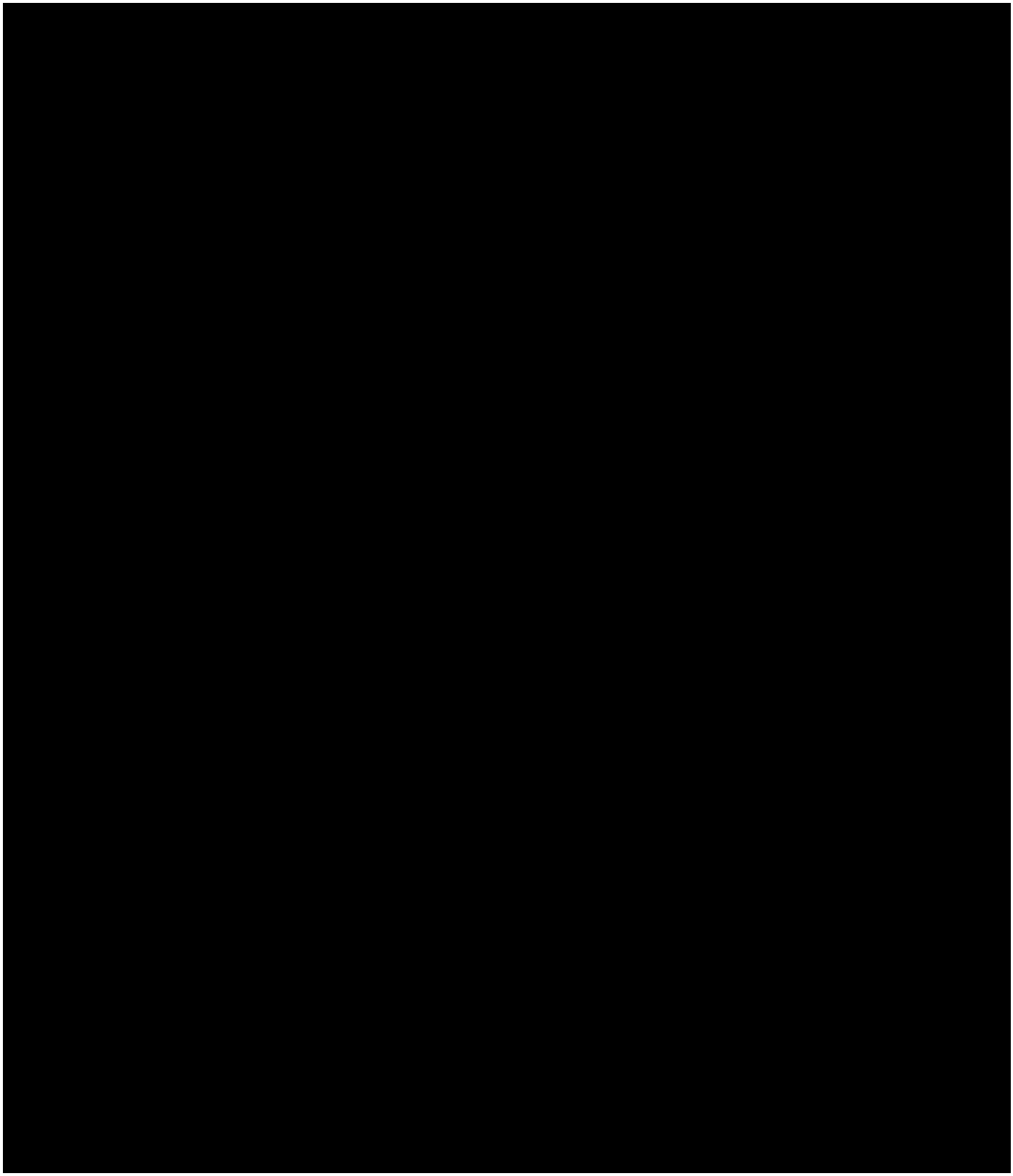
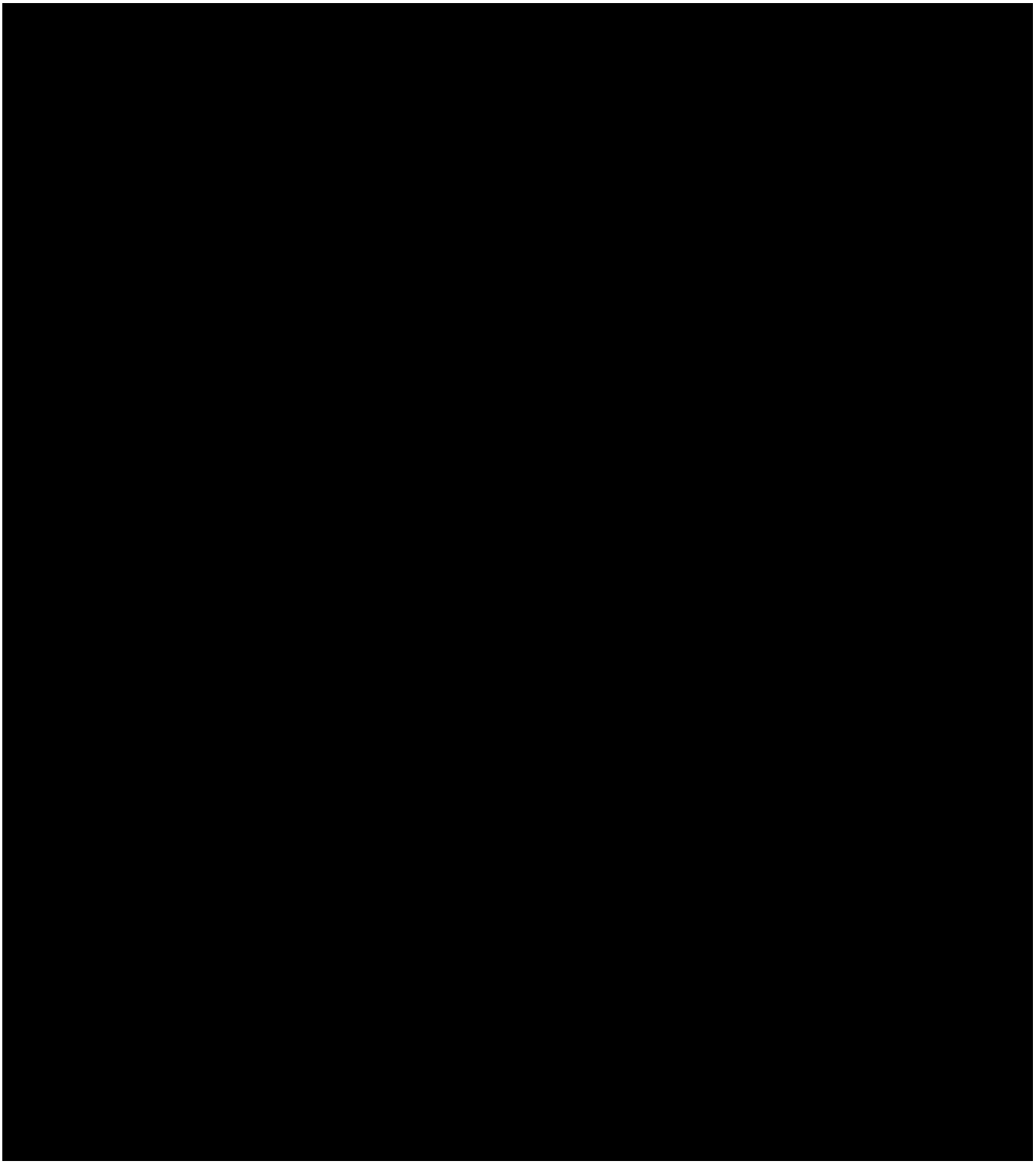
Doc. 560-37
Defendants' Summary Judgment Exhibit 187 (Redacted)





CONFIDENTIAL SOC8 PDF - not being released tomorrow

From: [redacted]
To: Eli Coleman <[redacted]
Cc: [redacted]
Date: Mon, 05 Sep 2022 12:50:01 -0400
Attachments: WIJT 23(S1).pdf (13.08 MB)

Dear Eli, [redacted]

It was a reasonably constructive meeting today and I hope this [redacted] will deliver.

I have no time for (further) political interference: TGD health is not a vote winner in the US - no matter how long you "pause" its release.

Just wanted to share with you the PDF that contains what was going to be published tomorrow. I think it looks very nice and hope that we can celebrate the online release of the SOC8 in the not too distant future.

Thank you for your amazing support,

[redacted]

[redacted]

CONFIDENTIAL Re: WPATH SOC8 endorsements/statements from Global/US Professional Societies/Associations

From: Walter Bouman [redacted]
To: [redacted]
Cc:
Date: Tue, 06 Sep 2022 08:07:48 -0400
Attachments: WIJT 23(S1).pdf (13.08 MB); 05.09.22 SOC8 Final edit WPB.pdf (12.52 MB)

Hi Loren,

Thanks for that. Their endorsements would be very very helpful.

I don't think you need to (re-)sign any NDA, but if any of your colleagues want to read it, please let them reach out to Blaine.

I am sending you 2 copies in confidence:

1. One is the SOC8 as it should have appeared online today

2. The other version is one with my edits to remove the minimum age limits for adolescents

This can be done quite easily. I do not want to delay the release of the SOC8 any further than is strictly necessary and I do think that the AAP will have to come with very persuasive and evidence based arguments as to why they would like us to make any further changes (other than the odd sentence and odd reference).

Jon and I checked all comments made during the public comment period in December2021/January2022 and there were no comments from the AAP. So, whilst I am not suspicious by nature, I am getting the distinct impression that we are being set up and that there are significant political issues that are being played out at the cost of a our current and prospective patients regarding a sound clinical document which followed a global clinical consensus process. I have not heard any convincing factual arguments other than scaremongering, TikTok, and supposition.

Anyhow, I am still very angry, but let's see what the AAP comes with. I am not bothered about the Trevor Project: we need medical support for fellow organisations to increase our legitimacy.

Warmest,

Walter

Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief *International Journal of Transgender Health* (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health

[redacted]

On 2022-09-06 12:13, Loren Schechter, M.D. wrote:

Hello Walter

I will check in with ASPS, and I have a call with ASGS this evening. ASGS is reorganized (or being reorganized) into
WSGS (world society). We haven't received an embargoed copy of the final
document. I would be glad to sign (or re-sign an NDA on the part of the group). The group has read the and reviewed the document during the public comment period (and I don't believe that much was changed)

Thanks

Loren

Sent from my iPhone

> On Sep 6, 2022, at 5:27 AM, Walter Bouman <[redacted]> wrote:
>
> Hi Loren,
>
> I am trying to muster as much support for the SOC8 as I can: we have ISSM and WAS's endorsements, so that is a step in the right direction.
>
> Any updates on ASPS and ASGS?
>
> I have looked at the Surgery chapter in depth yesterday following our meeting, and there is nothing that mentionns specific ages, other than the Table with suggestions for minimal ages for hormones and surgeries, which I am willing to scrap/delete, but that is as far as it goes.
>
> Anyhow, speak soon,
>
> Warmest,
>
> Walter
>
> Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief *International Journal of Transgender Health* (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health

[redacted]

On 2022-06-11 16:23, Walter Bouman wrote:

> Cheers Loren,
>
> That is great! Thank you so much!!
>
> Yes, we can make a full list on Wednesday and a plan of action who does what.
>
> I have approached the American Psychological Association, the American Psychiatric Association, Williams Institute, VA, Endocrine Society, World Psychiatric Association amongst others and we can expand our list as we see is fit.
>
> Cindi can use all the quotes (providing they are positive and constructive) for our press releases and promoting (and defending) the SOC-8 following its release.
>
> Have a great weekend,
>
> Warmest,
>
> Walter
>
> ---
>
> Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD
>
> Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK
>
> President World Professional Association for Transgender Health (WPATH)
>
> Editor-in-Chief *International Journal of Transgender Health* (Impact Factor 2020 = 5.333)
>
> Nottingham National Centre for Transgender Health

[redacted]

On 2022-06-11 16:17, Loren Schechter, M.D. wrote:

Hello Walter-yes. I can help with both. I will call the president of ASPS who is a friend of mine. I can do it on behalf of ASGS as well.

I would also consider urology and gynecology societies. I can speak to colleagues in both. We can also include American, European, and possibly Asian and or South American organizations as well

Thank you and enjoy the weekend, and looking forward to discussing

Loren

Sent from my iPhone

> On Jun 11, 2022, at 9:29 AM, Walter Bouman <[redacted]> wrote:
>
> Dear Loren,
>
> I hope this email find you well! And I hope you are enjoying your weekend!!
>
> As you know the SOC8 has been completed and we are going through the final (minute) edits before submission for online, Open Access publication in the International Journal of Transgender Health.
>
> Quick question: we are looking for someone (Executive Director/CEO/President, etc.) who would be willing to provide a short opinion/view regarding the SOC8 on behalf of the ASPS and/or ASGS. We are not asking for an official endorsement (although that would be wonderful too! - but I realise there may be a specific process for this), but simply a few sentences pertaining to the SOC8 on behalf of the ASPS and/or ASGS (which we can use in our Press releases and other materials to promote and "defend" the SOC8.
>
> Do you know anyone that can be approached and who has the authority to provide such opinion on behalf of the ASPS/ASGS? And if so, do you think it would be better for you to approach them directly, or do you think that I should approach them?
>
> Also, do you know of any other Society's we could approach on behalf of WPATH?
>
> With kind regards, and looking forward to your response,
>
> We will also discuss this issue further at next Wednesday's EC,

Walter

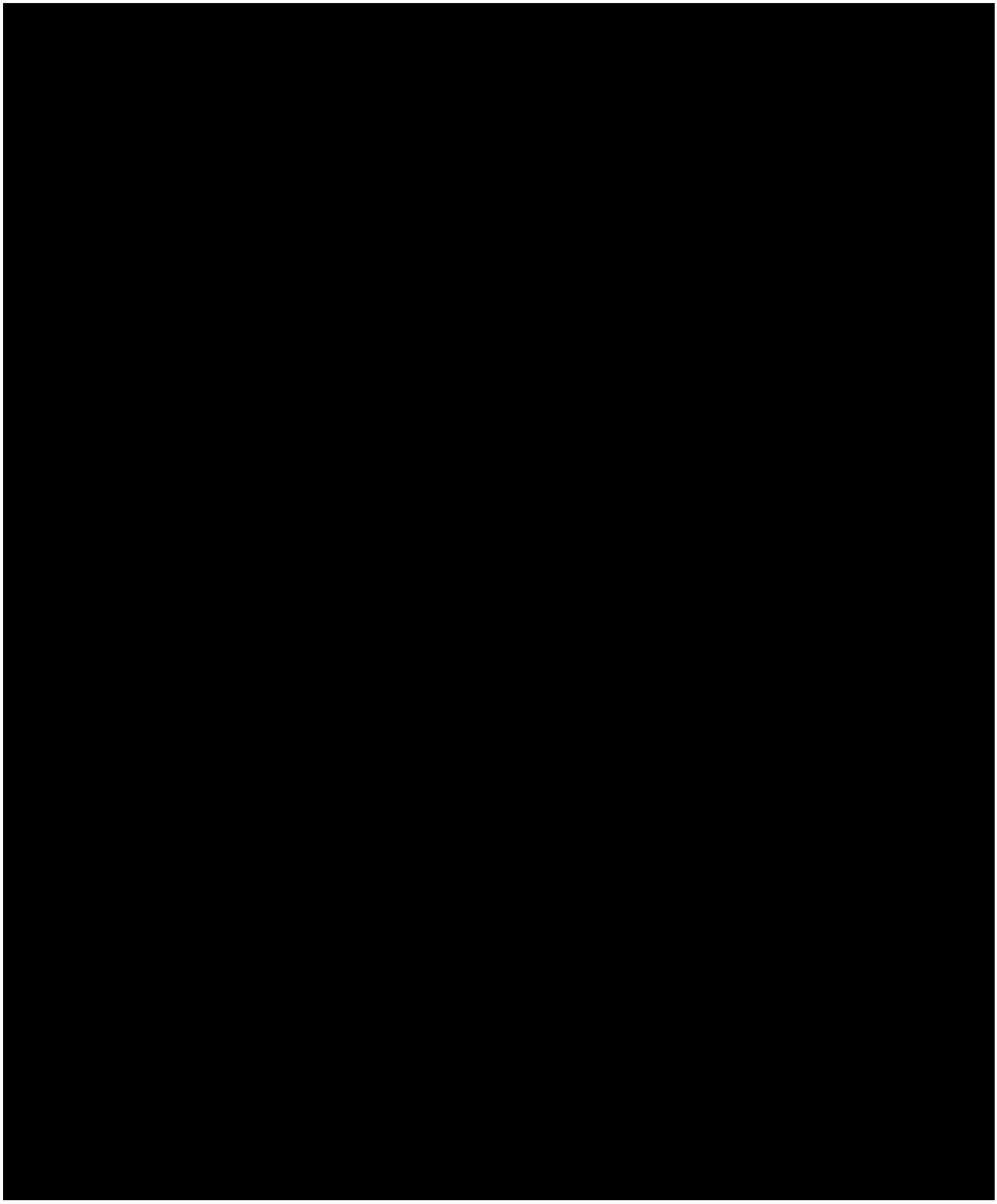
Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

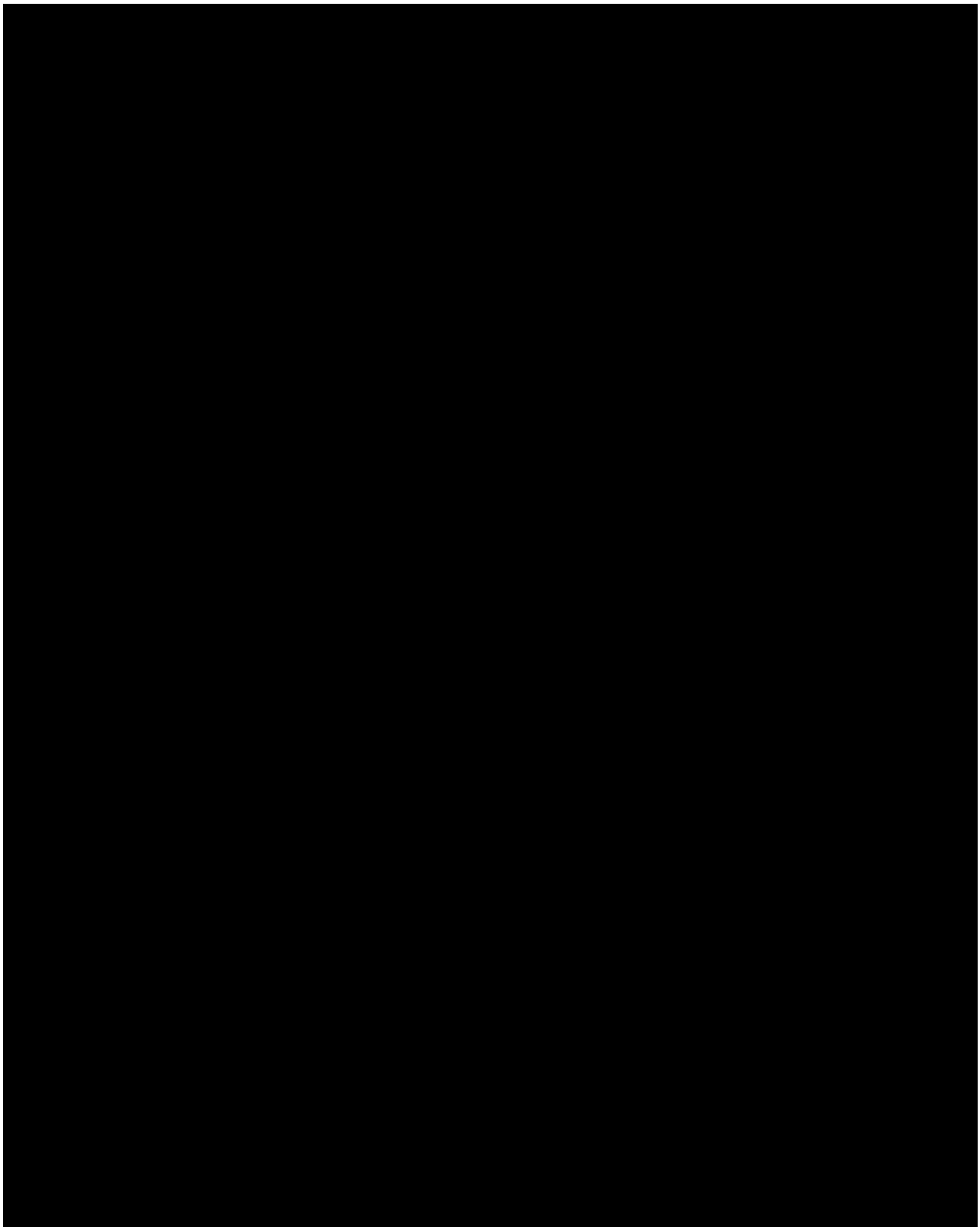
Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief *International Journal of Transgender Health* (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health





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[redacted] [redacted]

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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September 8, 2022

Walter Pierre Bouman MD, MA, MSc, UKCPreg, PhD
President, World Professional Association for Transgender Health (WPATH)
[redacted]

Dear Dr Bouman and [redacted]

Thank you for providing the American Academy of Pediatrics (AAP) with an opportunity to review Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC 8). We value the shared commitment to ensuring that transgender and gender diverse children and adolescents have access to evidence-based, medically necessary care in the United States and around the world.

AAP experts from the Section on LGBT Health and Wellness and the Section on Endocrinology recently completed a review of SOC 8. AAP experts reviewed the following pediatric focused chapters: Chapter 6-Adolescents, Chapter 7-Children, and Chapter 12-Hormone Therapy. While many areas of SOC 8 align with AAP policy (Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents), there are some portions of the final version that raise concerns for our clinical experts. While the attached PDF contains more detailed comments, we have highlighted a few specific issues for your consideration:

Chapter 6 Adolescents

- SOC 8 recommendations for gender-affirming surgery do not align with AAP policy. The AAP does not recommend surgery for minors except on an individualized, case-by-case basis with parental involvement and consent. Additionally, AAP experts agree SOC 8 lacks the evidence to justify the recommended surgery ages.

- Chapter 6 includes several anti-transgender arguments, such as social contagion, rapid onset gender dysphoria, desistence/persistence, and others, perhaps intended to demonstrate the lack of research and evidence behind these conclusions. However, our experts believe including these discussions/arguments will achieve the opposite effect. The AAP reviewers believe that the current framing of this section implies that WPATH, while not endorsing these arguments, gives validity to them and does so without the necessary supporting evidence. As written, the discussions about persistence/desistence support a view for social contagion because gender development is discussed from a social cognitive lens rather than citing data and other scientific evidence needed to consider these conditions.

As written, this section creates confusion and obscures the need to consider external factors that play a role in each patient's care, and that gender dysphoria is different for every child/adolescent. The AAP recommends the removal of theories or unsubstantiated claims that do not have sufficient evidence to be conclusions.

- The discussions on family involvement and support in gender-affirming care in Chapter 6 are crucial albeit not well-defined. Chapter 7 provides a framework for Chapter 6 to follow as it relates to family involvement and support. Chapter 7 clearly discusses complex gender expression in young children and consistent messaging about this care being developmentally mindful, family centered, and individualized while also discussing developmental trauma, culture, and stigma that may affect transgender and gender-diverse children. AAP recommends that Chapter 6 be reframed to better align with Chapter 7.

The AAP and WPATH share a common goal in ensuring that gender-affirming care is accessible and evidence-based, and that transgender and gender-diverse youth can lead healthy, fulfilling lives as their true selves. To that end, we are committed to working with WPATH and would request the opportunity for our subject-matter experts to meet with you to discuss these important matters upon receipt of this communication.

Thank you for your consideration.

Sincerely,

Moira A. Szilagyi, MD, PhD, FAAP
President

MAS/jh

CHAPTER 6 Adolescents

Historical context and changes since previous Standards of Care

Specialized health care for transgender adolescents began in the 1980s when a few specialized gender clinics for youth were developed around the world that served relatively 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, Bergman et al., 2020). Since then, new clinics have been founded, but clinical services in many places have not kept pace with the increasing number of youth seeking care. Hence, there are often long waitlists for services, and barriers to care exist for many transgender youth around the world (Tollit et al., 2018).

Until recently, there was limited information regarding the prevalence of gender diversity among adolescents. Studies from high school samples indicate much higher rates than earlier thought, with reports of up to 1.2% of participants 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; Kidd et al., 2021; Wang et al., 2020). These studies suggest gender diversit in outh should no lon er be viewed as rare. Additionall , a attern of uneven ratios b assi ned sex has been re orted in ender clinics, with adolescents assigned female at birth (AFAB) initiatin care 2.5–7.1 times more fre uentl as com ared to adolescents who are assigned male at birth (AMAB) (Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020).

A specific World Professional Association for Transgender Health's (WPATH) Standards of Care section dedicated to the needs of children and adolescents was first included in the 1998 WPATH Standards of Care, 5th version (Levine et al., 1998). Youth aged 16 or older were deemed potentially eligible for gender-affirming medical care, but only in select cases. The subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest "masculinizing" mastectomy, which had an age minimum of 16 years. Additional eligibility criteria for gender-related medical care included a persistent, long (childhood) history of gender "non-conformity"/dysphoria, emerging or intensifying at the onset of puberty; absence or management of psychological, medical, or social problems that interfere with treatment; provision of support for commencing the intervention by the parents/caregivers; and provision of informed consent. A chapter dedicated to transgender and gender diverse (TGD) adolescents, distinct from the child chapter, has been created for this 8th edition of the Standards of Care given 1) the exponential growth in adolescent referral rates; 2) the increased number of studies specific to adolescent gender diversity-related care; and 3) the unique developmental and gender-affirming care issues of this a e rou .

Non-s ecific terms for ender-related care are avoided (e. ., ender-affirmin model, ender ex lorator model) as these terms do not re resent unified ractices, but instead hetero enous care practices that are defined differently in various settings.

Adolescence overview

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood (Sanders, 2013). Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress. 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. For example, physical pubertal changes may

Summary of Comments on Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

Page: 45

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 7:41:45 AM -04'00'

[redacted] being twisted to suggest WPATH is against the gender-affirming care model as supported by AAP and other organizations

[redacted] ic terms for gender related care are avoided (eg gender affirming model) as these terms do not represent unified practices but instead heterogenous care practices that are defined differently in various settings.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:06:19 AM -04'00'

[redacted] istribution was more recently challenged by Jack Turban's review of the YRBSS data finding more even ratios of AFAB and AMAB people reporting gender diversity. (See https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2022-056567/188709/Sex-Assigned-at-Birth-Ratio-Among-Transgender-and). This is not mention that the references here are concerning - Bauer is based on ED presentations, de Graaf is a letter to the editor. Kaltiala et al 2015 is a very negative article - would need to look more at it and it raises red flags that at least 3 of the citations are from the same group/population.

One reason this is concerning is that the argument has arose that the AFAB prevalance supports social contangion and more even ratio run against it - that is the argument that Turban uses and I imagine with WPATH articulating this will be further "support" of social contagion (for what it is worth, I don't the ratios is a particularly strong argument to begin with)

[redacted] Ratio of afab 2.5-7.1 tiems more frequent Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020

begin in late childhood and executive control neural systems continue to develop well into the mid-20s (Ferguson et al., 2021). There is a lack of uniformity in how countries and governments define the age of majority (i.e., legal decision-making status; Dick et al., 2014). While many specify the age of majority as 18 years of age, in some countries it is as young as 15 years (e.g., Indonesia and Myanmar), and in others as high as 21 years (e.g., the U.S. state of Mississippi and Singapore).

For clarity, this chapter applies to adolescents from the start of puberty until the legal age of majority (in most cases 18 years), however there are developmental elements of this chapter, including the importance of parental/caregiver involvement, that are often relevant for the care of transitional-aged young adults and should be considered appropriately.

Cognitive development in adolescence is often characterized by gains in abstract thinking, complex reasoning, and metacognition (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 enables a young person to conceptualize implications regarding a particular decision. However, adolescence is also often associated with increased risk-taking behaviors. Along with these notable changes, adolescence is often characterized by individuation from parents and the development of increased ersonal autonom . here is often a hei htened focus on eer relationshi s, which can be both ositive and detrimental (Gardner & Steinberg, 2005). Adolescents often experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals (Van Leijenhorst et al., 2010). Social-emotional development typically advances during adolescence, although there is a great variability among young people in terms of the level of maturity applied to inter- and intra-personal communication and insight (Grootens-Wiegers et al., 2017). For TGD adolescents making decisions about gender-affirming treatments—decisions that may have lifelong consequences—it is critical to understand how all these aspects of development may impact decision-making for a given young person within their specific cultural context.

Gender identity development in adolescence

Our understanding of gender identity development in adolescence is continuing to evolve. When providing clinical care to gender diverse young people and their families, it is important to know what is and is not known about gender identity during development (Berenbaum, 2018). When considering treatments, families may have questions regarding the development of their adolescent's gender identity, and whether or not their 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/caregivers 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 conducted primarily with youth who were not gender diverse in identity or expression and was carried out under the assumption that sex correlated with a specific gender; therefore, little attention was given to gender identity development. In addition to biological factors influencing gender development, this research demonstrated psychological and social factors also play a role (Perry & Pauletti, 2011). While there has been less focus on gender identity development in TGD youth, there is ample reason to suppose, apart from biological factors, psychosocial factors are also involved (Steensma, Kreukels et al., 2013). or some youth, gender identit develop- ment appears fixed and is often expressed from a oun a e, while for others there ma be a developmental process that contributes to gender identity development over time.

Neuroimaging studies, enetic studies, and other hormone studies in ntersex individuals demonstrate a biological contribution to the

Page: 46

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:25:40 AM -04'00'

Interesting to point this out

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:25:16 AM -04'00'

This is a really good point to include instead of the "insistent, persistent, consistent" criteria.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 7:45:36 AM -04'00'

This [redacted] ntroversial in how much it reflects the experiences and therefore an accurate model of "gender" in TGD individuals. The intersex community often sees themselves as very distinct from the TGD community so this may lead to some conflict drawing on this research.

development of gender identity for some individuals whose gender identity does not match their assigned sex at birth (Steensma, Kreukels et al., 2013). As families often have questions about this very issue, it is important to note it is not possible to distinguish between those for whom gender identity may seem fixed from birth and those for whom gender identity development appears to be a developmental process. Since it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person, a comprehensive clinical approach is important and necessary (see Statement 3). Future research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups. Conceptualization of gender identity by shifting from dichotomous (e.g., binary) categorization of male and female to a dimensional gender spectrum along a continuum (APA, 2013) would also be necessary.

Adolescence may be a critical period for the development of gender identity for gender diverse young people (Steensma, Kreukels et al., 2013). Dutch longitudinal clinical follow-up studies of adolescents with childhood gender dysphoria who received puberty suppression, gender-affirming hormones, or both, found that none of the youth in adulthood regretted the decisions they had taken in adolescence (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014). These findings suggest adolescents who were comprehensively assessed and determined emotionally mature enough to make treatment decisions regarding gender- affirming medical care presented with stability of gender identity over the time period when the studies were conducted.

When extrapolating findings from the longer-term longitudinal Dutch cohort studies to present-day gender diverse adolescents seeking care, it is critical to consider the societal changes that have occurred over time in relation to TGD people. Given the increase in visibility of TGD identities, it is important to understand how increased awareness may impact gender development in different ways (Kornienko et al., 2016). One trend identified is that more young people are presenting to gender clinics with nonbinary identities (Twist & de Graaf, 2019). Another phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversit durin their childhood ears. One researcher attem ted to stud and describe a s e-cific form of later- resenting gender diversity experience (Littman, 2018). However, the findings of the study must be considered within the context of significant methodological challenges, including 1) the study surveyed parents and not youth perspectives; and 2) recruitment included parents from community settings in which treatments for gender dysphoria are viewed with scepticism and are criticized. or a select sub rou of oun eo le, susce tibilit to social influence im actin ender ma be an im ortant differential to consider (Kornienko et al., 2016). However, caution must be taken to avoid assumin these henomena occur rematurel in an individual adolescent while rel in on information from datasets that may have been ascertained with potential sampling bias (Bauer et al., 2022; WPATH, 2018). It is important to consider the benefits that social connectedness may have for youth who are linked with supportive people (Tuzun et al., 2022)(see Statement 4).

Given the emerging nature of knowledge re ardin adolescent ender identit develo ment, an individualized a roach to clinical care is considered both ethical and necessary. As is the case in all areas of medicine, each study has methodological limitations, and conclusions drawn from research cannot and should not be universally applied to all adolescents. This is also true when grappling with common parental questions regarding the stability versus instability of a particular young person's gender identity development. While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care.

Research evidence of gender-affirming medical treatment for transgender adolescents

A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical

Page: 47

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 8:53:44 AM -04'00'

[redacted] o be building into an argument in favor of social contagion

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 8:54:16 AM -04'00'

[redacted] rtant to consider" validates Littman's theory while at the same time recommending caution.

Author: [redacted] Subject: Highlight Date: 9/7/2022 8:54:34 AM -04'00'

[redacted] agraph is important and very much in line with what the AAP has been promoting (but it does not carry through the chapter).

and surgical treatments (GAMSTs) (see medically necessary statement in the Global chapter, Statement 2.1), over time. Given the lifelong implications of medical treatment and the young age at which treatments may be started, adolescents, their parents, and care providers should be informed about the nature of the evidence base. It seems reasonable that decisions to move forward with medical and surgical treatments should be made carefully. Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead.

At the time of this chapter's writing, there were several longer-term longitudinal cohort follow-up studies reporting positive results of early (i.e., adolescent) medical treatment; for a significant period of time, many of these studies were conducted through one Dutch clinic (e.g., Cohen-Kettenis & van Goozen, 1997; de Vries, Steensma et al., 2011; de Vries et al., 2014; Smith et al., 2001, 2005). The findings demonstrated the resolution of gender dysphoria is associated with improved psychological functioning and body image satisfaction. Most of these studies followed a pre-post methodological design and compared baseline psychological functioning with outcomes after the provision of medical gender-affirming treatments. Different studies evaluated individual aspects or combinations of treatment interventions and included 1) gender-affirming hormones and surgeries (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001, 2005); 2) puberty suppression (de Vries, Steensma et al., 2011); and 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 (pretreatment, mean age of 13.6) through young adulthood (posttreatment, mean age of 20.7). This was the first study to show gender-affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with satisfactory objective and subjective outcomes in adulthood (de Vries et al., 2014). While the study employed a small (n = 55), select, and socially supported sample, the results were convincing. Of note, the participants were part of the Dutch clinic known for employing a multidisciplinary approach, including provision of comprehensive, ongoing assessment and management of gender dysphoria, and support aimed at emotional well-being.

Several more recently published longitudinal studies followed and evaluated participants at different stages of their gender-affirming treatments. In these studies, some participants may not have started gender-affirming medical treatments, some had been treated with puberty suppression, while still others had started gender-affirming hormones or had even undergone gender-affirming surgery (GAS) (Achille et al., 2020; Allen et al., 2019; Becker-Hebly et al., 2021; Carmichael et al., 2021; Costa et al., 2015; Kuper et al., 2020, Tordoff et al., 2022). Given the heterogeneity of treatments and methods, this type of design makes interpreting outcomes more challenging. Nonetheless, when compared with baseline assessments, the data consistently demonstrate improved or stable psychological functioning, body image, and treatment satisfaction varying from three months to up to two years from the initiation of treatment.

Cross-sectional studies provide another design for evaluating the effects of gender-affirming treatments. One such study compared psychological functioning in transgender adolescents at baseline and while undergoing puberty suppression with that of cisgender high school peers at two different time points. At baseline, the transgender youth demonstrated lower psychological functioning compared with cisgender peers, whereas when undergoing puberty suppression, they demonstrated better functioning than their peers (van der Miesen et al., 2020). Grannis et al. (2021) demonstrated transgender males who started testosterone had lower internalizing mental health symptoms (depression and anxiety) compared with those who had not started testosterone treatment.

Four additional studies followed different outcome designs. In a retrospective chart study, Kaltiala, Heino et al. (2020) reported transgender

Page: 48

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:13:41 AM -04'00'

[redacted]dcitory given the recommendations of lower ages and less gatekeeping for adolescents.

adolescents with few or no mental health challenges prior to commencing gender-affirming hormones generally did well during the treatment. However, adolescents with more mental health challenges at baseline continued to experience the manifestations of those mental health challenges over the course of gender-affirming medical treatment. Nieder et al. (2021) studied satisfaction with care as an outcome measure and demonstrated transgender adolescents were more satisfied the further they progressed with the treatments they initially started. Hisle-Gorman et al. (2021) compared health care utilization pre- and post-initiation of gender-affirming pharmaceuticals as indicators of the severity of mental health conditions among 3,754 TGD adolescents in a large health care data set. Somewhat contrary to the authors' hypothesis of improved mental health, mental health care use did not significantly change, and psychotropic medication prescriptions increased. In a large non-probability sample of transgender-identified adults, Turban et al. (2022) found those who reported access to gender-affirming hormones in adolescence had lower odds of past-year suicidality compared with transgender people accessing gender- affirming hormones in adulthood.

Providers ma consider the ossibilit an adolescent ma re ret ender-affirmin decisions made durin adolescence, and a oun erson will want to sto treatment and return to livin in the birth-assi ned ender role in the future. Two Dutch studies report low rates of adolescents (1.9% and 3.5%) choosin to sto ubert suppression (Brik et al., 2019; Wie es et al., 2018). Again, these studies were conducted in clinics that follow a protocol that includes a com rehensive assessment before the ender-affirmin medical treatment is started. At resent, no clinical cohort studies have re orted on rofiles of adolescents who re ret their initial decision or detransition after irreversible affirmin treatment. ecent research indicate there are adolescents who detransition, but do not re ret initiatin treatment as the ex erienced the start of treatment as a art of understandin their ender-related care needs (Turban, 2018). However, this ma not be the predominant perspective of people who detransition (Littman, 2021; Vandenbussche, 2021). ome adolescents ma regret the ste s the have taken (D er, 2020). Therefore, it is im ortant to present the full ran e of possible outcomes when assistin trans ender adolescents. Providers ma discuss this to ic in a collaborative and trusting manner (i.e., as a " otential future experience and consideration") with the adolescent and their arents/care ivers before ender-affirmin medical treatments are started. lso, roviders should be re ared to su ort adolescents who detransition. In an internet convenience sam le surve of 237 self-identified detransitioners with a mean age of 25.02 ears, which consisted of over 90% of birth assi ned females, 25% had medicall transitioned before a e 18 and 14% detransitioned before age 18 (Vandenbussche, 2021). Althou h an internet convenience sam le is sub ect to selection of res ondents, this stud su ests detransitionin ma occur in oun trans ender adolescents and health care rofessionals should be aware of this. Man of them ex ressed di - ficulties findin hel durin their detransition rocess and re orted their detransition was an isolatin_ ex_erience durin_ which the did not receive either sufficient or appropriate support (Vandenbussche, 2021).

To conclude, althou_h the existin_ sam_les re orted on relativel small roups of outh (e. ., n = 22-101 _er stud_) and the time to follow-u_ varied across studies (6 months–7 ears), this emer in evidence base indicates a eneral im_rovement in the lives of trans_ender adolescents who, following careful assessment, receive medicall necessar gender-affirmin medical treatment. Further, rates of re orted re ret during the stud_ monitorin_ _eriods are low. aken as a whole, the data show early medical intervention—as part of broader combined assessment and treatment approaches focused on _ender dys- _horia and general well-bein_—can be effective and hel ful for man transgender adolescents seeking these treatments.

Ethical and human rights perspectives

Medical ethics and human rights perspectives were also considered while formulating the

Page: 49

Number: 1 Author [redacted] Subject: Highlight Date: 9/8/2022 1:41:00 PM -04'00'

[redacted]

There is to much credit to the studies about "detransition" here and this will be taken out of context by opponents of this care. They way it is all phrased just makes it seem like another piece of data to consider.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:20:00 AM -04'00'

[redacted]

This reference is a news article on the ruling in Tavistock. It is not scientific evidence and thus should be excluded.

Number: 3 Author [redacted] Subject: Highlight Date: 9/7/2022 10:20:25 AM -04'00'

[redacted]

This reinforces the binary that people "persist" with successful treatment and "desist" as treatment failures... it completely negates the experiences of people who are nonbinary or that some may stop hormones and not be regretful...

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:28:22 AM -04'00'

[redacted]

This is helpful... and it does not at all suggest de-transition is a treatment failure, rather they are people who need support.

Number: 5 Author: [redacted] Subject: Sticky Note Date: 9/8/2022 3:03:21 PM -04'00'

[redacted]

Language around “de-transition” and “desistance” appear throughout chapter 6 pointing to an assumption of regret, which is also explicitly stated with low quality references to commentaries and news articles. This assumes negative and harmful outcomes to those who find that a certain intervention may not be appropriate for them. While negative outcomes are possible, the evidence does not exist to support this as the only assumed “alternative” outcome to a certain intervention, treatment, etc., and available evidence (although limited) as well as experts in gender affirmative care suggest otherwise based on their experiences. The gender affirmative care model itself is NOT assume or require on any specific outcome (i.e. label, treatment, etc.), but instead focuses affirming the individual through their process of self-discovery (i.e. discovering that you are nonbinary instead of trans, or that hormones are not right for you can be valid, positive, and affirming outcomes of the approach).

Number: 6 Author [redacted] Subject: Highlight Date: 9/7/2022 10:29:51 AM -04'00'

[redacted]hat is the conclusion I took away from this discussion (and that others will take away). There is no defintion of "early medical intervention", so it is not clear if that means doing anything in an adolescent vs. waiting until adulthood, or actually intervening from early puberty (if the latter, then that is not discussed)

Author [redacted] Subject: Highlight Date: 9/7/2022 10:30:46 AM -04'00'

[redacted] a Viewpoint based on a case study.... it is not convincing evidence to justify such the theory.

Statements of Recommendations

6.1- We recommend health care professionals working with gender diverse adolescents:
6.1.a- Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.
6.1.b- Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
6.1.c- Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
6.1.d- Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
6.1.e- Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.
6.2- We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.
6.3- We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.
6.4- We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.
6.5- We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.
6.6- We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.
6.7- We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.
6.8- We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender- related surgery until the transition is made to adult care.
6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
6.10- We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.
6.11- We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):
6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
6.12.g- 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.

With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal ages for gender-affirming medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time 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 when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.

adolescent SOC statements. For example, allowing irreversible puberty to progress in adolescents who experience gender incongruence is not a neutral act given that it may have immediate and lifelong harmful effects for the transgender young person (Giordano, 2009; Giordano & Holm, 2020; Kreukels & Cohen-Kettenis, 2011). From a human rights perspective, considering gender diversity as a normal and expected variation within the broader diversity of the human experience, it is an adolescent's right to participate in their own decision-making process about their health and lives, including access to gender health services (Amnesty International, 2020).

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 aspects of identity, including gender identity. Statement 6.2 addresses identity exploration in the context of gender identity development. Statement 6.12.b accounts for the length of time needed for a young person to experience a gender diverse identity, express a gender diverse identity, or both, so as to make a meaningful decision regarding gender-affirming care.

Consent and decision-making: In adolescence, consent and decision-making require assessment of the individual's emotional, cognitive, and psychosocial development. Statement 6.12.c directly addresses emotional and cognitive maturity and describes the necessary components of the evaluation process used to assess decision-making capacity.

Caregivers/parent involvement: Adolescents are typically dependent on their caregivers/parents for guidance in numerous ways. This is also true as the young person navigates through the process of deciding about treatment options. Statement 6.11 addresses the importance of involving caregivers/parents and discusses the role they play in the assessment and treatment. No set of guidelines can account for every set of individual circumstances on a global scale.

Statement 6.1

We recommend health care professionals working with gender diverse adolescents:

a. **Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.**
b. **Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.**
c. **Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.**
d. **Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.**
e. **Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.**

When assessing and supporting TGD adolescents and their families, care providers/health care professionals (HCPs) need both general as well as gender-specific knowledge and training. Providers who are trained to work with adolescents and families play an important role in navigating aspects of adolescent development and family dynamics when caring for youth and families (Adelson et al., 2012; American Psychological Association, 2015; Hembree et al., 2017). Other chapters in these standards of care describe these criteria for professionals who provide gender care in more detail (see Chapter 5—Assessment for Adults; Chapter 7—Children; or Chapter 13—Surgery and Postoperative Care). Professionals working with adolescents should understand what is and is not known regarding adolescent gender identity development, and how this knowledge base differs from what applies to

adults and re ubertal children. Among HCPs, the mental health rofessional (MHP) has the most appropriate training and dedicated clinical time to conduct an assessment and elucidate treatment priorities and goals when working with transgender youth, including those seeking gender-affirming medical/surgical care. Understanding and managing the dynamics of family members who may share differing perspectives regarding the history and needs of the young person is an important competency that MHPs are often most prepared to address.

When access to professionals trained in child and adolescent development is not possible, HCPs should make a commitment to obtain training in the areas of family dynamics and adolescent development, including gender identity development. Similarly, considering autistic/neurodivergent transgender youth represent a substantial minority subpopulation of youth served in gender clinics globally, it is important HCPs seek additional training in the field of autism and understand the unique elements of care autistic gender diverse youth may require (Strang, Meagher et al., 2018). If these qualifications are not possible, then consultation and collaboration with a provider who specializes in autism and neurodiversity is advised.

Statement 6.2

We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so 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 et al., 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 over 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 (Arnoldussen et al., 2020; 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 a person's experience of themselves as a particular gender (Steensma, Kreukels et al., 2013), and for many others a process may begin well after pubertal changes are completed. 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, HCPs working with adolescents should promote supportive environments that simultaneously respect an adolescent's affirmed gender identity and also allows the adolescent to openly explore gender needs, including social, medical, and physical gender-affirming interventions should they change or evolve over time.

Statement 6.3

We recommend health care professionals work- in_ with _ender diverse adolescents undertake a comprehensive biops_chosocial assessment of adolescents who _resent with _ender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.

Given the many ways identity may unfold during adolescence, we recommend using a comprehensive biopsychosocial assessment to guide treatment decisions and optimize outcomes. This assessment should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care. As mentioned in Statement 6.1, MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here. The assessment process should be approached collaboratively with the adolescent and their caregiver(s), both separately and together, as described in more detail in Statement 6.11. An assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones,

Page: 52

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:35:06 AM -04'00'

I think this is a good way to recognize the role of the MHP without endorsing a gatekeeper approach - I think these recommendations 6.1-6.8 are very much in line with AAP messaging/PS, etc.

Number: 2 Author [redacted] Subject: Highlight Date: 9/6/2022 10:07:20 AM -04'00'

ehensive biopsychosocial assessment' seems like it does not mean it has to be a mental health assessment—they note mhp have the most availability, but this is a departure from previous.

surgeries). See medically necessary statement in Chapter 2—Global Applicability, Statement 2.1; see also Chapter 12—Hormone Therapy and Chapter 13—Surgery and Postoperative Care.

Youth may experience many different gender identity trajectories. Sociocultural definitions and experiences of gender continue to evolve over time, and youth are increasingly presenting with a range of identities and ways of describing their experiences and gender-related needs (Twist & de Graaf, 2019). For example, some youth will realize they are transgender or more broadly gender diverse and pursue steps to present accordingly. For some youth, obtaining gender-affirming medical treatment is important while for others these steps may not be necessary. For example, a process of exploration over time might not result in the young person self-affirming or embodying a different gender in relation to their assigned sex at birth and would not involve the use of medical interventions (Arnoldussen et al., 2019).

The most robust longitudinal evidence supporting the benefits of gender-affirming medical and surgical treatments in adolescence was obtained in a clinical setting that incorporated a detailed comprehensive diagnostic assessment process over time into its delivery of care protocol (de Vries & Cohen-Kettenis, 2012; de Vries et al., 2014). Given this research and the on oin evolution of ender diverse ex eriences in societ , a com rehensive dia nostic bio s chosocial assessment durin adolescence is both evidence-based and preserves the integrity of the decision-making process. In the absence of a full diagnostic profile, other mental health entities that need to be prioritized and treated may not be detected. There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) 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 at that time.

As delivery of health care and access to specialists varies globally, designing a particular assessment process to adapt existing resources is often necessary. In some cases, a more extended assessment process may be useful, such as for youth with more complex presentations (e.g., complicating mental health histories (Leibowitz & de Vries, 2016)), co-occurring autism spectrum characteristics (Strang, Powers et al., 2018), and/or an absence of experienced childhood gender incongruence (Ristori & Steensma, 2016). Given the unique cultural, financial, and geographical factors that exist for specific populations, providers should design assessment models that are flexible and allow for appropriately timed care for as many young people as possible, so long as the assessment effectively obtains information about the adolescent's strengths, vulnerabilities, diagnostic profile, and individual needs. Psychometrically validated psychosocial and gender measures can also be used to provide additional information.

The multidisci linar assessment for outh seekin gender-affirming medical/surgical interventions includes the following domains that correspond to the relevant statements:

- **Gender Identity Development:** Statements 6.12.a and 6.12.b elaborate on the factors associated with gender identity development within the specific cultural context when assessing TGD adolescents.
- **Social Development and Support; Intersectionality:** Statements 6.4 and 6.11 elaborate on the importance of assessing gender minority stress, family dynamics, and other aspects contributing to social development and intersectionality.
- **Diagnostic Assessment of Possible Co-Occurring Mental Health and/or Developmental Concerns:** Statement 6.12.d elaborates on the importance of understanding the relationship that exists, if at all, between any co-occurring mental health or developmental concerns and the young person's gender identity/gender diverse expression.
- **Capacity for Decision-Making:** Statement 6.12.c elaborates on the assessment of a young person's emotional maturity and the relevance when an adolescent is considering gender affirming-medical/surgical treatments.

Statement 6.4

We recommend health care professionals work with families, schools, and other relevant

Page: 53

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:31:54 AM -04'00'

Contradiction here with previous language stating SOC 8 would not use terminology such as "gender-affirming care".

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:32:08 AM -04'00'

This is a very important statement

settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.

Multiple studies and related expert consensus support the implementation of approaches that promote acceptance and affirmation of gender diverse youth across all settings, including families, schools, health care facilities, 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 we recommend be enacted across the various relationships and settings in which a young person exists and functions. It is important for the family members and community members involved in the adolescent's life to work collaboratively in these efforts unless their involvement is considered harmful to the adolescent. Examples proposed by Pariseau et al. (2019) and others of acceptance and affirmation of gender diversity and contemplation and expression of identit that can be im lemented by family, staff, and rganizations 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;
6. Education about gender diversity issues for people in the young person's life (e.g., family members, health care providers, social support networks), as needed, including information about how to advocate for gender diverse youth in community, school, health care, 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. Antibullying policies that are enforced;
10. Inclusion of nonbinary experiences in daily life, reading materials, and curricula (e.g., books, health, and sex education classes, assigned essay topics that move beyond the binary, LGBTQ, and ally groups);
11. Gender inclusive facilities that the youth can readily access without segregation from nongender diverse peers (e.g., bathrooms, locker rooms).

We recommend HCPs work with arents, schools, and other or anizations/ rou s to romote acceptance and affirmation of TGD identities and expressions, whether social or medical interventions are im lemented or not as acce tance and affirmation are associated with fewer negative mental health and behavioral s m toms and more ositive mental health and behavioral functionin (Da et al., 2015; de Vries et al., 2016; Gre tak 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 et al. (2018) found mental health 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 using the name and pronoun the youth does not identify with, not acknowledging affirmed gender identity, bullying, harassment, verbal and physical abuse, poor relationships, rejection for being TGD, eviction) was strongly linked to negative outcomes, such as anxiety, depression, suicidal ideation, suicide attempts, and substance use (Grossman et al., 2005; Klein & Golub; 2016; Pariseau et al., 2019; Peng et al., 2019; Reisner, Greytak et al., 2015; Roberts et al., 2013). It is important to be aware that negative symptoms increase with increased levels of rejection and continue into adulthood (Roberts et al., 2013).

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

Page: 54

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:33:13 AM -04'00'

This is very close to what the AAP message is, but it is interesting to say this after everything earlier about social cognition and giving it space.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:33:20 AM -04'00'

This list is really great

for the child about rejecting behavior from school staff or peers, not engaging or participating in other support mechanisms (e.g., with psychotherapists and support groups) have also been found to have negative consequences, such as increased de ressive s m toms (Pariseau et al., 2019). 1 or these reasons, it is im ortant not to i nore a outh's ender uestionin or dela consideration of the youth's gender-related care needs. There is particular value in professionals recognizing youth need individualized approaches, support, and consideration of needs around gender expression, identity, and embodiment 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, Lindley et al., 2019). It is important professionals collaborate with parents and others as they process their concerns and feelings and educate themselves about gender diversity because such processes may not necessarily reflect rejection or neutrality but may rather represent efforts to develop attitudes and gather information that foster acceptance (e.g., Katz-Wise et al., 2017).

Statement 6.5

We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.

Some health care providers, secular or religious organizations, and rejecting families may undertake efforts to thwart an adolescent's expression of gender diversity or assertion of a gender identity other than the expression and behavior that conforms to the sex assigned at birth. Such efforts at blocking reversible social expression or transition may include choosing not to use the youth's identified name and pronouns or restricting self-expression in clothing and hairstyles (Craig et al., 2017; Green et al., 2020). 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 or expectations based on 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 to be ineffective and are associated with increases in mental illness and poorer psychological functioning (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020).

2 Much of the research evaluating "conversion thera " and "re arative therapy" has investigated the im act of efforts to chan e ender ex ression (masculinit or femininit) and has conflated sexual orientation with ender identit (APA, 2009; Burnes et al., 2016; Craig et al., 2017). Some of these efforts have tar eted both ender identit and ex ression (AACAP, 2018). Conversion/re arative thera has been linked to increased anxiet , de ression, suicidal ideation, suicide attem ts, and health care avoidance (Crai et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020). Although some of these studies have been criticized for their methodologies and conclusions (e. ., D'An elo et al., 2020), this should not detract from the im ortance of em hasizin efforts undertaken a riori to chan e a erson's identit are clinicall and ethicall unsound. We recommend a ainst an t e of conversion or attem ts to chan e a erson's ender identit because 1) both secular and religion-based efforts to chan e ender identit /ex ression have been associated with ne ative s cholo ical functionin that endures into adulthood (Turban, Beckwith et al., 2020); and 2) larger ethical reasons exist that should underscore respect for gender diverse identities.

It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression (AACAP, 2018; see Statement 6.2). To ensure these explorations are therapeutic, we

Page: 55

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:33:53 AM -04'00'

This is essentially saying that "watchful waiting" is harmful without actually labeling it.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:34:15 AM -04'00'

This is one of the better discussions I have seen about conversion therapy with openness about the limitation but honesty around the ethical considerations.

recommend employing affirmative consideration and supportive tone in discussing what steps have been tried, considered, and planned for a youth's gender expression. These discussion topics may include what felt helpful or affirming, what felt unhelpful or distressing and why. We recommend employing affirmative responses to these steps and discussions, such as those identified in SOC-8 Statement 6.4.

Statement 6.6

We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including review of the benefits and risks.

TGD youth may experience distress related to chest and genital anatomy. Practices such as chest binding, chest padding, genital tucking, and genital packing are reversible, nonmedical interventions that may help alleviate this distress (Callen-Lorde, 2020a, 2020b; Deutsch, 2016a; Olson-Kennedy, Rosenthal et al., 2018; Transcare BC, 2020). It is important to assess the degree of distress related to physical development or anatomy, educate youth about potential nonmedical interventions to address this distress, and discuss the safe use of these interventions.

Chest binding involves compression of the breast tissue to create a flatter appearance of the chest. Studies suggest that up to 87% of trans masculine patients report a history of binding (Jones, 2015; Peitzmeier, 2017). Binding methods may include the use of commercial binders, sports bras, layering of shirts, layering of sports bras, or the use of elastics or other bandages (Peitzmeier, 2017). Currently, most youth report learning about binding practices from online communities composed of peers (Julian, 2019). Providers can play an important role in ensuring youth receive accurate and reliable information about the potential benefits and risks of chest binding. Additionally, providers can counsel patients about 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 and have been associated with chest binding in adults (Peitzmeier, 2017). If binding is employed, youth should be advised to use only those methods 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 restrict blood flow, damage skin, and restrict breathing. If youth report negative health impacts from chest binding, these should ideally be addressed by a gender-affirming medical provider with experience working with TGD youth. Many youth who bind may require chest masculinization surgery in the future (Olson-Kennedy, Warus et al., 2018).

Genital tucking is the practice of positioning the penis and testes to reduce the outward appearance of a genital bulge. 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 can be made or purchased. Limited studies are available on the specific risks and benefits of tucking in adults, and none have been carried out in youth. Previous studies have reported tight undergarments are associated with decreased sperm concentration and motility. In addition, elevated scrotal temperatures can be associated with poor sperm characteristics, and genital tucking could theoretically affect spermatogenesis and fertility (Marsh, 2019) although there are no definitive studies evaluating these adverse outcomes. Further research is needed to determine the specific benefits and risks of tucking in youth.

Statement 6.7

We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have

Page: 56

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:38:27 AM -04'00'

The intent here to suggest providers can challenge adolescents without pushing them away from genuine gender expression is well though out, but the wording choices make it read as though a provider could use conversion therapy if done in a supportive tone.

Author: [redacted] Subject: Highlight Date: 9/6/2022 10:55:46 AM -04'00'

Statement 6.6. I'm worried that the way this statement is phrased will also draw some criticism and inflammatory comments. In the past some groups had criticized handouts about tucking from another children's gender clinic, and the way this statement recommends discussing it with all youth may get picked on. I definitely agree with the rec, I just worry about how it will get twisted.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:44:22 AM -04'00'

This working is odd - It draws a connection between binding and surgery, which could be twisted to say that that allowing binding encourages surgery and not allowing it prevents interest in surgery... which is not want the Olson study is saying.

not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.

When discussing the available options of menstrual-suppressing medications with gender diverse youth, 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 in a sensitive, gender-affirmative manner (Bonnington et al., 2020; Krempasky et al., 2020). There is no formal research evaluating how menstrual suppression may impact gender incongruence and/or dysphoria. However, the use of menstrual suppression can be an initial intervention that allows for further exploration of gender-related goals of care, prioritization of other mental health care, or both, especially for those who experience a worsening of gender dysphoria from unwanted uterine bleeding (see Statement 6.12d; Mehringer & Dowshen, 2019). When testosterone is not used, menstrual suppression can be achieved via a progestin. To exclude any underlying menstrual disorders, it is important to obtain a detailed menstrual history and evaluation prior to implementing menstrual-suppressing therapy (Carswell & Roberts, 2017). As part of the discussion about menstrual-suppressing medications, the need for contraception and information regarding the effectiveness of menstrual-suppressing medications as methods of contraception also need to be addressed (Bonnington et al., 2020). A variety of menstrual suppression options, such as combined estrogen-progestin medications, oral progestins, depot and subdermal progestin, and intrauterine devices (IUDs), should be offered to allow for individualized treatment plans while properly considering availability, cost and insurance coverage, as well as contraindications and side effects (Kanj et al., 2019).

Progestin-only hormonal medication are options, especially in trans masculine or nonbinary youth who are not interested in estrogen-containing medical therapies as well as those at risk for thromboembolic events or who have other contraindications to estrogen therapy (Carswell & Roberts, 2017). Progestin-only hormonal medications include oral progestins, depo-medroxyprogesterone injection, etonogestrel implant, and levonorgestrel IUD (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 (Pradhan & Gomez-Lobo, 2019). A more detailed description of the relevant clinical studies is presented in Chapter 12—Hormone Therapy. HCPs should not make assumptions regarding the individual's preferred method of administration as some trans masculine youth may prefer vaginal rings or IUD implants (Akgul et al., 2019). Although hormonal medications require monitoring for potential mood lability, depressive effects, or both, the benefits and risks of untreated menstrual suppression in the setting of gender dysphoria should be evaluated on an individual basis. Some patients may opt for combined oral contraception that includes 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 and can be delivered as transdermal or vaginal rings.

The use of gonadotropin releasing hormone (GnRH) analogues may also result in menstrual suppression. However, it is recommended gender diverse youth meet the eligibility criteria (as outlined in Statement 6.12) before this medication is considered 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 while awaiting menstrual suppression with testosterone therapy. When exogenous testosterone is employed as a gender-affirming hormone, menstrual suppression is typically achieved in the first six months of therapy (Ahmad & Leinung, 2017). However, it is vital adolescents be counseled ovulation and pregnancy can still occur in the setting of amenorrhea (Gomez et al., 2020; Kanj et al., 2019).

Statement 6.8

We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.

HCPs with expertise in child and adolescent development, as described in Statement 6.1, play an important role in the continuity of care for young people over the course of their gender-related treatment needs. Supporting adolescents and their families necessitates approaching care using a developmental lens through which understanding a young person's evolving emotional maturity and care needs can take lace over time. s ender-affirmin treatment athwa s differ based on the needs and ex eriences of individual TGD adolescents, decision-making for these treatments (ubert su ression, estro- ens/andro ens, ender-affirmation sur eries) can occur at different points in time within a span of several years. Longitudinal research demonstrating the benefits of pubertal suppression and gender-affirming hormone treatment (GAHT) was carried out in a setting where an ongoing clinical relationship between the adolescents/families and the multidisciplinary team was maintained (de Vries et al., 2014).

Clinical settings that offer longer appointment times provide space for adolescents and caregivers to share important psychosocial aspects of emotional well-being (e.g., family dynamics, school, romantic, and sexual experiences) that contextualize individualized gender-affirming treatment needs and decisions as described elsewhere in the chapter. An ongoing clinical relationship can take place across settings, whether that be within a multidisciplinary team or with providers in different locations who collaborate with one another. Given the wide variability in the ability to obtain access to specialized gender care centers, particularly for marginalized groups who experience disparities with access, it is important for the HCP to appreciate the existence of any barriers to care while maintaining flexibility when defining how an ongoing clinical relationship can take place in that specific context.

An ongoing clinical relationship that increases resilience in the youth and provides support to parents/caregivers who may have their own treatment needs may ultimately lead to increased parental acceptance—when needed—which is associated with better mental health outcomes in youth (Ryan, Huebner et al., 2009).

Statement 6.9

We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

TGD adolescents with gender dysphoria/gender incongruence who seek gender-affirming medical and surgical treatments benefit from the involvement of health care professionals (HCPs) from different disciplines. Providing care to TGD adolescents includes addressing 1) diagnostic considerations (see Statements 6.3, 6.12a, and 6.12b) conducted by a specialized gender HCP (as defined in Statement 6.1) whenever possible and necessary; and 2) treatment considerations when prescribing, managing, and monitoring medications for gender-affirming medical and 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.

he evolvin evidence has shown a clinical benefit for trans ender outh who receive their ender-affirmin treatments in multidisci linar gender clinics (de Vries et al., 2014; Kuper et al., 2020; Tollit et al., 2019). Finally, adolescents seekin ender-affirmin care in multidisci linar clinics are resentin with si nificant complexit necessitatin close collaboration between mental health, medical, and/or sur ical rofessionals (McCallion et al., 2021; Sorbara et al., 2020; Tishelman et al., 2015).

Page: 58

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:44:50 AM -04'00'

It seems this recommendation is all about forming an individual approach, but again later wording in the surgical section is concerning in the way it sees the "individualized approach" as an exception not the rule.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:39:19 AM -04'00'

There is a big push for making gender care part of routine primary care as opposed to requiring it in large multidisciplinary centers... it is a bit controversial in children and teens because of barriers to care, need for mental health support, complexity, etc., etc.

As not all patients and families are in the position or in a location to access multidisciplinary care, 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, disciplines, or both, it is recommended efforts be made to include the relevant providers when developing a gender care team. However, this does not mean all disciplines are necessary to provide care to a particular youth and famil .

1 written documentation or a letter is required to recommend ender-affirmin medical and sur- ical treatment (GAMST) for an adolescent, onl one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical HCPs and MHPs (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). Further assessment results and written opinions may be requested when there is a specific clinical need or when team members are in different locations or choose to write their own summaries. For further information see Chapter 5—Assessment for Adults, Statement 5.5.

Statement 6.10

3 **We recommend health care rofessionals workin with trans ender and ender diverse adolescents re uestin ender-affirmin medical or sur ical treatments inform them, prior to the initiation of treatment, of the re roductive effects, includin the otential loss of fertilit and available o tions to reserve fertilit within the context of the youth's stage of pubertal development.**

While assessing adolescents seeking gender-affirming medical or surgical treatments, HCPs should discuss the specific ways in which the required treatment may affect reproductive capacity. Fertility issues and the specific preservation options are more thoroughly discussed in Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

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

HCPs should specifically pay attention to the developmental and psychological aspects of fertility preservation and decision-making competency for the individual adolescent. While adolescents may think they have made up their minds concerning their reproductive capacity, the possibility their opinions about having biologically related children in the future might change over time needs to be discussed with an HCP who has sufficient experience, is knowledgeable about adolescent development, and has experience workin with arents.

2 ddressin the lon -term conse uences on fertilit of ender-affirmin medical treatments and ensurin trans ender adolescents have realistic ex ectations concernin fertilit reservation o tions or ado tion cannot not be addressed with a one-time discussion but should be art of an on oin conversation. This conversation should occur not onl before initiatin an medical intervention (ubert su ression, hormones, or sur eries), but also during further treatment and during transition.

Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have. Research in childhood cancer survivors found participants who acknowledged missed opportunities for fertility preservation reported distress and regret surrounding potential infertility (Armuand et al., 2014; Ellis et al., 2016; Lehmann et al., 2017). Furthermore, 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 HCPs may experience discussing fertility with the adolescent and the family (Tishelman et al., 2019), a fertility consultation is an important

Page: 59

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:40:32 AM -04'00'

For adolescents who are undergoing life altering surgery, only 1 letter from a member of the care team seems like a low standard to put in place.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:14 PM -04'00'

It strikes me that there is much more understanding of shifting decisions when it comes to fertility than when it comes to a person's gender. I always say that gender cannot be addressed with a one-time discussion but should be a longitutidinal conversation and if things change, we support you in that... which is not the persist/desist concern that used to frame this earlier in the chapter.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:25 PM -04'00'

[redacted]y—this statement makes it sound like all interventions can cause infertility, doesn't distinguish between blockers and cross sex hormones, and makes it sounds like most adolescents will change their mind, its very misleading. The last sentence is also really odd "...unless its not available through insurance." Maybe it should read "insurance should cover access to fertility care"

consideration for ever trans ender adolescent who ursues medical-affirmin treatments unless the local situation is such that a fertility consultation is not covered b insurance or ublic health care lans, is not available locall , or the individual circumstances make this unpreferable.

tatement 6.11

We recommend when ender-affirmin medical or surgical treatments are indicated for adolescents, health care rofessionals workin with trans ender and ender diverse adolescents involve arent(s)/uardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

When there is an indication an adolescent might benefit from a gender-affirming medical or surgical treatment, involving the parent(s) or primary caregiver(s) in the assessment process is recommended in almost all situations (Edwards-Leeper & Spack, 2012; Rafferty et al., 2018). Exceptions to this might include situations in which an adolescent is in foster care, child protective services, or both, and custody and parent involvement would be impossible, inappropriate, or harmful. Parent and family support of TGD youth is a primary predictor of youth well-being and is protective of the mental health of TGD youth (Gower, Rider, Coleman et al., 2018; Grossman et al., 2019; Lefevor et al., 2019; McConnell et al., 2015; Pariseau et al., 2019; Ryan, 2009; Ryan et al., 2010; Simons et al., 2013; Wilson et al., 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, such as the young person's gender and overall developmental, medical, and mental health history as well as insights into the young person's level of current support, general functioning, and well-being. Concordance or divergence of reports given by the adolescent and their parent(s)/caregiver(s) may be important information for the assessment team and can aid in designing and shaping individualized youth and family supports (De Los Reyes et al., 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 about 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 et al., 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, a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept. Contextualization of the 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. Importantly, gender histories may be unknown to parent(s)/caregiver(s) because gender may be internal experience for youth, not known by others unless it is discussed. For this reason, an adolescent's report of their gender history and experience is central to the assessment process.

Some parents may present with unsupportive or antagonistic beliefs about TGD identities, clinical gender care, or both (Clark et al., 2020). Such unsupportive perspectives are an important therapeutic target for families. Although challenging parent perspectives may in some cases seem rigid, providers should not assume this is the case. There are many examples of parent(s)/caregiver(s) who,

Page: 60

Number: 1 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:56 PM -04'00'

[redacted]

This is a minor point, but from the human rights perspective alluded to earlier in this chapter, reproductive justice would suggest that all people, including TGD youth have a right to fertility and reproductive care regardless of ability to pay.

Number: 2 Author [redacted] Subject: Highlight Date: 9/6/2022 10:09:18 AM -04'00'

[redacted]n ignores kids who are in foster care or those who don't have parents but have other guardians who can help guide decisions. It also ignores the role of lawyer/judge/advocate in those circumstances.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:08:30 AM -04'00'

[redacted]

This seems very much in line with the AAP

[redacted]

6.11 "for example a parent/caregiver report may provide critical context in situations in which a young person experiences a very recent or sudden self-awareness…concern for excessive peer and social media influence". This makes it sound like parents are important when we're worried about ROGD—and gives too much credence to the idea that youth are being excessively influenced by peers and online and need parents there to explain that their gender is not 'real.'

over time with support and psychoeducation, have become increasingly accepting of their TGD child's gender diversity and care needs.

Helping youth and parent(s)/caregiver(s) 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 the necessary support and care (Dubin et al., 2020).

Statement 6.12

We recommend health care professionals assessing trans gender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:

Statement 6.12.a

The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.

When working with TGD adolescents, HCPs should realize while a classification may give access to care, pathologizing transgender identities may be experienced as stigmatizing (Beek et al., 2016). Assessments related to gender health and gender diversity have been criticized, and controversies exist around diagnostic systems (Drescher, 2016).

HCPs should assess the overall gender-related history and gender care-related needs of youth. Through this assessment process, HCPs may provide a diagnosis when it is required to get access to transgender-related care.

Gender incongruence and gender dysphoria are the two diagnostic terms used in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), respectively. 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, reflect a long history of reconceptualizing and de-psychopathologizing gender-related diagnoses (American Psychiatric Association, 2013; World Health Organization, 2019a). Compared with 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 the sex assigned at birth. In the most recent revision, the DSM-5-TR, no changes in the diagnostic criteria for gender dysphoria are made. However, terminology was adapted into the most appropriate current language (e.g., birth-assigned gender instead of natal-gender and gender-affirming treatment instead of gender reassignment (American Psychiatric Association, 2022). Compared with the ICD 10th edition, the gender incongruence classification was moved from the Mental Health chapter to the Conditions Related to Sexual Health chapter in the ICD-11. When compared with the DSM-5 classification of gender dysphoria, one important reconceptualization is distress is not a required indicator of the ICD-11 classification of gender incongruence (WHO, 2019a). 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 classification of gender incongruence may better capture the fullness of gender diversity experiences and related clinical gender needs.

Criteria for 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 need to "transition" 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 enable the individual's body to align as much as required, 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 noted "that gender variant behaviour and

Page: 61

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:51:54 AM -04'00'

[redacted]

Statement 6.12: I was hoping that they would discuss the recommendations for starting GnRHa separately from hormones or surgery, since GnRHa are reversible, but they don't really talk about this here.

They bring up fertility several times in this chapter, which is obviously important to discuss, but it seems a bit disjointed and odd that it is written in several different places like this.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:51:50 AM -04'00'

[redacted]

Note use of gender incongruence (ICD11/WHO) instead of gender dysphoria (DSM-5)

preferences alone are not a basis for assigning the classification" (WHO, ICD-11, 2019a).

Criteria for the DSM-5 and DSM-5-TR classification of 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; DSM-5, APA, 2013; DSM 5-TR, APA, 2022).

Of note, although a gender-related classification is one of the requirements for receiving medical gender-affirming care, such a classification alone 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. Counseling, gender exploration, mental health assessment and, when needed, treatment with MHPs trained in gender development may all be indicated with or without the implementation of medical-affirming care.

Statement 6.12.b

The experience of gender diversity/incongruence is marked and sustained over time.

Identity exploration and consolidation are experienced by many adolescents (Klimstra et al., 2010; Topolewska-Siedzik & Cieciuch, 2018). Identity exploration during adolescence may include a process of self-discovery around gender and gender identity (Steensma, Kreukels et al., 2013). Little is known about how processes that underlie consolidation of gender identity during adolescence (e.g., the process of commitment to specific identities) may impact a young person's experience(s) or needs over time.

Therefore, the level of reversibility of a gender-affirming medical intervention should be considered along with the sustained duration of a young person's experience of gender incongruence when initiating treatment. Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries. Puberty suppression treatment, which provides more time for younger adolescents to engage their decision-making capacities, also raises important considerations (see Statement 6.12f and Chapter 12—Hormone Therapy) suggesting the importance of a sustained experience of gender incongruence/diversity prior to initiation. However, in this age group of younger adolescents, several years is not always practical nor necessary given the promise of the treatment as a means to buy time while avoiding distress from irreversible pubertal changes. For youth who have experienced a shorter duration of gender incongruence, social transition-related and/or other medical supports (e.g., menstrual suppression/androgen blocking) may also provide some relief as well as furnishing additional information to the clinical team regarding a young person's broad gender care needs (see Statements 6.4, 6.6, and 6.7).

Establishing evidence of persistent gender diversity/incongruence typically requires careful assessment with the young person over time (see Statement 6.3). Whenever possible and when appropriate, the assessment and discernment process should also include the parent(s)/caregiver(s) (see Statement 6.11). Evidence demonstrating gender diversity/incongruence sustained over time can be provided via history obtained directly from the adolescent and parents/caregivers when this information is not documented in the medical records.

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 the experience of gender incongruence is not consistent for all children as they progress into adolescence. For example, a subset of youth who experienced gender incongruence or who socially transitioned prior to puberty over time can show a reduction in or even full discontinuation of gender incongruence (de Vries et al., 2010; Olson et al., 2022; Ristori & Steensma, 2016; Singh et al., 2021; Wagner et al., 2021). However, there has been less research focused on rates of continuity and discontinuity of gender incongruence and gender-related needs in

Page: 62

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:11:32 AM -04'00'

[redacted]
Again, arguing against watchful waiting while not explicitly labeling it.

[redacted] 6.12b very confusing conversation around blockers and the duration of gender incongruence. On one hand it says "however, in thi sage group of younger adolescents, several years is not always practical given the premise of the treatment as a means to buy time by avoiding distress from irreversible pubertal changes." But then it doesn't explicitly say hormone blockers are appropriate in this case, it says 'of youth who have experienced a shorter duration of gender incongruence, social transition and medical supports (menstrual suppression/androgen blocking) may provide some relief." It is deeply confusing because they're not clarifying the stage of puberty the kid is in when presenting, and it seems like they're saying blockers are ok in this population but not actually calling them blockers—and assuming we're only talking about kids in later puberty.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:45:07 AM -04'00'

[redacted]
This seems in line with the AAP policy statement.

Number: 3 Author [redacted] Subject: Highlight Date: 9/7/2022 10:52:07 AM -04'00'

[redacted] t really account for those who are unable to come to care early enough for that to be documented in the medical record, or for those who may not have disclosed to their family at a young age.

Number: 4 Author [redacted] Subject: Highlight Date: 9/7/2022 10:52:36 AM -04'00'

[redacted]
I think this suggests that youth need to "prove" something when instead the focus should be on affirming the child for who they are not having to prove anything (the goal is affirmation, not that you take on a specific label or treatment, etc.)

Number: 5 Author: [redacted] Subject: Highlight Date: 9/8/2022 3:18:49 PM -04'00'

[redacted]
Why is there such a focus on trying to predict who a child will be come and fear of regret? Again, this paradigm overgeneralizes the population of people who may stop interventions as a uniform population of angry, regretful treatment failures.

[redacted] talk about 'a subset of youth who experienced gender incongruence or who socially transitioned prior to puberty can show a reduction or full discontinuation of gender incongruence' but they cite a few papers that basically show the opposite. This statement makes it sound like it's a decent number, but the articles cited actually say its nearly zero (but I guess the 1-2 cases in those papers constitute 'a subset'). In addition ,they're clearly talking there about children, not adolescents, when the rest of this chapter is very much focused on adolescence, but they don't really make that clear.

But again, in the paragraph that follows on adolescence specifically they again refer to 'a subset' when actually its like 1-2 patients.

pubertal and 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 adolescents with gender incongruence presenting for gender care elect not to pursue gender-affirming medical care (Arnoldussen et al., 2019; de Vries, Steensma et al., 2011). Importantly, findings from studies of gender incongruent pubertal/adolescent cohorts, in which participants who have undergone comprehensive gender evaluation over time, have shown persistent gender incongruence and gender-related need and have received referrals for medical gender care, suggest 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 incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).

Statement 6.12.c

The adolescent demonstrates the emotional and co nitive maturity re uired to rovide informed consent/assent for the treatment.

The process of informed consent includes communication between a patient and their 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. In most settings, assent is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses the level of understanding and intention.

A necessary step in the informed consent/assent process for considering gender-affirming medical care is a careful discussion with qualified HCPs trained to assess the emotional and cognitive maturity of adolescents. The reversible and irreversible effects of the treatment, as well as fertility preservation options (when applicable), and all potential risks and benefits of the intervention are important components of the discussion. These discussions are required when obtaining 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 the risks and benefits; 3) appreciate the nature of the decision, including the long-term consequences; and 4) communicate choice (Grootens-Wiegers et al., 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 to appear (e.g., with gender-affirming hormones), and any implications of stopping the treatment. Gender-diverse youth should fully understand the reversible, partially reversible, and 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 and Loshak, 2020)). Gender-diverse youth should also understand, 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 this care is not a fit for them (Wiepjes et al., 2018). Youth should know such shifts are sometimes connected to a change in gender needs over time, and in some cases, a shift in gender identity itself. Given this information, gender diverse youth must be able to reason thoughtfully about treatment options, considering the implications of the choices at hand. Furthermore, 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 re uired for assent/consent ma not emer e at specific ages per se (Grootens-Wiegers et al., 2017). There may be variability in these capacities related to developmental differences and mental health presentations (Shumer & Tishelman, 2015) and dependent on the opportunities a young

Page: 63

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:53:35 AM -04'00'

Generally this section seems very reasonable.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 11:03:16 AM -04'00'

This statement contradicts the specific ages recommended later on.

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 et al., 2021).

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 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 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- and 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 to engage in conversations about the treatment options and affords the young person the opportunity to practice thinking into the future and flexibly consider 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 (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, Powers et al., 2018).

For unique situations in which an adolescent minor is consenting for their own treatment without parental permission (see Statement 6.11), extra care must be taken to support the adolescent's informed decision-making. This will typically require greater levels of engagement of and collaboration between the HCPs working with the adolescent to provide the young person appropriate cognitive and emotional support to consider options, weigh benefits and potential challenges/costs, and develop a plan for any needed (and potentially ongoing) supports associated with the treatment.

Statement 6.12.d

The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed.

Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments, and neurodiversity-related factors (e.g., de Vries et al., 2016; Pariseau et al., 2019; Ryan et al., 2010; Weinhardt et al., 2017). 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 or receive medical treatment. Additionally, like cisgender youth, TGD youth may experience mental health concerns irrespective of the presence of gender dysphoria or gender incongruence. In particular, depression and self-harm may be of specific concern; many studies reveal depression scores and emotional and behavioral problems comparable to those reported in populations referred to mental health clinics (Leibowitz & de Vries, 2016). Higher rates of suicidal ideation, suicide attempts, and self-harm have also been reported (de Graaf et al., 2020). In addition, eating disorders occur more frequently than expected in non-referred populations (Khatchadourian et al., 2013; Ristori et al., 2019; Spack et al., 2012). Importantly, TGD adolescents show high rates of autism spectrum disorder/characteristics (Øien et al., 2018; van der Miesen et al., 2016; see also Statement 6.1d). Other neurodevelopmental presentations and/or mental health challenges may also be present,

Page: 64

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:14:01 AM -04'00'

6.12d this section talks about the capacity to provide informed consent/assent for partially and fully reversible interventions but really doesn't talk about blockers at all, or make any distinction between the process for starting blockers/fully reversible versus irreversible interventions.

(e.g., ADHD, intellectual disability, and psychotic disorders (de Vries, Doreleijers et al., 2011; Meijer et al., 2018; Parkes & Hall, 2006).

