 739-750. doi.org/10.1037/0003-066x.64.8.739

Statement 9:

We recommend that clinicians should involve relevant disciplines, including mental health and medical professionals, in order to reach a decision as to whether puberty suppression, hormone initiation and/or gender related surgery for gender diverse and transgender adolescents is appropriate, and remains indicated throughout the course of treatment until transition to adult care.

Commented [REDACTED]: This sounds a bit similar, in spirit and intent, to Statement 3, re importance of assessment by qualified MHP before starting either puberty suppression or hormone initiation.

Transgender and gender diverse adolescents with gender dysphoria/gender incongruence, who seek gender affirming medical and surgical treatments need healthcare professionals of differing disciplines. Providing care to TGD adolescents includes addressing both: 1) diagnostic considerations (see Statement 3, 12A, 12B), conducted by a mental health professional whenever possible and 2) treatment considerations when prescribing, managing, and monitoring medications for gender affirming medical and/or surgical care, requiring the training of the relevant medical/surgical professional. The list of key disciplines includes but is not limited to: adolescent medicine/primary care, endocrinology, psychology, psychiatry, speech/language pathology, social work, support staff, and the surgical team.

Commented [24]: if required

Commented [REDACTED] comment 'if required' regarding diagnostic considerations 'if required,' instead of¶
'whenever possible.' Again, this practice pathologizes identity. I really appreciate the last paragraph¶
clarifying the importance of accessing care in a timely manner in order to remove barriers that are¶
impossible for many to overcome.

Transgender youth healthcare guidelines for have routinely emphasized the importance of a multidisciplinary care team that involves both medical and mental health professionals (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). The evolving evidence demonstrates clinical benefit from use gender of affirming treatments with transgender youth who come from gender clinics that are multidisciplinary (DeVries et al., 2014; Kuper et al., 2020; Tollit et al., 2019). Additionally, adolescents seeking gender affirming care in multidisciplinary clinics are presenting with significant complexity, necessitating close collaboration between mental health, medical, and/or surgical professionals (McCallion et al., 2021; Sorbara et al., 2020; Tishelman et al., 2015).

Not all patients and/or families are in the position or in a location to access multidisciplinary care, and so therefore the *lack of available disciplines* should not preclude a young person from accessing needed care in a timely manner. When disciplines *are available*, particularly in centers with existing multidisciplinary teams and/or disciplines, efforts to include the relevant providers when developing a gender care team, is recommended. This does not mean that all disciplines are necessary for the provision of care to a particular youth and family.

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist.* Vol. 70, No. 9, 832-864. http:/dx.doi/org/10.1037/a0039906

de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen- Kettenis PT. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 134(4):696–704

Gridley, S., Crouch, J., Evans, Y., Eng, W., Antoon, E., Lyapustina, M., Schimmel-Bristow, A., Woodward, J., Dundon, K., Schaff, R., McCarty, C., Ahrens, K., & Breland, D. (2016). Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth. J Adolesc Health: 59(3):254-261. DOI:10.1016/j.jadohealth.2016.03.017

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 102:3869–3903

Kuper, L., Stewart, S., Preston, S., Lau, M., Lopez, X. (2020). Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics.* 145(4):e20193006

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McCallion, S., Smith, S., Kyle, H., Shaikh M.G., Gordon, W., Kyriakou, A. (2021). An appraisal of current service delivery and future models of care for young people with gender dysphoria. Eur J Pediatr. PMID: 33855617. Online ahead of print. DOI: 10.1007/s00431-021-04075

Sorbara JC, Chiniara, LN, Thompson S, Palmert, M. (2020). Mental Health and Timing of Gender-Affirming Care. *Pediatrics* ;146(4) :e20193600.

Telfer MM, Tollit MA, Pace CC, *et al*. (2018) Australian standards of care and Treatment guidelines for transgender and gender diverse children and adolescents. *Med J Aust*;209:132–6.

Tishelman, A., Kaufman, R., Edwards-Leeper, L., Mandel, F., Shumer, D., & Spack, N. (2015). Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples. *Prof Psychol Res Pr.* 46(1): 37-45. Doi:10.1037/a0037490

Tollit, M., Pace, C., Telfer, M., Hoq, M., Bryson, J., Fulkoski, N., Cooper, C., Pang, K. (2019) What are the health outcomes of trans and gender diverse young people in Australia? Study Protocol for the Trans20 longitudinal cohort study. *BMJ Open. 9:e032151. Doi:10.1136/bmjopen-2019-032151*

Statement 10

We recommend that clinicians working with trans and gender diverse adolescents requesting gender affirming medical or surgical treatments inform of the reproductive effects that includes the potential loss of fertility and options to preserve fertility in the context of the youth's stage of pubertal development prior to the initiation of treatment

While assessing adolescents seeking gender affirming medical or surgical treatments, clinicians should discuss the specific ways in which the desired treatment may affect reproductive capacity. Fertility issues and the specific preservation options are more thoroughly discussed in the chapter on Fertility and the chapter on Hormones. Please see ~~that~~ those chapters for greater detail.

It is important that clinicians understand what fertility preservation options exist in order to relay the information to adolescents. Parents are advised to be involved in this and should also understand the pros and cons of the different options. Clinicians should acknowledge that adolescents and parents may have different views around fertility and may therefore come to different decisions (Quain et al., 2020). Clinicians can be helpful in guiding this process.

Clinicians should specifically pay attention to the developmental and psychological aspects of fertility preservation and decision-making competency for the individual adolescent. Adolescents may think they have made up their minds concerning fertility, but the chances that adolescents' opinions regarding having biologically related children in the future might change over time and needs to be discussed with a clinician who has sufficient experience and knowledge of adolescent development and working with parents.

Addressing the long-term consequences for fertility of gender affirming medical treatment and ensuring that transgender adolescents have realistic expectations concerning fertility preservation

Commented [redacted] Also discussed in the Hormone chapter and should be cross-referenced here, including the important recent advance of in vivo oocyte maturation in a transgender male adolescent on a GnRHa that was treated with a relatively short course of gonadotropins —see Rothenberg S et al NEJM, 2019: Rothenberg, S. S., Witchel, S. F. & Menke, M. N. Oocyte cryopreservation in a transgender male adolescent. *N. Engl. J. Med.* **380**, 886–887 (2019) ¶

options or adoption, is not a one-time discussion but should be part of an ongoing conversation. This conversation should occur not only before any medical intervention is started (puberty suppression, hormones or surgeries), but also during further treatment and transition.

Currently, there are only preliminary results of retrospective studies of transgender adults regarding decisions that they made about the consequences of medical affirming treatment on fertility when they were young. Meanwhile, it is important not to assume the future adult goals of an adolescent. Research in childhood cancer survivors reports distress about potential infertility, regret and missed opportunities for fertility preservation (Armuand et al, 2014, Ellis et al., 2016, Lehmann et al., 2017). Individuals with cancer who did not prioritize having biological children before treatment have reported "changing their minds" in survivorship (Armuand et al, 2014).

Given the complexities of the different fertility preservation options and the challenges that clinicians may experience around discussing fertility with the adolescent and the family (Tishelman et al 2019), a fertility consultation should be advised for every transgender adolescent who considers medical affirming treatments unless this is not covered by insurance, is not available locally, or the individual circumstances make this unpreferable.

Commented [redacted]: Yet another important statement, certainly, however there's a sentence that reads like a
recommendation, "a fertility consultation should be advised for every transgender adolescent who
considers medical affirming treatments."

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Armuand, G. M., Wettergren, L., Rodriguez-Wallberg, K. A., & Lampic, C. (2014). Desire for children, difficulties achieving a pregnancy, and infertility distress 3 to 7 years after cancer diagnosis. *Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer*, *22*(10), 2805–2812. https://doi.org/10.1007/s00520-014-2279-z

Brik, T., Vrouenraets, L., Schagen, S., Meissner, A., de Vries, M. C., & Hannema, S. E. (2019). Use of Fertility Preservation Among a Cohort of Transgirls in the Netherlands. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *64*(5), 589–593. https://doi.org/10.1016/j.jadohealth.2018.11.008

Chen, D., Kyweluk, M. A., Sajwani, A., Gordon, E. J., Johnson, E. K., Finlayson, C. A., & Woodruff, T. K. (2019). Factors Affecting Fertility Decision-Making Among Transgender Adolescents and Young Adults. *LGBT health*, *6*(3), 107–115. https://doi.org/10.1089/lgbt.2018.0250

Chen, D., Matson, M., Macapagal, K., Johnson, E. K., Rosoklija, I., Finlayson, C., Fisher, C. B., & Mustanski, B. (2018). Attitudes Toward Fertility and Reproductive Health Among Transgender and Gender-Nonconforming Adolescents. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, *63*(1), 62–68. https://doi.org/10.1016/j.jadohealth.2017.11.306

Ellis, S. J., Wakefield, C. E., McLoone, J. K., Robertson, E. G., & Cohn, R. J. (2016). Fertility concerns among child and adolescent cancer survivors and their parents: A qualitative analysis. *Journal of psychosocial oncology*, *34*(5), 347–362. https://doi.org/10.1080/07347332.2016.1196806

Lehmann, V., Keim, M. C., Nahata, L., Shultz, E. L., Klosky, J. L., Tuinman, M. A., & Gerhardt, C. A. (2017). Fertility-related knowledge and reproductive goals in childhood cancer survivors: short communication. *Human reproduction (Oxford, England)*, *32*(11), 2250–2253. https://doi.org/10.1093/humrep/dex297

Nilsson, J., Jervaeus, A., Lampic, C., Eriksson, L. E., Widmark, C., Armuand, G. M., Malmros, J., Marshall Heyman, M., & Wettergren, L. (2014). 'Will I be able to have a baby?' Results from online focus group discussions with childhood cancer survivors in Sweden. *Human reproduction (Oxford, England)*, *29*(12), 2704–2711. https://doi.org/10.1093/humrep/deu280

Pang, K. C., Peri, A., Chung, H. E., Telfer, M., Elder, C. V., Grover, S., & Jayasinghe, Y. (2020). Rates of Fertility Preservation Use Among Transgender Adolescents. *JAMA pediatrics*, *174*(9), 890–891. https://doi.org/10.1001/jamapediatrics.2020.0264

Tishelman AC, Sutter ME, Chen D, Sampson A, Nahata L, Kolbuck VD, Quinn GP. Health care provider perceptions of fertility preservation barriers and challenges with transgender patients and families: qualitative responses to an international survey. J Assist Reprod Genet. 2019 Mar;36(3):579-588. doi: 10.1007/s10815-018-1395-y. Epub 2019 Jan 3. PMID: 30604136; PMCID: PMC6439053.

Statement 11:

We advise that when gender affirming medical or surgical treatments are indicated for adolescents, clinicians working with trans and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful or unnecessary to the adolescent.

When there is indication that an adolescent might benefit from a gender affirming medical or surgical treatment, involving the parent(s) and/or primary caregiver(s) in the assessment process is recommended in almost all situations (Edwards-Leeper & Spack, 2012; Rafferty, Child, & Health, 2018). Exceptions to this might include situations in which an adolescent is in foster care and/or child protective services custody and parent involvement would be impossible, inappropriate, or harmful. Parent and family support of T/GD youth is a primary predictor of youth wellbeing and a protective factor for T/GD youth mental health (Gower et al., 2018; Grossman, Park, Frank, & Russell, 2019; Lefevor, Sprague, Boyd-Rogers, & Smack, 2019; McConnell, Birkett, & Mustanski, 2015; Pariseau et al.,

Commented [█]: I had a discussion with █ at EPATH with this statement versus the one in the hormone chapter. █ and I already agreed that this statement is more powerful and more transparent than the one in the endo chapter. It may be possible to take this one in the endo chapter. All parties agreed that the statement should be in both chapters.

Commented █: Statement 11 Parental Involvement¶
Serious issues with this statement. Case example: I am a primary care provider seeing a 19 year old who¶
desires to access hormone therapy – in a location where the age of majority is 18. How will a clinician¶
assess if parental involvement will be harmful or unnecessary? Is it reasonable to believe the 19 year old¶
when they tell the hormone provider that involving their caregivers would be harmful? I ask these¶
questions because I want to make sure we are on the same page when a provider gets sued by a parent¶
of a 19 year old for not contacting them and including them in the decision making process as per the¶
SOC8 guidelines.¶
If the young person does not want parental involvement, I believe a legal argument could be made that¶
forced involvement of parents for minors with legal capacity and/or adolescents at or over the age of¶
majority is a violation of confidentiality rights.

2019; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Simons, Schrager, Clark, Belzer, & Olson, 2013; Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016). Therefore, including parent(s)/caregiver(s) in the assessment process to encourage and facilitate increased parental understanding and support of the adolescent may be one of the most helpful practices available.

Parent(s)/caregiver(s) may provide key information for the clinical team, including report on the young person's gender and overall developmental, medical, and mental health history as well as information about the young person's level of current support and general functioning and wellbeing. Concordance or divergence of report between the adolescent and their parent(s)/caregiver(s) may be important information for the assessment team, including for the designing and shaping of individualized youth and family supports (De Los Reyes, Ohannessian, & Racz, 2019; Katz-Wise et al., 2017). Knowledge of the family context, including resilience factors and challenges can help providers know where special supports would be needed during the medical treatment process. Engagement of parent(s)/caregiver(s) is also important for educating families around various treatment approaches, ongoing follow-up and care needs, and potential treatment complications. Through psychoeducation regarding clinical gender care options and participation in the assessment process, which may unfold over time, parent(s)/caregiver(s) may better understand their adolescent child's gender-related experience and needs (Andrzejewski, Pampati, Steiner, Boyce, & Johns, 2020; Katz-Wise et al., 2017).

