POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
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# Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

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As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

## INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.[1,2] Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.[3]

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research

abstract

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**TABLE 1** Relevant Terms and Definitions Related to Gender Care

| Term | Definition |
|---|---|
| Sex | An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels |
| Gender identity | A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations |
| Gender expression | The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles |
| Gender perception | The way others interpret a person's gender expression |
| Gender diverse | A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer,[7] gender fluid, gender creative, gender independent, or noncisgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation. |
| Transgender | A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves. |
| Cisgender | A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth |
| Agender | A term that is used to describe a person who does not identify as having a particular gender |
| Affirmed gender | When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic |
| MTF; affirmed female; trans female | Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine |
| FTM; affirmed male; trans male | Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine |
| Gender dysphoria | A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the *DSM-5*, which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth. |
| Gender identity disorder | A psychiatric diagnosis defined previously in the *DSM-IV* (changed to "gender dysphoria" in the *DSM-5*); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research. |
| Sexual orientation | A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately. |

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.[3,4]

## DEFINITIONS

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field. "Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression" refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).[5,6]

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform

to the norms and stereotypes others expect of their assigned sex. "Transgender" is usually reserved for a subset of such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one's own gender experience.

Gender identity is not synonymous with "sexual orientation," which refers to a person's identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.[8] Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at www.thegenderbook.com, is a resource with illustrations that are used to highlight these core terms and concepts.)

## EPIDEMIOLOGY

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or "gender nonconforming" is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.[9] On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.[10] This number is much higher than previous estimates, which were extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining "transgender" in a way that is inclusive of all gender-diverse identities.[11]

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).[9] Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as "different" at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.[12]

## MENTAL HEALTH IMPLICATIONS

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.[13–20] Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.[21,22] In 1 retrospective cohort study of 180 trans youth and matched cisgender peers, 56 youth who identified as transgender reported previous suicidal ideation, and 31 reported a previous suicide attempt, compared with 20 and 11 among matched youth who identified as cisgender, respectively.[13] Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the incongruence between their assigned sex and their gender identity.[23]

There is no evidence that risk for mental illness is inherently attributable to one's identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.[24] This was affirmed by the American Psychological Association in 2008[25] (with practice guidelines released in 2015[8]) and the American Psychiatric Association, which made the following statement in 2012:

> *Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.… [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.*[26]

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.[5,6,12,27–31] Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender[32] and were also at particular risk for not knowing their HIV status.[30]

## GENDER-AFFIRMATIVE CARE

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.[5] In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.[27,33]

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.[24] Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.[5] A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.[34,35] There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.[24,36,37]

In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.[33] Reparative approaches have been proven to be not only unsuccessful[38] but also deleterious and are considered outside the mainstream of traditional medical practice.[29,39–42] The AAP described reparative approaches as "unfair and deceptive."[43] At the time of this writing,* conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.[44]

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.[35] If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD, particularly from pediatric to adult providers.

## DEVELOPMENTAL CONSIDERATIONS

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.[45] Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance.[46] This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").[45,47] More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.[5,45,48,49]

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

## MEDICAL MANAGEMENT

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits[50] and to be a reliable source of validation, support, and reassurance. They are often the first provider to be aware that a child may not identify as cisgender or that there may be distress related to a gender-diverse identity. The best way to approach gender with patients is to inquire directly and nonjudgmentally about their experience and feelings before applying any labels.[27,51]

Many medical interventions can be offered to youth who identify as TGD and their families. The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. Many protocols suggest that clinical assessment of youth who identify as TGD is ideally conducted on an ongoing basis in the setting of a collaborative, multidisciplinary approach, which, in addition to the patient and family, may include the pediatric provider, a mental health provider (preferably with expertise in caring for youth who identify as TGD ), social and legal supports, and a pediatric endocrinologist or adolescent-medicine gender specialist, if available.[6,28] There is no prescribed path, sequence, or end point. Providers can make every effort to be aware of the influence of their own biases. The medical options also vary depending on pubertal and developmental progression.

### Clinical Setting

In the past year, 1 in 4 adults who identified as transgender avoided a necessary doctor's visit because of fear of being mistreated.[31] All clinical office staff have a role in affirming a patient's gender identity. Making flyers available or displaying posters related to LGBTQ health issues, including information for children who identify as TGD and families, reveals inclusivity and awareness. Generally, patients who identify as TGD feel most comfortable when they have access to a gender-neutral restroom. Diversity training that encompasses sensitivity when caring for youth who identify as TGD and their families can be helpful in educating clinical and administrative staff. A patient-asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.[52,53] The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.[54,55] Explaining and maintaining confidentiality procedures promotes openness and trust, particularly with youth who identify as LGBTQ.[1] Maintaining a safe clinical space can provide at least 1 consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

### Pubertal Suppression

Gonadotrophin-releasing hormones have been used to delay puberty since the 1980s for central precocious puberty.[56] These reversible treatments can also be used in adolescents who experience gender dysphoria to prevent development of secondary sex characteristics and provide time up until 16 years of age for the individual and the family to explore gender identity, access psychosocial supports, develop coping skills, and further define appropriate treatment goals. If pubertal suppression treatment is suspended, then endogenous puberty will resume.[20,57,58]

Often, pubertal suppression creates an opportunity to reduce distress that may occur with the development of secondary sexual characteristics and allow for gender-affirming care, including mental health support for the adolescent and the family. It reduces the need for later surgery because physical changes that are otherwise irreversible (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc) are prevented. The available data reveal that pubertal suppression in children who identify as TGD generally leads to improved psychological functioning in adolescence and young adulthood.[20,57–59]

Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking.[60] Some experts believe that genital underdevelopment may limit some potential reconstructive options.[61] Research on long-term risks, particularly in terms of bone metabolism[62] and fertility,[63] is currently limited and provides varied results.[57,64,65] Families often look to pediatric providers for help in considering whether pubertal suppression is indicated in the context of their child's overall well-being as gender diverse.