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 those of their cisgender peers (e.g., de Vries et al., 2014; van der Miesen et al., 2020). A provider's key task 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 challenge the assessment and treatment of gender-related needs of TGD adolescents in various ways:

1. First, when a TGD adolescent is experiencin acute suicidalit , self-harm, eatin disorders, or other mental health crises that threaten h sical health, safet must be rioritized. Accordin to the local context and existin uidelines, a propriate care should seek to mitigate the threat or crisis so there is sufficient time and stabilization for thou htful ender-related assessment and decision-makin . For exam le, an activel suicidal adolescent ma not be emotionall able to make an informed decision re ardin ender-affirmin medical/surgical treatment. 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 the clarity of identity development and gender-related decision-making should be prioritized and addressed.
3. Third, decision-makin re arding 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 6.11). To be able to make such an informed decision, an adolescent should be able to understand the issues, express a choice, appreciate and give careful thought regarding the wish for medical-affirming treatment (see Statement 6.12c). Neurodevelopmental differences, such as autistic features or autism spectrum disorder (see Statement 6.1d, e.g., communication differences; a preference for concrete or rigid thinking; differences in self-awareness, future thinking and planning), may challenge the assessment and decision-making process; neurodivergent youth may require extra support, structure, psychoeducation, and time built into the assessment process (Strang, Powers et al., 2018). Other mental health presentations that involve reduced communication and self-advocacy, difficulty engaging in assessment, memory and concentration difficulties, hopelessness, and 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-affirmin treatment can be made.
4. Finall , while addressin mental health concerns is im ortant durin the course of medical treatment, it does not mean all mental health challenges can or should be resolved completely. However, it is important any mental health concerns are addressed sufficiently so that gender -affirming medical treatment can be provided optimally (e.g., medication adherence, attending follow-up medical appointments, and self-care, articularly during a ostoperative course).

Page: 65

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:14:41 AM -04'00'

[redacted]

What does extended time mean? I worry this could be use to delay the decision indefinitely for those with neurodiversity or developmental differences, or argue that they cannot provide informed consent and so cannot receive care.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 11:04:57 AM -04'00'

[redacted]

Important point

[redacted]

The last sentence seems to contradict the rest of the paragraph. The rest of the paragraph says that when there's an acute safety issue, it must be dealt with before informed consent conversations can happen, but the last sentence says 'safety-related interventions should not preclude starting gender-affirming care.'

Number: 3 Author [redacted] Subject: Highlight Date: 9/6/2022 8:54:40 AM -04'00'

[redacted]

Important point

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:09:17 PM -04'00'

[redacted] any mention about the role of stigma, prejudice, discrimination, and rejection as social processes that are more likely to adversely impact mental health separate from the gender identity.

Statement 6.12.e

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

For guidelines regarding the clinical approach, the scientific background, and the rationale, see Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

Statement 6.12.f

The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.

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 nonbinary gender identity) or even attenuation of a previously affirmed gender identity (Drummond et al., 2008; Steensma et al., 2011, Steensma, Kreukels et al., 2013; Wallien & Cohen-Kettenis, 2008). The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of pubertal development because the experience of physical pubertal maturation may be critical for further gender identity development for some TGD adolescents (Steensma et al., 2011). Therefore, puberty blockers should not be implemented in prepubertal gender diverse youth (Waal & Cohen-Kettenis, 2006). For some youth, GnRH agonists may be appropriate in late stages or in the post-pubertal period (e.g., Tanner stage 4 or 5), and this should be highly individualized. See Chapter 12—Hormone Therapy for a more comprehensive review of the use of GnRH agonists.

Variations in the timing of pubertal onset is due to multiple factors (e.g., sex assigned at birth, genetics, nutrition, etc.). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to post-pubertal, and adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969, 1970). For assigned females at birth, pubertal onset (e.g., gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and for birth-assigned males, the achievement of a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020). An experienced medical provider should be relied on to differentiate the onset of puberty from physical changes such as pubic hair and apocrine body odor due to sex steroids produced by the adrenal gland (e.g., adrenarche) 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 during which shared decision-making about gender-affirming medical therapies should be undertaken with their multidisciplinary team.

The importance of addressing other risks and benefits of pubertal suppression, both hypothetical and actual, cannot be overstated. Evidence supports the existence of surgical implications for transgender girls who proceed with pubertal suppression (van de Grift et al., 2020). Longitudinal data exists to demonstrate improvement in romantic and sexual satisfaction for adolescents receiving pubertal suppression, hormone treatment and surgery (Bungener et al., 2020). A study on surgical outcomes of laparoscopic intestinal vaginoplasty (performed because of limited genital tissue after the use of puberty blockers) in transgender women revealed that the majority experienced orgasm after surgery (84%), although a specific correlation between sexual pleasure outcomes and the timing of pubertal suppression initiation was not discussed in the study (Bouman, van der Sluis et al., 2016), nor does the study apply to those who would prefer a different surgical procedure. This underscores the importance of engaging in discussions with families about the future unknowns related to surgical and sexual health outcomes.

Statement 6.12.g

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.

Page: 66

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:14:00 PM -04'00'

6.12f. This is very confusing because the risks/benefits are conflated, there's not enough conversation about any of these post-surgical issues, the risk of bone density concerns are not accounted for and the focus is on tiny subset of post-surgical issues that are related to GAHT.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:55:45 AM -04'00'

this as a general take away, but there may be situations where GAH should be started before 14, and our guidelines suggest that puberty suppression or GAH should only be considered after Tanner 2. It is a bit more complicated because we articulate more a developmental approach, so especially for a trans male with early intervention, blockers would be considered before T because the child may reach tanner 2 at 9 or 10yo but cis boys do not have noticeable changes of puberty until around early teens, etc. However, we say that there is NO MEDICAL AFFIRMATION indicated before Tanner 2, period.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:18:23 PM -04'00'

Hypothetical risks?

Number: 4 Author [redacted] Subject: Highlight Date: 9/7/2022 12:20:19 PM -04'00'

It seems like an odd place to bring up sexual satisfaction, particularly ability to orgasm after blockers, hormones and then surgery... not as relevant to the discussion of just blockers.

Number: 5 Author [redacted] Subject: Highlight Date: 9/7/2022 12:21:45 PM -04'00'

This is the larger surgical implication, less tissue available for future surgery, rather than sexual satisfaction. And it's only a side in parenthesis.
.

Number: 6 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:22:03 PM -04'00'

I think the explanation is a little easier than this - if there is no puberty, then there is nothing to suppress.

Number: 7 Author [redacted] Subject: Highlight Date: 9/7/2022 12:30:15 PM -04'00'

ould include a stronger discussion of the risks with pubertal suppression.

Author: [redacted] Subject: Highlight Date: 9/7/2022 12:36:40 PM -04'00'

This recommendation doesn't break down the type of surgery. There's going to be a big difference between the different types of surgery and the impact of hormones. Additionally, the surgery conversation comes right after the conversation on blockers, omitting any discussion on the decision to start GAHT.

GAHT leads to anatomical, h siolo ical, and s cholo ical chan es. The onset of the anatomic effects (e. ., clitoral rowth, breast rowth, va - inal mucosal atro h) ma be in earl after the initiation of thera , and the eak effect is ex ected at 1–2 ears (T'S oen et al., 2019). To ensure sufficient time for s cholo ical ada ta- tions to the h sical chan e durin an im ortant developmental time for the adolescent, 12 months of hormone treatment is suggested. Depending upon the surgical result required, a period of hormone treatment may need to be longer (e.g., sufficient clitoral virilization prior to metoidio- plasty/phalloplasty, breast growth and skin expan- sion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).

For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of hormone therapy on the proposed surgery. In addition, for indi- viduals undergoing gonadectomy who are not taking hormones, a plan for hormone replace- ment can be developed with their prescribing professional prior to surgery.

With the aforementioned criteria fulfilled (6.12.a–6.12._), the followin_ are su__ested minimal a_es for _ender-affirmin_ medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estro ens or andro ens) unless there are si nificant, compellin reasons to take an individualized a roach when considerin the factors uni ue to the adolescent treat- ment time frame.
- 15 years and above for chest masculiniza- tion unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 16 years and above for breast augmenta- tion, acial sur er (includin rhino last , tracheal shave, and enio last) as art of ender-affirmin treatment unless there are si - nificant, com elling reasons to take an individ- ualized approach when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidio lasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treat- ment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the ado- lescent treatment time frame.

The ages outlined above provide general guid- ance for determining the age at which gender-affirmin interventions may be consid- ered. A e criteria should be considered in addi- tion to other criteria resented for ender-affirmin interventions in youth as outlined in Statements 6.12a-f. Individual needs, decision-makin ca ac- it for the s ecific treatment bein considered, and develo mental sta e (rather than a e) are most relevant when determinin the timing of treatment decisions for individuals. Age has a strong, albeit imperfect, correlation with cognitive and psychosocial development and may be a use- ful objective marker for determining the potential timing of interventions (Ferguson et al., 2021). Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility, com- plexity, or both. This approach allows for con- tinued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (see Statement 6.12c).

The recommendations above are based on available evidence, expert consensus, and ethical considerations, includin res ect for the emer in autonom of adolescents and the minimization of harm within the context of a limited evidence base. Historically, there has been hesitancy in the transgender health care setting to offer gender-affirming treatments with potential irre- versible effects to minors. The age criteria set forth in these guidelines are younger than ages stipulated in previous guidelines and are intended to facilitate youth's access to gender-affirming treatments (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender-affirming

Page: 67

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:41:50 PM -04'00'

Sterilizing procedures prior to the age of consent when the person can make the decision for themselves is going to be VERY controversial. Additionally, when reviewing the 3 studies to justify vaginoplasty at 17, none of the individuals referenced in the study were under 18 (unless there is a shared data set separate from the study)

Author: [redacted] Subject: Highlight Date: 9/7/2022 12:44:20 PM -04'00'

s is to improve overall outcome and give the medical intervention time to work. It should not be used as a "watchful waiting" or gatekeeping strategy. The other point here is that hormones work SLOWLY so if someone does not like what they are doing, providers should create a safe environment to explore that feeling and adjust the approach if necessary towards an ultimate goal of affirming the child for who they are

Author: [redacted] Subject: Highlight Date: 9/7/2022 12:46:53 PM -04'00'

endations appear to be categorized by ease of surgery, rather than risk of outcome.

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:48:02 PM -04'00'

portant, but is the exact opposite of the age qualifications for surgery. It is a direct contradiction.

Number: 5 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:49:34 PM -04'00'

hapter leads into a very conservative framework for providing this care, but then the surgery recommendations the age specific criteria without evidence to support.

Number: 6 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:49:57 PM -04'00'

This does not really take into consideration developmental differences between pubertal initiation in AMAB and AFAB pts.

Number: 7 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:51:59 PM -04'00'

"unless there are significant, compelling reasons to take an individualized approach..." is very concerning. The recommendations, as written, appear to be an opt out model rather than an individualized approach.

Number: 8 Author [redacted] Subject: Highlight Date: 9/7/2022 12:55:23 PM -04'00'

esented evidence throughout the next few paragraphs to support the recommendations for younger ages to be able to have these procedures. Surgery should be presented as the exception rather than the rule. This is going to heavily influence the current climate in the US and feeds directly in the anti-transgender arguments.

Number: 9 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:57:13 PM -04'00'

Facial surgery for minors is going to be a big deal, tracheal shaves are very high risk

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 6.12c).

A growing body of evidence indicates providing gender-affirming treatment for gender diverse youth who meet criteria leads to positive outcomes (Achille et al., 2020; de Vries et al., 2014; Kuper et al., 2020). There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth (Chen et al., 2020; Chew et al., 2018; Olson-Kennedy et al., 2016). Currently, the only existing longitudinal studies evaluating gender diverse youth and adult outcomes 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. [4] Lon itudinal studies are currentl underwa to better define outcomes as well as the safet and efficac of ender-affirmin treatments in outh (Olson-Kenned , Garofalo et al., 2019; Olson-Kennedy, Rosenthal 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 (de Vries et al., 2021). As the evidence base regarding outcomes of gender-affirming interventions in youth continues to grow, recommendations on the timing and readiness for these interventions may be updated.

Previous guidelines regarding gender-affirming treatment of adolescents recommended partially reversible GAHT could be initiated at approximatel 16 ears of a e (Coleman et al., 2012; [6] Hembree et al., 2009). [7] More recent uidelines suggest there ma be com ellin reasons to initiate GAHT rior to the a e of 16, althou h there are limited studies on youth who have initiated hormones rior to 14 years of age (Hembree et al., 2017). A compelling reason for earlier initiation of GAHT, for example, might be to avoid

rolon ed ubertal su ression, [1] iven otential bone health concerns and the s chosocial im lications of dela in ubert as described in more detail in Chapter 12—Hormone Therapy (Klink, Caris et al., 2015; Schagen et al., 2020; Vlot et al., 2017; Zhu & Chan, 2017). [2] ubert is a time of si nificant brain and co nitive develo ment. The otential neurodevelo mental im act of extended ubertal su ression in ender diverse outh has been s ecificall 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 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 requires continued study (Klink, Caris et al., 2015; Lee, Finla son et al., 2020; Schagen et al., 2020). [3] It should also be noted the ages for initiation of GAHT recommended above are dela ed when com ared with the a es at which cis ender peers initiate ubert with endo enous hormones in most re ions (Palmert & Dunkel, 2012). The _otential ne_ative _s_chosocial im_lications of not initiatin_ _ubert_ with _eers ma_ _lace additional stress on _ender diverse outh, although this has not been explicitly studied. When considering the timing of initiation of gender-affirming hormones, providers should compare the potential physical and psychological benefits and risks of starting treatment with the potential risks and benefits of delaying treatment. This process can also help identify compelling factors that may warrant an individualized a roach.

[5] A_e recommendations for irreversible sur_ical _rocedures were determined b_ a review of existin_ literature and the ex ert consensus of mental health _roviders, medical _roviders, and sur_eons hi hl ex erienced in providing care to TGD adolescents. Studies carried out with trans masculine youth have demonstrated 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 et al., 2018; Sood et al., 2021). [8] estosterone

Page: 68

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:58:30 PM -04'00'

The bone health issues seem to be discussed more in Chpt 12 and the discussion of puberty blocker risks in recommendation 6.12.f. None of the age recommendations deal with blockers. This will confuse people jumping from hormones to side effects of blockers and may be misinterpreted as hormone adverse effects just based on placement.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:59:43 PM -04'00'

Concerns about blockers delaying cognitive development have not panned out at all in the research. While it does need to be studied more, it is still hypothetical.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 1:24:24 PM -04'00'

Very good point to include

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:21:23 PM -04'00'

Raises the question why changes are being made before these longitudinal studies are available. This will be seen as seen as validating the arguments against this care.

Number: 5 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:21:45 PM -04'00'

[redacted]erature for this

[redacted] Author [redacted] Subject: Highlight Date: 9/8/2022 3:20:01 PM -04'00'

2017 Endocrine Society guidelines referenced here? These state:
hormones can be used prior to the age of 16 and never before Tanner 2 using an individualized approach which really leaves it open to the provider and the family to decide what is best.

[redacted] Author: [redacted] Subject: Highlight Date: 9/7/2022 2:24:36 PM -04'00'

[redacted]mmending GAHT at 14, the recommendations then present evidence saying that there's actually limited evidence for starting this care at age 14. I agree 14 is reasonable, but its being presented in a way that will be construed as "saying 14 is a good age to start, we just don't have evidence to support that'

Number: 8 Author [redacted] Subject: Highlight Date: 9/7/2022 2:25:44 PM -04'00'

Top of page 67 "testosterone unfortunately does little to alleviate this distress" I'm very worried this could be used out of context to go against using testosterone and that there is no accompanying citation. There's no evidence that testosterone does NOT alleviate the chest dysphoria—my experience is that it does, but still top surgery can be important for some.

Unfortunately does little to alleviate this distress, althou h chest masculinization is an o tion for some individuals to address this distress lon -term. Studies with outh who sou ht chest masculinization sur er to alleviate chest d s ho-ria demonstrated ood sur ical outcomes, satisfaction with results, and minimal re ret durin the stud monitorin eriod (Marinkovic & Newfield, 2017; Olson-Kennedy, Warus et al., 2018). Chest masculinization sur er can be considered in minors when clinicall and develo -mentall a ro riate as determined by a multidisci linar team ex erienced in adolescent and ender develo ment (see relevant statements in this cha ter). The duration or current use of testosterone thera should not reclude sur er if otherwise indicated. The needs of some TGD outh ma be met by chest masculinization surgery alone. Breast augmentation may be needed by trans feminine youth, although there is less data about this procedure in youth, possibly due to fewer individuals requesting this procedure (Boskey et al., 2019; James, 2016). GAHT, specifically estrogen, can hel with develo ment of breast tissue, and it is recommended outh have a minimum of 12 months of hormone therapy, or longer as is surgically indicated, prior to breast augmentation unless hormone therapy is not clinicall indicated or is medicall contraindicated.

Data are limited on the o timal timin for initiatin other ender-affirmin sur ical treatments in adolescents. This is artl due to the limited access to these treatments, which varies in different geographical locations (Mahfouda et al., 2019). Data indicate rates of gender-affirming surgeries have increased since 2000, and there has been an increase in the number of TGD youth seeking vaginoplasty (Mahfouda et al., 2019; Milrod & Karasic, 2017). A 2017 study of 20 WPATH-affiliated sur eons in the US re orted sli htl more than half had erformed vaginoplasty in minors (Milrod & Karasic, 2017). Limited data are available on the outcomes for youth undergoing vaginoplasty. Small studies have reported improved psychosocial functioning and decreased gender dysphoria in adolescents who have under one va ino lasty (Becker et al., 2018; Cohen-Kettenis & van Goozen, 1997; Smith et al.,2001). While the sample sizes are small, these studies suggest there may be a benefit for 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 postoperative 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) (Boskey et al., 2018; 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 (Boskey et al., 2019). Given the complexity of phalloplasty, and current high rates of complications in comparison to other gender-affirming surgical treatments, it is not recommended this surgery be considered in youth under 18 at this time (see Chapter 13—Surgery and Postoperative Care).

Additional key factors that should be taken into consideration when discussing the timing of interventions with youth and families are addressed in detail in statements 6.12a-f. For a summary of the criteria/recommendations for medically necessary gender-affirming medical treatment in adolescents, see Appendix D.

Page: 69

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While not specifically saying surgeries are being, this instead simply states that institutions are performing surgery and then does not include any mention of outcome data.

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This is all valid... Chest masculinization in minors statement does not have a reference though so will be seen by the anti-trans movement as bias.

[redacted]ment: "duration or current use of testosterone therapy should to preclude surgery if otherwise indicated," is in direct contradiction to the statement about minimum 1 year of testosterone prior to surgery.

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[redacted]data in these studies, its difficult to ascertain if any of the youth had surgery prior to 18 or if they youth were just referred for surgery prior to 18. The 1997 and 2001 paper discuss series of "tests" including partial and full hormone treatment, living in real life as the asserted gender, etc., that would have taken time (and no one started hormones before 16)... its unclear if these studies really show evidence of success for minors undergoing vaginoplasty as it suggests here (and if it does the number of subjects are in the single digits). The 2018 paper says that in Germany surgery can take place as young as 16 but it does not provide any data that I can see to say any of the adolescents in the study specifically had vaginoplasty.

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[redacted]ates maximum breast growth is 2-5 years after initiation of Estradiol, so it is going to bring up a question of why wait 1 year when breast growth can take 2 or more years.

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[redacted]other point for proponents of gender-affirming care.

CHAPTER 7 Children

These Standards of Care pertain to prepubescent gender diverse children and are based on research, ethical principles, and accumulated expert knowledge. The principles underlying these standards include the following 1) childhood gender diversity is an expected aspect of general human development (Endocrine Society and Pediatric Endocrine Society, 2020; Telfer et al., 2018); 2) childhood gender diversity is not a pathology or mental health disorder (Endocrine Society and Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018); 3) diverse gender expressions in children cannot always be assumed to reflect a transgender identity or gender incongruence (Ehrensaft, 2016; Ehrensaft, 2018; Rael et al., 2019); 4) guidance from mental health professionals (MHPs) with expertise in gender care for children can be helpful in supporting positive adaptation as well as discernment of gender-related needs over time (APA, 2015; Ehrensaft, 2018; Telfer et al., 2018); 5) conversion therapies for gender diversity in children (i.e., any "therapeutic" attempts to compel a gender diverse child through words, actions, or both to identify with, or behave in accordance with, the gender associated with the sex assigned at birth are harmful and we repudiate their use (APA, 2021; Ashley, 2019b, Paré, 2020; SAMHSA, 2015; Telfer et al., 2018; UN Human Rights Council, 2020).

Throughout the text, the term "health care professional" (HCP) is used broadly to refer to professionals workin with ender diverse children. nlike ubescent outh and adults, re ubescent ender diverse children are not eli ible to access medical intervention (Pediatric Endocrine Society, 2020); therefore, when professional input is sought, it is most likely to be from an HCP specialized in psychosocial supports and gender development. Thus, this chapter is uniquely focused on developmentally appropriate psychosocial practices, although other HCPs, such as pediatricians and family practice HCPs may also find these standards useful as they engage in professional work with gender diverse children and their families.

This chapter employs the term "gender diverse" given that gender trajectories in prepubescent children cannot be predicted and may evolve over time (Steensma, Kreukels et al., 2013). At the same time, this chapter recognizes some children will remain stable in a gender identity they articulate early in life that is discrepant from the sex assigned at birth (Olson et al., 2022). The term, "gender diverse" includes transgender binary and nonbinary children, as well as gender diverse children who will ultimately not identify as transgender later in life. Terminology is inherently culturally bound and evolves over time. Thus, it is possible terms used here may become outdated and we will find better descriptors.

This chapter describes aspects of medical necessary care intended to promote the well-being and gender-related needs of children (see medically necessary statement in the Global Applicability chapter, Statement 2.1). This chapter advocates everyone employs these standards, to the extent possible. There may be situations or locations in which the recommended resources are not fully available. HCPs/teams lacking resources need to work toward meeting these standards. However, if unavoidable limitations preclude components of these recommendations, this should not hinder rovidin the best services currentl available. In those locations where some but not all recommended services exist, choosin not to im lement otentiall beneficial care services risks harm to a child (Murchison et al., 2016; Telfer et al., 2018; Riggs et al., 2020). Overall, it is imperative to prioritize a child's best interests.

A vast empirical psychological literature indicates early childhood experiences frequently set the stage for lifelong patterns of risk and/or resilience and contribute to a trajectory of development more or less conducive to well-being and a positive quality of life (Anda et al., 2010; Masten & Cicchetti, 2010; Shonkoff & Garner, 2012). The available research indicates, in general, gender diverse youth are at greater risk for experiencing psychological difficulties (Ristori & Steensma, 2016) than age- matched cisgender peers as a result of encountering destructive experiences, including trauma and maltreatment stemming from gender diversity-related rejection and other harsh, non-accepting interactions (Barrow & Apostle, 2018; Giovanardi et al., 2018; Gower, Rider, Brown et al., 2018; Grossman & D'Augelli, 2006; Hendricks & Testa, 2012; Reisner, Greytak

Page: 70

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:34:44 PM -04'00'

Into. In contrast to chapter 6, this chapter explicitly endorses 'gender-affirming care' for prepubescent children.

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Very much in line with AAP

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In line with AAP

et al., 2015; Roberts et al., 2014; Tishelman & Neumann-Mascis, 2018). Further, literature indicates prepubescent children who are well accepted in their gender diverse identities are generally well-adjusted (Malpas et al., 2018; Olson et al., 2016). Assessment and treatment of children typically emphasizes an *ecological* approach, recognizing children need to be safe and nurtured in each setting they frequent (Belsky, 1993; Bronfenbrenner, 1979; Kaufman & Tishelman, 2018; Lynch & Cicchetti, 1998; Tishelman et al., 2010; Zielinski & Bradshaw, 2006). Thus, the perspective of this chapter draws on basic psychological literature and knowledge of the unique risks to gender diverse children and emphasizes the integration of an ecological approach to understanding their needs and to facilitating positive mental health in all gender care. This perspective prioritizes fostering well-being and quality of life for a child throughout their development. Additionally, this chapter also embraces the viewpoint, supported by the substantial psychological research cited above, that psychosocial gender-affirming care (Hidalgo et al., 2013) for prepubescent children offers a window of opportunity to promote a trajectory of well-being that will sustain them over time and during the transition to adolescence. This approach potentially can mitigate some of the common mental health risks faced by transgender and gender diverse (TGD) teens, as frequently described in literature (Chen et al., 2021; Edwards-Leeper et al., 2017; Haas et al., 2011; Leibowitz & de Vries, 2016; Reisner, Bradford et al., 2015; Reisner, Greytak et al., 2015).

Developmental research has focused on understanding various aspects of gender development in the earliest years of childhood based on a general population of prepubescent children. This research has typically relied on the assumption that child research participants are cisgender (Olezeski et al., 2020) and has reported gender identity stability is established in the preschool years for the general population of children, most of whom are likely not gender diverse (Kohlberg, 1966; Steensma, Kreukels et al., 2013). Recently, developmental research has demonstrated gender diversity can be observed and identified in young prepubescent children (Fast & Olson, 2018; Olson & Gülgöz, 2018; Robles et al., 2016). Nonetheless, empirical study in this area is limited, and at this time there are no psychometrically sound assessment measures capable of reliably and/or fully ascertaining a prepubescent child's self-understanding of their own gender and/or gender-related needs and preferences (Bloom et al., 2021). Therefore, this chapter emphasizes the importance of a nuanced and individualized clinical approach to gender assessment, consistent with the recommendations from various guidelines and literature (Berg & Edwards-Leeper, 2018; de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2018; Steensma & Wensing-Kruger, 2019). Research and clinical experience have indicated gender diversity in prepubescent children may, for some, be fluid; there are no reliable means of predicting an individual child's gender evolution (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013), and the gender-related needs for a particular child may vary over the course of their childhood.

It is important to understand the meaning of the term "assessment" (sometimes used synonymously with the term "evaluation"). There are multiple contexts for assessment (Krishnamurthy et al., 2004) including rapid assessments that take place during an immediate crisis (e.g., safety assessment when a child may be suicidal) and focused assessments when a family may have a circumscribed question, often in the context of a relatively brief consultation (Berg & Edwards-Leeper, 2018). The term assessment is also often used in reference to "diagnostic assessment," which can also be called an "intake" and is for the purpose of determining whether there is an issue that is diagnosable and/or could benefit from a therapeutic process. This chapter focus on comprehensive assessments, useful for understanding a child and family's needs and goals (APA, 2015; de Vries & Cohen-Kettenis, 2012; Srinath et al., 2019; Steensma & Wensing-Kruger, 2019). This type of psychosocial assessment is not necessary for all gender diverse children, but may be requested for a number of reasons. Assessments may present a useful opportunity to start a process of support for a gender diverse child and their family, with the understanding that gender diverse children benefit when their family dynamics include

Page: 71

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This sentence here is a little confusing; it seems to say children don't know their gender as well as adults although it cannot be measured.

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Very much in line with AAP

Statements of Recommendations

7.1- We recommend health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span.
7.2- We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.
7.3- We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.
7.4- We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.
7.5- We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.
7.6- We recommend health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning, and language skills.
7.7- We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).
7.8- We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.
7.9- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.
7.10- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age-appropriate psychoeducation about gender development.
7.11- We recommend that health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.
7.12- We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.
7.13- We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.
7.14- We recommend the health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.
7.15- We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

acceptance of their gender diversity and parenting guidance when requested. Comprehensive assessments are appropriate when solicited by a family requesting a full understanding of the child's gender and mental health needs in the context of gender diversity.

In these circumstances, family member mental health issues, family dynamics, and social and cultural contexts, all of which impact a gender diverse child, should be taken into consideration (Barrow & Apostle, 2018; Brown & Mar, 2018; Cohen-Kettenis et al., 2003; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Ristori & Steensma, 2016; Tishelman & Neumann-Mascis, 2018). This is further elaborated upon in the text below.

It is important HCPs working with gender diverse children strive to understand the child and the family's various aspects of identity and experience: racial, ethnic, immigrant/refugee status, religious, geographic, and socio-economic, for example, and be respectful and sensitive to cultural context in clinical interactions (Telfer et al., 2018). Many factors may be relevant to culture and gender, including religious beliefs, gender-related expectations, and the degree to which gender diversity is accepted (Oliphant et al., 2018). Intersections between gender diversity, sociocultural diversity, and minority statuses can be sources of strength, social stress, or both (Brown & Mar, 2018; Oliphant et al., 2018; Riggs & Treharne, 2016).

Each child, family member, and family dynamic is unique and potentially encompasses multiple cultures and belief atterns. Thus, HCPs of all disci lines should avoid stereot in based on reconceived ideas that ma be incorrect or biased (e. ., that a famil who belon s to a religious organization that is o osed to a reciatin ender diversit will necessaril be unsu ortive of their child's gender diversity) (Brown & Mar, 2018). Instead, it is essential to approach each family openly and understand each family member and family pattern as distinct.

Page: 72

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Great!

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statement 7.1

We recommend the health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess general knowledge of gender diversity across the life span.

HCPs working with gender diverse children should acquire and maintain the necessary training and credentials relevant to the scope of their role as professionals. This includes licensure, certification, or both by appropriate national and/or regional accrediting bodies. We recognize the specifics of credentialing and regulation of professionals vary globally. Importantly, basic licensure, certification, or both may be insufficient in and of itself to ensure competency working with gender diverse children, as HCPs specifically require in-depth training and supervised experience in childhood gender development and gender diversity to provide appropriate care.

Statement 7. 2

We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.

HCPs should receive training and supervised expertise in general child and family mental health across the developmental spectrum from toddlerhood through adolescence, including evidence-based assessment and intervention approaches. Gender diversity is not a mental health disorder; however, as cited above, we know mental health can be adversely impacted for gender diverse children (e.g., through gender minority stress) (Hendricks & Testa, 2012) that may benefit from exploration and support; therefore, mental health expertise is highly recommended. Working with children is a complex endeavor, involving an understanding of a child's developmental needs at various ages, the ability to comprehend the forces impacting a child's well-being both inside and outside the family (Kaufman & Tishelman, 2018), and an ability to fully assess when a child is unhappy or experiencing significant mental health difficulties, related or unrelated to gender. Research has indicated high levels of adverse experiences and trauma in the gender diverse community of children, including susceptibility to rejection or even maltreatment (APA, 2015; Barrow & Apostle, 2018; Giovanardi et al., 2018; Reisner, Greytak et al., 2015; Roberts et al., 2012; Tishelman & Neumann-Mascis, 2018). HCPs need to be cognizant of the potential for adverse experiences and be able to initiate effective interventions to prevent harm and promote positive well-being.

Statement 7.3

We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.

The experience of gender diversity in autistic children as well as in children with other forms of neurodivergence may present extra clinical complexities (de Vries et al., 2010; Stran , Mea her et al., 2018). For example, autistic children may find it difficult to self-advocate for their ender-related needs and may communicate in hi hl individualistic wa s (Kuvalanka et al., 2018; Strang, Powers et al., 2018). The ma have varied inter retations of gender-related ex eriences given common differences in communication and thinkin st le. Because of the uni ue needs of ender diverse neurodiver ent children, the ma be at hi h risk for bein misunderstood (i.e., for their communications to be misinterpreted). Therefore, professionals providing support to these children can best serve them by receiving training and developing expertise in autism and related neurodevelopmental presentations and/or collaborating with autism specialists (Strang, Meagher et al., 2018). Such training is especially relevant as research has documented

Page: 73

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In the adolescent chapter, ASD was seen as a complicating factor that made assessment difficult, but here it is so nicely worded that neuro-divergent kids need more help and support which is something providers can really help with.

higher rates of autism among gender diverse youth than in the general population (de Vries et al., 2010; Hisle-Gorman et al., 2019; Shumer et al., 2015).

Statement 7.4

We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.

Continuing professional development regarding gender diverse children and families may be acquired through various means, including through readings (journal articles, books, websites associated with gender knowledgeable organizations), attending on-line and in person trainings, and joining peer supervision/consultation groups (Bartholomaeus et al., 2021).

Continuing education includes 1) maintaining up-to-date knowledge of available and relevant research on gender development and gender diversity in prepubescent children and gender diversity across the life span; 2) maintaining current knowledge regarding best practices for assessment, support, and treatment approaches with gender diverse children and families. This is a relatively new area of practice and health care professionals need to adapt as new information emerges through research and other avenues (Bartholomaeus et al., 2021).

Statement 7.5

We recommend health care professionals conductin_ an assessment with _ender diverse children access and integrate information from multiple sources as part of the assessment.

A comprehensive assessment, when requested by a family and/or an HCP can be useful for developing intervention recommendations, as needed, to benefit the well-being of the child and other family members. Such an assessment can be beneficial in a variety of situations when a child and/or their family/guardians, in coordination with providers, feel some type of intervention would be helpful. Neither assessments nor interventions should ever be used as a means of covertly or overtly discouraging a child's gender diverse expressions or identity. Instead, with appropriately trained providers, assessment can be an effective means of better understanding how to support a child and their family without privileging any particular gender identity or expression. An assessment can be especially important for some children and their families by collaborating to promote a child's gender health, well-being, and self-fulfillment.

A comprehensive assessment can facilitate the formation of an individualized plan to assist a gender diverse prepubescent children and family members (de Vries & Cohen-Kettenis, 2012; Malpas et al., 2018; Steensma & Wensing-Kruger, 2019; Telfer et al., 2018; Tishelman & Kaufman, 2018). In such an assessment, integrating information from multiple sources is important to 1) best understand the child's gender needs and make recommendations; and 2) identify areas of child, family/caregiver, and community strengths and supports specific to the child's gender status and development as well as risks and concerns for the child, their family/caregivers and environment. Multiple informants for both evaluation and support/intervention planning purposes may include the child, parents/caregivers, extended family members, siblings, school personnel, HCPs, the community, broader cultural and legal contexts and other sources as indicated (Berg & Edwards-Leeper, 2018; Srinath, 2019).

An HCP conducting an assessment of gender diverse children needs to explore gender-related issues but must also take a broad view of the child and the environment, consistent with the ecological model described above (Bronfenbrenner, 1979) to fully understand the factors impacting a child's well-being and areas of gender support and risk (Berg & Edwards-Leeper, 2018; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Tishelman & Neumann-Mascis, 2018). This includes understanding the strengths and challenges experienced by the child/family and that are present in the environment. We advise HCPs conducting an assessment with gender diverse children to consider incorporating multiple assessment domains, depending on the child and the family's needs and circumstances. Although some of the latter listed domains below do not directly address the child's gender (see items 7–12 below), they need to be accounted for in a gender assessment, as indicated by clinical judgment, to understand the complex web of factors

Page: 74

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It's not clear whether this applies to the ambiguous definition of assessment recommended in the adolescent chapter.

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Very much in line with AAP

that may be affecting the child's well-being in an integrated fashion, including gender health, consistent with evaluation best practices a (APA, 2015; Berg & Edwards-Leeper, 2018; Malpas et al., 2018) and develop a multi-pronged intervention when needed.

Summarizing from relevant research and clinical expertise, assessment domains often include 1) a child's asserted gender identity and gender expression, currently and historically; 2) evidence of dysphoria, gender incongruence, or both; 3) strengths and challenges related to the child, family, peer and others' beliefs and attitudes about gender diversity, acceptance and support for child; 4) child and family experiences of gender minority stress and rejection, hostility, or both due to the child's gender diversity; 5) level of support related to gender diversity in social contexts (e.g., school, faith community, extended family); 6) evaluation of conflict regarding the child's gender and/or parental/caregiver/sibling concerning behavior related to the child's gender diversity; 7) child mental health, communication and/or cognitive strengths and challenges, neurodivergence, and/or behavioral challenges causing significant functional difficulty; 8) relevant medical and developmental history; 9) areas that may pose risks (e.g., exposure to domestic and/or community violence, any form of child maltreatment; history of trauma; safety and/or victimization with peers or in any other setting; suicidality); 10) co-occurring significant family stressors, such as chronic or terminal illness, homelessness or poverty; 11) parent/caregiver and/or sibling mental health and/or behavioral challenges causing significant functional difficulty; and 12) child's and family's strengths and challenges.

A thorough assessment incorporating multiple forms of information gathering is helpful for understanding the needs, strengths, protective factors, and risks for a specific child and family across environments (e.g., home/school). Methods of information gathering often include 1) interviews with the child, family members and others (e.g., teachers), structured and unstructured; 2) caregiver and child completed standardized measures related to gender; general child well-being; child cognitive and communication skills and developmental disorders/disabilities; support and acceptance by parent/caregiver, sibling, extended family and peers; parental stress; history of childhood adversities; and/or other issues as appropriate (APA, 2020; Berg & Edwards-Leeper, 2018; Kaufman & Tishelman, 2018; Srinath, 2019).

Depending on the family characteristics, the developmental profile of the child, or both, methods of information gathering also may also benefit from including the following 1) child and/or family observation, structured and unstructured; and 2) structured and visually supported assessment techniques (worksheets; self-portraits; family drawings, etc.) (Berg & Edwards-Leeper, 2018).

Statement 7.6

We recommend that health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning and language skills.

Given the complexities of assessing young children who, unlike adults, are in the process of development across a range of domains (cognitive, social, emotional, physiological), it is important to consider the developmental status of a child and gear assessment modalities and interactions to the individualized abilities of the child. This includes tailoring the assessment to a child's developmental stage and abilities (preschoolers, school age, early puberty prior to adolescence), including using language and assessment approaches that prioritize a child's comfort, language skills, and means of self-expression (Berg & Edwards-Leeper, 2018; Srinath, 2019). For example, relevant developmental factors, such as neurocognitive differences (e.g., autism spectrum conditions), and receptive and expressive language skills should be considered in conducting the assessment. Health care professionals may need to consult with specialists for guidance in cases in which they do not possess the specialized skills themselves (Strang et al., 2021).

Statement 7.7

We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).

Page: 75

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:47:39 PM -04'00'

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very much in line with AAP

HCPs conducting an assessment with gender diverse children and families need to account for developmental, emotional, and environmental factors that may constrain a child's, caregiver's, sibling or other's report or influence their belief systems related to gender (Riggs & Bartholomaeus, 2018). As with all child psychological assessments, environmental and family/caregiver reactions (e.g., punishment), and/or cognitive and social factors may influence a child's comfort and/or ability to directly discuss certain factors, including gender identit and related issues (Srinath, 2019). Similarl , family members ma feel constrained in freel ex ressin their concerns and ideas de endin on famil conflicts or d namics and/or other influences (e. ., cultural/ reli ious; extended family pressure) (Riggs & Bartholomaeus, 2018).

Statement 7.8

We recommend health care professionals consider consultation, _s_chothera_ _, or both for a _ender diverse child and famil_/care_ivers when families and health care _rofessionals believe this would benefit the well-being and development of a child and/or family.

The goal of psychotherapy should never be aimed at modifying a child's gender identity (APA, 2021; Ashley, 2019b; Paré, 2020; SAMHSA, 2015; UN Human Rights Council, 2020), either covertly or overtly. Not all gender diverse children or their families need input from MHPs as gender diversity is not a mental health disorder (Pediatric Endocrine Society, 2020; Telfer et al., 2018). Nevertheless, it is often appropriate and helpful to seek psychotherapy when there is distress or concerns are expressed by parents to improve psychosocial health and prevent further distress (APA, 2015). Some of the common reasons for considering psychotherapy for a gender diverse child and family include the following 1) A child is demonstrating significant conflicts, confusion, stress or distress about their gender identity or needs a protected space to explore their gender (Ehrensaft, 2018; Spivey and Edwards-Leeper, 2019); 2) A child is experiencing external pressure to express their gender in a way that conflicts with their self-knowledge, desires, and beliefs (APA, 2015); 3) A child is struggling with mental health concerns, related to or independent of their gender (Barrow & Apostle, 2018); 4) A child would benefit from strengthening their resilience in the face of negative environmental responses to their gender identity or presentation (Craig & Auston, 2018; Malpas et al., 2018); 5) A child may be experiencing mental health and/or environmental concerns, including family system problems that can be misinterpreted as gender congruence or incongruence (Berg & Edwards-Leeper, 2018); and 6) A child expresses a desire to meet with an MHP to get gender-related support. In these situations, the psychotherapy will focus on supporting the child with the understanding that the child's parent(s)/caregiver(s) and potentially other family members will be included as necessary (APA, 2015; Ehrensaft, 2018; McLaughlin & Sharp, 2018). Unless contraindicated, it is extremely helpful for parents/guardians to participate in some capacity in the psychotherapy process involving prepubescent children as family factors are often central to a child's well-being. Although relatively unexplored in research involving gender diverse children, it may be important to attend to the relationship between siblings and the gender diverse child (Pariseau et al., 2019; Parker & Davis-McCabe, 2021).

HCPs should employ interventions tailor-made to the individual needs of the child that are designed to 1) foster protective social and emotional coping skills to promote resilience in the face of potential negative reactions to the child's gender identity, expressions, or both (Craig & Austin, 2016; Malpas et al., 2018; Spencer, Berg et al., 2021); 2) collaboratively problem-solve social challenges to reduce gender minority stress (Barrow & Apostle, 2018; Tishelman & Neumann-Mascis, 2018); 3) strengthen environmental supports for the child and/or members of the immediate and extended family (Kaufman & Tishelman, 2018); and 4) provide the child an opportunity to further understand their internal gender experiences (APA, 2015; Barrow& Apostle, 2018; Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). It is helpful for HCPs to develop a relationship with a gender diverse child and family that can endure over time as needed. This enables the child/family to establish a long-term trusting relationship throughout childhood whereby the HCP can offer support and guidance as a child matures and as potentially

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different challenges or needs emerge for the child/family (Spencer, Berg et al., 2021; Murchison et al., 2016). In addition to the above and within the limits of available resources, when a child is neurodivergent, an HCP who has the skill set to address both neurodevelopmental differences and gender is most appropriate (Strang et al., 2021).

As outlined in the literature, there are numerous reasons parents/caregivers, siblings, and extended family members of a prepubescent child may find it useful to seek psychotherapy for themselves (Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). As summarized below, some of these common catalysts for seeking such treatment occur when one or more *family members* 1) desire education around gender development (Spivey & Edwards-Leeper, 2019); 2) are experiencing significant confusion or stress about the child's gender identity, expression, or both (Ashley, 2019c; Ehrensaft, 2018); 3) need guidance related to emotional and behavioral concerns regarding the gender diverse child (Barrow & Apostle, 2018; 4) need support to promote affirming environments outside of the home (e.g., school, sports, camps) (Kaufman & Tishelman, 2018); 5) are seeking assistance to make informed decisions about social transition, including how to do so in a way that is optimal for a child's gender development and health (Lev & Wolf-Gould, 2018); 6) are seeking guidance for dealing with condemnation from others, including political entities and accompanying legislation, regarding their support for their gender diverse child (negative reactions directed toward parents/caregivers can sometimes include rejection and/or harassment/abuse from the social environment arising from affirming decisions (Hidalgo & Chen, 2019); 7) are seeking to process their own emotional reactions and needs about their child's gender identity, including grief about their child's gender diversity and/or potential fears or anxieties for their child's current and future well-being (Pullen Sansfaçon et al., 2019); and 8) are emotionally distressed and/or in conflict with other family members regarding the child's gender diversity (as needed, HCPs can provide separate sessions for parents/caregivers, siblings and extended family members for support, guidance, and/or psychoeducation) (McLaughlin & Sharp, 2018; Pullen Sansfaçon et al., 2019; Spivey & Edwards-Leeper, 2019).

Statement 7.9

We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.

Consistent with the ecological model described above and, as appropriate, based on individual/family circumstances, it can be extremely helpful for HCPs to prioritize coordination with important others (e.g., teachers, coaches, religious leaders) in a child's life to promote emotional and physical safety across settings (e.g., school settings, sports and other recreational activities, faith-based involvement) (Kaufman & Tishelman, 2018). Therapeutic and/or support groups are often recommended as a valuable resource for families/caregivers and/or gender diverse children themselves (Coolhart, 2018; Horton et al., 2021; Malpas et al., 2018; Murchison et al., 2016).

Statement 7.10

We recommend HCPs offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age appropriate psycho-education about gender development.

Parents/caregivers and their gender diverse child should have the opportunity to develop knowledge regarding ways in which families/caregivers can best support their child to maximize resilience, self-awareness, and functioning (APA, 2015; Ehrensaft, 2018; Malpas, 2018; Spivey & Edwards-Leeper, 2019). It is neither possible nor is it the role of the HCP to predict with certainty the child's ultimate gender identity; instead, the HCP's task is to provide a safe space for the child's identity to develop and evolve over time without attempts to prioritize any particular developmental trajectory with regard to gender (APA, 2015; Spivey & Edwards-Leeper, 2019). Gender diverse children and early adolescents have different needs and experiences than older adolescents, socially and physiologically, and those differences should be reflected in the individualized approach HCPs

provide to each child/family (Keo-Meir & Ehrensaft, 2018; Spencer, Berg et al., 2021).

Parents/caregivers and their children should also have the opportunity to develop knowledge about gender development and gender literacy through age-appropriate psychoeducation (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy involves understanding the distinctions between sex designated at birth, gender identity, and gender expression, including the ways in which these three factors uniquely come together for a child (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). As a child gains gender literacy, they begin to understand their body parts do not necessarily define their gender identity and/or their gender expression (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy also involves learning to identify messages and experiences related to gender within society. As a child gains gender literacy, they may view their developing gender identity and gender expression more positively, promoting resilience and self-esteem, and diminishing risk of shame in the face of negative messages from the environment. Gaining gender literacy through psychoeducation may also be important for siblings and/or extended family members who are important to the child (Rider, Vencill et al., 2019; Spencer, Berg et al., 2021).

Statement 7.11

We recommend health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender-affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.

As a child matures and approaches puberty, HCPs should prioritize working with children and their parents/caregivers to integrate psychoeducation about puberty, engage in shared decision-making about potential gender-affirming medical interventions, and discuss fertility-related and other reproductive health implications of medical treatments (Nahata, Quinn et al., 2018; Spencer, Berg et al., 2021). Although only limited empirical research exists to evaluate such interventions, expert consensus and developmental psychological literature generally support the notion that open communication with children about their bodies and preparation for physiological changes of puberty, combined with gender-affirming acceptance, will promote resilience and help to foster positive sexuality as a child matures into adolescence (Spencer, Berg et al., 2019). All these discussions may be extended (e.g., starting earlier) to include neurodivergent children, to ensure there is enough time for reflection and understanding, especially as choices regarding future gender- affirming medical care potentially arise (Strang, Jarin et al., 2018). These discussions could include the following topics:

- Review of body parts and their different functions;
- The ways in which a child's body may change over time with and without medical intervention;
- The impact of medical interventions on later sexual functioning and fertility;
- The impact of puberty suppression on potential later medical interventions;
- Acknowledgment of the current lack of clinical data in certain areas related to the impacts of puberty suppression;
- The importance of appropriate sex education prior to puberty.

These discussions should employ developmentally appropriate language and teaching styles, and be geared to the specific needs of each individual child (Spencer, Berg et al., 2021).

Statement 7.12

We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.

Gender social transition refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm and has no singular set of parameters or actions (Ehrensaft et al., 2018).

Gender social transition has often been conceived in the past as binary—a girl transitions to a boy, a boy to a girl. The concept has expanded to include children who shift to a nonbinary or individually shaped iteration of gender identity (Chew et al., 2020; Clark et al., 2018). Newer research indicates the social transition process may serve a protective function for some prepubescent children and serve to foster positive mental health and well-being (Durwood et al., 2017; Gibson et al., 2021; Olson et al., 2016). Thus, recognition that a child's gender may be fluid and develop over time (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013) is not sufficient justification to negate or deter social transition for a prepubescent child when it would be beneficial. Gender identity evolution may continue even after a partial or complete social transition process has taken place (Ashley, 2019e; Edwards-Leeper et al., 2018; Ehrensaft, 2020; Ehrensaft et al., 2018; Spivey & Edwards-Leeper, 2019). Although empirical data remains limited, existing research has indicated children who are most assertive about their gender diversity are most likely to persist in a diverse gender identity across time, including children who socially transition prior to puberty (Olson et al., 2022; Rae et al., 2019; Steensma, McGuire et al., 2013). Thus, when considering a social transition, we suggest parents/caregivers and HCPs pay particular attention to children who consistently and often persistently articulate a gender identity that does not match the sex designated at birth. This includes those children who may explicitly request or desire a social acknowledgement of the gender that better matches the child's articulated gender identity and/or children who exhibit distress when their gender as they know it is experienced as incongruent with the sex designated at birth (Rae et al., 2019; Steensma, Kreukels et al., 2013).

Although there is a dearth of empirical literature regarding best practices related to the social transition process, clinical literature and expertise provides the following guidance that prioritizes a child's best interests (Ashley, 2019e; Ehrensaft, 2018; Ehrensaft et al, 2018; Murchison et al., 2016; Telfer et al., 2018): 1) social transition should originate from the child and reflect the child's wishes in the process of making the decision to initiate a social transition process; 2) an HCP may assist exploring the advantages/benefits, plus potential challenges of social transition; 3) social transition may best occur in all or in specific contexts/settings only (e.g., school, home); and 4) a child may or may not choose to disclose to others that they have socially transitioned, or may designate, typically with the help of their parents/caregivers, a select group of people with whom they share the information.

In summary, social transition, when it takes place, is likely to best serve a child's well-being when it takes place thoughtfully and individually for each child. A child's social transition (and gender as well) may evolve over time and is not necessarily static, but best reflects the cross-section of the child's established self-knowledge of their present gender identity and desired actions to express that identity (Ehrensaft et al., 2018).

A social transition process can include one or more of a number of different actions consistent with a child's affirmed gender (Ehrensaft et al., 2018), including:

- Name change;
- Pronoun change;
- Change in sex/gender markers (e.g., birth certificate; identification cards; passport; school and medical documentation; etc.);
- Participation in gender-segregated programs (e.g., sports teams; recreational clubs and camps; schools; etc.);
- Bathroom and locker room use;
- Personal expression (e.g., hair style; clothing choice; etc.);
- Communication of affirmed gender to others (e.g., social media; classroom or school announcements; letters to extended families or social contacts; etc.).

Statement 7.13

We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.

It is important children who have engaged in social transition be afforded the same opportunities as other children to continue considering

meanings and expressions of gender throughout their childhood years (Ashley 2019e; Spencer, Berg et al., 2021). Some research has found children may experience gender fluidity or even detransition after an initial social transition. Research has not been conclusive about when in the life span such detransition is most likely to occur, or what percentage of youth will eventually experience gender fluidity and/or a desire to detransition—due to gender evolution, or potentially other reasons (e.g., safety concerns; gender minority stress) (Olson et al., 2022; Steensma, Kreukels et al., 2013). A recent research report indicates in the US, detransition occurs with only a small percentage of youth five years after a binary social transition (Olson et al., 2022); further follow-up of these young people would be helpful. Replication of these findings is important as well since this study was conducted with a limited and self-selected participant pool in the US and thus may not be applicable to all gender diverse children. In summary, we have limited ability to know in advance the ways in which a child's gender identity and expressions may evolve over time and whether or why detransition may take place for some. In addition, not all gender diverse children wish to explore their gender (Telfer et al., 2018). Cisgender children are not expected to undertake this exploration, and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing, intrusive and/or cisnormative (Ansara & Hegarty, 2012; Bartholomaeus et al., 2021; Oliphant et al., 2018).

Statement 7.14

We recommend health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.

Social transition in prepubescent children consists of a variety of choices, can occur as a process over time, is individualized based on both a child's wishes and other psychosocial considerations (Ehrensaft, 2018), and is a decision for which possible benefits and challenges should be weighted and discussed.

A social transition may have potential benefits as outlined in clinical literature (e.g., Ehrensaft et al., 2018) and supported by research (Fast & Olson, 2018; Rae et al., 2019). These include facilitating gender congruence while reducing gender dysphoria and enhancing psychosocial adjustment and well-being (Ehrensaft et al., 2018). Studies have indicated socially transitioned gender diverse children largely mirror the mental health characteristics of age matched cisgender siblings and peers (Durwood et al., 2017). These findings differ markedly from the mental health challenges consistently noted in prior research with gender diverse children and adolescents (Barrow & Apostle, 2018) and suggest the impact of social transition may be positive. Additionally, social transition for children typically can only take place with the support and acceptance of parents/caregivers, which has also been demonstrated to facilitate well-being in gender diverse children (Durwood et al., 2021; Malpas et al., 2018; Pariseau et al., 2019), although other forms of support, such as school-based support, have also been identified as important (Durwood et al., 2021; Turban, King et al., 2021). HCPs should discuss the potential benefits of a social transition with children and families in situations in which 1) there is a consistent, stable articulation of a gender identity that is incongruent with the sex assigned at birth (Fast & Olson, 2018). This should be differentiated from gender diverse expressions/behaviors/interests (e.g., playing with toys, expressing oneself through clothing or appearance choices, and/or engaging in activities socially defined and typically associated with the other gender in a binary model of gender) (Ehrensaft, 2018; Ehrensaft et al., 2018); 2) the child is expressing a strong desire or need to transition to the gender they have articulated as being their authentic gender (Ehrensaft et al., 2018; Fast & Olson, 2018; Rae et al., 2019); and 3) the child will be emotionally and physically safe during and following transition (Brown & Mar, 2018). Prejudice and discrimination should be considerations, especially in localities where acceptance of gender diversity is limited or prohibited (Brown & Mar, 2018; Hendricks & Testa, 2012; Turban, King et al., 2021). Of note, there can also be possible risks to a gender diverse child who does not socially transition, including 1) being ostracized or bullied for being perceived as not conforming to prescribed community

gender roles and/or socially expected patterns of behavior; and 2) living with the internal stress or distress that the gender they know themselves to be is incongruent with the gender they are being asked to present to the world.

To promote gender health, the HCP should discuss the potential challenges of a social transition. One concern often expressed relates to fear that a child will preclude considering the possible evolution of their gender identity as they mature or be reluctant to initiate another gender transition even if they no longer feel their social transition matches their current gender identity (Edwards-Leeper et al., 2016; Ristori & Steensma, 2016). Although limited, recent research has found some parents/caregivers of children who have socially transitioned may discuss with their children the option of new gender iterations (for example, reverting to an earlier expression of gender) and are comfortable about this possibility (Olson et al., 2019). Another often identified social transition concern is that a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth (Chen et al., 2018; Edwards-Leeper et al., 2019; Steensma & Cohen-Kettenis, 2011). From this point of view, parents/caregivers should be aware of the potential developmental effect of a social transition on a child.

HCPs should provide guidance to parents/caregivers and supports to a child when a social gender transition is being considered or taking place by 1) providing consultation, assessment, and gender supports when needed and sought by the parents/caregivers; 2) aiding family members, as needed, to understand the child's desires for a social transition and the family members' own feelings about the child's expressed desires; 3) exploring with, and learning from, the parents/caregivers whether and how they believe a social transition would benefit their child both now and in their ongoing development; 4) providing guidance when parents/caregivers are not in agreement about a social transition and offering the opportunity to work together toward a consistent understanding of their child's gender status and needs; 5) providing guidance about safe and supportive ways to disclose their child's social transition to others and to facilitate their child transitioning in their various social environments (e.g., schools, extended family); 6) facilitating communication, when desired by the child, with peers about gender and social transition as well as fortifying positive peer relationships; 7) providing guidance when social transition may not be socially accepted or safe, either everywhere or in specific situations, or when a child has reservations about initiating a transition despite their wish to do so; there may be multiple reasons for reservations, including fears and anxieties; 8) working collaboratively with family members and MHPs to facilitate a social transition in a way that is optimal for the child's unfolding gender development, overall well-being, and physical and emotional safety; and 9) providing psychoeducation about the many different trajectories the child's gender may take over time, leaving pathways open to future iterations of gender for the child, and emphasizing there is no need to predict an individual child's gender identity in the future (Malpas et al., 2018).

All of these tasks incorporate enhancing the quality of communication between the child and family members and providing an opportunity for the child to be heard and listened to by all family members involved. These relational processes in turn facilitate the parents/caregivers' success in making informed decisions about the advisability and/or parameters of a social transition for their child (Malpas et al., 2018).

One role of HCPs is to provide guidance and support in situations in which children and parents/caregivers wish to proceed with a social transition but conclude that the social environment would not be accepting of those choices, by 1) helping parents/caregivers define and extend safe spaces in which the child can express their authentic gender freely; 2) discussing with parents/caregivers ways to advocate that increase the likelihood of the social environment being supportive in the future, if this is a realistic goal; 3) intervening as needed to help the child/family with any associated distress and/or shame brought about by the continued suppression of authentic gender identity and the need for secrecy; and 4) building both the child's and the family's resilience, instilling the understanding that if the social environment is having difficulty accepting a child's social transition and affirmed gender identity, it is not because of some shortcoming in the child but because of

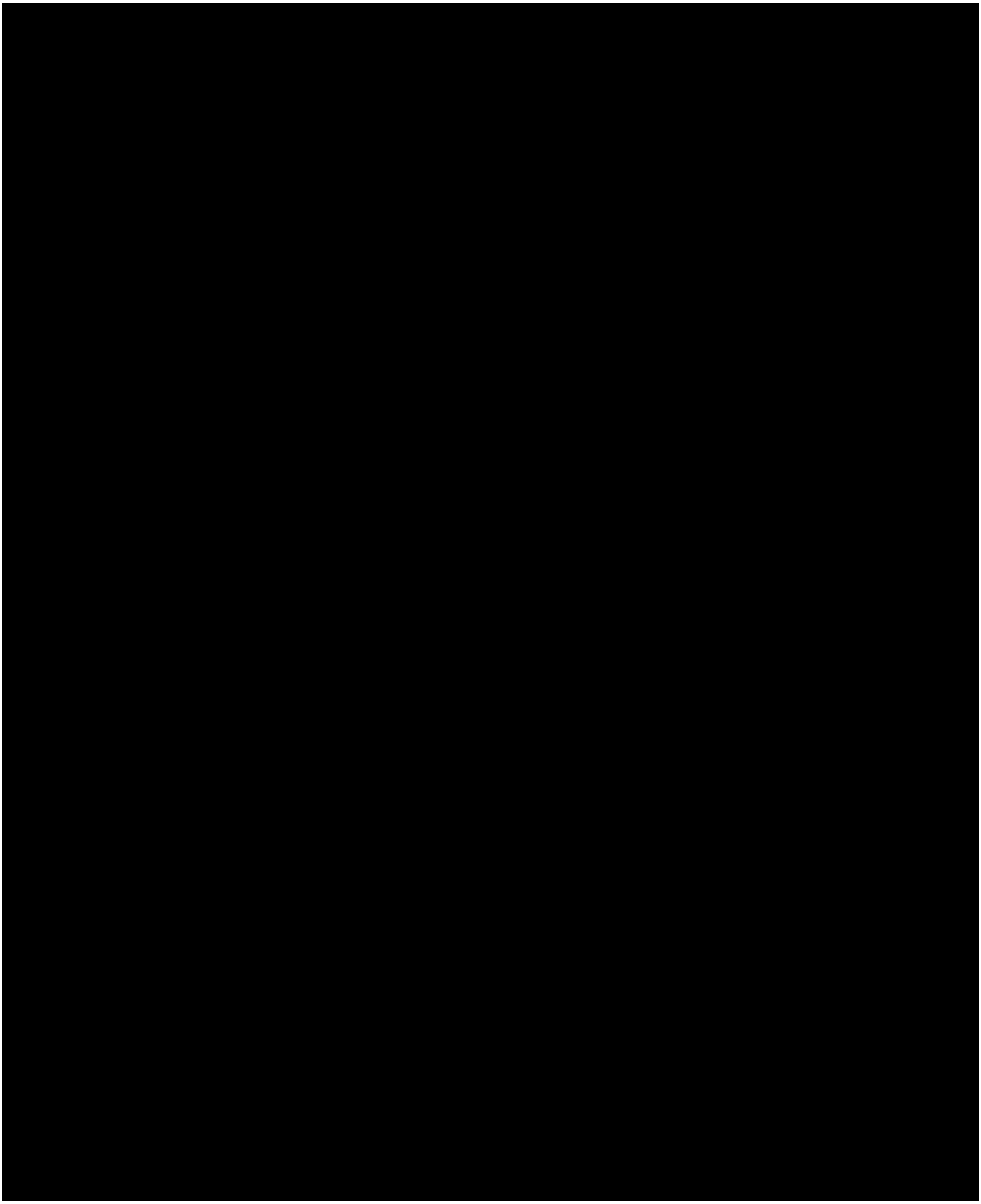
insufficient gender literacy in the social environment (Ehrensaft et al., 2018).

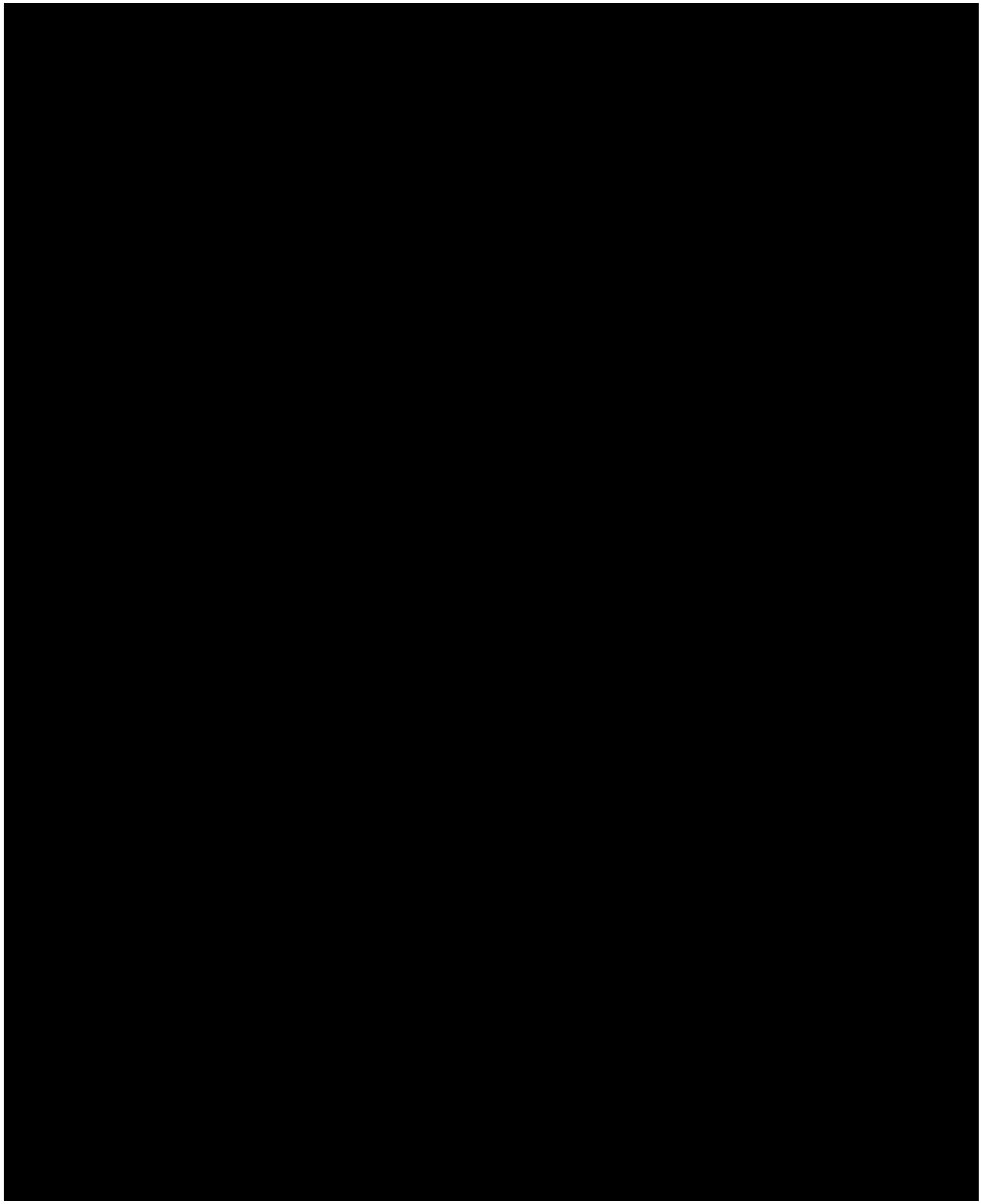
Statement 7.15

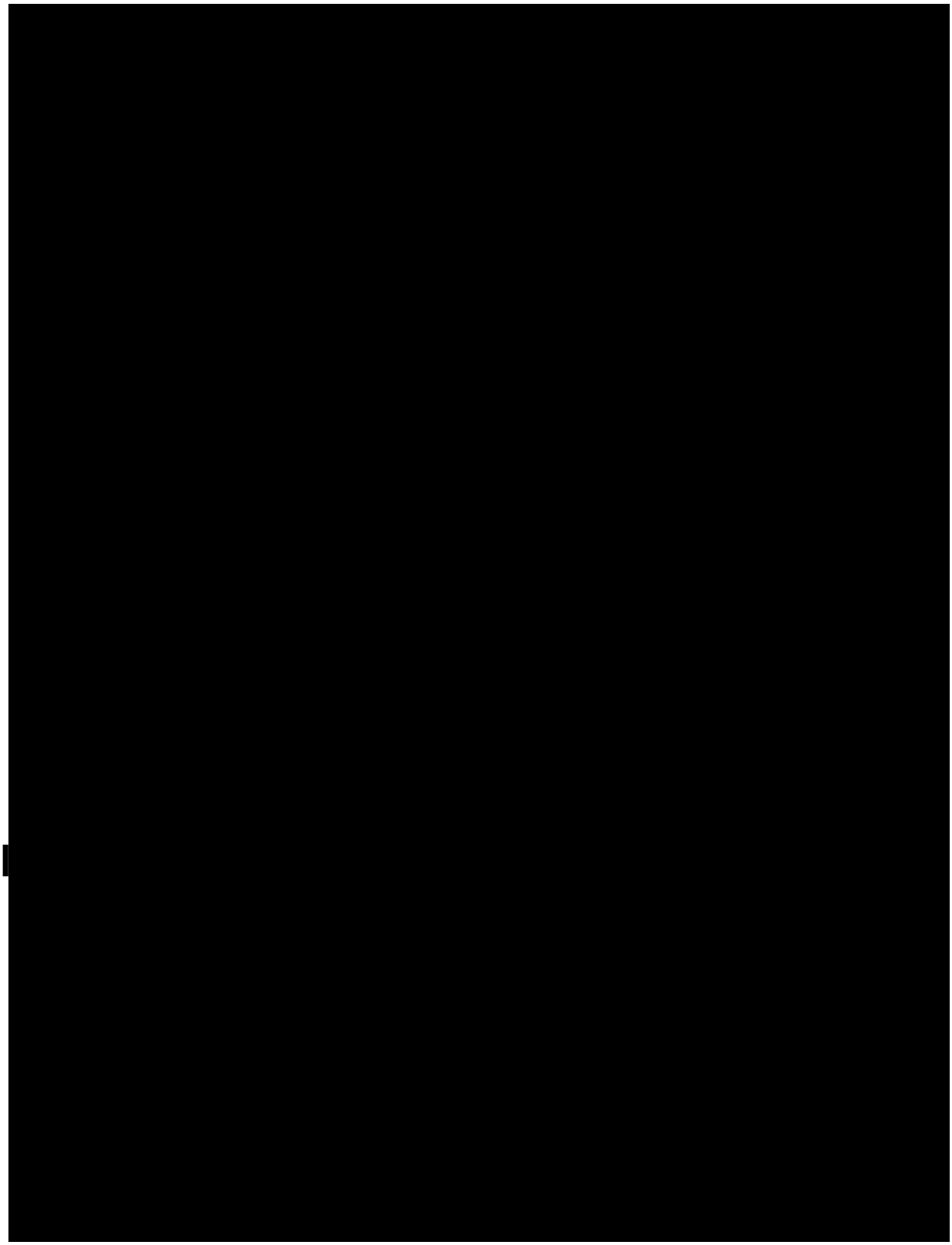
We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

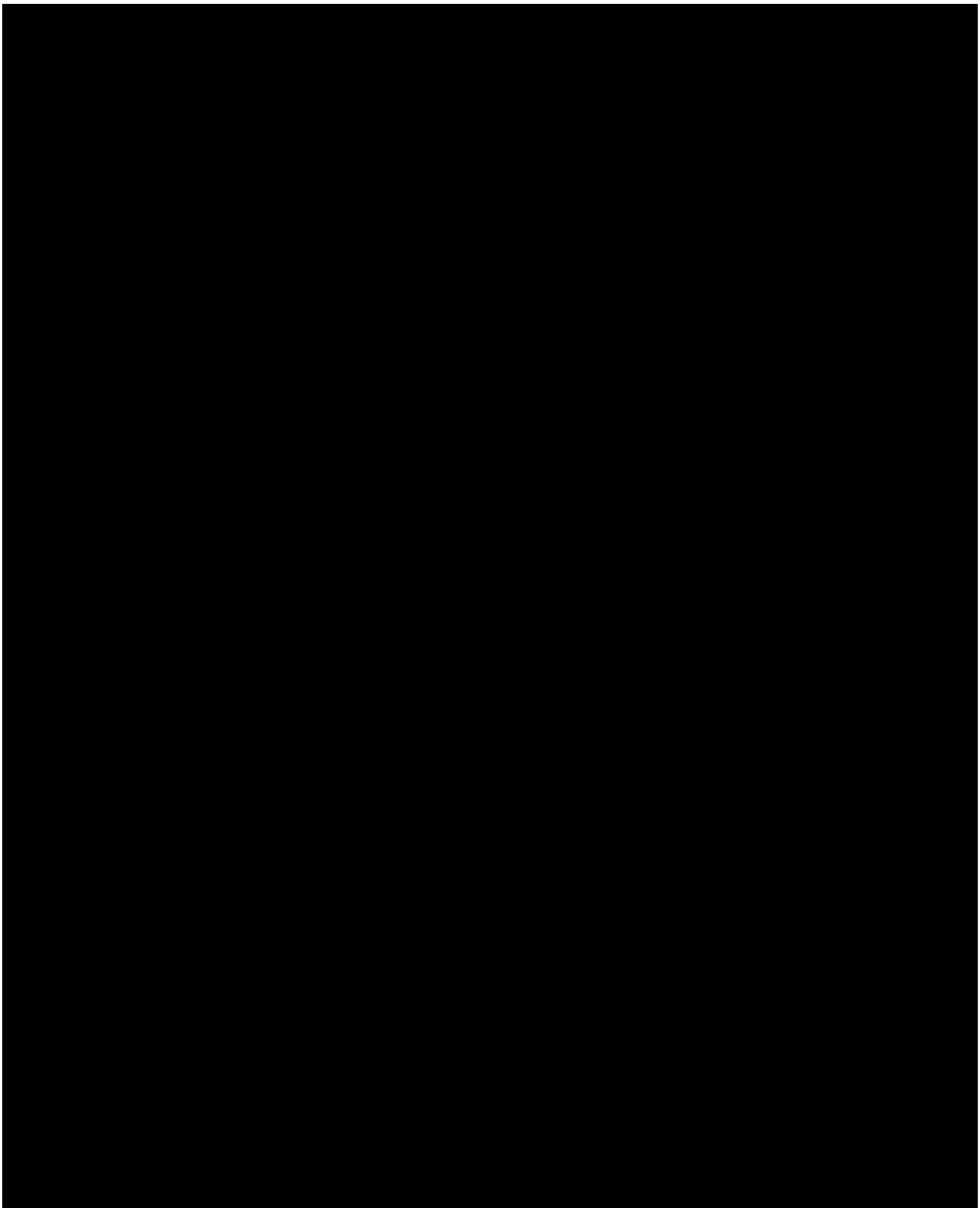
All children have the right to be supported and respected in their gender identities (Human Rights Campaign, 2018; Paré, 2020; SAMHSA, 2015). As noted above, gender diverse children are a particularly vulnerable group (Barrow & Apostle, 2018; Cohen-Kettenis et al., 2003; Giovanardi et al., 2018; Gower, Rider, Coleman et al., 2018; Grossman & D'Augelli, 2007; Hendricks & Testa, 2012; Reisner, Greytak et al., 2015; Ristori & Steensma, 2016; Roberts et al., 2012; Tishelman & Neumann-Mascis, 2018). The responsibilities of HCPs as advocates encompass acknowledging social determinants of health are critical for marginalized minorities (Barrow & Mar, 2018; Hendricks & Testa, 2012). Advocacy is taken up by all HCPs in the form of child and family support (APA, 2015; Malpas et al., 2018). Some HCPs may be called on to move beyond their individual offices or programs to advocate for gender diverse children in the larger community, often in partnership with stakeholders, including parents/caregivers, allies, and youth (Kaufman & Tishelman, 2018; Lopez et al., 2017; Vanderburgh, 2009). These efforts may be instrumental in enhancing children's gender health and promoting their civil rights (Lopez et al., 2017).

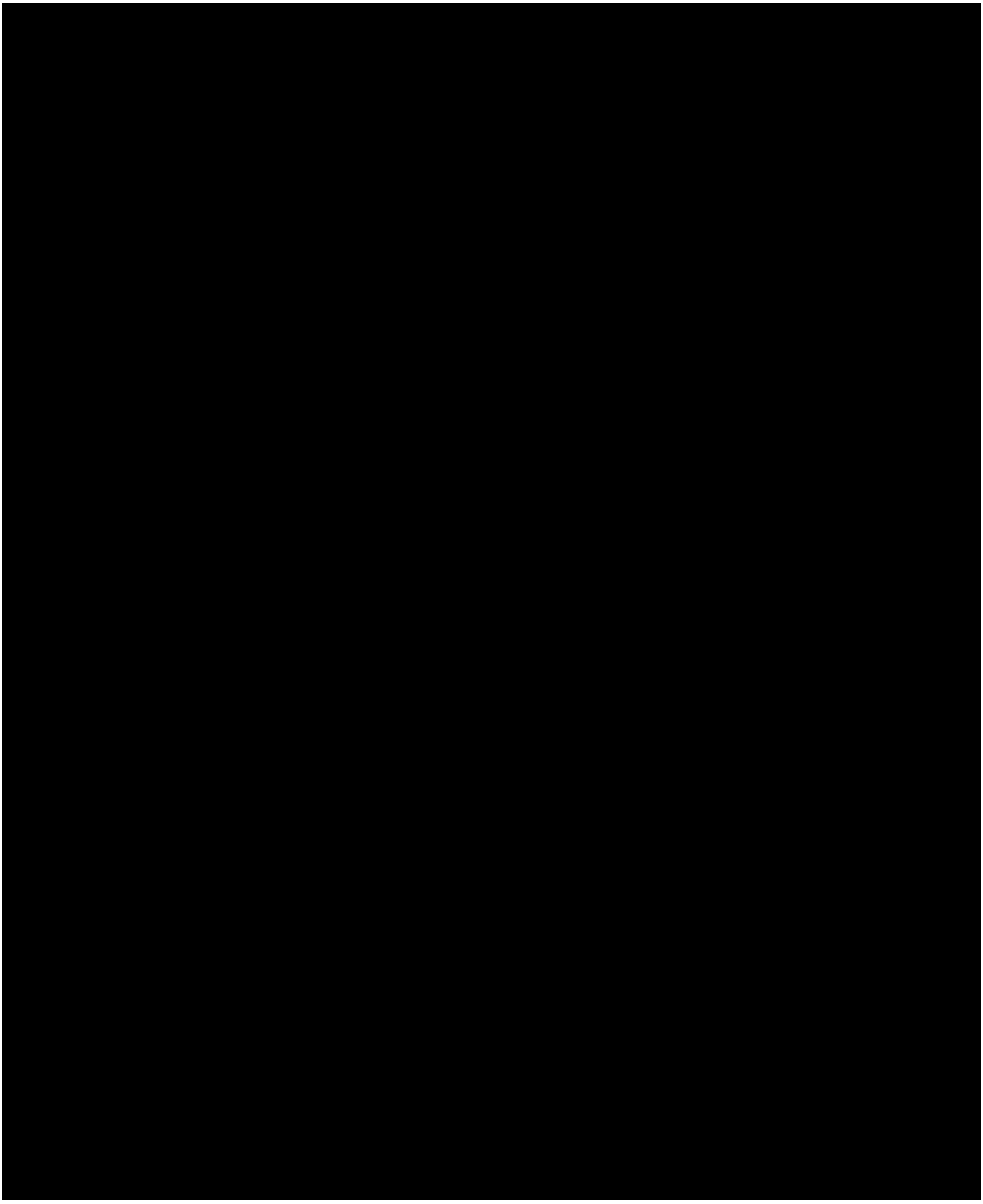
HCP's voices may be essential in schools, in parliamentary bodies, in courts of law, and in the media (Kuvalanka et al., 2019; Lopez et al., 2017; Whyatt-Sames, 2017; Vanderburgh, 2009). In addition, HCPs may have a more generalized advocacy role in acknowledging and addressing the frequent intentional or unintentional negating of the experience of gender diverse children that may be transmitted or communicated by adults, peers, and in media (Rafferty et al., 2018). Professionals who possess the skill sets and find themselves in appropriate situations can provide clear de-pathologizing statements on the needs and rights of gender diverse children and on the damage caused by discriminatory and transphobic rules, laws, and norms (Rafferty et al., 2018).