Parent/caregiver concerns or questions regarding the stability of gender-related needs over time and implications of various gender affirming interventions are common, and should not be dismissed. It is appropriate for parent(s)/caregiver(s) to ask these questions, and there are cases in which the parent(s)/caregiver(s)' questions or concerns are particularly helpful in informing treatment decisions and plans. For example, parent/caregiver report may provide critical context in situations in which a young person experiences very recent and/or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and/or social media influence on a young person's current self-gender concept. Contextualization of parent/caregiver report is also critical, as the report of a young person's gender history as provided by parent(s)/caregiver(s) may or may not align with the young person's self-report. Gender histories may be unknown to parent(s)/caregiver(s) because gender may be an inward experience for youth, not known by others unless it is discussed.

Some parents may present with unsupportive or antagonistic beliefs about T/GD identities and/or clinical gender care (Clark, Marshall, & Saewyc, 2020). Such parent perspectives may in some cases seem rigid, but providers should not assume this is the case. There are many examples of parent(s)/caregiver(s) who, over time with support and psychoeducation, have become increasingly accepting of their T/GD's child's gender diversity and care needs. Helping youth and parent(s)/caregiver(s) to work together on important gender care decisions is a primary goal. However, in some cases, parent(s)/caregiver(s) may be too rejecting of their adolescent child and their child's gender needs to be part of the clinical evaluation process. In these situations, youth may require the

engagement of larger systems of advocacy and support to move forward with necessary supports and care (Dubin et al., 2020).

Andrzejewski, J., Pampati, S., Steiner, R. J., Boyce, L., & Johns, M. M. (2020). Perspectives of transgender youth on parental support: qualitative findings from the resilience and transgender youth study. *Health Education & Behavior*, 1090198120965504.

Clark, B. A., Marshall, S. K., & Saewyc, E. M. (2020). Hormone therapy decision-making processes: Transgender youth and parents. *Journal of adolescence, 79*, 136-147.

De Los Reyes, A., Ohannessian, C. M., & Racz, S. J. (2019). Discrepancies between adolescent and parent reports about family relationships. *Child Development Perspectives, 13*(1), 53-58.

Dubin, S., Lane, M., Morrison, S., Radix, A., Belkind, U., Vercler, C., & Inwards-Breland, D. (2020). Medically assisted gender affirmation: when children and parents disagree. *J Med Ethics, 46*(5), 295-299. doi:10.1136/medethics-2019-105567

Edwards-Leeper, L., & Spack, N. P. (2012). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service"(GeMS) in a major pediatric center. *Journal of homosexuality, 59*(3), 321-336.

Gower, A. L., Rider, G. N., Brown, C., McMorris, B. J., Coleman, E., Taliaferro, L. A., & Eisenberg, M. E. (2018). Supporting Transgender and Gender Diverse Youth: Protection Against Emotional Distress and Substance Use. *Am J Prev Med, 55*(6), 787-794. doi:10.1016/j.amepre.2018.06.030

Grossman, A. H., Park, J. Y., Frank, J. A., & Russell, S. T. (2019). Parental Responses to Transgender and Gender Nonconforming Youth: Associations with Parent Support, Parental Abuse, and Youths' Psychological Adjustment. *Journal of Homosexuality*, 1-18. doi:10.1080/00918369.2019.1696103

Katz-Wise, S. L., Budge, S. L., Fugate, E., Flanagan, K., Touloumtzis, C., Rood, B., . . . Leibowitz, S. (2017). Transactional pathways of transgender identity development in transgender and gender-nonconforming youth and caregiver perspectives from the Trans Youth Family Study. *International Journal of Transgenderism, 18*(3), 243-263.

Lefevor, G. T., Sprague, B. M., Boyd-Rogers, C. C., & Smack, A. C. P. (2019). How well do various types of support buffer psychological distress among transgender and gender nonconforming students? *Int J Transgend, 20*(1), 39-48. doi:10.1080/15532739.2018.1452172

McConnell, E. A., Birkett, M. A., & Mustanski, B. (2015). Typologies of Social Support and Associations with Mental Health Outcomes Among LGBT Youth. *LGBT Health, 2*(1), 55-61. doi:10.1089/lgbt.2014.0051

Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology, 7*(3), 267.

Rafferty, J., Child, C. o. P. A. o., & Health, F. (2018). Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics, 142*(4).

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346-352. doi:10.1542/peds.2007-3524
Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs, 23*(4), 205-213. doi:10.1111/j.1744-6171.2010.00246.x
Simons, L., Schrager, S. M., Clark, L. F., Belzer, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *J Adolesc Health, 53*(6), 791-793. doi:10.1016/j.jadohealth.2013.07.019
Wilson, E. C., Chen, Y. H., Arayasirikul, S., Raymond, H. F., & McFarland, W. (2016). The Impact of Discrimination on the Mental Health of Trans*Female Youth and the Protective Effect of Parental Support. *AIDS Behav, 20*(10), 2203-2211. doi:10.1007/s10461-016-1409-7

Statement 12A
The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 where a diagnosis is necessary to access health care. In countries which have not implemented the latest ICD other taxonomies may be used but efforts should be undertaken to utilize the latest ICD as soon as is practicably possible.

When working with transgender and gender diverse adolescents, clinicians should realize that a classification may give access to care, but pathologizing transgender identities may be experienced as stigmatizing (van Beek et al., 2016). Assessments related to gender health and gender diversity have been criticized, and controversies exist around classification systems (Drescher, 2016). Healthcare professionals should realize they do not diagnose a gender identity per se, as one's gender identity is the subjective experience of being male or female or another gender. Clinicians should assess the overall and gender-related history and transgender care related needs of youth. Through this assessment process, health care providers may provide a classification when needed to get access to transgender-related care. However, a classification involving gender diversity connotes no pathology, in and of itself.

Commented [redacted] From Colt: "...pathologizing transgender identities may be experienced as stigmatizing." I wonder why a stronger¶
statement of how pathologizing transgender identities is a stigmatizing practice is not made? If not, it¶
makes it seem that trans people are the ones with the problem with being pathologized instead of the¶
practice itself.

Gender Incongruence and Gender Dysphoria are the two diagnostic terms used in respectively the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Of these two widely used classification systems, the DSM is for psychiatric classifications only and the ICD contains all diseases and conditions related to physical as well as mental health. The most recent versions of these two systems, the DSM-5 and the ICD-11 respectively, reflect a long history of reconceptualizing and depsychopathologizing gender related diagnoses (American Psychiatric Association, 2013, World Health Organization, 2019). Compared to the earlier version, the DSM-5 replaced Gender Identity *Disorder* with Gender *Dysphoria* acknowledging the distress experienced by *some* people stemming from the incongruence between experienced gender identity and sex assigned at birth. Compared to the ICD 10th

edition, the Gender Incongruence classification was moved from the Mental Health Chapter to a Chapter "Conditions related to Sexual Health" in the ICD-11. One important reconceptualization in comparison to the DSM-5 Gender Dysphoria classification is that distress is not a required indicator of the ICD-11 Gender Incongruence classification (WHO, 2019). After all, when growing up in a supporting and accepting environment, the distress and impairment criterion, an inherent part of every mental health condition, may not be applicable (Drescher, 2012). As such, the ICD-11 Gender Incongruence classification may better capture the fullness of gender diversity experiences and related clinical gender needs.

Criteria of the ICD-11 classification *"Gender Incongruence of Adolescence or Adulthood"* require a marked and persistent incongruence between an individual´s experienced gender and the assigned sex which often leads to a desire to 'transition,' in order to live and be accepted as a person of the experienced gender. For some, this includes hormonal treatment, surgery, or other health care services to make the individual´s body align as much as desired, and to the extent possible, with the person's experienced gender. Relevant for adolescents is the indicator that a classification cannot be assigned '*prior to the onset of puberty'.* Finally, it is prescribed *"that gender variant behaviour and preferences alone are not a basis for assigning the classification*" (WHO, ICD-11, 2019).

Criteria for the DSM-5 classification *"Gender Dysphoria in Adolescence and Adulthood"* denote 'a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration' (criterion A, fulfilled when 2 of 6 subcriteria are manifest), associated with 'clinically significant distress or impairment in social, occupational, or other important areas of functioning' (Criterion B, APA 2013). As noted before, not all transgender and gender diverse people experience gender dysphoria and this should not preclude them from accessing medical affirming care. For adolescents, the DSM-5 makes two specific remarks, which make it possible to give the classification when secondary sex characteristics have yet to fully develop. First, there should be a marked incongruence between one's experienced/expressed gender and one's primary and/or secondary sex characteristics *(or in younger adolescents, the anticipated secondary sex characteristics)*. Second, the strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (*or in younger adolescents, a desire to prevent the anticipated secondary sex characteristics*).

Of note, a gender related classification is one of the requirements for medical gender affirming care, but such a classification solely does not *indicate* a person *needs* medical affirming care. The range of youth experiences of gender incongruence necessitates professionals provide a range of treatments or interventions based on the individual's needs. Counselling, gender exploration and mental health assessment, and when needed, treatment with mental health providers trained in gender development may all be indicated with or without medical affirming care.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. 5th ed. (DSM-V). Arlington, VA: American Psychiatric Association Publishing, 2013.

Beek, T. F., Cohen-Kettenis, P. T., & Kreukels, B. P. (2016). Gender incongruence/gender dysphoria and its classification history. *International review of psychiatry (Abingdon, England)*, *28*(1), 5–12. https://doi.org/10.3109/09540261.2015.1091293

Drescher, J., Cohen-Kettenis, P. T., & Reed, G. M. (2016). Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *The lancet. Psychiatry*, *3*(3), 297–304. https://doi.org/10.1016/S2215-0366(15)00586-6

Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: situating gender identity diagnoses in the ICD-11. *International review of psychiatry (Abingdon, England)*, *24*(6), 568–577. https://doi.org/10.3109/09540261.2012.741575

World Health Organization: International Statistical Classification of Diseases and Related Health Problems (2019). 11th ed. https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/90875286

Statement 12B

There is well-documented (according to local context) evidence of persistent gender incongruence or gender nonconformity / diversity of several years,

Identity exploration and consolidation are experienced by many adolescents (Klimstra, Hale III, Raaijmakers, Branje, & Meeus, 2010; Topolewska-Siedzik & Cieciuch, 2018). Identity exploration during the teen years may include exploration of gender and gender identity (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). Little is known about how processes of adolescent identity consolidation (e.g., the process of commitment to specific identities) may impact a young person's experience(s) of gender. Given potential shifts in gender-related experiences and needs during adolescence, as discussed below, it is important to establish that the young person has experienced several years of persistent gender incongruence or gender diversity prior to initiating gender-affirming hormones or providing gender-affirming surgeries. Establishing evidence of persistent gender incongruence or gender diversity typically requires careful assessment with the young person over time (see Statement 3). Whenever possible and appropriate, the assessment and discernment process should also include the parent(s)/caregiver(s) (see Statement 11).

The research literature on continuity versus discontinuity of gender affirming medical care needs/requests is complex and somewhat difficult to interpret. A series of studies conducted over the last several decades, including some with methodological challenges (as noted by Temple Newhook et al., 2018; Winters et al., 2018), suggest that gender diversity is not consistent for all children as they progress into adolescence: A subset of youth who experienced gender diversity prior to puberty show reduced (or fully discontinued) gender diversity over time (de Vries, Noens, Cohen-Kettenis, van

Commented [redacted]: It is unclear as to if this statement refers to accessing pubertal suppression. In one paragraph it reads¶
hormones and surgery with no mention of pubertal suppression and in another paragraph it says the¶
duration may be much shorter before initiating 'pubertal blockers' but does not go into any specifics¶
here.¶
In the case of onset of dysphoria with initiation of puberty, it seems inappropriate to add a barrier of¶
time without even specifying what that time is before intervening with this reversible intervention –¶
especially since it is not clear if you are referring to pubertal suppression in this statement. Also, 'several¶
years' will certainly come back to bite us in court, I'm wondering why this arbitrary time frame is not¶
defined, what constitutes several years? Are there significant and compelling reasons to initiate any¶
treatments before several years have gone by? What are these reasons? Again,

Berckelaer-Onnes, & Doreleijers, 2010; Ristori & Steensma, 2016; Singh, Bradley, & Zucker, 2021, Wagner et al., 2021). However, there has been less research focus on rates of continuity and discontinuity of gender diversity and gender-related needs in pubertal and/or adolescent populations. The data available regarding broad *unselected* gender-referred pubertal/adolescent cohorts (from the Amsterdam transgender clinic) suggest that, following extended assessments over time, a subset of gender diverse adolescents presenting for gender care elect not to pursue gender-affirming medical care (Arnoldussen et al., 2019; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011). Importantly, findings from studies of gender diverse pubertal/adolescent cohorts who have undergone comprehensive gender evaluation over time, shown persistent gender diversity and gender-related need, and received resulting referrals for medical gender care, suggest very low levels of regret regarding gender-related medical care decisions (de Vries et al., 2014; Wiepjes et al., 2018). Critically, these findings of low regret can only currently be applied to youth who have demonstrated sustained gender diversity and gender-related needs over time, as established through comprehensive and iterative assessment (see Statement 3). Although by clinical observation an increasing number of youth are coming to self-identify as gender diverse in later adolescence, nothing is known about how their gender trajectories compare to those of youth who have come to know their gender diversity earlier (Kaltiala-Heino, Bergman, Työläjärvi, & Frisén, 2018). This is a much-needed area of research.