### Gender Affirmation

As youth who identify as TGD reflect on and evaluate their gender identity, various interventions may be considered to better align their gender expression with their underlying identity. This process of reflection, acceptance, and, for some, intervention is known as "gender affirmation." It was formerly referred to as "transitioning," but many view the process as an affirmation and acceptance of who they have always been rather than a transition

**TABLE 2** The Process of Gender Affirmation May Include ≥1 of the Following Components

| Component | Definition | General Age Range[a] | Reversibility[a] |
|---|---|---|---|
| Social affirmation | Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities | Any | Reversible |
| Puberty blockers | Gonadotropin-releasing hormone analogues, such as leuprolide and histrelin | During puberty (Tanner stage 2–5)[b] | Reversible[c] |
| Cross-sex hormone therapy | Testosterone (for those who were assigned female at birth and are masculinizing); estrogen plus androgen inhibitor (for those who were assigned male at birth and are feminizing) | Early adolescence onward | Partially reversible (skin texture, muscle mass, and fat deposition); irreversible once developed (testosterone: Adam's apple protrusion, voice changes, and male pattern baldness; estrogen: breast development); unknown reversibility (effect on fertility) |
| Gender-affirming surgeries | "Top" surgery (to create a male-typical chest shape or enhance breasts); "bottom" surgery (surgery on genitals or reproductive organs); facial feminization and other procedures | Typically adults (adolescents on case-by-case basis[d]) | Not reversible |
| Legal affirmation | Changing gender and name recorded on birth certificate, school records, and other documents | Any | Reversible |

[a] Note that the provided age range and reversibility is based on the little data that are currently available.
[b] There is limited benefit to starting gonadotropin-releasing hormone after Tanner stage 5 for pubertal suppression. However, when cross-sex hormones are initiated with a gradually increasing schedule, the initial levels are often not high enough to suppress endogenous sex hormone secretion. Therefore, gonadotropin-releasing hormone may be continued in accordance with the Endocrine Society Guidelines.[68]
[c] The effect of sustained puberty suppression on fertility is unknown. Pubertal suppression can be, and often is indicated to be, followed by cross-sex hormone treatment. However, when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased.[68]
[d] Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.[68–71]

from 1 gender identity to another. Accordingly, some people who have gone through the process prefer to call themselves "affirmed females, males, etc" (or just "females, males, etc"), rather than using the prefix "trans-." Gender affirmation is also used to acknowledge that some individuals who identify as TGD may feel affirmed in their gender without pursuing medical or surgical interventions.[7,66]

Supportive involvement of parents and family is associated with better mental and physical health outcomes.[67] Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.[64] Most protocols for gender-affirming interventions incorporate World Professional Association of Transgender Health[35] and Endocrine Society[68] recommendations and include ≥1 of the following elements (Table 2):

1. Social Affirmation: This is a reversible intervention in which children and adolescents express partially or completely in their asserted gender identity by adapting hairstyle, clothing, pronouns, name, etc. Children who identify as transgender and socially affirm and are supported in their asserted gender show no increase in depression and only minimal (clinically insignificant) increases in anxiety compared with age-matched averages.[48] Social affirmation can be complicated given the wide range of social interactions children have (eg, extended families, peers, school, community, etc). There is little guidance on the best approach (eg, all at once, gradual, creating new social networks, or affirming within existing networks, etc). Pediatric providers can best support families by anticipating and discussing such complexity proactively, either in their own practice or through enlisting a qualified mental health provider.

2. Legal Affirmation: Elements of a social affirmation, such as a name and gender marker, become official on legal documents, such as birth certificates, passports, identification cards, school documents, etc. The processes for making these changes depend on state laws and may require specific documentation from pediatric providers.

3. Medical Affirmation: This is the process of using cross-sex hormones to allow adolescents who have initiated puberty to develop secondary sex characteristics of the opposite biological sex. Some changes are partially reversible if hormones are stopped, but others become

irreversible once they are fully developed (Table 2).

4. Surgical Affirmation: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults,[35,68] they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.[69–71]

For some youth who identify as TGD whose natal gender is female, menstruation, breakthrough bleeding, and dysmenorrhea can lead to significant distress before or during gender affirmation. The American College of Obstetrics and Gynecology suggests that, although limited data are available to outline management, menstruation can be managed without exogenous estrogens by using a progesterone-only pill, a medroxyprogesterone acetate shot, or a progesterone-containing intrauterine or implantable device.[72] If estrogen can be tolerated, oral contraceptives that contain both progesterone and estrogen are more effective at suppressing menses.[73] The Endocrine Society guidelines also suggest that gonadotrophin-releasing hormones can be used for menstrual suppression before the anticipated initiation of testosterone or in combination with testosterone for breakthrough bleeding (enables phenotypic masculinization at a lower dose than if testosterone is used alone).[68] Masculinizing hormones in natal female patients may lead to a cessation of menses, but unplanned pregnancies have been reported, which emphasizes the need for ongoing contraceptive counseling with youth who identify as TGD.[72]

## HEALTH DISPARITIES

In addition to societal challenges, youth who identify as TGD face several barriers within the health care system, especially regarding access to care. In 2015, a focus group of youth who identified as transgender in Seattle, Washington, revealed 4 problematic areas related to health care:

1. safety issues, including the lack of safe clinical environments and fear of discrimination by providers;
2. poor access to physical health services, including testing for sexually transmitted infections;
3. inadequate resources to address mental health concerns; and
4. lack of continuity with providers.[74]

This study reveals the obstacles many youth who identify as TGD face in accessing essential services, including the limited supply of appropriately trained medical and psychological providers, fertility options, and insurance coverage denials for gender-related treatments.[74]

Insurance denials for services related to the care of patients who identify as TGD are a significant barrier. Although the Office for Civil Rights of the US Department of Health and Human Services explicitly stated in 2012 that the nondiscrimination provision in the Patient Protection and Affordable Care Act includes people who identify as gender diverse,[75,76] insurance claims for gender affirmation, particularly among youth who identify as TGD, are frequently denied.[54,77] In 1 study, it was found that approximately 25% of individuals who identified as transgender were denied insurance coverage because of being transgender.[31] The burden of covering medical expenses that are not covered by insurance can be financially devastating, and even when expenses are covered, families describe high levels of stress in navigating and submitting claims appropriately.[78] In 2012, a large gender center in Boston, Massachusetts, reported that most young patients who identified as transgender and were deemed appropriate candidates for recommended gender care were unable to obtain it because of such denials, which were based on the premise that gender dysphoria was a mental disorder, not a physical one, and that treatment was not medically or surgically necessary.[24] This practice not only contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes,[77] but it may also lead patients to seek nonmedically supervised treatments that are potentially dangerous.[24] Furthermore, insurance denials can reinforce a socioeconomic divide between those who can finance the high costs of uncovered care and those who cannot.[24,77]

The transgender youth group in Seattle likely reflected the larger TGD population when they described how obstacles adversely affect self-esteem and contribute to the perception that they are undervalued by society and the health care system.[74,77] Professional medical associations, including the AAP, are increasingly calling for equity in health care provisions regardless of gender identity or expression.[1,8,23,72] There is a critical need for investments in research on the prevalence, disparities, biological underpinnings, and standards of care relating to gender-diverse populations. Pediatric providers who work with state government and insurance officials can play an essential role in advocating for

stronger nondiscrimination policies and improved coverage.

There is a lack of quality research on the experience of youth of color who identify as transgender. One theory suggests that the intersection of racism, transphobia, and sexism may result in the extreme marginalization that is experienced among many women of color who identify as transgender,[79] including rejection from their family and dropping out of school at younger ages (often in the setting of rigid religious beliefs regarding gender),[80] increased levels of violence and body objectification,[81] 3 times the risk of poverty compared with the general population,[31] and the highest prevalence of HIV compared with other risk groups (estimated as high as 56.3% in 1 meta-analysis).[30] One model suggests that pervasive stigma and oppression can be associated with psychological distress (anxiety, depression, and suicide) and adoption of risk behaviors by such youth to obtain a sense of validation toward their complex identities.[79]

## FAMILY ACCEPTANCE

Research increasingly suggests that familial acceptance or rejection ultimately has little influence on the gender identity of youth; however, it may profoundly affect young people's ability to openly discuss or disclose concerns about their identity. Suppressing such concerns can affect mental health.[82] Families often find it hard to understand and accept their child's gender-diverse traits because of personal beliefs, social pressure, and stigma.[49,83] Legitimate fears may exist for their child's welfare, safety, and acceptance that pediatric providers need to appreciate and address. Families can be encouraged to communicate their concerns and questions. Unacknowledged concerns can contribute to shame and hesitation in regard to offering support and understanding,[84] which is essential for the child's self-esteem, social involvement, and overall health as TGD.[48,85–87] Some caution has been expressed that unquestioning acceptance per se may not best serve questioning youth or their families. Instead, psychological evidence suggests that the most benefit comes when family members and youth are supported and encouraged to engage in reflective perspective taking and validate their own and the other's thoughts and feelings despite divergent views.[49,82]

In this regard, suicide attempt rates among 433 adolescents in Ontario who identified as "trans" were 4% among those with strongly supportive parents and as high as 60% among those whose parents were not supportive.[85] Adolescents who identify as transgender and endorse at least 1 supportive person in their life report significantly less distress than those who only experience rejection. In communities with high levels of support, it was found that nonsupportive families tended to increase their support over time, leading to dramatic improvement in mental health outcomes among their children who identified as transgender.[88]

Pediatric providers can create a safe environment for parents and families to better understand and listen to the needs of their children while receiving reassurance and education.[83] It is often appropriate to assist the child in understanding the parents' concerns as well. Despite expectations by some youth with transgender identity for immediate acceptance after "coming out," family members often proceed through a process of becoming more comfortable and understanding of the youth's gender identity, thoughts, and feelings. One model suggests that the process resembles grieving, wherein the family separates from their expectations for their child to embrace a new reality. This process may proceed through stages of shock, denial, anger, feelings of betrayal, fear, self-discovery, and pride.[89] The amount of time spent in any of these stages and the overall pace varies widely. Many family members also struggle as they are pushed to reflect on their own gender experience and assumptions throughout this process. In some situations, youth who identify as TGD may be at risk for internalizing the difficult emotions that family members may be experiencing. In these cases, individual and group therapy for the family members may be helpful.[49,78]

Family dynamics can be complex, involving disagreement among legal guardians or between guardians and their children, which may affect the ability to obtain consent for any medical management or interventions. Even in states where minors may access care without parental consent for mental health services, contraception, and sexually transmitted infections, parental or guardian consent is required for hormonal and surgical care of patients who identify as TGD.[72,90] Some families may take issue with providers who address gender concerns or offer gender-affirming care. In rare cases, a family may deny access to care that raises concerns about the youth's welfare and safety; in those cases, additional legal or ethical support may be useful to consider. In such rare situations, pediatric providers may want to familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child.