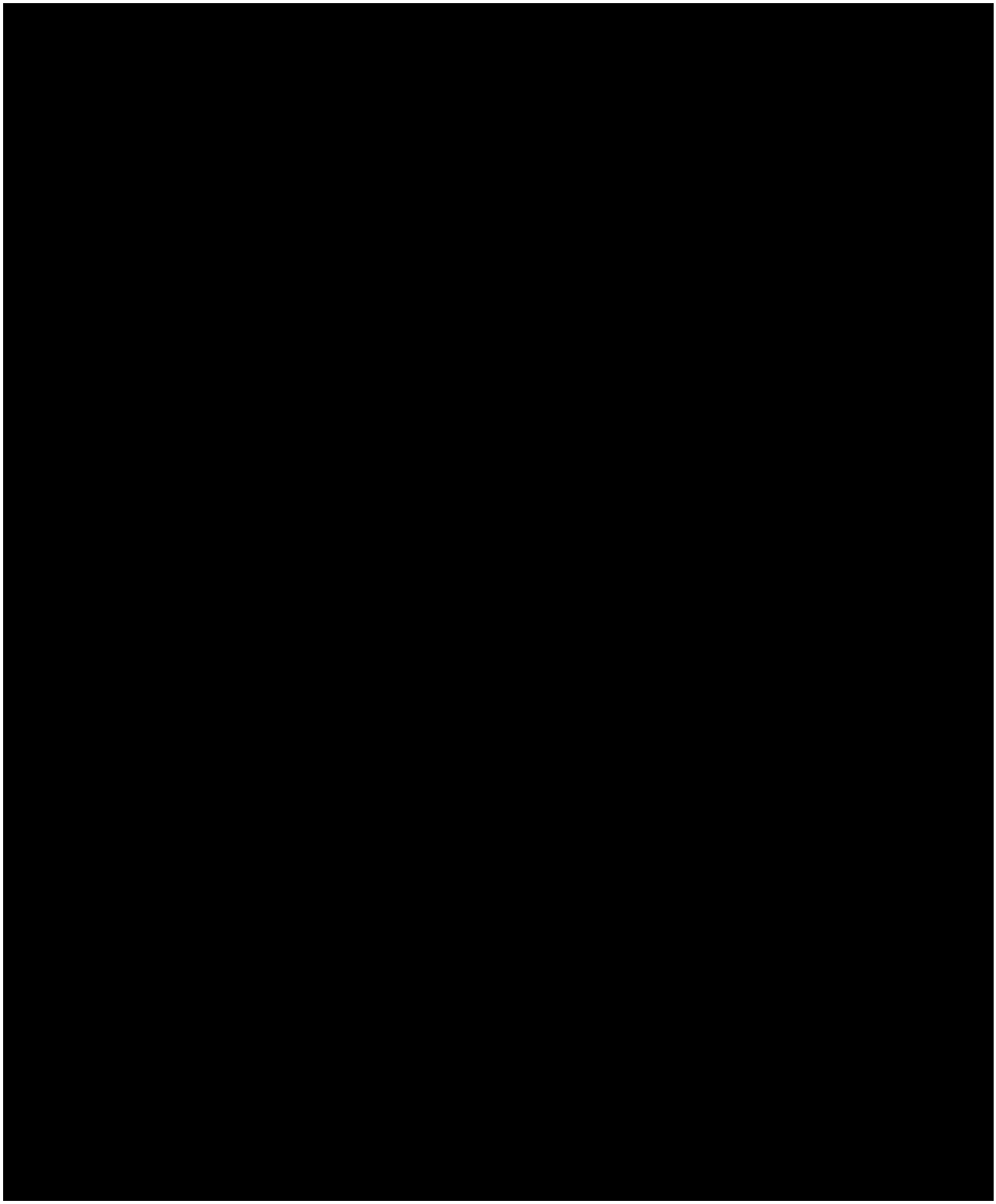


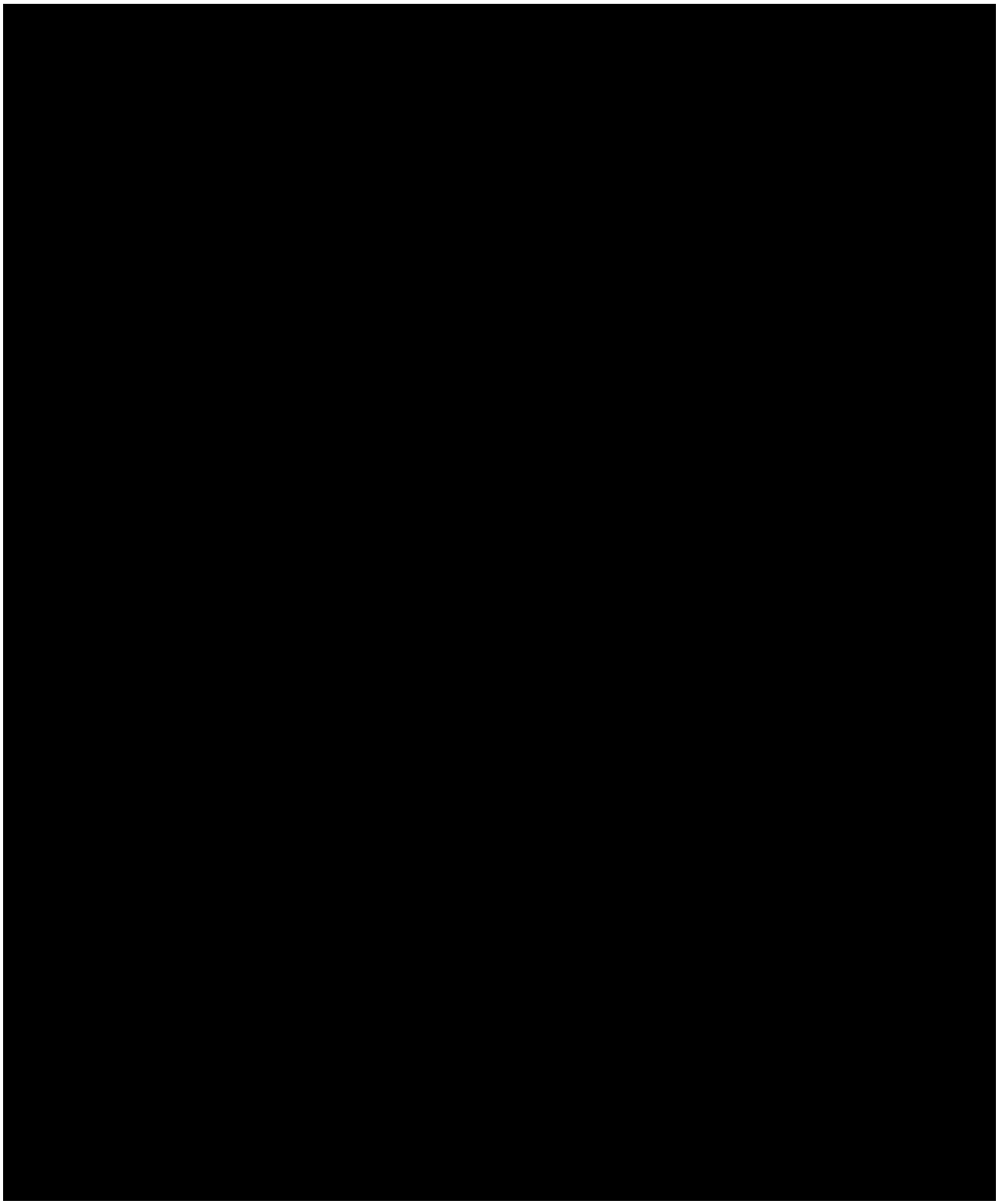


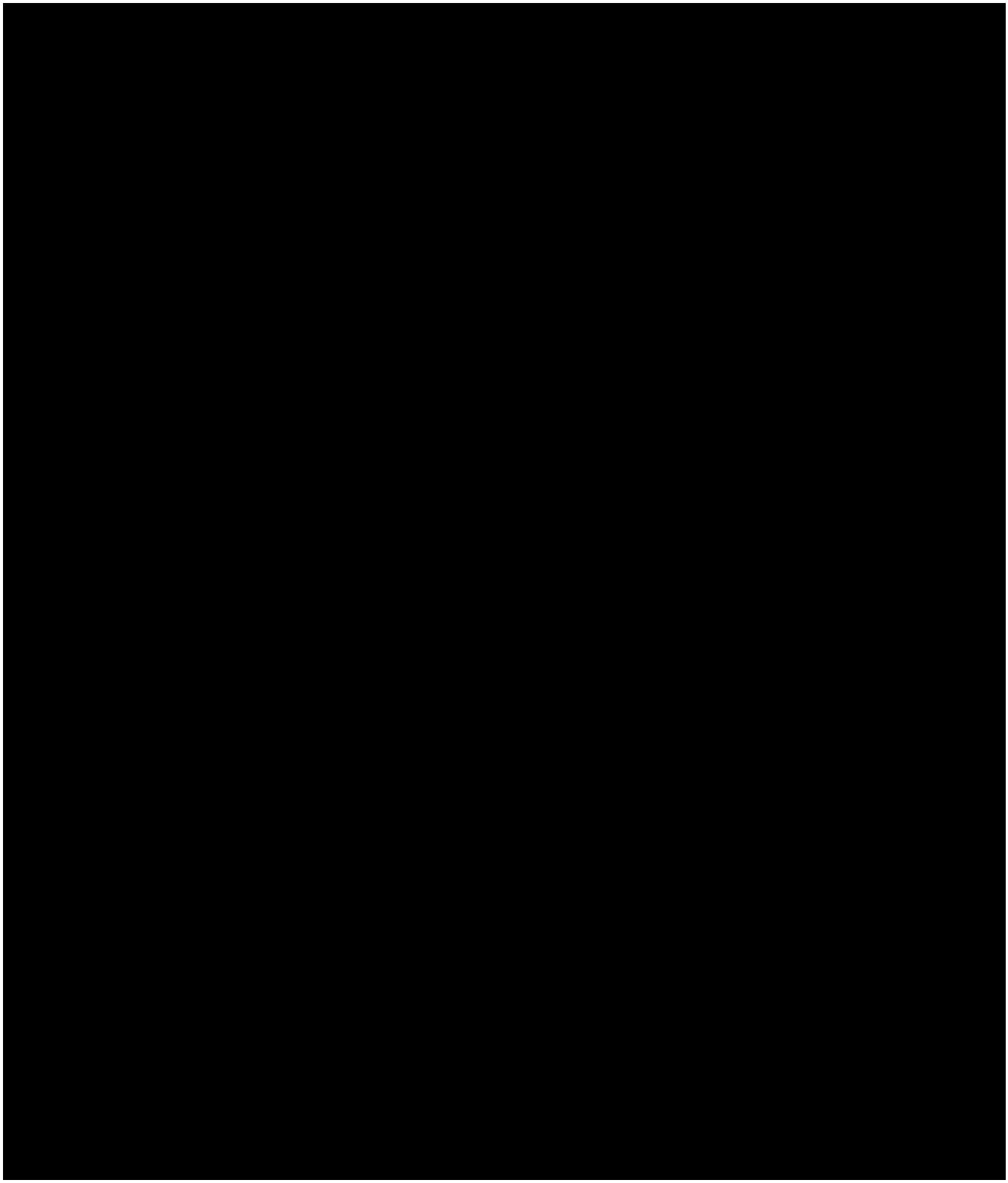


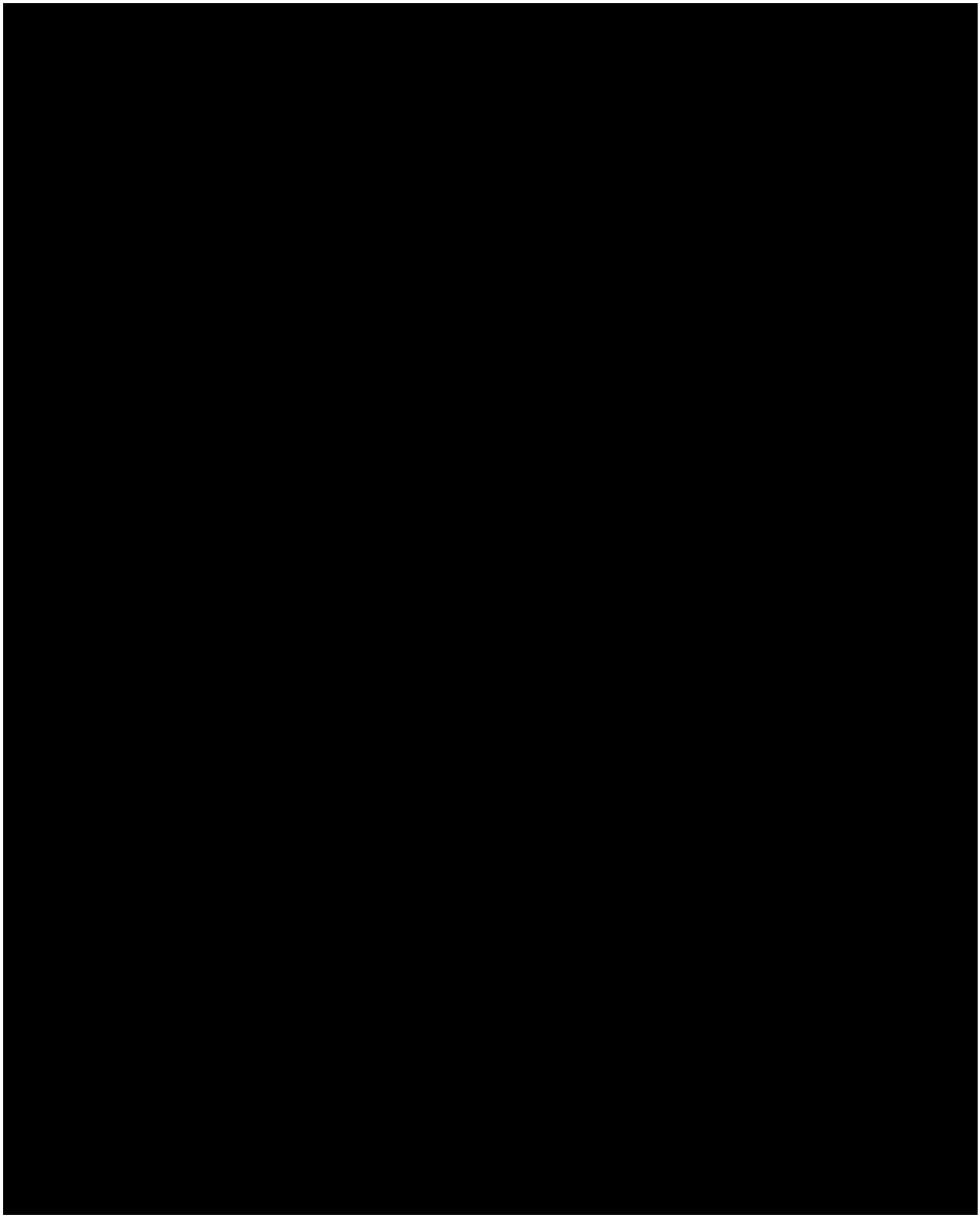


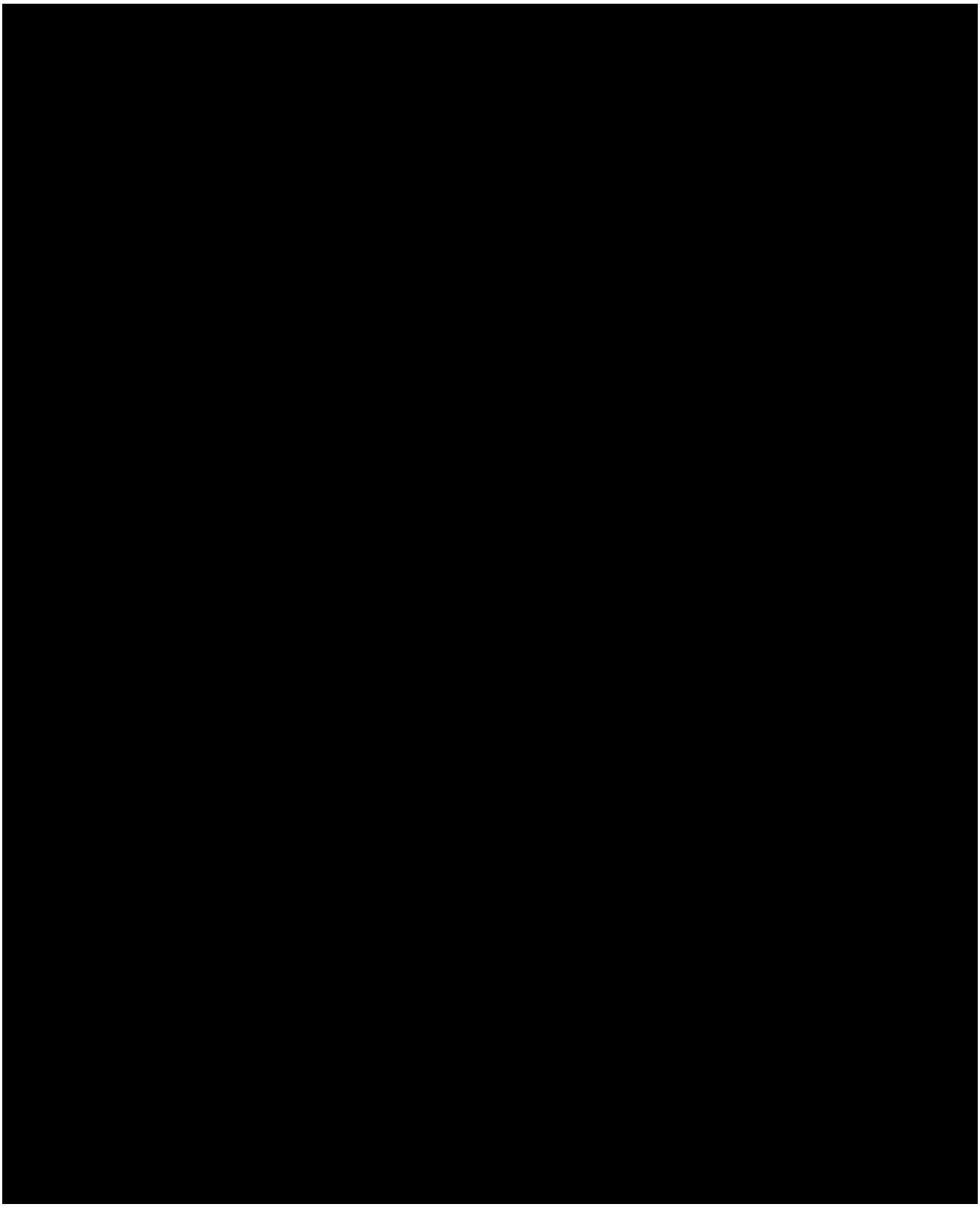


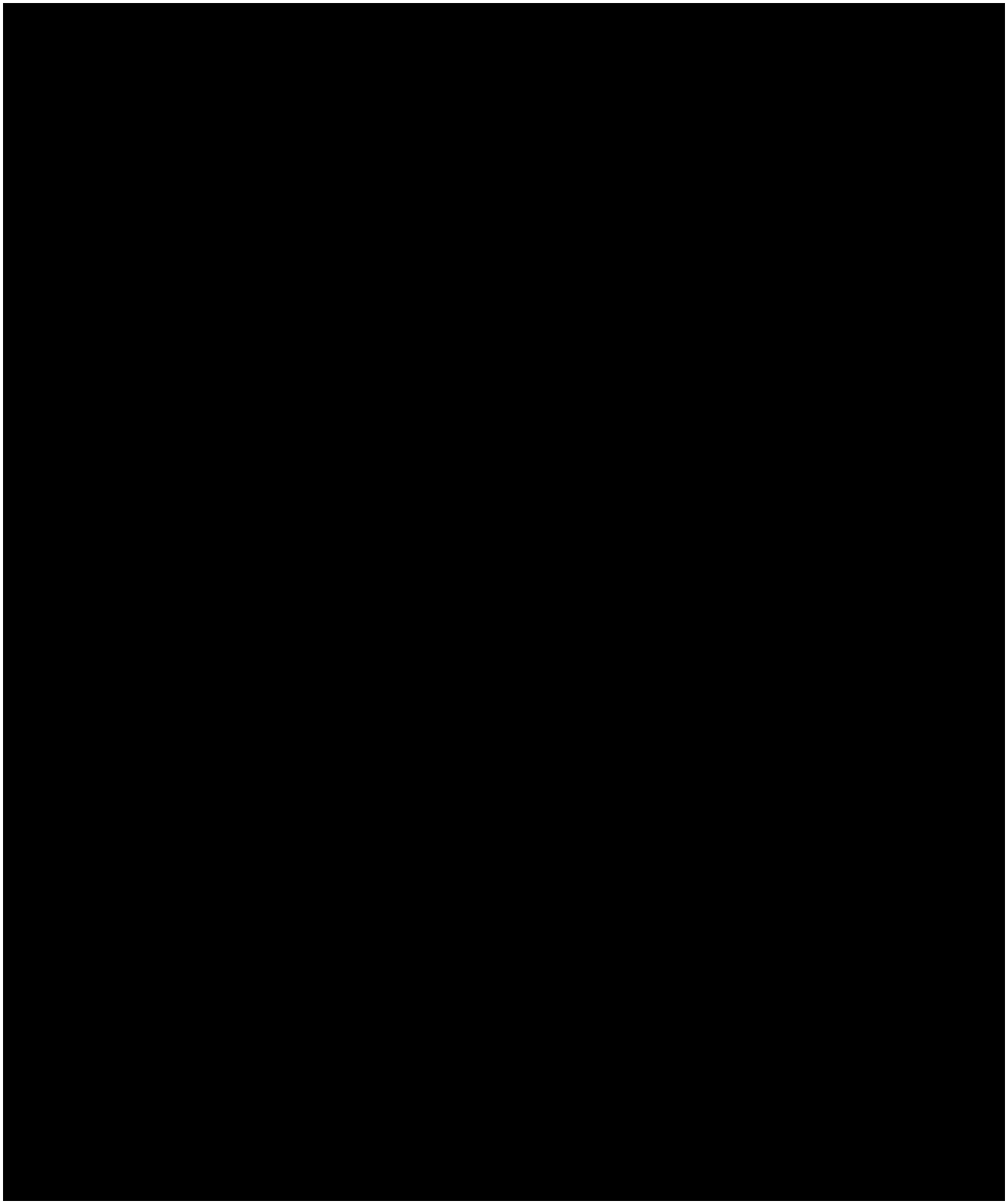


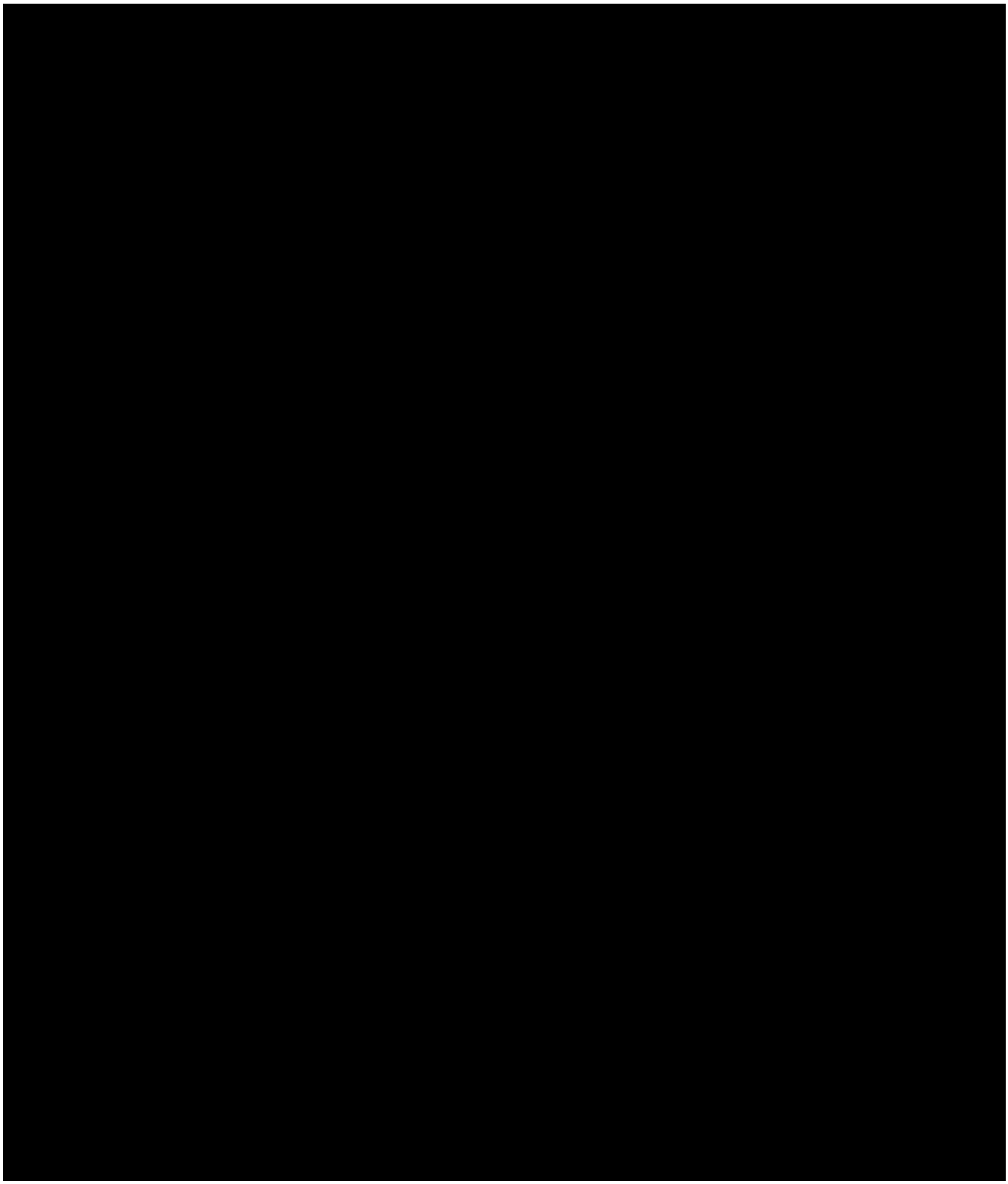


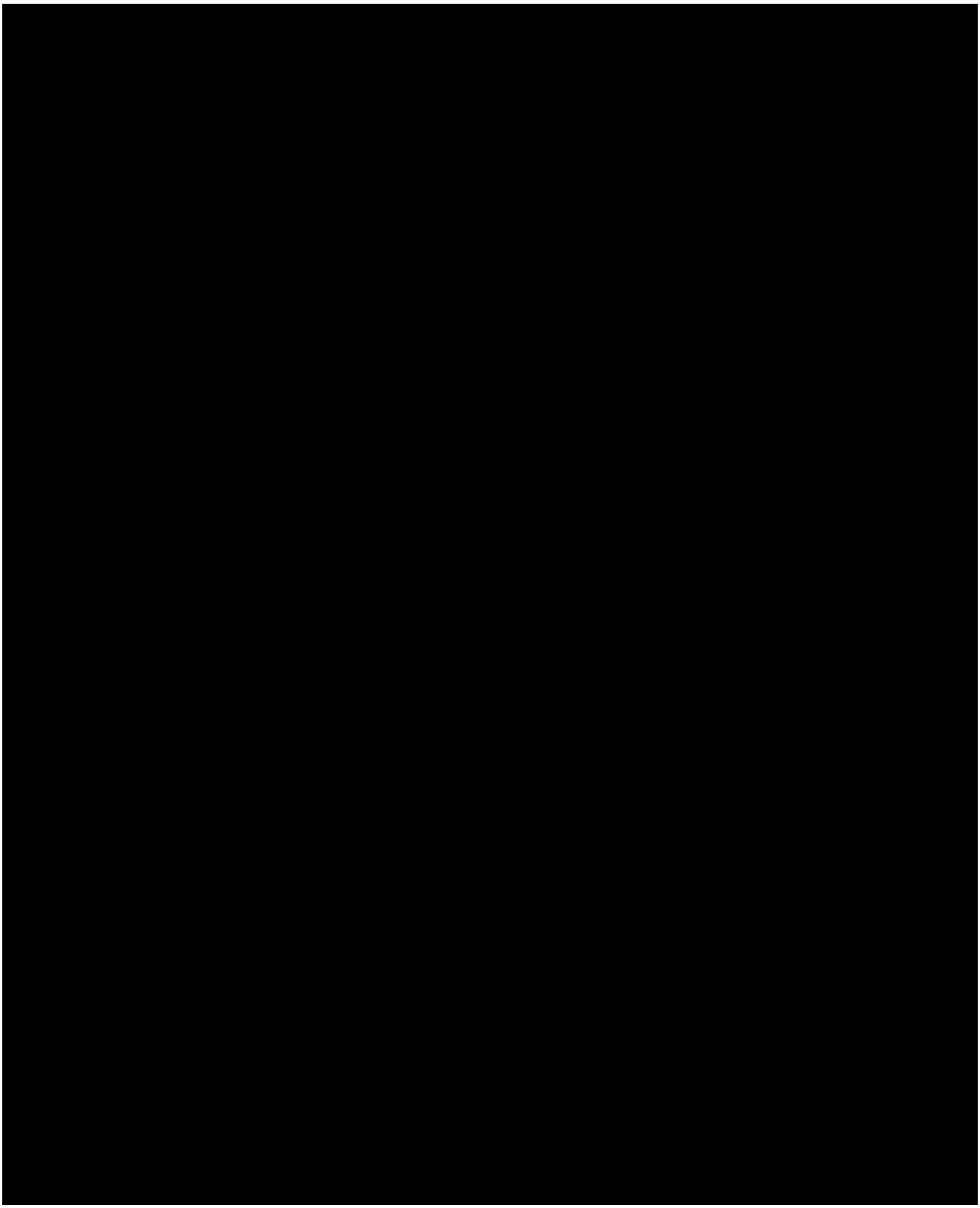


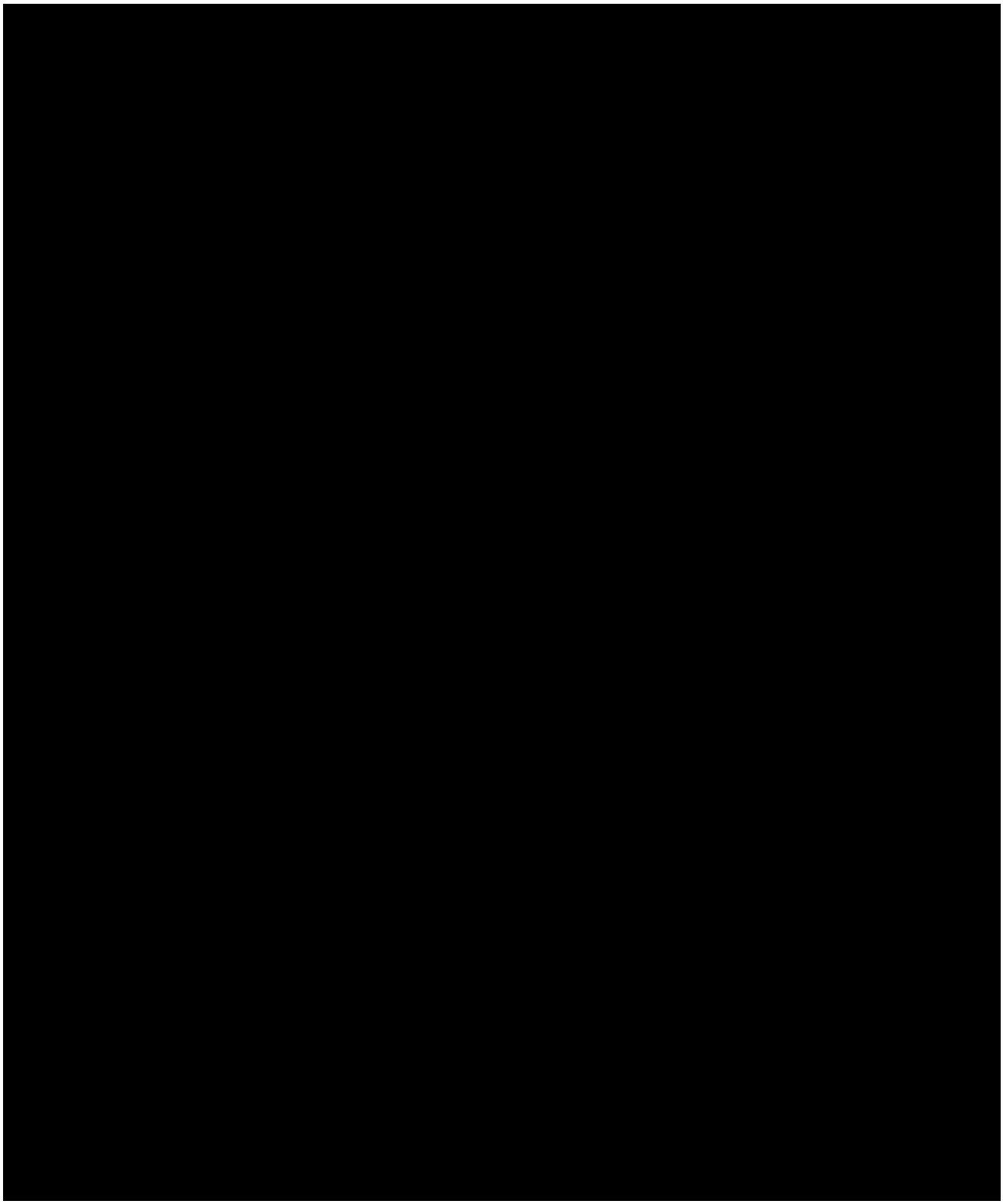


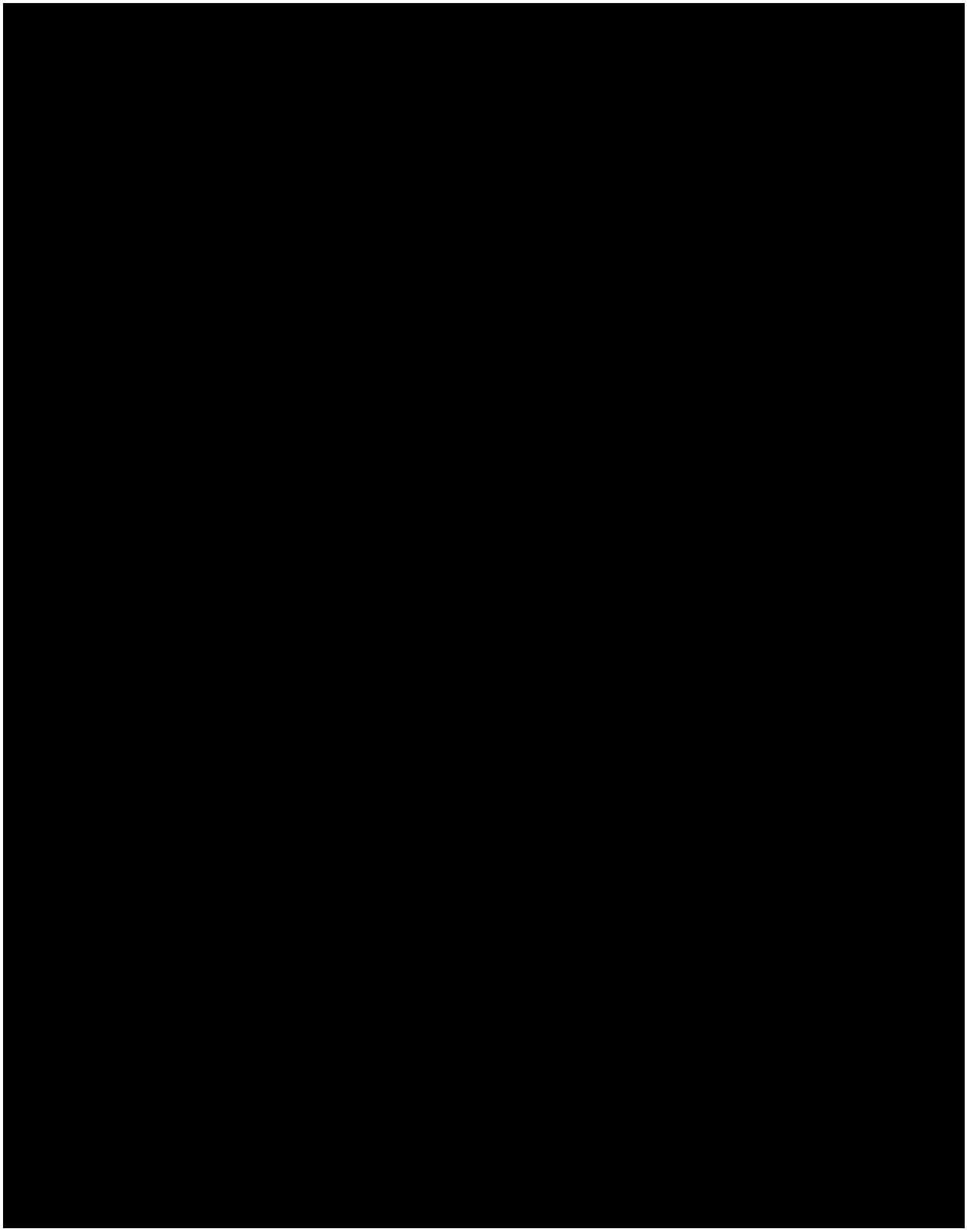












Re: CONFIDENTIAL - FW: AAP Communication to WPATH (Confidential)

From: Jon Arcelus [redacted]
To: [redacted]
Cc: asa.radix [redacted] Eli Coleman [redacted], WPATH EC 2022 <wpathec2022@wpath.org>, Scott Leibowitz [redacted], Annelou de Vries [redacted], walterbouman [redacted]
Date: Fri, 09 Sep 2022 04:50:13 -0400
Attachments: Letter to WPATH.pdf (106.7 kB); WIJT 23(S1) FINAL (AAP Comments).pdf (12.49 MB)

Dear all
You may have had some time to read and think about the comments from the AAP. I hope so.

The letter asks for modifications in 3 sections, but when you look at the comments in pdf there are many changes that they are requested. As far as I can see they are asking for us to remove anything that it does not fit into their narrative, most of this is part of the introduction in the chapter.

We need to focus as to what the SOC8 is about and the strong methodology we have. In the last few days I have heard from Marci that the ages don't have any scientific backup. Our guidelines are not only evidence based but they are primarily consensus based. There are many recommendations in the SOC that don't have direct evidence (most of the direct evidence is in the hormone chapter) but they have background evidence. This is why we have Delphi. Having evidence based and Delphi within our methodology makes our guidelines as strong as possible and unique. The AAP guidelines that they mentioned so many times have a very weak methodology, written by few friends who think the same.

Regarding ages, in view of the weak evidence, they are not recommendations but suggestions, as it is agreed by the methodology and it was approved by more that 75% of the over 100 that voted via Delphi.

I would like to ask people to think what will it really mean to remove ages. If we don't have any suggested ages, some clinicians will still use SOC7 (age of majority) and others will be able to refer people at any age (for genital at 15 or 16). That will make things very confusing and I have no doubt that if we remove age, we will have to write an amendment to the Soc8 to avoid this confusion very soon. That will look terrible for WPATH and the SOC.

In addition, having the age of, chest for sample, as age of majority, is in my view unethical. This will mean to leave a young trans man on testosterone from 15 years but force to live with their chest (breast) maybe hairy for at least 3 more years. That will affect the mental health of the person terribly and I will not agree to that.

The AAP comments asked us to remove age as it does not fit to their AAP, and they say that they want us to have "case by case" following a good MDT assessment, but we are asking for everyone to have a comprehensive MDT assessment, including with a mental health worker to reach a decision. That is the same thing.

My view is that we should not remove “ages” they are a suggestion, they have as much background evidence as many suggested statements, and they have been approved via Delphi and approved by the WPATH board.

We can’t not write a document that looks like theirs, as it has a one sided narrative, extremely biased. I will be surprised in their guidelines are used at all. Looking at the AAP people in Google they clearly see a group of trans people that I don’t recognise, where gender identity appear always at childhood, that is not my experience.

Personally, as an academic Trans specialist, who is a child and adolescent psychiatrist as well as a general practitioner and hormone prescriber, I think it will not be in the benefit of our community to remove ages as an suggestion and to make any of the changes that they are recommending. This will make a joke of our methodology and will see us as weak.

I do really wonder whether a meeting is needed at all, as we are not going to reach any decision that will satisfy them. We may want to put an explanatory letter as they did to us, and explain our rational and thank them for the time they put on it, they may want to get involved in SCO9.

But the most important thing, is that we all…everyone in the board and in SOC8, need to talk with one voice that ages are suggestions, consented via Delphi and back up by a limited background literature. They may become recommendations and not suggestion in the SOC9 if we have enough evidence. We need to believe that we are the experts and we know what we are saying and no being shaken by others.

I am happy to have a meeting today to agree our next step. But I will oppose any other changes in the document.

I still think the chapter that Scott and Annelou lead in writing is beautifully written and they provide a balance view which is exactly what guidelines should be about.

Kind regards

Jon

Prof. Jon Arcelus Alonso, MD, PhD(Pronouns: He/Him)
Professor Emeritus of Mental Health and Wellbeing
Director of Research, Nottingham Centre for Transgender Health Network, UK

School of Medicine, University of Nottingham, Nottingham, United Kingdom
Bellvitge Biomedical Research Institute (IDIBELL), University of Barcelona, Spain

Editor of the International Journal of Transgender Health (IF 5.33)
Co-Chair of the Standards of Care 8th Edition (World Professional Association of Transgender Health-WPATH)
https://www.nottingham.ac.uk/medicine/people/jon.arcelus

> On 8 Sep 2022, at 21:54, [redacted] > wrote:

Dear Asa, Eli, Jon

Please see attached from the AAP, it looks to me like a call is in order, please advise best days/times over the next few days so we can schedule, if that's what you would like to do.

All best
[redacted]

Best Regards

[redacted]

From: Hudson, Jeff <[redacted]>
Sent: Thursday, September 8, 2022 4:45 PM
To: walterbouman [redacted]
Cc: Eli Coleman [redacted] asa.radix[redacted] Jon Arcelus <Jon.Arcelus[redacted]; Del Monte, Mark <[redacted]>
Subject: AAP Communication to WPATH (Confidential)
Importance: High

Dr Bouman [redacted]

Please see the attached letter from the American Academy of Pediatrics. Additionally, please see the attached SOC 8 version with AAP expert comments.

I look forward to continuing our dialogue and please let me know next steps.

Best,
Jeff

From: Walter Bouman <[redacted]
Sent: Monday, September 5, 2022 1:56 PM
To: Hudson, Jeff <[redacted]>>
Cc: Coleman, Eli <[redacted] Asa Radix [redacted] Jon Arcelus [redacted]
Subject: Re: FINAL DRAFT SOC8
Importance: High

Dear Jeff,

It was good to meet with you today and thank you for being available at such short notice (on a public holiday!).

I am very grateful that you want to help us with a short and efficient turnaround of whichever the issues your expert panel feel are the issues with the current version of the SOC8. As Eli Coleman, the SOC8 said: there may have to be compromises, but first and foremost, as clinicians who provide trans health care to adolescents, we must not fail our young people to receive the care they need; and, also, our guidelines serve tens of millions of TGD people globally, so there needs to be perspective and empathy towards other people who live outside the US too.

Looking forward to working with you,

Walter

Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief International Journal of Transgender Health (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health

[redacted]

On 2022-09-05 17:13, [redacted] wrote:<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7C[redacted]0wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06[redacted]d88%7C1%7C0%7C637982668339621145%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

Hi Jeff<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7C[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C637982668339621145%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

Please see attached, looking forward to speaking with you.<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7Cblaine%40wpath.org%7Cda2234a621d145d5be9c08da91db

0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C63798266833962114 5%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

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Best Regards<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C63798266833977738 1%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=eQ0xblyWmk2CS1%2Ffb5GAlVkyH981gkuF8%2Fb5Ikl4Hog%3D&reserved=0>

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Re: CONFIDENTIAL - FW: AAP Communication to WPATH (Confidential)

From: Scott Leibowitz <[redacted]
To: Eli Coleman [redacted]
Cc: walterbouman [redacted], Jon Arcelus [redacted] asa.radix[redacted], WPATH EC 2022 <wpathec2022@wpath.org>, Annelou de Vries [redacted]
Date: Fri, 09 Sep 2022 10:53:25 -0400

I admittedly haven't had the time to read this chain in its entirety, nor the feedback from aap (I've been clinical all morning starting at 8am), and so I am simply responding to Eli's email, seeing a vote is being proposed.

A missing step has been having a conversation with those of us in the pediatric realm, including two pediatricians on our chapter workgroup, with Rachel Levine and whoever in AAP is reviewing and making recommendations.

Have they consulted their lgbt and adolescent health sections on this? Have we leveraged WPATH members who are involved in AAP activities (Aron Janssen sits as liaison from AACAP to aap) to be involved.

The conversations need to happen at a level of pediatric provider to pediatric provider.

Sent from my iPhone

> On Sep 9, 2022, at 9:37 AM, Eli Coleman [redacted] wrote:
>
> Before you take this to a vote, I would like the chairs to consider this feedback and consider Scott and Annalou's input as well. We are suppose to have a meeting this morning to review the input from AAP - and the board might appreciate our recommendation. But of course the BOD is in charge.
>
> Best,
>
> Eli
>
> On Fri, Sep 9, 2022 at 5:24 AM Walter Bouman [redacted] wrote:
>
> Dear Jon,
>
> Thank you for this.
>
> I have also read all the comments from the AAP and struggle to find any sound evidence-based argument(s) underpinning these. I am seriously surprised that a "reputable" association as the AAP is so thin on scientific evidence.
>
> We certainly can not revert to age of majority for all surgeries as this would be grossly unethical for all the obvious reasons.

May I remind everyone that the entire BOD has signed the SOC8 off as it is, so what I would like the SOC8 leadership to do today is to make a decision as to whether:

1. any changes are needed to be made to the SOC8: yes/no

2. if yes, make those changes to the document (in collaboration with Scott and Annelou and their Working Group); and then

3. ask the entire BOD whether they are still willing to support the SOC8 with those revisions with a yes/no voice

The alternatives to the above are self explanatory.

Warmest,

Walter

Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief *International Journal of Transgender Health* (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health

On 2022-09-09 09:50, Jon Arcelus wrote:

Dear all
You may have had some time to read and think about the comments from the AAP. I hope so.

The letter asks for modifications in 3 sections, but when you look at the comments in pdf there are many changes that they are requested. As far as I can see they are asking for us

to remove anything that it does not fit into their narrative, most of this is part of the introduction in the chapter.

We need to focus as to what the SOC8 is about and the strong methodology we have. In the last few days I have heard from Marci that the ages don't have any scientific backup. Our guidelines are not only evidence based but they are primarily consensus based. There are many recommendations in the SOC that don't have direct evidence (most of the direct evidence is in the hormone chapter) but they have background evidence. This is why we have Delphi. Having evidence based and Delphi within our methodology makes our guidelines as strong as possible and unique. The AAP guidelines that they mentioned so many times have a very weak methodology, written by few friends who think the same.

Regarding ages, in view of the weak evidence, they are not recommendations but suggestions, as it is agreed by the methodology and it was approved by more that 75% of the over 100 that voted via Delphi.

I would like to ask people to think what will it really mean to remove ages. If we don't have any suggested ages, some clinicians will still use SOC7 (age of majority) and others will be able to refer people at any age (for genital at 15 or 16). That will make things very confusing and I have no doubt that if we remove age, we will have to write an amendment to the Soc8 to avoid this confusion very soon. That will look terrible for WPATH and the SOC.

In addition, having the age of, chest for sample, as age of majority, is in my view unethical. This will mean to leave a young trans man on testosterone from 15 years but force to live with their chest (breast) maybe hairy for at least 3 more years. That will affect the mental health of the person terribly and I will not agree to that.

The AAP comments asked us to remove age as it does not fit to their AAP, and they say that they want us to have "case by case" following a good MDT assessment, but we are asking for everyone to have a comprehensive MDT assessment, including with a mental health worker to reach a decision. That is the same thing.

My view is that we should not remove "ages" they are a suggestion, they have as much background evidence as many suggested statements, and they have been approved via Delphi and approved by the WPATH board.

We can't not write a document that looks like theirs, as it has a one sided narrative, extremely biased. I will be surprised in their guidelines are used at all. Looking at the AAP people in Google they clearly see a group of trans people that I don't recognise, where gender identity appear always at childhood, that is not my experience.

Personally, as an academic Trans specialist, who is a child and adolescent psychiatrist as well as a general practitioner and hormone prescriber, I think it will not be in the benefit of our community to remove ages as an suggestion and to make any of the changes that they are recommending. This will make a joke of our methodology and will see us as weak.

I do really wonder whether a meeting is needed at all, as we are not going to reach any decision that will satisfy them. We may want to put an explanatory letter as they did to us, and explain our rational and thank them for the time they put on it, they may want to get involved in SCO9.

But the most important thing, is that we all...everyone in the board and in SOC8, need to talk with one voice that ages are suggestions, consented via Delphi and back up by a limited background literature. They may become recommendations and not suggestion in the SOC9 if we have enough evidence. We need to believe that we are the experts and we know what we are saying and no being shaken by others.

I am happy to have a meeting today to agree our next step. But I will oppose any other changes in the document.

I still think the chapter that Scott and Annelou lead in writing is beautifully written and they provide a balance view which is exactly what guidelines should be about.

Kind regards

Jon

Prof. Jon Arcelus Alonso, MD, PhD(Pronouns: He/Him)
Professor Emeritus of Mental Health and Wellbeing
Director of Research, Nottingham Centre for Transgender Health Network, UK

School of Medicine, University of Nottingham, Nottingham, United Kingdom
Bellvitge Biomedical Research Institute (IDIBELL), University of Barcelona, Spain

Editor of the International Journal of Transgender Health (IF 5.33)
Co-Chair of the Standards of Care 8th Edition (World Professional Association of Transgender Health-WPATH)
https://www.nottingham.ac.uk/medicine/people/jon.arcelus

> On 8 Sep 2022, at 21:54, [redacted] wrote:
>
> Dear Asa, Eli, Jon
>
> Please see attached from the AAP, it looks to me like a call is in order, please advise best days/times over the next few days so we can schedule, if that's what you would like to do.
>
> All best
> [redacted]
>
> Best Regards
> [redacted]

[redacted]

From: Hudson, Jeff <[redacted]>
Sent: Thursday, September 8, 2022 4:45 PM
To: walterbouman [redacted]
Cc: Eli Coleman <[redacted]; asa.radix[redacted] Jon Arcelus
<[redacted] Del Monte, Mark <[redacted]>
Subject: AAP Communication to WPATH (Confidential)
Importance: High

Dr Bouman and [redacted]

Please see the attached letter from the American Academy of Pediatrics. Additionally, please see the attached SOC 8 version with AAP expert comments.

I look forward to continuing our dialogue and please let me know next steps.

Best,
Jeff

From: Walter Bouman
[redacted]
Sent: Monday, September 5, 2022 1:56 PM
To: Hudson, Jeff <[redacted]>>
Cc: Coleman, Eli [redacted]; Asa Radix
[redacted]>>; Jon Arcelus
[redacted]
Subject: Re: FINAL DRAFT SOC8
Importance: High

Dear Jeff,

It was good to meet with you today and thank you for being available at such short notice (on a public holiday!).

I am very grateful that you want to help us with a short and efficient turnaround of whichever the issues your expert panel feel are the issues with the current version of the SOC8. As Eli Coleman, the SOC8 said: there may have to be compromises, but first and foremost, as clinicians who provide trans health care to adolescents, we must not fail our young people to receive the care they need; and, also, our guidelines serve tens of millions of TGD people globally, so there needs to be perspective and empathy towards other people who live outside the US too.

Looking forward to working with you,

Walter

Dr Walter Pierre Bouman MD MA MSc UKCPreg PhD

Consultant in Trans Health/Honorary Professor School of Medicine, University of Nottingham, UK

President World Professional Association for Transgender Health (WPATH)

Editor-in-Chief International Journal of Transgender Health (Impact Factor 2020 = 5.333)

Nottingham National Centre for Transgender Health

[redacted]

On 2022-09-05 17:13, [redacted] wrote:<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C637982668339621145%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

Hi Jeff<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C637982668339621145%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

Please see attached, looking forward to speaking with you.<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C637982668339621145%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ARhk1tlVyz7TtSisIjl9AF%2BbCz%2ByXFCQcbja09wvTT4%3D&reserved=0>

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Best Regards<https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fepath.eu%2Fconference-2019%2Fcall-for-abstracts%2F&data=05%7C01%7[redacted]%40wpath.org%7Cda2234a621d145d5be9c08da91db0b92%7Ca4b64a6b52d34815aa06bf8de66ded88%7C1%7C0%7C637982668339777381%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=eQ0xbIyWmk2CS1%2Ffb5GAlVkyH981gkuF8%2Fb5Ikl4Hog%3D&reserved=0>

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Eli Coleman, PhD.
Academic Chair in Sexual Health
Professor and Director
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
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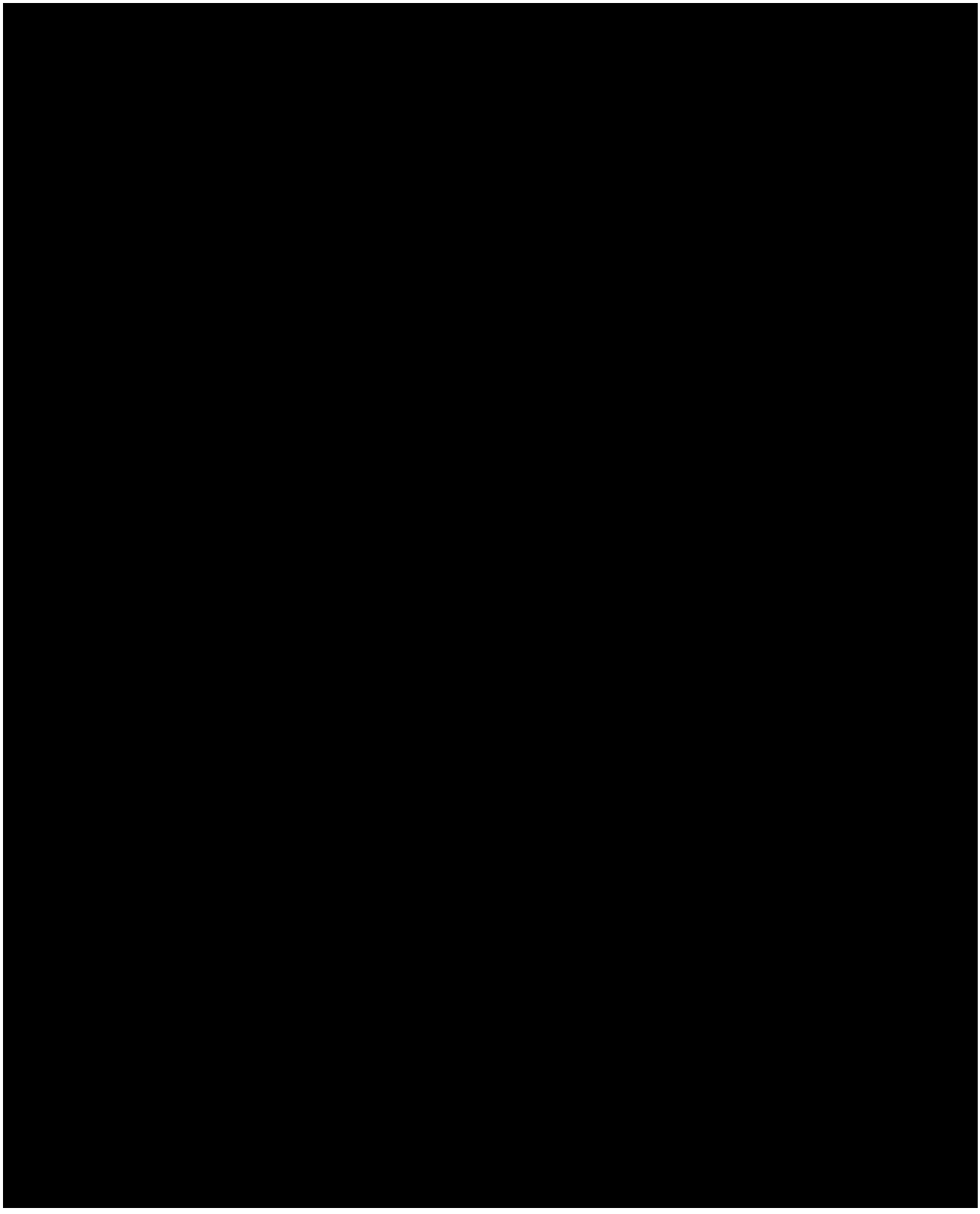