The level of reversibility of a gender affirming medical intervention should be considered along with the sustained duration of young person's gender incongruence. For example, the duration of persistent gender incongruence before initiating pubertal blockers may be much shorter than for initiating gender affirming hormones, given that pubertal suppression is intended to provide a young person with the time to explore their gender-related needs before deciding whether to progress to treatments that involve more irreversible elements. For youth who have experienced shorter duration gender incongruence, social transition-related supports may provide some relief as well as additional information for the clinical team regarding a young person's broad gender care needs (see Statements 4, 6, and 7).

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Statement 12C
The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

The process of informed consent includes communication between a patient and provider regarding the patient's understanding of a potential intervention as well as, ultimately, the patient's decision whether to receive the intervention. In most settings, for minors, the legal guardian is integral to the informed consent process: If a treatment is to be given, the legal guardian (often the parent[s]/caregiver[s]) provides the informed consent to do so. Assent, in most settings, is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses understanding and intention.

A necessary step in the informed consent/assent process for consideration of gender affirming medical care is careful discussion with qualified mental health and medical healthcare professionals of the reversible and irreversible effects of the treatment, as well as fertility preservation options (when applicable), and any additional potential risks and benefits of the intervention. These discussions are required for informed consent/assent. Assessment of cognitive and emotional maturity is important because it helps the care team understand the adolescent's capacity *to be informed.*

The skills necessary to assent/consent to any medical intervention or treatment include the ability to: (1) comprehend the nature of the treatment, (2) reason about treatment options, including risks and benefits, (3) appreciate the nature of the decision, including the long-term consequences; and (4) communicate choice (Appelbaum, 2007; Grootens-Wiegers, Hein, van den Broek, & de Vries, 2017). In the case of gender affirming medical treatments, a young person should be well-informed about what the treatment may and may not accomplish, typical timelines for changes (e.g., with gender affirming hormones), and any implications of stopping the treatment. Gender-diverse youth should fully understand the reversible, partially reversible, and ~~un~~irreversible aspects of a treatment, as well as the limits of what is known about certain treatments (e.g., the impact of pubertal suppression on brain development; (Chen et al., 2020). Gender-diverse youth should also understand that although many gender-diverse youth begin gender affirming medical care and experience that care as a good fit for them long-term, there is a subset of individuals who over time discover that this care is not a fit for them (Wiepjes et al., 2018). Youth should know that such shifts are sometimes connected to a change in gender needs over time~~s~~, and in some cases, a shift in gender itself. Given this information, gender-diverse youth must be able to reason thoughtfully about treatment options, considering the implications

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"Qualified mental health professional AND/OR medical professional." The hormone¶
chapter does not require a mental health professional assessment for every patient, so this is a¶
discrepancy. Also, primary care providers routinely assess this in their patients and can certainly¶
determine if additional input from a mental health professional may be helpful or necessary.

of the choices at hand. And as a foundation for providing assent, the gender-diverse young person needs to be able to communicate their choice.

The skills needed to accomplish the tasks required for assent/consent may not emerge at specific ages per se (Grootens-Wiegers et al., 2017), and there may be variability in these capacities related to developmental differences and mental health presentations (Shumer & Tishelman, 2015) as well as the opportunities a young person has had to practice these skills (Alderson, 2007). Further, assessment of emotional and cognitive maturity must be conducted separately for each gender-related treatment decision Vrouenraets, de Vries, De Vries, van der Miesen, & Hein, submitted).

The following questions may be useful to consider in assessing a young person's emotional and cognitive readiness to assent or consent to a specific gender affirming treatment:

- Can the young person think carefully into the future and consider the implications of a partially and/or fully irreversible intervention?
- Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time, and that gender-related priorities at a certain point in time might change?
- Has the young person, to some extent, thought through the implications of what they might do if their priorities around gender do change in the future?
- Is the young person able to understand and manage the day-to-day short-term and/or long-term aspects of a specific medical treatment (e.g., medication adherence, administration, and necessary medical follow-ups).

Assessment of emotional and cognitive maturity may be accomplished over time as the care team continues conversations about the treatment options and affords the young person the opportunity to practice thinking into the future and flexibly considering options and implications. For youth with neurodevelopmental and/or some types of mental health differences, skills for future thinking, planning, big picture thinking, and self-reflection may be less-well developed (Olde Dubbelink & Geurts, 2017). In these cases, a more careful approach to consent and assent may be required, and this may include additional time and structured opportunities for the young person to practice the skills necessary for medical decision-making (Strang et al., 2018).

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Statement 12 D

The adolescent mental health concerns (if any) that may interfere diagnostic clarity, capacity to consent and/or gender affirmative medical treatment have been addressed.

While assessing trans and gender diverse adolescents for possible gender affirming medical treatments, clinicians should assess resilience and vulnerabilities of the adolescent. Gender health providers must understand the adolescent's mental health needs, if any, and provide or facilitate appropriate interventions as necessary. A young person's mental health challenges may impact their conceptualization of their gender development history and gender identity related needs, the adolescent's capacity to consent, and the ability of the young person to engage in/receive medical treatment. Clinicians should consider these challenges in their assessment and recommendations and address them when indicated.

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difficulty is missing the word difficulty so it reads that mental health can complicate assessment...please¶
specify that it is the MH difficulty that can complicate assessment.

Evidence indicates transgender and gender diverse adolescents are at increased risk for mental health challenges (for an overview, see e.g. Leibowitz & de Vries, 2016), often related to family/caregiver rejection, non-affirming community environments, and neurodiversity-related factors (e.g. Weinhardt et al, 2017, Ryan et al., 2010, de Vries et al., 2016, Pariseau et al, 2019). Additionally, transgender and gender diverse youth may experience mental health concerns irrespective of the

presence of gender dysphoria gender incongruence, similar to cisgender youth. Depression and self-harm may be of specific concern; many studies reveal depression scores and emotional and behavioral problems that are comparable to mental health clinic referred populations (Leibowitz & de Vries, 2016) and higher rates of not only suicidal ideation, but also suicide attempts and self harm (de Graaf et al., 2020). Also, eating disorders occur more frequently than expected in non-referred populations (Spack et al., 2012, Khatchadourian et al., 2013, Ristori et al., 2019). Importantly, transgender and gender diverse adolescents show high rates of autism spectrum disorders/characteristics (see this chapter statement 1.4, van der Miesen et al., 2016, Øien et al., 2018). Other mental health challenges may also be present, (e.g. ADHD, intellectual disability and psychotic disorders; de Vries et al., 2011, Parkes et al., 2006, Meijer et al., 2018). Stabilizing the mental health of transgender youth prior to initiation of gender affirming treatment has also been associated with reduced psychiatric acuity during treatment with hormones when compared to those youth who had more challenges at baseline (Kaltiala et al., 2020).

Of note, many transgender adolescents are well-functioning and experience few if any mental health concerns. For example, socially transitioned pubertal adolescents who receive medical gender affirming treatment at specialized gender clinics may experience mental health outcomes equivalent to cisgender peers (e.g. de Vries et al., 2014, van der Miesen, 2020). A key task of the provider is to assess the direction of the relationships that exist between any mental health challenges and the young person's self-understanding of gender care needs, and then prioritize accordingly.

Mental health difficulties may in various ways challenge the assessment and treatment of gender related needs of TGD adolescents:

1) First, when a TGD adolescent is experiencing acute suicidality, self-harm, eating disorders or other mental health crises that threaten physical health, safety must be prioritized. According to the local context and guidelines, appropriate care should seek to mitigate threat or crisis such that there is sufficient time and stabilization for thoughtful gender-related assessment and decision making. For example, an actively suicidal adolescent may not be emotionally able to make an informed decision regarding. If indicated, safety-related interventions should not preclude starting gender affirming care.

2) Second, mental health can also complicate the assessment of gender development and gender identity related needs. For example, it is critical to differentiate gender incongruence from specific mental health presentations, such as obsessions (and compulsions), special interests in autism, rigid thinking, broader identity problems, parent child interaction difficulties, severe developmental anxieties (e.g. fear of growing up and pubertal changes unrelated to gender identity), trauma, or psychotic thoughts. Mental health challenges that interfere with clarity of identity development and gender-related decision making should be prioritized and addressed.

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3) Third, decision-making regarding gender affirming medical treatments that have life-long consequences requires thoughtful, future-oriented thinking by the adolescent, with support from the parents/caregivers, as indicated (see statement 11). To be able to make such an informed decision, an adolescent should be able to understand, express a choice, appreciate and give careful thought regarding the wish for medical affirming treatment (see statement 12 C). Neurodevelopmental differences such as autistic features or autism spectrum disorder (see statement 1.4, e.g. communication differences, a preference for concrete and rigid thinking, differences in self-awareness and future thinking and planning) may challenge the assessment and decision-making process; neurodiverse youth may require extra support, structure, psychoeducation, and time built into the assessment process (Strang et al, 2016). Other mental health presentations that involve reduced communication and self-advocacy, difficulty engaging in assessment, memory and concentration difficulties, hopelessness and and/or difficulty engaging in future-oriented thinking may complicate assessment and decision making. In such cases, extended time is often necessary before any decisions regarding medical affirming treatment can be made.

4) Finally, when medical treatment is provided, mental health problems should be addressed such that they do not hinder therapeutic adherence, such as taking medication, attending to medical check-ups, and self-care.

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Statement 12 E

The adolescent has been informed of the reproductive effects that includes the potential loss of fertility, and options to preserve fertility have been discussed in the context of the adolescent's stage of pubertal development.

For the clinical approach, the scientific background, the rationale and concerned *values* we refer to the Fertility and Hormone chapters and background text above for statement 10 in this chapter (Adolescent chapter). For a detailed description of available preservation options and general consideration regarding fertility consequences of medical affirming treatment, see Fertility chapter.

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Statement 12F
The adolescent has reached Tanner stage 2 of puberty for pubertal suppression.

The onset of puberty is a pivotal point for many gender diverse youth. For some, it creates an intensification of their gender incongruence, and for others, pubertal onset may lead to gender fluidity (e.g. a transition from binary to non-binary gender identity) or even attenuation of a previously affirmed gender identity (Drummond et al., 2008; Steensma et al., 2011, 2013; Wallien & Cohen-Kettenis, 2008). The use of puberty-blocking medications, such as GnRH analogue, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty and should not be implemented in prepubertal gender diverse youth (Waal & Cohen-Kettenis, 2006). For some youth, GnRH agonists may be appropriate in late or post-puberty (e.g. Tanner stage 4 or 5) and this should be highly individualized.

Variations in the timing of pubertal onset is due to multiple factors (e.g. sex assigned at birth, genetic, nutritional, etc). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to postpubertal, adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969, 1970). For birth-assigned females, pubertal onset (e.g. gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and in birth-assigned males, by achieving a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020). The onset of puberty should be differentiated from physical changes such as pubic hair and apocrine body odor due to sex steroids produced by the adrenal gland (e.g. adrenarche) by an experienced medical provider as adrenarche does not warrant the use of puberty-blocking medications (Roberts & Kaiser, 2020). Educating parents and families about the difference between adrenarche and gonadarche helps families understand the timing for shared decision making with their multidisciplinary team related to gender-affirming medical therapies.

Commented [REDACTED]: I would reference the Hormone chapter here, as we have a text discussion about the use of GnRHa as a monotherapy in late or post-pubertal adolescents. Specifically we say that "…in adolescents older than 14, we do not currently have the data to inform whether GnRH agonists, as mono-therapy, can be used (and for what duration) without posing significant risk to skeletal health."¶
I think this is an important point to include in any chapter that discusses use of GnRHa as a monotherapy in a late or post-pubertal adolescent.

Commented [REDACTED] comment here. I also appreciate y'all outlining adrenarche and gonadarche.

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Statement 12G

We suggest/recommend that clinicians assessing trans and gender diverse adolescents should only recommend gender affirming medical or surgical treatments requested by the patient when:

The adolescent is:

14 years and above for hormone treatment (oestrogens or androgens), unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.

15 years and above for chest masculinization; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.

16 years and above for breast augmentation, facial surgery (including rhinoplasty, tracheal shave, and genioplasty) as part of gender affirming treatment; unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.

17 and above for metoidioplasty , orchidectomy, vaginoplasty, and hysterectomy and fronto-orbital remodeling as part of gender affirming treatment unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.

18 years or above for phalloplasty, unless there are significant, compelling reasons to take an individualized approach, considering the factors unique to the adolescent treatment frame.

The ages outlined above provide general guidance on the age at which gender affirming interventions may be considered. Age criteria should be considered in addition to other criteria outlined for gender affirming interventions in youth as outlined in statements 12 A-F. Individual needs, decision making capacity for the specific treatment being considered, and developmental stage (rather than age) are *most* relevant when determining timing of treatment decisions for individuals. Age has a strong correlation, though not perfect, with cognitive development and may be a useful objective marker in determining potential timing of interventions. Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility and/or complexity. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (See 12C).

Recommendations above are based on available evidence; expert consensus; and ethical considerations including, respect for the emerging autonomy of adolescents and minimizing harm in the setting of a limited evidence base. Historically, there has been hesitancy in the transgender healthcare setting to offer gender affirming treatments with potential irreversible effects to minors. The age criteria set forth in these guidelines are intended to facilitate youth's access to gender affirming treatments, and are younger than ages stipulated in previous guidelines.(E. Coleman, 2012; Hembree et al., 2017) Importantly, for each gender affirming intervention being considered youth must communicate consent/assent and be able to demonstrate an understanding and appreciation of potential benefits and risks specific to the intervention (See statement 12C).