## SAFE SCHOOLS AND COMMUNITIES

Youth who identify as TGD are becoming more visible because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities. Regardless of whether a youth with a gender-diverse

identity ultimately identifies as transgender, challenges exist in nearly every social context, from lack of understanding to outright rejection, isolation, discrimination, and victimization. In the US Transgender Survey of nearly 28 000 respondents, it was found that among those who were out as or perceived to be TGD between kindergarten and eighth grade, 54% were verbally harassed, 24% were physically assaulted, and 13% were sexually assaulted; 17% left school because of maltreatment.[31] Education and advocacy from the medical community on the importance of safe schools for youth who identify as TGD can have a significant effect.

At the time of this writing,* only 18 states and the District of Columbia had laws that prohibited discrimination based on gender expression when it comes to employment, housing, public accommodations, and insurance benefits. Over 200 US cities have such legislation. In addition to basic protections, many youth who identify as TGD also have to navigate legal obstacles when it comes to legally changing their name and/or gender marker.[54] In addition to advocating and working with policy makers to promote equal protections for youth who identify as TGD, pediatric providers can play an important role by developing a familiarity with local laws and organizations that provide social work and legal assistance to youth who identify as TGD and their families.

School environments play a significant role in the social and emotional development of children. Every child has a right to feel safe and respected at school, but for youth who identify as TGD, this can be challenging. Nearly every aspect of school life may present safety concerns and require negotiations regarding their gender expression, including name/pronoun use, use of bathrooms and locker rooms, sports teams, dances and activities, overnight activities, and even peer groups. Conflicts in any of these areas can quickly escalate beyond the school's control to larger debates among the community and even on a national stage.

The formerly known Gay, Lesbian, and Straight Education Network (GLSEN), an advocacy organization for youth who identify as LGBTQ, conducts an annual national survey to measure LGBTQ well-being in US schools. In 2015, students who identified as LGBTQ reported high rates of being discouraged from participation in extracurricular activities. One in 5 students who identified as LGBTQ reported being hindered from forming or participating in a club to support lesbian, gay, bisexual, or transgender students (eg, a gay straight alliance, now often referred to as a genders and sexualities alliance) despite such clubs at schools being associated with decreased reports of negative remarks about sexual orientation or gender expression, increased feelings of safety and connectedness at school, and lower levels of victimization. In addition, >20% of students who identified as LGBTQ reported being blocked from writing about LGBTQ issues in school yearbooks or school newspapers or being prevented or discouraged by coaches and school staff from participating in sports because of their sexual orientation or gender expression.[91]

One strategy to prevent conflict is to proactively support policies and protections that promote inclusion and safety of all students. However, such policies are far from consistent across districts. In 2015, GLSEN found that 43% of children who identified as LGBTQ reported feeling unsafe at school because of their gender expression, but only 6% reported that their school had official policies to support youth who identified as TGD, and only 11% reported that their school's antibullying policies had specific protections for gender expression.[91] Consequently, more than half of the students who identified as transgender in the study were prevented from using the bathroom, names, or pronouns that aligned with their asserted gender at school. A lack of explicit policies that protected youth who identified as TGD was associated with increased reported victimization, with more than half of students who identified as LGBTQ reporting verbal harassment because of their gender expression. Educators and school administrators play an essential role in advocating for and enforcing such policies. GLSEN found that when students recognized actions to reduce gender-based harassment, both students who identified as transgender and cisgender reported a greater connection to staff and feelings of safety.[91] In another study, schools were open to education regarding gender diversity and were willing to implement policies when they were supported by external agencies, such as medical professionals.[92]

Academic content plays an important role in building a safe school environment as well. The 2015 GLSEN survey revealed that when positive representations of people who identified as LGBTQ were included in the curriculum, students who identified as LGBTQ reported less hostile school environments, less victimization and greater feelings of safety, fewer school absences because of feeling unsafe, greater feelings of connectedness to their school

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

community, and an increased interest in high school graduation and postsecondary education.[91] At the time of this writing,* 8 states had laws that explicitly forbade teachers from even discussing LGBTQ issues.[54]

## MEDICAL EDUCATION

One of the most important ways to promote high-quality health care for youth who identify as TGD and their families is increasing the knowledge base and clinical experience of pediatric providers in providing culturally competent care to such populations, as recommended by the recently released guidelines by the Association of American Medical Colleges.[93] This begins with the medical school curriculum in areas such as human development, sexual health, endocrinology, pediatrics, and psychiatry. In a 2009–2010 survey of US medical schools, it was found that the median number of hours dedicated to LGBTQ health was 5, with one-third of US medical schools reporting no LGBTQ curriculum during the clinical years.[94]

During residency training, there is potential for gender diversity to be emphasized in core rotations, especially in pediatrics, psychiatry, family medicine, and obstetrics and gynecology. Awareness could be promoted through the inclusion of topics relevant to caring for children who identify as TGD in the list of core competencies published by the American Board of Pediatrics, certifying examinations, and relevant study materials. Continuing education and maintenance of certification activities can include topics relevant to TGD populations as well.

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@ aap.org.

## RECOMMENDATIONS

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;
2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;
3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;
4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;
5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families;
6. that pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;
7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;
8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and
9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.