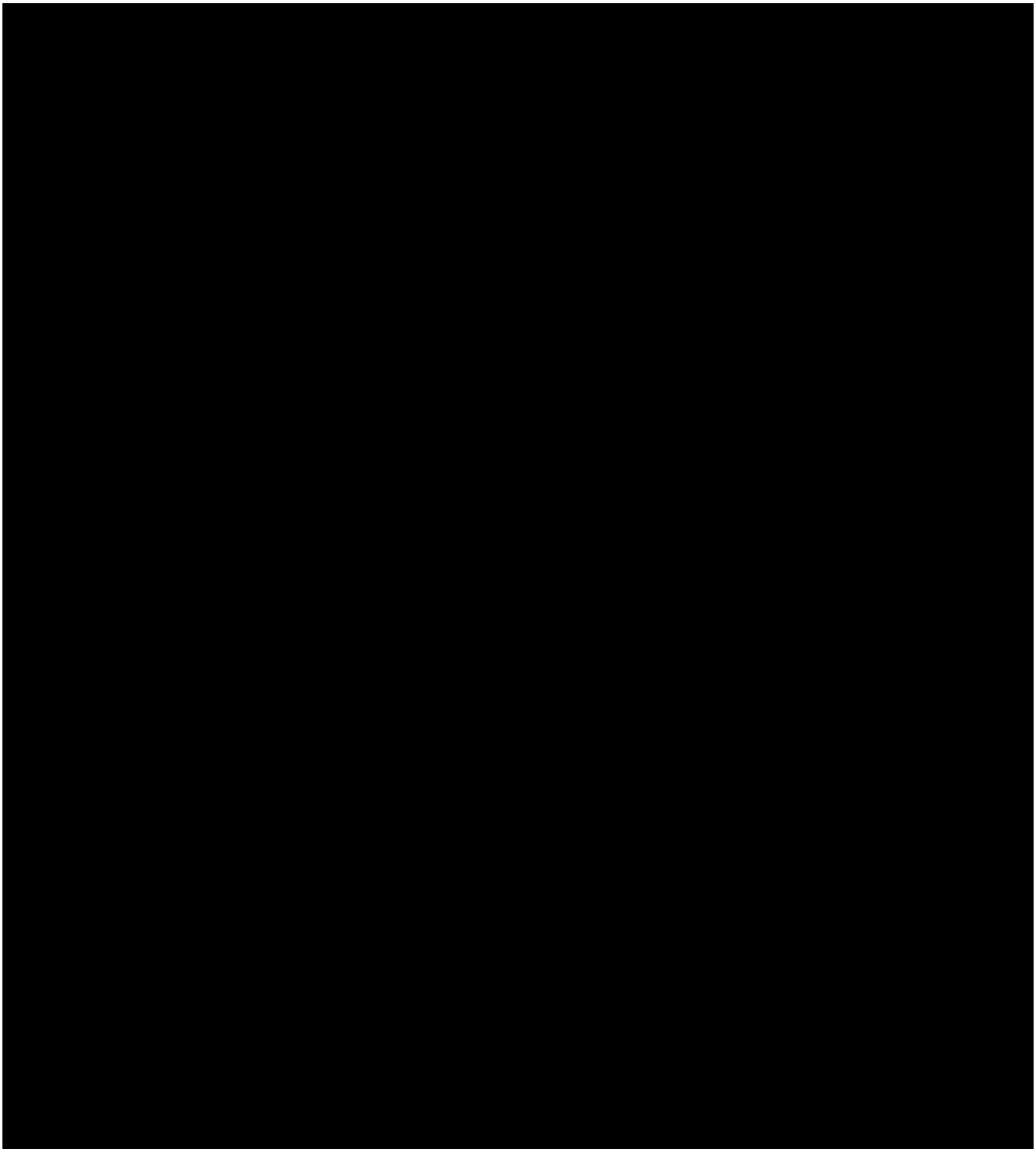

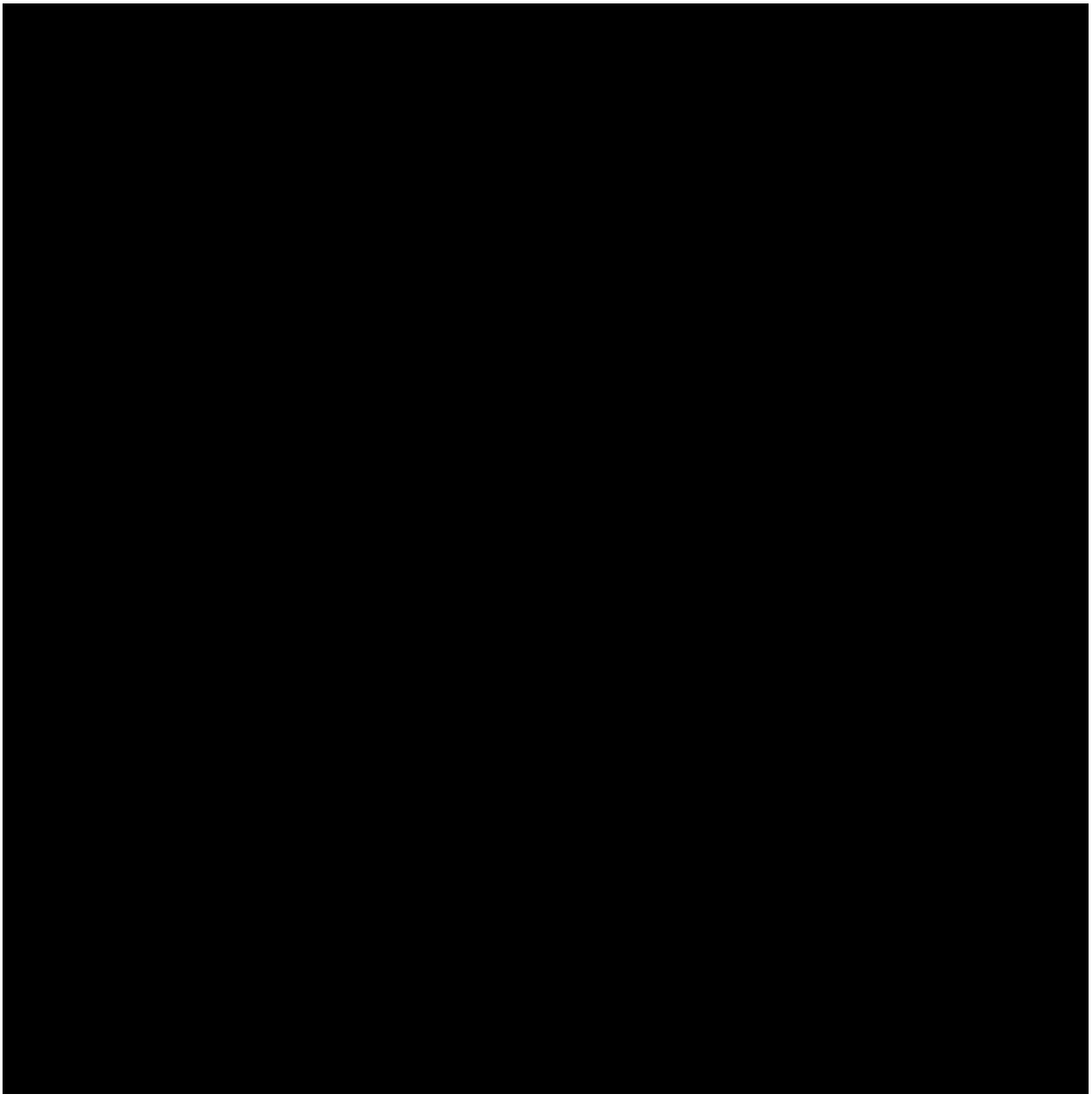

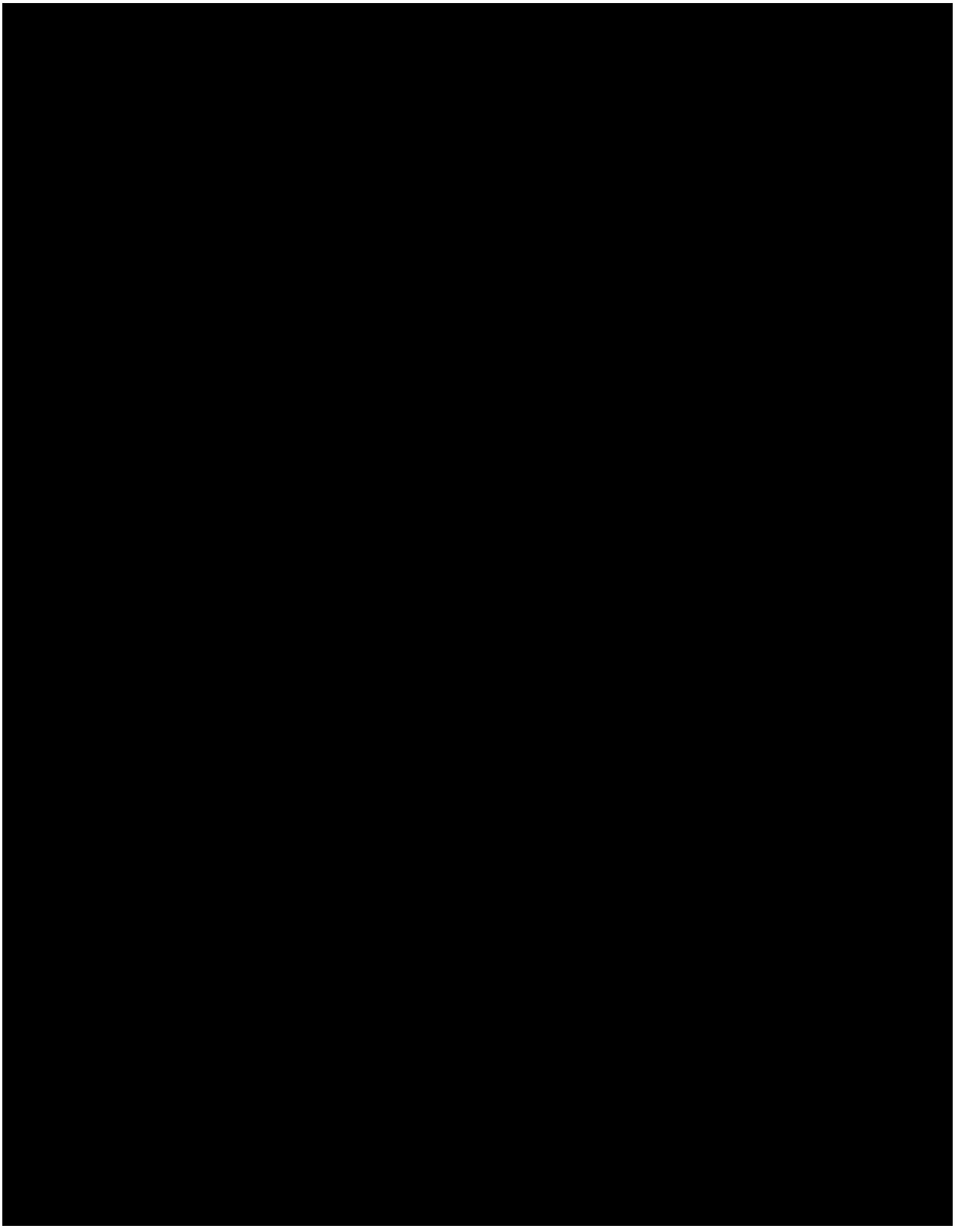

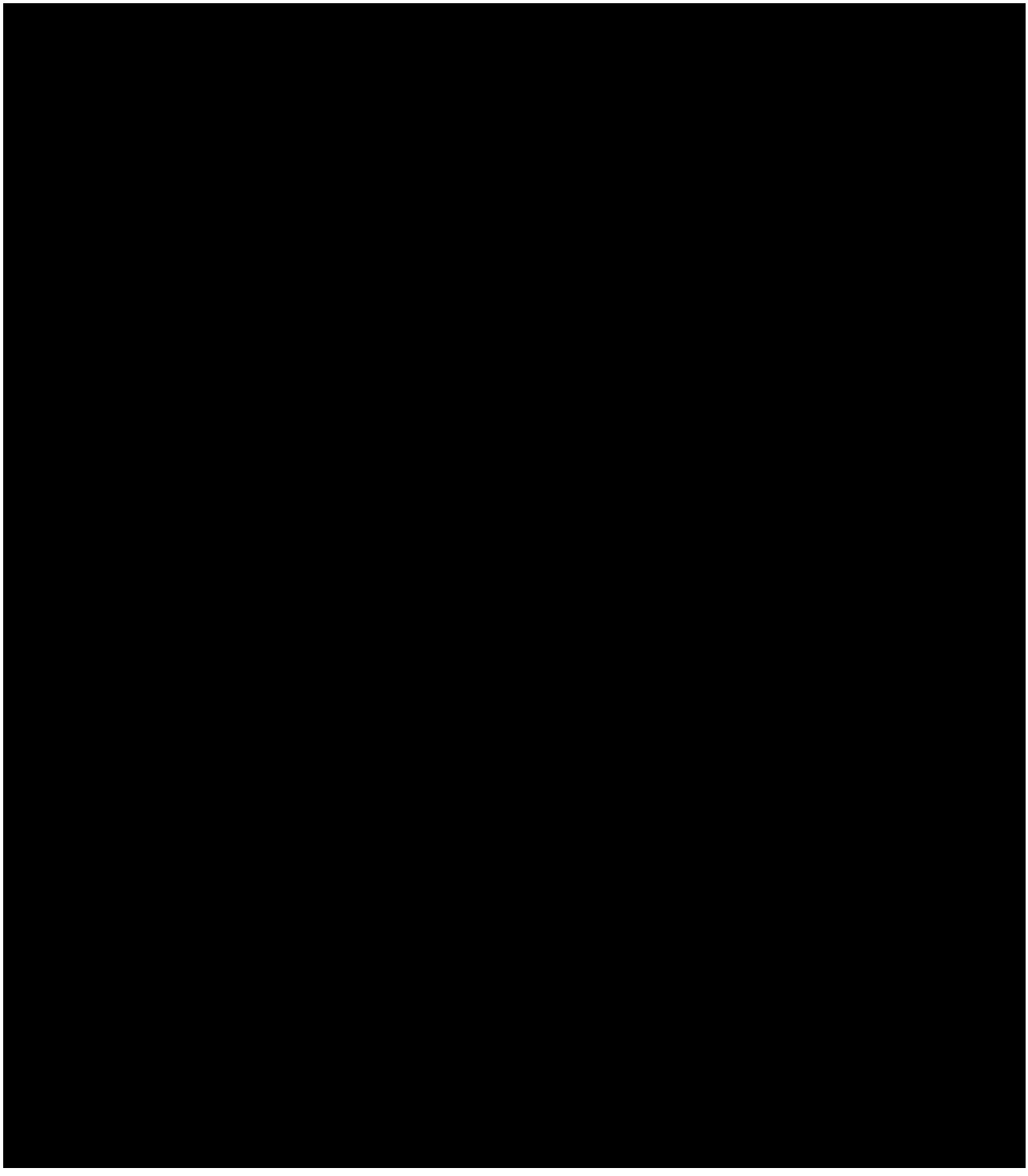

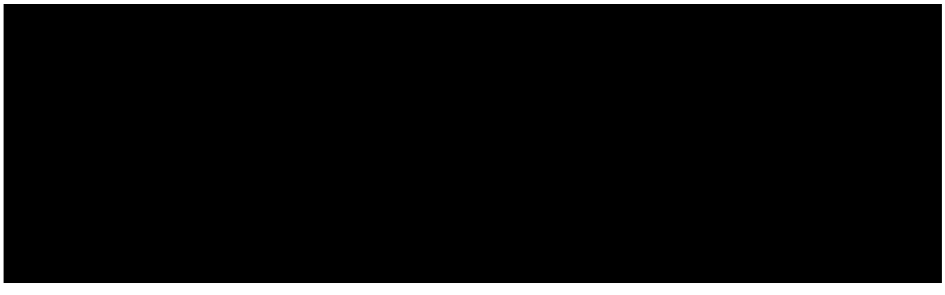

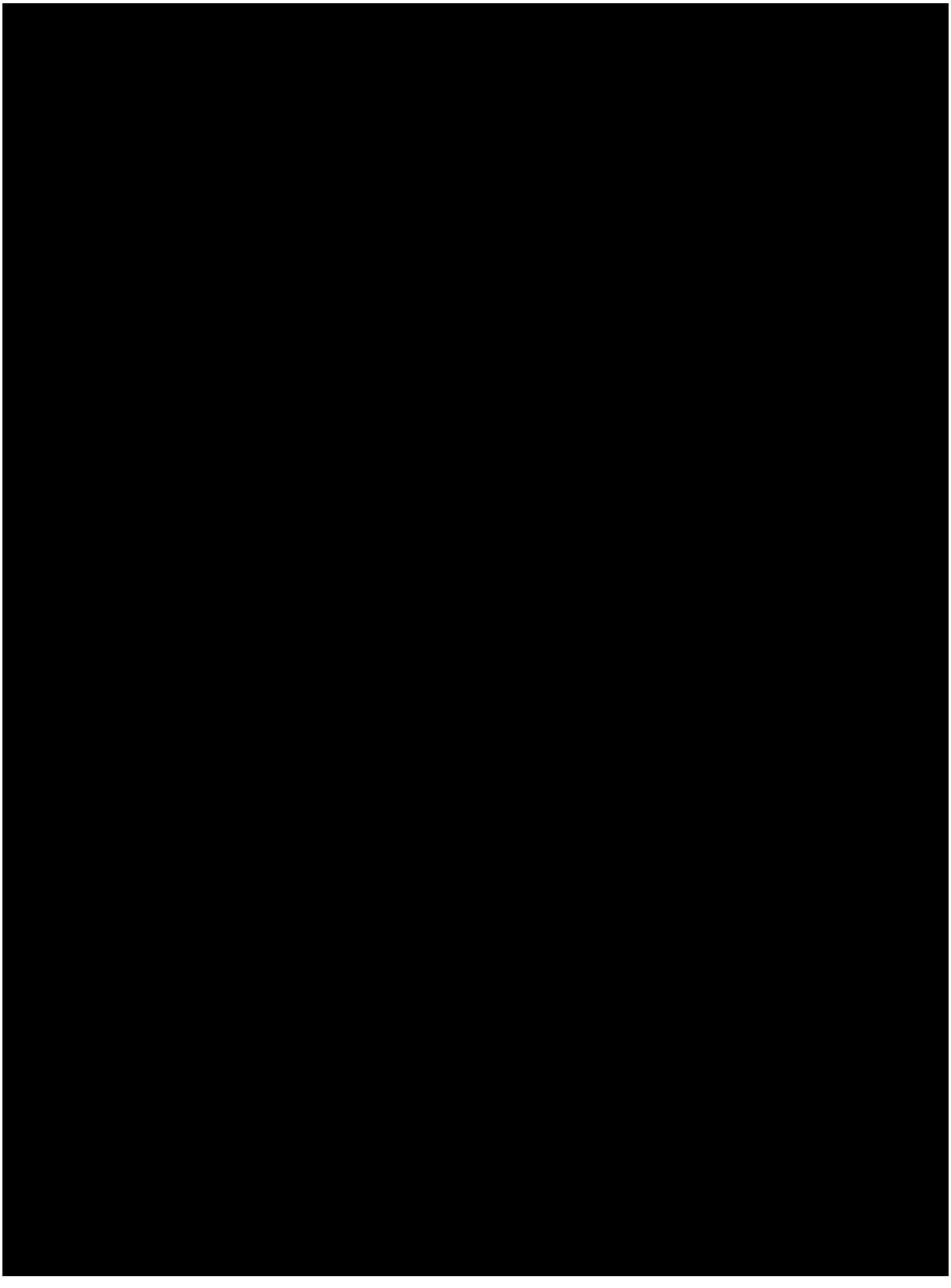

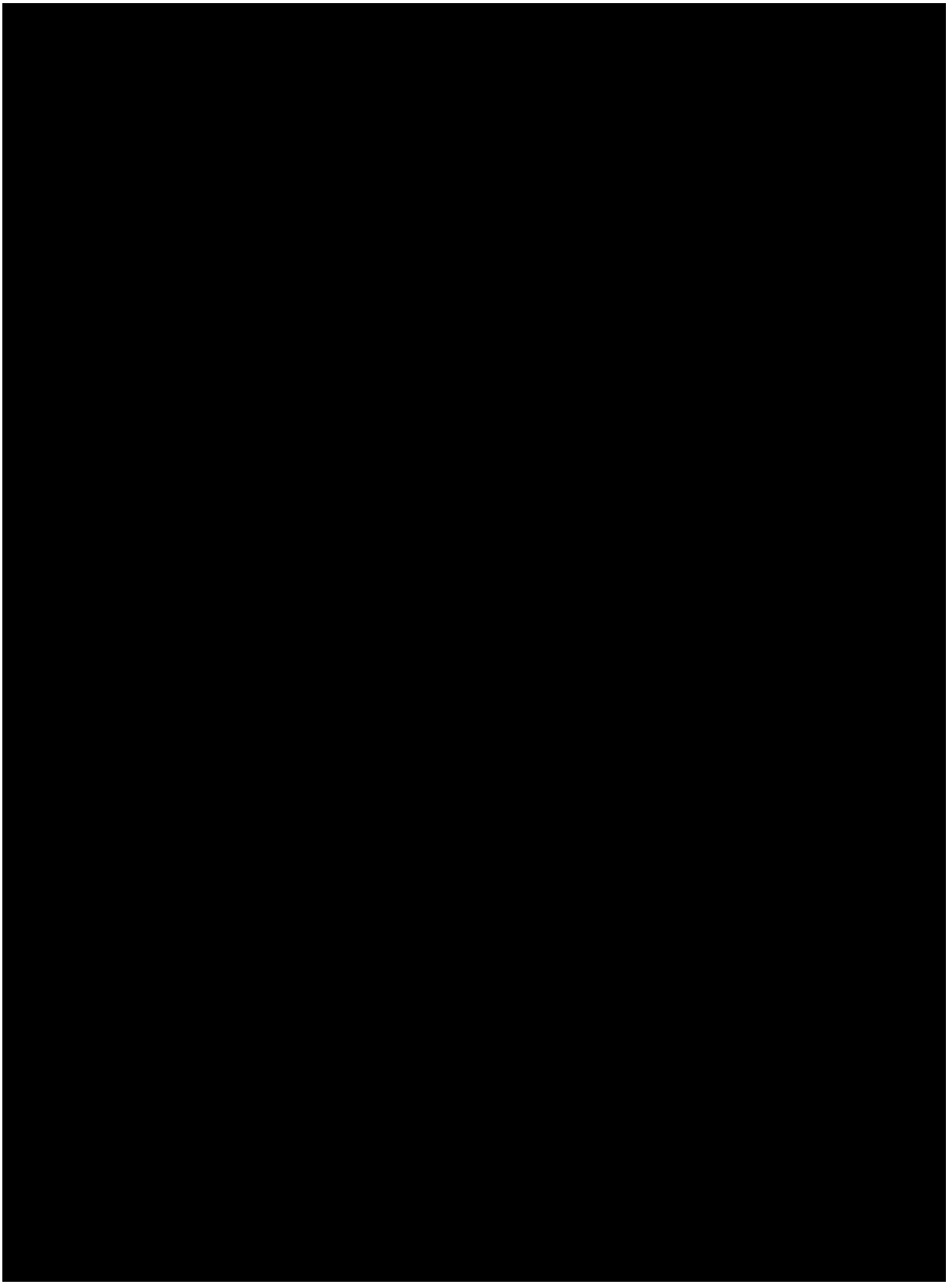

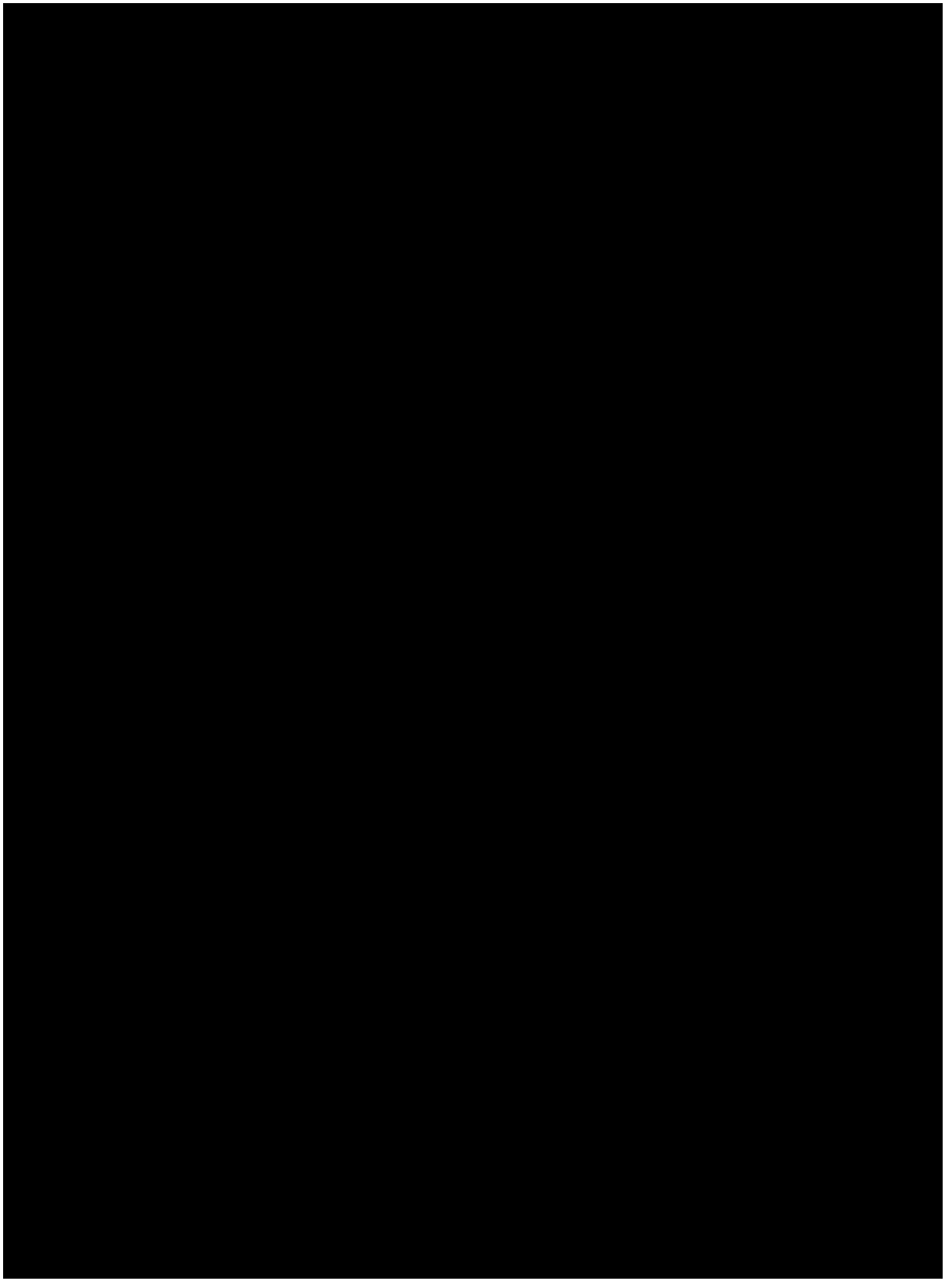

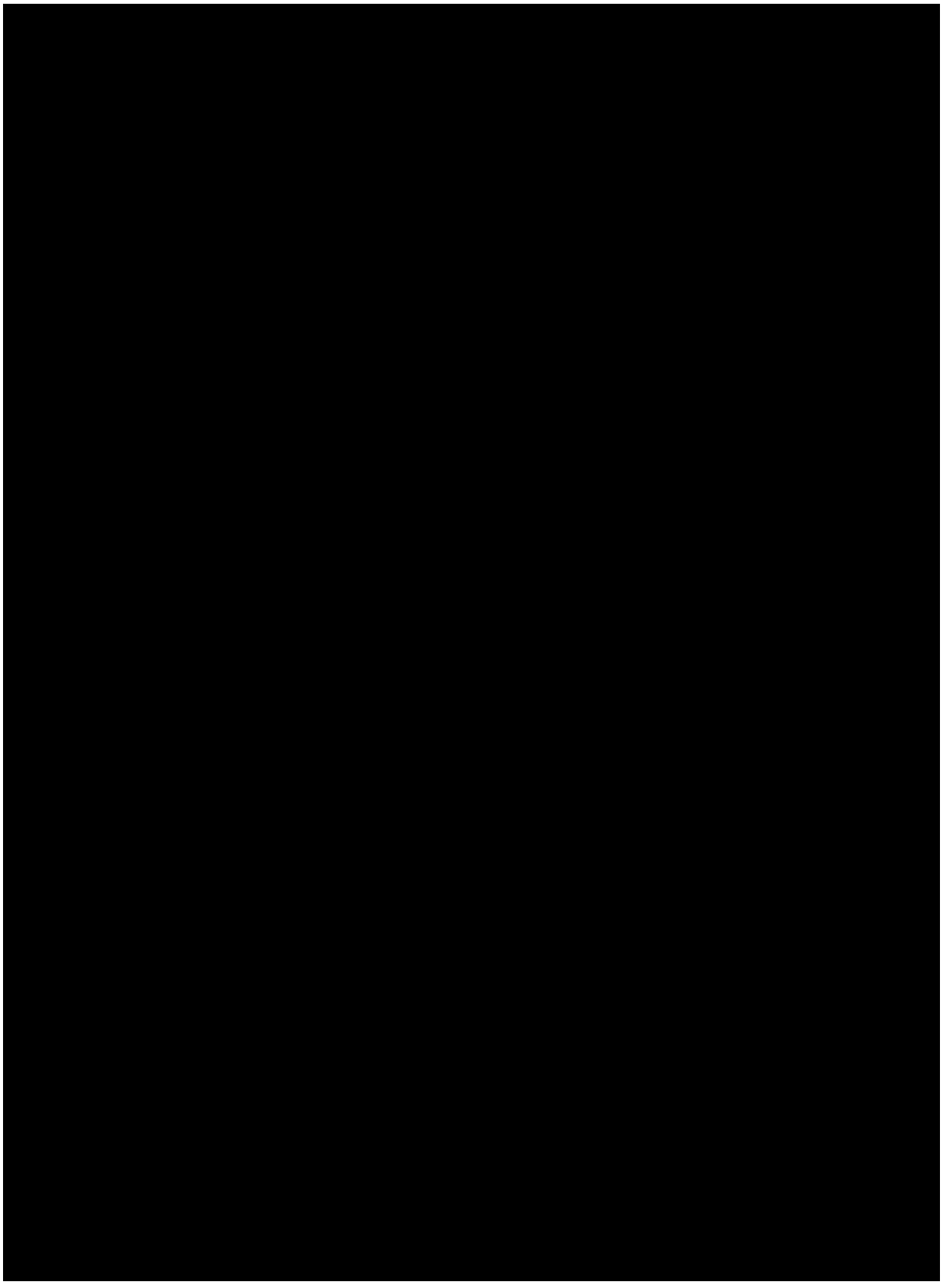

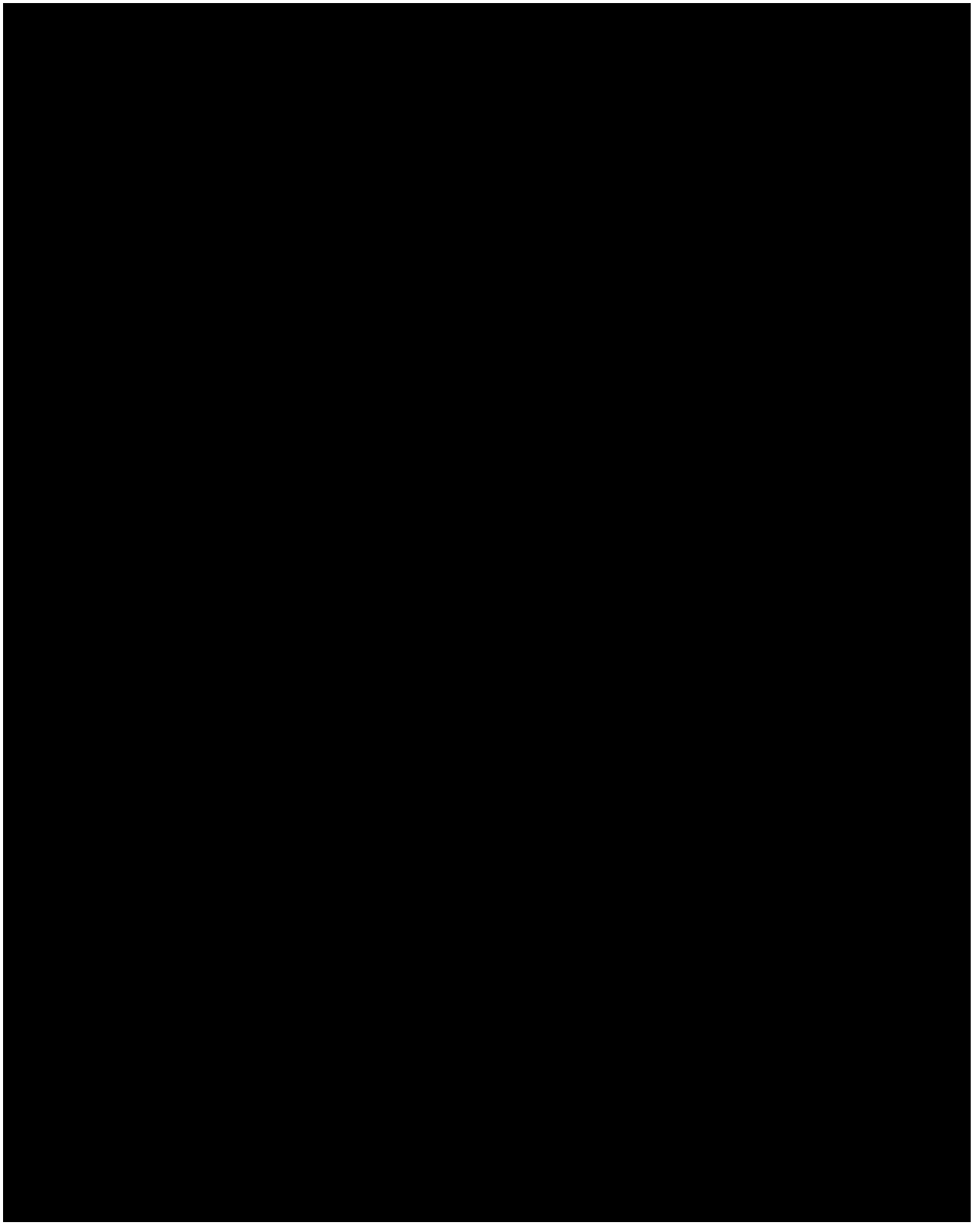

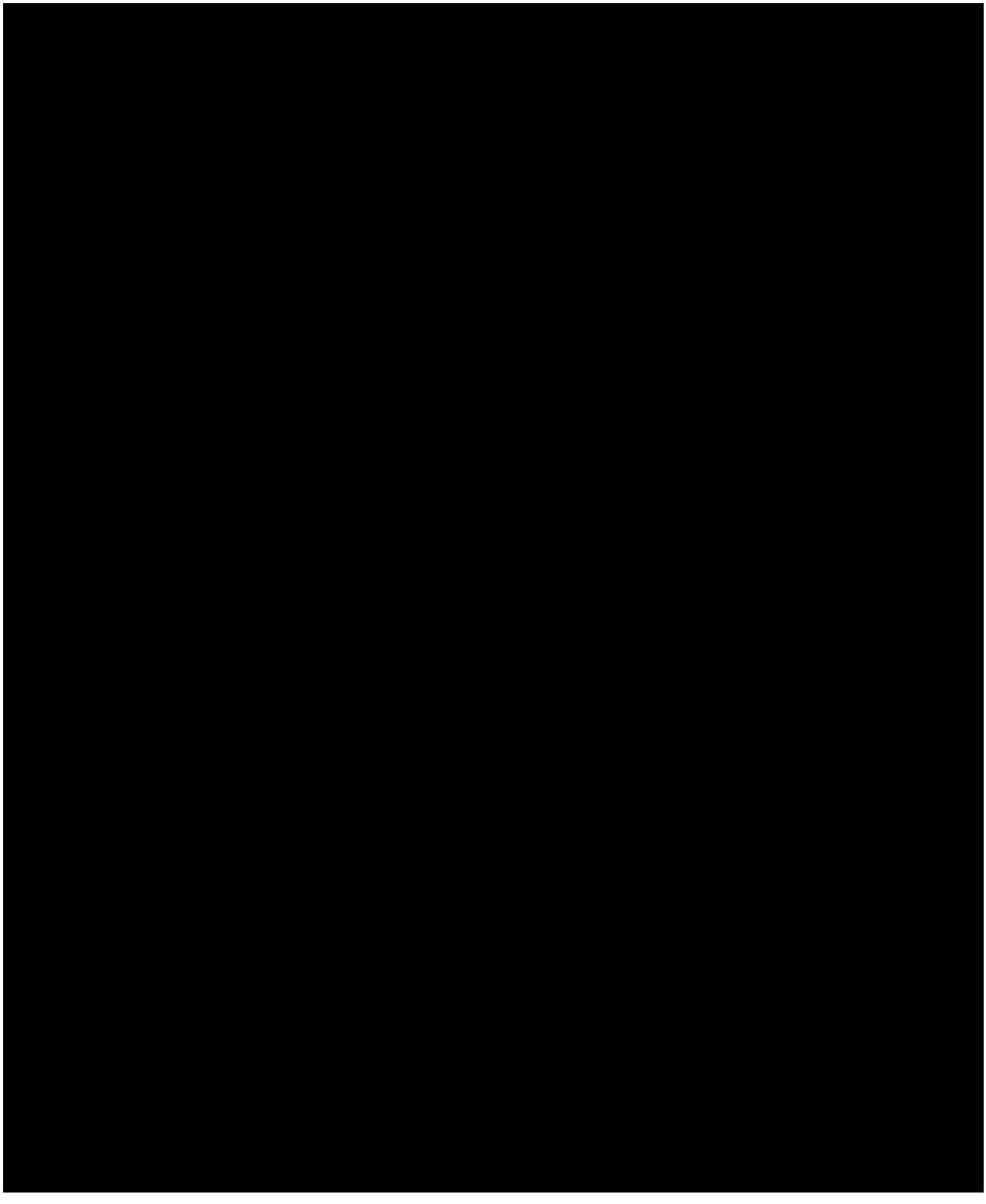

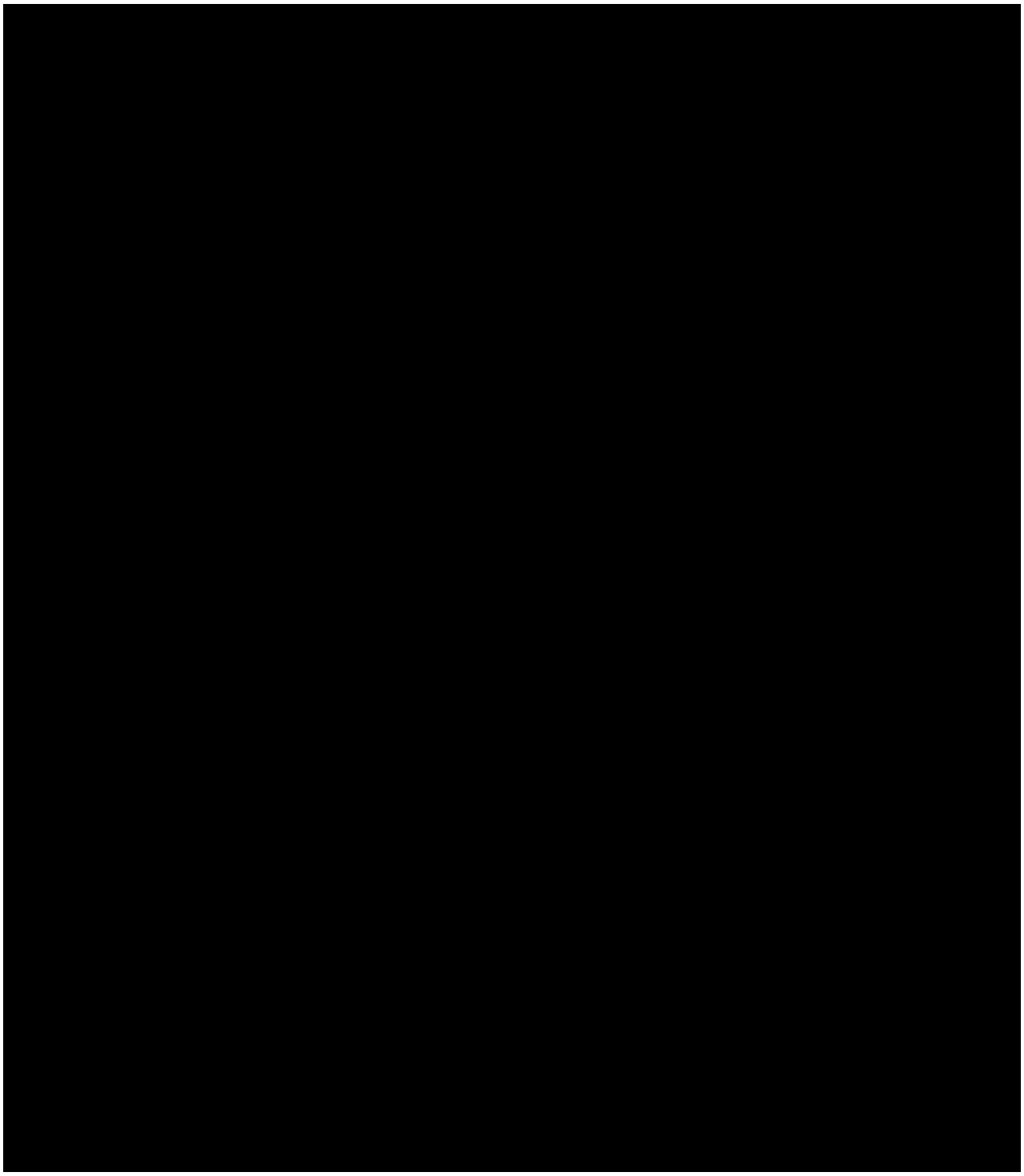

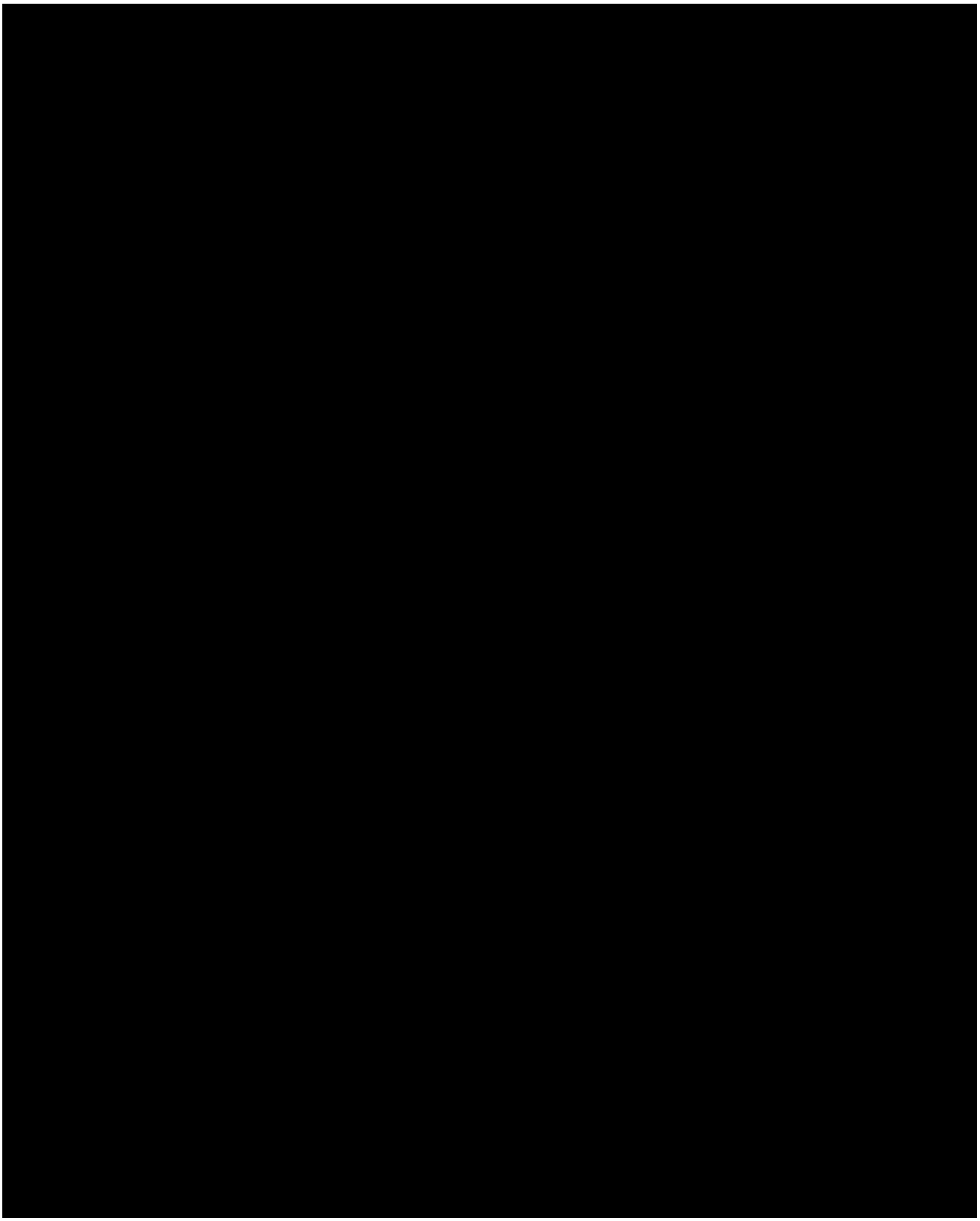

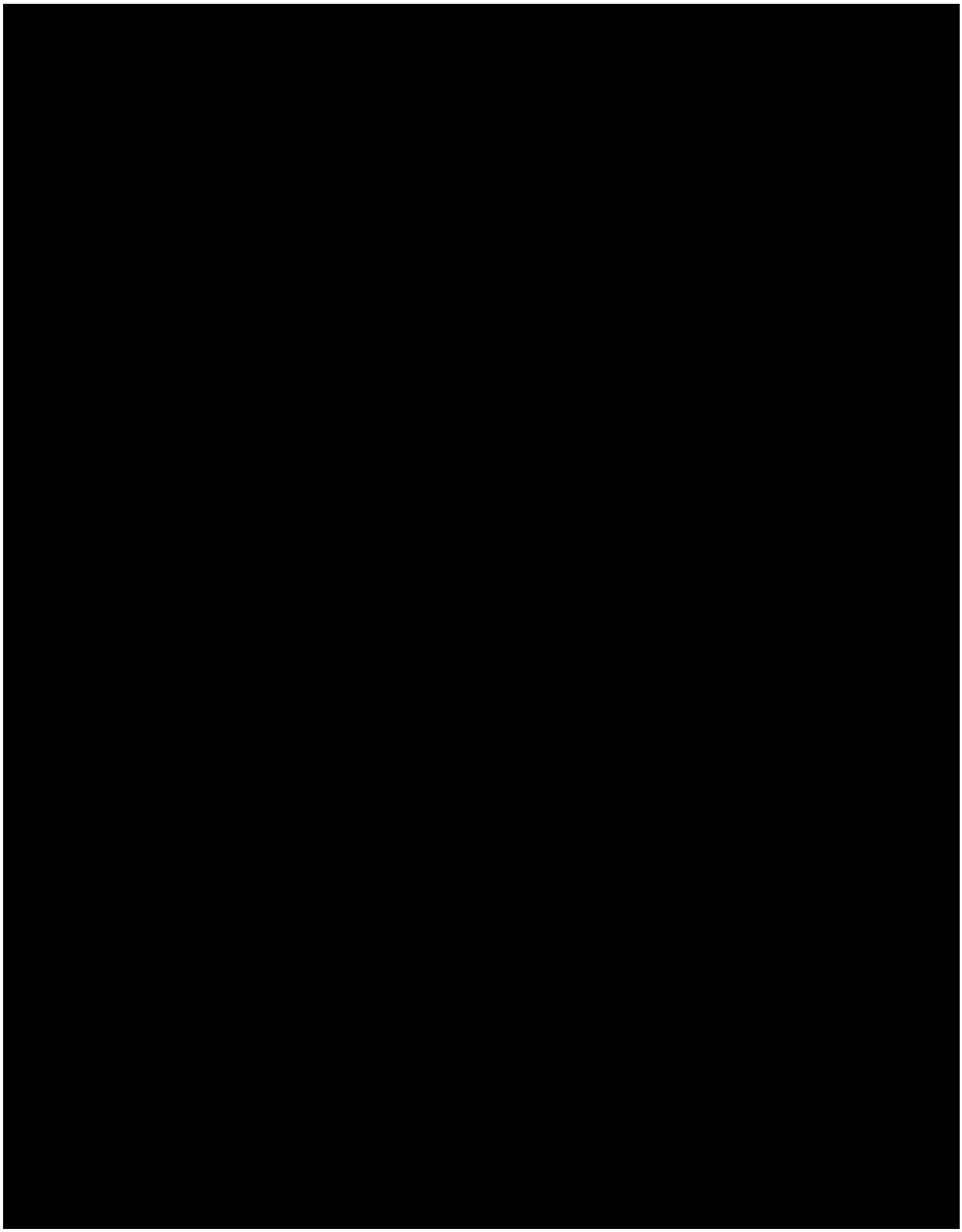

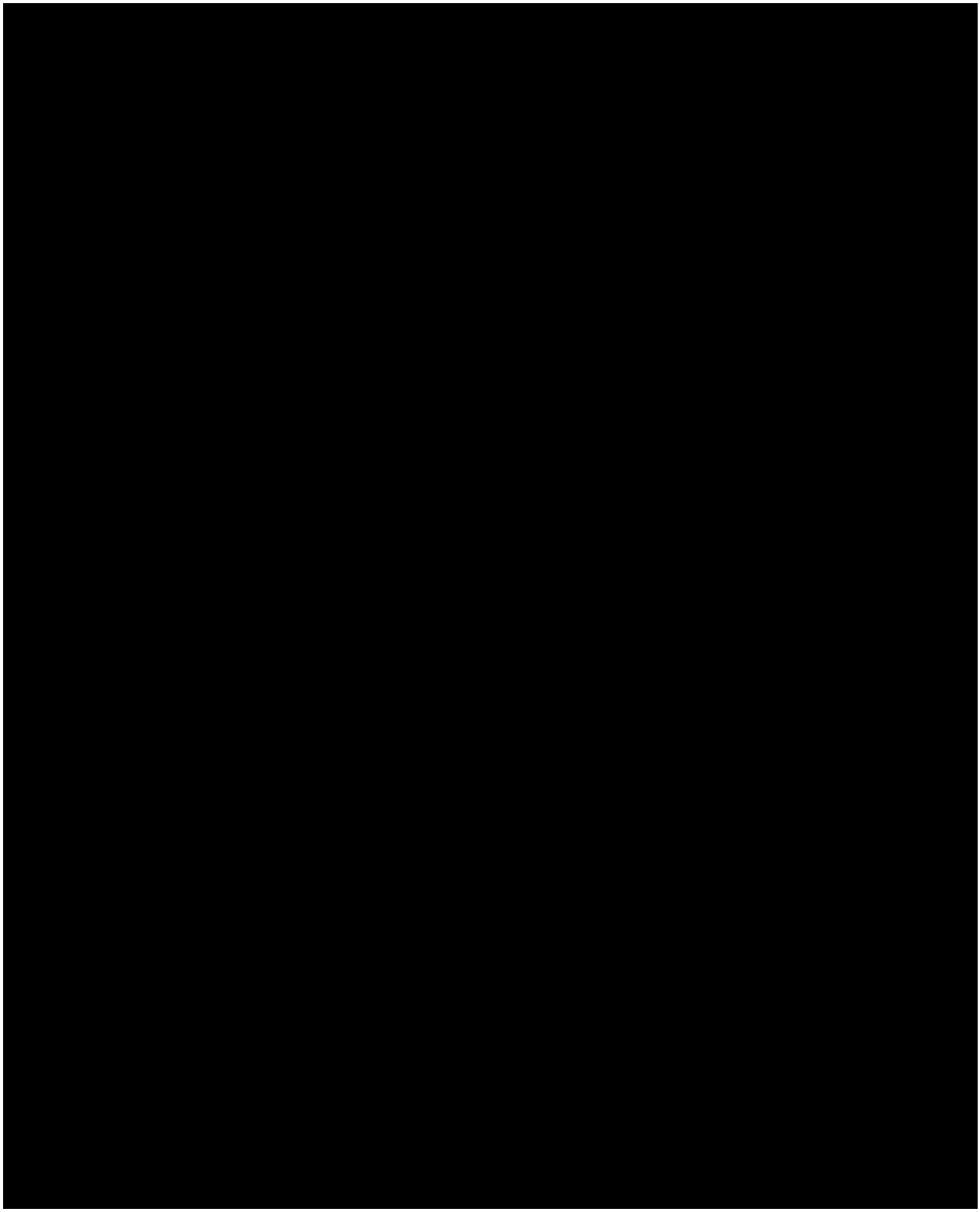

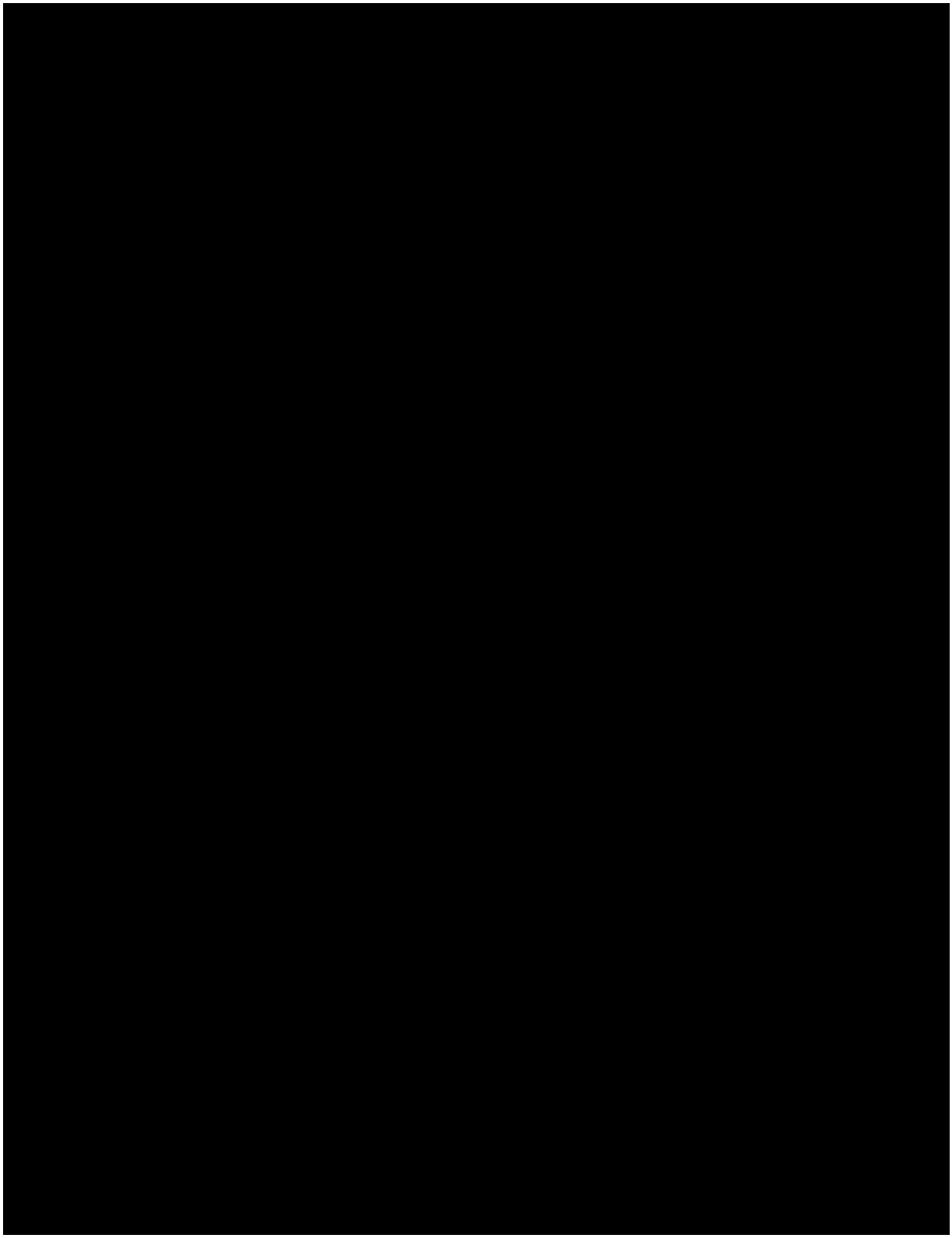

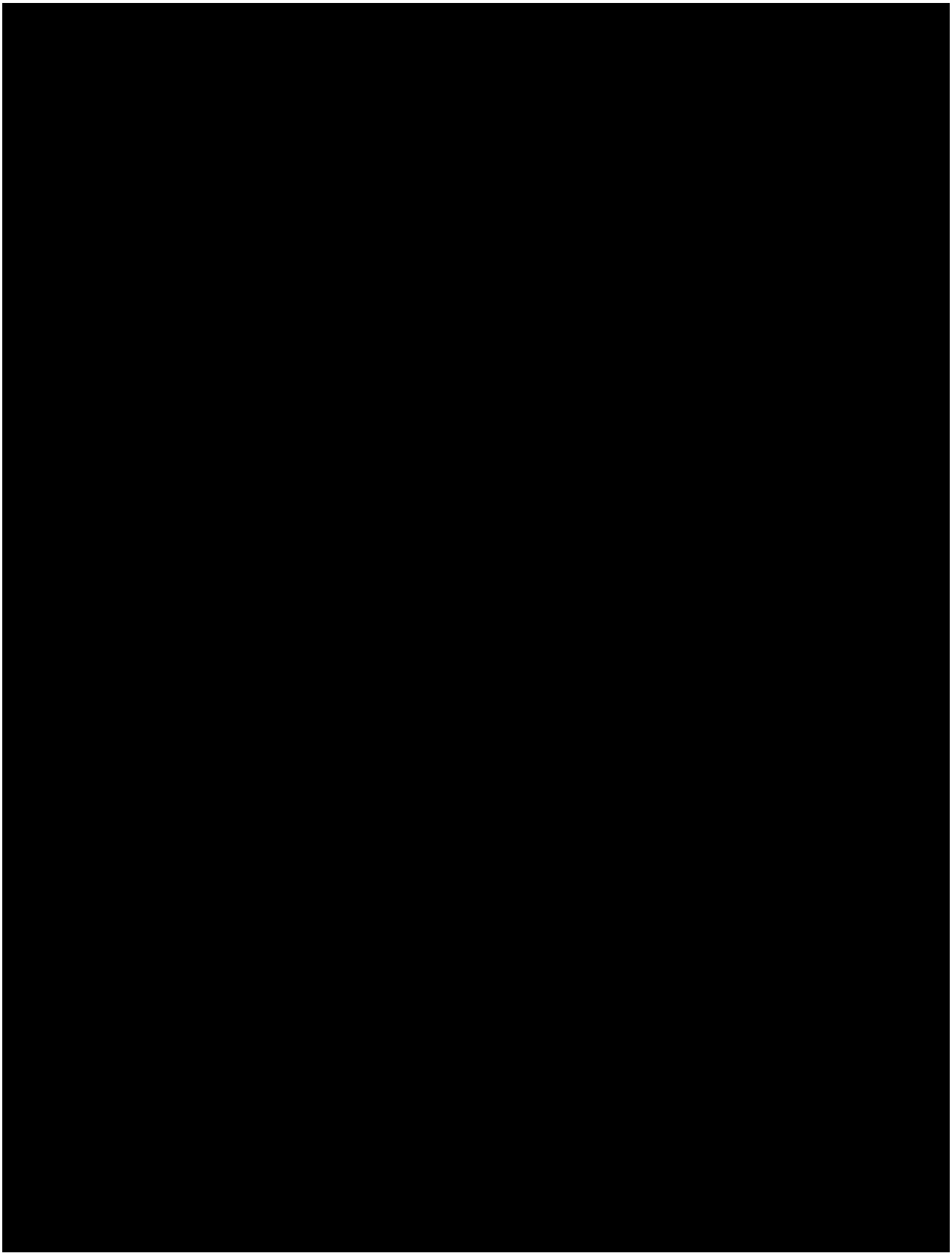

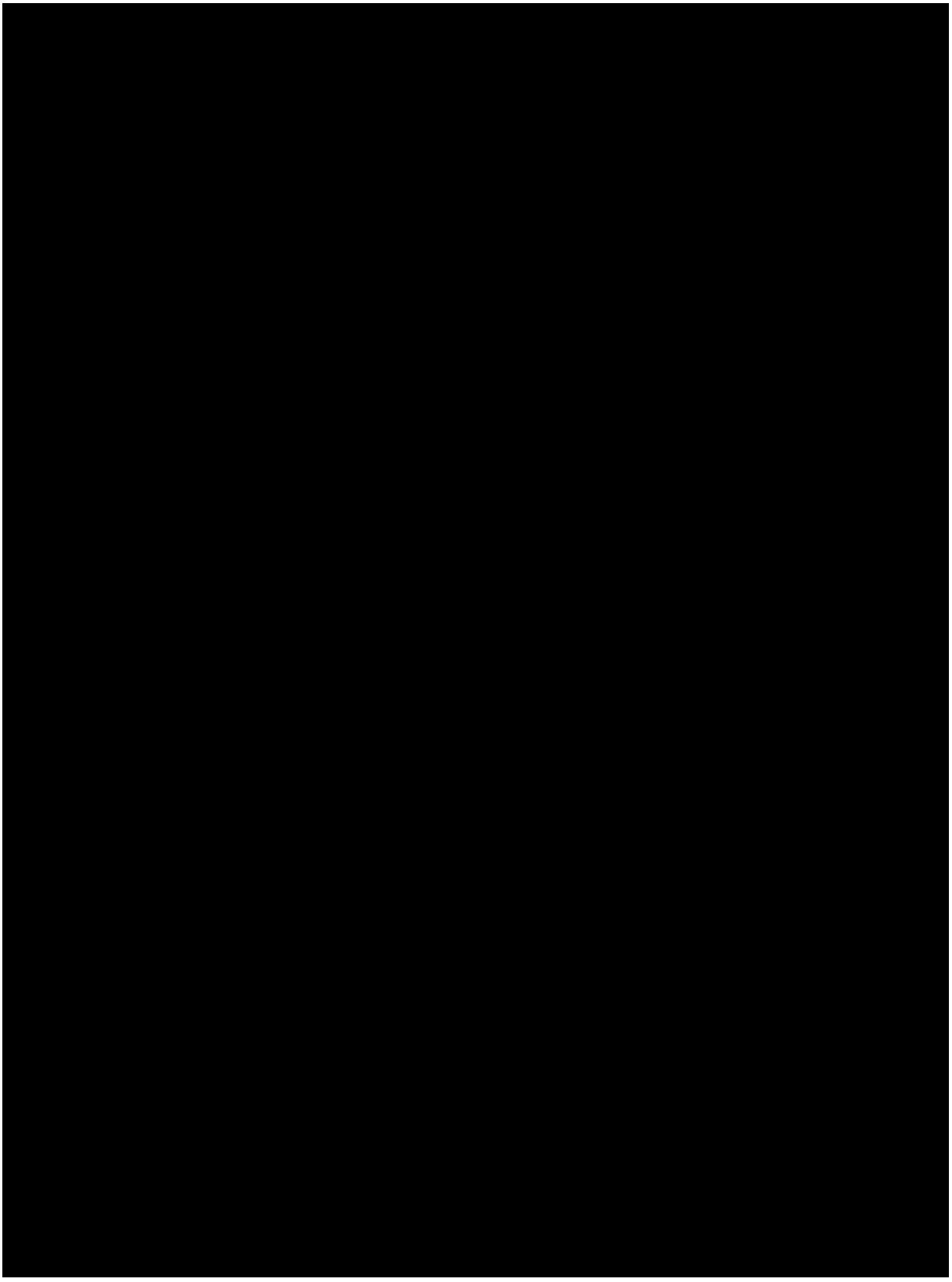

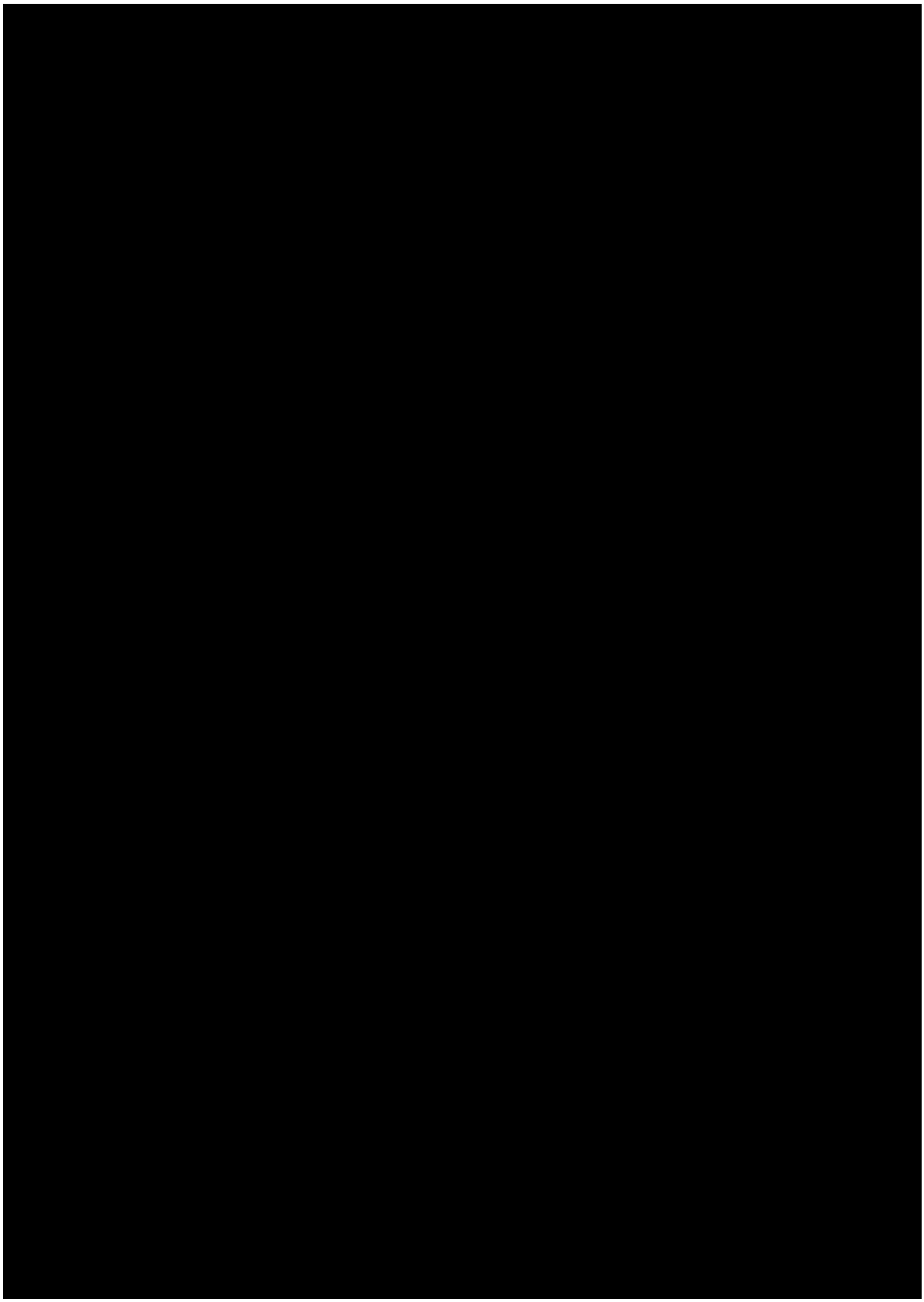

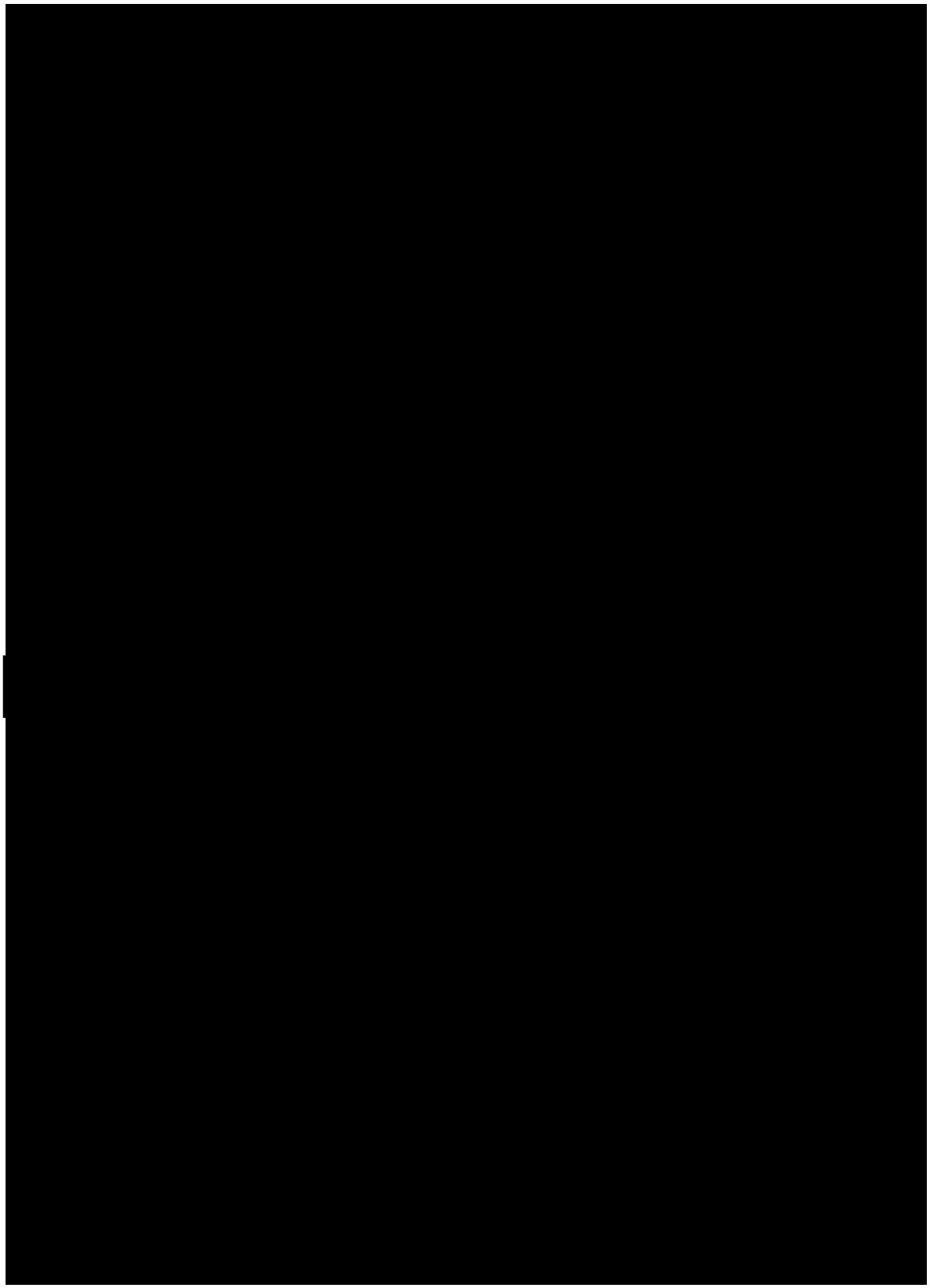

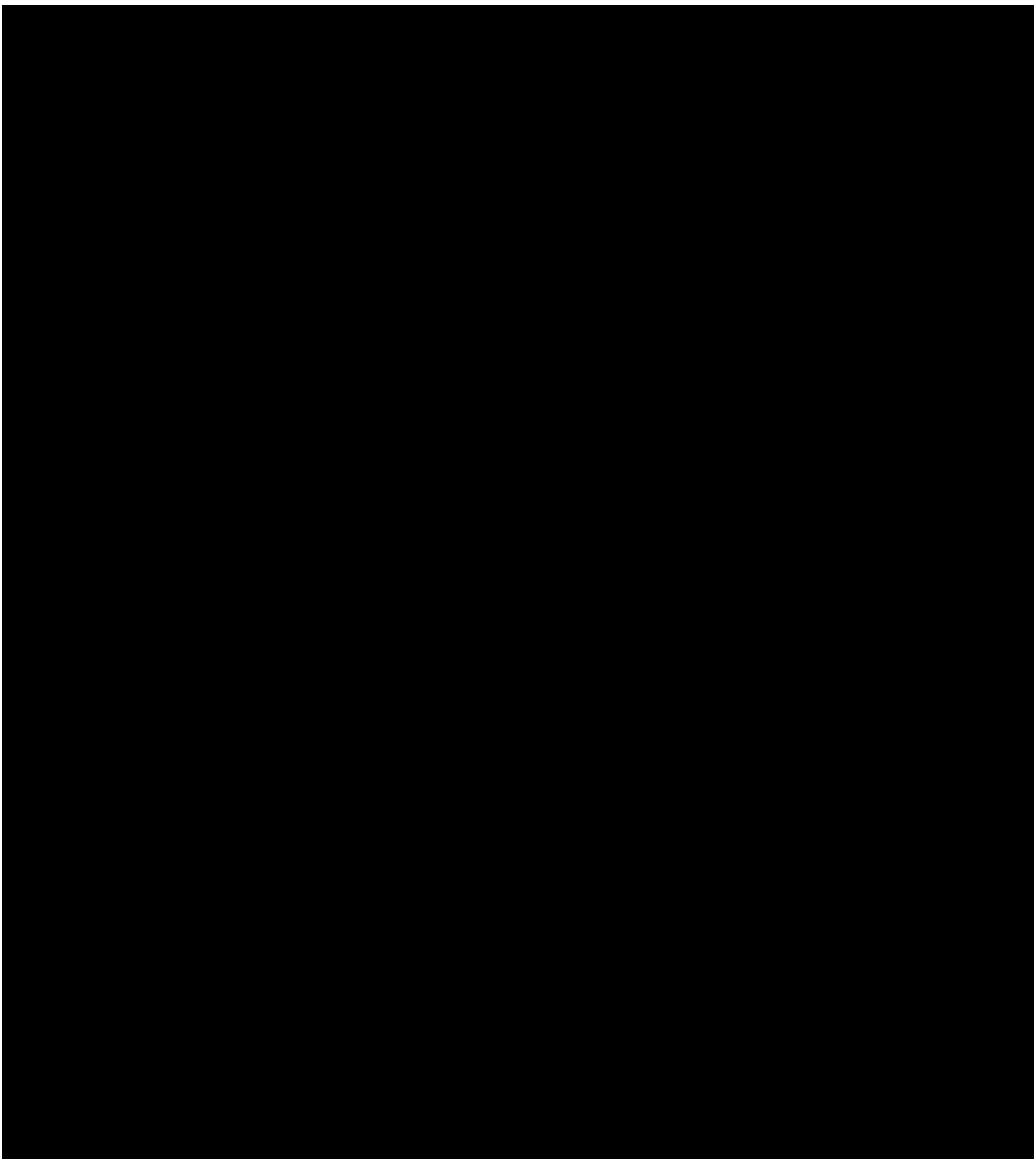

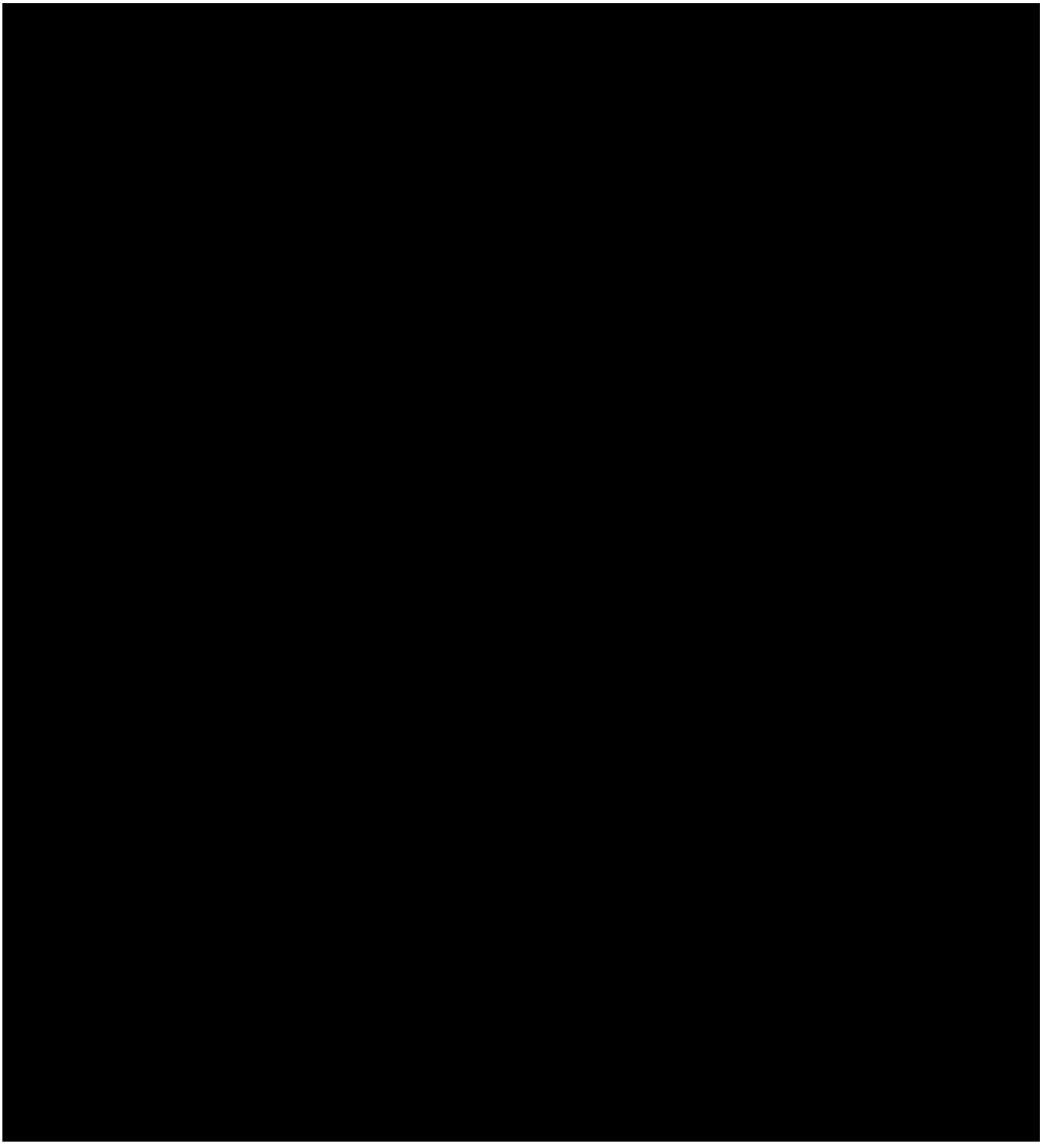

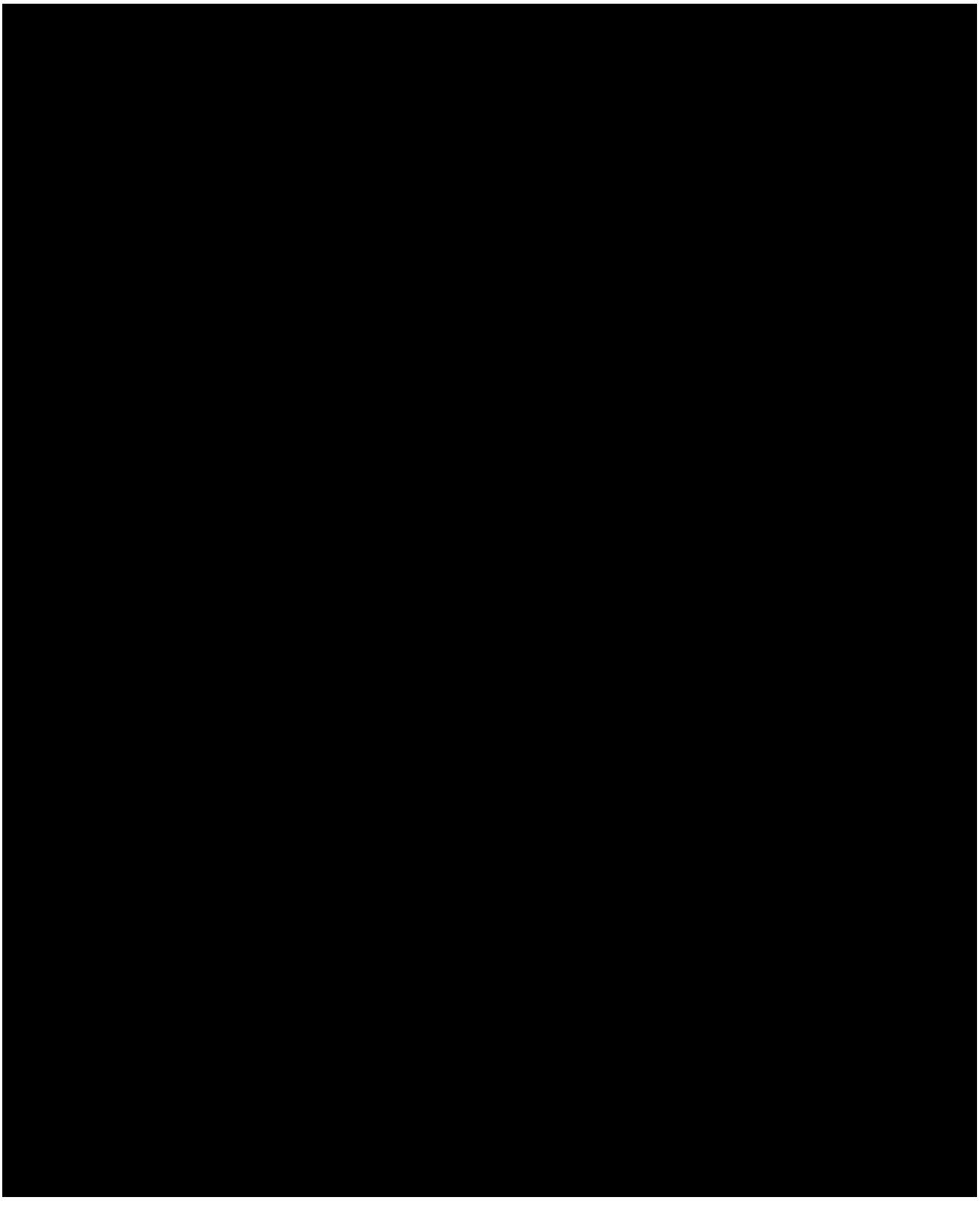

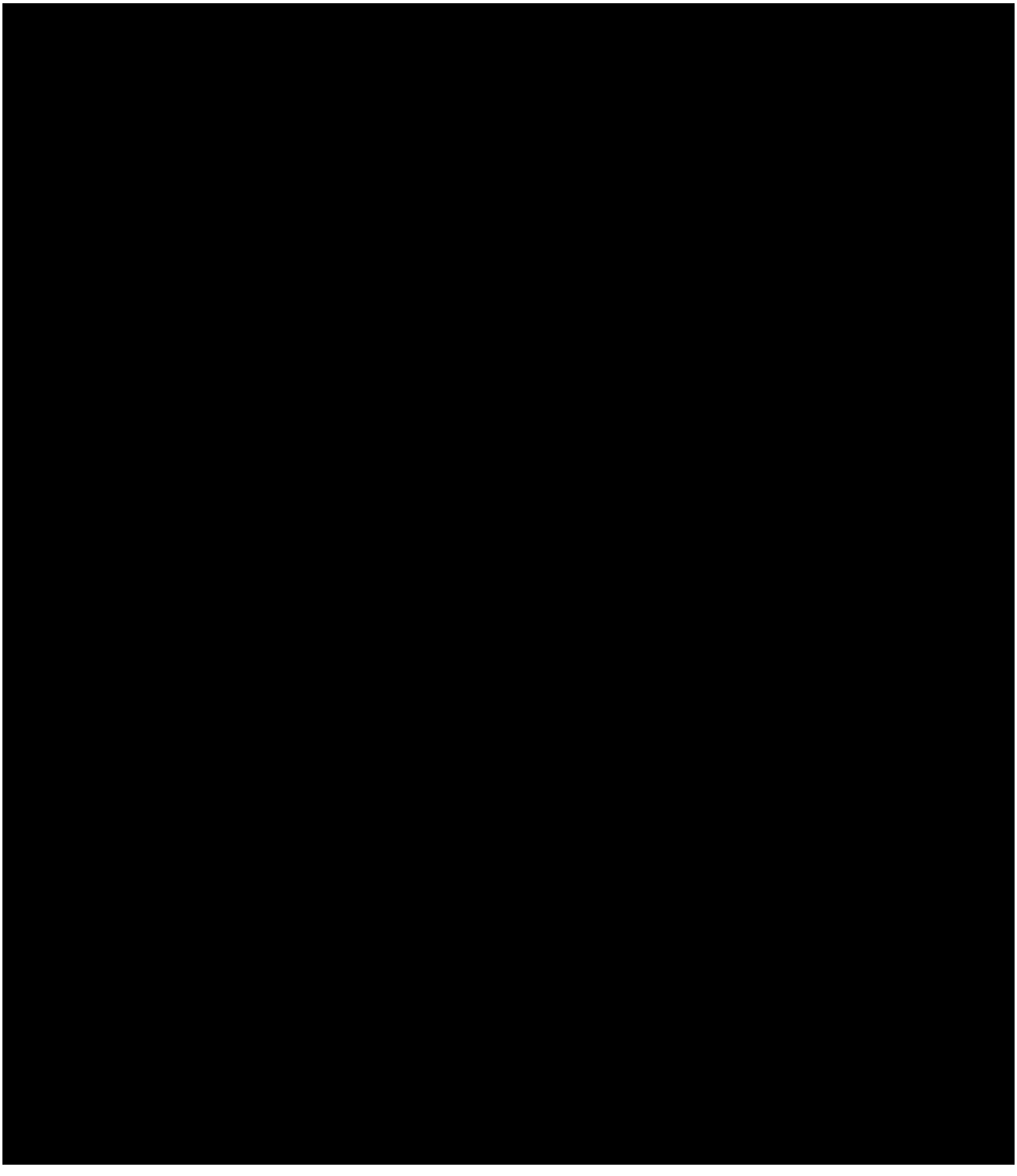

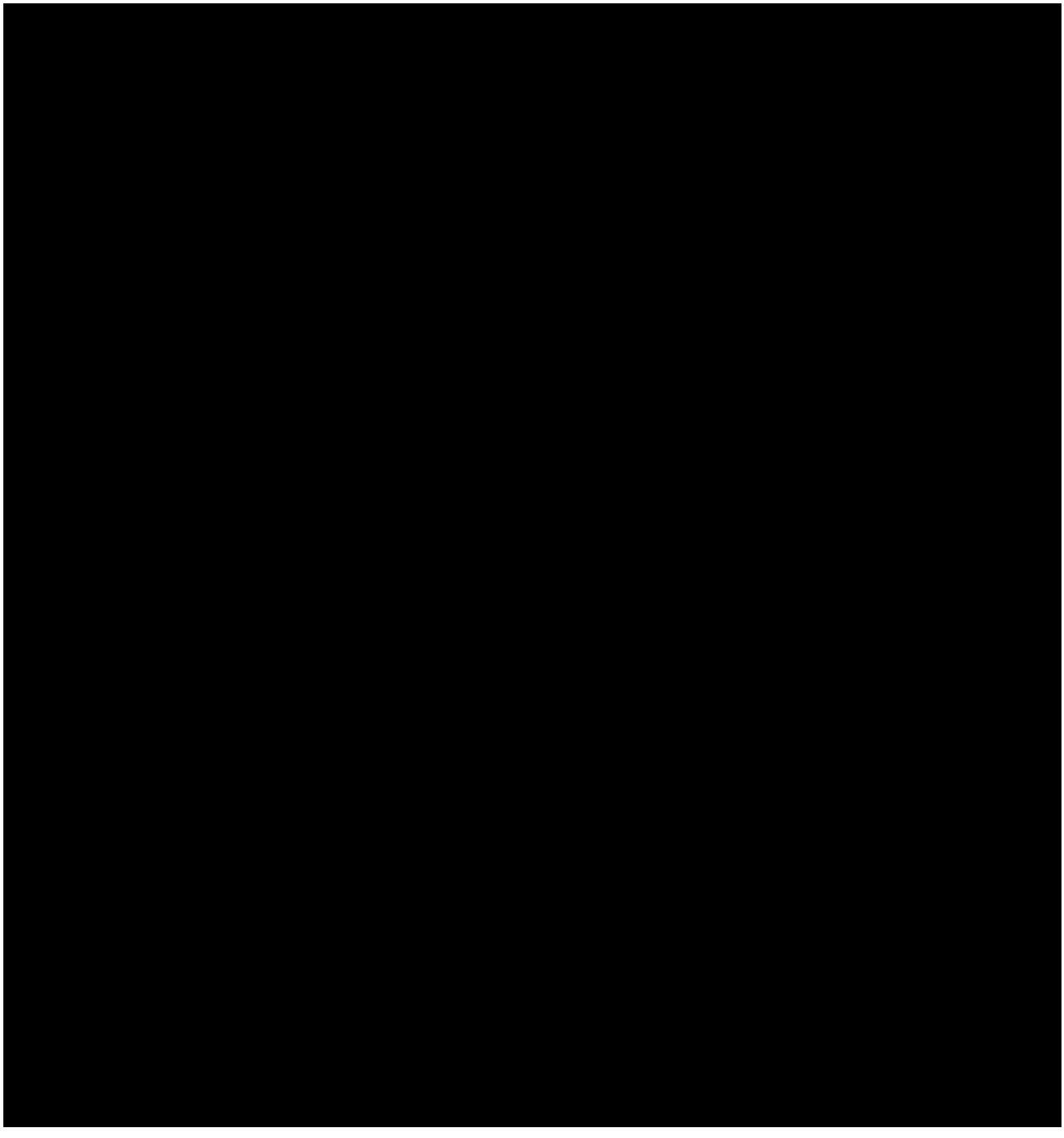

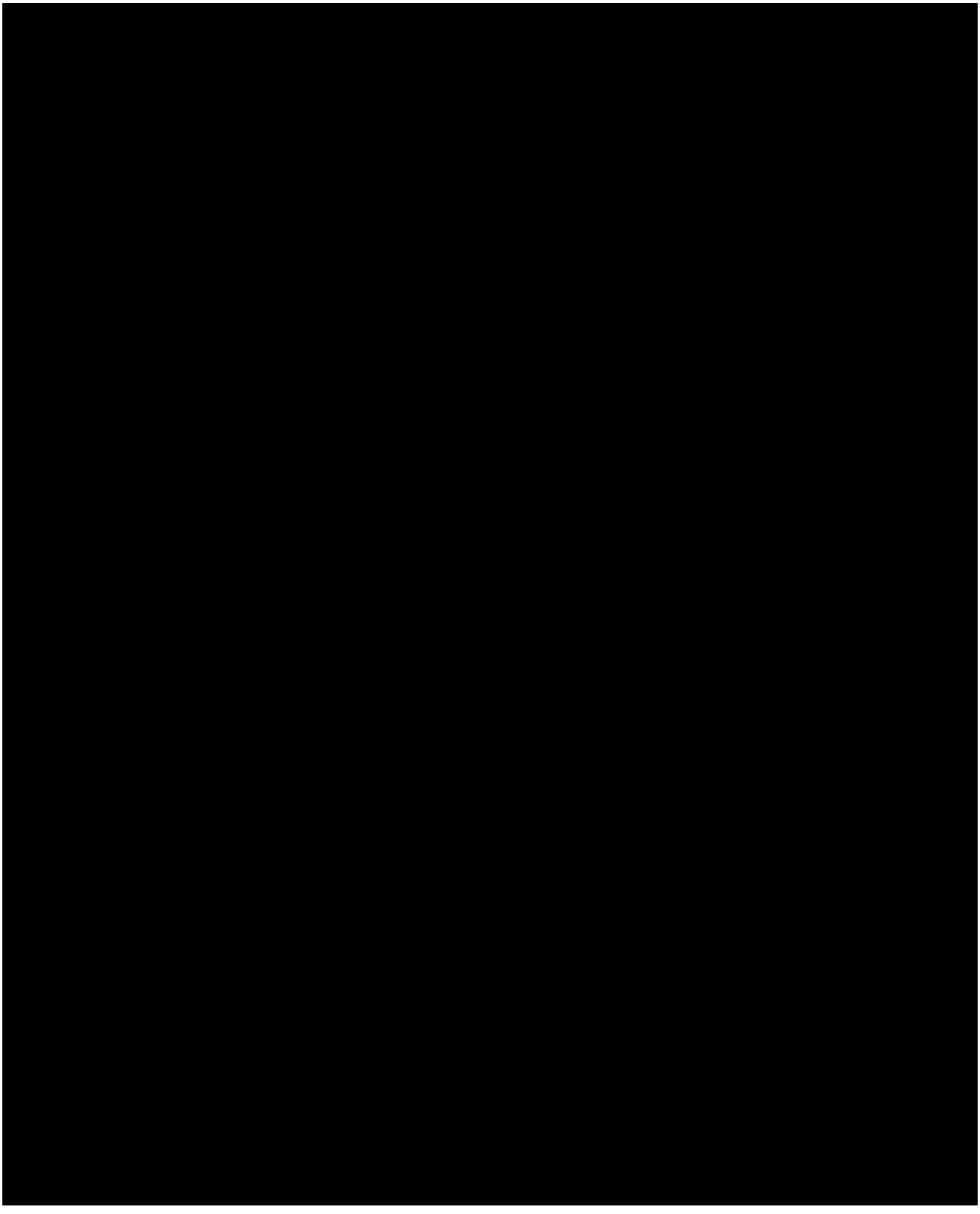

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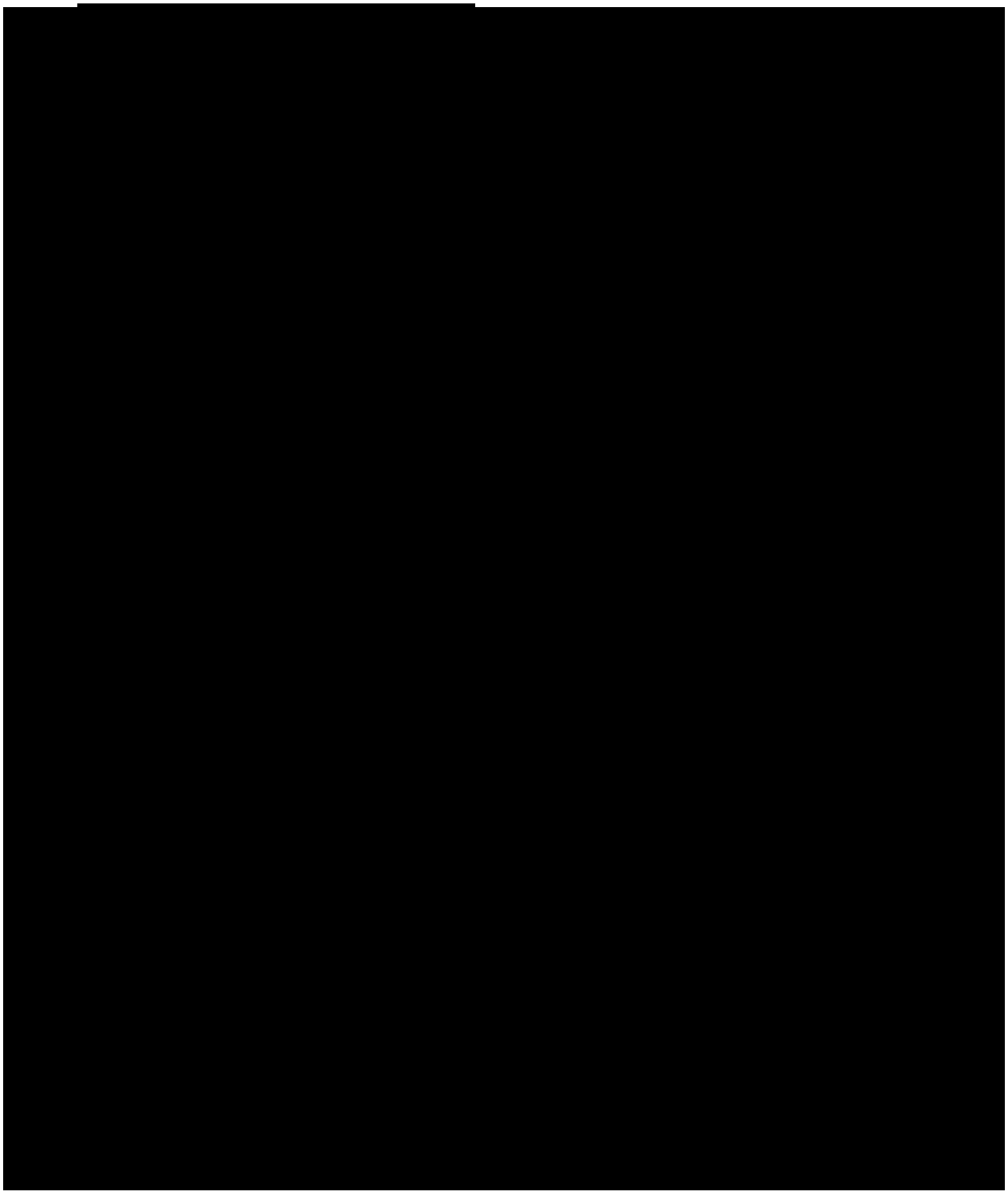