A growing body of evidence indicates that provision of gender affirming treatment for gender diverse youth who meet criteria, leads to positive outcomes (Achille et al., 2020; A. L. de Vries et al., 2014; Kuper, Stewart, Preston, Lau, & Lopez, 2020). There ~~is~~ are however, limited data on the optimal timing of gender affirming interventions, and long-term physical, psychological, and neurodevelopmental outcomes in youth.(Chen et al., 2020; Chew, Anderson, Williams, May, & Pang, 2018; Olson-Kennedy et al., 2016).The only existing longitudinal studies in gender diverse youth with adult outcomes at this time are based on a specific model (i.e. the Dutch approach) that involved a comprehensive initial assessment with follow-up. In this approach pubertal suppression was considered at age 12, GAHT at age 16 and surgical interventions after age 18 with exceptions in some cases. It is not clear if deviations from this approach would lead to the same or different outcomes. Longitudinal studies are currently underway to better define outcomes as well as the safety and efficacy of gender affirming treatments in youth. (Olson-Kennedy et al., 2019) While the long-term effects of gender affirming treatments initiated in adolescence are not fully known, the potential negative health consequences of delaying treatment should also be considered.(A. L. C. de Vries et al., 2021) As the evidence base regarding outcomes of gender affirming interventions in youth continues to grow, recommendations on timing and readiness for gender affirming interventions may be updated.

Previous guidelines regarding gender affirming treatment of adolescents recommended that initiation of partially reversible gender affirming hormone treatment (GAHT) could begin at about 16 years of age. (E. Coleman, 2012; Hembree et al., 2009) More recent guidelines suggest that there may

Commented [REDACTED] Statement 12G Age Restrictions¶
For documentation purposes: I have spent considerable time and energy registering my opposition to¶
age barriers restricting trans youth's access to hormone therapy at each Delphi process and when¶
discussing hormone therapy initiation with the hormone chapter co-authors. On 5/25/21, our chapter¶
chai[REDACTED]
[REDACTED] and me attempting to get a meeting set¶
up between the adolescent specialists on the hormone chapter [REDACTED] and me) and the¶
adolescent co-chairs [REDACTED]n order to discuss the age restrictions. No doodle poll was¶
sent[REDACTED] followed up with [REDACTED] on 6/2/21 who said she was working on it. I did not receive any¶
further emails to set up this meeting. It is unclear as to why this meeting did not take place as this topic¶
is directly related to our chapter – and now I am told by Jon A that these discussions have already taken¶
place in Europe and the decision has been made to have age restrictions on hormone therapy. As we¶
were not included in these discussions, I did not realize that the conversation was over, so I will offer my¶
perspective with a compromise.¶
My perspective is informed as mental health provider (psychologist) and primary care provider¶
(physician) who has practiced in Texas, USA where litigation on access to healthcare for trans youth is¶
threatening to shut down many of our amazing multidisciplinary clinics. We certainly have youth that are¶
under the age of 14 (agreed, not the majority) who are appropriately started on hormone therapy. When¶
SOC8 is published with the age 14 restriction, this will add fuel to their litigious fire as they continue to¶
come down hard on our practices.¶
If you absolutely must have age barriers to care for trans youth, then I ask that the chapter authors¶
develop VERY CLEAR examples of "significant, compelling reasons to take an individualized approach,¶
considering the factors unique to the adolescent treatment frame." It is unclear why we are not¶
recommending an individualized approach for every patient, but, since this is how y'all are choosing to¶
frame things, I wonder why only one example of a significant, compelling reason (avoiding prolonged¶
pubertal suppression) is presented for initiating hormone

be compelling reasons to initiate GAHT prior to the age of 16, though there are limited studies on youth who have initiated hormones prior to 14yo. (Hembree et al., 2017) A compelling reason for earlier initiation of GAHT, for example, might be to avoid prolonged pubertal suppression, given potential bone health concerns and the psychosocial implications of delaying puberty. Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study.(Chen et al., 2020) While GnRH analogs have been shown to be safe when used for the treatment of precocious puberty, there are concerns that delaying exposure to sex hormones (endogenous or exogenous) at a time of peak bone mineralization may lead to decreased bone mineral density. The potential decrease in bone mineral density as well as the clinical significance of any decrease needs continued study. (Klink, Caris, Heijboer, van Trotsenburg, & Rotteveel, 2015; Lee et al., 2020; Schagen, Wouters, Cohen-Kettenis, Gooren, & Hannema, 2020) It should also be noted that ages for initiation of GAHT recommended above are delayed when compared to when cisgender peers initiate puberty with endogenous hormones in most regions.(Palmert & Dunkel, 2012) The potential negative psychosocial implications of not initiating puberty with peers may place additional stress on gender diverse youth, though this has not been explicitly studied When considering timing of initiation of gender affirming hormones providers should consider the potential physical and psychological benefits and risks of starting treatment with the potential risks and benefits of delaying treatment.

Age recommendations for irreversible surgical procedures were determined by review of existing literature and expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to gender diverse adolescents. Studies done with transmasculine youth have demonstrated that chest dysphoria is associated with higher rates of anxiety, depression, and distress; and can lead to functional limitations such as avoiding exercising or bathing.(Mehringer et al., 2021; Olson-Kennedy, Warus, Okonta, Belzer, & Clark, 2018; Sood et al., 2021) Testosterone unfortunately does little to alleviate this distress and chest masculinization is an option for some individuals to address this distress long-term. Studies with youth who sought chest masculinization surgery to alleviate chest dysphoria demonstrated good surgical outcomes, satisfaction with results, and minimal regret during the study monitoring period.(Marinkovic & Newfield, 2017; Olson-Kennedy et al., 2018) Chest masculinization surgery can be considered in minors when clinically and developmentally appropriate as determined by a multidisciplinary team experienced in adolescent and gender development (See statements 1-12). Duration or presence of testosterone therapy should not preclude surgery if otherwise indicated. The needs of some gender diverse youth may be met by chest masculinization surgery alone. Breast augmentation may be desired by transfeminine youth though there is less data on this procedure in youth, possibly due to fewer individuals requesting this procedure.(E. R. Boskey et al., 2019; James, 2016) GAHT, specifically estrogen, can help with development of breast tissue and it is recommended that youth have a minimum of 12 months of hormone therapy, or longer if required for surgical effect prior to breast augmentation unless hormone therapy is not clinically indicated or is medically contraindicated (See Surgery Chapter).

Commented [REDACTED]: Note that this is all discussed with references in the Hormone chapter.

Commented [REDACTED]: This also discussed in the hormone chapter in detail. It should be cross refered

Commented [REDACTED]: See previous ref on dosage

Data are limited on the optimal timing of other gender affirming surgical treatments in adolescents. Part of this is due to the fact that access to these treatments is limited and is variable in different geographical locations.(Mahfouda et al., 2019) Data indicate that rates of gender affirming surgeries have increased since 2000, and that there has been an increase in the number of gender diverse youth seeking vaginoplasty.(Mahfouda et al., 2019; Milrod & Karasic, 2017) A 2017 study of 20 WPATH affiliated surgeons in the United States reported that slightly more than half had performed vaginoplasty in minors.(Milrod & Karasic, 2017) Limited data are available on outcomes for youth undergoing vaginoplasty. Small studies have reported improved psychosocial functioning and decreased gender dysphoria in adolescents who have undergone vaginoplasty.(Becker et al., 2018; Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001) While the sample sizes are small these studies suggest that there may be a benefit in some adolescents to having these procedures performed before the age of 18. Factors that may support pursuing these procedures for youth under 18 years of age include the increased availability of support from family members, greater ease of managing post-operative care prior to transitioning to tasks of early adulthood (e.g. entering university or the workforce), and safety concerns in public spaces (i.e to reduce transphobic violence).(E. Boskey, Taghinia, & Ganor, 2018; E. R. Boskey et al., 2019; Mahfouda et al., 2019) Given the complexity and irreversibility of these procedures an assessment of the adolescent's ability to adhere to post-surgical care recommendations and to comprehend the long-term impacts of these procedures on reproductive and sexual function is crucial.(E. R. Boskey et al., 2019) Given the complexity of phalloplasty and current rates of complication it is not recommended that this surgery be considered in youth under 18 at this time.

Additional key factors that should be taken into consideration when discussing timing of interventions with youth and families are addressed in detail in Statements 12 A-F.

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Adolescents Seeking Gender-Affirming Care. *J Adolesc Health.*
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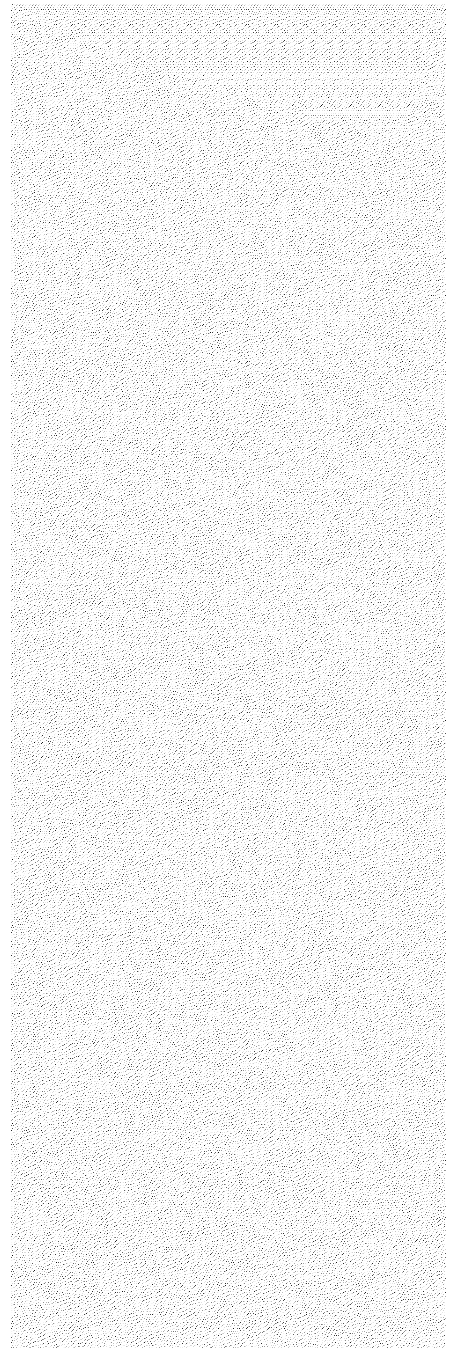


Re: Attached revised Child chapter

From:
To: Eli Coleman < >
Cc:

Date: Sat, 07 May 2022 10:02:28 -0400
Attachments: Revised sent 4-25 et al SOC8 child chapter subsection .docx (109.85 kB)

Dear
Thanks a lot for sending us the next draft of the child chapter. This has now been reviewed by the chairs.

We all think that the chapter reads beautifully and that you have done a great job, thanks for all the hard work particularly during such a difficult time for you.

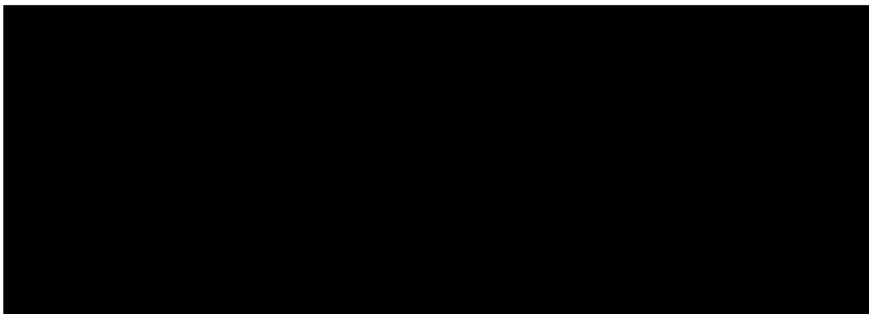
Our comments are particularly related to two main issue:

1. The change from gender diverse children to TGD children. Please see our comments. Gender diverse is also the term that the adolescent chapter is using. We don't agree with this change, the delphi statements were all with gender diverse and we cant modify this. Please see comments from asa and eli about this too in the file. Please do change it back to gender diverse.

2. We are reviewing all the statements in the SOC-8 to make sure that there is enough evidence in the text to support a strong recommendation. We don't agree that some statements in your chapter should be "recommend", they should be "suggest" as the text does not provide enough strong evidence. We would like for these statements to change to "suggest"

Can you please make any changes using tracker change and send it back to us. I have accepted the changes (most of them) that we were happy with and leave the ones with did not agree which are mainly related to TGD.

We would like to get the next draft by the 13th of May at the latest, it should not take long to make the changes suggested. We have now most of the chapters finished and we need to send the whole SOC-8 to the editor again at the end of May, so we will be grateful for your speeding work on it.
Kind regards



From:
Date: Friday, 29 April 2022 at 18:34
To: Eli Coleman < >
Cc:
Subject: Re: Attached revised Child chapter

I have received some suggested edits from a few chapter authors that I will integrate. This should be a track changes version. I think I explained that somehow track hangers wasn't working for the first page or two but I made every few changes- I think just to the terminology section, explaining we would use TGD terminology.

Sent from my iPad

On Apr 29, 2022, at 12:15 PM, Eli Coleman < wrote:

Thank you Can we please have a track change version?