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## ABBREVIATIONS

AAP: American Academy of Pediatrics
GACM: gender-affirmative care model
GLSEN: Gay, Lesbian, and Straight Education Network
LGBTQ: lesbian, gay, bisexual, transgender, or questioning
TGD: transgender and gender diverse


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## REFERENCES


1. Levine DA; Committee on Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 2013;132(1). Available at: www.pediatrics.org/cgi/content/full/132/1/e297
2. American Academy of Pediatrics Committee on Adolescence. Homosexuality and adolescence. *Pediatrics*. 1983;72(2):249–250
3. Institute of Medicine; Committee on Lesbian Gay Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011. Available at: https://www.ncbi.nlm.nih.gov/books/NBK64806. Accessed May 19, 2017
4. Deutsch MB, Radix A, Reisner S. What's in a guideline? Developing collaborative and sound research designs that substantiate best practice recommendations for transgender health care. *AMA J Ethics*. 2016;18(11):1098–1106
5. Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016
6. Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192
7. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non-binary or genderqueer genders. *Int Rev Psychiatry*. 2016;28(1):95–102
8. American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol*. 2015;70(9):832–864
9. Flores AR, Herman JL, Gates GJ, Brown TNT. *How Many Adults Identify as Transgender in the United States*. Los Angeles, CA: The Williams Institute; 2016
10. Herman JL, Flores AR, Brown TNT, Wilson BDM, Conron KJ. *Age of Individuals Who Identify as Transgender in the United States*. Los Angeles, CA: The Williams Institute; 2017
11. Gates GJ. *How Many People are Lesbian, Gay, Bisexual, and Transgender?* Los Angeles, CA: The Williams Institute; 2011
12. Olson J, Schrager SM, Belzer M, Simons LK, Clark LF. Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *J Adolesc Health*. 2015;57(4):374–380
13. Reisner SL, Vetters R, Leclerc M, et al. Mental health of transgender youth in care

at an adolescent urban community health center: a matched retrospective cohort study. *J Adolesc Health*. 2015;56(3):274–279

14. Clements-Nolle K, Marx R, Katz M. Attempted suicide among transgender persons: the influence of gender-based discrimination and victimization. *J Homosex*. 2006;51(3):53–69
15. Colizzi M, Costa R, Todarello O. Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*. 2014;39:65–73
16. Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. 2011;58(1):10–51
17. Maguen S, Shipherd JC. Suicide risk among transgender individuals. *Psychol Sex*. 2010;1(1):34–43
18. Connolly MD, Zervos MJ, Barone CJ II, Johnson CC, Joseph CL. The mental health of transgender youth: advances in understanding. *J Adolesc Health*. 2016;59(5):489–495
19. Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. *Suicide Life Threat Behav*. 2007;37(5):527–537
20. Spack NP, Edwards-Leeper L, Feldman HA, et al. Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*. 2012;129(3):418–425
21. van Schalkwyk GI, Klingensmith K, Volkmar FR. Gender identity and autism spectrum disorders. *Yale J Biol Med*. 2015;88(1):81–83
22. Jacobs LA, Rachlin K, Erickson-Schroth L, Janssen A. Gender dysphoria and co-occurring autism spectrum disorders: review, case examples, and treatment considerations. *LGBT Health*. 2014;1(4):277–282
23. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association; 2013
24. Edwards-Leeper L, Spack NP. Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "Gender Management Service" (GeMS) in a major pediatric center. *J Homosex*. 2012;59(3):321–336
25. Anton BS. Proceedings of the American Psychological Association for the legislative year 2008: minutes of the annual meeting of the Council of Representatives, February 22–24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors. *Am Psychol*. 2009;64(5):372–453
26. Drescher J, Haller E; American Psychiatric Association Caucus of Lesbian, Gay and Bisexual Psychiatrists. *Position Statement on Discrimination Against Transgender and Gender Variant Individuals*. Washington, DC: American Psychiatric Association; 2012
27. Hidalgo MA, Ehrensaft D, Tishelman AC, et al. The gender affirmative model: what we know and what we aim to learn. *Hum Dev*. 2013;56(5):285–290
28. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, Shumer DE, Spack NP. Serving transgender youth: challenges, dilemmas and clinical examples. *Prof Psychol Res Pr*. 2015;46(1):37–45
29. Adelson SL; American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *J Am Acad Child Adolesc Psychiatry*. 2012;51(9):957–974
30. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N; HIV/AIDS Prevention Research Synthesis Team. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav*. 2008;12(1):1–17
31. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality; 2016
32. Centers for Disease Control and Prevention. *CDC-Funded HIV Testing: United States, Puerto Rico, and the U.S. Virgin Islands*. Atlanta, GA: Centers for Disease Control and Prevention; 2015. Available at: https://www.cdc.gov/hiv/pdf/library/reports/cdc-hiv-funded-testing-us-puerto-rico-2015.pdf. Accessed August 2, 2018
33. Substance Abuse and Mental Health Services Administration. *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2015
34. Korell SC, Lorah P. An overview of affirmative psychotherapy and counseling with transgender clients. In: Bieschke KJ, Perez RM, DeBord KA, eds. *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients*. 2nd ed. Washington, DC: American Psychological Association; 2007:271–288
35. World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 7th ed. Minneapolis, MN: World Professional Association for Transgender Health; 2011. Available at: https://www.wpath.org/publications/soc. Accessed April 15, 2018
36. Menvielle E. A comprehensive program for children with gender variant behaviors and gender identity disorders. *J Homosex*. 2012;59(3):357–368
37. Hill DB, Menvielle E, Sica KM, Johnson A. An affirmative intervention for families with gender variant children: parental ratings of child mental health and gender. *J Sex Marital Ther*. 2010;36(1):6–23
38. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol*. 1994;62(2):221–227
39. Byne W. Regulations restrict practice of conversion therapy. *LGBT Health*. 2016;3(2):97–99
40. Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. The treatment of adolescent transsexuals: changing insights. *J Sex Med*. 2008;5(8):1892–1897

41. Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Soc Policy*. 2006;3(3):23–39