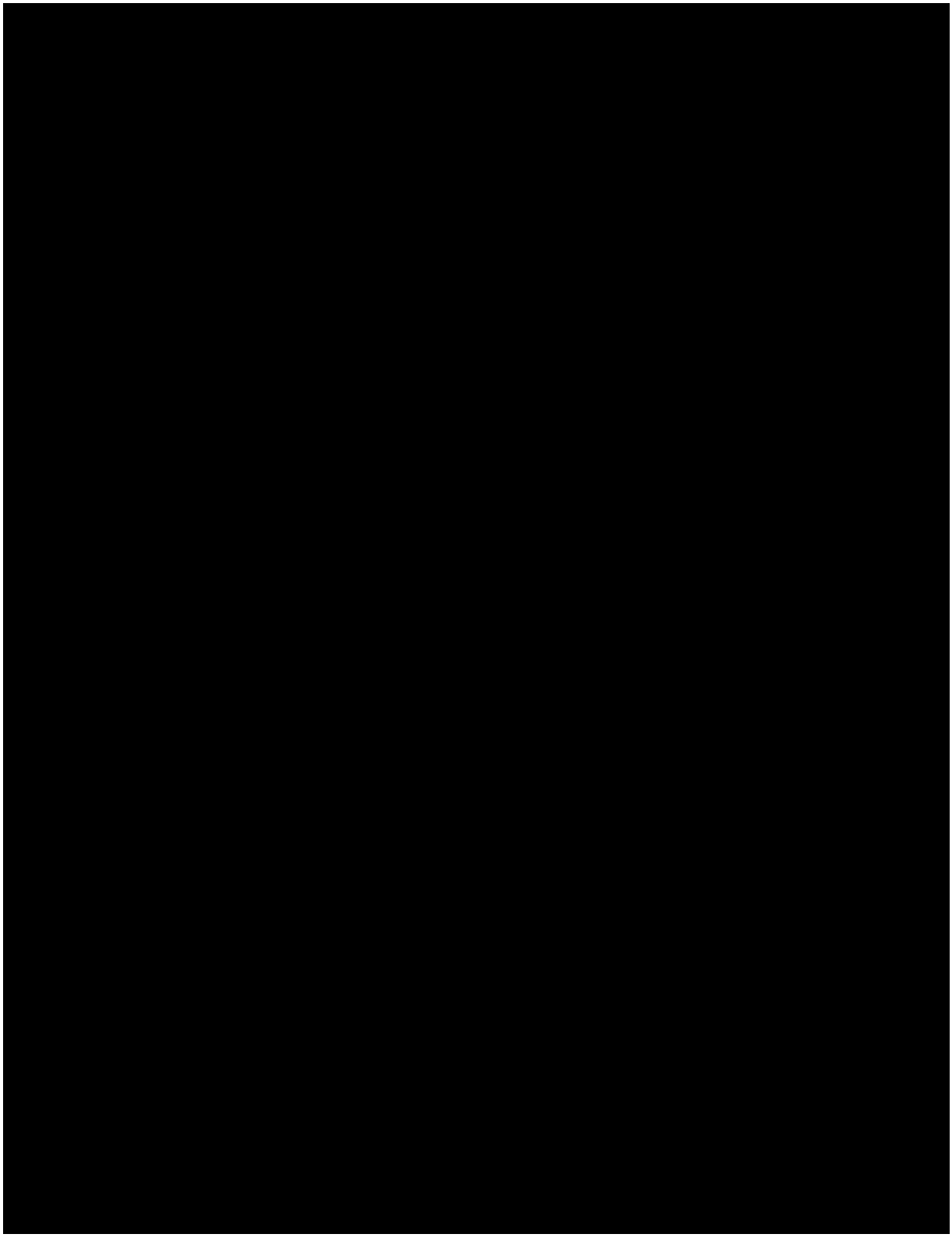

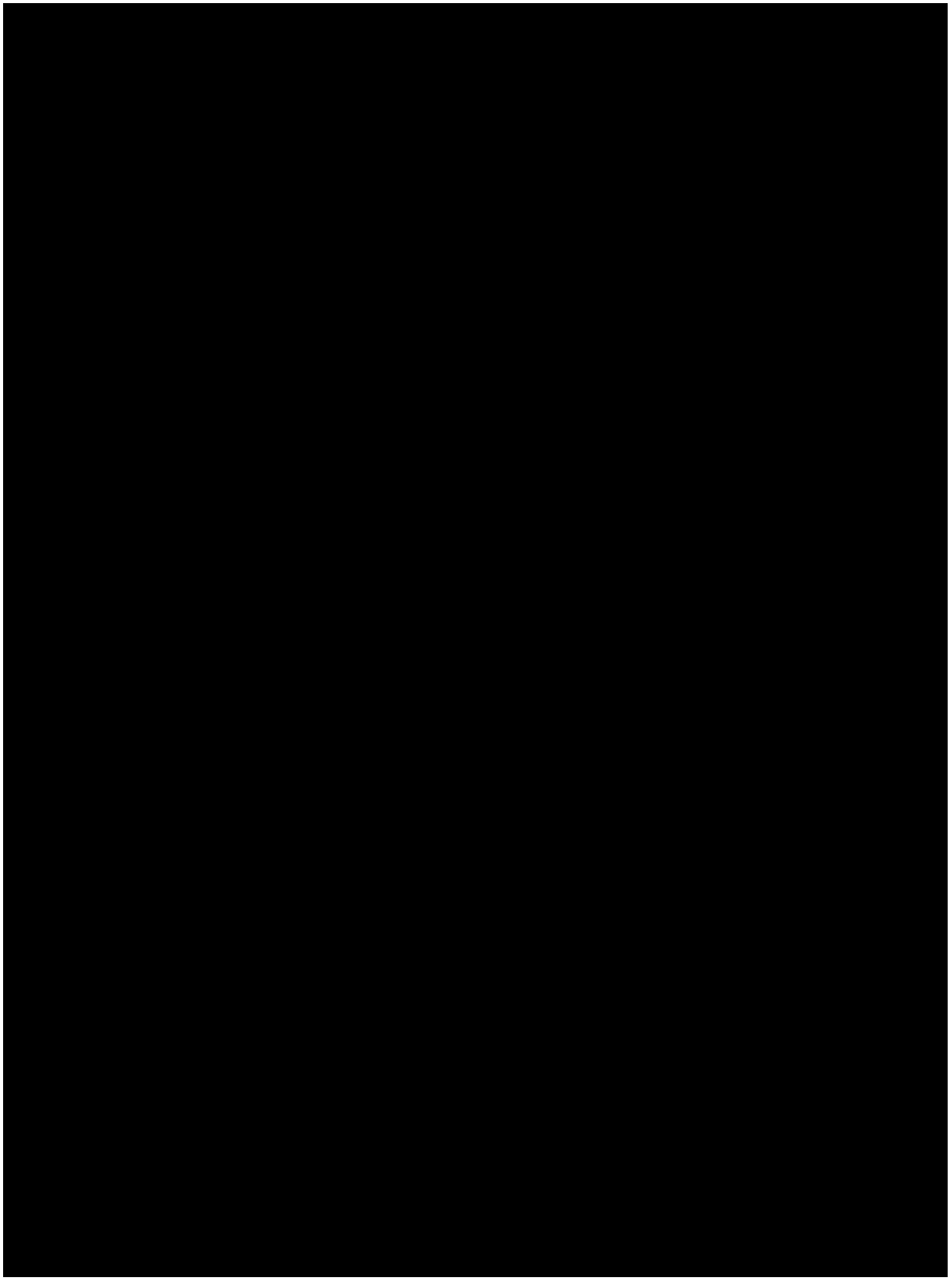

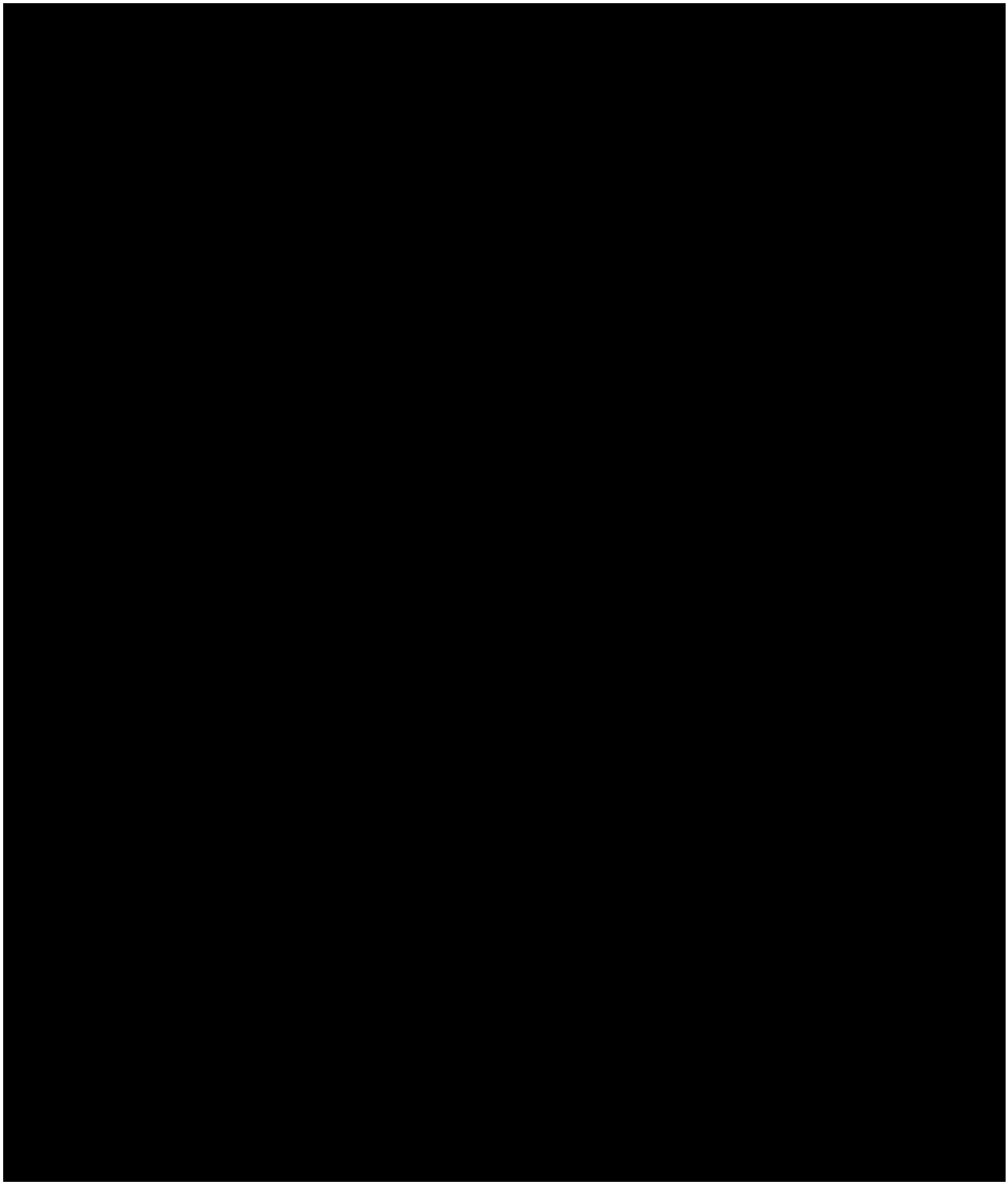

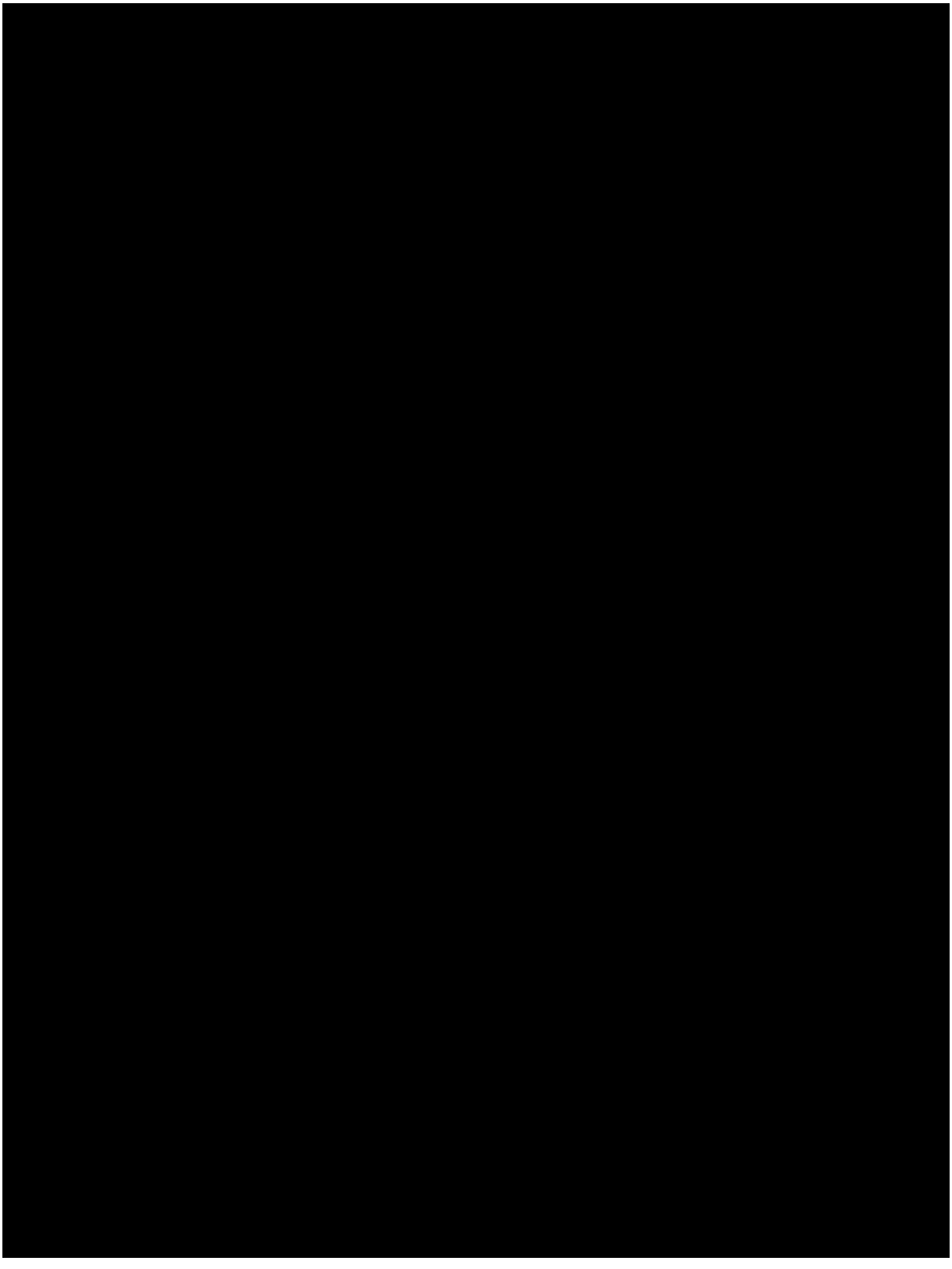

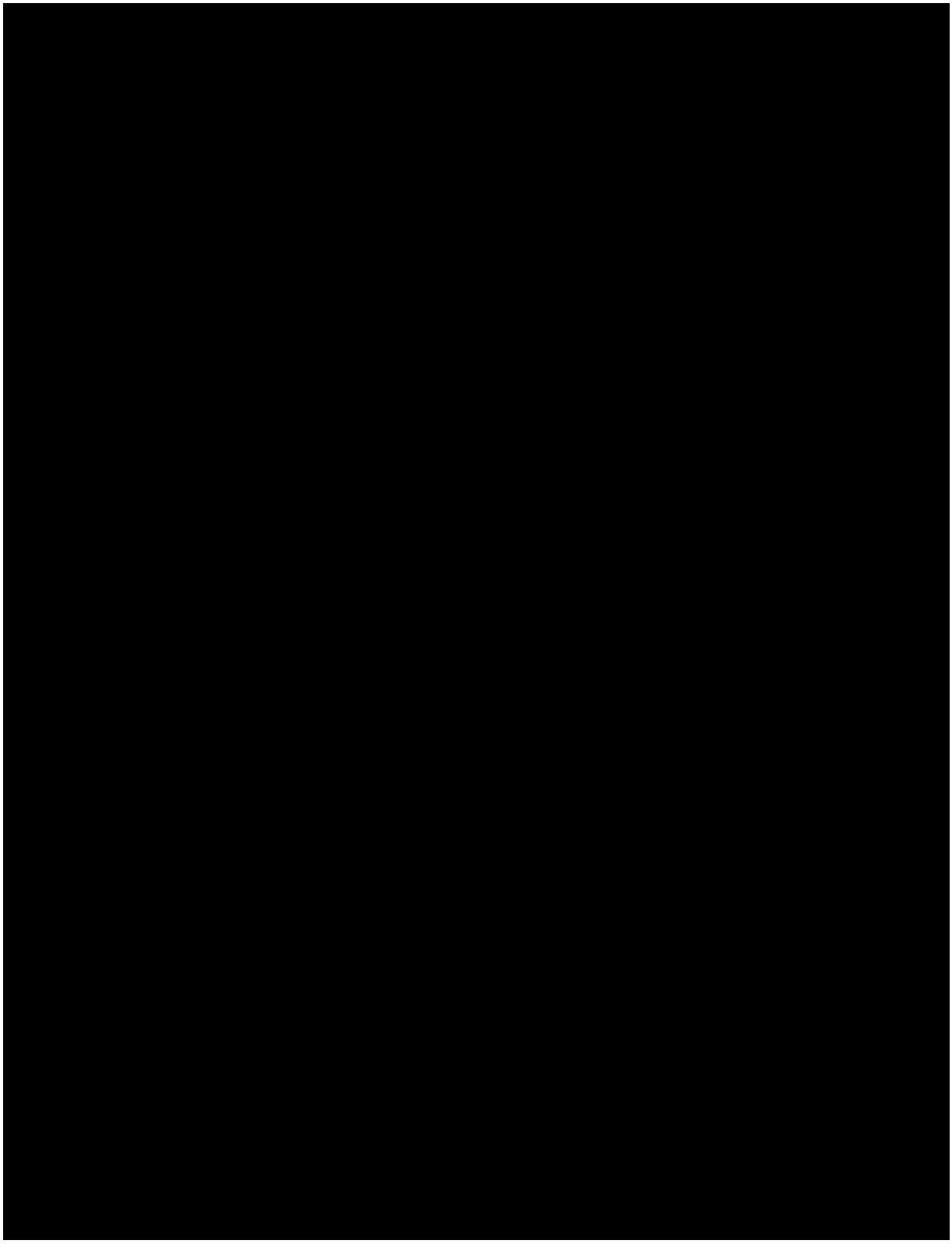

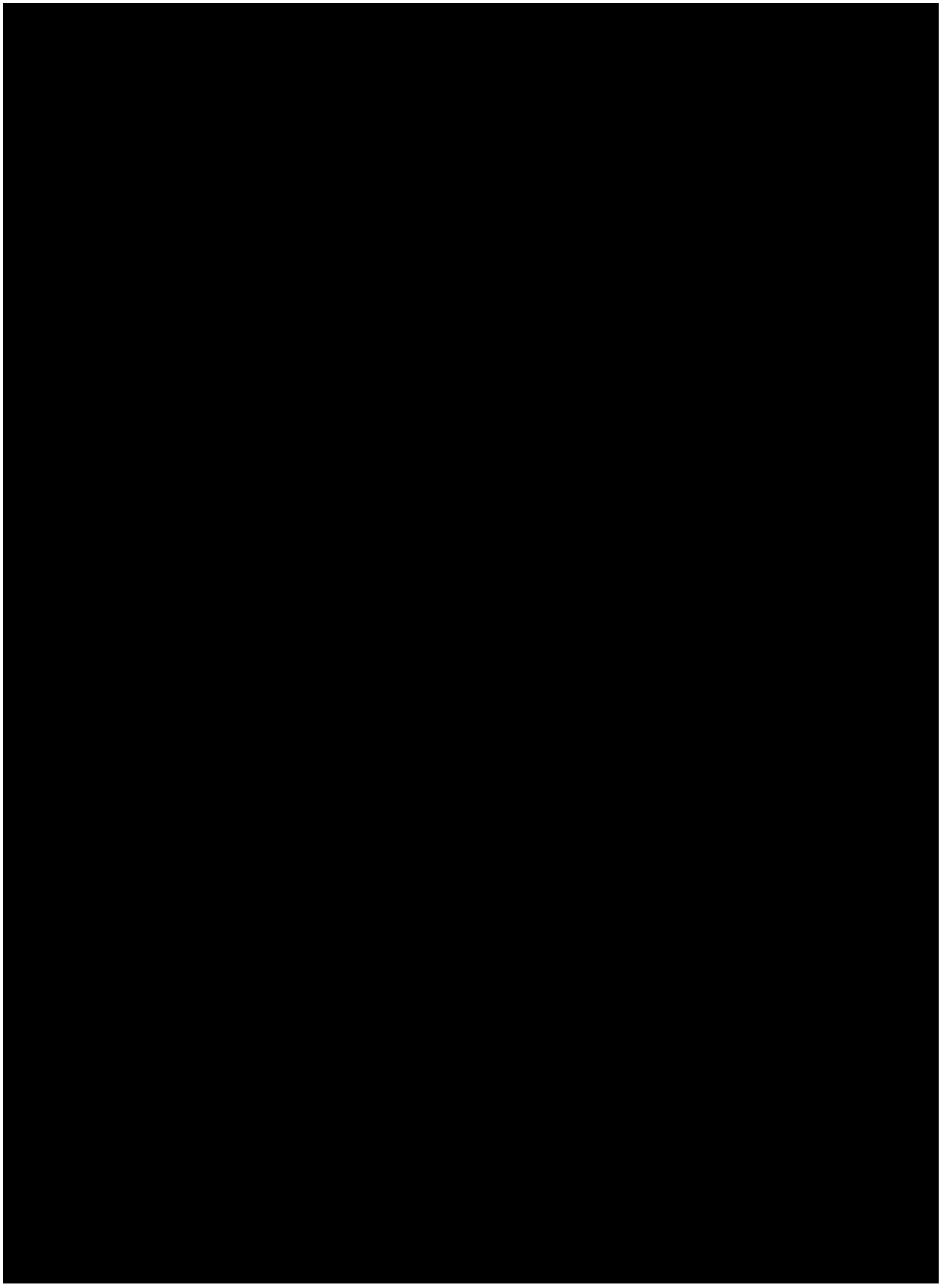

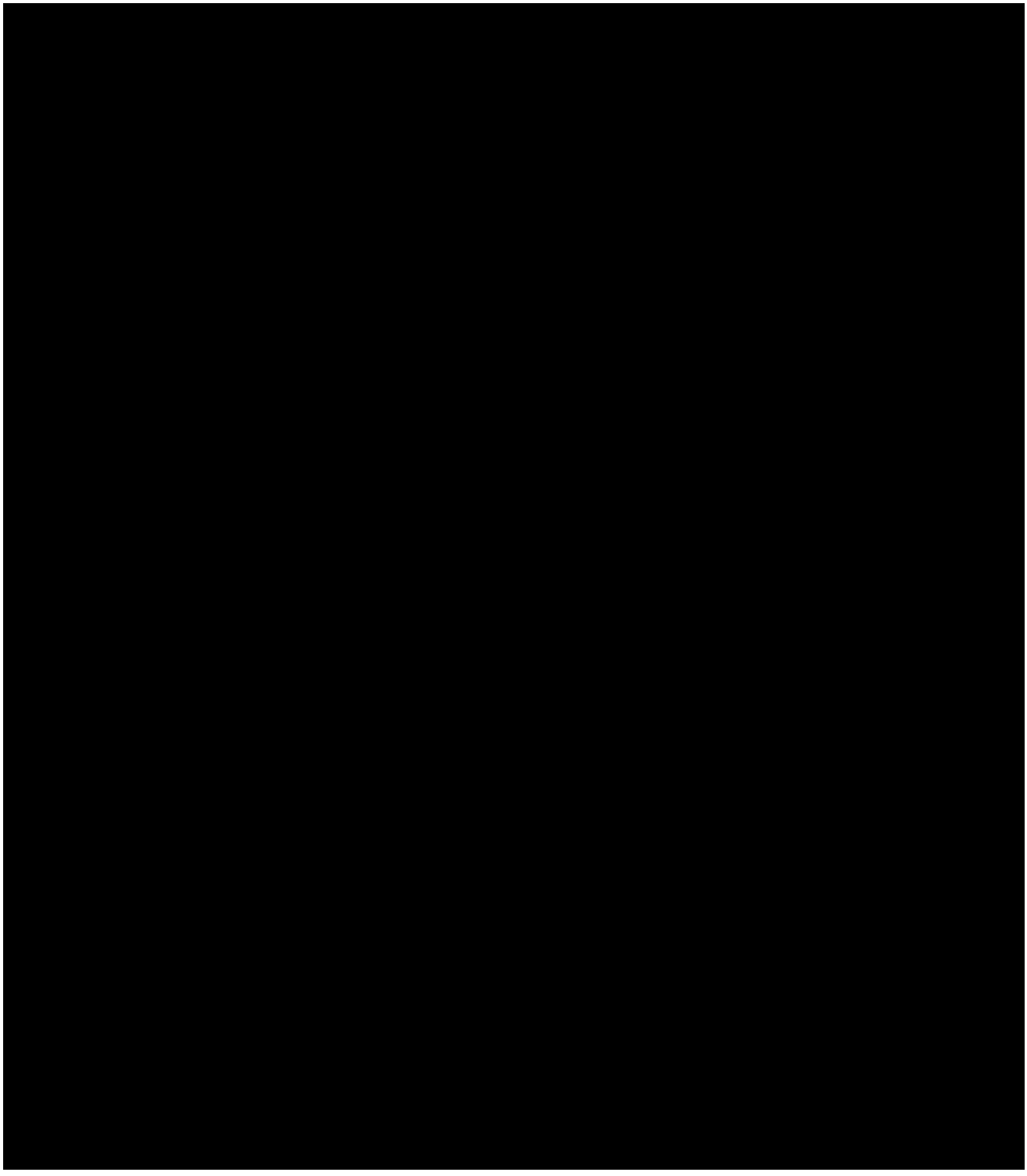

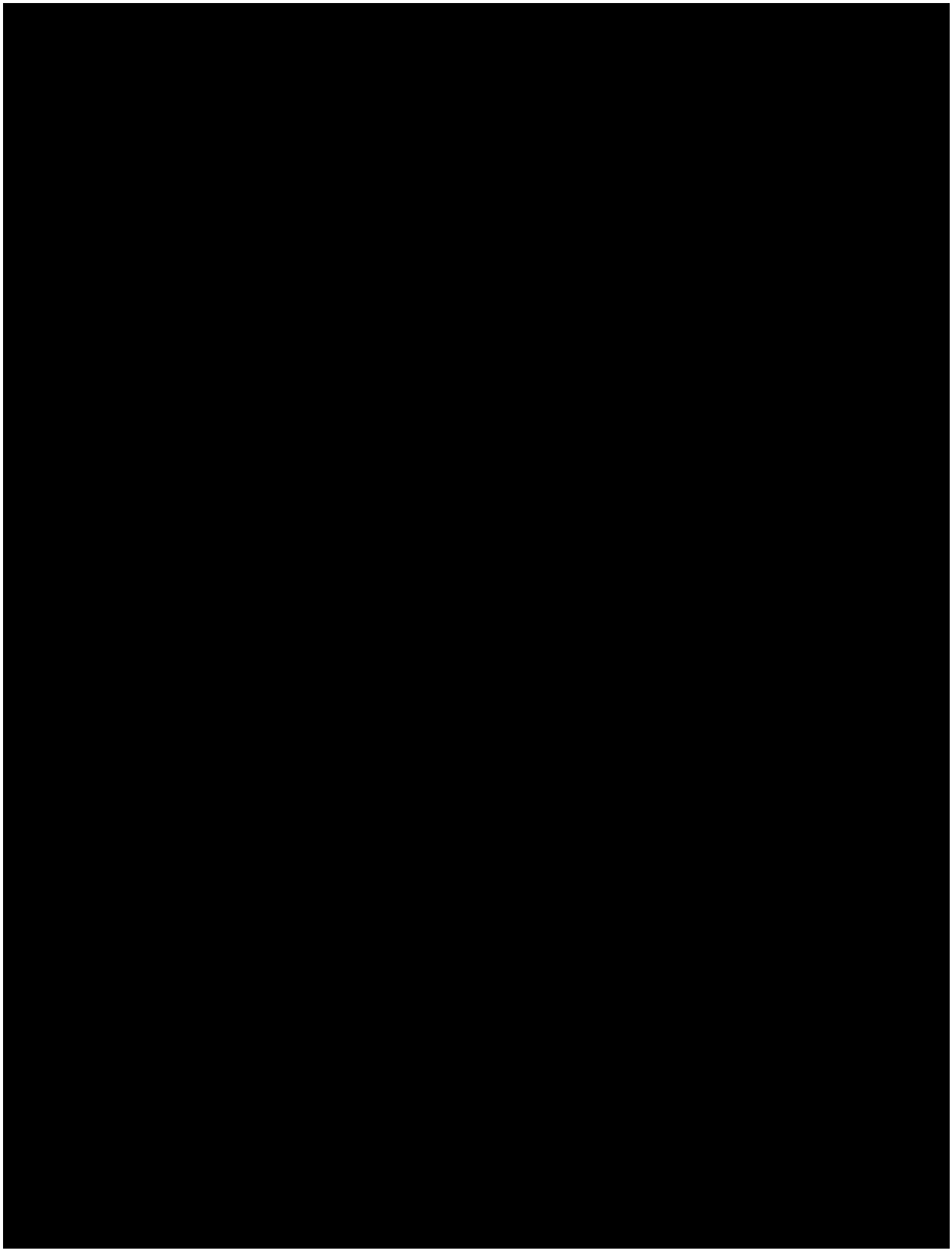

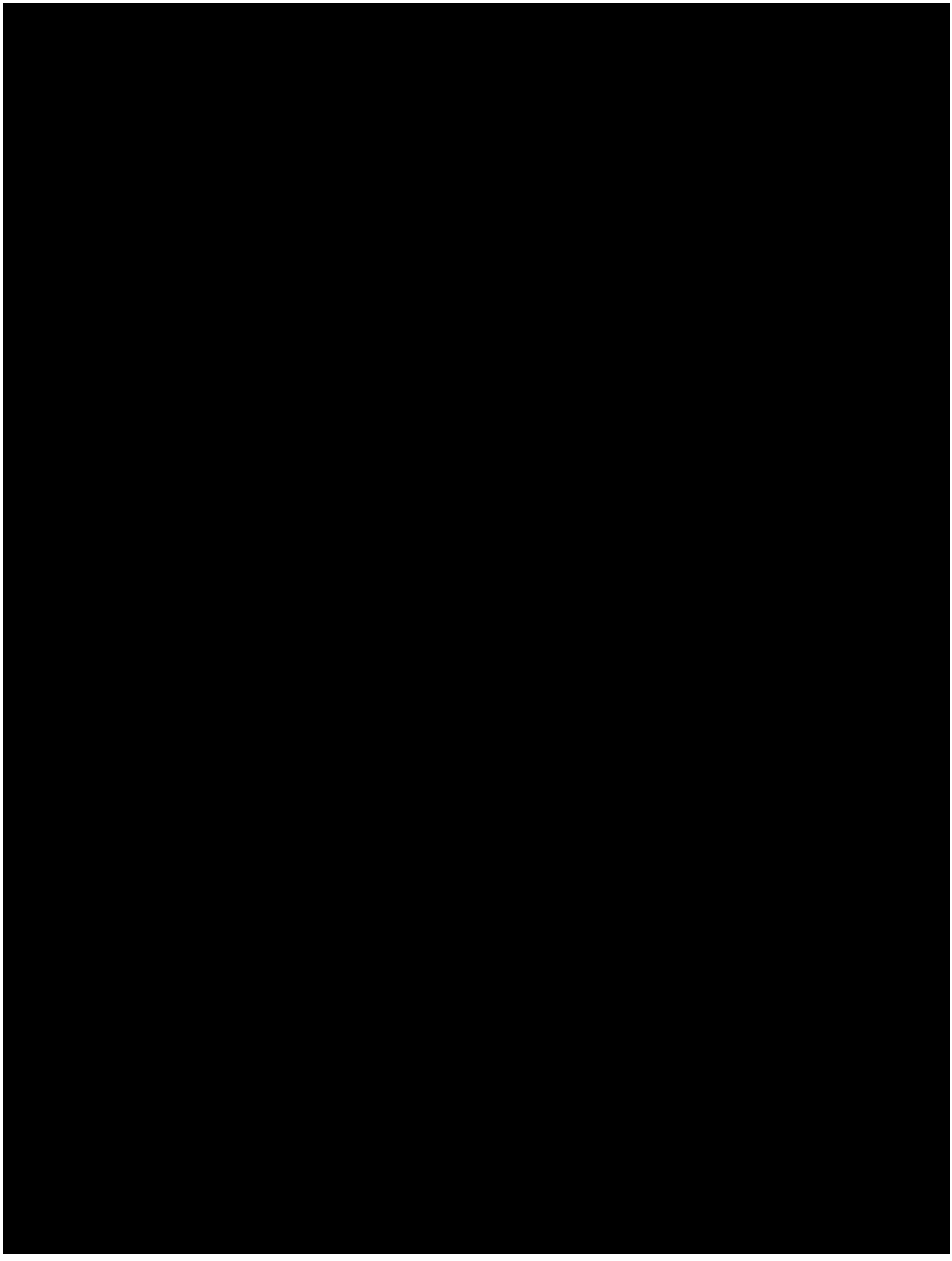

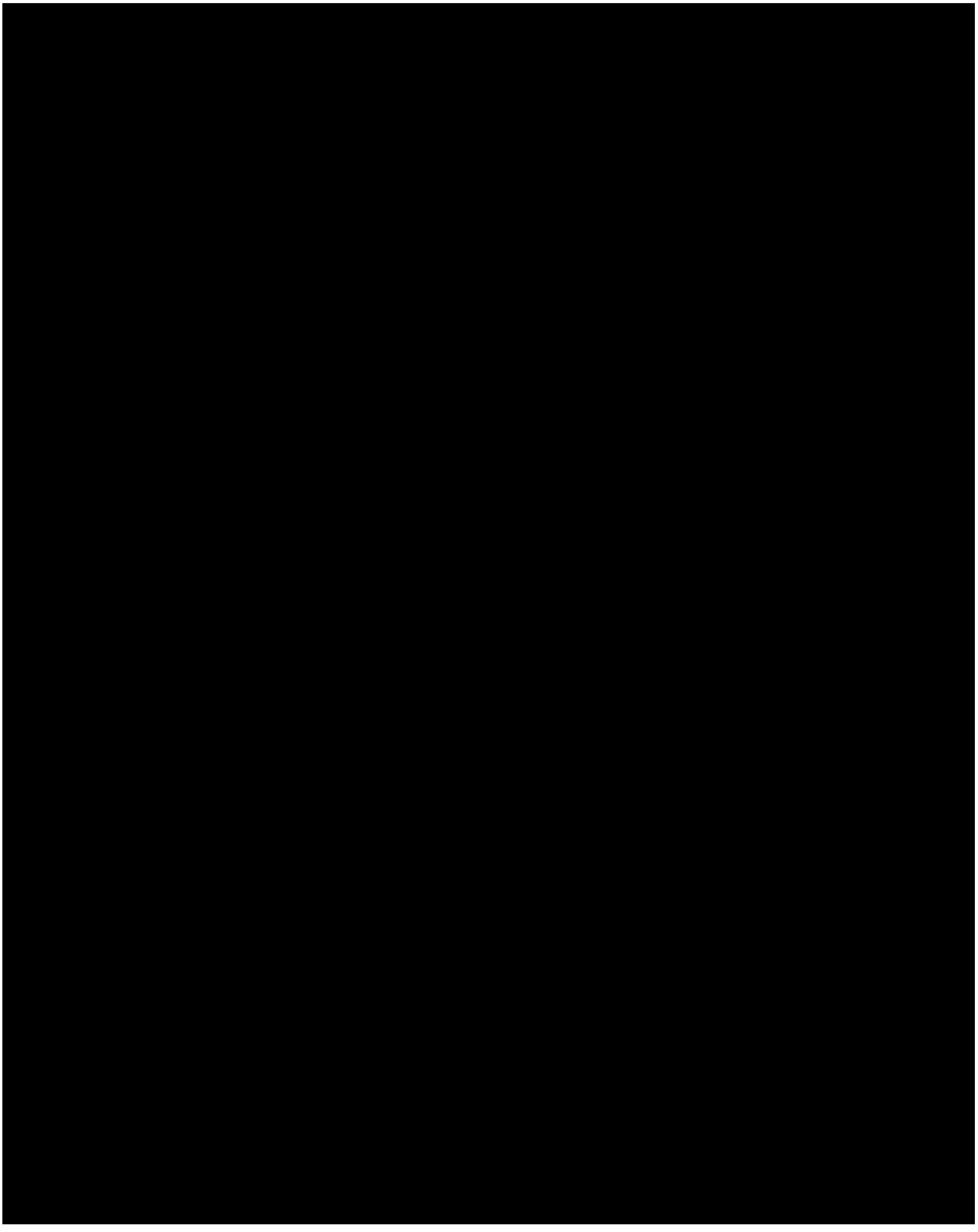

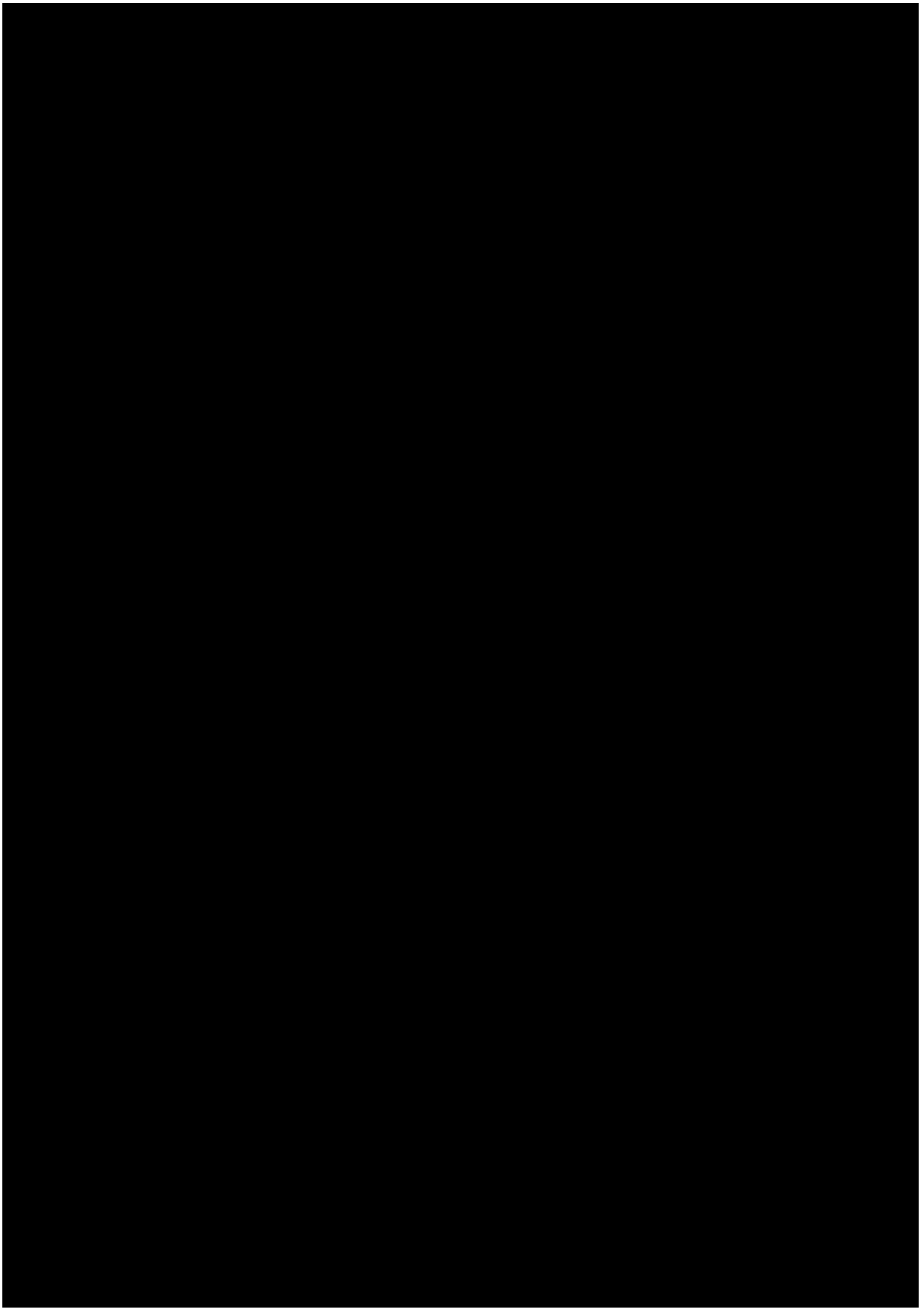

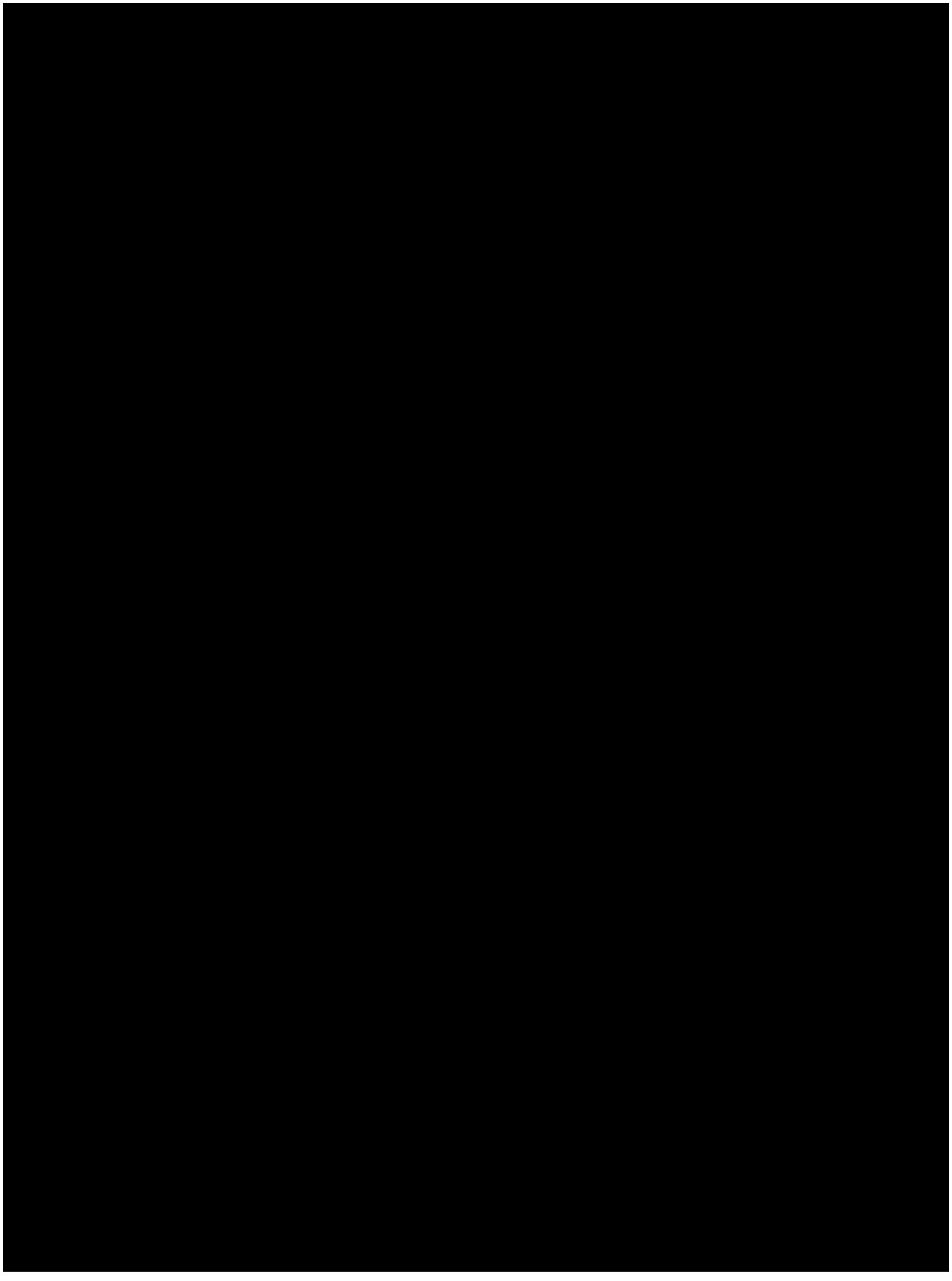

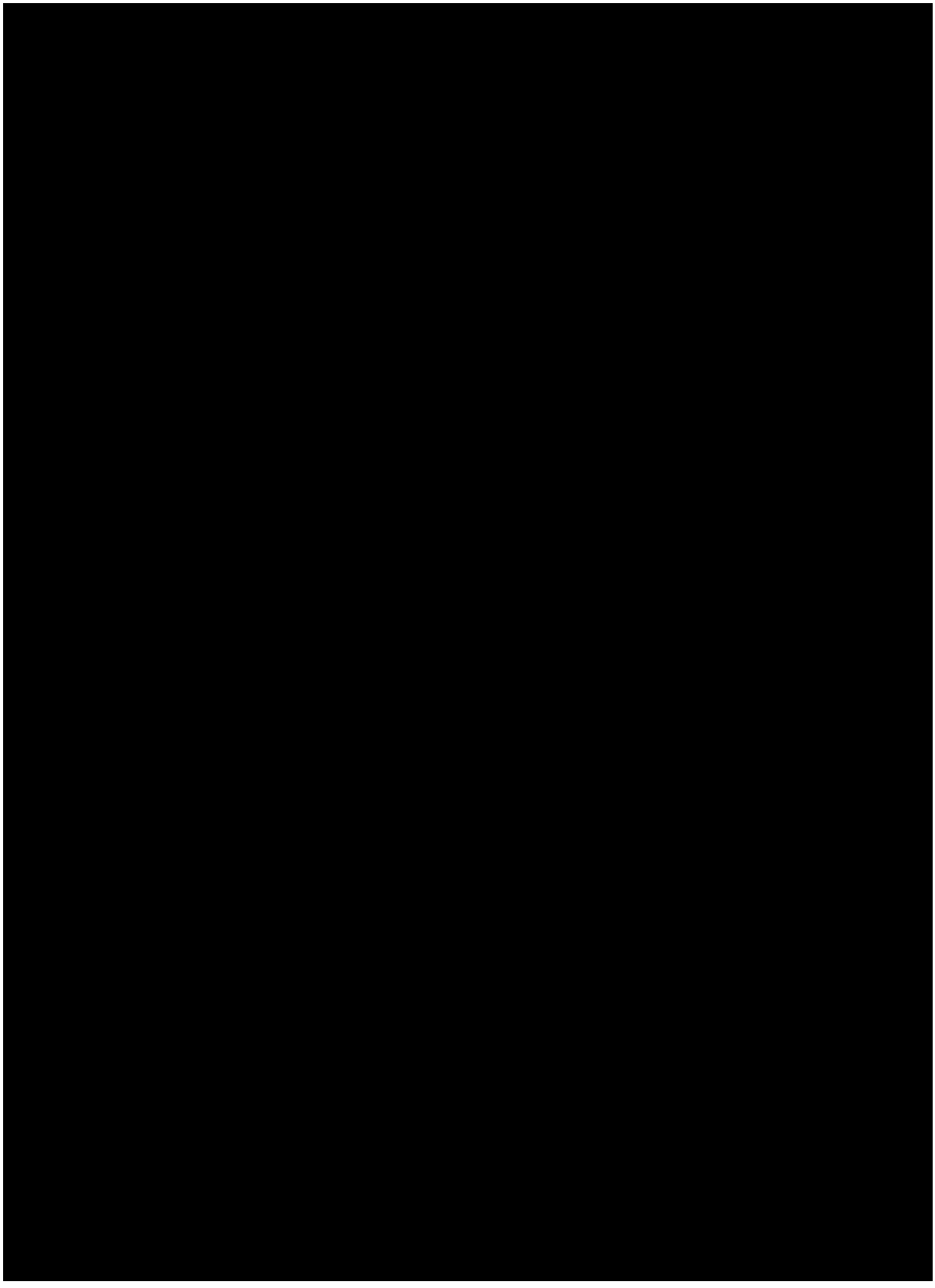

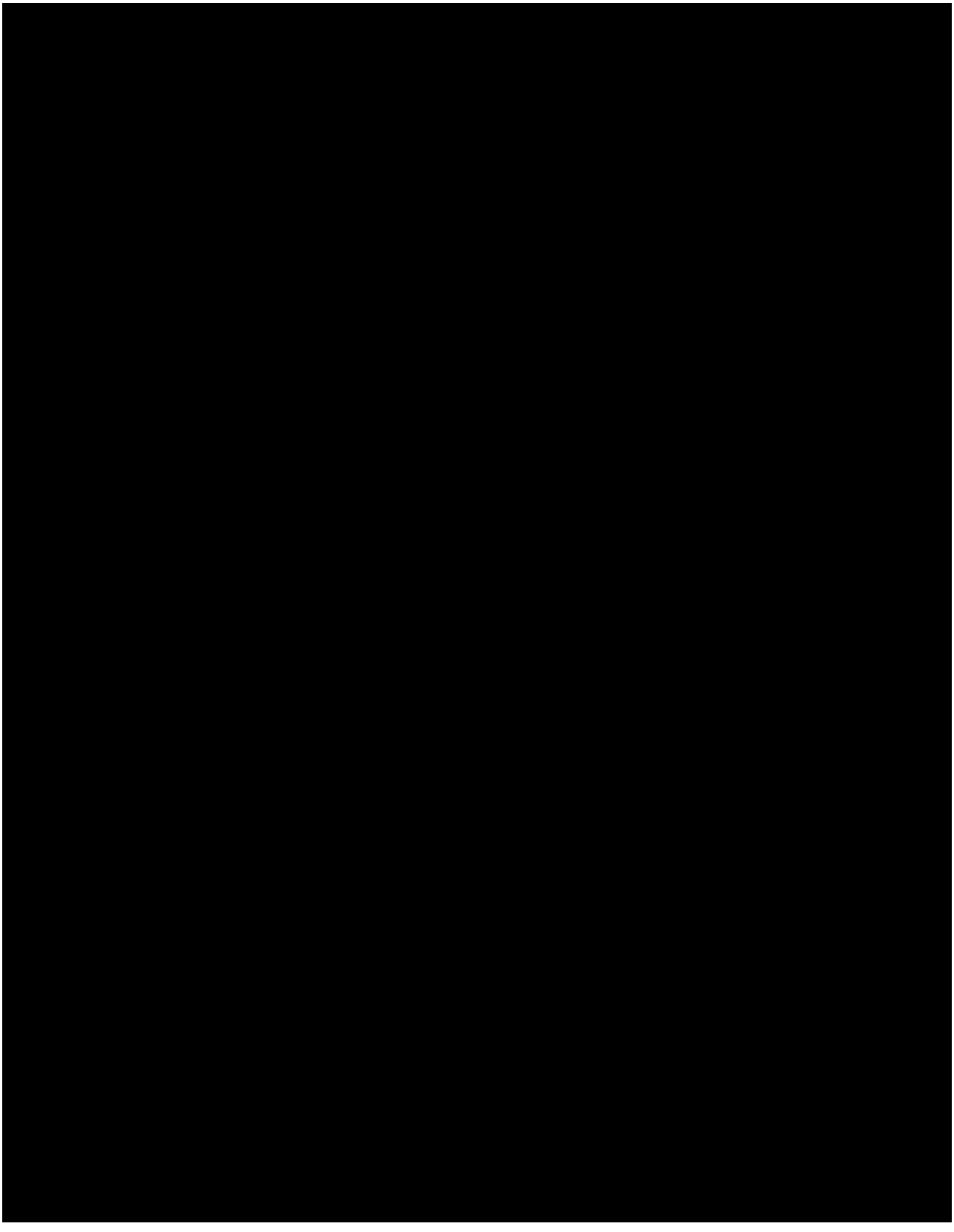

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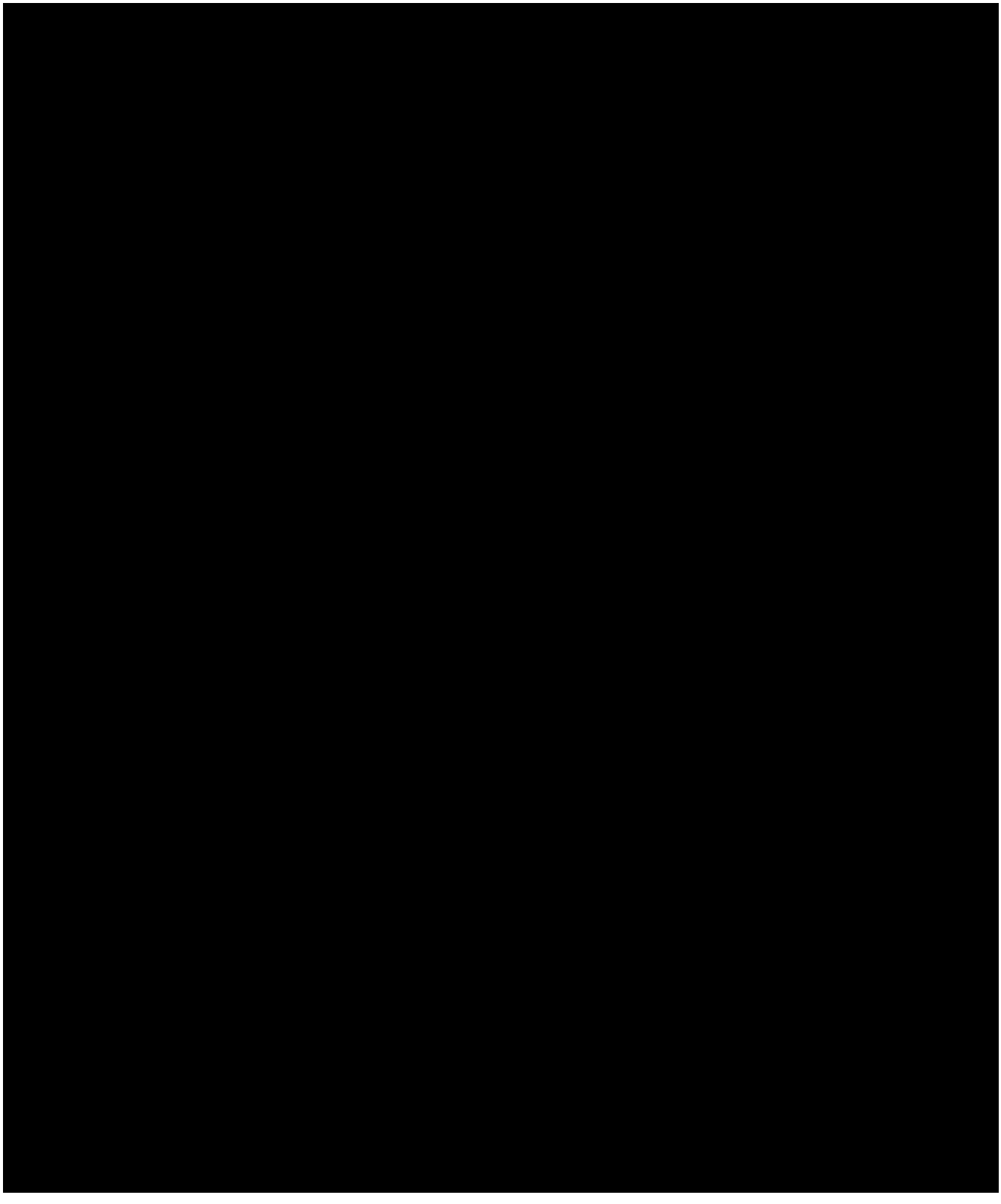
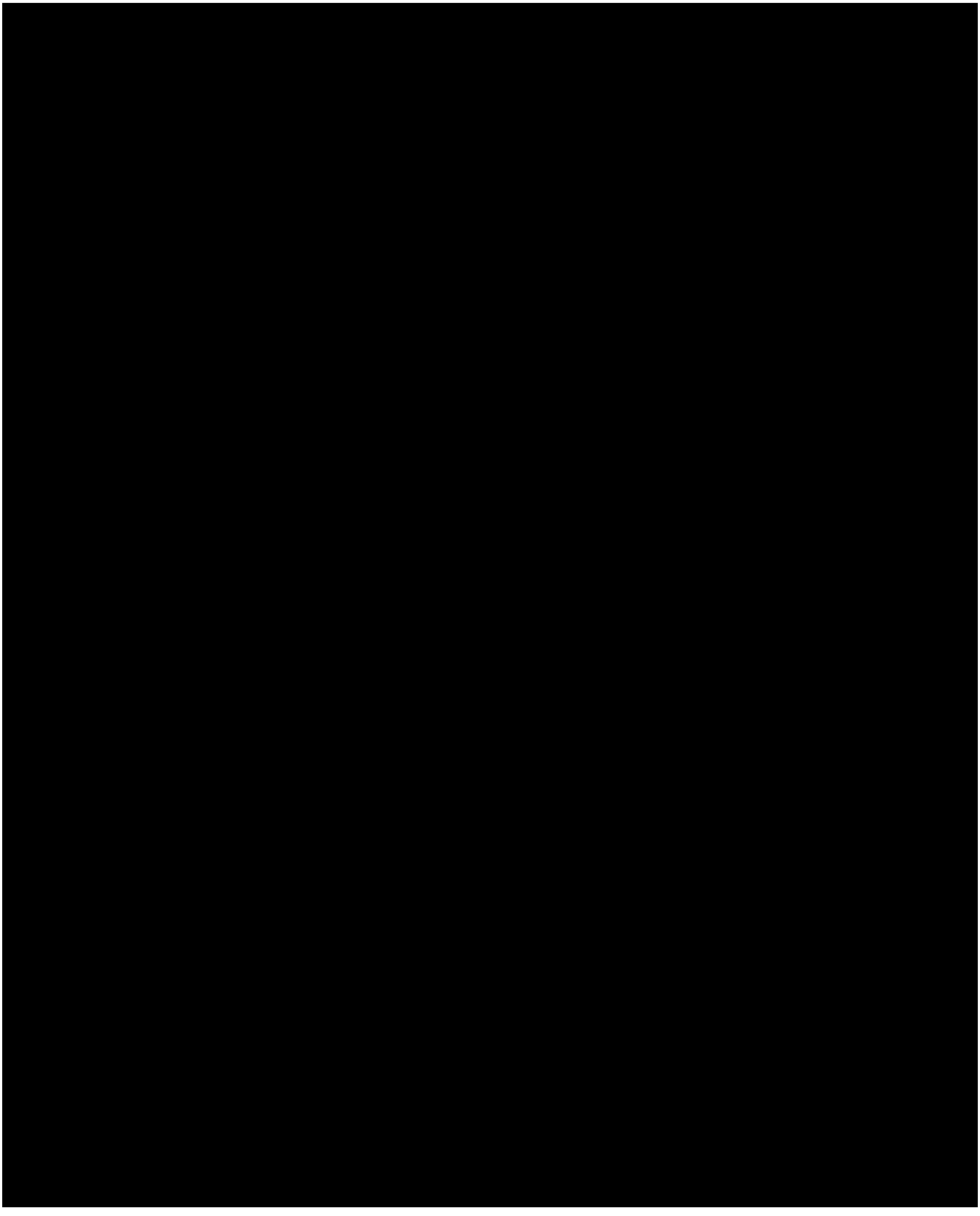
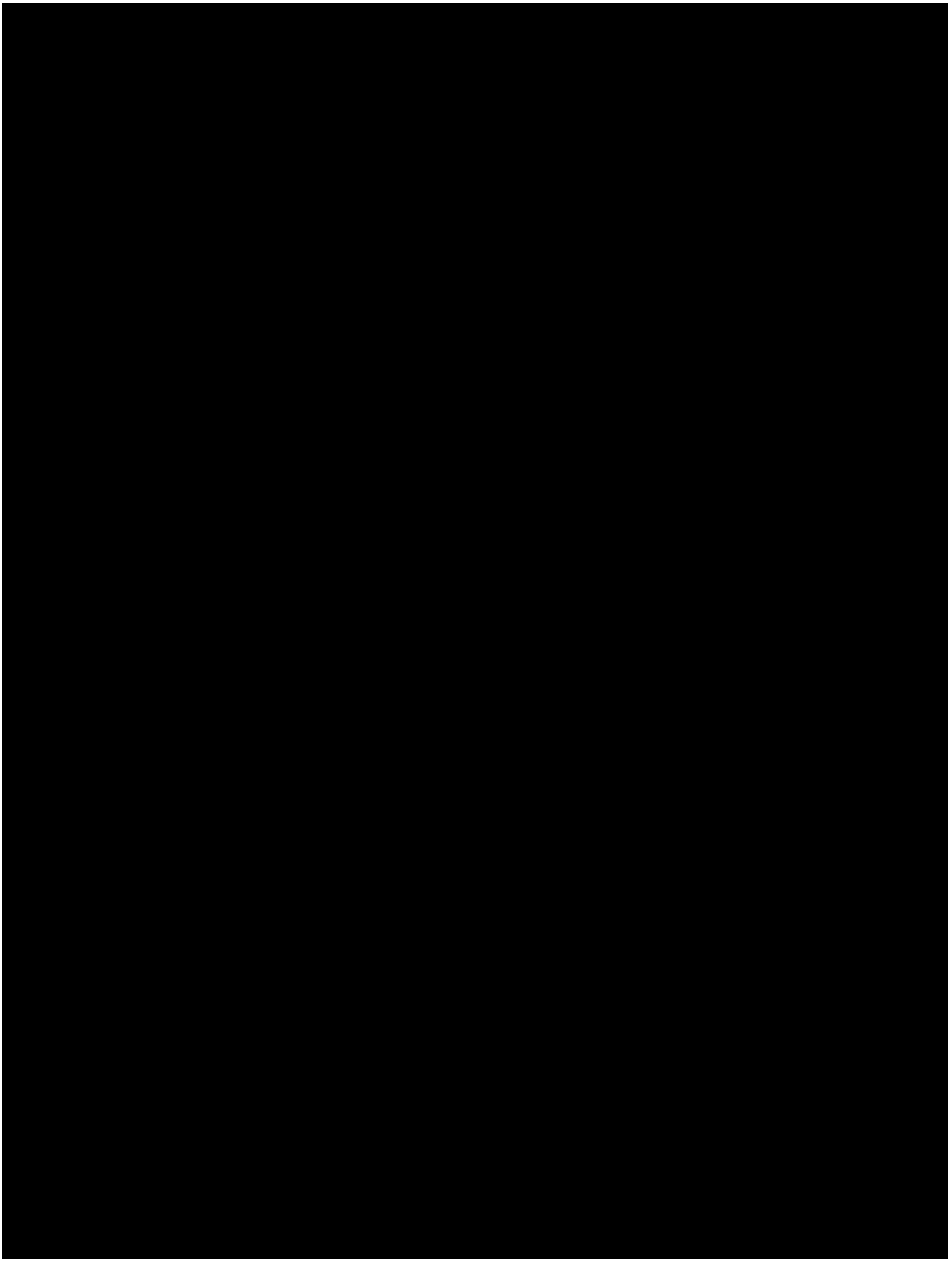
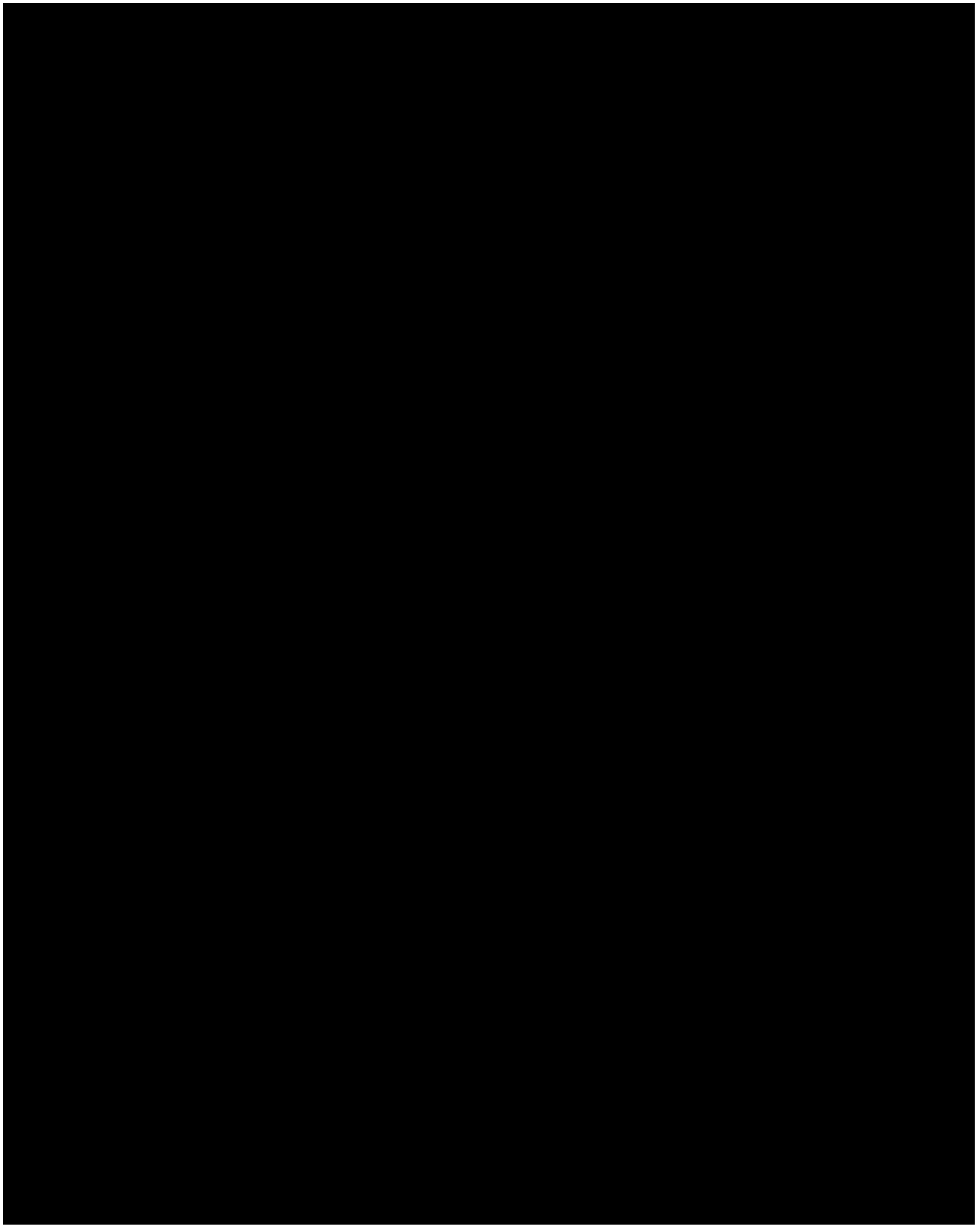
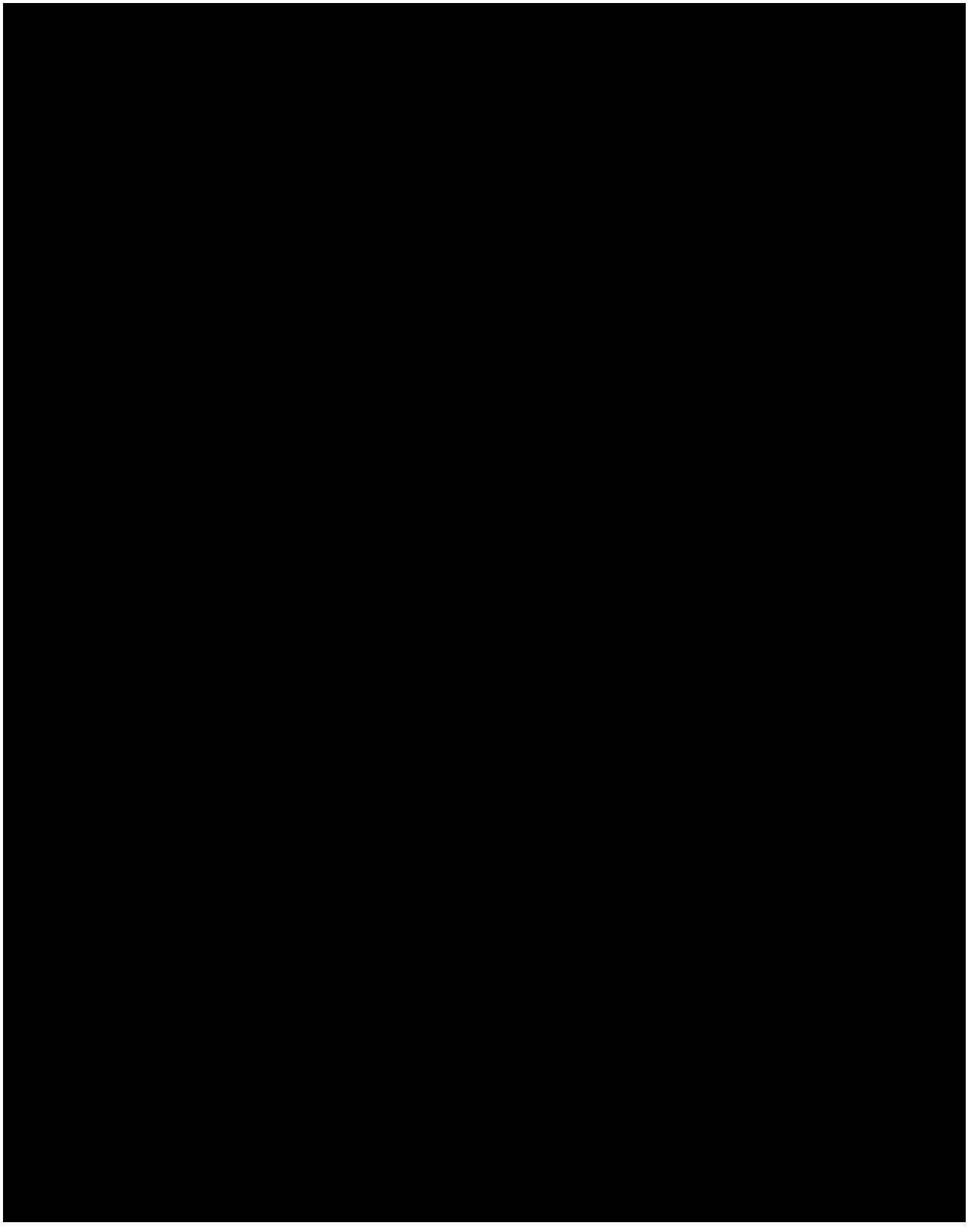
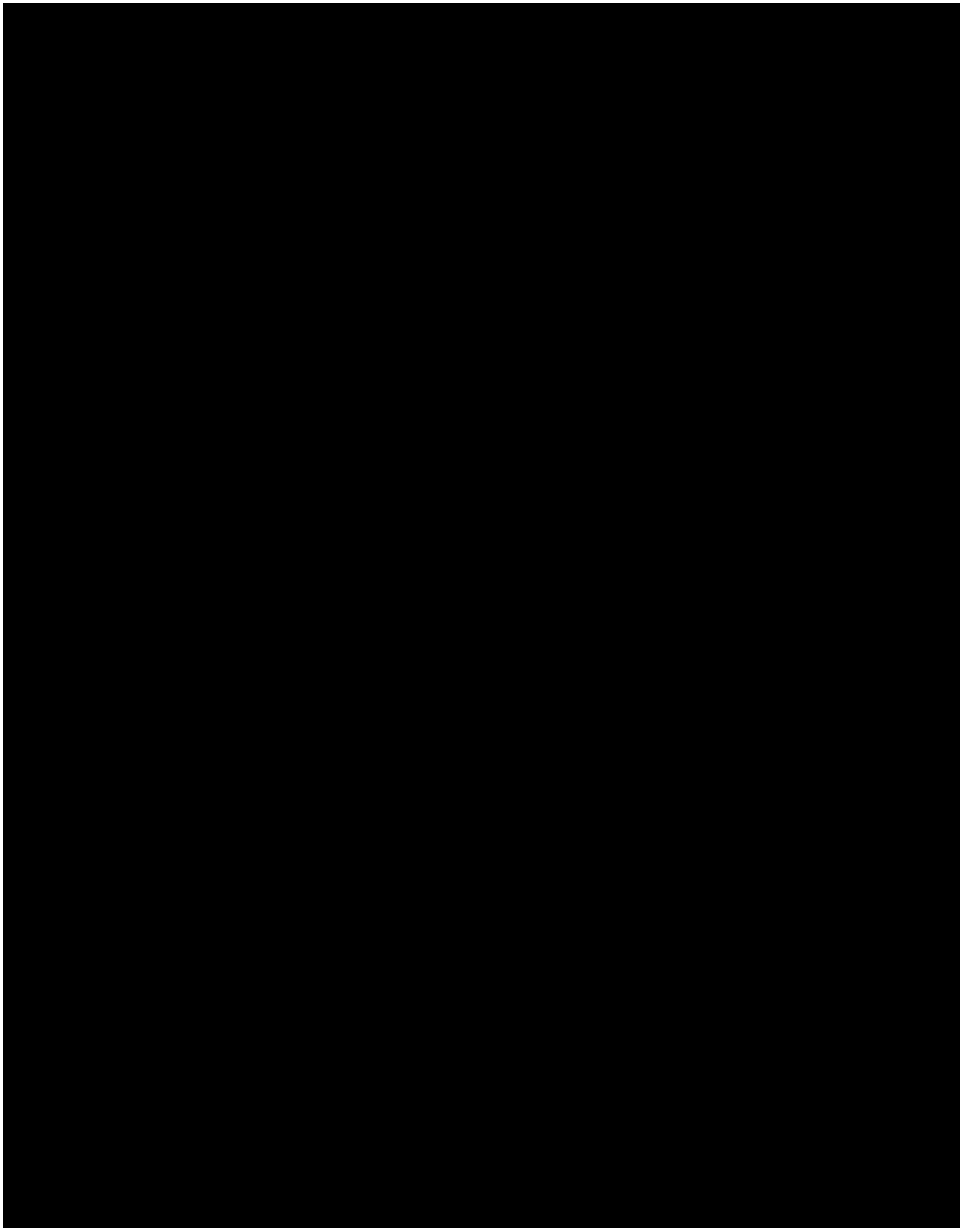