Best,

Eli

On Mon, Apr 25, 2022 at 3:10 PM > wrote:

Hi All,
I am attaching the revised child chapter. I sent it to the other authors last week and asked them to get back to me with any requested edits by today but have only heard back from one person who had no requested changes. I think it would be helpful if you reviewed it as well, so it can be finalized. Here are some bullet points:

1. I started editing the chapter and realized that for the first page or so track changes were not on. I am sorry about that. Please read those pages carefully--I did not make a whole lot of modifications to those sections but did change the section on terminology and now use TGD throughout. I made some other minor changes as well. I used track changes for all other edits.

2. I changed the language throughout to TGD (from gender diverse) in the practice statements.

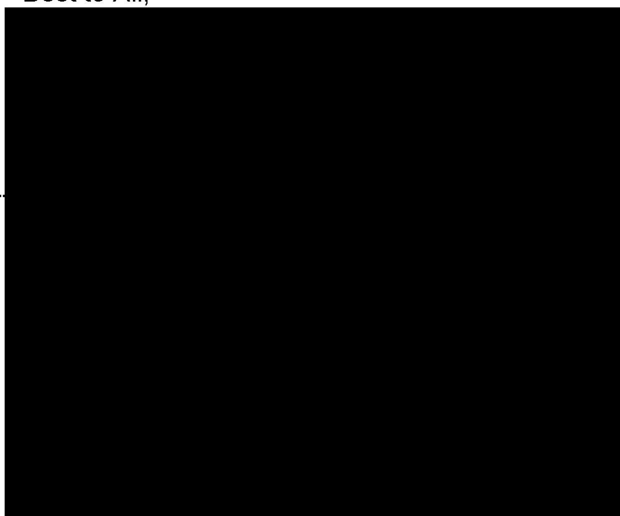
3. I deleted the word "should " from most practice statements, as I did not think those deletions changed the meaning of the statements and I believe the statements read more smoothly with this modification.

4.I made other minor changes throughout, particularly minimizing or completely deleting the term "exploratory therapy".

5. Based on comments, I revised the social transition section and I think it is much improved now. I added something about how a TGD child who does not does not socially transition may also be bullied and ostracized ---because they may not meet socially prescribed expectations for a person of their gender.

6. [redacted] and I edited the sections referring to ASD and neurodivergent youth and we very slightly changed the terminology in the practice statement (from neurodiverse to neurodivergent) to match the chapter but not in a way that I think modifies the meaning of the statement.

Best to All,



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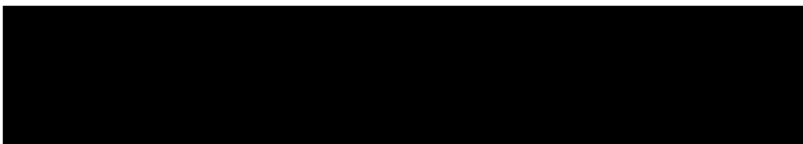