42. World Professional Association for Transgender Health. *WPATH De-Psychopathologisation Statement*. Minneapolis, MN: World Professional Association for Transgender Health; 2010. Available at: https://www.wpath.org/policies. Accessed April 16, 2017

43. American Academy of Pediatrics. AAP support letter conversion therapy ban [letter]. 2015. Available at: https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Documents/AAPsupportletterconversiontherapyban.pdf. Accessed August 1, 2018

44. Movement Advancement Project. *LGBT Policy Spotlight: Conversion Therapy Bans*. Boulder, CO: Movement Advancement Project; 2017. Available at: http://www.lgbtmap.org/policy-and-issue-analysis/policy-spotlight-conversion-therapy-bans. Accessed August 6, 2017

45. Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Keo-Meier C. Prepubertal social gender transitions: what we know; what we can learn—a view from a gender affirmative lens. *Int J Transgend*. 2018;19(2):251–268

46. Olson KR, Key AC, Eaton NR. Gender cognition in transgender children. *Psychol Sci*. 2015;26(4):467–474

47. Olson KR. Prepubescent transgender children: what we do and do not know. *J Am Acad Child Adolesc Psychiatry*. 2016;55(3):155–156.e3

48. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics*. 2016;137(3):e20153223

49. Malpas J. Between pink and blue: a multi-dimensional family approach to gender nonconforming children and their families. *Fam Process*. 2011;50(4):453–470

50. Hagan JF Jr, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove, IL: American Academy of Pediatrics; 2016

51. Minter SP. Supporting transgender children: new legal, social, and medical approaches. *J Homosex*. 2012;59(3):422–433

52. AHIMA Work Group. Improved patient engagement for LGBT populations: addressing factors related to sexual orientation/gender identity for effective health information management. *J AHIMA*. 2017;88(3):34–39

53. Deutsch MB, Green J, Keatley J, Mayer G, Hastings J, Hall AM; World Professional Association for Transgender Health EMR Working Group. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. *J Am Med Inform Assoc*. 2013;20(4):700–703

54. Dowshen N, Meadows R, Byrnes M, Hawkins L, Eder J, Noonan K. Policy perspective: ensuring comprehensive care and support for gender nonconforming children and adolescents. *Transgend Health*. 2016;1(1):75–85

55. Cahill SR, Baker K, Deutsch MB, Keatley J, Makadon HJ. Inclusion of sexual orientation and gender identity in stage 3 meaningful use guidelines: a huge step forward for LGBT health. *LGBT Health*. 2016;3(2):100–102

56. Mansfield MJ, Beardsworth DE, Loughlin JS, et al. Long-term treatment of central precocious puberty with a long-acting analogue of luteinizing hormone-releasing hormone. Effects on somatic growth and skeletal maturation. *N Engl J Med*. 1983;309(21):1286–1290

57. Olson J, Garofalo R. The peripubertal gender-dysphoric child: puberty suppression and treatment paradigms. *Pediatr Ann*. 2014;43(6):e132–e137

58. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med*. 2011;8(8):2276–2283

59. Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008;47(12):1413–1423

60. Waylen A, Wolke D. Sex 'n' drugs 'n' rock 'n' roll: the meaning and social consequences of pubertal timing. *Eur J Endocrinol*. 2004;151(suppl 3):U151–U159

61. de Vries AL, Klink D, Cohen-Kettenis PT. What the primary care pediatrician needs to know about gender incongruence and gender dysphoria in children and adolescents. *Pediatr Clin North Am*. 2016;63(6):1121–1135

62. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017;95:11–19

63. Finlayson C, Johnson EK, Chen D, et al. Proceedings of the working group session on fertility preservation for individuals with gender and sex diversity. *Transgend Health*. 2016;1(1):99–107

64. Kreukels BP, Cohen-Kettenis PT. Puberty suppression in gender identity disorder: the Amsterdam experience. *Nat Rev Endocrinol*. 2011;7(8):466–472

65. Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab*. 2014;99(12):4379–4389

66. Fenway Health. *Glossary of Gender and Transgender Terms*. Boston, MA: Fenway Health; 2010. Available at: http://fenwayhealth.org/documents/the-fenway-institute/handouts/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Accessed August 16, 2017

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

68. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869–3903

69. Milrod C, Karasic DH. Age is just a number: WPATH-affiliated surgeons' experiences and attitudes toward

vaginoplasty in transgender females under 18 years of age in the United States. *J Sex Med*. 2017;14(4):624–634

70. Milrod C. How young is too young: ethical concerns in genital surgery of the transgender MTF adolescent. *J Sex Med*. 2014;11(2):338–346

71. 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;172(5):431–436

72. Committee on Adolescent Health Care. Committee opinion no. 685: care for transgender adolescents. *Obstet Gynecol*. 2017;129(1):e11–e16

73. Greydanus DE, Patel DR, Rimsza ME. Contraception in the adolescent: an update. *Pediatrics*. 2001;107(3):562–573

74. Gridley SJ, Crouch JM, Evans Y, et al. Youth and caregiver perspectives on barriers to gender-affirming health care for transgender youth. *J Adolesc Health*. 2016;59(3):254–261

75. Sanchez NF, Sanchez JP, Danoff A. Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *Am J Public Health*. 2009;99(4):713–719

76. Transgender Law Center. *Affordable Care Act Fact Sheet*. Oakland, CA: Transgender Law Center; 2016. Available at: https://transgenderlawcenter.org/resources/health/aca-fact-sheet. Accessed August 8, 2016

77. Nahata L, Quinn GP, Caltabellotta NM, Tishelman AC. Mental health concerns and insurance denials among transgender adolescents. *LGBT Health*. 2017;4(3):188–193

78. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011 Available at: http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf. Accessed August 6, 2018

79. Sevelius JM. Gender affirmation: a framework for conceptualizing risk behavior among transgender women of color. *Sex Roles*. 2013;68(11–12):675–689

80. Koken JA, Bimbi DS, Parsons JT. Experiences of familial acceptance-rejection among transwomen of color. *J Fam Psychol*. 2009;23(6):853–860

81. Lombardi EL, Wilchins RA, Priesing D, Malouf D. Gender violence: transgender experiences with violence and discrimination. *J Homosex*. 2001;42(1):89–101

82. Wren B. 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': dilemmas in parenting a transgendered adolescent. *Clin Child Psychol Psychiatry*. 2002;7(3):377–397

83. Riley EA, Sitharthan G, Clemson L, Diamond M. The needs of gender-variant children and their parents: a parent survey. *Int J Sex Health*. 2011;23(3):181–195

84. Whitley CT. Trans-kin undoing and redoing gender: negotiating relational identity among friends and family of transgender persons. *Sociol Perspect*. 2013;56(4):597–621

85. Travers R, Bauer G, Pyne J, Bradley K, Gale L, Papadimitriou M; Trans PULSE; Children's Aid Society of Toronto; Delisle Youth Services. *Impacts of Strong Parental Support for Trans Youth: A Report Prepared for Children's Aid Society of Toronto and Delisle Youth Services*. Toronto, ON: Trans PULSE; 2012. Available at: http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf

86. Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J. Family acceptance in adolescence and the health of LGBT young adults. *J Child Adolesc Psychiatr Nurs*. 2010;23(4):205–213

87. Grossman AH, D'augelli AR, Frank JA. Aspects of psychological resilience among transgender youth. *J LGBT Youth*. 2011;8(2):103–115

88. McConnell EA, Birkett M, Mustanski B. Families matter: social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *J Adolesc Health*. 2016;59(6):674–680

89. Ellis KM, Eriksen K. Transsexual and transgenderist experiences and treatment options. *Fam J Alex Va*. 2002;10(3):289–299

90. Lamda Legal. *Transgender Rights Toolkit: A Legal Guide for Trans People and Their Advocates*. New York, NY: Lambda Legal; 2016 Available at: https://www.lambdalegal.org/publications/trans-toolkit. Accessed August 6, 2018

91. Kosciw JG, Greytak EA, Giga NM, Villenas C, Danischewski DJ. *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools*. New York, NY: GLSEN; 2016. Available at: https://www.glsen.org/article/2015-national-school-climate-survey. Accessed August 8, 2018

92. McGuire JK, Anderson CR, Toomey RB, Russell ST. School climate for transgender youth: a mixed method investigation of student experiences and school responses. *J Youth Adolesc*. 2010;39(10):1175–1188

93. Association of American Medical Colleges Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. In: Hollenback AD, Eckstrand KL, Dreger A, eds. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*. Washington, DC: Association of American Medical Colleges; 2014. Available at: https://members.aamc.org/eweb/upload/Executive LGBT FINAL.pdf. Accessed August 8, 2018

94. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971–977

ENDOCRINE SOCIETY
Hormone Science to Health

PES PEDIATRIC ENDOCRINE SOCIETY

# TRANSGENDER HEALTH POSITION STATEMENT

## INTRODUCTION

Over the last few decades, there has been a rapid expansion in the understanding of gender identity along with the implications for the care of transgender and gender diverse individuals. In parallel with the greater societal awareness of transgender individuals, evidence-based practices in caring for pediatric and adult transgender patients have been developed in response to scientific research. While there continue to be gaps in knowledge about the optimal care for transgender individuals, the framework for providing care is increasingly well-established as is the recognition of needed policy changes.

## BACKGROUND

The medical consensus in the late 20th century was that transgender and gender incongruent individuals suffered a mental health disorder termed "gender identity disorder." Gender identity was considered malleable and subject to external influences. Today, however, this attitude is no longer considered valid. Considerable scientific evidence has emerged demonstrating a durable biological element underlying gender identity.[1,2] Individuals may make choices due to other factors in their lives, but there do not seem to be external forces that genuinely cause individuals to change gender identity.

Although the specific mechanisms guiding the biological underpinnings of gender identity are not entirely understood, there is evolving consensus that being transgender is not a mental health disorder. Such evidence stems from scientific studies suggesting that: 1) attempts to change gender identity in intersex patients to match external genitalia or chromosomes are typically unsuccessful[1,2]; 2) identical twins (who share the exact same genetic background) are more likely to both experience transgender identity as compared to fraternal (non-identical) twins[3]; 3) among individuals with female chromosomes (XX), rates of male gender identity are higher for those exposed to higher levels of androgens *in utero* relative to those without such exposure, and male (XY)-chromosome individuals with complete androgen insensitivity syndrome typically have female gender identity[4]; and 4) there are associations of certain brain scan or staining patterns with gender identity rather than external genitalia or chromosomes.[1,2]

## CONSIDERATIONS

Transgender individuals are often denied insurance coverage for appropriate medical and psychological treatment. Those gender diverse youth who have barriers to accessing adequate healthcare have poorer overall physical and mental health compared to their cisgender peers.[5] Over the last decade, there has been considerable research on and development of evidence-based standards of care that have proven to be both safe and efficacious for the treatment of gender dysphoria/gender incongruence in youth and adults. There is also a growing understanding of the positive impact that increased access to such treatments can have on the mental health of these individuals.