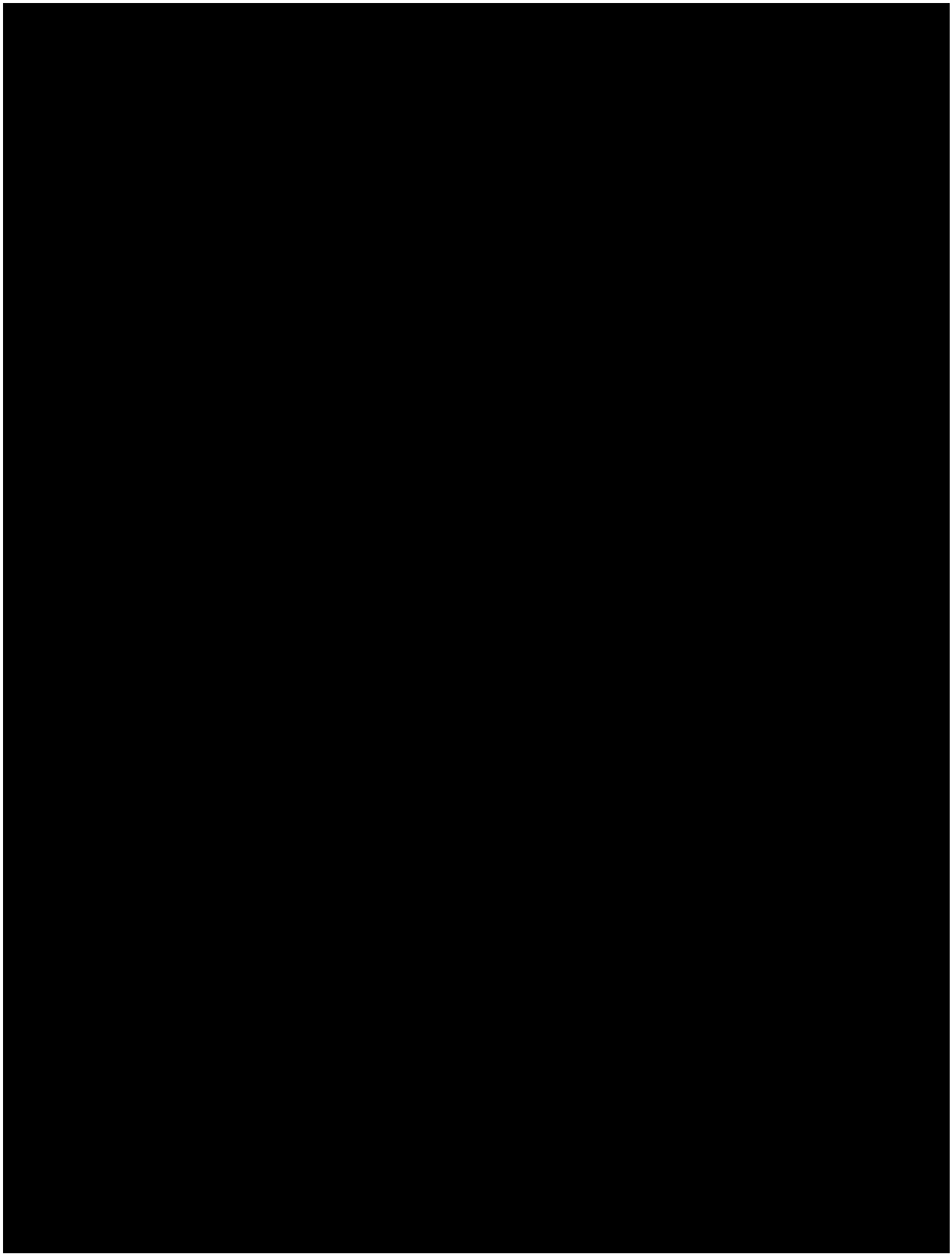


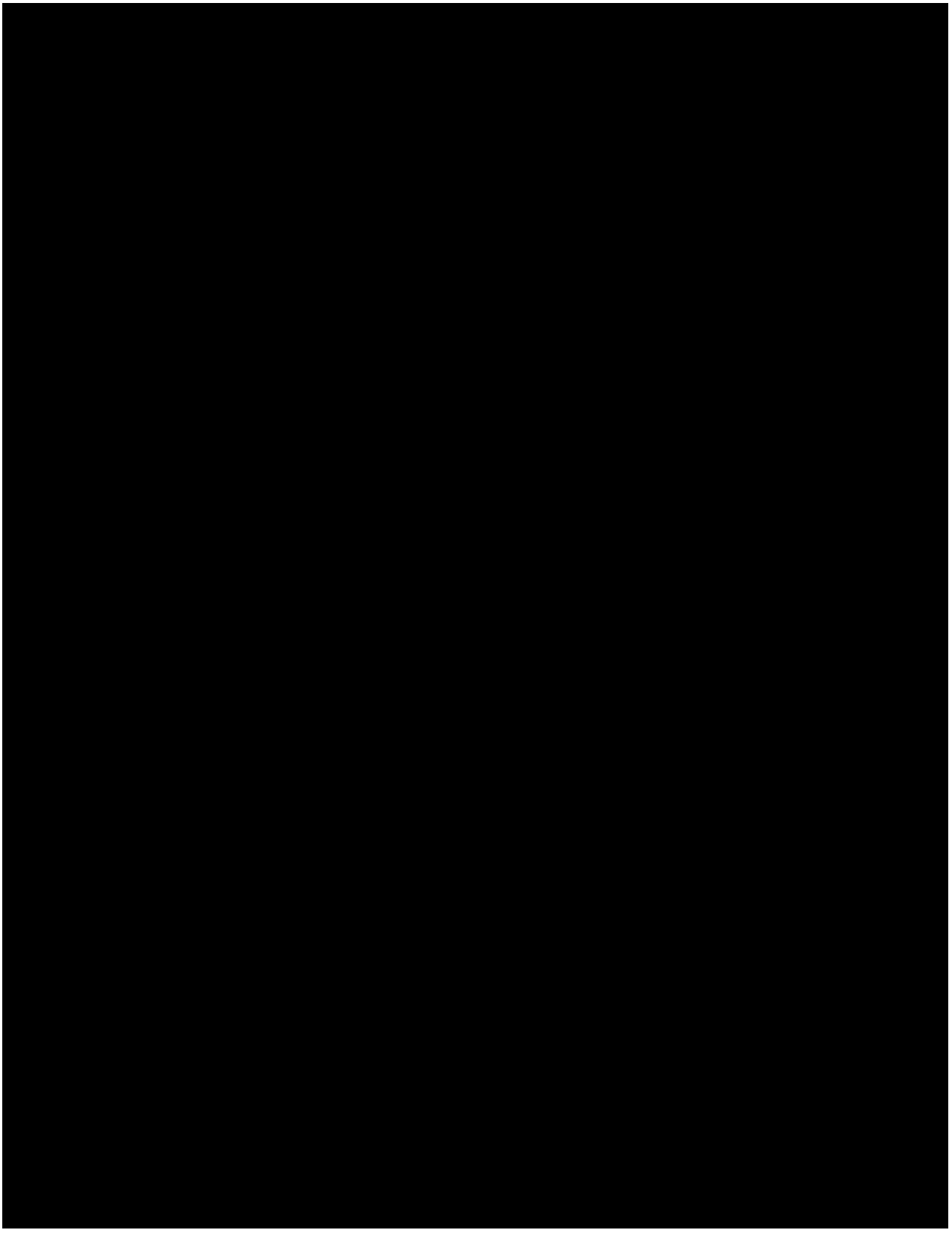


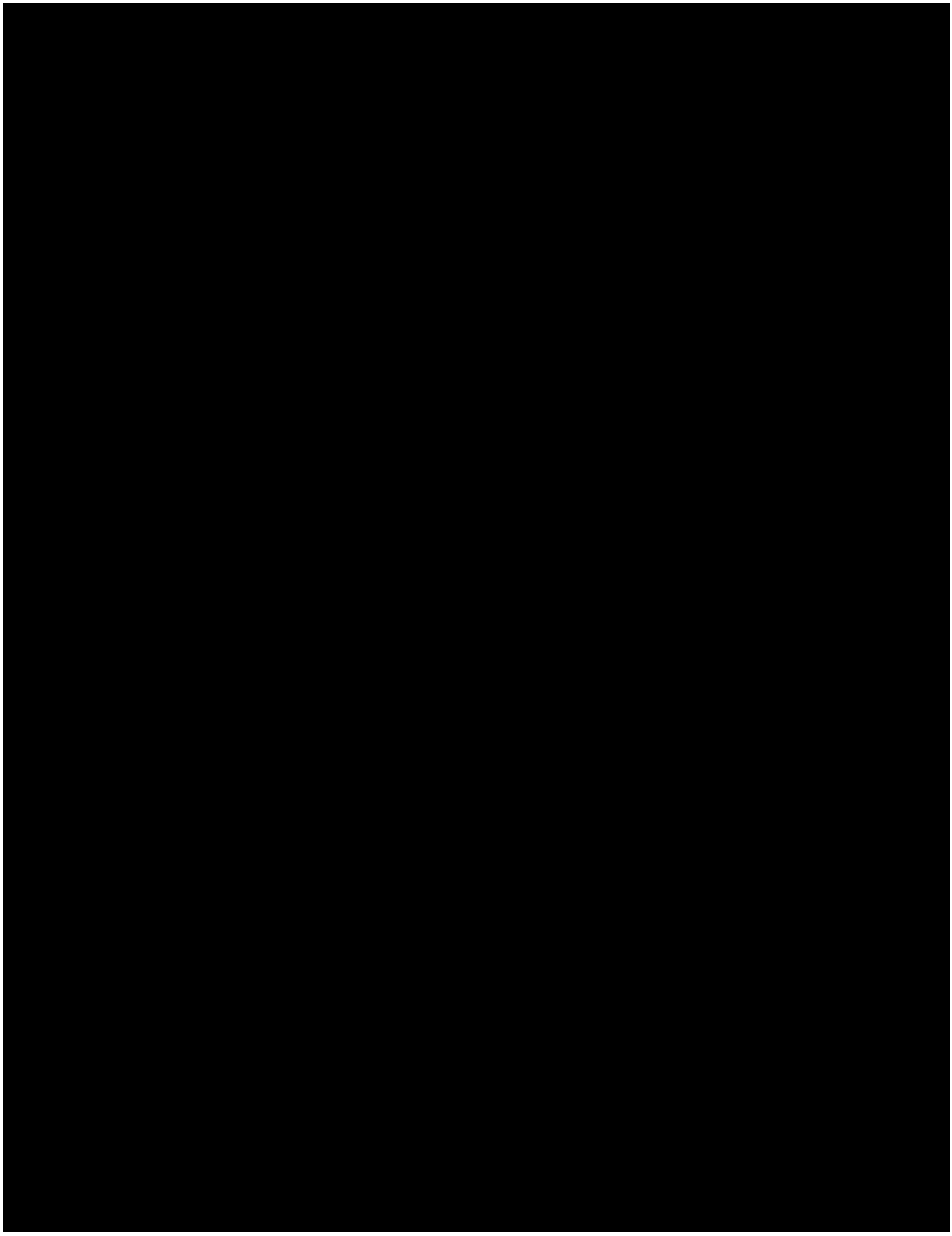


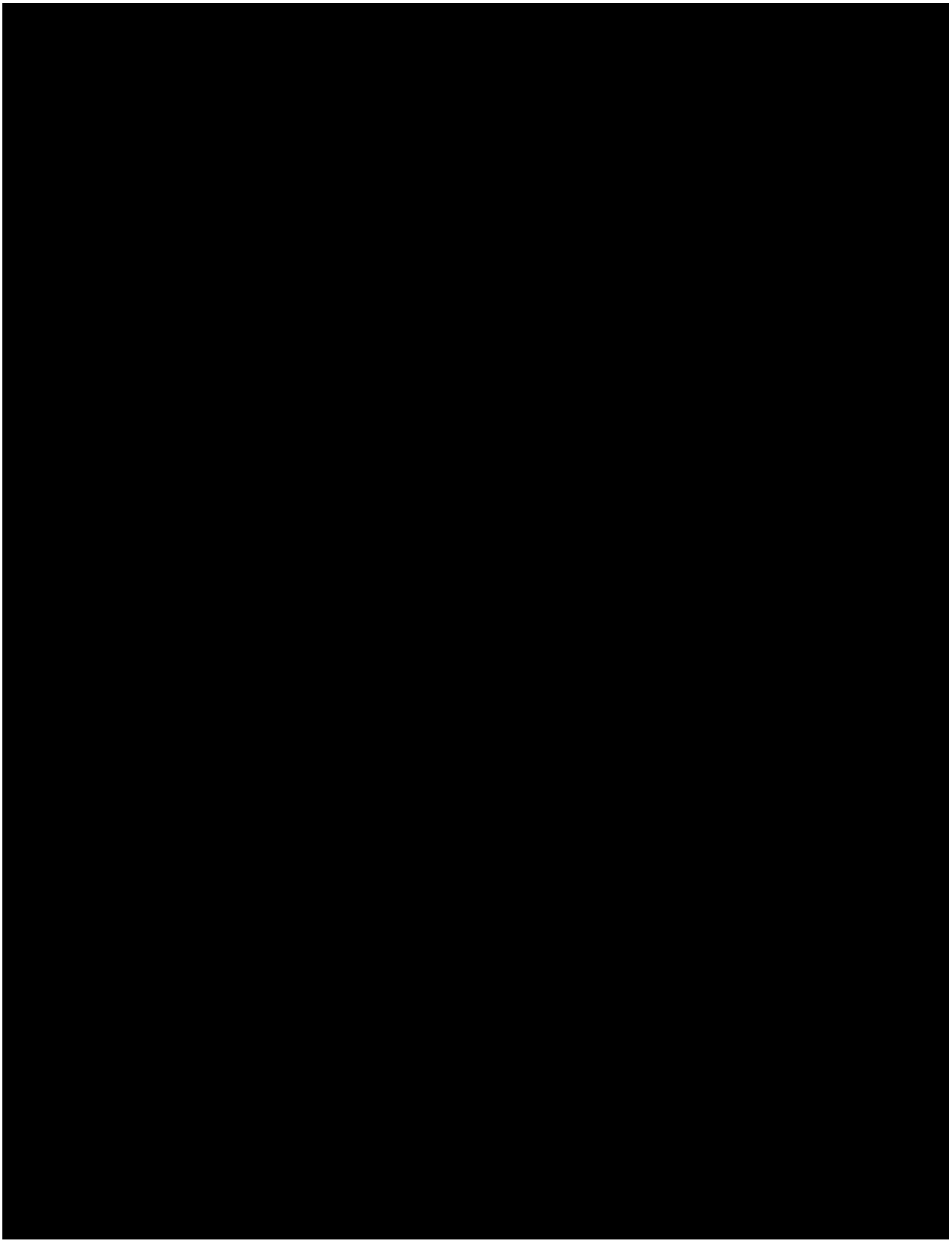


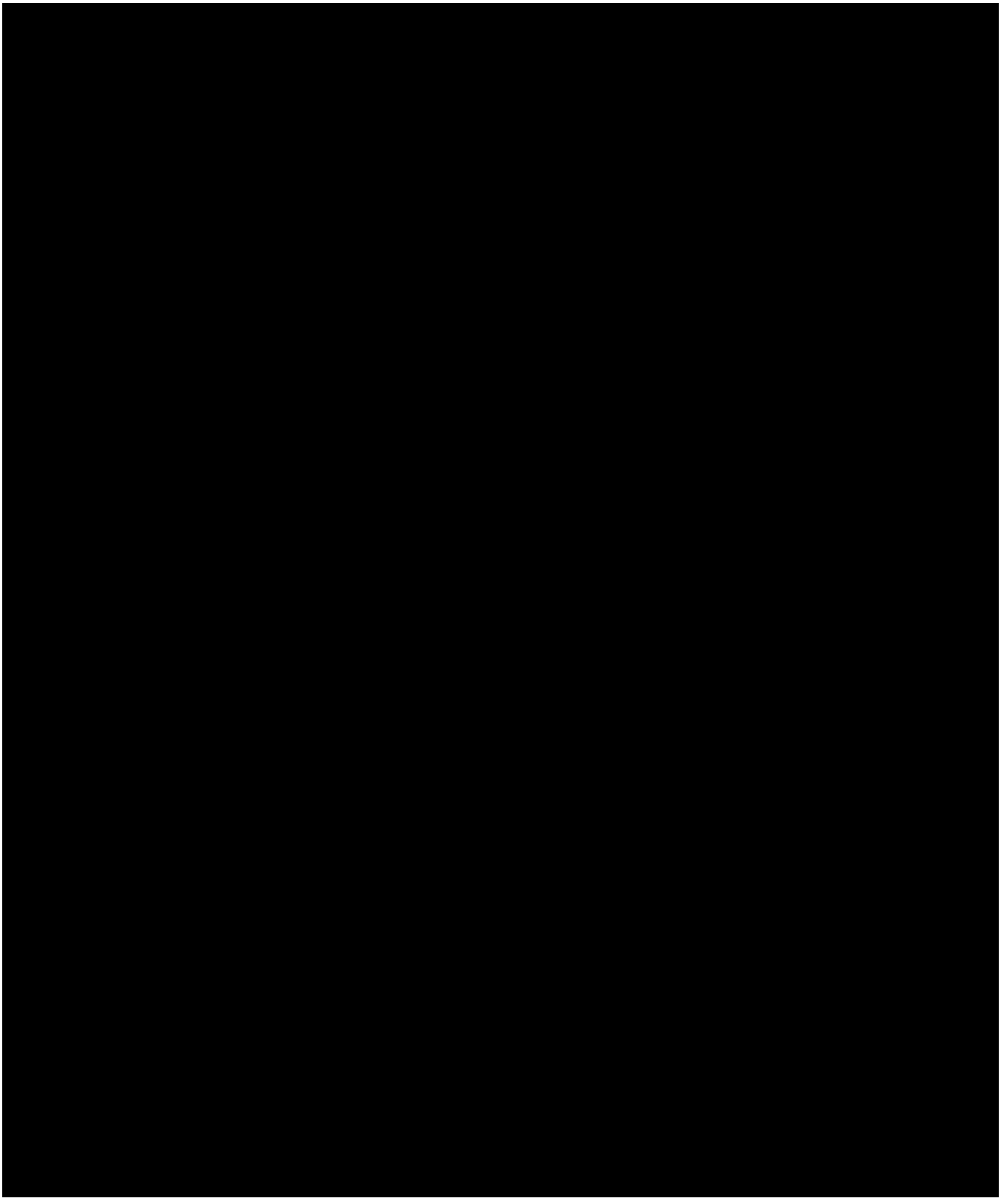


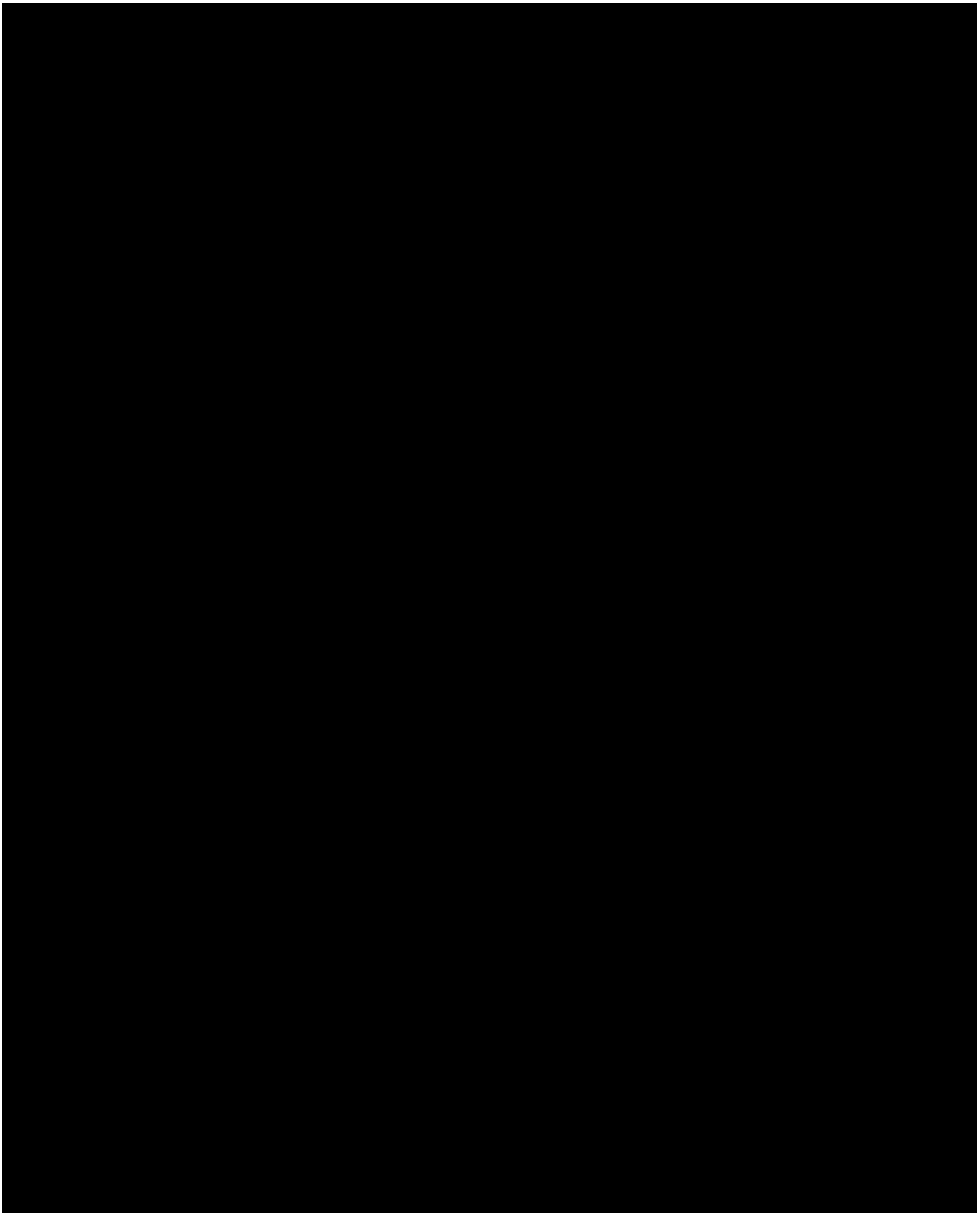


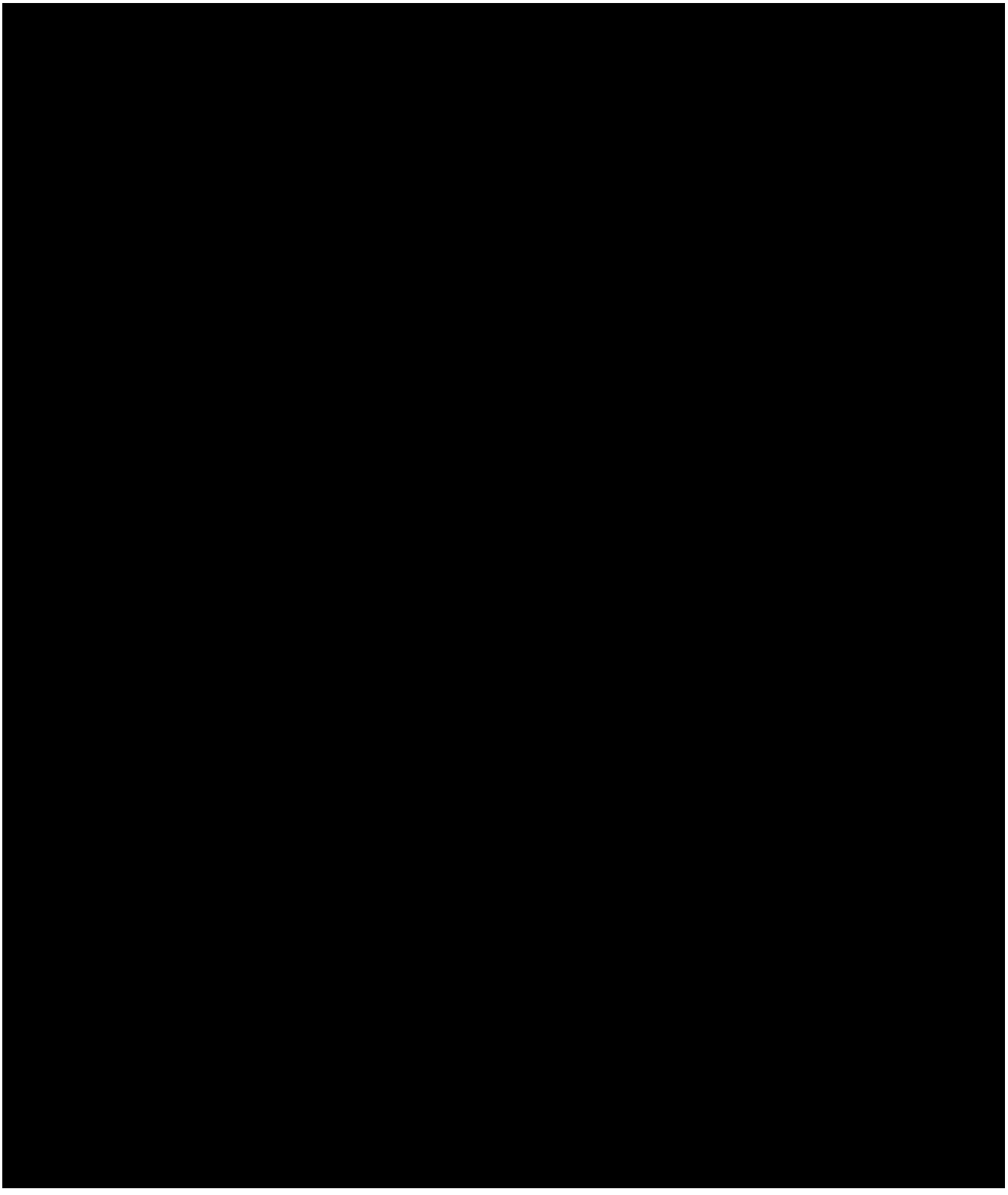


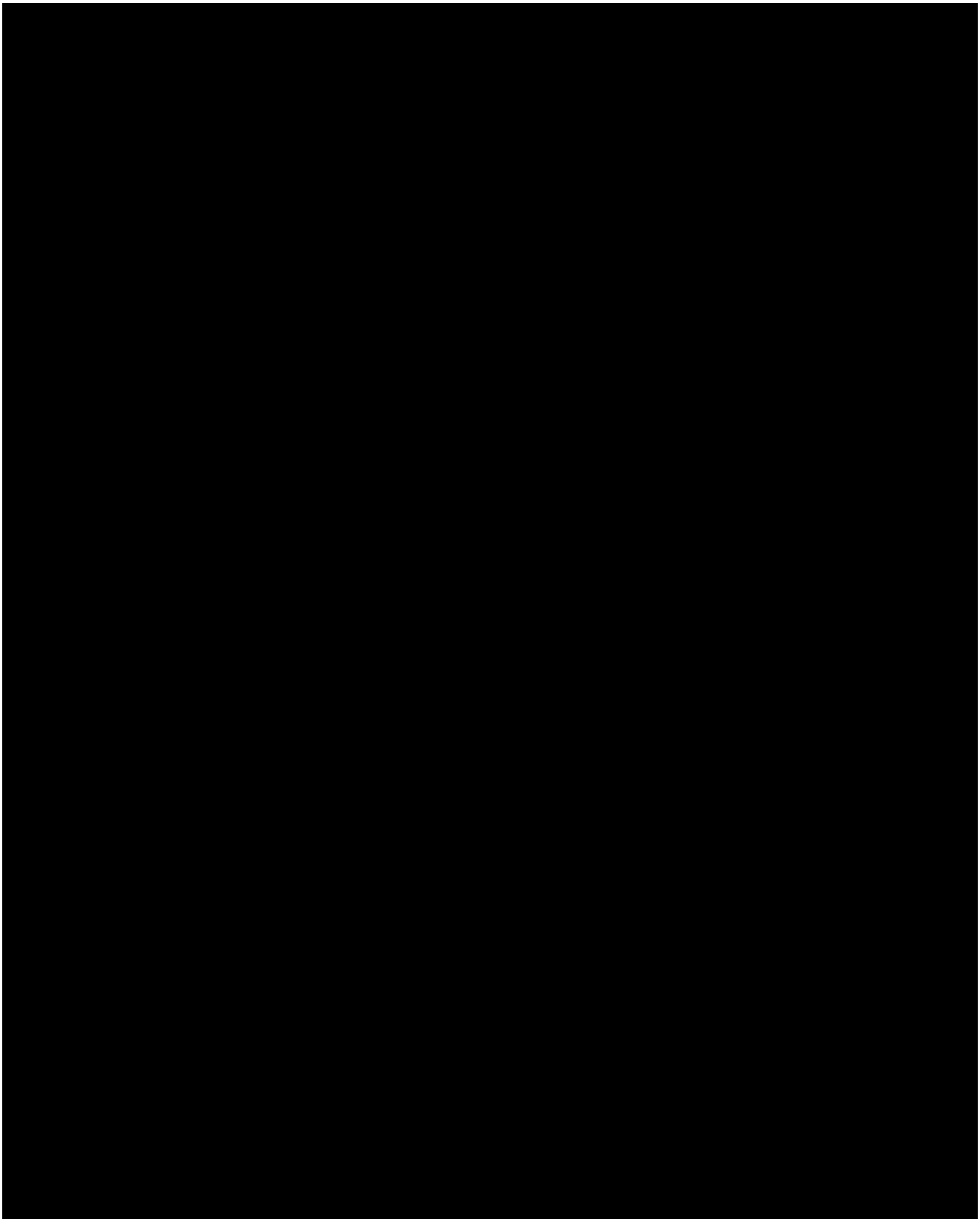


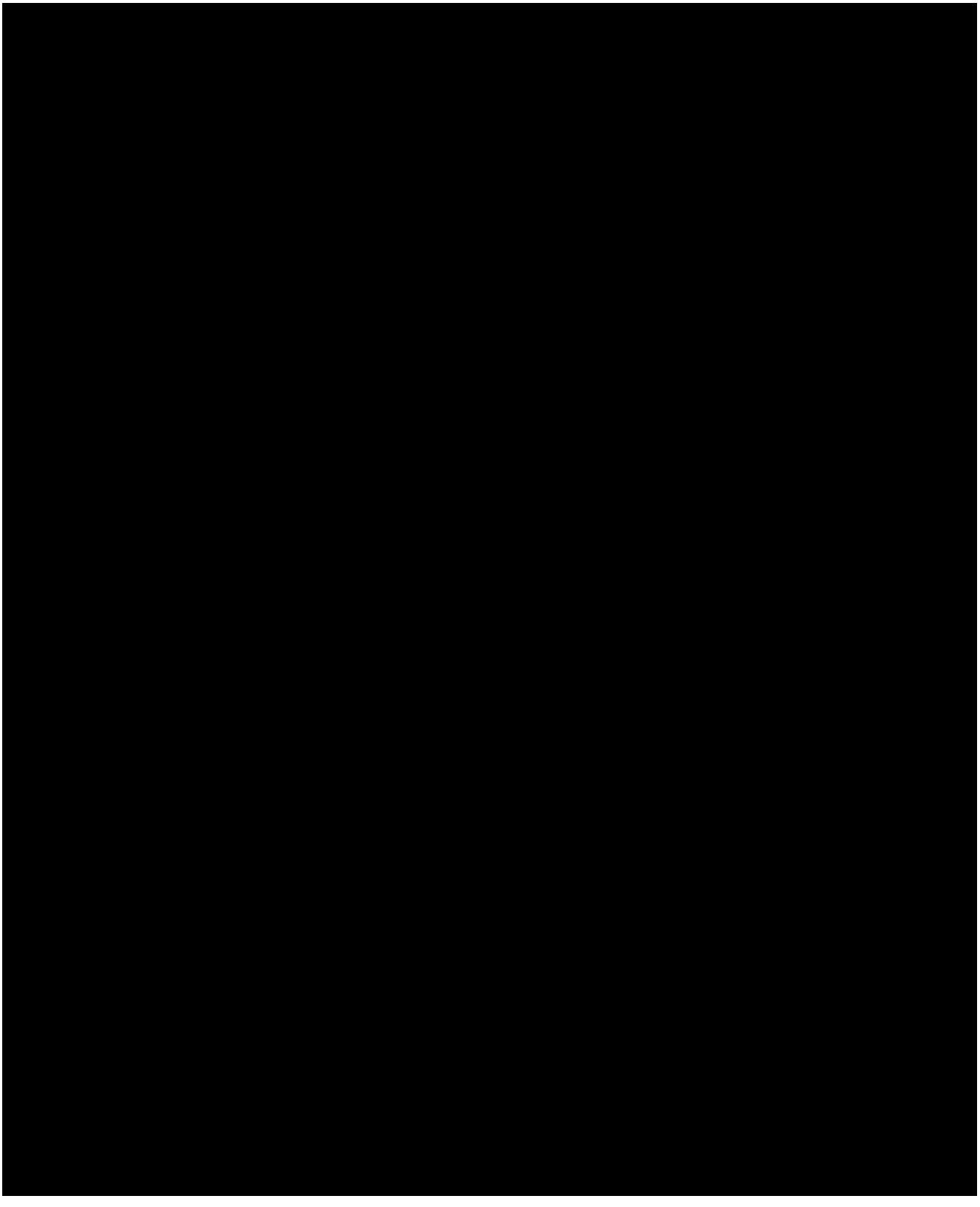


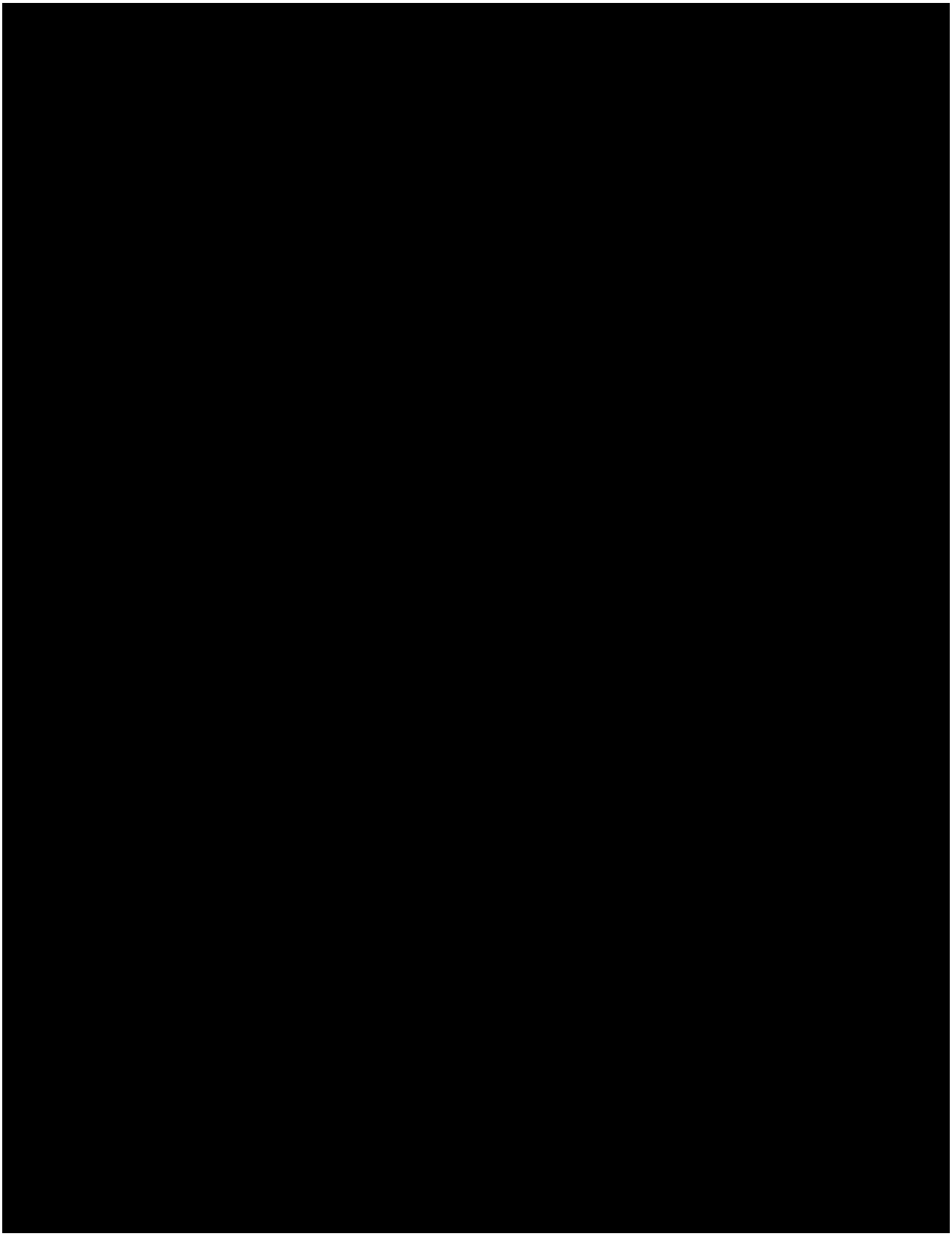


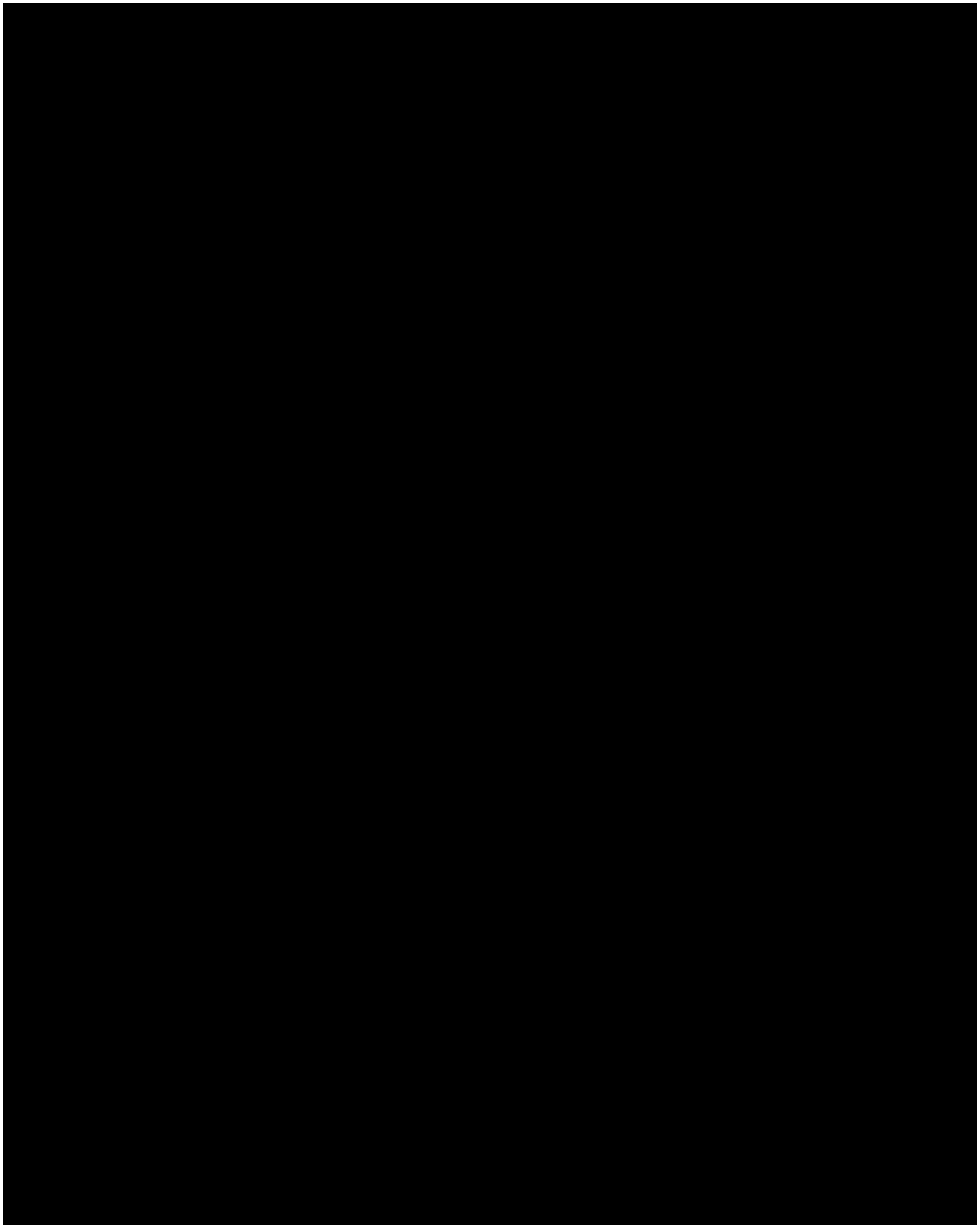


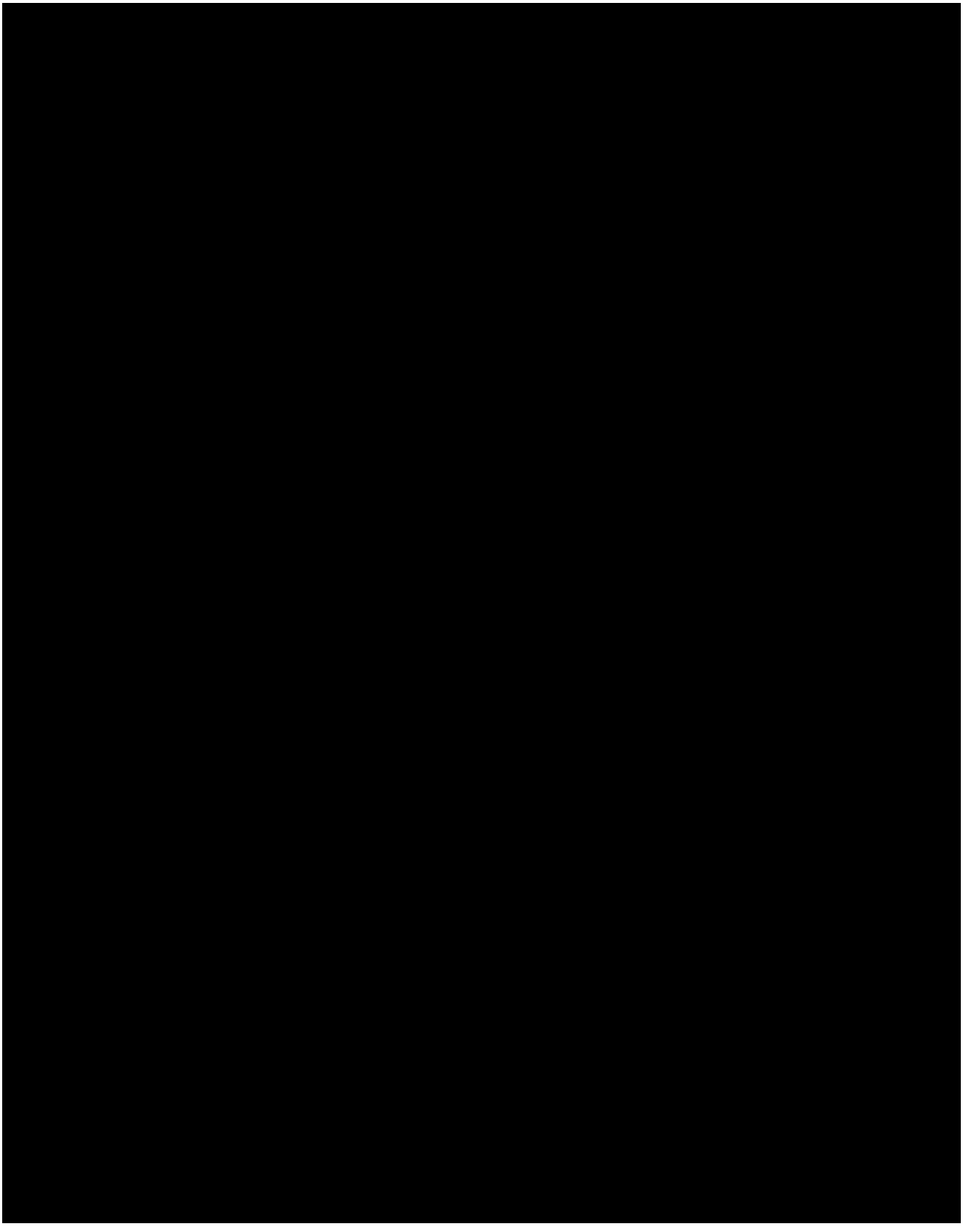


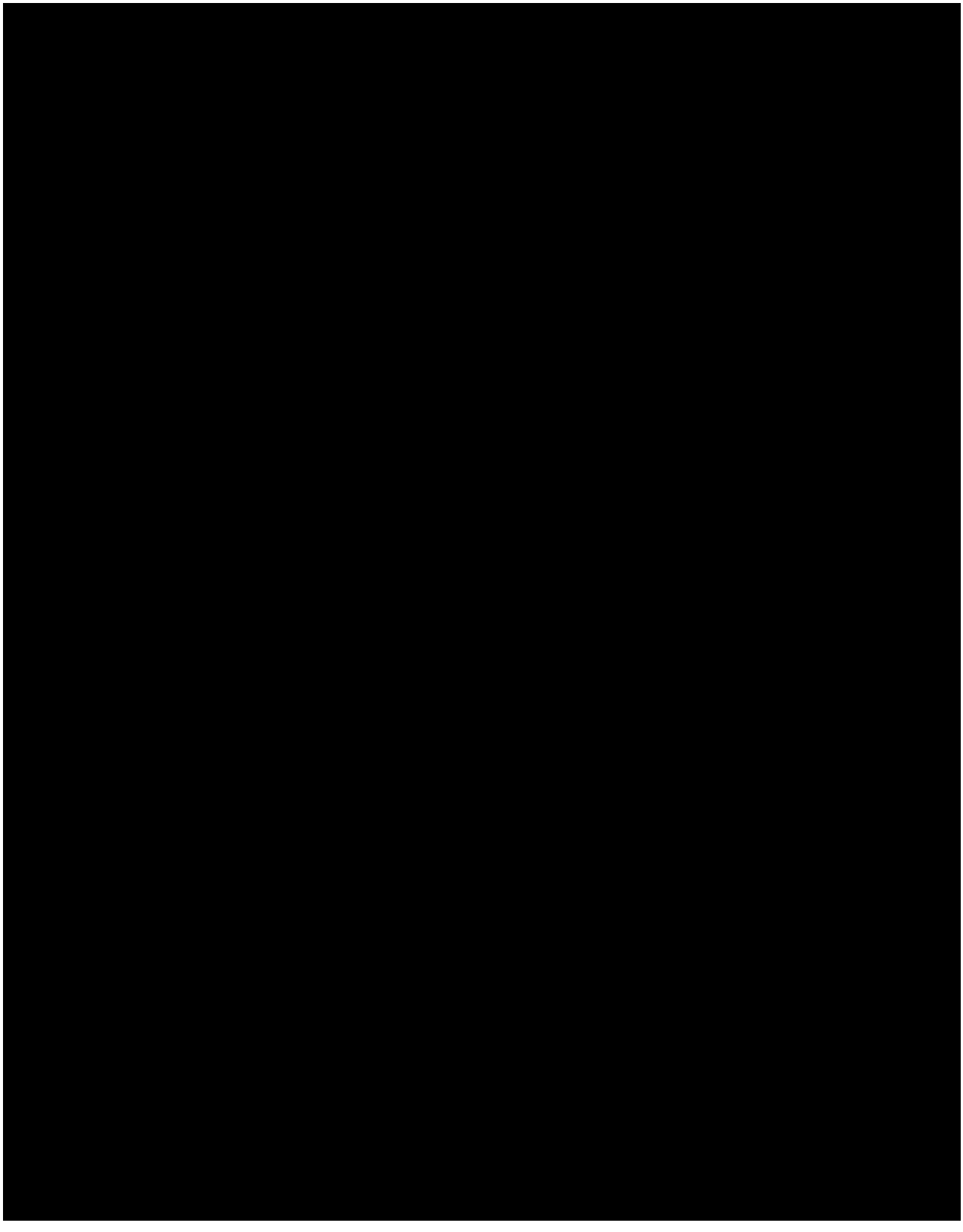


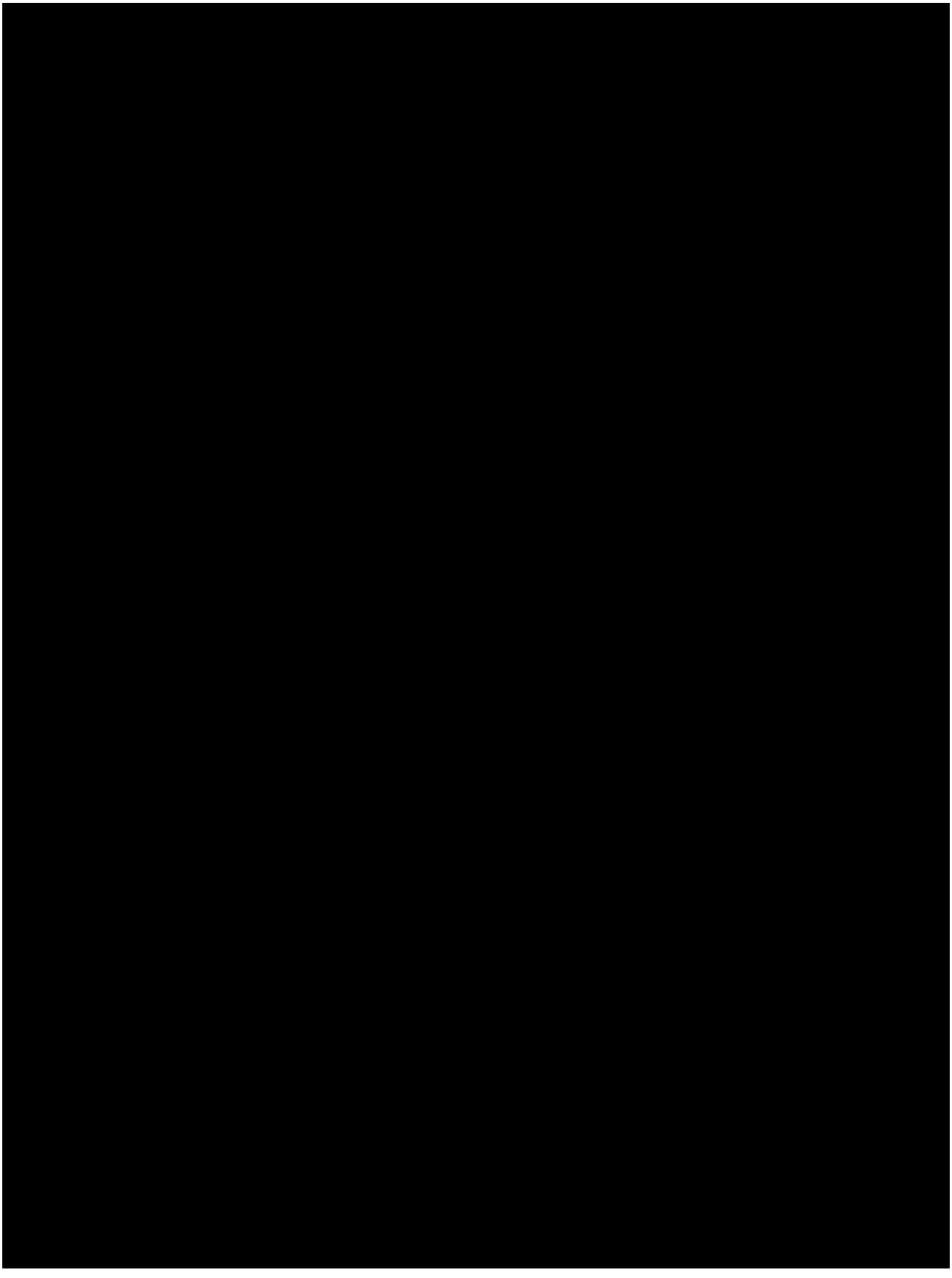


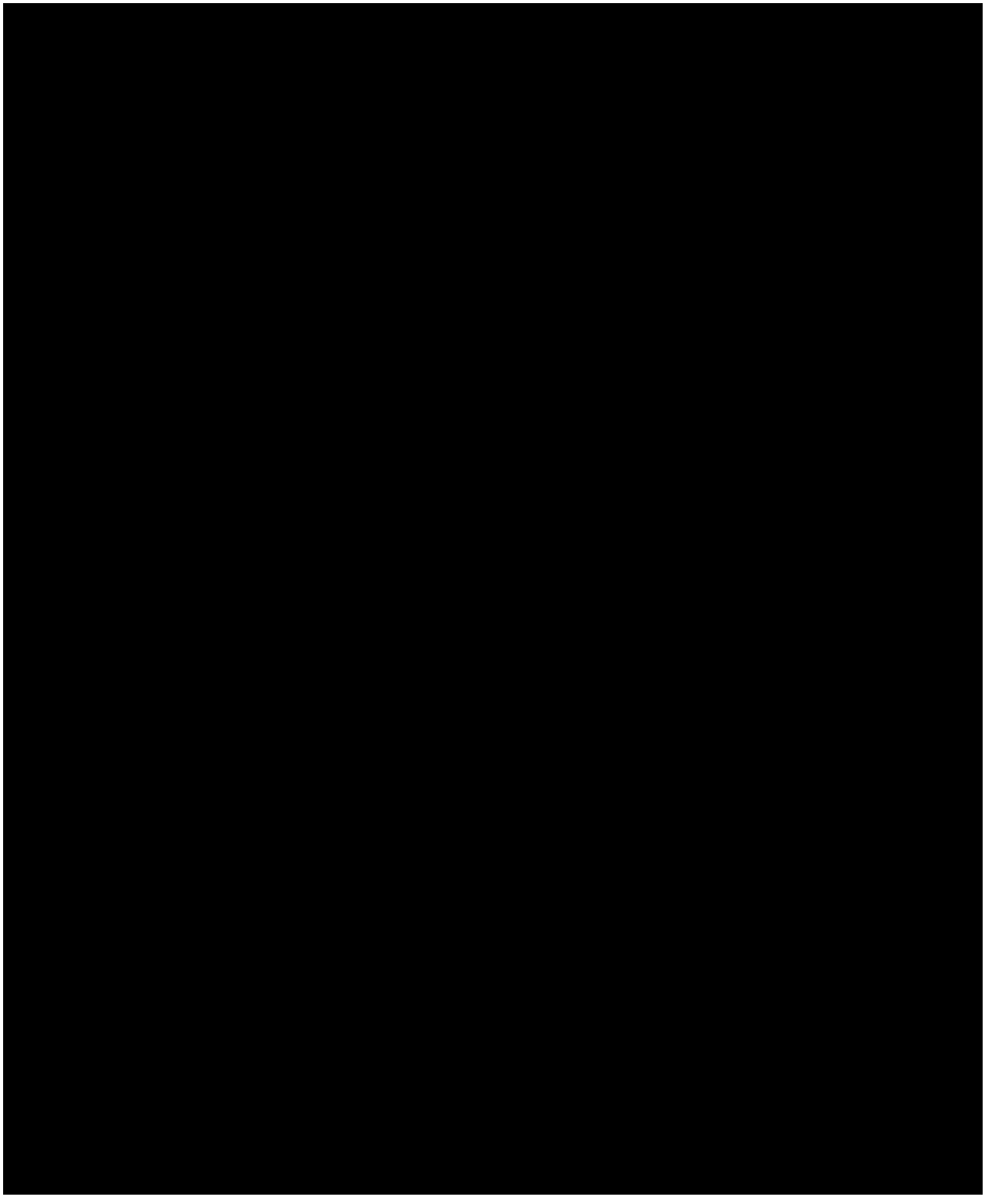












Fwd: ages and treatment

From: [redacted]
To:

Date: Fri, 09 Sep 2022 14:21:37 -0400
Attachments: Ages for gender affirming medical and surgical treatment for adolescents.docx (18.61 kB)

Here are [redacted] edits removing ages. This looks terrific, in my opinion. Having a later insurance supplement is a good idea, thanks [redacted]

---------- Forwarded message ---------
From: [redacted]
Date: Tue, Sep 6, 2022, 5:09 AM
Subject: ages and treatment
[redacted]

Dear Both

Following yesterdays conversation and in view that it is likely that we will have to remove “ages” from the document, I include the section of the SOC8 that talks about ages in the adolescent chapter. [redacted] would like to have this ready as much as possible and as soon as possible so we can make changes as soon as we can. I have highlighted in yellow the sections that we think they need to be remove, and add some words and a sentence. Can you please look at it and see if there is anything else that needs to be removed or added and send it to me? This comes at the end of the adolescent chapter. We are keen not to remove many references or make any major changes if at all possible.

Regards

[redacted]

[redacted]

Re: SOC delay- URGENT taskforce

From: [redacted]
To: Eli Coleman [redacted]
Cc: [redacted]
Date: Fri, 09 Sep 2022 16:36:49 -0400

[redacted] is indeed, Eli.
Ok, I'm saying nothing to [redacted] until we have resolution and we have our messaging clear.
Later we can let her know you're interested in the deck she made.

[redacted]

On Fri, Sep 9, 2022 at 4:12 PM Eli Coleman <[redacted]> wrote:

> [redacted] is the powerpoint queen!
> I'd love to see those.
> I would not alert her - as it is unnecessary now.
>
> All of this will mean some minor modification of her slides or anyone else's that we can communicate with when resolved.
>
> Let's keep this highly confidential till resolution.
>
> Thanks!
>
> On Fri, Sep 9, 2022 at 3:06 PM [redacted] wrote:
>
> > Hey [redacted] Eli, [redacted]
> > Heads up on a problem-- [redacted] has made fantastic slides of ALL the SOC8 statements to scroll during breaks in the GEI courses.
> > Shall I tell her about this issue now? (Or a limited version of this situation?) Or wait till we have a resolution?
> > Seems likely she will have to make some changes to the relevant Adolescent slides.
> >
> > [redacted]

[redacted]

On Fri, Sep 9, 2022 at 3:55 PM [redacted] wrote:

[redacted]

Well hello friends. I'm writing this email confidentially and urgently. I've also now touched base with each of you (or have attempted to do so) to discuss a matter of great importance related to the SOC8 release. This is time-sensitive.

In a nutshell, you likely saw the email that the SOC8 was going to be released by the biennial meeting (next week) in Montreal, particularly since we have GEI sessions and other sessions designed to train attendees on its release. Then you saw another email regarding an inadvertent delay in the release. I'm writing about the reason why and this is top-level confidential, as you will see.

The American Academy of Pediatrics (AAP)- a MAJOR organization in the United States that is typically very pro-transhealth/gender affirming care- voiced its *opposition* to the SOC8, specifically due to aspects of the Adolescent chapter. Not only did they say they would not endorse the SOC, they indicated that they would *actively publicly oppose it.* They had several concerns, one of which was the age criteria for minors (they believe that surgery of any type should not happen until the patient is age of majority). They also disagree with verbiage on social factors and adolescent identity development. They were tasked with providing feedback, which they did. We actually know some of the pediatricians who provided this feedback, which makes it rather shocking.

Clearly, if AAP were to publicly oppose the SOC8, it would be a major challenge for WPATH, SOC8, and trans youth access to care in the U.S.

You have been identified by me as someone to be a part of an urgent taskforce to figure out next steps. WPATH leadership has already proposed certain changes (removing of ages verbiage), however, we need to do the following: 1) Review the AAP feedback; 2) Review suggestions from SOC8 co-chairs; 3) Meet **tomorrow (Saturday) at some point between 12-3 PM EST** to discuss our thoughts on the subject and come up with a united approach; and 4) Meet with AAP colleagues **at some point shortly thereafter (potentially Sunday** depending on availability) to make sure we can come to an agreement to obtain their endorsement.

Can you all please reply with your ability to meet tomorrow and participate in this very important collaborative effort? I realize this might evoke some emotion and we'll have time to navigate that when in person over beverages in Montreal- so let's try to compartmentalize that for now and get our hard work efforts across the finish line. This is too important

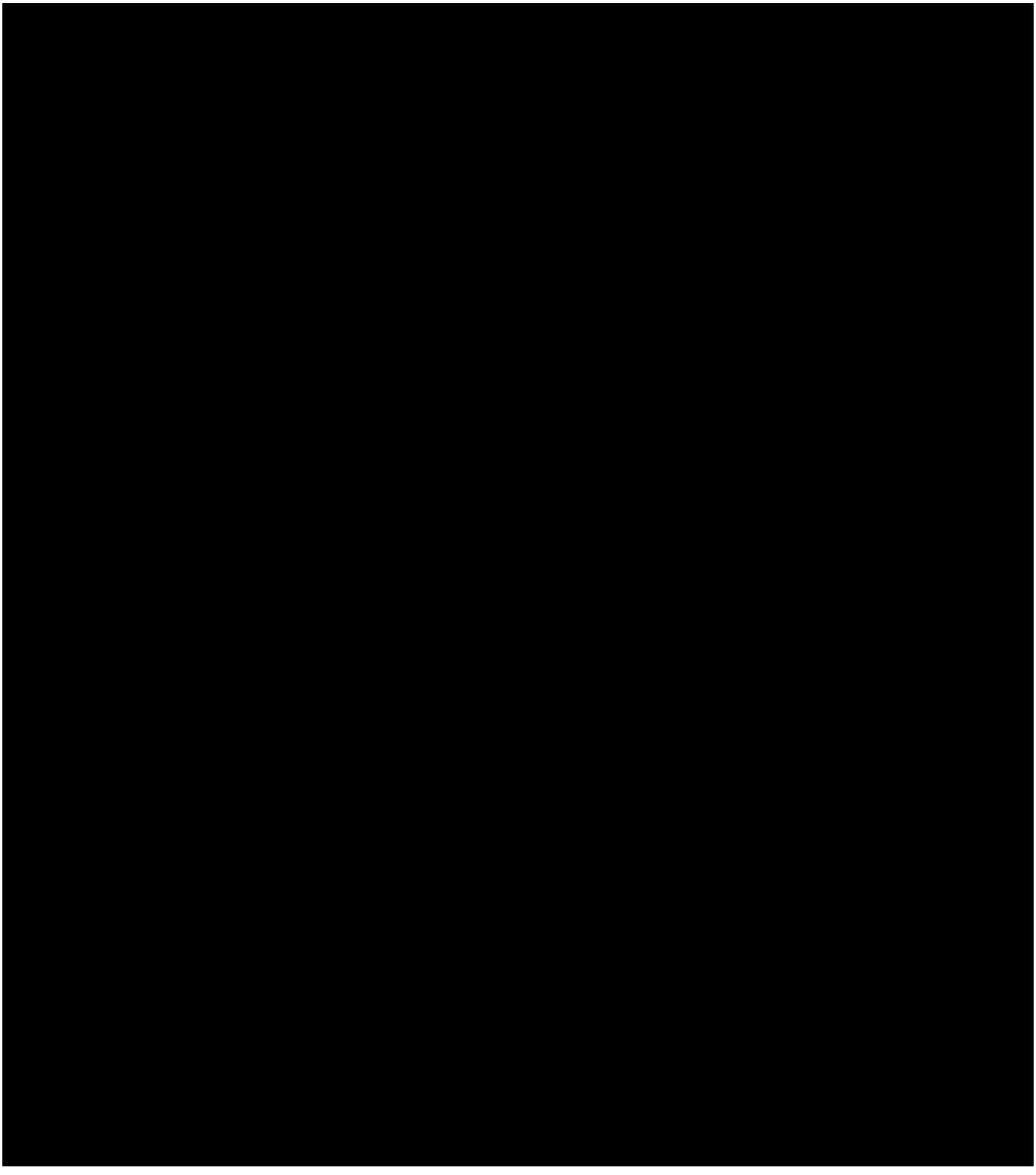
Many thanks,

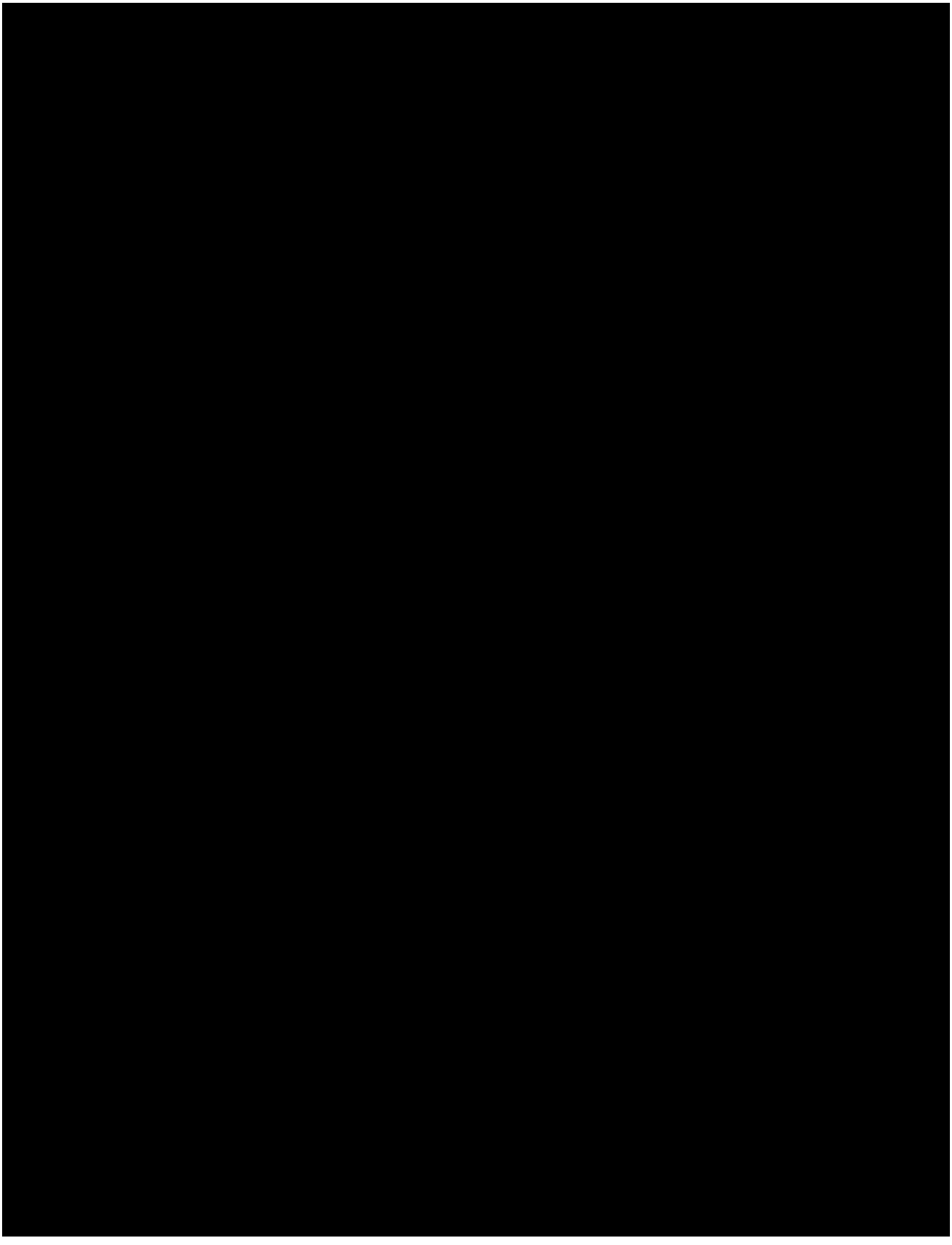
[redacted]

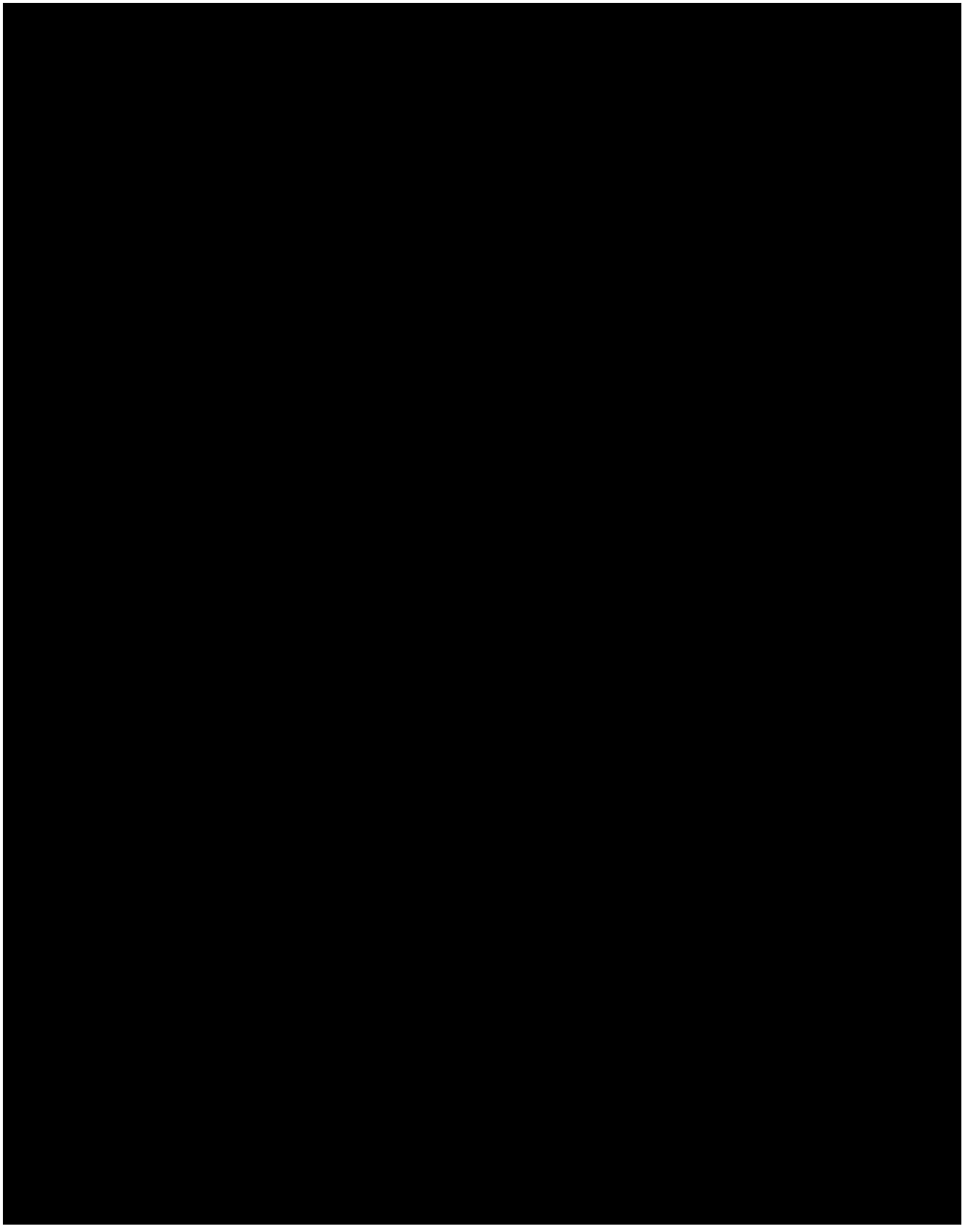
[redacted]

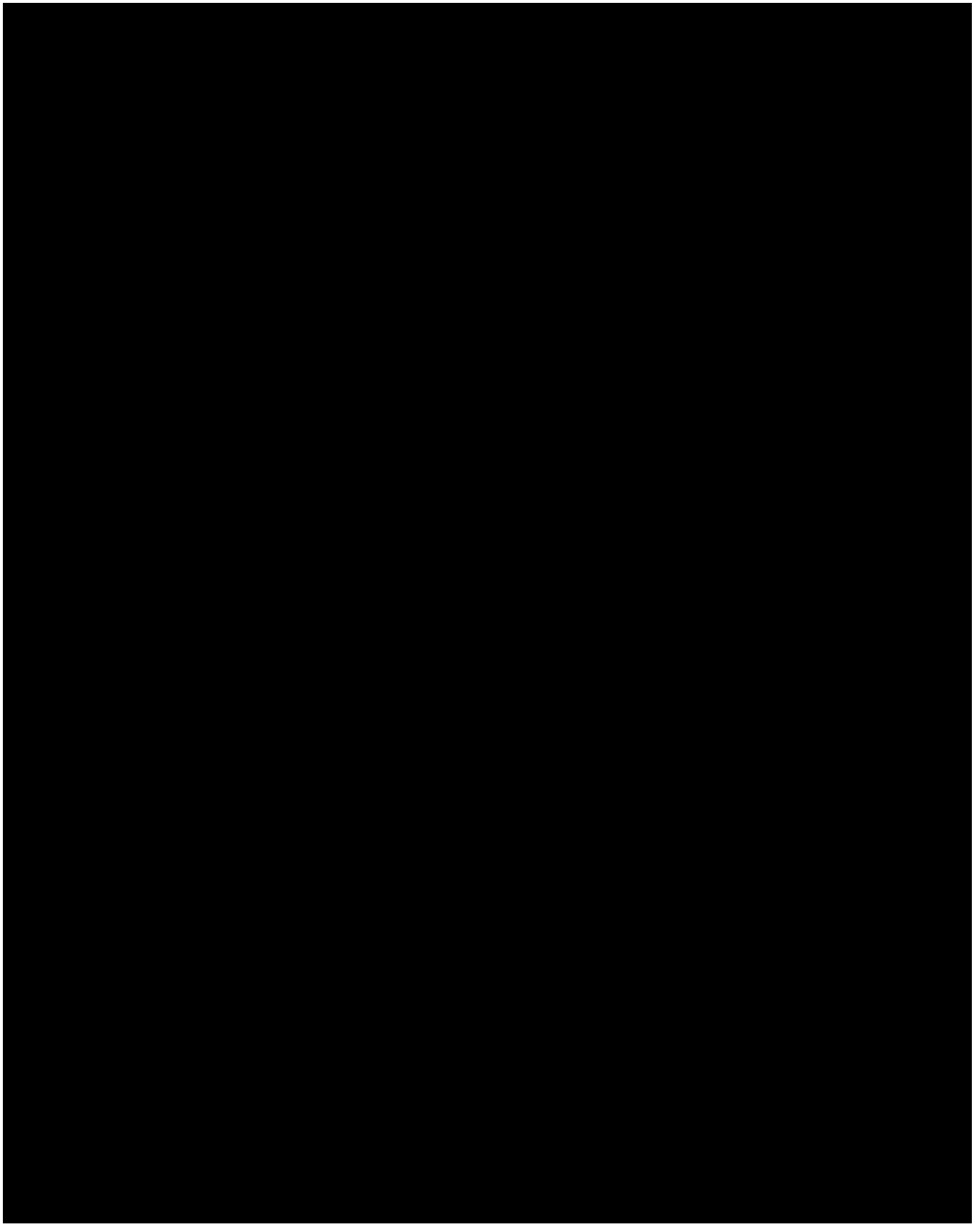
--

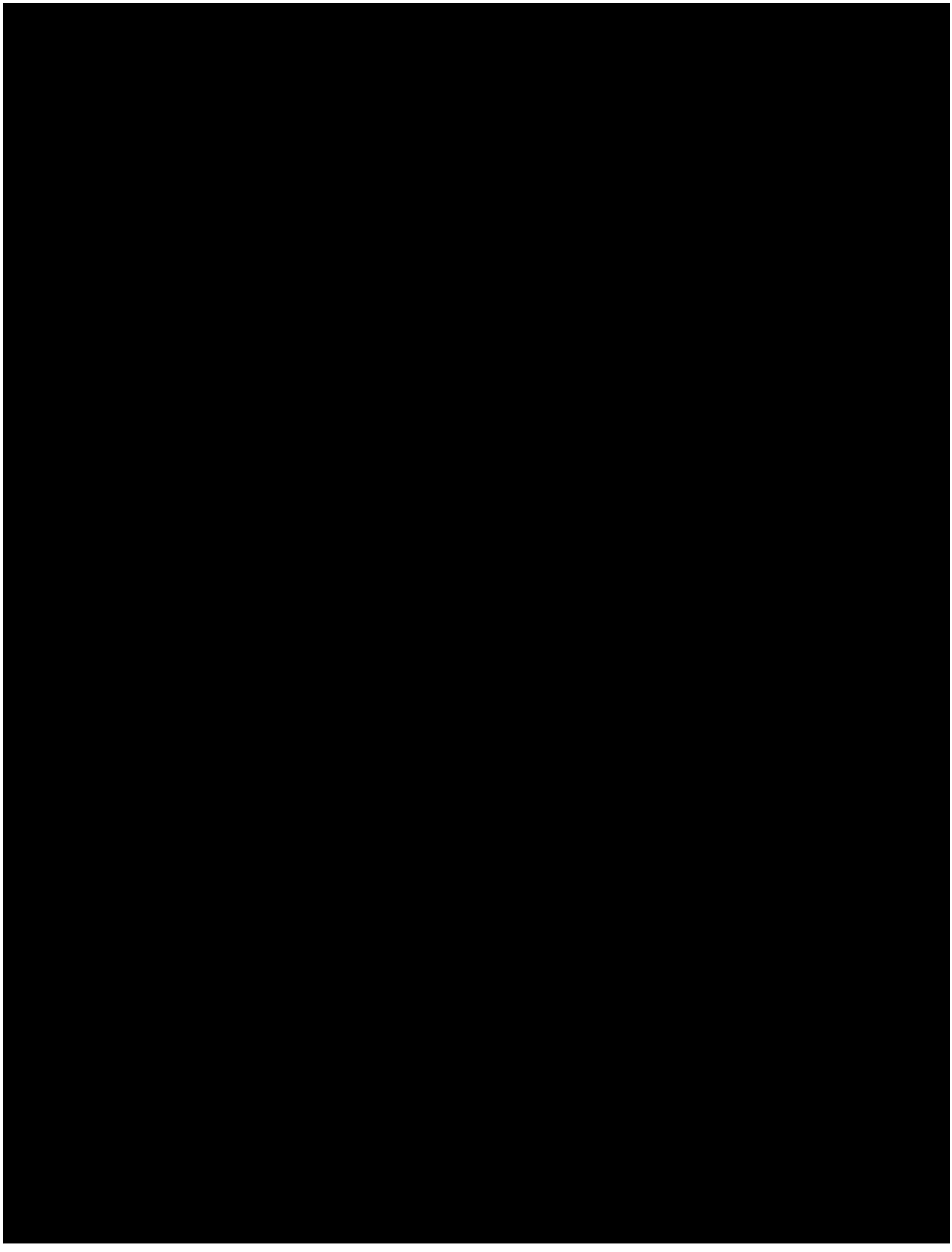
Eli Coleman, PhD.
Academic Chair in Sexual Health
Professor and Director
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
sexualhealth.umn.edu











[redacted]

[redacted]

Re: SOC delay- URGENT taskforce

From: Jon Arcelus <[redacted]>
To: [redacted] Scott Leibowitz [redacted],
Cc: [redacted] "Vries, A.L.C. de" <[redacted], Eli Coleman <[redacted]>, [redacted]
Date: Sat, 10 Sep 2022 03:18:06 -0400
Attachments: WIJT 23(S1) FINAL (AAP Comments).pdf (13.55 MB)

dear all,
In preparation for the meeting tomorrow with the adolescent chapter I am including the pdf with the comments from AAP. I have gone one by one through them and add my comments (in capiatal letter within their comment) as to why we are not going to make changes or if we are say that we are removing it. please have a look at this before the meeting and in the meeting we need to discuss whether you agree. the main issue is whether to remove ages from the document.

i also include the document wpb edits, with highlighted sections that represent what it will be removed so you can see what the chapter may look like..

time is a problem as we want the soc8 to be out for montreal, so we need to agree tomorrow whether 1) we ignore all their comments 2) we remove the sections that I suggest or more if you feel. we cant change statements and we dont want to add text as it will not be time for it.

speak tomorrow. please dont share the document with anyone. i need to send this in two pdfs as there document is too big

jon

Prof. Jon Arcelus Alonso, MD, PhD(Pronouns: He/Him/El)
Professor (Em.) of Mental Health and Wellbeing
Director of Research, Nottingham Centre for Transgender Health Network, UK

School of Medicine, University of Nottingham, Nottingham, United Kingdom
Bellvitge Biomedical Research Institute (IDIBELL), University of Barcelona, Spain
Honorary Professor Shanghai Jiao Tong University, Shanghai, China.

Editor of the International Journal of Transgender Health (IF 5.33)
Co-Chair of the Standards of Care 8th Edition (World Professional Association of Transgender Health-WPATH)
https://www.nottingham.ac.uk/medicine/people/jon.arcelus
From: Rosenthal, Stephen [redacted]
Sent: 09 September 2022 22:32

To: Jon Arcelus [redacted]; Scott Leibowitz [redacted]; Chelvakumar, Gayathri [redacted]
Cc: Ren Massey [redacted] Aron Janssen [redacted], Vries, A.L.C. de [redacted], Eli Coleman [redacted] oren Schechter [redacted], ASA RADIX [redacted]
Subject: Re: SOC delay- URGENT taskforce

I can meet between 9-10 AM Pacific time on Saturday.

Thanks,

Steve

Stephen M. Rosenthal, M.D.
Professor of Pediatrics
Division of Pediatric Endocrinology
Medical Director, Child and Adolescent Gender Center
University of California, San Francisco
Mission Hall: Global Health and Clinical Sciences
[redacted]

Director, World Professional Association for Transgender Health
Past Vice President and Director, Endocrine Society
Past President, Pediatric Endocrine Society
[redacted]

From: Jon Arcelus [redacted]
Sent: Friday, September 9, 2022 2:09 PM
To: Scott Leibowitz [redacted], Chelvakumar, Gayathri [redacted]
Cc: Ren Massey [redacted]; Aron Janssen [redacted] Rosenthal, Stephen [redacted]; Vries, A.L.C. de [redacted]; Eli Coleman [redacted] Loren Schechter [redacted]; ASA RADIX [redacted]
Subject: Re: SOC delay- URGENT taskforce

This Message Is From an External Sender
This message came from outside your organization.

This is very confusing as I did not have any suggestions. I was shocked to see the feedback from very junior people from AAP, my suggestion was not to make any changes. We need to publish the SOC By Montreal so unless it goes asap it will not be ready

Prof. Jon Arcelus Alonso, MD, PhD(Pronouns: He/Him)
Professor (Em.) of Mental Health and Wellbeing
Director of Research, Nottingham Centre for Transgender Health Network, UK

School of Medicine, University of Nottingham, Nottingham, United Kingdom
Bellvitge Biomedical Research Institute (IDIBELL), University of Barcelona, Spain
Honorary Professor Shanghai Jiao Tong University, Shanghai, China.

Editor of the International Journal of Transgender Health (IF 5.33)
Co-Chair of the Standards of Care 8th Edition (World Professional Association of Transgender Health-WPATH)
https://www.nottingham.ac.uk/medicine/people/jon.arcelus

From: Scott Leibowitz [redacted]
Sent: Friday, September 9, 2022 9:34:01 PM
To: Chelvakumar, Gayathri [redacted]
Cc: Ren Massey [redacted]; Aron Janssen [redacted]; Rosenthal, Stephen [redacted] Vries, A.L.C. de [redacted]; Eli Coleman [redacted]; Loren Schechter [redacted] ASA RADIX [redacted] Jon Arcelus [redacted]
Subject: Re: SOC delay- URGENT taskforce

I think it would be helpful to get the feedback, and Jon's suggestions once the Chairs choose a time for the meeting.

Sent from my iPhone

> On Sep 9, 2022, at 4:23 PM, Chelvakumar, Gayathri [redacted] wrote:
>
> Are you able to send us the AAP feedback or are we discussing whenever we meet?
>
> Get Outlook for iOS
> **From:** Chelvakumar, Gayathri [redacted]
> **Sent:** Friday, September 9, 2022 4:02:31 PM
> **To:** Ren Massey [redacted] Aron Janssen [redacted]
> **Cc:** Scott Leibowitz [redacted]; Rosenthal, Stephen [redacted] Vries, A.L.C. de [redacted]; Eli Coleman [redacted]; Loren Schechter [redacted] Asa Radix [redacted] Jon Arcelus [redacted]
> **Subject:** Re: SOC delay- URGENT taskforce
>
> I can be available Saturday and Sunday.
> Thanks Scott!
> Gaya
>
> Get Outlook for iOS

From: Ren Massey <[redacted]
Sent: Friday, September 9, 2022 4:00:17 PM
To: Aron Janssen <[redacted]
Cc: Scott Leibowitz <[redacted]>; Rosenthal, Stephen <[redacted]; Chelvakumar, Gayathri [redacted] Vries, A.L.C. de [redacted]; Eli Coleman <[redacted]>; Loren Schechter [redacted]; Asa Radix [redacted]>; Jon Arcelus [redacted]
Subject: Re: SOC delay- URGENT taskforce

This Message Is From an External Sender
This message came from outside your organization.
Search "email warning banner" on ANCHOR for more information
Report Suspicious

I can definitely meet Saturday, and I will make Sunday work.
Ren

Ren Massey, Ph.D.
Co-Chair/Mental Health Chair, WPATH GEI
Past President, Georgia Psychological Association
Adjunct Assistant Professor, Dept. of Psychiatry & Behavioral Sciences,
Emory University School of Medicine
Licensed Psychologist
(He, him, his)

[redacted]

On Fri, Sep 9, 2022 at 3:57 PM Aron Janssen <[redacted] wrote:
Happy to help! Let me know the times for the calls and I'll do my best.

Get Outlook for iOS
From: Scott Leibowitz <[redacted]
Sent: Friday, September 9, 2022 2:55:45 PM
To: Rosenthal, Stephen [redacted] Gayathri.Chelvakumar [redacted]; Aron Janssen <[redacted] Vries, A.L.C. de <[redacted]; Ren Massey <[redacted]
Cc: Eli Coleman <[redacted]; Loren Schechter <[redacted]; Asa Radix [redacted]; Jon Arcelus <[redacted]; Scott Leibowitz <[redacted]
Subject: SOC delay- URGENT taskforce

Aron, Annelou, Gaya, Ren, and Steve,

Well hello friends. I'm writing this email confidentially and urgently. I've also now touched base with each of you (or have attempted to do so) to discuss a matter of great importance related to the SOC8 release. This is time-sensitive.

In a nutshell, you likely saw the email that the SOC8 was going to be released by the biennial meeting (next week) in Montreal, particularly since we have GEI sessions and other sessions designed to train attendees on its release. Then you saw another email regarding an inadvertent delay in the release. I'm writing about the reason why and this is top-level confidential, as you will see.

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Can you all please reply with your ability to meet tomorrow and participate in this very important collaborative effort? I realize this might evoke some emotion and we'll have time to navigate that when in person over beverages in Montreal- so let's try to compartmentalize that for now and get our hard work efforts across the finish line. This is too important

Many thanks,
Scott

Scott Leibowitz, MD
Child and Adolescent Psychiatrist | Nationwide Children's Hospital, Columbus, OH
Medical Director of Behavioral Health | THRIVE (gender and sex development) program | he/him/his
Associate Clinical Professor | The Ohio State University College of Medicine

[redacted]

CHAPTER 6 Adolescents

Historical context and changes since previous Standards of Care

Specialized health care for transgender adolescents began in the 1980s when a few specialized gender clinics for youth were developed around the world that served relatively 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, Bergman et al., 2020). Since then, new clinics have been founded, but clinical services in many places have not kept pace with the increasing number of youth seeking care. Hence, there are often long waitlists for services, and barriers to care exist for many transgender youth around the world (Tollit et al., 2018).

Until recently, there was limited information regarding the prevalence of gender diversity among adolescents. Studies from high school samples indicate much higher rates than earlier thought, with reports of up to 1.2% of participants 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; Kidd et al., 2021; Wang et al., 2020). These studies suggest gender diversit in outh should no lon er be viewed as rare. [2] Additionall , a attern of uneven ratios b assi ned sex has been re orted in ender clinics, with adolescents assigned female at birth (AFAB) initiatin care 2.5–7.1 times more fre uentl as com ared to adolescents who are assigned male at birth (AMAB) (Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020).

A specific World Professional Association for Transgender Health's (WPATH) Standards of Care section dedicated to the needs of children and adolescents was first included in the 1998 WPATH Standards of Care, 5th version (Levine et al., 1998). Youth aged 16 or older were deemed potentially eligible for gender-affirming medical care, but only in select cases. The subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest "masculinizing" mastectomy, which had an age minimum of 16 years. Additional eligibility criteria for gender-related medical care included a persistent, long (childhood) history of gender "non-conformity"/dysphoria, emerging or intensifying at the onset of puberty; absence or management of psychological, medical, or social problems that interfere with treatment; provision of support for commencing the intervention by the parents/caregivers; and provision of informed consent. A chapter dedicated to transgender and gender diverse (TGD) adolescents, distinct from the child chapter, has been created for this 8th edition of the Standards of Care given 1) the exponential growth in adolescent referral rates; 2) the increased number of studies specific to adolescent gender diversity-related care; and 3) the unique developmental and gender-affirming care issues of this a e rou .

[1] Non-s ecific terms for ender-related care are avoided (e. ., ender-affirmin model, ender ex lorator model) as these terms do not re resent unified ractices, but instead hetero enous care practices that are defined differently in various settings.

Adolescence overview

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood (Sanders, 2013). Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress. 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. For example, physical pubertal changes may

Summary of Comments on Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

Page: 45

Number: 1 Author [redacted] Subject: Highlight Date: 9/7/2022 7:41:45 AM -04'00'

[redacted] being twisted to suggest WPATH is against the gender-affirming care model as supported by AAP and other organizations

[redacted] Non specific terms for gender related care are avoided (eg gender affirming model) as these terms do not represent unified practices but instead heterogenous care practices that are defined differently in various settings.

WE HOPE THAT AFTER READING THE CHAPTER THAT WILL NOT BE THE VIEW, IN ADDTION THE MOST IMPORTANT PART OF THE SOC ARE THE RECOMMENDATIONS

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:06:19 AM -04'00'

[redacted] istribution was more recently challenged by Jack Turban's review of the YRBSS data finding more even ratios of AFAB and AMAB people reporting gender diversity. (See https://publications.aap.org/pediatrics/article/doi/10.1542/peds.2022-056567/188709/Sex-Assigned-at-Birth-Ratio-Among-Transgender-and). This is not mention that the references here are concerning - Bauer is based on ED presentations, de Graaf is a letter to the editor. Kaltiala et al 2015 is a very negative article - would need to look more at it and it raises red flags that at least 3 of the citations are from the same group/population.

One reason this is concerning is that the argument has arose that the AFAB prevalance supports social contangion and more even ratio run against it - that is the argument that Turban uses and I imagine with WPATH articulating this will be further "support" of social contagion (for what it is worth, I don't the ratios is a particularly strong argument to begin with)

[redacted] b 2.5-7.1 tiems more frequent Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020

THANKS, WE DO HAVE AN EPIDMIOLOGY CHAPTER IN THE SOC8 THAT DISCUSSES THIS

begin in late childhood and executive control neural systems continue to develop well into the mid-20s (Ferguson et al., 2021). There is a lack of uniformity in how countries and governments define the age of majority (i.e., legal decision-making status; Dick et al., 2014). While many specify the age of majority as 18 years of age, in some countries it is as young as 15 years (e.g., Indonesia and Myanmar), and in others as high as 21 years (e.g., the U.S. state of Mississippi and Singapore).

For clarity, this chapter applies to adolescents from the start of puberty until the legal age of majority (in most cases 18 years), however there are developmental elements of this chapter, including the importance of parental/caregiver involvement, that are often relevant for the care of transitional-aged young adults and should be considered appropriately.

Cognitive development in adolescence is often characterized by gains in abstract thinking, complex reasoning, and metacognition (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 enables a young person to conceptualize implications regarding a particular decision. However, adolescence is also often associated with increased risk-taking behaviors. Along with these notable changes, adolescence is often characterized by individuation from parents and the development of increased ersonal autonom . here is often a hei htened focus on eer relationshi s, which can be both ositive and detrimental (Gardner & Steinberg, 2005). Adolescents often experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals (Van Leijenhorst et al., 2010). Social-emotional development typically advances during adolescence, although there is a great variability among young people in terms of the level of maturity applied to inter- and intra-personal communication and insight (Grootens-Wiegers et al., 2017). For TGD adolescents making decisions about gender-affirming treatments—decisions that may have lifelong consequences—it is critical to understand how all these aspects of development may impact decision-making for a given young person within their specific cultural context.

Gender identity development in adolescence

Our understanding of gender identity development in adolescence is continuing to evolve. When providing clinical care to gender diverse young people and their families, it is important to know what is and is not known about gender identity during development (Berenbaum, 2018). When considering treatments, families may have questions regarding the development of their adolescent's gender identity, and whether or not their 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/caregivers 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 conducted primarily with youth who were not gender diverse in identity or expression and was carried out under the assumption that sex correlated with a specific gender; therefore, little attention was given to gender identity development. In addition to biological factors influencing gender development, this research demonstrated psychological and social factors also play a role (Perry & Pauletti, 2011). While there has been less focus on gender identity development in TGD youth, there is ample reason to suppose, apart from biological factors, psychosocial factors are also involved (Steensma, Kreukels et al., 2013). or some youth, gender identit develop- ment appears fixed and is often expressed from a oun a e, while for others there ma be a developmental process that contributes to gender identity development over time.

Neuroimaging studies, enetic studies, and other hormone studies in ntersex individuals demonstrate a biological contribution to the

Page: 46

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:25:40 AM -04'00'

[redacted] point this out

GREAT

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:25:16 AM -04'00'

This is a really good point to include instead of the "insistent, persistent, consistent" criteria.

THANKS

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 7:45:36 AM -04'00'

[redacted] ontroversial in how much it reflects the experiences and therefore an accurate model of "gender" in TGD individuals. The intersex community often sees themselves as very distinct from the TGD community so this may lead to some conflict drawing on this research.

PART OF THE INTERSEX CHAPTER

development of gender identity for some individuals whose gender identity does not match their assigned sex at birth (Steensma, Kreukels et al., 2013). As families often have questions about this very issue, it is important to note it is not possible to distinguish between those for whom gender identity may seem fixed from birth and those for whom gender identity development appears to be a developmental process. Since it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person, a comprehensive clinical approach is important and necessary (see Statement 3). Future research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups. Conceptualization of gender identity by shifting from dichotomous (e.g., binary) categorization of male and female to a dimensional gender spectrum along a continuum (APA, 2013) would also be necessary.

Adolescence may be a critical period for the development of gender identity for gender diverse young people (Steensma, Kreukels et al., 2013). Dutch longitudinal clinical follow-up studies of adolescents with childhood gender dysphoria who received puberty suppression, gender-affirming hormones, or both, found that none of the youth in adulthood regretted the decisions they had taken in adolescence (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014). These findings suggest adolescents who were comprehensively assessed and determined emotionally mature enough to make treatment decisions regarding gender- affirming medical care presented with stability of gender identity over the time period when the studies were conducted.