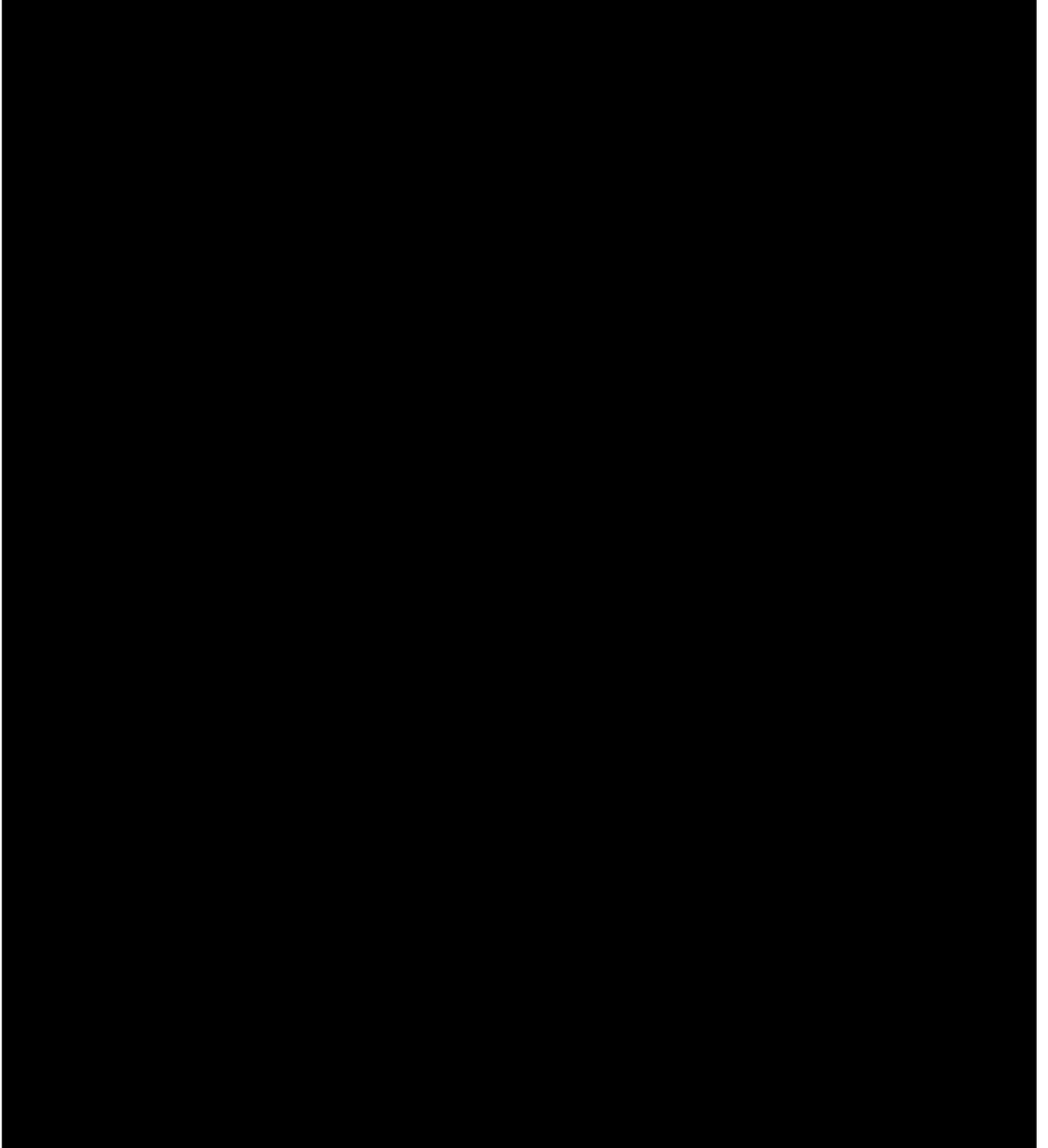

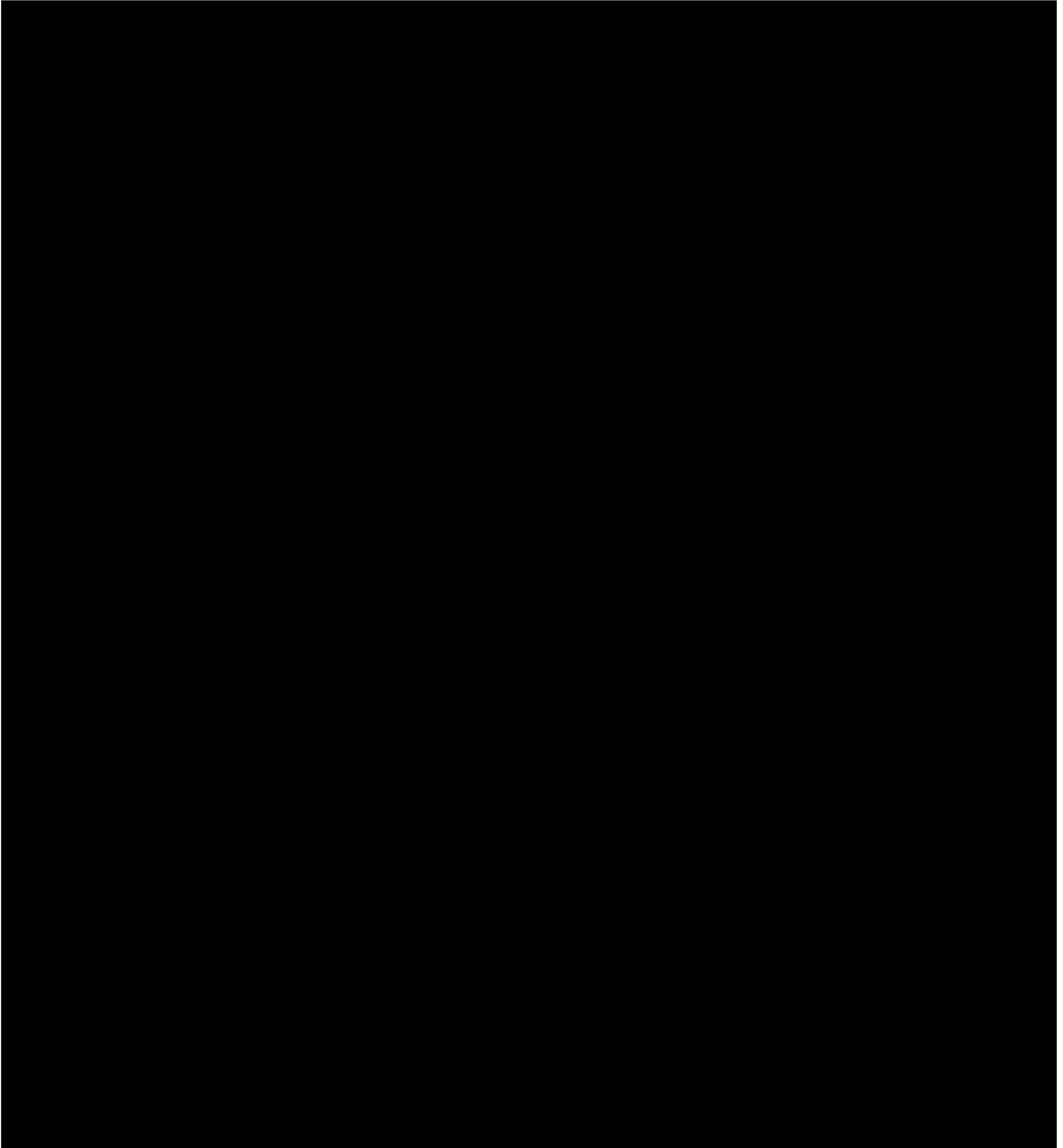

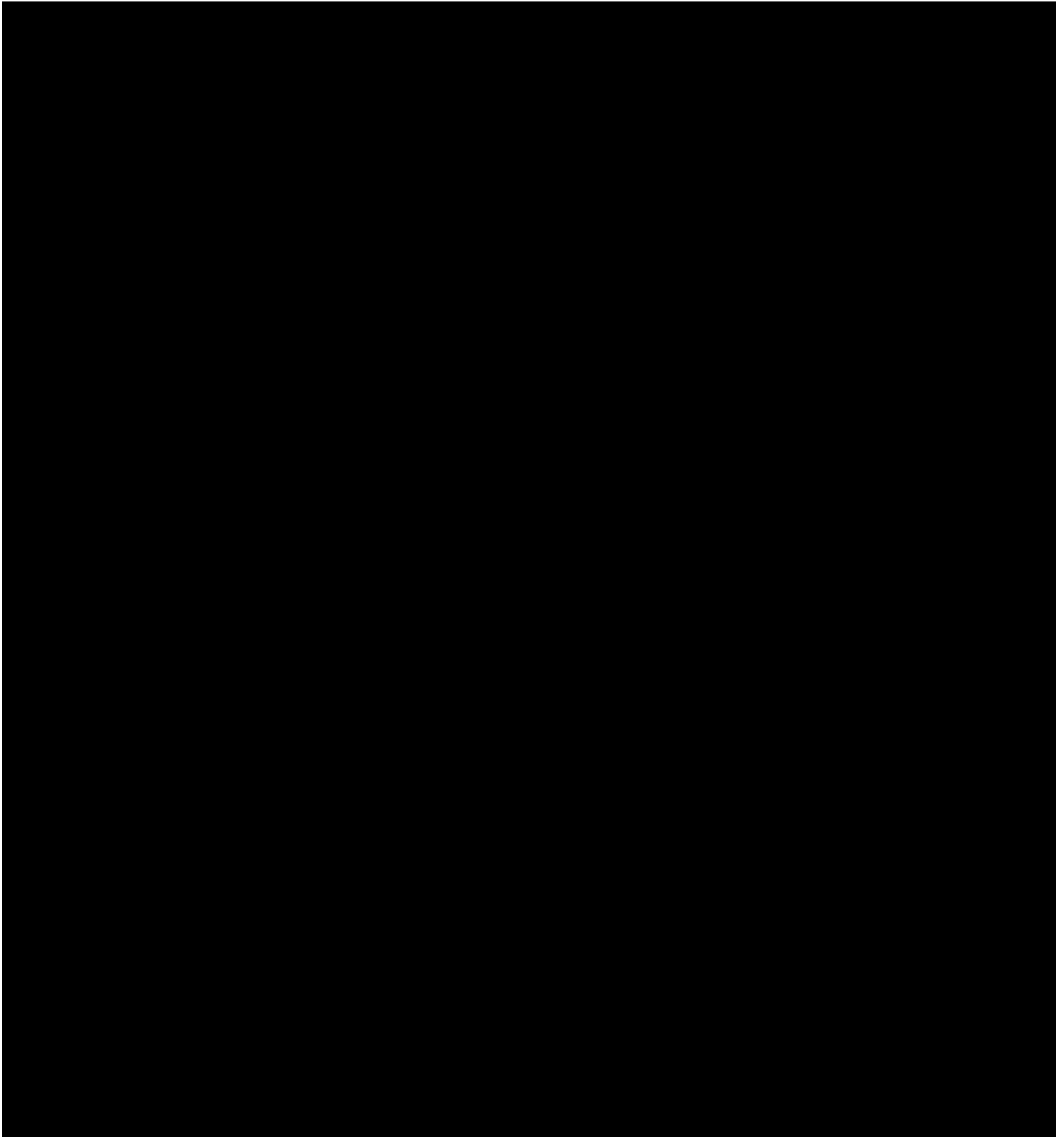

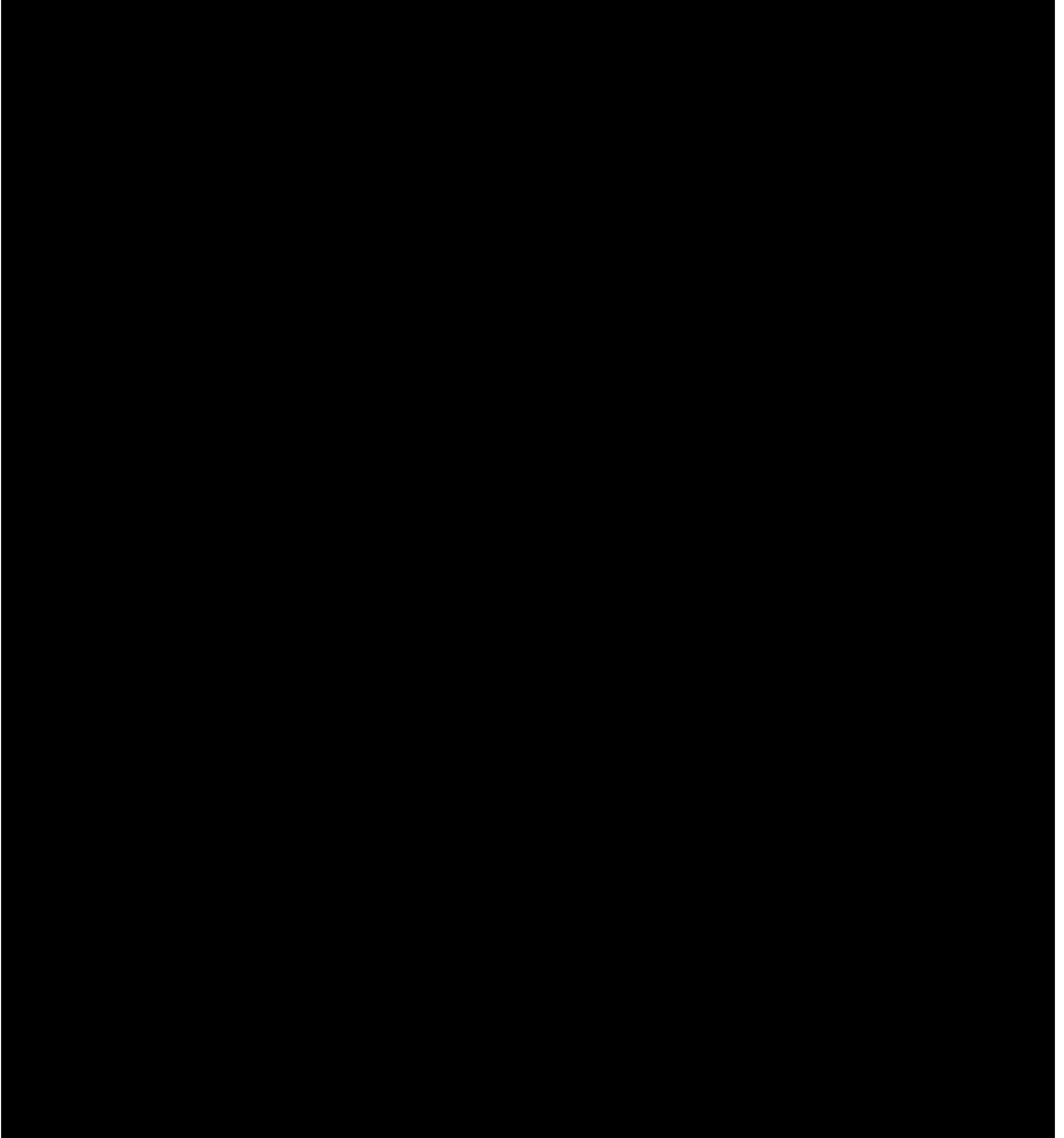

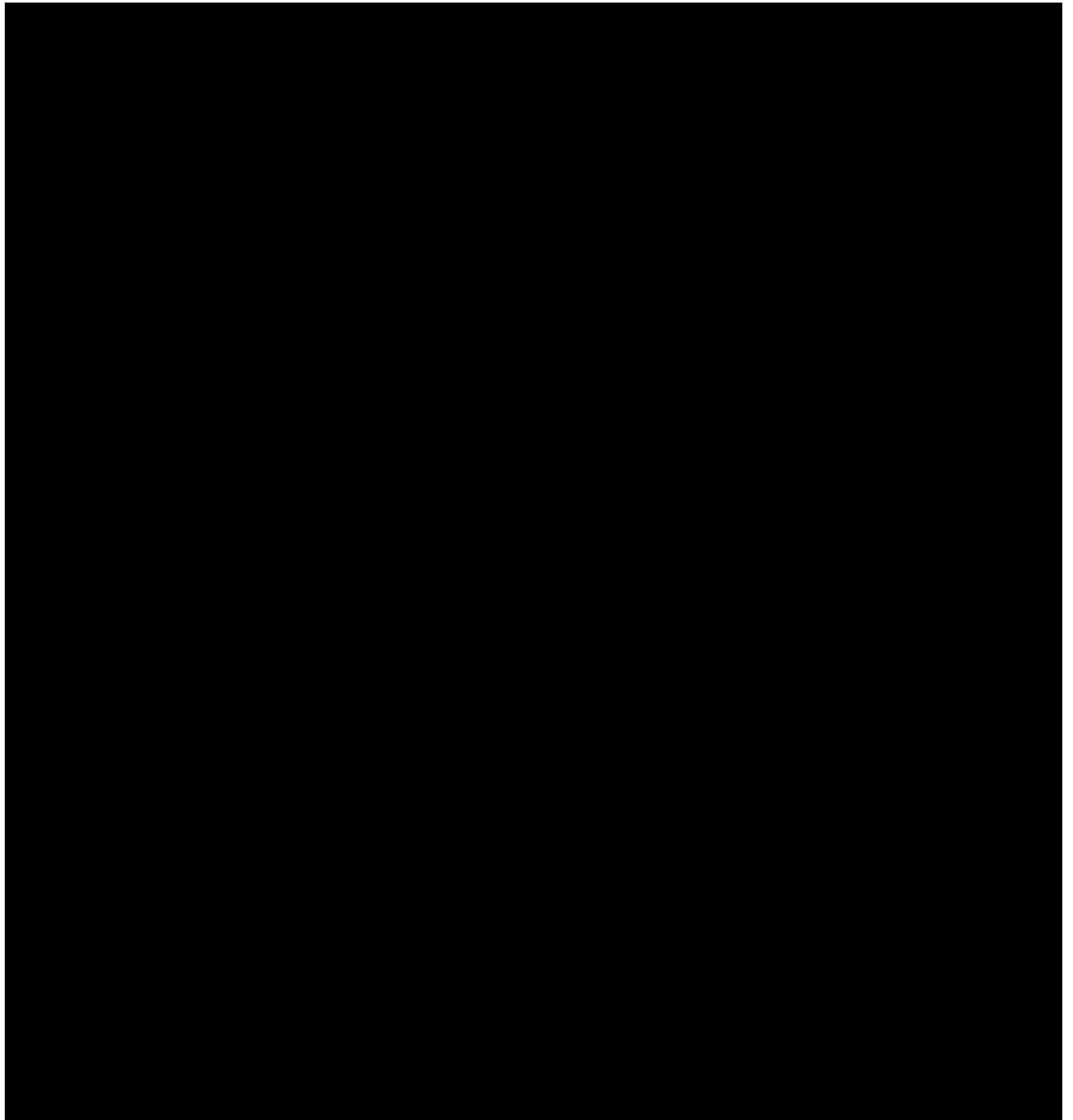

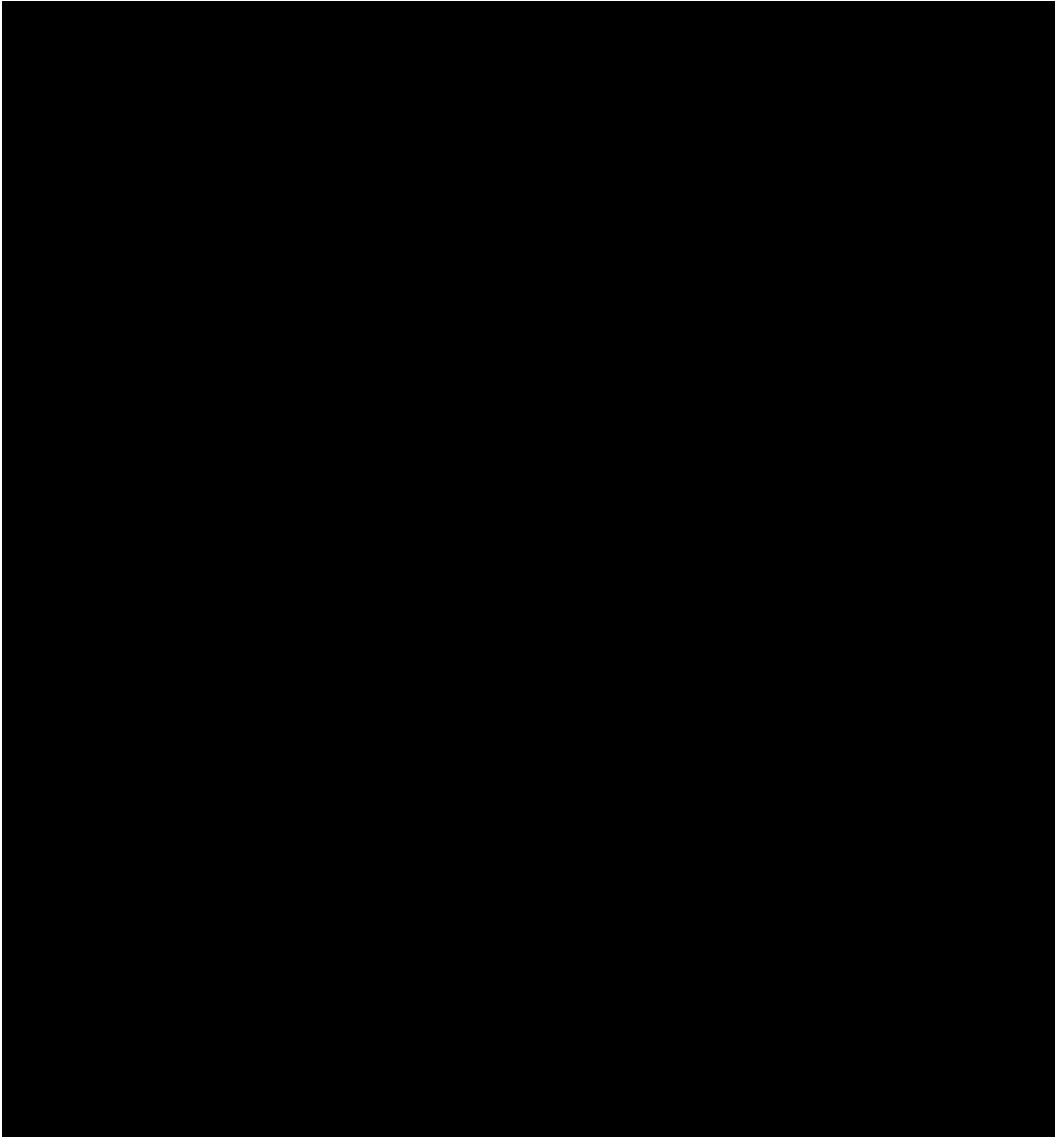

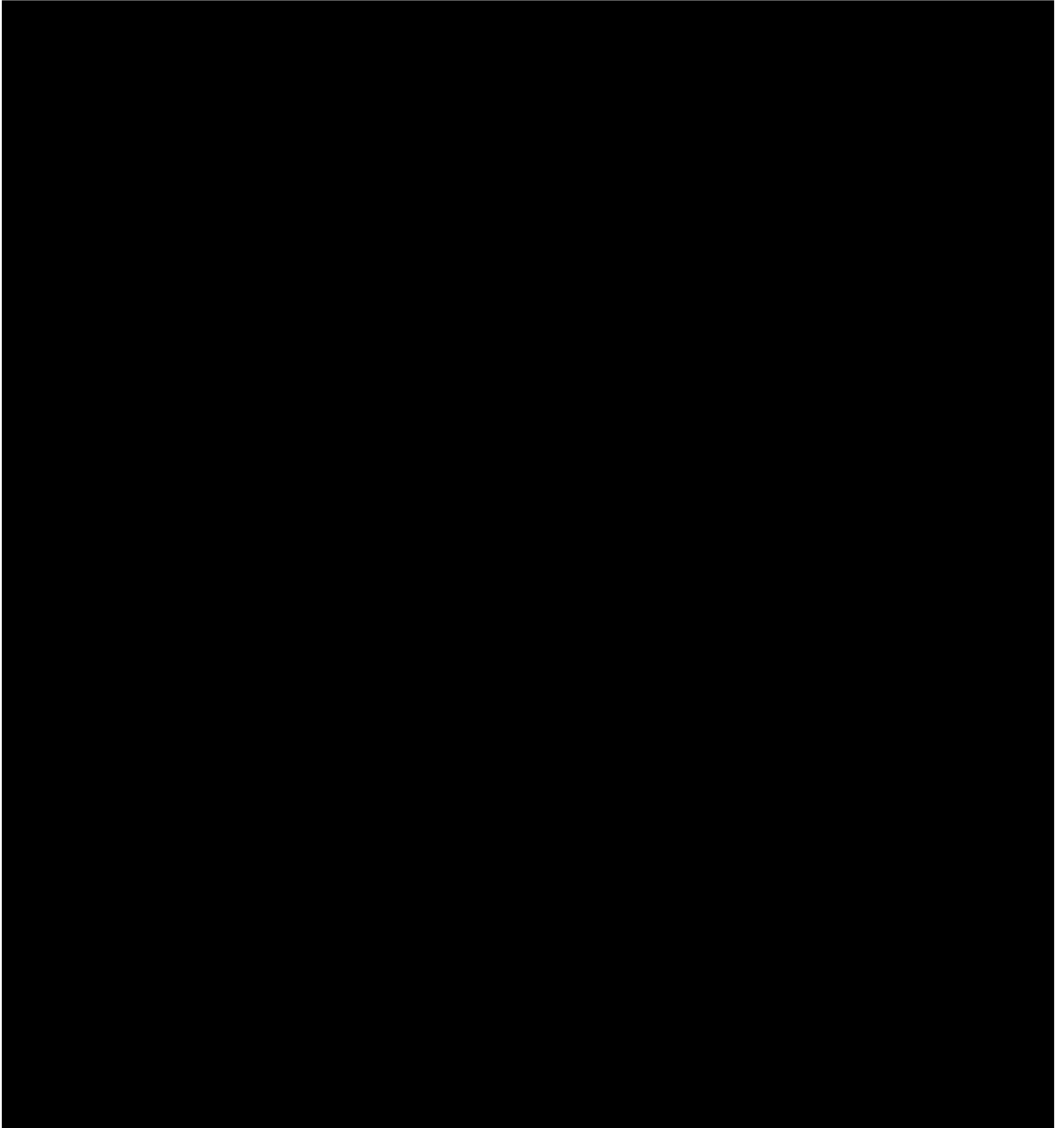

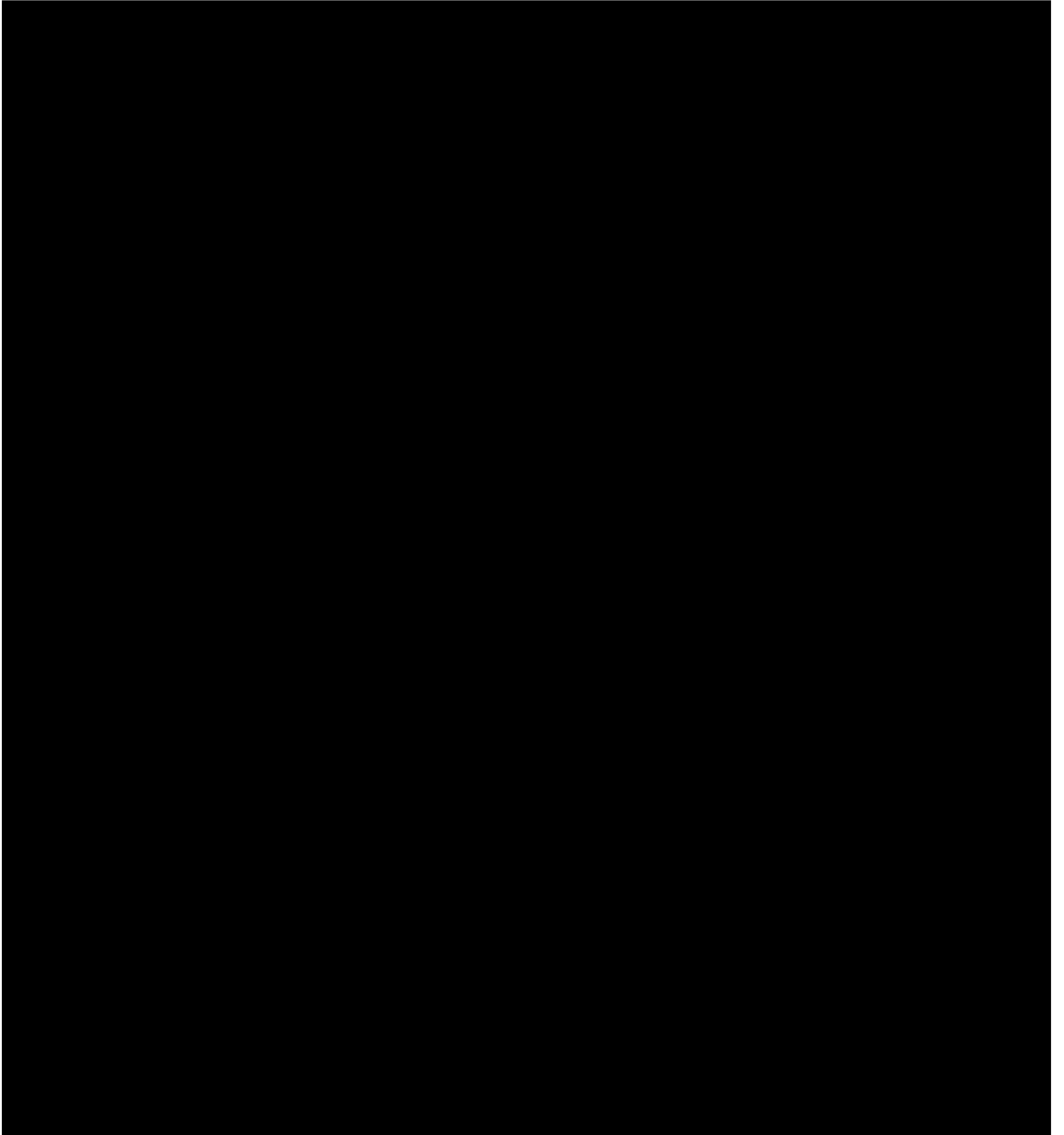

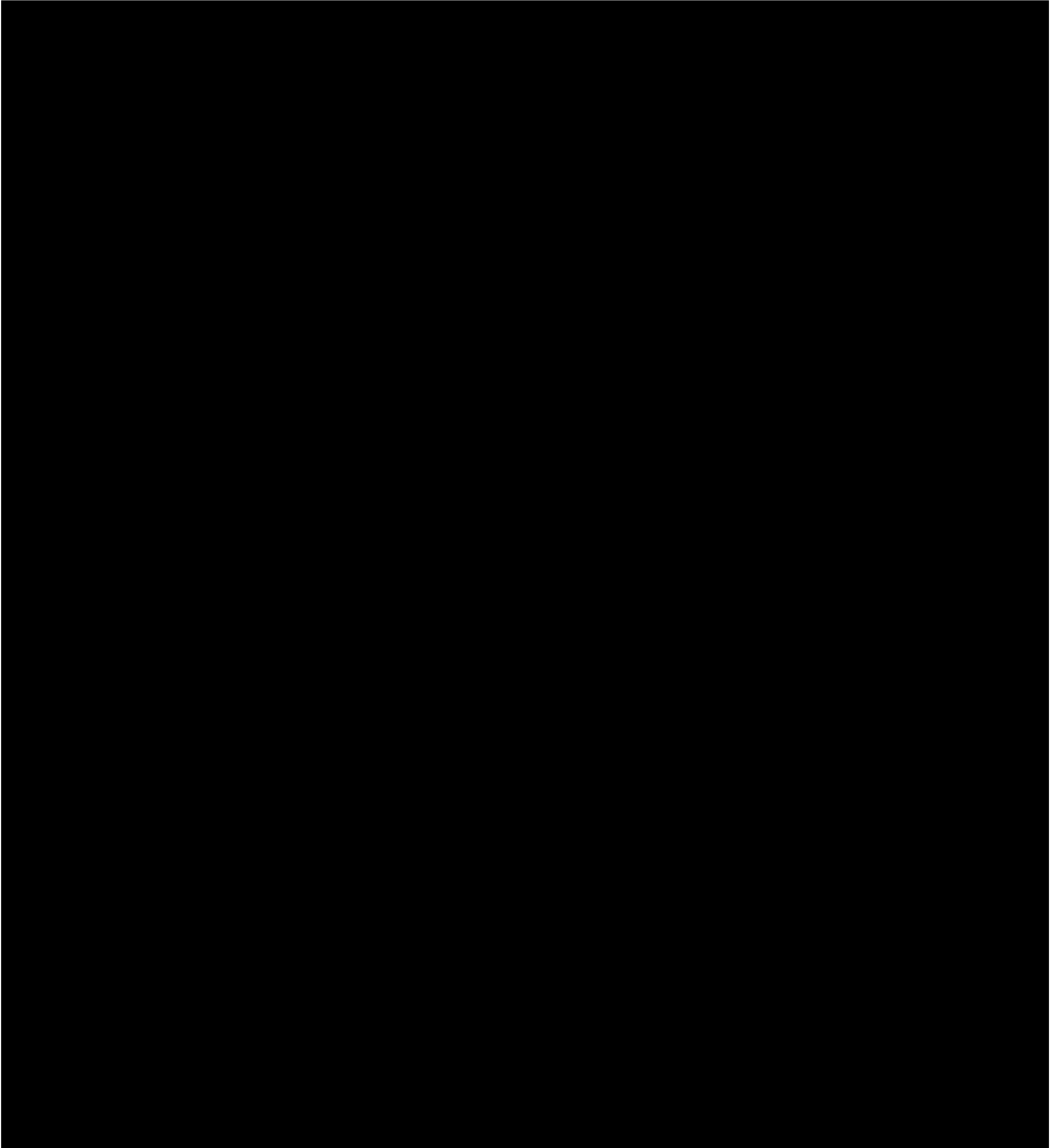

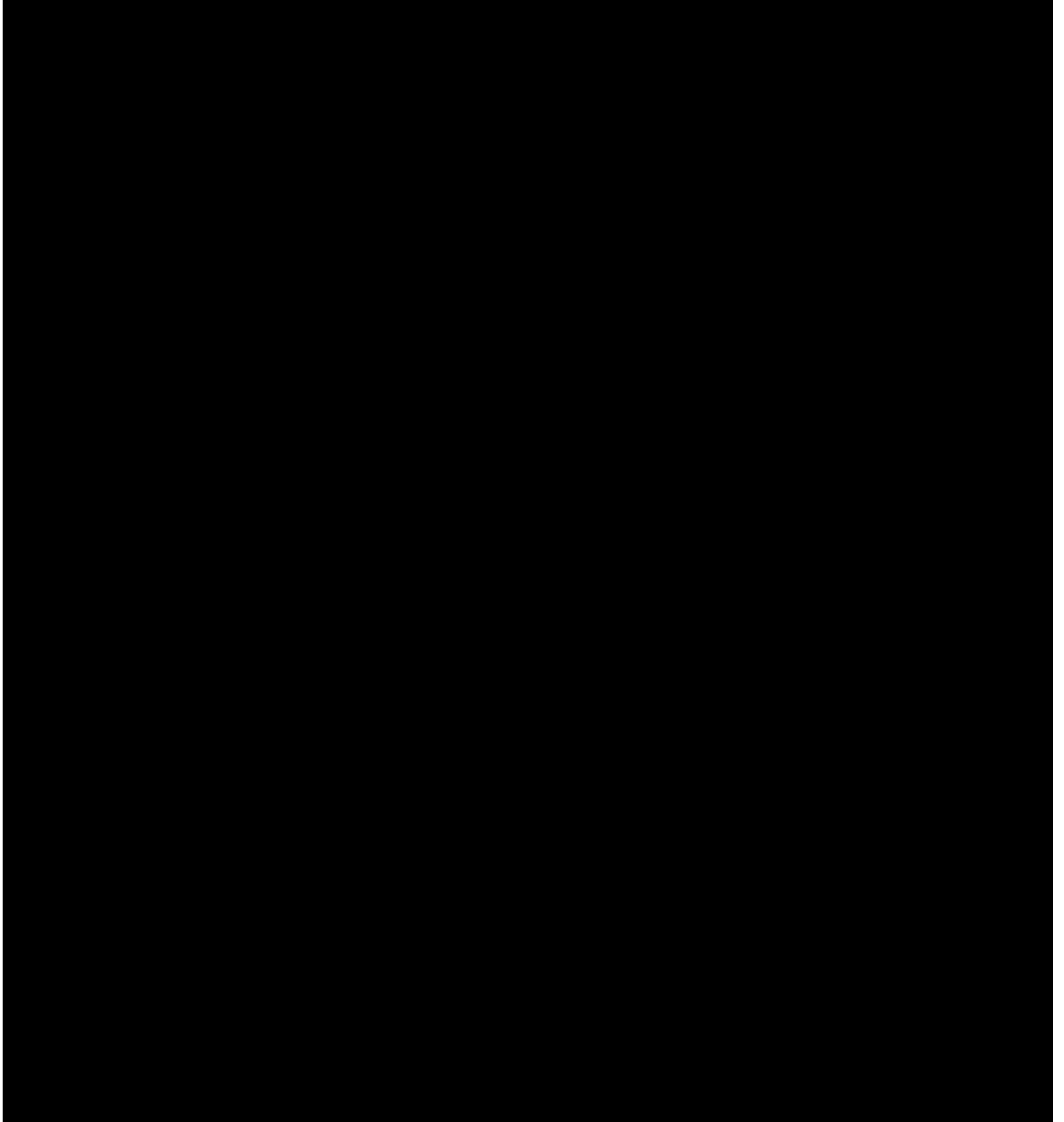

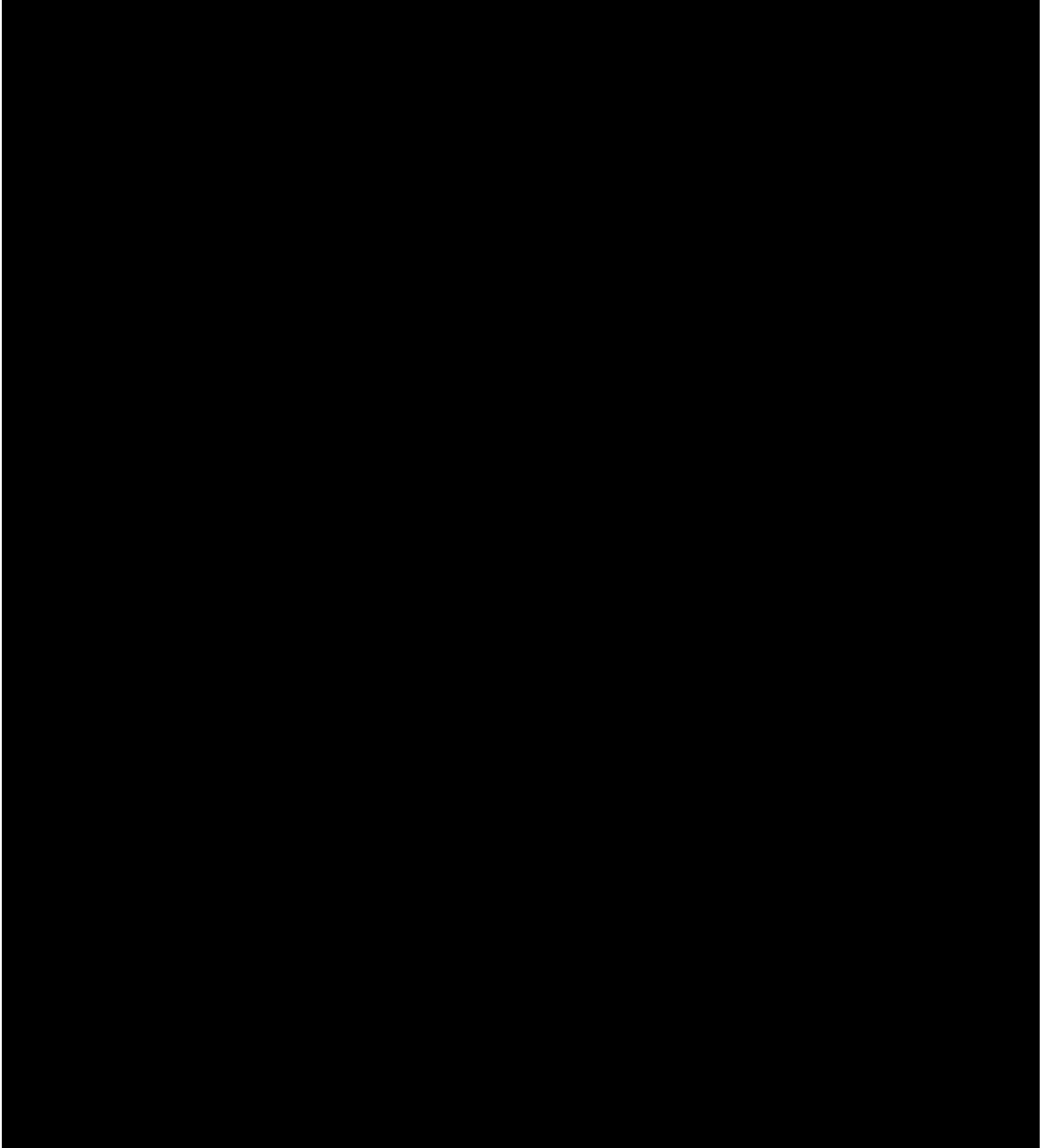

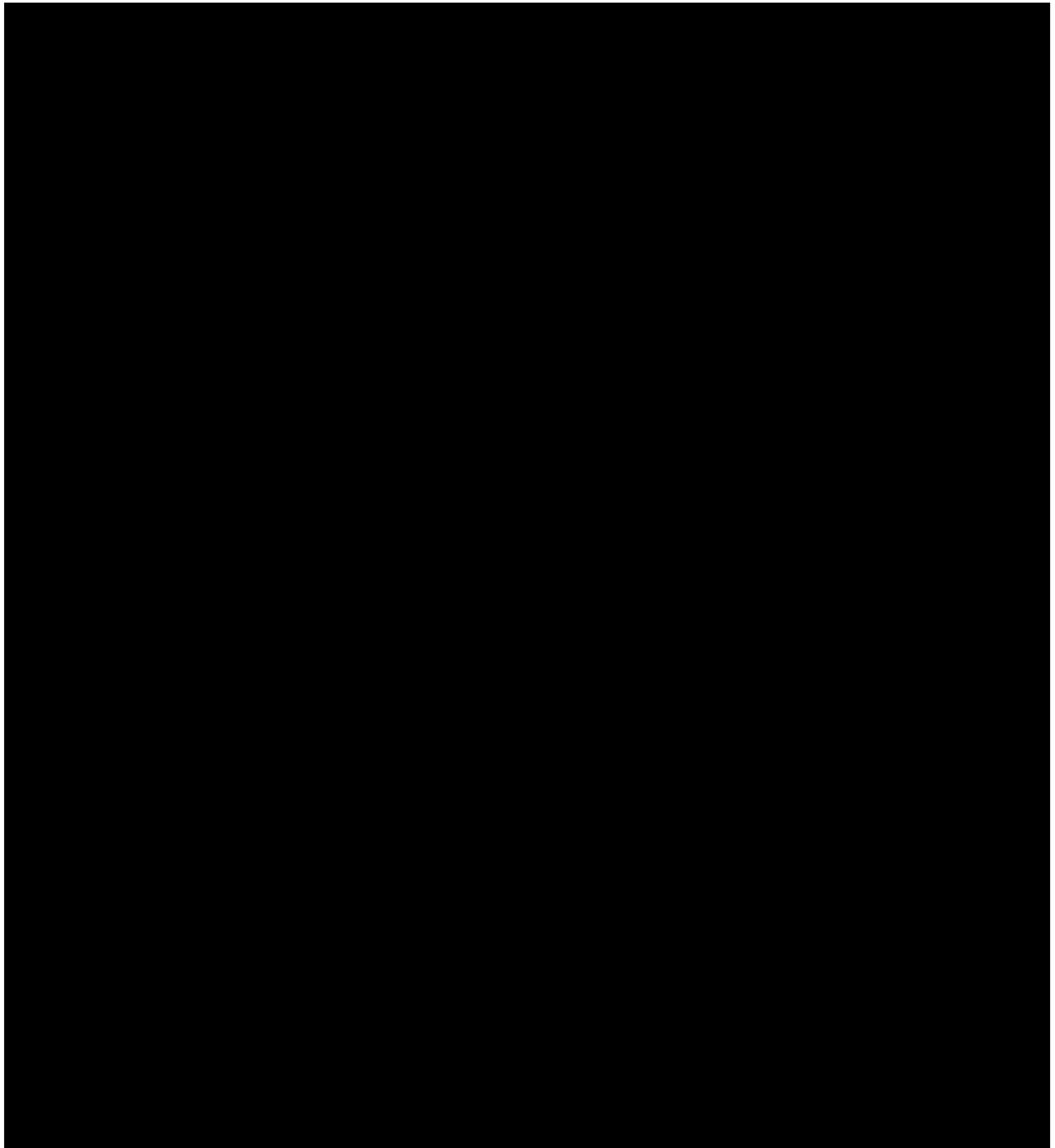

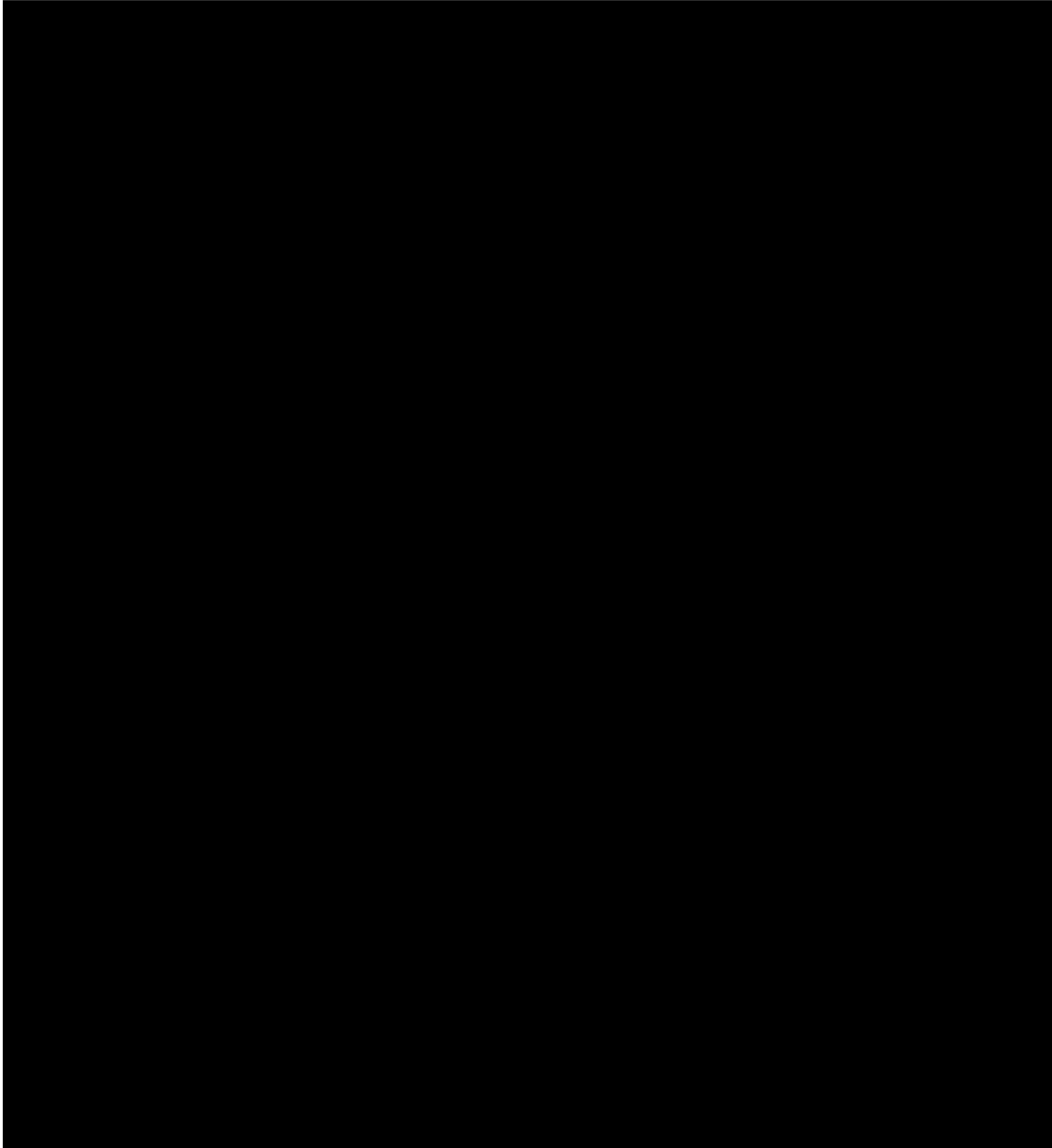

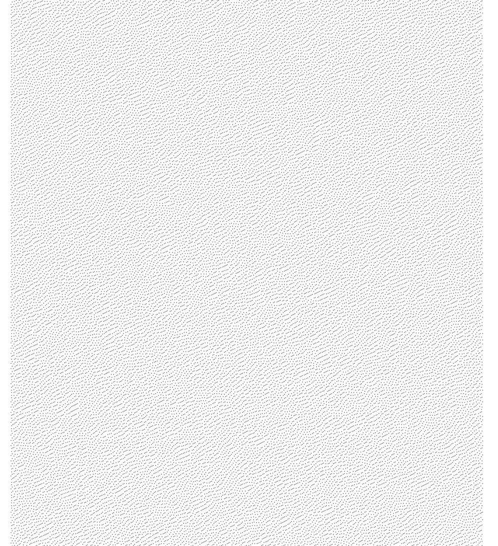

Child Chapter Final

From:
To: Eli Coleman <>,

Date: Thu, 12 May 2022 19:35:59 -0400
Attachments: Final Child Chapter 5-12-22.docx (123.37 kB)

HI-
I have attached the Child Chapter in what I hope is the final version! I am opposed to switching the recommendations to suggestions. I think I addressed all other comments and edited in order to use our original terminology of "gender diverse" throughout. I added a little bit about the Olson 2022 article. I also made a few minor changes myself and/or based on other author feedback. Everything is in track changes, including edits you have already seen from the last review.
Please let me know how else I can help with this process. I am so glad to be nearing the finish line--and I have a feeling you all may be even happier about this than I am.

On another note, I plan to go to WPATH and present about the SOC8 Child Chapter. I just don't know which other authors will be there, because they all do not know, so I will complete the presentation survey without all that information.

Please let me know if this final version is acceptable to you.

Thanks for everything -