The Endocrine Society's Clinical Practice Guideline on gender dysphoria/gender incongruence[6] provides the standard of care for supporting transgender individuals. The guideline establishes a methodical, conservative framework for gender-affirming care, including pubertal suppression, hormones and surgery and standardizes terminology to be used by healthcare professionals. These recommendations include evidence that treatment of gender dysphoria/incongruence is medically necessary and should be covered by insurance.

Despite increased awareness, many barriers to improving the health and well-being of transgender youth and adults remain. Oftentimes, medical treatment for gender dysphoria/gender incongruence is considered elective by insurance companies, which fail to provide coverage for physician-prescribed treatment. Access to appropriately trained healthcare professionals can also be challenging as there


[1]Saraswat A, Weinand JD, Safer JD. Evidence supporting the biologic nature of gender identity. *Endocr Pract.* Feb 2015;21(2):199-204. doi:10.4158/ep14351.ra

[2]Rosenthal SM. Approach to the patient: transgender youth: endocrine considerations. *J Clin Endocrinol Metab.* Dec 2014;99(12):4379-89. doi:10.1210/jc.2014-1919

[3]Heylens G, De Cuypere G, Zucker KJ, et al. Gender identity disorder in twins: a review of the case report literature. *J Sex Med.* Mar 2012;9(3):751-7. doi:10.1111/j.1743-6109.2011.02567.x

[4]Dessens AB, Slijper FM, Drop SL. Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Arch Sex Behav.* Aug 2005;34(4):389-97. doi:10.1007/s10508-005-4338-5

[5]Rider GN, McMorris BJ, Gower AL, Coleman E, Eisenberg ME. Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. *Pediatrics.* 2018;141(3):e20171683. doi:10.1542/peds.2017-1683

[6]Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* Nov 1 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658

is a lack of formal education on gender dysphoria/gender incongruence among clinicians trained in the United States. A 2016 survey of endocrinologists, the physicians most likely to care for these patients, found that over 80% have never received training on care of transgender patients.[7]

This can have an adverse impact on patient outcomes, particularly in rural and underserved areas. In fact, studies have indicated that 70% of transgender individuals have experienced maltreatment by medical providers, including harassment and violence.[7] Many transgender individuals have been subjected to conversion therapy, or efforts to change a transgender person's gender identity using psychological interventions; this is known to be associated with adverse mental health outcomes, including suicidality, and is banned in 20 states and the District of Columbia.[8]

Transgender individuals who have been denied care show an increased likelihood of dying by suicide and engaging in self-harm.[7] Transgender/gender incongruent youth who had access to pubertal suppression, a treatment which is fully reversible and prevents development of secondary sex characteristics not in alignment with their gender identity, have lower lifetime odds of suicidal ideation compared to those youth who desired pubertal suppression but did not have access to such treatment.[9] Youth who are able to access gender-affirming care, including pubertal suppression, hormones and surgery based on conservative medical guidelines and consultation from medical and mental health experts, experience significantly improved mental health outcomes over time, similar to their cis-gender peers.[10-12] Pre-pubertal youth who are supported and affirmed in their social transitions long before medical interventions are indicated, experience no elevation in depression compared to their cis-gender peers.[12] It is critical that transgender individuals have access to the appropriate treatment and care to ensure their health and well-being.

## FUTURE CONSIDERATIONS

While the data are strong for both a biological underpinning to gender identity and the relative safety of hormone treatment (when appropriately monitored medically), there are gaps in knowledge that are necessary to address in order to optimize care. Comparative effectiveness research in hormone regimens is needed to determine: the best endocrine and surgical protocols[13], as it is not yet known if certain regimens are safer or more effective than others; the degree of improvement as a result of the intervention (e.g. decrease in mental health diagnoses); the need for training of health care providers and the most effective training methods; and to build the body of evidence pertaining to cardiovascular, malignancy, or other long-term risks from hormone interventions, particularly as the transgender individual ages. Additional studies are needed to elucidate the biological processes underlying gender identity; such studies may lead to destigmatization and may also decrease health disparities for gender minorities. In addition, further studies are needed to determine strategies for fertility preservation and to investigate long-term outcomes of early medical intervention, including pubertal suppression, gender-affirming hormones and gender-affirming surgeries for transgender/gender incongruent youth. To successfully establish and enact these protocols requires long-term, large-scale studies across countries that employ similar care protocols.

## POSITIONS

- There is a durable biological underpinning to gender identity that should be considered in policy determinations.
- Medical intervention for transgender youth and adults (including puberty suppression, hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.[6] Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have.
- Increased funding for national pediatric and adult transgender health research programs is needed to close the gaps in knowledge regarding transgender medical care and should be made a priority.

[7]Davidge-Pitts C, Nippoldt TB, Danoff A, Radziejewski L, Natt N. Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Programs and Practicing Clinicians. *J Clin Endocrinol Metab*. Apr 1 2017;102(4):1286-1290. doi:10.1210/jc.2016-3007

[8]Turban JL, Beckwith N, Reisner SL, Keuroghlian AS. Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*. Sep 11 2019;77(1):1-9. doi:10.1001/jamapsychiatry.2019.2285

[9]Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. Feb 2020;145(2)doi:10.1542/peds.2019-1725

[10]de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. Oct 2014;134(4):696-704. doi:10.1542/peds.2013-2958

[11]Kuper LE, Stewart S, Preston S, Lau M, Lopez X. Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*. Apr 2020;145(4)doi:10.1542/peds.2019-3006

[12]Achille C, Taggart T, Eaton NR, et al. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *Int J Pediatr Endocrinol*. 2020;2020:8. doi:10.1186/s13633-020-00078-2

[13]Safer JD, Tangpricha V. Care of the Transgender Patient. *Ann Intern Med*. Jul 2 2019;171(1):ltc1-itc16. doi:10.7326/aitc201907020