When extrapolating findings from the longer-term longitudinal Dutch cohort studies to present-day gender diverse adolescents seeking care, it is critical to consider the societal changes that have occurred over time in relation to TGD people. Given the increase in visibility of TGD identities, it is important to understand how increased awareness may impact gender development in different ways (Kornienko et al., 2016). One trend identified is that more young people are presenting to gender clinics with nonbinary identities (Twist & de Graaf, 2019). Another phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversit durin their childhood ears. One researcher attem ted to stud and describe a s e-cific form of later- resenting gender diversity experience (Littman, 2018). However, the findings of the study must be considered within the context of significant methodological challenges, including 1) the study surveyed parents and not youth perspectives; and 2) recruitment included parents from community settings in which treatments for gender dysphoria are viewed with scepticism and are criticized. or a select sub rou of oun eo le, susce tibilit to social influence im actin ender ma be an im ortant differential to consider (Kornienko et al., 2016). However, caution must be taken to avoid assumin these henomena occur rematurel in an individual adolescent while rel in on information from datasets that may have been ascertained with potential sampling bias (Bauer et al., 2022; WPATH, 2018). It is important to consider the benefits that social connectedness may have for youth who are linked with supportive people (Tuzun et al., 2022)(see Statement 4).

Given the emerging nature of knowledge re ardin adolescent ender identit develo ment, an individualized a roach to clinical care is considered both ethical and necessary. As is the case in all areas of medicine, each study has methodological limitations, and conclusions drawn from research cannot and should not be universally applied to all adolescents. This is also true when grappling with common parental questions regarding the stability versus instability of a particular young person's gender identity development. While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care.

Research evidence of gender-affirming medical treatment for transgender adolescents

A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical

Page: 47

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 8:53:44 AM -04'00'

[redacted] to be building into an argument in favor of social contagion

WE WANTED TO REFLECT WHAT IS OUT THERE WITHOUT BEING SELECTIVE BUT PROVIDING CIRITISM WHEN NEEDED

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 8:54:16 AM -04'00'

"May be important to consider" validates Littman's theory while at the same time recommending caution.

AGREE

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 8:54:34 AM -04'00'

[redacted] ragraph is important and very much in line with what the AAP has been promoting (but it does not carry through the chapter).

GREAT

and surgical treatments (GAMSTs) (see medically necessary statement in the Global chapter, Statement 2.1), over time. Given the lifelong implications of medical treatment and the young age at which treatments may be started, adolescents, their parents, and care providers should be informed about the nature of the evidence base. It seems reasonable that decisions to move forward with medical and surgical treatments should be made carefull . Des ite the slowl rowin bod of evidence supporting the effectiveness of earl medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead.

At the time of this chapter's writing, there were several longer-term longitudinal cohort follow-up studies reporting positive results of early (i.e., adolescent) medical treatment; for a significant period of time, many of these studies were conducted through one Dutch clinic (e.g., Cohen-Kettenis & van Goozen, 1997; de Vries, Steensma et al., 2011; de Vries et al., 2014; Smith et al., 2001, 2005). The findings demonstrated the resolution of gender dysphoria is associated with improved psychological functioning and body image satisfaction. Most of these studies followed a pre-post methodological design and compared baseline psychological functioning with outcomes after the provision of medical gender-affirming treatments. Different studies evaluated individual aspects or combinations of treatment interventions and included 1) gender-affirming hormones and surgeries (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001, 2005); 2) puberty suppression (de Vries, Steensma et al., 2011); and 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 (pretreatment, mean age of 13.6) through young adulthood (posttreatment, mean age of 20.7). This was the first study to show gender-affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with satisfactory objective and subjective outcomes in adulthood (de Vries et al., 2014). While the study employed a small (n = 55), select, and socially supported sample, the results were convincing. Of note, the participants were part of the Dutch clinic known for employing a multidisciplinary approach, including provision of comprehensive, ongoing assessment and management of gender dysphoria, and support aimed at emotional well-being.

Several more recently published longitudinal studies followed and evaluated participants at different stages of their gender-affirming treatments. In these studies, some participants may not have started gender-affirming medical treatments, some had been treated with puberty suppression, while still others had started gender-affirming hormones or had even undergone gender-affirming surgery (GAS) (Achille et al., 2020; Allen et al., 2019; Becker-Hebly et al., 2021; Carmichael et al., 2021; Costa et al., 2015; Kuper et al., 2020, Tordoff et al., 2022). Given the heterogeneity of treatments and methods, this type of design makes interpreting outcomes more challenging. Nonetheless, when compared with baseline assessments, the data consistently demonstrate improved or stable psychological functioning, body image, and treatment satisfaction varying from three months to up to two years from the initiation of treatment.

Cross-sectional studies provide another design for evaluating the effects of gender-affirming treatments. One such study compared psychological functioning in transgender adolescents at baseline and while undergoing puberty suppression with that of cisgender high school peers at two different time points. At baseline, the transgender youth demonstrated lower psychological functioning compared with cisgender peers, whereas when undergoing puberty suppression, they demonstrated better functioning than their peers (van der Miesen et al., 2020). Grannis et al. (2021) demonstrated transgender males who started testosterone had lower internalizing mental health symptoms (depression and anxiety) compared with those who had not started testosterone treatment.

Four additional studies followed different outcome designs. In a retrospective chart study, Kaltiala, Heino et al. (2020) reported transgender

Page: 48

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:13:41 AM -04'00'

[redacted] dcitory given the recommendations of lower ages and less gatekeeping for adolescents.

WE HAVE REMOVED AGES

adolescents with few or no mental health challenges prior to commencing gender-affirming hormones generally did well during the treatment. However, adolescents with more mental health challenges at baseline continued to experience the manifestations of those mental health challenges over the course of gender-affirming medical treatment. Nieder et al. (2021) studied satisfaction with care as an outcome measure and demonstrated transgender adolescents were more satisfied the further they progressed with the treatments they initially started. Hisle-Gorman et al. (2021) compared health care utilization pre- and post-initiation of gender-affirming pharmaceuticals as indicators of the severity of mental health conditions among 3,754 TGD adolescents in a large health care data set. Somewhat contrary to the authors' hypothesis of improved mental health, mental health care use did not significantly change, and psychotropic medication prescriptions increased. In a large non-probability sample of transgender-identified adults, Turban et al. (2022) found those who reported access to gender-affirming hormones in adolescence had lower odds of past-year suicidality compared with transgender people accessing gender- affirming hormones in adulthood.

Providers ma consider the ossibilit an adolescent ma re ret ender-affirmin decisions made durin adolescence, and a oun erson will want to sto treatment and return to livin in the birth-assi ned ender role in the future. Two Dutch studies report low rates of adolescents (1.9% and 3.5%) choosin to sto ubert suppression (Brik et al., 2019; Wie es et al., 2018). Again, these studies were conducted in clinics that follow a protocol that includes a com rehensive assessment before the ender-affirmin medical treatment is started. At resent, no clinical cohort studies have re orted on rofiles of adolescents who re ret their initial decision or detransition after irreversible affirmin treatment. Recent research indicate there are adolescents who detransition, but do not re ret initiatin treatment as the ex erienced the start of treatment as a art of understandin their ender-related care needs (Turban, 2018). However, this ma not be the predominant perspective of people who detransition (Littman, 2021; Vandenbussche, 2021). Some adolescents ma regret the ste s the have taken (D er, 2020). Therefore, it is im ortant to present the full ran e of possible outcomes when assistin trans ender adolescents. Providers ma discuss this to ic in a collaborative and trusting manner (i.e., as a " otential future experience and consideration") with the adolescent and their arents/care ivers before ender-affirmin medical treatments are started. Also, roviders should be re ared to su ort adolescents who detransition. In an internet convenience sam le surve of 237 self-identified detransitioners with a mean age of 25.02 ears, which consisted of over 90% of birth assi ned females, 25% had medicall transitioned before a e 18 and 14% detransitioned before age 18 (Vandenbussche, 2021). Althou h an internet convenience sam le is sub ect to selection of res ondents, this stud su ests detransitionin ma occur in oun trans ender adolescents and health care rofessionals should be aware of this. Man of them ex ressed di - ficulties findin hel durin their detransition rocess and re orted their detransition was an isolatin_ ex_erience durin_ which the_ did not receive either sufficient or appropriate support (Vandenbussche, 2021).

To conclude, althou_h the existin_ sam_les re orted on relativel small roups of outh (e. ., n = 22-101 _er stud_) and the time to follow-u_ varied across studies (6 months–7 ears), this emer in evidence base indicates a eneral im_rovement in the lives of trans_ender adolescents who, following careful assessment, receive medicall necessar gender-affirmin medical treatment. Further, rates of re orted re ret during the stud_ monitorin_ _eriods are low. Taken as a whole, the data show early medical intervention—as part of broader combined assessment and treatment approaches focused on _ender dys- horia and general well-bein —can be effective and hel_ful for man_ transgender adolescents seeking these treatments.

Ethical and human rights perspectives

Medical ethics and human rights perspectives were also considered while formulating the

Page: 49

Number: 1 Author [redacted] Subject: Highlight Date: 9/8/2022 1:41:00 PM -04'00'

[redacted]uch credit to the studies about "detransition" here and this will be taken out of context by opponents of this care. They way it is all phrased just makes it seem like another piece of data to consider.

WE FELT, MAINLY AFTER THE PUBLIC COMMENT PERIOD THAT IT WAS BETTER TO DESCRIBE THE AVAILABLE LITERATRUE BUT TO DISCUSS THEIR LIMITATIONS, NOT MENTIONING COULD IMPLY THAT WE WERE BIAS TOWARDS THE LITERATURE SELECTED.

Number: 2 Author [redacted] Subject: Highlight Date: 9/7/2022 10:20:00 AM -04'00'

[redacted]e is a news article on the ruling in Tavistock. It is not scientific evidence and thus should be excluded.

HAPPY TO REMOVE THIS

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:20:25 AM -04'00'

This reinforces the binary that people "persist" with successful treatment and "desist" as treatment failures... it completely negates the experiences of people who are nonbinary or that some may stop hormones and not be regretful...

THANKS, THE NED TO SUPPROT THOSE WHO DETRANSTION WHETHER YOUTH OR ADULTS IS VERY IMPORTANT.

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:28:22 AM -04'00'

This is helpful... and it does not at all suggest de-transition is a treatment failure, rather they are people who need support.

Number: 5 Author: [redacted] Subject: Sticky Note Date: 9/8/2022 3:03:21 PM -04'00'

Language around “de-transition” and “desistance” appear throughout chapter 6 pointing to an assumption of regret, which is also explicitly stated with low quality references to commentaries and news articles. This assumes negative and harmful outcomes to those who find that a certain intervention may not be appropriate for them. While negative outcomes are possible, the evidence does not exist to support this as the only assumed “alternative” outcome to a certain intervention, treatment, etc., and available evidence (although limited) as well as experts in gender affirmative care suggest otherwise based on their experiences. The gender affirmative care model itself is NOT assume or require on any specific outcome (i.e. label, treatment, etc.), but instead focuses affirming the individual through their process of self-discovery (i.e. discovering that you are nonbinary instead of trans, or that hormones are not right for you can be valid, positive, and affirming outcomes of the approach).

THIS IS A VALID POINT , AS MANY REVIEWS (AND THIS NOT A RECOMENDATION BUT AN INTRODUCTION) WE NEED TO REFLECT THE AVAIABLE LITERATURE EVEN IF WE CRITISISE IT, NOTE MENTIONING WILL BE WORSE.

Number: 6 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:29:51 AM -04'00'

I am not sure that is the conclusion I took away from this discussion (and that others will take away). There is no defintion of "early medical intervention", so it is not clear if that means doing anything in an adolescent vs. waiting until adulthood, or actually intervening from early puberty (if the latter, then that is not discussed)

ALWAYS A DIFFICULT BALANCE AND WE TRIED TO BALANCE THEIR VIEWS OF THE LIMITED LITERATURE AS MUCH AS WE CAN.

Number: 7 Author [redacted] Subject: Highlight Date: 9/7/2022 10:30:46 AM -04'00'

Turban 2018 is a Viewpoint based on a case study.... it is not convincing evidence to justify such the theory.

THANKS, WE FELT THAT THIS WAS IMPORTANT TO CITE

Statements of Recommendations

6.1- We recommend health care professionals working with gender diverse adolescents:
6.1.a- Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.
6.1.b- Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
6.1.c- Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
6.1.d- Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
6.1.e- Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.
6.2- We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.
6.3- We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.
6.4- We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.
6.5- We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.
6.6- We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.
6.7- We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.
6.8- We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender- related surgery until the transition is made to adult care.
6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
6.10- We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.
6.11- We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):
6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
6.12.g- 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.

With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal ages for gender-affirming medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time 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 when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.

adolescent SOC statements. For example, allowing irreversible puberty to progress in adolescents who experience gender incongruence is not a neutral act given that it may have immediate and lifelong harmful effects for the transgender young person (Giordano, 2009; Giordano & Holm, 2020; Kreukels & Cohen-Kettenis, 2011). From a human rights perspective, considering gender diversity as a normal and expected variation within the broader diversity of the human experience, it is an adolescent's right to participate in their own decision-making process about their health and lives, including access to gender health services (Amnesty International, 2020).

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 aspects of identity, including gender identity. Statement 6.2 addresses identity exploration in the context of gender identity development. Statement 6.12.b accounts for the length of time needed for a young person to experience a gender diverse identity, express a gender diverse identity, or both, so as to make a meaningful decision regarding gender-affirming care.

Consent and decision-making: In adolescence, consent and decision-making require assessment of the individual's emotional, cognitive, and psychosocial development. Statement 6.12.c directly addresses emotional and cognitive maturity and describes the necessary components of the evaluation process used to assess decision-making capacity.

Caregivers/parent involvement: Adolescents are typically dependent on their caregivers/parents for guidance in numerous ways. This is also true as the young person navigates through the process of deciding about treatment options. Statement 6.11 addresses the importance of involving caregivers/parents and discusses the role they play in the assessment and treatment. No set of guidelines can account for every set of individual circumstances on a global scale.

Statement 6.1

We recommend health care professionals working with gender diverse adolescents:

a. **Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.**
b. **Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.**
c. **Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.**
d. **Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.**
e. **Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.**

When assessing and supporting TGD adolescents and their families, care providers/health care professionals (HCPs) need both general as well as gender-specific knowledge and training. Providers who are trained to work with adolescents and families play an important role in navigating aspects of adolescent development and family dynamics when caring for youth and families (Adelson et al., 2012; American Psychological Association, 2015; Hembree et al., 2017). Other chapters in these standards of care describe these criteria for professionals who provide gender care in more detail (see Chapter 5—Assessment for Adults; Chapter 7—Children; or Chapter 13—Surgery and Postoperative Care). Professionals working with adolescents should understand what is and is not known regarding adolescent gender identity development, and how this knowledge base differs from what applies to

adults and re ubertal children. Among HCPs, the mental health rofessional (MHP) has the most appropriate training and dedicated clinical time to conduct an assessment and elucidate treatment priorities and goals when working with transgender youth, including those seeking gender-affirming medical/surgical care. Understanding and managing the dynamics of family members who may share differing perspectives regarding the history and needs of the young person is an important competency that MHPs are often most prepared to address.

When access to professionals trained in child and adolescent development is not possible, HCPs should make a commitment to obtain training in the areas of family dynamics and adolescent development, including gender identity development. Similarly, considering autistic/neurodivergent transgender youth represent a substantial minority subpopulation of youth served in gender clinics globally, it is important HCPs seek additional training in the field of autism and understand the unique elements of care autistic gender diverse youth may require (Strang, Meagher et al., 2018). If these qualifications are not possible, then consultation and collaboration with a provider who specializes in autism and neurodiversity is advised.

Statement 6.2

We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so 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 et al., 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 over 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 (Arnoldussen et al., 2020; 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 a person's experience of themselves as a particular gender (Steensma, Kreukels et al., 2013), and for many others a process may begin well after pubertal changes are completed. 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, HCPs working with adolescents should promote supportive environments that simultaneously respect an adolescent's affirmed gender identity and also allows the adolescent to openly explore gender needs, including social, medical, and physical gender-affirming interventions should they change or evolve over time.

Statement 6.3

We recommend health care professionals work- in_ with _ender diverse adolescents undertake a comprehensive biops_chosocial assessment of adolescents who _resent with _ender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.

Given the many ways identity may unfold during adolescence, we recommend using a comprehensive biopsychosocial assessment to guide treatment decisions and optimize outcomes. This assessment should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care. As mentioned in Statement 6.1, MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here. The assessment process should be approached collaboratively with the adolescent and their caregiver(s), both separately and together, as described in more detail in Statement 6.11. An assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones,

Page: 52

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 7:35:06 AM -04'00'

[redacted] a good way to recognize the role of the MHP without endorsing a gatekeeper approach - I think these recommendations 6.1-6.8 are very much in line with AAP messaging/PS, etc.

GREAT

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:07:20 AM -04'00'

[redacted] 6.3 'comprehensive biopsychosocial assessment' seems like it does not mean it has to be a mental health assessment—they note mhp have the most availability, but this is a departure from previous.

THANKS, WE CANT MODIFY STATEMENTS, WE ARE HAPPY WITH THIS ONE

surgeries). See medically necessary statement in Chapter 2—Global Applicability, Statement 2.1; see also Chapter 12—Hormone Therapy and Chapter 13—Surgery and Postoperative Care.

Youth may experience many different gender identity trajectories. Sociocultural definitions and experiences of gender continue to evolve over time, and youth are increasingly presenting with a range of identities and ways of describing their experiences and gender-related needs (Twist & de Graaf, 2019). For example, some youth will realize they are transgender or more broadly gender diverse and pursue steps to present accordingly. For some youth, obtaining gender-affirming medical treatment is important while for others these steps may not be necessary. For example, a process of exploration over time might not result in the young person self-affirming or embodying a different gender in relation to their assigned sex at birth and would not involve the use of medical interventions (Arnoldussen et al., 2019).

The most robust longitudinal evidence supporting the benefits of gender-affirming medical and surgical treatments in adolescence was obtained in a clinical setting that incorporated a detailed comprehensive diagnostic assessment process over time into its delivery of care protocol (de Vries & Cohen-Kettenis, 2012; de Vries et al., 2014). Given this research and the on oin evolution of ender diverse ex eriences in societ , a com rehensive dia nostic bio s chosocial assessment durin ado-lescence is both evidence-based and preserves the integrity of the decision-making process. In the absence of a full diagnostic profile, other mental health entities that need to be prioritized and treated may not be detected. There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) 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 at that time.

As delivery of health care and access to specialists varies globally, designing a particular assessment process to adapt existing resources is often necessary. In some cases, a more extended assessment process may be useful, such as for youth with more complex presentations (e.g., complicating mental health histories (Leibowitz & de Vries, 2016)), co-occurring autism spectrum characteristics (Strang, Powers et al., 2018), and/or an absence of experienced childhood gender incongruence (Ristori & Steensma, 2016). Given the unique cultural, financial, and geographical factors that exist for specific populations, providers should design assessment models that are flexible and allow for appropriately timed care for as many young people as possible, so long as the assessment effectively obtains information about the adolescent's strengths, vulnerabilities, diagnostic profile, and individual needs. Psychometrically validated psychosocial and gender measures can also be used to provide additional information.

The multidisci linar assessment for outh seekin gender-affirming medical/surgical interventions includes the following domains that correspond to the relevant statements:

- **Gender Identity Development:** Statements 6.12.a and 6.12.b elaborate on the factors associated with gender identity development within the specific cultural context when assessing TGD adolescents.
- **Social Development and Support; Intersectionality:** Statements 6.4 and 6.11 elaborate on the importance of assessing gender minority stress, family dynamics, and other aspects contributing to social development and intersectionality.
- **Diagnostic Assessment of Possible Co-Occurring Mental Health and/or Developmental Concerns:** Statement 6.12.d elaborates on the importance of understanding the relationship that exists, if at all, between any co-occurring mental health or developmental concerns and the young person's gender identity/gender diverse expression.
- **Capacity for Decision-Making:** Statement 6.12.c elaborates on the assessment of a young person's emotional maturity and the relevance when an adolescent is considering gender affirming-medical/surgical treatments.

Statement 6.4

We recommend health care professionals work with families, schools, and other relevant

Page: 53

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:31:54 AM -04'00'

[redacted] here with previous language stating SOC 8 would not use terminology such as "gender-affirming care".

SORRY, NOT SURE WHAT THIS MEANS

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:32:08 AM -04'00'

[redacted] This is a very important statement

GREAT

settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.

Multiple studies and related expert consensus support the implementation of approaches that promote acceptance and affirmation of gender diverse youth across all settings, including families, schools, health care facilities, 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 we recommend be enacted across the various relationships and settings in which a young person exists and functions. It is important for the family members and community members involved in the adolescent's life to work collaboratively in these efforts unless their involvement is considered harmful to the adolescent. Examples proposed by Pariseau et al. (2019) and others of acceptance and affirmation of gender diversity and contemplation and expression of identit that can be im lemented by family, staff, and organizations 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;
6. Education about gender diversity issues for people in the young person's life (e.g., family members, health care providers, social support networks), as needed, including information about how to advocate for gender diverse youth in community, school, health care, 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. Antibullying policies that are enforced;
10. Inclusion of nonbinary experiences in daily life, reading materials, and curricula (e.g., books, health, and sex education classes, assigned essay topics that move beyond the binary, LGBTQ, and ally groups);
11. Gender inclusive facilities that the youth can readily access without segregation from nongender diverse peers (e.g., bathrooms, locker rooms).

We recommend HCPs work with arents, schools, and other or anizations/ rou s to romote acceptance and affirmation of TGD identities and expressions, whether social or medical interventions are im lemented or not as acce tance and affirmation are associated with fewer negative mental health and behavioral s m toms and more ositive mental health and behavioral functionin (Da et al., 2015; de Vries et al., 2016; Gre tak 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 et al. (2018) found mental health 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 using the name and pronoun the youth does not identify with, not acknowledging affirmed gender identity, bullying, harassment, verbal and physical abuse, poor relationships, rejection for being TGD, eviction) was strongly linked to negative outcomes, such as anxiety, depression, suicidal ideation, suicide attempts, and substance use (Grossman et al., 2005; Klein & Golub; 2016; Pariseau et al., 2019; Peng et al., 2019; Reisner, Greytak et al., 2015; Roberts et al., 2013). It is important to be aware that negative symptoms increase with increased levels of rejection and continue into adulthood (Roberts et al., 2013).

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

Page: 54

Number: 1 Author [redacted] Subject: Highlight Date: 9/7/2022 10:33:13 AM -04'00'

[redacted] ose to what the AAP message is, but it is interesting to say this after everything earlier about social cognition and giving it space.

GREAT

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:33:20 AM -04'00'

[redacted] This list is really great

THANKS

for the child about rejecting behavior from school staff or peers, not engaging or participating in other support mechanisms (e.g., with psychotherapists and support groups) have also been found to have negative consequences, such as increased de ressive s m toms (Pariseau et al., 2019). [1] or these reasons, it is im ortant not to i nore a outh's ender uestionin or dela consideration of the youth's gender-related care needs. There is particular value in professionals recognizing youth need individualized approaches, support, and consideration of needs around gender expression, identity, and embodiment 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, Lindley et al., 2019). It is important professionals collaborate with parents and others as they process their concerns and feelings and educate themselves about gender diversity because such processes may not necessarily reflect rejection or neutrality but may rather represent efforts to develop attitudes and gather information that foster acceptance (e.g., Katz-Wise et al., 2017).

Statement 6.5

We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.

Some health care providers, secular or religious organizations, and rejecting families may undertake efforts to thwart an adolescent's expression of gender diversity or assertion of a gender identity other than the expression and behavior that conforms to the sex assigned at birth. Such efforts at blocking reversible social expression or transition may include choosing not to use the youth's identified name and pronouns or restricting self-expression in clothing and hairstyles (Craig et al., 2017; Green et al., 2020). 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 or expectations based on 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 to be ineffective and are associated with increases in mental illness and poorer psychological functioning (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020).

[2] uch of the research evaluating "conversion thera " and "re arative therapy" has investigated the im act of efforts to chan e ender ex ression (masculinit or femininit) and has conflated sexual orientation with ender identit (APA, 2009; Burnes et al., 2016; Craig et al., 2017). Some of these efforts have tar eted both ender identit and ex ression (AACAP, 2018). Conversion/re arative thera has been linked to increased anxiet , de ression, suicidal ideation, suicide attem ts, and health care avoidance (Crai et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020). Although some of these studies have been criticized for their methodologies and conclusions (e. ., D'An elo et al., 2020), this should not detract from the im ortance of em hasizin efforts undertaken a riori to chan e a erson's identit are clinicall and ethicall unsound. We recommend a ainst an t e of conversion or attem ts to chan e a erson's ender identit because 1) both secular and religion-based efforts to chan e ender identit /ex ression have been associated with ne ative s cholo ical functionin that endures into adulthood (Turban, Beckwith et al., 2020); and 2) larger ethical reasons exist that should underscore respect for gender diverse identities.

It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression (AACAP, 2018; see Statement 6.2). To ensure these explorations are therapeutic, we

Page: 55

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:33:53 AM -04'00'

[redacted] ally saying that "watchful waiting" is harmful without actually labeling it.

THANKS, WE DONT AGREE WITH YOUR VIEW AND WE WOULD LIKE TO KEEP IT

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:34:15 AM -04'00'

This is one of the better discussions I have seen about conversion therapy with openness about the limitation but honesty around the ethical considerations.

THANKS

recommend employing affirmative consideration and supportive tone in discussing what steps have been tried, considered, and planned for a youth's gender expression. These discussion topics may include what felt helpful or affirming, what felt unhelpful or distressing and why. We recommend employing affirmative responses to these steps and discussions, such as those identified in SOC-8 Statement 6.4.

Statement 6.6

We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including review of the benefits and risks.

TGD youth may experience distress related to chest and genital anatomy. Practices such as chest binding, chest padding, genital tucking, and genital packing are reversible, nonmedical interventions that may help alleviate this distress (Callen-Lorde, 2020a, 2020b; Deutsch, 2016a; Olson-Kennedy, Rosenthal et al., 2018; Transcare BC, 2020). It is important to assess the degree of distress related to physical development or anatomy, educate youth about potential nonmedical interventions to address this distress, and discuss the safe use of these interventions.

Chest binding involves compression of the breast tissue to create a flatter appearance of the chest. Studies suggest that up to 87% of trans masculine patients report a history of binding (Jones, 2015; Peitzmeier, 2017). Binding methods may include the use of commercial binders, sports bras, layering of shirts, layering of sports bras, or the use of elastics or other bandages (Peitzmeier, 2017). Currently, most youth report learning about binding practices from online communities composed of peers (Julian, 2019). Providers can play an important role in ensuring youth receive accurate and reliable information about the potential benefits and risks of chest binding. Additionally, providers can counsel patients about 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 and have been associated with chest binding in adults (Peitzmeier, 2017). If binding is employed, youth should be advised to use only those methods 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 restrict blood flow, damage skin, and restrict breathing. If youth report negative health impacts from chest binding, these should ideally be addressed by a gender-affirming medical provider with experience working with TGD youth. Many youth who bind may require chest masculinization surgery in the future (Olson-Kennedy, Warus et al., 2018).

Genital tucking is the practice of positioning the penis and testes to reduce the outward appearance of a genital bulge. 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 can be made or purchased. Limited studies are available on the specific risks and benefits of tucking in adults, and none have been carried out in youth. Previous studies have reported tight undergarments are associated with decreased sperm concentration and motility. In addition, elevated scrotal temperatures can be associated with poor sperm characteristics, and genital tucking could theoretically affect spermatogenesis and fertility (Marsh, 2019) although there are no definitive studies evaluating these adverse outcomes. Further research is needed to determine the specific benefits and risks of tucking in youth.

Statement 6.7

We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have

Page: 56

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:38:27 AM -04'00'

[redacted] re to suggest providers can challenge adolescents without pushing them away from genuine gender expression is well though out, but the wording choices make it read as though a provider could use conversion therapy if done in a supportive tone.

WE HOPE NOT, THERE IS A LOT OF INFORMATION ABOUT AGAINTS CONVERSION THERAPY

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:55:46 AM -04'00'

[redacted] Statement 6.6. I'm worried that the way this statement is phrased will also draw some criticism and inflammatory comments. In the past some groups had criticized handouts about tucking from another children's gender clinic, and the way this statement recommends discussing it with all youth may get picked on. I definitely agree with the rec, I just worry about how it will get twisted.

THANKS, WE HAD TO MODIFY THIS STATEMENT FOLLOWING THE PUBLIC COMMENTS, WE FELT THAT THIS IS THE BEST WE COULD DO AND WAS APPROVED VIA DELPHI

Number: 3 Author [redacted] Subject: Highlight Date: 9/6/2022 8:44:22 AM -04'00'

[redacted] This working is odd - It draws a connection between binding and surgery, which could be twisted to say that that allowing binding encourages surgery and not allowing it prevents interest in surgery... which is not want the Olson study is saying.

THANKS FOR THIS POINT, WE FEEL IT REFLECTS WHAT THE MESSAGE THAT THE MEMBERS WANTED TO PROVIDE AND WE WOULD LIKE TO KEEP IT AS IT IS

not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.

When discussing the available options of menstrual-suppressing medications with gender diverse youth, 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 in a sensitive, gender-affirmative manner (Bonnington et al., 2020; Krempasky et al., 2020). There is no formal research evaluating how menstrual suppression may impact gender incongruence and/or dysphoria. However, the use of menstrual suppression can be an initial intervention that allows for further exploration of gender-related goals of care, prioritization of other mental health care, or both, especially for those who experience a worsening of gender dysphoria from unwanted uterine bleeding (see Statement 6.12d; Mehringer & Dowshen, 2019). When testosterone is not used, menstrual suppression can be achieved via a progestin. To exclude any underlying menstrual disorders, it is important to obtain a detailed menstrual history and evaluation prior to implementing menstrual-suppressing therapy (Carswell & Roberts, 2017). As part of the discussion about menstrual-suppressing medications, the need for contraception and information regarding the effectiveness of menstrual-suppressing medications as methods of contraception also need to be addressed (Bonnington et al., 2020). A variety of menstrual suppression options, such as combined estrogen-progestin medications, oral progestins, depot and subdermal progestin, and intrauterine devices (IUDs), should be offered to allow for individualized treatment plans while properly considering availability, cost and insurance coverage, as well as contraindications and side effects (Kanj et al., 2019).

Progestin-only hormonal medication are options, especially in trans masculine or nonbinary youth who are not interested in estrogen-containing medical therapies as well as those at risk for thromboembolic events or who have other contraindications to estrogen therapy (Carswell & Roberts, 2017). Progestin-only hormonal medications include oral progestins, depo-medroxyprogesterone injection, etonogestrel implant, and levonorgestrel IUD (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 (Pradhan & Gomez-Lobo, 2019). A more detailed description of the relevant clinical studies is presented in Chapter 12—Hormone Therapy. HCPs should not make assumptions regarding the individual's preferred method of administration as some trans masculine youth may prefer vaginal rings or IUD implants (Akgul et al., 2019). Although hormonal medications require monitoring for potential mood lability, depressive effects, or both, the benefits and risks of untreated menstrual suppression in the setting of gender dysphoria should be evaluated on an individual basis. Some patients may opt for combined oral contraception that includes 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 and can be delivered as transdermal or vaginal rings.

The use of gonadotropin releasing hormone (GnRH) analogues may also result in menstrual suppression. However, it is recommended gender diverse youth meet the eligibility criteria (as outlined in Statement 6.12) before this medication is considered 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 while awaiting menstrual suppression with testosterone therapy. When exogenous testosterone is employed as a gender-affirming hormone, menstrual suppression is typically achieved in the first six months of therapy (Ahmad & Leinung, 2017). However, it is vital adolescents be counseled ovulation and pregnancy can still occur in the setting of amenorrhea (Gomez et al., 2020; Kanj et al., 2019).

Statement 6.8

We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.

HCPs with expertise in child and adolescent development, as described in Statement 6.1, play an important role in the continuity of care for young people over the course of their gender-related treatment needs. Supporting adolescents and their families necessitates approaching care using a developmental lens through which understanding a young person's evolving emotional maturity and care needs can take lace over time. As ender-affirmin treatment athwa s differ based on the needs and ex eriences of individual TGD adolescents, decision-making for these treatments (ubert su ression, estro- ens/andro ens, ender-affirmation sur eries) can occur at different points in time within a span of several years. Longitudinal research demonstrating the benefits of pubertal suppression and gender-affirming hormone treatment (GAHT) was carried out in a setting where an ongoing clinical relationship between the adolescents/families and the multidisciplinary team was maintained (de Vries et al., 2014).

Clinical settings that offer longer appointment times provide space for adolescents and caregivers to share important psychosocial aspects of emotional well-being (e.g., family dynamics, school, romantic, and sexual experiences) that contextualize individualized gender-affirming treatment needs and decisions as described elsewhere in the chapter. An ongoing clinical relationship can take place across settings, whether that be within a multidisciplinary team or with providers in different locations who collaborate with one another. Given the wide variability in the ability to obtain access to specialized gender care centers, particularly for marginalized groups who experience disparities with access, it is important for the HCP to appreciate the existence of any barriers to care while maintaining flexibility when defining how an ongoing clinical relationship can take place in that specific context.

An ongoing clinical relationship that increases resilience in the youth and provides support to parents/caregivers who may have their own treatment needs may ultimately lead to increased parental acceptance—when needed—which is associated with better mental health outcomes in youth (Ryan, Huebner et al., 2009).

Statement 6.9

We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

TGD adolescents with gender dysphoria/gender incongruence who seek gender-affirming medical and surgical treatments benefit from the involvement of health care professionals (HCPs) from different disciplines. Providing care to TGD adolescents includes addressing 1) diagnostic considerations (see Statements 6.3, 6.12a, and 6.12b) conducted by a specialized gender HCP (as defined in Statement 6.1) whenever possible and necessary; and 2) treatment considerations when prescribing, managing, and monitoring medications for gender-affirming medical and 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.

The evolvin evidence has shown a clinical benefit for trans ender outh who receive their ender-affirmin treatments in multidisci linar gender clinics (de Vries et al., 2014; Kuper et al., 2020; Tollit et al., 2019). Finally, adolescents seekin ender-affirmin care in multidisci linar clinics are resentin with si nificant complexit necessitatin close collaboration between mental health, medical, and/or sur ical rofessionals (McCallion et al., 2021; Sorbara et al., 2020; Tishelman et al., 2015).

Page: 58

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:44:50 AM -04'00'

[redacted]ecommendation is all about forming an individual approach, but again later wording in the surgical section is concerning in the way it sees the "individualized approach" as an exception not the rule.

WE HAVE REMOVED AGES, SO HOPEFULLY THE CHAPTER WILL READ MORE LIKE AN INDIVIDUAL APPROACH

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:39:19 AM -04'00'

[redacted]There is a big push for making gender care part of routine primary care as opposed to requiring it in large multidisciplinary centers... it is a bit controversial in children and teens because of barriers to care, need for mental health support, complexity, etc., etc.

THANKS. WE DONT AGREE WITH YOUR POINT, WE FEEL THAT THIS EXPLAINS THE NEED TO HAVE CARE AS PART OF AN MDT

As not all patients and families are in the position or in a location to access multidisciplinary care, 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, disciplines, or both, it is recommended efforts be made to include the relevant providers when developing a gender care team. However, this does not mean all disciplines are necessary to provide care to a particular youth and famil .

1 written documentation or a letter is required to recommend ender-affirmin medical and sur- ical treatment (GAMST) for an adolescent, onl one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical HCPs and MHPs (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). Further assessment results and written opinions may be requested when there is a specific clinical need or when team members are in different locations or choose to write their own summaries. For further information see Chapter 5—Assessment for Adults, Statement 5.5.

Statement 6.10

3 **We recommend health care _rofessionals workin_ with trans_ender and _ender diverse adolescents re_uestin_ _ender-affirmin_ medical or sur_ical treatments inform them, prior to the initiation of treatment, of the re_roductive effects, includin_ the _otential loss of fertilit_ and available o_tions to _reserve fertilit_ within the context of the youth's stage of pubertal development.**

While assessing adolescents seeking gender-affirming medical or surgical treatments, HCPs should discuss the specific ways in which the required treatment may affect reproductive capacity. Fertility issues and the specific preservation options are more thoroughly discussed in Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

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

HCPs should specifically pay attention to the developmental and psychological aspects of fertility preservation and decision-making competency for the individual adolescent. While adolescents may think they have made up their minds concerning their reproductive capacity, the possibility their opinions about having biologically related children in the future might change over time needs to be discussed with an HCP who has sufficient experience, is knowledgeable about adolescent development, and has experience workin with arents.

2 ddressin the lon -term conse uences on fertilit of ender-affirmin medical treatments and ensurin trans ender adolescents have realistic ex ectations concernin fertilit reservation o tions or ado tion cannot not be addressed with a one-time discussion but should be art of an on oin conversation. This conversation should occur not onl before initiatin an medical intervention (ubert su ression, hormones, or sur eries), but also during further treatment and during transition.

Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have. Research in childhood cancer survivors found participants who acknowledged missed opportunities for fertility preservation reported distress and regret surrounding potential infertility (Armuand et al., 2014; Ellis et al., 2016; Lehmann et al., 2017). Furthermore, 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 HCPs may experience discussing fertility with the adolescent and the family (Tishelman et al., 2019), a fertility consultation is an important

Page: 59

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:40:32 AM -04'00'

[redacted] ts who are undergoing life altering surgery, only 1 letter from a member of the care team seems like a low standard to put in place.

THIS IS ONE LETTER THAT REFLECT THE ASSESSMENT OF THE MDT HENCE THERE ARE MANY PEOPLE INVOLVED IN THIS LETTER.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:14 PM -04'00'

[redacted] It strikes me that there is much more understanding of shifting decisions when it comes to fertility than when it comes to a person's gender. I always say that gender cannot be addressed with a one-time discussion but should be a longitutidinal conversation and if things change, we support you in that... which is not the persist/desist concern that used to frame this earlier in the chapter.

WE FEEL THAT EARLY CNVERSATIONS ABOUT FERTILITY ARE IMPORTANT

Number: 3 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:25 PM -04'00'

[redacted] 6.10 fertility—this statement makes it sound like all interventions can cause infertility, doesn't distinguish between blockers and cross sex hormones, and makes it sounds like most adolescents will change their mind, its very misleading. The last sentence is also really odd "...unless its not available through insurance." Maybe it should read "insurance should cover access to fertility care"

STATEMENTS CANT BE MDIFIED AS VOTED VIA DELPHI

consideration for ever trans ender adolescent who ursues medical-affirmin treatments unless the local situation is such that a fertility consultation is not covered b insurance or ublic health care lans, is not available locall , or the individual circumstances make this unpreferable.

tatement 6.11

We recommend when ender-affirmin medical or surgical treatments are indicated for adolescents, health care rofessionals workin with trans ender and ender diverse adolescents involve arent(s)/uardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

When there is an indication an adolescent might benefit from a gender-affirming medical or surgical treatment, involving the parent(s) or primary caregiver(s) in the assessment process is recommended in almost all situations (Edwards-Leeper & Spack, 2012; Rafferty et al., 2018). Exceptions to this might include situations in which an adolescent is in foster care, child protective services, or both, and custody and parent involvement would be impossible, inappropriate, or harmful. Parent and family support of TGD youth is a primary predictor of youth well-being and is protective of the mental health of TGD youth (Gower, Rider, Coleman et al., 2018; Grossman et al., 2019; Lefevor et al., 2019; McConnell et al., 2015; Pariseau et al., 2019; Ryan, 2009; Ryan et al., 2010; Simons et al., 2013; Wilson et al., 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, such as the young person's gender and overall developmental, medical, and mental health history as well as insights into the young person's level of current support, general functioning, and well-being. Concordance or divergence of reports given by the adolescent and their parent(s)/caregiver(s) may be important information for the assessment team and can aid in designing and shaping individualized youth and family supports (De Los Reyes et al., 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 about 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 et al., 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, a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept. Contextualization of the 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. Importantly, gender histories may be unknown to parent(s)/caregiver(s) because gender may be internal experience for youth, not known by others unless it is discussed. For this reason, an adolescent's report of their gender history and experience is central to the assessment process.

Some parents may present with unsupportive or antagonistic beliefs about TGD identities, clinical gender care, or both (Clark et al., 2020). Such unsupportive perspectives are an important therapeutic target for families. Although challenging parent perspectives may in some cases seem rigid, providers should not assume this is the case. There are many examples of parent(s)/caregiver(s) who,

Page: 60

Number: 1 Author: [redacted] Subject: Highlight Date: 9/8/2022 1:42:56 PM -04'00'

[redacted]r point, but from the human rights perspective alluded to earlier in this chapter, reproductive justice would suggest that all people, including TGD youth have a right to fertility and reproductive care regardless of ability to pay.

THANKS, WE WILL LIKE TO KEEP IT AS IT IS

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:09:18 AM -04'00'

[redacted] This section ignores kids who are in foster care or those who don't have parents but have other guardians who can help guide decisions. It also ignores the role of lawyer/judge/advocate in those circumstances.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:08:30 AM -04'00'

[redacted]ry much in line with the AAP

[redacted]xample a parent/caregiver report may provide critical context in situations in which a young person experiences a very recent or sudden self-awareness…concern for excessive peer and social media influence". This makes it sound like parents are important when we're worried about ROGD—and gives too much credence to the idea that youth are being excessively influenced by peers and online and need parents there to explain that their gender is not 'real.'

THANKS

over time with support and psychoeducation, have become increasingly accepting of their TGD child's gender diversity and care needs.

Helping youth and parent(s)/caregiver(s) 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 the necessary support and care (Dubin et al., 2020).

Statement 6.12

We recommend health care professionals assessin_ trans_ender and _ender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:

Statement 6.12.a

The adolescent meets the diagnostic criteria of _ender incon_ruence as _er the ICD-11 in situations where a dia_nosis is necessar_ to access health care. In countries that have not implemented the latest ICD, other taxonomies ma_ be used althou_h efforts should be undertaken to utilize the latest ICD as soon as practicable.

When working with TGD adolescents, HCPs should realize while a classification may give access to care, pathologizing transgender identities may be experienced as stigmatizing (Beek et al., 2016). Assessments related to gender health and gender diversity have been criticized, and controversies exist around diagnostic systems (Drescher, 2016).

HCPs should assess the overall gender-related history and gender care-related needs of youth. Through this assessment process, HCPs may provide a diagnosis when it is required to get access to transgender-related care.

Gender incongruence and gender dysphoria are the two diagnostic terms used in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), respectively. 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, reflect a long history of reconceptualizing and de-psychopathologizing gender-related diagnoses (American Psychiatric Association, 2013; World Health Organization, 2019a). Compared with 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 the sex assigned at birth. In the most recent revision, the DSM-5-TR, no changes in the diagnostic criteria for gender dysphoria are made. However, terminology was adapted into the most appropriate current language (e.g., birth-assigned gender instead of natal-gender and gender-affirming treatment instead of gender reassignment (American Psychiatric Association, 2022). Compared with the ICD 10th edition, the gender incongruence classification was moved from the Mental Health chapter to the Conditions Related to Sexual Health chapter in the ICD-11. When compared with the DSM-5 classification of gender dysphoria, one important reconceptualization is distress is not a required indicator of the ICD-11 classification of gender incongruence (WHO, 2019a). 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 classification of gender incongruence may better capture the fullness of gender diversity experiences and related clinical gender needs.

Criteria for 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 need to "transition" 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 enable the individual's body to align as much as required, 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 noted "that gender variant behaviour and

Page: 61

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:51:54 AM -04'00'

[redacted]2: I was hoping that they would discuss the recommendations for starting GnRHa separately from hormones or surgery, since GnRHa are reversible, but they don't really talk about this here.

They bring up fertility several times in this chapter, which is obviously important to discuss, but it seems a bit disjointed and odd that it is written in several different places like this.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:51:50 AM -04'00'

[redacted]ender incongruence (ICD11/WHO) instead of gender dysphoria (DSM-5)

STATEMENTS CANT BE MODIFIED, THE WHOLE DOCUMENT IS ICD-11

preferences alone are not a basis for assigning the classification" (WHO, ICD-11, 2019a).

Criteria for the DSM-5 and DSM-5-TR classification of 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; DSM-5, APA, 2013; DSM 5-TR, APA, 2022).

Of note, althou h a ender-related classification is one of the re uirements for receivin medical ender-affirmin care, such a classification alone does not indicate a person needs medical-affirmin care. The ran e of outh ex eriences of ender incon ruence necessitates rofessionals rovide a ran e of treatments or interventions based on the individual's needs. Counselin , ender ex loration, mental health assessment and, when needed, treatment with MHPs trained in ender develo ment ma all be indicated with or without the implementation of medical-affirming care.

Statement 6.12.b

The ex erience of gender diversit /incongruence is marked and sustained over time.

Identity exploration and consolidation are experienced by many adolescents (Klimstra et al., 2010; Topolewska-Siedzik & Cieciuch, 2018). Identity exploration during adolescence may include a process of self-discovery around gender and gender identity (Steensma, Kreukels et al., 2013). Little is known about how processes that underlie consolidation of gender identity during adolescence (e.g., the process of commitment to specific identities) may impact a young person's experience(s) or needs over time.

Therefore, the level of reversibility of a gender-affirming medical intervention should be considered along with the sustained duration of a young person's experience of gender incongruence when initiating treatment. Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries. Puberty suppression treatment, which provides more time for younger adolescents to engage their decision-making capacities, also raises important considerations (see Statement 6.12f and Chapter 12—Hormone Therapy) suggesting the importance of a sustained experience of gender incon- ruence/diversit rior to initiation. However, in this age rou of oun er adolescents, several ears is not alwa s ractical nor necessar iven the remise of the treatment as a means to bu time while avoiding distress from irreversible pubertal changes. For youth who have experienced a shorter duration of gender incongruence, social transition-related and/or other medical supports (e.g., menstrual suppression/androgen blocking) may also provide some relief as well as furnishing additional information to the clinical team regarding a young person's broad gender care needs (see Statements 6.4, 6.6, and 6.7).

Establishin evidence of ersistent ender diversit /incon ruence t icall re uires careful assessment with the young person over time (see Statement 6.3). Whenever possible and when appropriate, the assessment and discernment process should also include the parent(s)/caregiver(s) (see Statement 6.11). Evidence demonstrating gender diversity/incongruence sustained over time can be provided via history obtained directly from the adolescent and parents/caregivers when this information is not documented in the medical records.

The research literature on continuity versus discontinuit of ender-affirmin medical care needs/re uests is com lex and somewhat difficult to interpret. A series of studies conducted over the last several decades, includin some with methodolo ical challen es (as noted b Tem le Newhook et al., 2018; Winters et al., 2018) sug- est the ex erience of ender incon ruence is not consistent for all children as the ro ress into adolescence. For exam le, a subset of outh who ex erienced ender incon ruence or who sociall transitioned rior to ubert over time can show a reduction in or even full discontinuation of ender incon ruence (de Vries et al., 2010; Olson et al., 2022; Ristori & Steensma, 2016; Singh et al., 2021; Wagner et al., 2021). However, there has been less research focused on rates of continuit and discontinuit of ender incongruence and gender-related needs in

Page: 62

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:11:32 AM -04'00'

[redacted] g against watchful waiting while not explicitly labeling it.

[redacted] 6.12b very confusing conversation around blockers and the duration of gender incongruence. On one hand it says "however, in thi sage group of younger adolescents, several years is not always practical given the premise of the treatment as a means to buy time by avoiding distress from irreversible pubertal changes." But then it doesn't explicitly say hormone blockers are appropriate in this case, it says 'of youth who have experienced a shorter duration of gender incongruence, social transition and medical supports (menstrual suppression/androgen blocking) may provide some relief." It is deeply confusing because they're not clarifying the stage of puberty the kid is in when presenting, and it seems like they're saying blockers are ok in this population but not actually calling them blockers—and assuming we're only talking about kids in later puberty.

THANKS, WE HAD A LONG DEBATE ABOUT THIS IN OUR GROUP AND FELT THAT THIS WAS AN IMPORTANT SENTENCE TO HAVE

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:45:07 AM -04'00'

[redacted] This seems in line with the AAP policy statement.

GREAT

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:52:07 AM -04'00'

[redacted] t really account for those who are unable to come to care early enough for that to be documented in the medical record, or for those who may not have disclosed to their family at a young age.

WE HAVE TRIED TO COVER EVERYONE IN THIS SECTION

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 10:52:36 AM -04'00'

[redacted] I think this suggests that youth need to "prove" something when instead the focus should be on affirming the child for who they are not having to prove anything (the goal is affirmation, not that you take on a specific label or treatment, etc.)

WE WANTED TO MAKE SURE THAT THIS DID NOT MEAN THAT YOU HAVE TO PROVEGENDER DIVERSE AND AS THE ADULT STATMENT, WE ARE NOT SAYING THAT THEY NEED TO ASSESS THAT THE GENDER DIVERSE IS MARKED AND SUSTAINED BUT THAT THE GENDER DIVERSE THAT THEY EXPERIENCE (NO NEED TO ASSESS THIS) IS MARKED AND SUSTAINED. IT WAS FELT THAT THIS WAS THE BEST WAY TO PRESENT THIS AND IT WAS APPROVED FOLLWING DELPHI AFTER PUBLIC COMMENTS

Number: 5 Author: [redacted] Subject: Highlight Date: 9/8/2022 3:18:49 PM -04'00'

[redacted] Why is there such a focus on trying to predict who a child will be come and fear of regret? Again, this paradigm overgeneralizes the population of people who may stop interventions as a uniform population of angry, regretful treatment failures.

[redacted] alk about 'a subset of youth who experienced gender incongruence or who socially transitioned prior to puberty can show a reduction or full discontinuation of gender incongruence' but they cite a few papers that basically show the opposite. This statement makes it sound like it's a decent number, but the articles cited actually say its nearly zero (but I guess the 1-2 cases in those papers constitute 'a subset'). In addition ,they're clearly talking there about children, not adolescents, when the rest of this chapter is very much focused on adolescence, but they don't really make that clear.

But again, in the paragraph that follows on adolescence specifically they again refer to 'a subset' when actually its like 1-2 patients.

THANKS. THIS IS ALWAYS A DIFFICULT DEBATE, WE NEED TO SATISFY ALSO MANY OF THE PUBLIC COMMENTS REGARDING THIS AND FELT THAT THIS WAS THE EBST WE COULD DO

pubertal and 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 adolescents with gender incongruence presenting for gender care elect not to pursue gender-affirming medical care (Arnoldussen et al., 2019; de Vries, Steensma et al., 2011). Importantly, findings from studies of gender incongruent pubertal/adolescent cohorts, in which participants who have undergone comprehensive gender evaluation over time, have shown persistent gender incongruence and gender-related need and have received referrals for medical gender care, suggest 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 incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).

Statement 6.12.c

The adolescent demonstrates the emotional and co_nitive maturity re_uired to _rovide informed consent/assent for the treatment.

The process of informed consent includes communication between a patient and their 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. In most settings, assent is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses the level of understanding and intention.

A necessary step in the informed consent/assent process for considering gender-affirming medical care is a careful discussion with qualified HCPs trained to assess the emotional and cognitive maturity of adolescents. The reversible and irreversible effects of the treatment, as well as fertility preservation options (when applicable), and all potential risks and benefits of the intervention are important components of the discussion. These discussions are required when obtaining 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 the risks and benefits; 3) appreciate the nature of the decision, including the long-term consequences; and 4) communicate choice (Grootens-Wiegers et al., 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 to appear (e.g., with gender-affirming hormones), and any implications of stopping the treatment. Gender-diverse youth should fully understand the reversible, partially reversible, and 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 and Loshak, 2020)). Gender-diverse youth should also understand, 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 this care is not a fit for them (Wiepjes et al., 2018). Youth should know such shifts are sometimes connected to a change in gender needs over time, and in some cases, a shift in gender identity itself. Given this information, gender diverse youth must be able to reason thoughtfully about treatment options, considering the implications of the choices at hand. Furthermore, 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 re_uired for assent/consent ma_ not emer_e at specific ages per se (Grootens-Wiegers et al., 2017). There may be variability in these capacities related to developmental differences and mental health presentations (Shumer & Tishelman, 2015) and dependent on the opportunities a young

Page: 63

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:53:35 AM -04'00'

[redacted] section seems very reasonable.

THANKS

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 11:03:16 AM -04'00'

[redacted]

This statement contradicts the specific ages recommended later on.

AGES ARE NOW REMOVED

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 et al., 2021).

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 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 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- and 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 to engage in conversations about the treatment options and affords the young person the opportunity to practice thinking into the future and flexibly consider 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 (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, Powers et al., 2018).

For unique situations in which an adolescent minor is consenting for their own treatment without parental permission (see Statement 6.11), extra care must be taken to support the adolescent's informed decision-making. This will typically require greater levels of engagement of and collaboration between the HCPs working with the adolescent to provide the young person appropriate cognitive and emotional support to consider options, weigh benefits and potential challenges/costs, and develop a plan for any needed (and potentially ongoing) supports associated with the treatment.

Statement 6.12.d

The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed.

Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments, and neurodiversity-related factors (e.g., de Vries et al., 2016; Pariseau et al., 2019; Ryan et al., 2010; Weinhardt et al., 2017). 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 or receive medical treatment. Additionally, like cisgender youth, TGD youth may experience mental health concerns irrespective of the presence of gender dysphoria or gender incongruence. In particular, depression and self-harm may be of specific concern; many studies reveal depression scores and emotional and behavioral problems comparable to those reported in populations referred to mental health clinics (Leibowitz & de Vries, 2016). Higher rates of suicidal ideation, suicide attempts, and self-harm have also been reported (de Graaf et al., 2020). In addition, eating disorders occur more frequently than expected in non-referred populations (Khatchadourian et al., 2013; Ristori et al., 2019; Spack et al., 2012). Importantly, TGD adolescents show high rates of autism spectrum disorder/characteristics (Øien et al., 2018; van der Miesen et al., 2016; see also Statement 6.1d). Other neurodevelopmental presentations and/or mental health challenges may also be present,

Page: 64

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:14:01 AM -04'00'

[redacted] section talks about the capacity to provide informed consent/assent for partially and fully reversible interventions but really doesn't talk about blockers at all, or make any distinction between the process for starting blockers/fully reversible versus irreversible interventions.

THERE IS A DEBATE REGARDING REVERSIBILITY WHETHER IS REALLY FULL, WE DID NOT WANT TO BE PART OF THIS DEBATE, SO WE WANT TO KEEP THIS AS IT IS

(e.g., ADHD, intellectual disability, and psychotic disorders (de Vries, Doreleijers et al., 2011; Meijer et al., 2018; Parkes & Hall, 2006).

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 those of their cisgender peers (e.g., de Vries et al., 2014; van der Miesen et al., 2020). A provider's key task 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 challenge the assessment and treatment of gender-related needs of TGD adolescents in various ways:

1. First, when a TGD adolescent is experiencin acute suicidalit , self-harm, eatin disorders, or other mental health crises that threaten h sical health, safet must be rioritized. Accordin to the local context and existin uidelines, a propriate care should seek to mitigate the threat or crisis so there is sufficient time and stabilization for thou htful ender-related assessment and decision-makin . For exam le, an activel suicidal adolescent ma not be emotionall able to make an informed decision re ardin ender-affirmin medical/surgical treatment. 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 the clarity of identity development and gender-related decision-making should be prioritized and addressed.
3. Third, decision-makin re arding 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 6.11). To be able to make such an informed decision, an adolescent should be able to understand the issues, express a choice, appreciate and give careful thought regarding the wish for medical-affirming treatment (see Statement 6.12c). Neurodevelopmental differences, such as autistic features or autism spectrum disorder (see Statement 6.1d, e.g., communication differences; a preference for concrete or rigid thinking; differences in self-awareness, future thinking and planning), may challenge the assessment and decision-making process; neurodivergent youth may require extra support, structure, psychoeducation, and time built into the assessment process (Strang, Powers et al., 2018). Other mental health presentations that involve reduced communication and self-advocacy, difficulty engaging in assessment, memory and concentration difficulties, hopelessness, and 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-affirmin treatment can be made.
4. Finall , while addressin mental health concerns is im ortant durin the course of medical treatment, it does not mean all mental health challenges can or should be resolved completely. However, it is important any mental health concerns are addressed sufficiently so that gender -affirming medical treatment can be provided optimally (e.g., medication adherence, attending follow-up medical appointments, and self-care, articularly during a ostoperative course).

Page: 65

Number: 1 Author: [redacted] Subject: Highlight Date: 9/6/2022 10:14:41 AM -04'00'

[redacted] extended time mean? I worry this could be use to delay the decision indefinitely for those with neurodiversity or developmental differences, or argue that they cannot provide informed consent and so cannot receive care.

WE THINK THE EXPLANATION COVER THIS.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 11:04:57 AM -04'00'

[redacted] Important point

[redacted] tence seems to contradict the rest of the paragraph. The rest of the paragraph says that when there's an acute safety issue, it must be dealt with before informed consent conversations can happen, but the last sentence says 'safety-related interventions should not preclude starting gender-affirming care.'

THANKS . WE WOULD LIKE TO KEEP IT AS IT IS

Number: 3 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:54:40 AM -04'00'

[redacted] nt

THANKS

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:09:17 PM -04'00'

[redacted] g any mention about the role of stigma, prejudice, discrimination, and rejection as social processes that are more likely to adversely impact mental health separate from the gender identity.

THIS IS COVER IN MANY CHAPTERS

Statement 6.12.e

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

For guidelines regarding the clinical approach, the scientific background, and the rationale, see Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

Statement 6.12.f

The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.

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 nonbinary gender identity) or even attenuation of a previously affirmed gender identity (Drummond et al., 2008; Steensma et al., 2011, Steensma, Kreukels et al., 2013; Wallien & Cohen-Kettenis, 2008). The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty because the experience of physical puberty may be critical for further gender identity development for some TGD adolescents (Steensma et al., 2011). Therefore, puberty blockers should not be implemented in prepubertal gender diverse youth (Waal & Cohen-Kettenis, 2006). For some youth, GnRH agonists may be appropriate in late stages or in the post-pubertal period (e.g., Tanner stage 4 or 5), and this should be highly individualized. See Chapter 12—Hormone Therapy for a more comprehensive review of the use of GnRH agonists.

Variations in the timing of pubertal onset is due to multiple factors (e.g., sex assigned at birth, genetics, nutrition, etc.). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to post-pubertal, and adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969, 1970). For assigned females at birth, pubertal onset (e.g., gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and for birth-assigned males, the achievement of a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020). An experienced medical provider should be relied on to differentiate the onset of puberty from physical changes such as pubic hair and apocrine body odor due to sex steroids produced by the adrenal gland (e.g., adrenarche) 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 during which shared decision-making about gender-affirming medical therapies should be undertaken with their multidisciplinary team.

The importance of addressing other risks and benefits of pubertal suppression, both hypothetical and actual, cannot be overstated. Evidence supports the existence of surgical implications for transgender girls who proceed with pubertal suppression (van de Grift et al., 2020). Longitudinal data exists to demonstrate improvement in romantic and sexual satisfaction for adolescents receiving pubertal suppression, hormone treatment and surgery (Bungener et al., 2020). A study on surgical outcomes of laparoscopic intestinal vaginoplasty (performed because of limited genital tissue after the use of puberty blockers) in transgender women revealed that the majority experienced orgasm after surgery (84%), although a specific correlation between sexual pleasure outcomes and the timing of pubertal suppression initiation was not discussed in the study (Bouman, van der Sluis et al., 2016), nor does the study apply to those who would prefer a different surgical procedure. This underscores the importance of engaging in discussions with families about the future unknowns related to surgical and sexual health outcomes.

Statement 6.12.

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.

Page: 66

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:14:00 PM -04'00'

[redacted] s very confusing because the risks/benefits are conflated, there's not enough conversation about any of these post-surgical issues, the risk of bone density concerns are not accounted for and the focus is on tiny subset of post-surgical issues that are related to GAHT.

SOME OF THE EXPLANATIONS ARE COVERED IN OTHER CHAPTERS. AT THIS STAGE WE ARE UNABLE TO ADD ANY FURTHER INFORMATION ONLY DELTE SENTENCES IF THERE ARE STRONG VIEWS FROM AAP AND AGREEMENT WITH SOC8

Number: 2 Author: [redacted] Subject: Highlight Date: 9/6/2022 8:55:45 AM -04'00'

[redacted] this as a general take away, but there may be situations where GAH should be started before 14, and our guidelines suggest that puberty suppression or GAH should only be considered after Tanner 2. It is a bit more complicated because we articulate more a developmental approach, so especially for a trans male with early intervention, blockers would be considered before T because the child may reach tanner 2 at 9 or 10yo but cis boys do not have noticeable changes of puberty until around early teens, etc. However, we say that there is NO MEDICAL AFFIRMATION indicated before Tanner 2, period.

THANKS, WE CANT MODIFY DELPHI STATEMENTS AT THIS STAGE, WE HOPE THAT THE EXPLANATION COVER YOUR POINT

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:18:23 PM -04'00'

[redacted] Hypothetical risks?

AT THIS STAGE WE ARE UNABLE TO ADD ANY FURTHER INFORMATION ONLY DELTE SENTENCES IF THERE ARE STRONG VIEWS FROM AAP AND AGREEMENT WITH SOC8

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:20:19 PM -04'00'

[redacted] an odd place to bring up sexual satisfaction, particularly ability to orgasm after blockers, hormones and then surgery... not as relevant to the discussion of just blockers.

WE FELT IMPORTANT TO ADD THIS AND FELT AS A GROUP THAT THIS WAS THE RIGHT PLACE. ALSO MENTIONED IN THE SEXUAL HEALTH CHAPTER

Number: 5 Author [redacted] Subject: Highlight Date: 9/7/2022 12:21:45 PM -04'00'

[redacted] ger surgical implication, less tissue available for future surgery, rather than sexual satisfaction. And it's only a side in parenthesis.
.

WE WOULD LIKE TO KEEP IT S IT IS

Number: 6 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:22:03 PM -04'00'

[redacted] I think the explanation is a little easier than this - if there is no puberty, then there is nothing to suppress.

AT THIS STAGE WE ARE UNABLE TO ADD ANY FURTHER INFORMATION ONLY DELTE SENTENCES IF THERE ARE STRONG VIEWS FROM AAP AND AGREEMENT WITH SOC8

Number: 7 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:30:15 PM -04'00'

[redacted] hould include a stronger discussion of the risks with pubertal suppression.

AT THIS STAGE WE ARE UNABLE TO ADD ANY FURTHER INFORMATION ONLY DELTE SENTENCES IF THERE ARE STRONG VIEWS FROM AAP AND AGREEMENT WITH SOC8

Number: 8 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:36:40 PM -04'00'

[redacted] This recommendation doesn't break down the type of surgery. There's going to be a big difference between the different types of surgery and the impact of hormones. Additionally, the surgery conversation comes right after the conversation on blockers, omitting any discussion on the decision to start GAHT.

WE ARE NOT ABLE TO MODIFY STATEMENTS, AS THEY HAVE BEEN ACCEPTED VIA DELPHI

GAHT leads to anatomical, h siolo ical, and s cholo ical chan es. The onset of the anatomic effects (e. ., clitoral rowth, breast rowth, va - inal mucosal atro h) ma be in earl after the initiation of thera , and the eak effect is ex ected at 1–2 ears (T'S oen et al., 2019). To ensure sufficient time for s cholo ical ada ta- tions to the h sical chan e durin an im ortant developmental time for the adolescent, 12 months of hormone treatment is suggested. Depending upon the surgical result required, a period of hormone treatment may need to be longer (e.g., sufficient clitoral virilization prior to metoidio- plasty/phalloplasty, breast growth and skin expan- sion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).

For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of hormone therapy on the proposed surgery. In addition, for indi- viduals undergoing gonadectomy who are not taking hormones, a plan for hormone replace- ment can be developed with their prescribing professional prior to surgery.

With the aforementioned criteria fulfilled (6.12.a–6.12._), the followin_ are su__ested minimal a_es for _ender-affirmin_ medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estro ens or andro ens) unless there are si nificant, compellin reasons to take an individualized a roach when considerin the factors uni ue to the adolescent treat- ment time frame.
- 15 years and above for chest masculiniza- tion unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 16 years and above for breast augmenta- tion, acial sur er (includin rhino last , tracheal shave, and enio last) as art of ender-affirmin treatment unless there are si - nificant, com elling reasons to take an individ- ualized approach when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidio lasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treat- ment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the ado- lescent treatment time frame.

The ages outlined above provide general guid- ance for determining the age at which gender-affirmin interventions may be consid- ered. A e criteria should be considered in addi- tion to other criteria resented for ender-affirmin interventions in youth as outlined in Statements 6.12a-f. Individual needs, decision-makin ca ac- it for the s ecific treatment bein considered, and develo mental sta e (rather than a e) are most relevant when determinin the timing of treatment decisions for individuals. Age has a strong, albeit imperfect, correlation with cognitive and psychosocial development and may be a use- ful objective marker for determining the potential timing of interventions (Ferguson et al., 2021). Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility, com- plexity, or both. This approach allows for con- tinued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (see Statement 6.12c).

The recommendations above are based on available evidence, expert consensus, and ethical considerations, includin res ect for the emer in autonom of adolescents and the minimization of harm within the context of a limited evidence base. Historically, there has been hesitancy in the transgender health care setting to offer gender-affirming treatments with potential irre- versible effects to minors. The age criteria set forth in these guidelines are younger than ages stipulated in previous guidelines and are intended to facilitate youth's access to gender-affirming treatments (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender-affirming

Page: 67

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:41:50 PM -04'00'

[redacted] cedures prior to the age of consent when the person can make the decision for themselves is going to be VERY controversial. Additionally, when reviewing the 3 studies to justify vaginoplasty at 17, none of the individuals referenced in the study were under 18 (unless there is a shared data set separate from the study)

THE WHOLE PARAGRAGH WILL BE REMOVED. AGES TO BE REMOVED

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:44:20 PM -04'00'

[redacted] hs is to improve overall outcome and give the medical intervention time to work. It should not be used as a "watchful waiting" or gatekeeping strategy. The other point here is that hormones work SLOWLY so if someone does not like what they are doing, providers should create a safe environment to explore that feeling and adjust the approach if necessary towards an ultimate goal of affirming the child for who they are

WE WOULD LIKE TO KEEP THIS

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:46:53 PM -04'00'

[redacted] These recommendations appear to be categorized by ease of surgery, rather than risk of outcome.

THIS WILL BE MOVED AS THE WHOLE PARAGRAGH WILL BE RMEOVED

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:48:02 PM -04'00'

[redacted] portant, but is the exact opposite of the age qualifications for surgery. It is a direct contradiction.

AGE WILL BE REMOVED

Number: 5 Author [redacted] Subject: Highlight Date: 9/7/2022 12:49:34 PM -04'00'

[redacted] The entire chapter leads into a very conservative framework for providing this care, but then the surgery recommendations the age specific criteria without evidence to support.

THIS WILL BE MODIFED TO AGES FOR GAMST AS A DEBATE WITH NOT AGES

Number: 6 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:49:57 PM -04'00'

[redacted] really take into consideration developmental differences between pubertal initiation in AMAB and AFAB pts.

THIS WILL BE REMOVED

Number: 7 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:51:59 PM -04'00'

[redacted] The language "unless there are significant, compelling reasons to take an individualized approach..." is very concerning. The recommendations, as written, appear to be an opt out model rather than an individualized approach.

THIS WILL BE REMOVED

Number: 8 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:55:23 PM -04'00'

[redacted] esented evidence throughout the next few paragraphs to support the recommendations for younger ages to be able to have these procedures. Surgery should be presented as the exception rather than the rule. This is going to heavily influence the current climate in the US and feeds directly in the anti-transgender arguments.

TO BE REMOVED

Number: 9 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:57:13 PM -04'00'

[redacted] y for minors is going to be a big deal, tracheal shaves are very high risk

WE WILL REMOVE AGES SO THIS WILL BE REMOVED

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 6.12c).

A growing body of evidence indicates providing gender-affirming treatment for gender diverse youth who meet criteria leads to positive outcomes (Achille et al., 2020; de Vries et al., 2014; Kuper et al., 2020). There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth (Chen et al., 2020; Chew et al., 2018; Olson-Kennedy et al., 2016). Currently, the only existing longitudinal studies evaluating gender diverse youth and adult outcomes 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. [4] Lon itudinal studies are currentl underwa to better define outcomes as well as the safet and efficac of ender-affirmin treatments in outh (Olson-Kenned , Garofalo et al., 2019; Olson-Kennedy, Rosenthal 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 (de Vries et al., 2021). As the evidence base regarding outcomes of gender-affirming interventions in youth continues to grow, recommendations on the timing and readiness for these interventions may be updated.

Previous guidelines regarding gender-affirming treatment of adolescents recommended partially reversible GAHT could be initiated at approximatel 16 ears of a e (Coleman et al., 2012; [6] Hembree et al., 2009). [7] More recent uidelines suggest there ma be com ellin reasons to initiate GAHT rior to the a e of 16, althou h there are limited studies on youth who have initiated hormones rior to 14 years of age (Hembree et al., 2017). A compelling reason for earlier initiation of GAHT, for example, might be to avoid rolon ed ubertal su ression, [1] iven otential bone health concerns and the s chosocial im lications of dela in ubert as described in more detail in Chapter 12—Hormone Therapy (Klink, Caris et al., 2015; Schagen et al., 2020; Vlot et al., 2017; Zhu & Chan, 2017). [2] ubert is a time of si nificant brain and co nitive develo ment. The otential neurodevelo mental im act of extended ubertal su ression in ender diverse outh has been s ecificall 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 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 requires continued study (Klink, Caris et al., 2015; Lee, Finla son et al., 2020; Schagen et al., 2020). [3] It should also be noted the ages for initiation of GAHT recommended above are dela ed when com ared with the a es at which cis ender peers initiate ubert with endo enous hormones in most re ions (Palmert & Dunkel, 2012). The _otential ne_ative _s_chosocial im_lications of not initiatin_ _ubert_ with _eers ma_ _lace additional stress on _ender diverse outh, although this has not been explicitly studied. When considering the timing of initiation of gender-affirming hormones, providers should compare the potential physical and psychological benefits and risks of starting treatment with the potential risks and benefits of delaying treatment. This process can also help identify compelling factors that may warrant an individualized a roach.

[5] A_e recommendations for irreversible sur_ical _rocedures were determined b a review of existin literature and the ex ert consensus of mental health _roviders, medical _roviders, and sur_eons hi hl ex erienced in providing care to TGD adolescents. Studies carried out with trans masculine youth have demonstrated 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 et al., 2018; Sood et al., 2021). [8] estosterone

Page: 68

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:58:30 PM -04'00'

[redacted]lth issues seem to be discussed more in Chpt 12 and the discussion of puberty blocker risks in recommendation 6.12.f. None of the age recommendations deal with blockers. This will confuse people jumping from hormones to side effects of blockers and may be misinterpreted as hormone adverse effects just based on placement.

WE WILL REMOVE SPECFIC AGES

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 12:59:43 PM -04'00'

[redacted]ut blockers delaying cognitive development have not panned out at all in the research. While it does need to be studied more, it is still hypothetical.

WE WOULD LIKE TO LEAVE THIS AS THIS IS A REQUEST FOR FUTURE STUDIES

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 1:24:24 PM -04'00'

[redacted]Very good point to include

thanks

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:21:23 PM -04'00'

[redacted]estion why changes are being made before these longitudinal studies are available. This will be seen as seen as validating the arguments against this care.

THIS IS A CONSENT DOCUMENT PRIMARILY WHEN DATA IS NOT AVAILABLE

Number: 5 Author [redacted] Subject: Highlight Date: 9/7/2022 2:21:45 PM -04'00'

[redacted]Very limited literature for this

TO BE REMOVED

Number: 6 Author: [redacted] Subject: Highlight Date: 9/8/2022 3:20:01 PM -04'00'

[redacted]e 2017 Endocrine Society guidelines referenced here? These state:
hormones can be used prior to the age of 16 and never before Tanner 2 using an individualized approach which really leaves it open to the provider and the family to decide what is best.

THIS IS ALREADY DISCUSSED IN THE HORMONE CHAPTER, WE ARE GOING TO MOVE AWAY FROM SPECIFIC AGES

Number: 7 Author [redacted] Subject: Highlight Date: 9/7/2022 2:24:36 PM -04'00'

[redacted]After recommending GAHT at 14, the recommendations then present evidence saying that there's actually limited evidence for starting this care at age 14. I agree 14 is reasonable, but its being presented in a way that will be construed as "saying 14 is a good age to start, we just don't have evidence to support that'

Number: 8 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:25:44 PM -04'00'

[redacted]e 67 "testosterone unfortunately does little to alleviate this distress" I'm very worried this could be used out of context to go against using testosterone and that there is no accompanying citation. There's no evidence that testosterone does NOT alleviate the chest dysphoria—my experience is that it does, but still top surgery can be important for some.

WE WOULD LIKE TO KEEP THE FIRST SENTENCE, AS OUR OWN EXPERIENCE IS THAT TESTOSTERONE DOES LITTLE TO ALLEVAITE CHEST DISTRESS AND 100% OF OUR PATIENTS REQUEST CHEST RECONSTRUCTION

Unfortunately does little to alleviate this distress, althou h chest masculinization is an o tion for some individuals to address this distress lon -term. Studies with outh who sou ht chest masculinization sur er to alleviate chest d s horia demonstrated ood sur ical outcomes, satisfaction with results, and minimal re ret durin the stud monitorin eriod (Marinkovic & Newfield, 2017; Olson-Kennedy, Warus et al., 2018). Chest masculinization sur er can be considered in minors when clinicall and develo mentall a ro riate as determined by a multidisci linar team ex erienced in adolescent and ender develo ment (see relevant statements in this cha ter). The duration or current use of testosterone thera should not reclude sur er if otherwise indicated. The needs of some TGD outh ma be met by chest masculinization surgery alone. Breast augmentation may be needed by trans feminine youth, although there is less data about this procedure in youth, possibly due to fewer individuals requesting this procedure (Boskey et al., 2019; James, 2016). GAHT, specifically estrogen, can hel with develo ment of breast tissue, and it is recommended outh have a minimum of 12 months of hormone therapy, or longer as is surgically indicated, prior to breast augmentation unless hormone therapy is not clinicall indicated or is medicall contraindicated.

Data are limited on the o timal timin for initiatin other ender-affirmin sur ical treatments in adolescents. This is artl due to the limited access to these treatments, which varies in different geographical locations (Mahfouda et al., 2019). Data indicate rates of gender-affirming surgeries have increased since 2000, and there has been an increase in the number of TGD youth seeking vaginoplasty (Mahfouda et al., 2019; Milrod & Karasic, 2017). A 2017 study of 20 WPATH-affiliated sur eons in the US re orted sli htl more than half had erformed vaginoplasty in minors (Milrod & Karasic, 2017). Limited data are available on the outcomes for youth undergoing vaginoplasty. Small studies have reported improved psychosocial functioning and decreased gender dysphoria in adolescents who have under one va ino lasty (Becker et al., 2018; Cohen-Kettenis & van Goozen, 1997; Smith et al.,2001). While the sample sizes are small, these studies suggest there may be a benefit for 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 postoperative 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) (Boskey et al., 2018; 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 postsurgical care recommendations and to comprehend the long-term impacts of these procedures on reproductive and sexual function is crucial (Boskey et al., 2019). Given the complexity of phalloplasty, and current high rates of complications in comparison to other gender-affirming surgical treatments, it is not recommended this surgery be considered in youth under 18 at this time (see Chapter 13—Surgery and Postoperative Care).

Additional key factors that should be taken into consideration when discussing the timing of interventions with youth and families are addressed in detail in statements 6.12a-f. For a summary of the criteria/recommendations for medically necessary gender-affirming medical treatment in adolescents, see Appendix D.

Page: 69

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:27:08 PM -04'00'

[redacted] cifically saying surgeries are being, this instead simply states that institutions are performing surgery and then does not include any mention of outcome data.

WE WOULD LIKE TO KEEP THIS

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:28:05 PM -04'00'

[redacted] h s r ll al d... Chest masculinization in minors statement does not have a reference though so will be seen by the anti-trans movement as bias.

[redacted] ment: "duration or current use of testosterone therapy should to preclude surgery if otherwise indicated," is in direct contradiction to the statement about minimum 1 year of testosterone prior to surgery.

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:31:12 PM -04'00'

[redacted] Based on the data in these studies, its difficult to ascertain if any of the youth had surgery prior to 18 or if they youth were just referred for surgery prior to 18. The 1997 and 2001 paper discuss series of "tests" including partial and full hormone treatment, living in real life as the asserted gender, etc., that would have taken time (and no one started hormones before 16)... its unclear if these studies really show evidence of success for minors undergoing vaginoplasty as it suggests here (and if it does the number of subjects are in the single digits). The 2018 paper says that in Germany surgery can take place as young as 16 but it does not provide any data that I can see to say any of the adolescents in the study specifically had vaginoplasty.

Number: 4 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:33:40 PM -04'00'

[redacted] tates maximum breast growth is 2-5 years after initiation of Estradiol, so it is going to bring up a question of why wait 1 year when breast growth can take 2 or more years.

WE WOULD LIKE TO KEEP THIS AS THIS IS FOR ALL SURGERIES, WITH A MINIMUM OF 1 YEAR

Number: 5 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:34:17 PM -04'00'

[redacted] This will be another point for proponents of gender-affirming care.

THIS IS CORRECT

CHAPTER 7 Children

These Standards of Care pertain to prepubescent gender diverse children and are based on research, ethical principles, and accumulated expert knowledge. The principles underlying these standards include the following 1) childhood gender diversity is an expected aspect of general human development (Endocrine Society and Pediatric Endocrine Society, 2020; Telfer et al., 2018); 2) childhood gender diversity is not a pathology or mental health disorder (Endocrine Society and Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018); 3) diverse gender expressions in children cannot always be assumed to reflect a transgender identity or gender incongruence (Ehrensaft, 2016; Ehrensaft, 2018; Rael et al., 2019); 4) guidance from mental health professionals (MHPs) with expertise in gender care for children can be helpful in supporting positive adaptation as well as discernment of gender-related needs over time (APA, 2015; Ehrensaft, 2018; Telfer et al., 2018); 5) conversion therapies for gender diversity in children (i.e., any "therapeutic" attempts to compel a gender diverse child through words, actions, or both to identify with, or behave in accordance with, the gender associated with the sex assigned at birth are harmful and we repudiate their use (APA, 2021; Ashley, 2019b, Paré, 2020; SAMHSA, 2015; Telfer et al., 2018; UN Human Rights Council, 2020).

Throughout the text, the term "health care professional" (HCP) is used broadly to refer to professionals workin with ender diverse children. nlike ubescent outh and adults, re ubescent ender diverse children are not eli ible to access medical intervention (Pediatric Endocrine Society, 2020); therefore, when professional input is sought, it is most likely to be from an HCP specialized in psychosocial supports and gender development. Thus, this chapter is uniquely focused on developmentally appropriate psychosocial practices, although other HCPs, such as pediatricians and family practice HCPs may also find these standards useful as they engage in professional work with gender diverse children and their families.

This chapter employs the term "gender diverse" given that gender trajectories in prepubescent children cannot be predicted and may evolve over time (Steensma, Kreukels et al., 2013). At the same time, this chapter recognizes some children will remain stable in a gender identity they articulate early in life that is discrepant from the sex assigned at birth (Olson et al., 2022). The term, "gender diverse" includes transgender binary and nonbinary children, as well as gender diverse children who will ultimately not identify as transgender later in life. Terminology is inherently culturally bound and evolves over time. Thus, it is possible terms used here may become outdated and we will find better descriptors.

This chapter describes aspects of medical necessary care intended to promote the well-being and gender-related needs of children (see medically necessary statement in the Global Applicability chapter, Statement 2.1). This chapter advocates everyone employs these standards, to the extent possible. There may be situations or locations in which the recommended resources are not fully available. HCPs/teams lacking resources need to work toward meeting these standards. However, if unavoidable limitations preclude components of these recommendations, this should not hinder rovidin the best services currentl available. In those locations where some but not all recommended services exist, choosin not to im lement otentiall beneficial care services risks harm to a child (Murchison et al., 2016; Telfer et al., 2018; Riggs et al., 2020). Overall, it is imperative to prioritize a child's best interests.

A vast empirical psychological literature indicates early childhood experiences frequently set the stage for lifelong patterns of risk and/or resilience and contribute to a trajectory of development more or less conducive to well-being and a positive quality of life (Anda et al., 2010; Masten & Cicchetti, 2010; Shonkoff & Garner, 2012). The available research indicates, in general, gender diverse youth are at greater risk for experiencing psychological difficulties (Ristori & Steensma, 2016) than age- matched cisgender peers as a result of encountering destructive experiences, including trauma and maltreatment stemming from gender diversity-related rejection and other harsh, non-accepting interactions (Barrow & Apostle, 2018; Giovanardi et al., 2018; Gower, Rider, Brown et al., 2018; Grossman & D'Augelli, 2006; Hendricks & Testa, 2012; Reisner, Greytak

Page: 70

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:34:44 PM -04'00'

Into. In contrast to chapter 6, this chapter explicitly endorses 'gender-affirming care' for prepubescent children.

Number: 2 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:34:55 PM -04'00'

Very much in line with AAP

Number: 3 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:34:52 PM -04'00'

In line with AAP

et al., 2015; Roberts et al., 2014; Tishelman & Neumann-Mascis, 2018). Further, literature indicates prepubescent children who are well accepted in their gender diverse identities are generally well-adjusted (Malpas et al., 2018; Olson et al., 2016). Assessment and treatment of children typically emphasizes an *ecological* approach, recognizing children need to be safe and nurtured in each setting they frequent (Belsky, 1993; Bronfenbrenner, 1979; Kaufman & Tishelman, 2018; Lynch & Cicchetti, 1998; Tishelman et al., 2010; Zielinski & Bradshaw, 2006). Thus, the perspective of this chapter draws on basic psychological literature and knowledge of the unique risks to gender diverse children and emphasizes the integration of an ecological approach to understanding their needs and to facilitating positive mental health in all gender care. This perspective prioritizes fostering well-being and quality of life for a child throughout their development. Additionally, this chapter also embraces the viewpoint, supported by the substantial psychological research cited above, that psychosocial gender-affirming care (Hidalgo et al., 2013) for prepubescent children offers a window of opportunity to promote a trajectory of well-being that will sustain them over time and during the transition to adolescence. This approach potentially can mitigate some of the common mental health risks faced by transgender and gender diverse (TGD) teens, as frequently described in literature (Chen et al., 2021; Edwards-Leeper et al., 2017; Haas et al., 2011; Leibowitz & de Vries, 2016; Reisner, Bradford et al., 2015; Reisner, Greytak et al., 2015).

Developmental research has focused on understanding various aspects of gender development in the earliest years of childhood based on a general population of prepubescent children. This research has typically relied on the assumption that child research participants are cisgender (Olezeski et al., 2020) and has reported gender identity stability is established in the preschool years for the general population of children, most of whom are likely not gender diverse (Kohlberg, 1966; Steensma, Kreukels et al., 2013). Recently, developmental research has demonstrated gender diversity can be observed and identified in young prepubescent children (Fast & Olson, 2018; Olson & Gülgöz, 2018; Robles et al., 2016). Nonetheless, empirical study in this area is limited, and at this time there are no psychometrically sound assessment measures capable of reliably and/or fully ascertaining a prepubescent child's self-understanding of their own gender and/or gender-related needs and preferences (Bloom et al., 2021). Therefore, this chapter emphasizes the importance of a nuanced and individualized clinical approach to gender assessment, consistent with the recommendations from various guidelines and literature (Berg & Edwards-Leeper, 2018; de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2018; Steensma & Wensing-Kruger, 2019). Research and clinical experience have indicated gender diversity in prepubescent children may, for some, be fluid; there are no reliable means of predicting an individual child's gender evolution (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013), and the gender-related needs for a particular child may vary over the course of their childhood.

It is important to understand the meaning of the term "assessment" (sometimes used synonymously with the term "evaluation"). There are multiple contexts for assessment (Krishnamurthy et al., 2004) including rapid assessments that take place during an immediate crisis (e.g., safety assessment when a child may be suicidal) and focused assessments when a family may have a circumscribed question, often in the context of a relatively brief consultation (Berg & Edwards-Leeper, 2018). The term assessment is also often used in reference to "diagnostic assessment," which can also be called an "intake" and is for the purpose of determining whether there is an issue that is diagnosable and/or could benefit from a therapeutic process. This chapter focus on comprehensive assessments, useful for understanding a child and family's needs and goals (APA, 2015; de Vries & Cohen-Kettenis, 2012; Srinath et al., 2019; Steensma & Wensing-Kruger, 2019). This type of psychosocial assessment is not necessary for all gender diverse children, but may be requested for a number of reasons. Assessments may present a useful opportunity to start a process of support for a gender diverse child and their family, with the understanding that gender diverse children benefit when their family dynamics include

Page: 71

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This sentence here is a little confusing; it seems to say children don't know their gender as well as adults although it cannot be measured.

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Very much in line with AAP

Statements of Recommendations

7.1- We recommend health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span.
7.2- We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.
7.3- We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.
7.4- We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.
7.5- We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.
7.6- We recommend health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning, and language skills.
7.7- We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).
7.8- We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.
7.9- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.
7.10- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age-appropriate psychoeducation about gender development.
7.11- We recommend that health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.
7.12- We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.
7.13- We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.
7.14- We recommend the health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.
7.15- We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

acceptance of their gender diversity and parenting guidance when requested. Comprehensive assessments are appropriate when solicited by a family requesting a full understanding of the child's gender and mental health needs in the context of gender diversity.

In these circumstances, family member mental health issues, family dynamics, and social and cultural contexts, all of which impact a gender diverse child, should be taken into consideration (Barrow & Apostle, 2018; Brown & Mar, 2018; Cohen-Kettenis et al., 2003; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Ristori & Steensma, 2016; Tishelman & Neumann-Mascis, 2018). This is further elaborated upon in the text below.

It is important HCPs working with gender diverse children strive to understand the child and the family's various aspects of identity and experience: racial, ethnic, immigrant/refugee status, religious, geographic, and socio-economic, for example, and be respectful and sensitive to cultural context in clinical interactions (Telfer et al., 2018). Many factors may be relevant to culture and gender, including religious beliefs, gender-related expectations, and the degree to which gender diversity is accepted (Oliphant et al., 2018). Intersections between gender diversity, sociocultural diversity, and minority statuses can be sources of strength, social stress, or both (Brown & Mar, 2018; Oliphant et al., 2018; Riggs & Treharne, 2016).

Each child, family member, and family dynamic is unique and potentially encompasses multiple cultures and belief atterns. Thus, HCPs of all disci lines should avoid stereot in based on reconceived ideas that ma be incorrect or biased (e. ., that a famil who belon s to a religious organization that is o osed to a reciatin ender diversit will necessaril be unsu ortive of their child's gender diversity) (Brown & Mar, 2018). Instead, it is essential to approach each family openly and understand each family member and family pattern as distinct.

Page: 72

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Great!

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

Statement 7.1

We recommend the health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess general knowledge of gender diversity across the life span.

HCPs working with gender diverse children should acquire and maintain the necessary training and credentials relevant to the scope of their role as professionals. This includes licensure, certification, or both by appropriate national and/or regional accrediting bodies. We recognize the specifics of credentialing and regulation of professionals vary globally. Importantly, basic licensure, certification, or both may be insufficient in and of itself to ensure competency working with gender diverse children, as HCPs specifically require in-depth training and supervised experience in childhood gender development and gender diversity to provide appropriate care.

Statement 7. 2

We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.

HCPs should receive training and supervised expertise in general child and family mental health across the developmental spectrum from toddlerhood through adolescence, including evidence-based assessment and intervention approaches. Gender diversity is not a mental health disorder; however, as cited above, we know mental health can be adversely impacted for gender diverse children (e.g., through gender minority stress) (Hendricks & Testa, 2012) that may benefit from exploration and support; therefore, mental health expertise is highly recommended. Working with children is a complex endeavor, involving an understanding of a child's developmental needs at various ages, the ability to comprehend the forces impacting a child's well-being both inside and outside the family (Kaufman & Tishelman, 2018), and an ability to fully assess when a child is unhappy or experiencing significant mental health difficulties, related or unrelated to gender. Research has indicated high levels of adverse experiences and trauma in the gender diverse community of children, including susceptibility to rejection or even maltreatment (APA, 2015; Barrow & Apostle, 2018; Giovanardi et al., 2018; Reisner, Greytak et al., 2015; Roberts et al., 2012; Tishelman & Neumann-Mascis, 2018). HCPs need to be cognizant of the potential for adverse experiences and be able to initiate effective interventions to prevent harm and promote positive well-being.

Statement 7.3

We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.

The experience of gender diversity in autistic children as well as in children with other forms of neurodivergence may present extra clinical complexities (de Vries et al., 2010; Stran , Mea her et al., 2018). For example, autistic children may find it difficult to self-advocate for their ender-related needs and may communicate in hi hl individualistic wa s (Kuvalanka et al., 2018; Strang, Powers et al., 2018). The ma have varied inter retations of gender-related ex eriences given common differences in communication and thinkin st le. Because of the uni ue needs of ender diverse neurodiver ent children, the ma be at hi h risk for bein misunderstood (i.e., for their communications to be misinterpreted). Therefore, professionals providing support to these children can best serve them by receiving training and developing expertise in autism and related neurodevelopmental presentations and/or collaborating with autism specialists (Strang, Meagher et al., 2018). Such training is especially relevant as research has documented

Page: 73

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:36:54 PM -04'00'

In the adolescent chapter, ASD was seen as a complicating factor that made assessment difficult, but here it is so nicely worded that neuro-divergent kids need more help and support which is something providers can really help with.

higher rates of autism among gender diverse youth than in the general population (de Vries et al., 2010; Hisle-Gorman et al., 2019; Shumer et al., 2015).

Statement 7.4

We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.

Continuing professional development regarding gender diverse children and families may be acquired through various means, including through readings (journal articles, books, websites associated with gender knowledgeable organizations), attending on-line and in person trainings, and joining peer supervision/consultation groups (Bartholomaeus et al., 2021).

Continuing education includes 1) maintaining up-to-date knowledge of available and relevant research on gender development and gender diversity in prepubescent children and gender diversity across the life span; 2) maintaining current knowledge regarding best practices for assessment, support, and treatment approaches with gender diverse children and families. This is a relatively new area of practice and health care professionals need to adapt as new information emerges through research and other avenues (Bartholomaeus et al., 2021).

Statement 7.5

We recommend health care professionals conductin_ an assessment with _ender diverse children access and integrate information from multiple sources as part of the assessment.

A comprehensive assessment, when requested by a family and/or an HCP can be useful for developing intervention recommendations, as needed, to benefit the well-being of the child and other family members. Such an assessment can be beneficial in a variety of situations when a child and/or their family/guardians, in coordination with providers, feel some type of intervention would be helpful. Neither assessments nor interventions should ever be used as a means of covertly or overtly discouraging a child's gender diverse expressions or identity. Instead, with appropriately trained providers, assessment can be an effective means of better understanding how to support a child and their family without privileging any particular gender identity or expression. An assessment can be especially important for some children and their families by collaborating to promote a child's gender health, well-being, and self-fulfillment.

A comprehensive assessment can facilitate the formation of an individualized plan to assist a gender diverse prepubescent children and family members (de Vries & Cohen-Kettenis, 2012; Malpas et al., 2018; Steensma & Wensing-Kruger, 2019; Telfer et al., 2018; Tishelman & Kaufman, 2018). In such an assessment, integrating information from multiple sources is important to 1) best understand the child's gender needs and make recommendations; and 2) identify areas of child, family/caregiver, and community strengths and supports specific to the child's gender status and development as well as risks and concerns for the child, their family/caregivers and environment. Multiple informants for both evaluation and support/intervention planning purposes may include the child, parents/caregivers, extended family members, siblings, school personnel, HCPs, the community, broader cultural and legal contexts and other sources as indicated (Berg & Edwards-Leeper, 2018; Srinath, 2019).

An HCP conducting an assessment of gender diverse children needs to explore gender-related issues but must also take a broad view of the child and the environment, consistent with the ecological model described above (Bronfenbrenner, 1979) to fully understand the factors impacting a child's well-being and areas of gender support and risk (Berg & Edwards-Leeper, 2018; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Tishelman & Neumann-Mascis, 2018). This includes understanding the strengths and challenges experienced by the child/family and that are present in the environment. We advise HCPs conducting an assessment with gender diverse children to consider incorporating multiple assessment domains, depending on the child and the family's needs and circumstances. Although some of the latter listed domains below do not directly address the child's gender (see items 7–12 below), they need to be accounted for in a gender assessment, as indicated by clinical judgment, to understand the complex web of factors

Page: 74

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It's not clear whether this applies to the ambiguous definition of assessment recommended in the adolescent chapter.

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Very much in line with AAP

that may be affecting the child's well-being in an integrated fashion, including gender health, consistent with evaluation best practices a (APA, 2015; Berg & Edwards-Leeper, 2018; Malpas et al., 2018) and develop a multi-pronged intervention when needed.

Summarizing from relevant research and clinical expertise, assessment domains often include 1) a child's asserted gender identity and gender expression, currently and historically; 2) evidence of dysphoria, gender incongruence, or both; 3) strengths and challenges related to the child, family, peer and others' beliefs and attitudes about gender diversity, acceptance and support for child; 4) child and family experiences of gender minority stress and rejection, hostility, or both due to the child's gender diversity; 5) level of support related to gender diversity in social contexts (e.g., school, faith community, extended family); 6) evaluation of conflict regarding the child's gender and/or parental/caregiver/sibling concerning behavior related to the child's gender diversity; 7) child mental health, communication and/or cognitive strengths and challenges, neurodivergence, and/or behavioral challenges causing significant functional difficulty; 8) relevant medical and developmental history; 9) areas that may pose risks (e.g., exposure to domestic and/or community violence, any form of child maltreatment; history of trauma; safety and/or victimization with peers or in any other setting; suicidality); 10) co-occurring significant family stressors, such as chronic or terminal illness, homelessness or poverty; 11) parent/caregiver and/or sibling mental health and/or behavioral challenges causing significant functional difficulty; and 12) child's and family's strengths and challenges.

A thorough assessment incorporating multiple forms of information gathering is helpful for understanding the needs, strengths, protective factors, and risks for a specific child and family across environments (e.g., home/school). Methods of information gathering often include 1) interviews with the child, family members and others (e.g., teachers), structured and unstructured; 2) caregiver and child completed standardized measures related to gender; general child well-being; child cognitive and communication skills and developmental disorders/disabilities; support and acceptance by parent/caregiver, sibling, extended family and peers; parental stress; history of childhood adversities; and/or other issues as appropriate (APA, 2020; Berg & Edwards-Leeper, 2018; Kaufman & Tishelman, 2018; Srinath, 2019).

Depending on the family characteristics, the developmental profile of the child, or both, methods of information gathering also may also benefit from including the following 1) child and/or family observation, structured and unstructured; and 2) structured and visually supported assessment techniques (worksheets; self-portraits; family drawings, etc.) (Berg & Edwards-Leeper, 2018).

Statement 7.6

We recommend that health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning and language skills.

Given the complexities of assessing young children who, unlike adults, are in the process of development across a range of domains (cognitive, social, emotional, physiological), it is important to consider the developmental status of a child and gear assessment modalities and interactions to the individualized abilities of the child. This includes tailoring the assessment to a child's developmental stage and abilities (preschoolers, school age, early puberty prior to adolescence), including using language and assessment approaches that prioritize a child's comfort, language skills, and means of self-expression (Berg & Edwards-Leeper, 2018; Srinath, 2019). For example, relevant developmental factors, such as neurocognitive differences (e.g., autism spectrum conditions), and receptive and expressive language skills should be considered in conducting the assessment. Health care professionals may need to consult with specialists for guidance in cases in which they do not possess the specialized skills themselves (Strang et al., 2021).

Statement 7.7

We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).

Page: 75

Number: 1 Author: [redacted] Subject: Highlight Date: 9/7/2022 2:47:39 PM -04'00'

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HCPs conducting an assessment with gender diverse children and families need to account for developmental, emotional, and environmental factors that may constrain a child's, caregiver's, sibling or other's report or influence their belief systems related to gender (Riggs & Bartholomaeus, 2018). As with all child psychological assessments, environmental and family/caregiver reactions (e.g., punishment), and/or cognitive and social factors may influence a child's comfort and/or ability to directly discuss certain factors, including gender identit and related issues (Srinath, 2019). Similarl , family members ma feel constrained in freel ex ressin their concerns and ideas de endin on famil conflicts or d namics and/or other influences (e. ., cultural/ reli ious; extended family pressure) (Riggs & Bartholomaeus, 2018).

Statement 7.8

We recommend health care professionals consider consultation, _s_chothera_ _, or both for a _ender diverse child and famil_/care_ivers when families and health care _rofessionals believe this would benefit the well-being and development of a child and/or family.

The goal of psychotherapy should never be aimed at modifying a child's gender identity (APA, 2021; Ashley, 2019b; Paré, 2020; SAMHSA, 2015; UN Human Rights Council, 2020), either covertly or overtly. Not all gender diverse children or their families need input from MHPs as gender diversity is not a mental health disorder (Pediatric Endocrine Society, 2020; Telfer et al., 2018). Nevertheless, it is often appropriate and helpful to seek psychotherapy when there is distress or concerns are expressed by parents to improve psychosocial health and prevent further distress (APA, 2015). Some of the common reasons for considering psychotherapy for a gender diverse child and family include the following 1) A child is demonstrating significant conflicts, confusion, stress or distress about their gender identity or needs a protected space to explore their gender (Ehrensaft, 2018; Spivey and Edwards-Leeper, 2019); 2) A child is experiencing external pressure to express their gender in a way that conflicts with their self-knowledge, desires, and beliefs (APA, 2015); 3) A child is struggling with mental health concerns, related to or independent of their gender (Barrow & Apostle, 2018); 4) A child would benefit from strengthening their resilience in the face of negative environmental responses to their gender identity or presentation (Craig & Auston, 2018; Malpas et al., 2018); 5) A child may be experiencing mental health and/or environmental concerns, including family system problems that can be misinterpreted as gender congruence or incongruence (Berg & Edwards-Leeper, 2018); and 6) A child expresses a desire to meet with an MHP to get gender-related support. In these situations, the psychotherapy will focus on supporting the child with the understanding that the child's parent(s)/caregiver(s) and potentially other family members will be included as necessary (APA, 2015; Ehrensaft, 2018; McLaughlin & Sharp, 2018). Unless contraindicated, it is extremely helpful for parents/guardians to participate in some capacity in the psychotherapy process involving prepubescent children as family factors are often central to a child's well-being. Although relatively unexplored in research involving gender diverse children, it may be important to attend to the relationship between siblings and the gender diverse child (Pariseau et al., 2019; Parker & Davis-McCabe, 2021).

HCPs should employ interventions tailor-made to the individual needs of the child that are designed to 1) foster protective social and emotional coping skills to promote resilience in the face of potential negative reactions to the child's gender identity, expressions, or both (Craig & Austin, 2016; Malpas et al., 2018; Spencer, Berg et al., 2021); 2) collaboratively problem-solve social challenges to reduce gender minority stress (Barrow & Apostle, 2018; Tishelman & Neumann-Mascis, 2018); 3) strengthen environmental supports for the child and/or members of the immediate and extended family (Kaufman & Tishelman, 2018); and 4) provide the child an opportunity to further understand their internal gender experiences (APA, 2015; Barrow& Apostle, 2018; Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). It is helpful for HCPs to develop a relationship with a gender diverse child and family that can endure over time as needed. This enables the child/family to establish a long-term trusting relationship throughout childhood whereby the HCP can offer support and guidance as a child matures and as potentially

Page: 76

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different challenges or needs emerge for the child/family (Spencer, Berg et al., 2021; Murchison et al., 2016). In addition to the above and within the limits of available resources, when a child is neurodivergent, an HCP who has the skill set to address both neurodevelopmental differences and gender is most appropriate (Strang et al., 2021).

As outlined in the literature, there are numerous reasons parents/caregivers, siblings, and extended family members of a prepubescent child may find it useful to seek psychotherapy for themselves (Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). As summarized below, some of these common catalysts for seeking such treatment occur when one or more *family members* 1) desire education around gender development (Spivey & Edwards-Leeper, 2019); 2) are experiencing significant confusion or stress about the child's gender identity, expression, or both (Ashley, 2019c; Ehrensaft, 2018); 3) need guidance related to emotional and behavioral concerns regarding the gender diverse child (Barrow & Apostle, 2018; 4) need support to promote affirming environments outside of the home (e.g., school, sports, camps) (Kaufman & Tishelman, 2018); 5) are seeking assistance to make informed decisions about social transition, including how to do so in a way that is optimal for a child's gender development and health (Lev & Wolf-Gould, 2018); 6) are seeking guidance for dealing with condemnation from others, including political entities and accompanying legislation, regarding their support for their gender diverse child (negative reactions directed toward parents/caregivers can sometimes include rejection and/or harassment/abuse from the social environment arising from affirming decisions (Hidalgo & Chen, 2019); 7) are seeking to process their own emotional reactions and needs about their child's gender identity, including grief about their child's gender diversity and/or potential fears or anxieties for their child's current and future well-being (Pullen Sansfaçon et al., 2019); and 8) are emotionally distressed and/or in conflict with other family members regarding the child's gender diversity (as needed, HCPs can provide separate sessions for parents/caregivers, siblings and extended family members for support, guidance, and/or psychoeducation) (McLaughlin & Sharp, 2018; Pullen Sansfaçon et al., 2019; Spivey & Edwards-Leeper, 2019).

Statement 7.9

We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.

Consistent with the ecological model described above and, as appropriate, based on individual/family circumstances, it can be extremely helpful for HCPs to prioritize coordination with important others (e.g., teachers, coaches, religious leaders) in a child's life to promote emotional and physical safety across settings (e.g., school settings, sports and other recreational activities, faith-based involvement) (Kaufman & Tishelman, 2018). Therapeutic and/or support groups are often recommended as a valuable resource for families/caregivers and/or gender diverse children themselves (Coolhart, 2018; Horton et al., 2021; Malpas et al., 2018; Murchison et al., 2016).

Statement 7.10

We recommend HCPs offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age appropriate psycho-education about gender development.

Parents/caregivers and their gender diverse child should have the opportunity to develop knowledge regarding ways in which families/caregivers can best support their child to maximize resilience, self-awareness, and functioning (APA, 2015; Ehrensaft, 2018; Malpas, 2018; Spivey & Edwards-Leeper, 2019). It is neither possible nor is it the role of the HCP to predict with certainty the child's ultimate gender identity; instead, the HCP's task is to provide a safe space for the child's identity to develop and evolve over time without attempts to prioritize any particular developmental trajectory with regard to gender (APA, 2015; Spivey & Edwards-Leeper, 2019). Gender diverse children and early adolescents have different needs and experiences than older adolescents, socially and physiologically, and those differences should be reflected in the individualized approach HCPs

provide to each child/family (Keo-Meir & Ehrensaft, 2018; Spencer, Berg et al., 2021).

Parents/caregivers and their children should also have the opportunity to develop knowledge about gender development and gender literacy through age-appropriate psychoeducation (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy involves understanding the distinctions between sex designated at birth, gender identity, and gender expression, including the ways in which these three factors uniquely come together for a child (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). As a child gains gender literacy, they begin to understand their body parts do not necessarily define their gender identity and/or their gender expression (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy also involves learning to identify messages and experiences related to gender within society. As a child gains gender literacy, they may view their developing gender identity and gender expression more positively, promoting resilience and self-esteem, and diminishing risk of shame in the face of negative messages from the environment. Gaining gender literacy through psychoeducation may also be important for siblings and/or extended family members who are important to the child (Rider, Vencill et al., 2019; Spencer, Berg et al., 2021).

Statement 7.11

We recommend health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender-affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.

As a child matures and approaches puberty, HCPs should prioritize working with children and their parents/caregivers to integrate psychoeducation about puberty, engage in shared decision-making about potential gender-affirming medical interventions, and discuss fertility-related and other reproductive health implications of medical treatments (Nahata, Quinn et al., 2018; Spencer, Berg et al., 2021). Although only limited empirical research exists to evaluate such interventions, expert consensus and developmental psychological literature generally support the notion that open communication with children about their bodies and preparation for physiological changes of puberty, combined with gender-affirming acceptance, will promote resilience and help to foster positive sexuality as a child matures into adolescence (Spencer, Berg et al., 2019). All these discussions may be extended (e.g., starting earlier) to include neurodivergent children, to ensure there is enough time for reflection and understanding, especially as choices regarding future gender- affirming medical care potentially arise (Strang, Jarin et al., 2018). These discussions could include the following topics:

- Review of body parts and their different functions;
- The ways in which a child's body may change over time with and without medical intervention;
- The impact of medical interventions on later sexual functioning and fertility;
- The impact of puberty suppression on potential later medical interventions;
- Acknowledgment of the current lack of clinical data in certain areas related to the impacts of puberty suppression;
- The importance of appropriate sex education prior to puberty.

These discussions should employ developmentally appropriate language and teaching styles, and be geared to the specific needs of each individual child (Spencer, Berg et al., 2021).

Statement 7.12

We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.

Gender social transition refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm and has no singular set of parameters or actions (Ehrensaft et al., 2018).

Gender social transition has often been conceived in the past as binary—a girl transitions to a boy, a boy to a girl. The concept has expanded to include children who shift to a nonbinary or individually shaped iteration of gender identity (Chew et al., 2020; Clark et al., 2018). Newer research indicates the social transition process may serve a protective function for some prepubescent children and serve to foster positive mental health and well-being (Durwood et al., 2017; Gibson et al., 2021; Olson et al., 2016). Thus, recognition that a child's gender may be fluid and develop over time (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013) is not sufficient justification to negate or deter social transition for a prepubescent child when it would be beneficial. Gender identity evolution may continue even after a partial or complete social transition process has taken place (Ashley, 2019e; Edwards-Leeper et al., 2018; Ehrensaft, 2020; Ehrensaft et al., 2018; Spivey & Edwards-Leeper, 2019). Although empirical data remains limited, existing research has indicated children who are most assertive about their gender diversity are most likely to persist in a diverse gender identity across time, including children who socially transition prior to puberty (Olson et al., 2022; Rae et al., 2019; Steensma, McGuire et al., 2013). Thus, when considering a social transition, we suggest parents/caregivers and HCPs pay particular attention to children who consistently and often persistently articulate a gender identity that does not match the sex designated at birth. This includes those children who may explicitly request or desire a social acknowledgement of the gender that better matches the child's articulated gender identity and/or children who exhibit distress when their gender as they know it is experienced as incongruent with the sex designated at birth (Rae et al., 2019; Steensma, Kreukels et al., 2013).

Although there is a dearth of empirical literature regarding best practices related to the social transition process, clinical literature and expertise provides the following guidance that prioritizes a child's best interests (Ashley, 2019e; Ehrensaft, 2018; Ehrensaft et al, 2018; Murchison et al., 2016; Telfer et al., 2018): 1) social transition should originate from the child and reflect the child's wishes in the process of making the decision to initiate a social transition process; 2) an HCP may assist exploring the advantages/benefits, plus potential challenges of social transition; 3) social transition may best occur in all or in specific contexts/settings only (e.g., school, home); and 4) a child may or may not choose to disclose to others that they have socially transitioned, or may designate, typically with the help of their parents/caregivers, a select group of people with whom they share the information.

In summary, social transition, when it takes place, is likely to best serve a child's well-being when it takes place thoughtfully and individually for each child. A child's social transition (and gender as well) may evolve over time and is not necessarily static, but best reflects the cross-section of the child's established self-knowledge of their present gender identity and desired actions to express that identity (Ehrensaft et al., 2018).

A social transition process can include one or more of a number of different actions consistent with a child's affirmed gender (Ehrensaft et al., 2018), including:

- Name change;
- Pronoun change;
- Change in sex/gender markers (e.g., birth certificate; identification cards; passport; school and medical documentation; etc.);
- Participation in gender-segregated programs (e.g., sports teams; recreational clubs and camps; schools; etc.);
- Bathroom and locker room use;
- Personal expression (e.g., hair style; clothing choice; etc.);
- Communication of affirmed gender to others (e.g., social media; classroom or school announcements; letters to extended families or social contacts; etc.).

Statement 7.13

We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.

It is important children who have engaged in social transition be afforded the same opportunities as other children to continue considering

meanings and expressions of gender throughout their childhood years (Ashley 2019e; Spencer, Berg et al., 2021). Some research has found children may experience gender fluidity or even detransition after an initial social transition. Research has not been conclusive about when in the life span such detransition is most likely to occur, or what percentage of youth will eventually experience gender fluidity and/or a desire to detransition—due to gender evolution, or potentially other reasons (e.g., safety concerns; gender minority stress) (Olson et al., 2022; Steensma, Kreukels et al., 2013). A recent research report indicates in the US, detransition occurs with only a small percentage of youth five years after a binary social transition (Olson et al., 2022); further follow-up of these young people would be helpful. Replication of these findings is important as well since this study was conducted with a limited and self-selected participant pool in the US and thus may not be applicable to all gender diverse children. In summary, we have limited ability to know in advance the ways in which a child's gender identity and expressions may evolve over time and whether or why detransition may take place for some. In addition, not all gender diverse children wish to explore their gender (Telfer et al., 2018). Cisgender children are not expected to undertake this exploration, and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing, intrusive and/or cisnormative (Ansara & Hegarty, 2012; Bartholomaeus et al., 2021; Oliphant et al., 2018).

Statement 7.14

We recommend health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.

Social transition in prepubescent children consists of a variety of choices, can occur as a process over time, is individualized based on both a child's wishes and other psychosocial considerations (Ehrensaft, 2018), and is a decision for which possible benefits and challenges should be weighted and discussed.

A social transition may have potential benefits as outlined in clinical literature (e.g., Ehrensaft et al., 2018) and supported by research (Fast & Olson, 2018; Rae et al., 2019). These include facilitating gender congruence while reducing gender dysphoria and enhancing psychosocial adjustment and well-being (Ehrensaft et al., 2018). Studies have indicated socially transitioned gender diverse children largely mirror the mental health characteristics of age matched cisgender siblings and peers (Durwood et al., 2017). These findings differ markedly from the mental health challenges consistently noted in prior research with gender diverse children and adolescents (Barrow & Apostle, 2018) and suggest the impact of social transition may be positive. Additionally, social transition for children typically can only take place with the support and acceptance of parents/caregivers, which has also been demonstrated to facilitate well-being in gender diverse children (Durwood et al., 2021; Malpas et al., 2018; Pariseau et al., 2019), although other forms of support, such as school-based support, have also been identified as important (Durwood et al., 2021; Turban, King et al., 2021). HCPs should discuss the potential benefits of a social transition with children and families in situations in which 1) there is a consistent, stable articulation of a gender identity that is incongruent with the sex assigned at birth (Fast & Olson, 2018). This should be differentiated from gender diverse expressions/behaviors/interests (e.g., playing with toys, expressing oneself through clothing or appearance choices, and/or engaging in activities socially defined and typically associated with the other gender in a binary model of gender) (Ehrensaft, 2018; Ehrensaft et al., 2018); 2) the child is expressing a strong desire or need to transition to the gender they have articulated as being their authentic gender (Ehrensaft et al., 2018; Fast & Olson, 2018; Rae et al., 2019); and 3) the child will be emotionally and physically safe during and following transition (Brown & Mar, 2018). Prejudice and discrimination should be considerations, especially in localities where acceptance of gender diversity is limited or prohibited (Brown & Mar, 2018; Hendricks & Testa, 2012; Turban, King et al., 2021). Of note, there can also be possible risks to a gender diverse child who does not socially transition, including 1) being ostracized or bullied for being perceived as not conforming to prescribed community

gender roles and/or socially expected patterns of behavior; and 2) living with the internal stress or distress that the gender they know themselves to be is incongruent with the gender they are being asked to present to the world.

To promote gender health, the HCP should discuss the potential challenges of a social transition. One concern often expressed relates to fear that a child will preclude considering the possible evolution of their gender identity as they mature or be reluctant to initiate another gender transition even if they no longer feel their social transition matches their current gender identity (Edwards-Leeper et al., 2016; Ristori & Steensma, 2016). Although limited, recent research has found some parents/caregivers of children who have socially transitioned may discuss with their children the option of new gender iterations (for example, reverting to an earlier expression of gender) and are comfortable about this possibility (Olson et al., 2019). Another often identified social transition concern is that a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth (Chen et al., 2018; Edwards-Leeper et al., 2019; Steensma & Cohen-Kettenis, 2011). From this point of view, parents/caregivers should be aware of the potential developmental effect of a social transition on a child.

HCPs should provide guidance to parents/caregivers and supports to a child when a social gender transition is being considered or taking place by 1) providing consultation, assessment, and gender supports when needed and sought by the parents/caregivers; 2) aiding family members, as needed, to understand the child's desires for a social transition and the family members' own feelings about the child's expressed desires; 3) exploring with, and learning from, the parents/caregivers whether and how they believe a social transition would benefit their child both now and in their ongoing development; 4) providing guidance when parents/caregivers are not in agreement about a social transition and offering the opportunity to work together toward a consistent understanding of their child's gender status and needs; 5) providing guidance about safe and supportive ways to disclose their child's social transition to others and to facilitate their child transitioning in their various social environments (e.g., schools, extended family); 6) facilitating communication, when desired by the child, with peers about gender and social transition as well as fortifying positive peer relationships; 7) providing guidance when social transition may not be socially accepted or safe, either everywhere or in specific situations, or when a child has reservations about initiating a transition despite their wish to do so; there may be multiple reasons for reservations, including fears and anxieties; 8) working collaboratively with family members and MHPs to facilitate a social transition in a way that is optimal for the child's unfolding gender development, overall well-being, and physical and emotional safety; and 9) providing psychoeducation about the many different trajectories the child's gender may take over time, leaving pathways open to future iterations of gender for the child, and emphasizing there is no need to predict an individual child's gender identity in the future (Malpas et al., 2018).

All of these tasks incorporate enhancing the quality of communication between the child and family members and providing an opportunity for the child to be heard and listened to by all family members involved. These relational processes in turn facilitate the parents/caregivers' success in making informed decisions about the advisability and/or parameters of a social transition for their child (Malpas et al., 2018).

One role of HCPs is to provide guidance and support in situations in which children and parents/caregivers wish to proceed with a social transition but conclude that the social environment would not be accepting of those choices, by 1) helping parents/caregivers define and extend safe spaces in which the child can express their authentic gender freely; 2) discussing with parents/caregivers ways to advocate that increase the likelihood of the social environment being supportive in the future, if this is a realistic goal; 3) intervening as needed to help the child/family with any associated distress and/or shame brought about by the continued suppression of authentic gender identity and the need for secrecy; and 4) building both the child's and the family's resilience, instilling the understanding that if the social environment is having difficulty accepting a child's social transition and affirmed gender identity, it is not because of some shortcoming in the child but because of

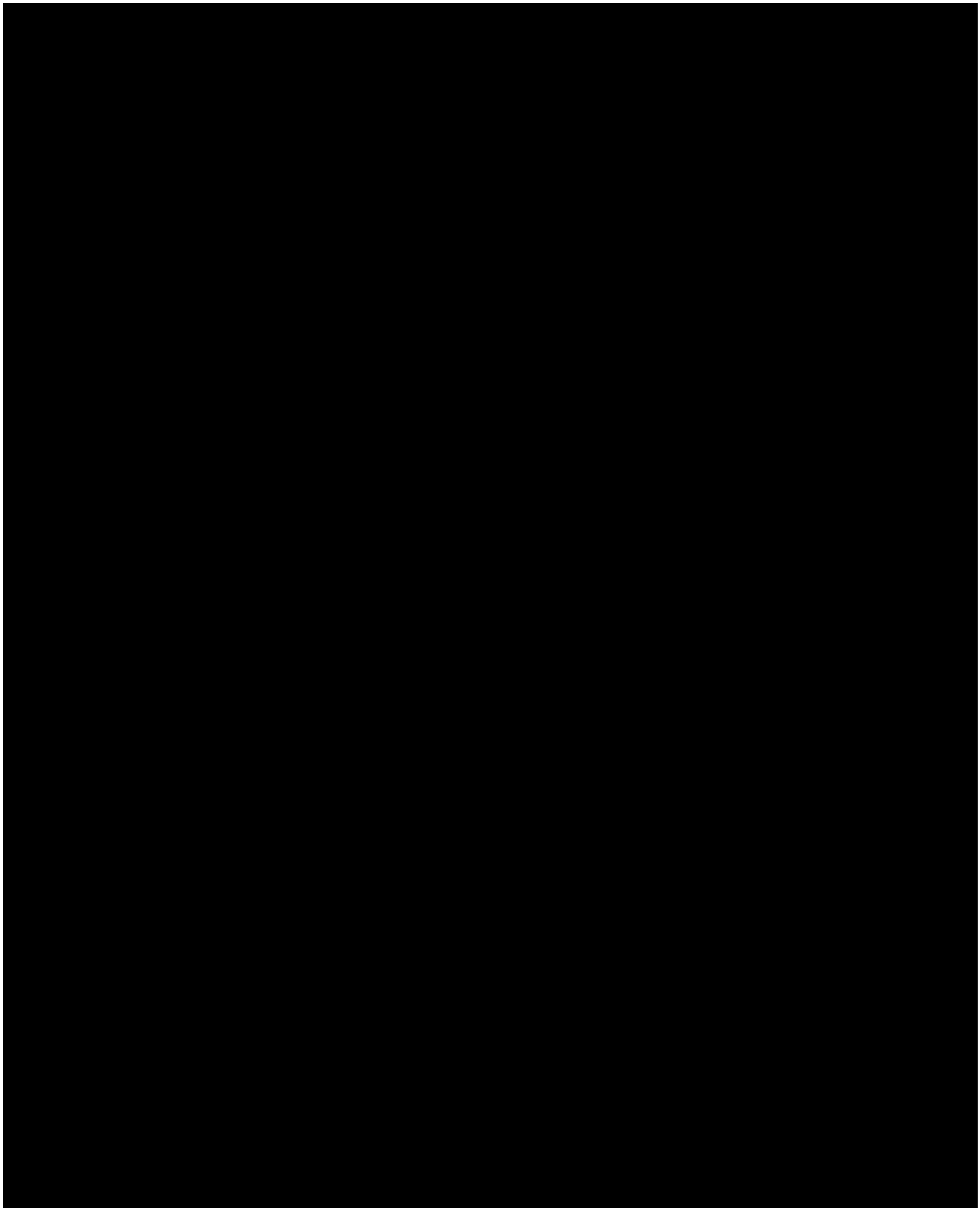
insufficient gender literacy in the social environment (Ehrensaft et al., 2018).

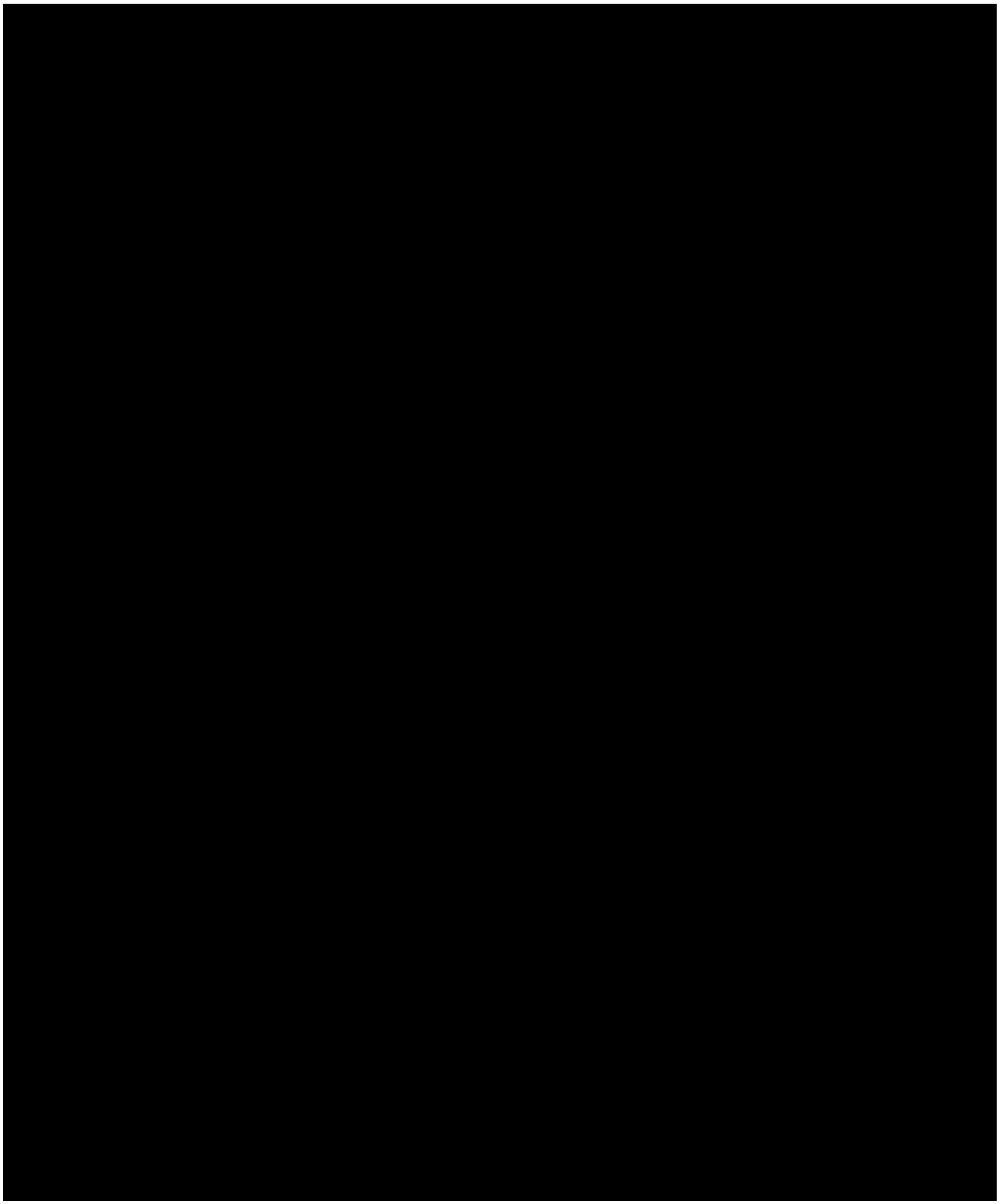
Statement 7.15

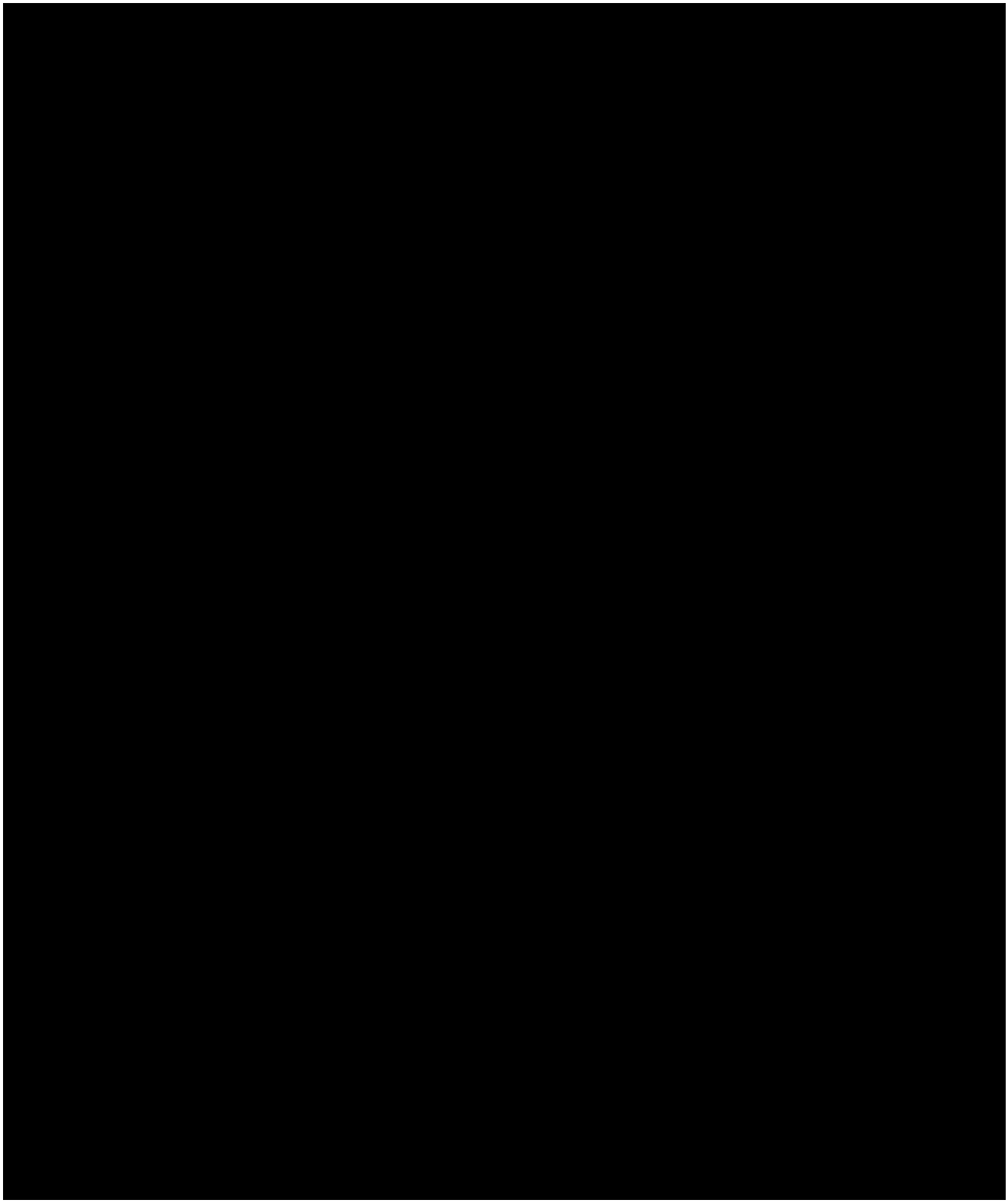
We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

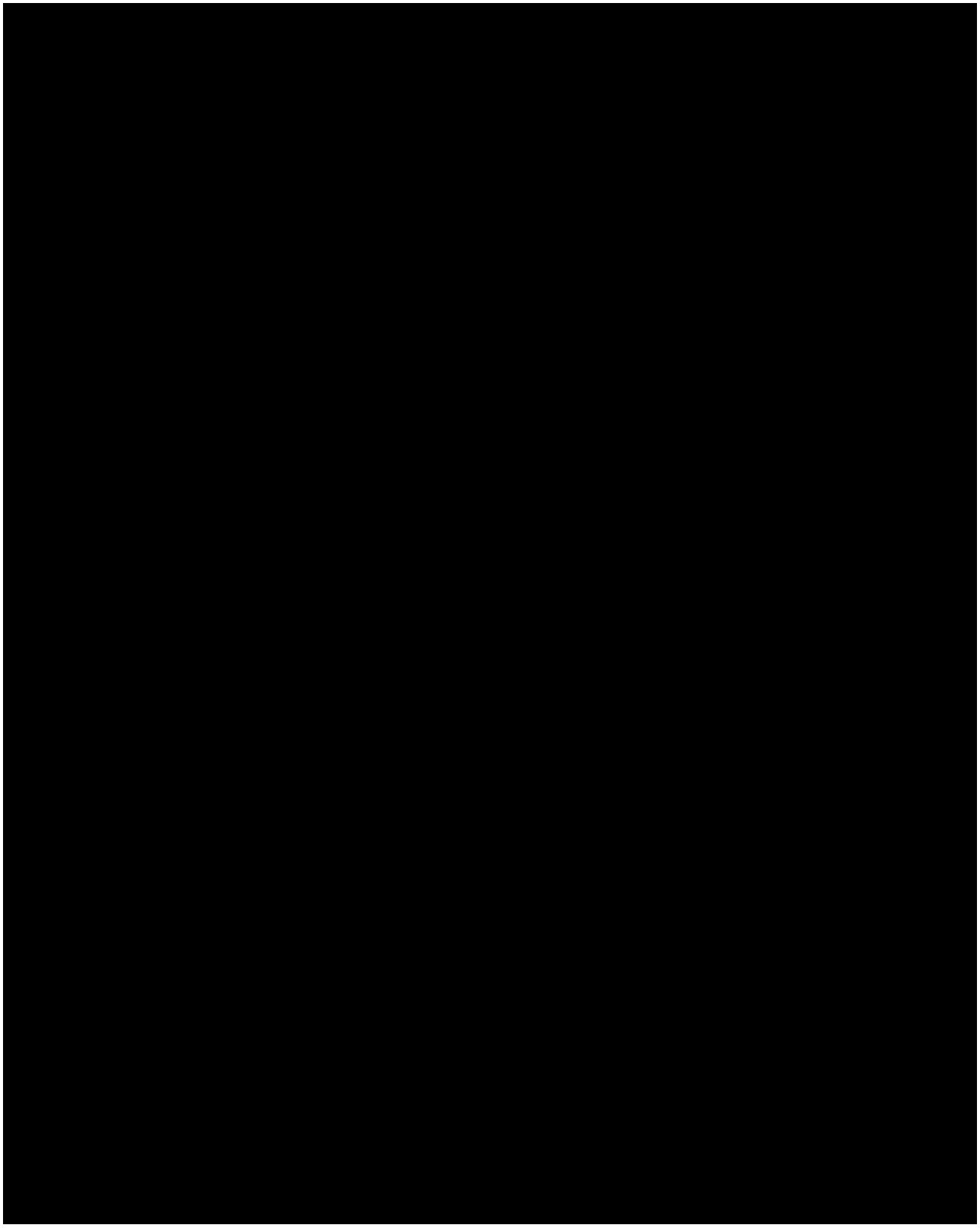
All children have the right to be supported and respected in their gender identities (Human Rights Campaign, 2018; Paré, 2020; SAMHSA, 2015). As noted above, gender diverse children are a particularly vulnerable group (Barrow & Apostle, 2018; Cohen-Kettenis et al., 2003; Giovanardi et al., 2018; Gower, Rider, Coleman et al., 2018; Grossman & D'Augelli, 2007; Hendricks & Testa, 2012; Reisner, Greytak et al., 2015; Ristori & Steensma, 2016; Roberts et al., 2012; Tishelman & Neumann-Mascis, 2018). The responsibilities of HCPs as advocates encompass acknowledging social determinants of health are critical for marginalized minorities (Barrow & Mar, 2018; Hendricks & Testa, 2012). Advocacy is taken up by all HCPs in the form of child and family support (APA, 2015; Malpas et al., 2018). Some HCPs may be called on to move beyond their individual offices or programs to advocate for gender diverse children in the larger community, often in partnership with stakeholders, including parents/caregivers, allies, and youth (Kaufman & Tishelman, 2018; Lopez et al., 2017; Vanderburgh, 2009). These efforts may be instrumental in enhancing children's gender health and promoting their civil rights (Lopez et al., 2017).

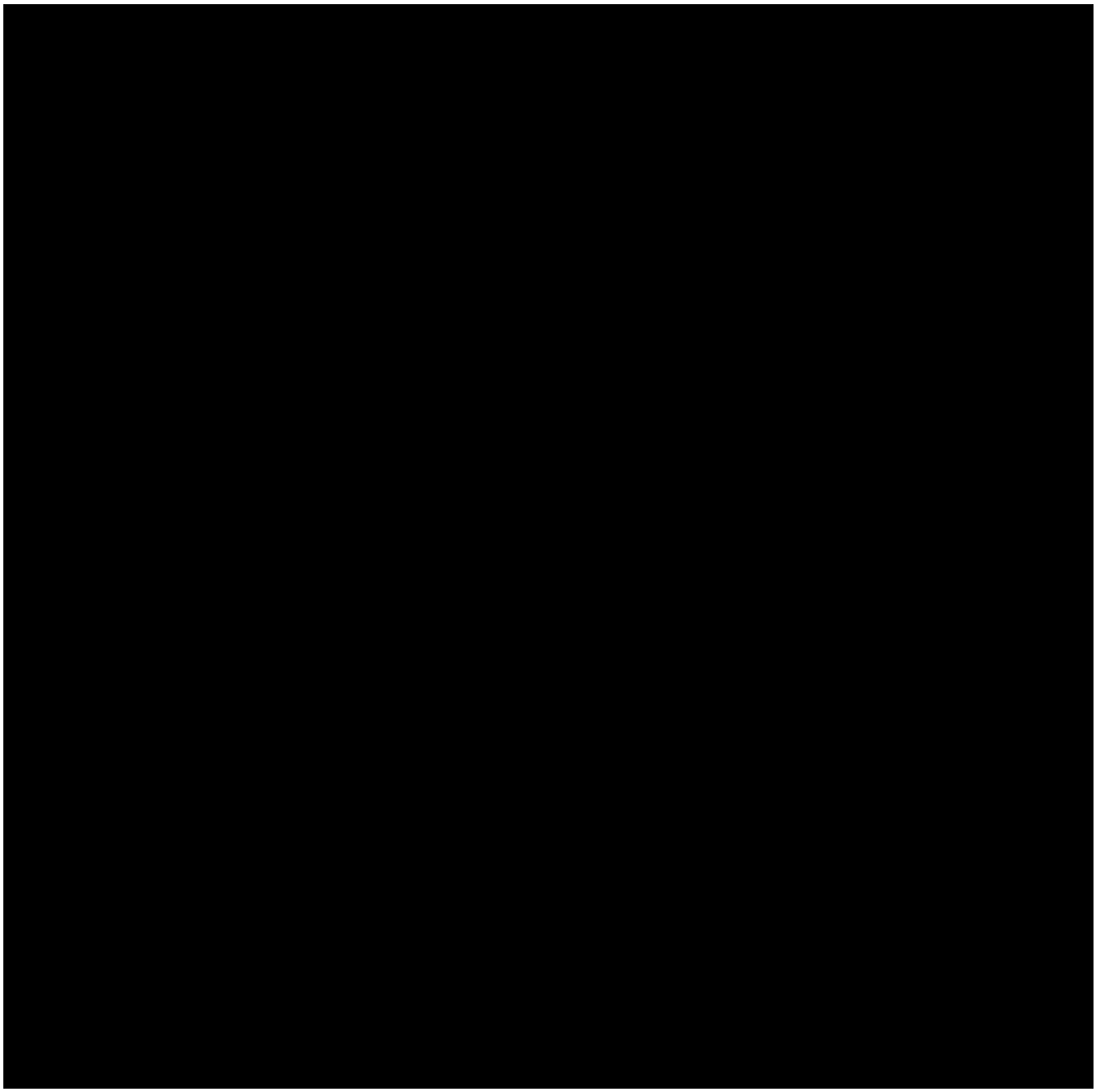
HCP's voices may be essential in schools, in parliamentary bodies, in courts of law, and in the media (Kuvalanka et al., 2019; Lopez et al., 2017; Whyatt-Sames, 2017; Vanderburgh, 2009). In addition, HCPs may have a more generalized advocacy role in acknowledging and addressing the frequent intentional or unintentional negating of the experience of gender diverse children that may be transmitted or communicated by adults, peers, and in media (Rafferty et al., 2018). Professionals who possess the skill sets and find themselves in appropriate situations can provide clear de-pathologizing statements on the needs and rights of gender diverse children and on the damage caused by discriminatory and transphobic rules, laws, and norms (Rafferty et al., 2018).











CHAPTER 6 Adolescents

Historical context and changes since previous Standards of Care

Specialized health care for transgender adolescents began in the 1980s when a few specialized gender clinics for youth were developed around the world that served relatively 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, Bergman et al., 2020). Since then, new clinics have been founded, but clinical services in many places have not kept pace with the increasing number of youth seeking care. Hence, there are often long waitlists for services, and barriers to care exist for many transgender youth around the world (Tollit et al., 2018).

Until recently, there was limited information regarding the prevalence of gender diversity among adolescents. Studies from high school samples indicate much higher rates than earlier thought, with reports of up to 1.2% of participants 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; Kidd et al., 2021; Wang et al., 2020). These studies suggest gender diversity in youth 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 (AFAB) initiating care 2.5–7.1 times more frequently as compared to adolescents who are assigned male at birth (AMAB) (Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020).

A specific World Professional Association for Transgender Health's (WPATH) Standards of Care section dedicated to the needs of children and adolescents was first included in the 1998 WPATH Standards of Care, 5th version (Levine et al., 1998). Youth aged 16 or older were deemed potentially eligible for gender-affirming medical care, but only in select cases. The subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest "masculinizing" mastectomy, which had an age minimum of 16 years. Additional eligibility criteria for gender-related medical care included a persistent, long (childhood) history of gender "non-conformity"/dysphoria, emerging or intensifying at the onset of puberty; absence or management of psychological, medical, or social problems that interfere with treatment; provision of support for commencing the intervention by the parents/caregivers; and provision of informed consent. A chapter dedicated to transgender and gender diverse (TGD) adolescents, distinct from the child chapter, has been created for this 8th edition of the Standards of Care given 1) the exponential growth in adolescent referral rates; 2) the increased number of studies specific to adolescent gender diversity-related care; and 3) the unique developmental and gender-affirming care issues of this age group.

Non-specific terms for gender-related care are avoided (e.g., gender-affirming model, gender exploratory model) as these terms do not represent unified practices, but instead heterogenous care practices that are defined differently in various settings.

Adolescence overview

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood (Sanders, 2013). Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress. 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. For example, physical pubertal changes may

begin in late childhood and executive control neural systems continue to develop well into the mid-20s (Ferguson et al., 2021). There is a lack of uniformity in how countries and governments define the age of majority (i.e., legal decision-making status; Dick et al., 2014). While many specify the age of majority as 18 years of age, in some countries it is as young as 15 years (e.g., Indonesia and Myanmar), and in others as high as 21 years (e.g., the U.S. state of Mississippi and Singapore).

For clarity, this chapter applies to adolescents from the start of puberty until the legal age of majority (in most cases 18 years), however there are developmental elements of this chapter, including the importance of parental/caregiver involvement, that are often relevant for the care of transitional-aged young adults and should be considered appropriately.

Cognitive development in adolescence is often characterized by gains in abstract thinking, complex reasoning, and metacognition (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 enables a young person to conceptualize implications regarding a particular decision. However, adolescence is also often associated with increased risk-taking behaviors. Along with these notable changes, adolescence is often characterized by individuation from parents and the development of increased personal autonomy. There is often a heightened focus on peer relationships, which can be both positive and detrimental (Gardner & Steinberg, 2005). Adolescents often experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals (Van Leijenhorst et al., 2010). Social-emotional development typically advances during adolescence, although there is a great variability among young people in terms of the level of maturity applied to inter- and intra-personal communication and insight (Grootens-Wiegers et al., 2017). For TGD adolescents making decisions about gender-affirming treatments—decisions that may have lifelong consequences—it is critical to understand how all these aspects of development may impact decision-making for a given young person within their specific cultural context.

Gender identity development in adolescence

Our understanding of gender identity development in adolescence is continuing to evolve. When providing clinical care to gender diverse young people and their families, it is important to know what is and is not known about gender identity during development (Berenbaum, 2018). When considering treatments, families may have questions regarding the development of their adolescent's gender identity, and whether or not their 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/caregivers 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 conducted primarily with youth who were not gender diverse in identity or expression and was carried out under the assumption that sex correlated with a specific gender; therefore, little attention was given to gender identity development. In addition to biological factors influencing gender development, this research demonstrated psychological and social factors also play a role (Perry & Pauletti, 2011). While there has been less focus on gender identity development in TGD youth, there is ample reason to suppose, apart from biological factors, psychosocial factors are also involved (Steensma, Kreukels et al., 2013). For some youth, gender identity development appears fixed and is often expressed from a young age, while for others there may be a developmental process that contributes to gender identity development over time.

Neuroimaging studies, genetic studies, and other hormone studies in intersex individuals demonstrate a biological contribution to the

development of gender identity for some individuals whose gender identity does not match their assigned sex at birth (Steensma, Kreukels et al., 2013). As families often have questions about this very issue, it is important to note it is not possible to distinguish between those for whom gender identity may seem fixed from birth and those for whom gender identity development appears to be a developmental process. Since it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person, a comprehensive clinical approach is important and necessary (see Statement 3). Future research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups. Conceptualization of gender identity by shifting from dichotomous (e.g., binary) categorization of male and female to a dimensional gender spectrum along a continuum (APA, 2013) would also be necessary.

Adolescence may be a critical period for the development of gender identity for gender diverse young people (Steensma, Kreukels et al., 2013). Dutch longitudinal clinical follow-up studies of adolescents with childhood gender dysphoria who received puberty suppression, gender-affirming hormones, or both, found that none of the youth in adulthood regretted the decisions they had taken in adolescence (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014). These findings suggest adolescents who were comprehensively assessed and determined emotionally mature enough to make treatment decisions regarding gender- affirming medical care presented with stability of gender identity over the time period when the studies were conducted.

When extrapolating findings from the longer-term longitudinal Dutch cohort studies to present-day gender diverse adolescents seeking care, it is critical to consider the societal changes that have occurred over time in relation to TGD people. Given the increase in visibility of TGD identities, it is important to understand how increased awareness may impact gender development in different ways (Kornienko et al., 2016). One trend identified is that more young people are presenting to gender clinics with nonbinary identities (Twist & de Graaf, 2019). Another phenomenon occurring in clinical practice is the increased number of adolescents seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years. One researcher attempted to study and describe a specific form of later-presenting gender diversity experience (Littman, 2018). However, the findings of the study must be considered within the context of significant methodological challenges, including 1) the study surveyed parents and not youth perspectives; and 2) recruitment included parents from community settings in which treatments for gender dysphoria are viewed with scepticism and are criticized. For a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider (Kornienko et al., 2016). However, caution must be taken to avoid assuming these phenomena occur prematurely in an individual adolescent while relying on information from datasets that may have been ascertained with potential sampling bias (Bauer et al., 2022; WPATH, 2018). It is important to consider the benefits that social connectedness may have for youth who are linked with supportive people (Tuzun et al., 2022)(see Statement 4).

Given the emerging nature of knowledge regarding adolescent gender identity development, an individualized approach to clinical care is considered both ethical and necessary. As is the case in all areas of medicine, each study has methodological limitations, and conclusions drawn from research cannot and should not be universally applied to all adolescents. This is also true when grappling with common parental questions regarding the stability versus instability of a particular young person's gender identity development. While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care.

Research evidence of gender-affirming medical treatment for transgender adolescents

A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical

and surgical treatments (GAMSTs) (see medically necessary statement in the Global chapter, Statement 2.1), over time. Given the lifelong implications of medical treatment and the young age at which treatments may be started, adolescents, their parents, and care providers should be informed about the nature of the evidence base. It seems reasonable that decisions to move forward with medical and surgical treatments should be made carefully. Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead.

At the time of this chapter's writing, there were several longer-term longitudinal cohort follow-up studies reporting positive results of early (i.e., adolescent) medical treatment; for a significant period of time, many of these studies were conducted through one Dutch clinic (e.g., Cohen-Kettenis & van Goozen, 1997; de Vries, Steensma et al., 2011; de Vries et al., 2014; Smith et al., 2001, 2005). The findings demonstrated the resolution of gender dysphoria is associated with improved psychological functioning and body image satisfaction. Most of these studies followed a pre-post methodological design and compared baseline psychological functioning with outcomes after the provision of medical gender-affirming treatments. Different studies evaluated individual aspects or combinations of treatment interventions and included 1) gender-affirming hormones and surgeries (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001, 2005); 2) puberty suppression (de Vries, Steensma et al., 2011); and 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 (pretreatment, mean age of 13.6) through young adulthood (posttreatment, mean age of 20.7). This was the first study to show gender-affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with satisfactory objective and subjective outcomes in adulthood (de Vries et al., 2014). While the study employed a small (n = 55), select, and socially supported sample, the results were convincing. Of note, the participants were part of the Dutch clinic known for employing a multidisciplinary approach, including provision of comprehensive, ongoing assessment and management of gender dysphoria, and support aimed at emotional well-being.

Several more recently published longitudinal studies followed and evaluated participants at different stages of their gender-affirming treatments. In these studies, some participants may not have started gender-affirming medical treatments, some had been treated with puberty suppression, while still others had started gender-affirming hormones or had even undergone gender-affirming surgery (GAS) (Achille et al., 2020; Allen et al., 2019; Becker-Hebly et al., 2021; Carmichael et al., 2021; Costa et al., 2015; Kuper et al., 2020, Tordoff et al., 2022). Given the heterogeneity of treatments and methods, this type of design makes interpreting outcomes more challenging. Nonetheless, when compared with baseline assessments, the data consistently demonstrate improved or stable psychological functioning, body image, and treatment satisfaction varying from three months to up to two years from the initiation of treatment.

Cross-sectional studies provide another design for evaluating the effects of gender-affirming treatments. One such study compared psychological functioning in transgender adolescents at baseline and while undergoing puberty suppression with that of cisgender high school peers at two different time points. At baseline, the transgender youth demonstrated lower psychological functioning compared with cisgender peers, whereas when undergoing puberty suppression, they demonstrated better functioning than their peers (van der Miesen et al., 2020). Grannis et al. (2021) demonstrated transgender males who started testosterone had lower internalizing mental health symptoms (depression and anxiety) compared with those who had not started testosterone treatment.

Four additional studies followed different outcome designs. In a retrospective chart study, Kaltiala, Heino et al. (2020) reported transgender

adolescents with few or no mental health challenges prior to commencing gender-affirming hormones generally did well during the treatment. However, adolescents with more mental health challenges at baseline continued to experience the manifestations of those mental health challenges over the course of gender-affirming medical treatment. Nieder et al. (2021) studied satisfaction with care as an outcome measure and demonstrated transgender adolescents were more satisfied the further they progressed with the treatments they initially started. Hisle-Gorman et al. (2021) compared health care utilization pre- and post-initiation of gender-affirming pharmaceuticals as indicators of the severity of mental health conditions among 3,754 TGD adolescents in a large health care data set. Somewhat contrary to the authors' hypothesis of improved mental health, mental health care use did not significantly change, and psychotropic medication prescriptions increased. In a large non-probability sample of transgender-identified adults, Turban et al. (2022) found those who reported access to gender-affirming hormones in adolescence had lower odds of past-year suicidality compared with transgender people accessing gender- affirming hormones in adulthood.

Providers may consider the possibility an adolescent may regret gender-affirming decisions made during adolescence, and a young person will want to stop treatment and return to living in the birth-assigned gender role in the future. Two Dutch studies report low rates of adolescents (1.9% and 3.5%) choosing to stop puberty suppression (Brik et al., 2019; Wiepjes et al., 2018). Again, these studies were conducted in clinics that follow a protocol that includes a comprehensive assessment before the gender-affirming medical treatment is started. At present, no clinical cohort studies have reported on profiles of adolescents who regret their initial decision or detransition after irreversible affirming treatment. Recent research indicate there are adolescents who detransition, but do not regret initiating treatment as they experienced the start of treatment as a part of understanding their gender-related care needs (Turban, 2018). However, this may not be the predominant perspective of people who detransition (Littman, 2021; Vandenbussche, 2021). Some adolescents may regret the steps they have taken (Dyer, 2020). Therefore, it is important to present the full range of possible outcomes when assisting transgender adolescents. Providers may discuss this topic in a collaborative and trusting manner (i.e., as a "potential future experience and consideration") with the adolescent and their parents/caregivers 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 with a mean age of 25.02 years, which consisted of over 90% of birth assigned females, 25% had medically transitioned before age 18 and 14% detransitioned before age 18 (Vandenbussche, 2021). Although an internet convenience sample is subject to selection of respondents, this study suggests detransitioning may occur in young transgender adolescents and health care professionals should be aware of this. Many of them expressed difficulties finding help during their detransition process and reported their detransition was an isolating experience during which they did not receive either sufficient or appropriate support (Vandenbussche, 2021).

To conclude, although the existing samples reported on relatively small groups of youth (e.g., n = 22-101 per study) and the time to follow-up varied across studies (6 months–7 years), this emerging evidence base indicates a general improvement in the lives of transgender adolescents who, following careful assessment, receive medically necessary gender-affirming medical treatment. Further, rates of reported regret during the study monitoring periods are low. Taken as a whole, the data show early medical intervention—as part of broader combined assessment and treatment approaches focused on gender dysphoria and general well-being—can be effective and helpful for many transgender adolescents seeking these treatments.

Ethical and human rights perspectives

Medical ethics and human rights perspectives were also considered while formulating the

Summary of Comments on Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

Page: 49

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Statements of Recommendations

6.1- We recommend health care professionals working with gender diverse adolescents:
6.1.a- Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.
6.1.b- Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
6.1.c- Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
6.1.d- Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
6.1.e- Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.
6.2- We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.
6.3- We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.
6.4- We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.
6.5- We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.
6.6- We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.
6.7- We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.
6.8- We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender- related surgery until the transition is made to adult care.
6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
6.10- We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.
6.11- We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):
6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
6.12.g- 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.

2 1
With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal ages for gender-affirming medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time 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 when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.

Page: 50

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Remove this entire sentence (all highlighted), including all the remaining bullet points with ages.

So, remove: "With the aforementioned criteria fulfilled (6.12.a-6.12.g), the following.....considering the factors unique to the adolescent treatment time frame."

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adolescent SOC statements. For example, allowing irreversible puberty to progress in adolescents who experience gender incongruence is not a neutral act given that it may have immediate and lifelong harmful effects for the transgender young person (Giordano, 2009; Giordano & Holm, 2020; Kreukels & Cohen-Kettenis, 2011). From a human rights perspective, considering gender diversity as a normal and expected variation within the broader diversity of the human experience, it is an adolescent's right to participate in their own decision-making process about their health and lives, including access to gender health services (Amnesty International, 2020).

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 aspects of identity, including gender identity. Statement 6.2 addresses identity exploration in the context of gender identity development. Statement 6.12.b accounts for the length of time needed for a young person to experience a gender diverse identity, express a gender diverse identity, or both, so as to make a meaningful decision regarding gender-affirming care.

Consent and decision-making: In adolescence, consent and decision-making require assessment of the individual's emotional, cognitive, and psychosocial development. Statement 6.12.c directly addresses emotional and cognitive maturity and describes the necessary components of the evaluation process used to assess decision-making capacity.

Caregivers/parent involvement: Adolescents are typically dependent on their caregivers/parents for guidance in numerous ways. This is also true as the young person navigates through the process of deciding about treatment options. Statement 6.11 addresses the importance of involving caregivers/parents and discusses the role they play in the assessment and treatment. No set of guidelines can account for every set of individual circumstances on a global scale.

Statement 6.1

We recommend health care professionals working with gender diverse adolescents:

a. **Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.**
b. **Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.**
c. **Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.**
d. **Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.**
e. **Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.**

When assessing and supporting TGD adolescents and their families, care providers/health care professionals (HCPs) need both general as well as gender-specific knowledge and training. Providers who are trained to work with adolescents and families play an important role in navigating aspects of adolescent development and family dynamics when caring for youth and families (Adelson et al., 2012; American Psychological Association, 2015; Hembree et al., 2017). Other chapters in these standards of care describe these criteria for professionals who provide gender care in more detail (see Chapter 5—Assessment for Adults; Chapter 7—Children; or Chapter 13—Surgery and Postoperative Care). Professionals working with adolescents should understand what is and is not known regarding adolescent gender identity development, and how this knowledge base differs from what applies to

adults and prepubertal children. Among HCPs, the mental health professional (MHP) has the most appropriate training and dedicated clinical time to conduct an assessment and elucidate treatment priorities and goals when working with transgender youth, including those seeking gender-affirming medical/surgical care. Understanding and managing the dynamics of family members who may share differing perspectives regarding the history and needs of the young person is an important competency that MHPs are often most prepared to address.

When access to professionals trained in child and adolescent development is not possible, HCPs should make a commitment to obtain training in the areas of family dynamics and adolescent development, including gender identity development. Similarly, considering autistic/neurodivergent transgender youth represent a substantial minority subpopulation of youth served in gender clinics globally, it is important HCPs seek additional training in the field of autism and understand the unique elements of care autistic gender diverse youth may require (Strang, Meagher et al., 2018). If these qualifications are not possible, then consultation and collaboration with a provider who specializes in autism and neurodiversity is advised.

Statement 6.2

We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so 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 et al., 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 over 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 (Arnoldussen et al., 2020; 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 a person's experience of themselves as a particular gender (Steensma, Kreukels et al., 2013), and for many others a process may begin well after pubertal changes are completed. 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, HCPs working with adolescents should promote supportive environments that simultaneously respect an adolescent's affirmed gender identity and also allows the adolescent to openly explore gender needs, including social, medical, and physical gender-affirming interventions should they change or evolve over time.

Statement 6.3

We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.

Given the many ways identity may unfold during adolescence, we recommend using a comprehensive biopsychosocial assessment to guide treatment decisions and optimize outcomes. This assessment should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care. As mentioned in Statement 6.1, MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here. The assessment process should be approached collaboratively with the adolescent and their caregiver(s), both separately and together, as described in more detail in Statement 6.11. An assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones,

surgeries). See medically necessary statement in Chapter 2—Global Applicability, Statement 2.1; see also Chapter 12—Hormone Therapy and Chapter 13—Surgery and Postoperative Care.

Youth may experience many different gender identity trajectories. Sociocultural definitions and experiences of gender continue to evolve over time, and youth are increasingly presenting with a range of identities and ways of describing their experiences and gender-related needs (Twist & de Graaf, 2019). For example, some youth will realize they are transgender or more broadly gender diverse and pursue steps to present accordingly. For some youth, obtaining gender-affirming medical treatment is important while for others these steps may not be necessary. For example, a process of exploration over time might not result in the young person self-affirming or embodying a different gender in relation to their assigned sex at birth and would not involve the use of medical interventions (Arnoldussen et al., 2019).

The most robust longitudinal evidence supporting the benefits of gender-affirming medical and surgical treatments in adolescence was obtained in a clinical setting that incorporated a detailed comprehensive diagnostic assessment process over time into its delivery of care protocol (de Vries & Cohen-Kettenis, 2012; de Vries et al., 2014). Given this research and the ongoing evolution of gender diverse experiences in society, a comprehensive diagnostic biopsychosocial assessment during adolescence is both evidence-based and preserves the integrity of the decision-making process. In the absence of a full diagnostic profile, other mental health entities that need to be prioritized and treated may not be detected. There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) 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 at that time.

As delivery of health care and access to specialists varies globally, designing a particular assessment process to adapt existing resources is often necessary. In some cases, a more extended assessment process may be useful, such as for youth with more complex presentations (e.g., complicating mental health histories (Leibowitz & de Vries, 2016)), co-occurring autism spectrum characteristics (Strang, Powers et al., 2018), and/or an absence of experienced childhood gender incongruence (Ristori & Steensma, 2016). Given the unique cultural, financial, and geographical factors that exist for specific populations, providers should design assessment models that are flexible and allow for appropriately timed care for as many young people as possible, so long as the assessment effectively obtains information about the adolescent's strengths, vulnerabilities, diagnostic profile, and individual needs. Psychometrically validated psychosocial and gender measures can also be used to provide additional information.

The multidisciplinary assessment for youth seeking gender-affirming medical/surgical interventions includes the following domains that correspond to the relevant statements:

- **Gender Identity Development:** Statements 6.12.a and 6.12.b elaborate on the factors associated with gender identity development within the specific cultural context when assessing TGD adolescents.
- **Social Development and Support; Intersectionality:** Statements 6.4 and 6.11 elaborate on the importance of assessing gender minority stress, family dynamics, and other aspects contributing to social development and intersectionality.
- **Diagnostic Assessment of Possible Co-Occurring Mental Health and/or Developmental Concerns:** Statement 6.12.d elaborates on the importance of understanding the relationship that exists, if at all, between any co-occurring mental health or developmental concerns and the young person's gender identity/gender diverse expression.
- **Capacity for Decision-Making:** Statement 6.12.c elaborates on the assessment of a young person's emotional maturity and the relevance when an adolescent is considering gender affirming-medical/surgical treatments.

Statement 6.4

We recommend health care professionals work with families, schools, and other relevant

settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.

Multiple studies and related expert consensus support the implementation of approaches that promote acceptance and affirmation of gender diverse youth across all settings, including families, schools, health care facilities, 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 we recommend be enacted across the various relationships and settings in which a young person exists and functions. It is important for the family members and community members involved in the adolescent's life to work collaboratively in these efforts unless their involvement is considered harmful to the adolescent. Examples proposed by Pariseau et al. (2019) and others of acceptance and affirmation of gender diversity and contemplation and expression of identity that can be implemented by family, staff, and organizations 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;
6. Education about gender diversity issues for people in the young person's life (e.g., family members, health care providers, social support networks), as needed, including information about how to advocate for gender diverse youth in community, school, health care, 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. Antibullying policies that are enforced;
10. Inclusion of nonbinary experiences in daily life, reading materials, and curricula (e.g., books, health, and sex education classes, assigned essay topics that move beyond the binary, LGBTQ, and ally groups);
11. Gender inclusive facilities that the youth can readily access without segregation from nongender diverse peers (e.g., bathrooms, locker rooms).

We recommend HCPs work with parents, schools, and other organizations/groups to promote acceptance and affirmation of TGD identities and expressions, whether social or medical interventions are implemented or not as 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 et al. (2018) found mental health 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 using the name and pronoun the youth does not identify with, not acknowledging affirmed gender identity, bullying, harassment, verbal and physical abuse, poor relationships, rejection for being TGD, eviction) was strongly linked to negative outcomes, such as anxiety, depression, suicidal ideation, suicide attempts, and substance use (Grossman et al., 2005; Klein & Golub; 2016; Pariseau et al., 2019; Peng et al., 2019; Reisner, Greytak et al., 2015; Roberts et al., 2013). It is important to be aware that negative symptoms increase with increased levels of rejection and continue into adulthood (Roberts et al., 2013).

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 support mechanisms (e.g., with psychotherapists and support groups) have also been found to have negative consequences, such as increased depressive symptoms (Pariseau et al., 2019). For these reasons, it is important not to ignore a youth's gender questioning or delay consideration of the youth's gender-related care needs. There is particular value in professionals recognizing youth need individualized approaches, support, and consideration of needs around gender expression, identity, and embodiment 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, Lindley et al., 2019). It is important professionals collaborate with parents and others as they process their concerns and feelings and educate themselves about gender diversity because such processes may not necessarily reflect rejection or neutrality but may rather represent efforts to develop attitudes and gather information that foster acceptance (e.g., Katz-Wise et al., 2017).

Statement 6.5

We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.

Some health care providers, secular or religious organizations, and rejecting families may undertake efforts to thwart an adolescent's expression of gender diversity or assertion of a gender identity other than the expression and behavior that conforms to the sex assigned at birth. Such efforts at blocking reversible social expression or transition may include choosing not to use the youth's identified name and pronouns or restricting self-expression in clothing and hairstyles (Craig et al., 2017; Green et al., 2020). 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 or expectations based on 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 to be ineffective and are associated with increases in mental illness and poorer psychological functioning (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020).

Much of the research evaluating "conversion therapy" and "reparative therapy" has investigated the impact of efforts to change gender expression (masculinity or femininity) and has conflated 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 has been linked to increased anxiety, depression, suicidal ideation, suicide attempts, and health care avoidance (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020). Although some of these studies have been criticized for their methodologies and conclusions (e.g., D'Angelo et al., 2020), this should not detract from the importance of emphasizing efforts undertaken a priori to change a person's identity are clinically and ethically unsound. We recommend against any type of conversion or attempts to change a person's gender identity because 1) both secular and religion-based efforts to change gender identity/expression have been associated with negative psychological functioning that endures into adulthood (Turban, Beckwith et al., 2020); and 2) larger ethical reasons exist that should underscore respect for gender diverse identities.

It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression (AACAP, 2018; see Statement 6.2). To ensure these explorations are therapeutic, we

recommend employing affirmative consideration and supportive tone in discussing what steps have been tried, considered, and planned for a youth's gender expression. These discussion topics may include what felt helpful or affirming, what felt unhelpful or distressing and why. We recommend employing affirmative responses to these steps and discussions, such as those identified in SOC-8 Statement 6.4.

Statement 6.6

We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including review of the benefits and risks.

TGD youth may experience distress related to chest and genital anatomy. Practices such as chest binding, chest padding, genital tucking, and genital packing are reversible, nonmedical interventions that may help alleviate this distress (Callen-Lorde, 2020a, 2020b; Deutsch, 2016a; Olson-Kennedy, Rosenthal et al., 2018; Transcare BC, 2020). It is important to assess the degree of distress related to physical development or anatomy, educate youth about potential nonmedical interventions to address this distress, and discuss the safe use of these interventions.

Chest binding involves compression of the breast tissue to create a flatter appearance of the chest. Studies suggest that up to 87% of trans masculine patients report a history of binding (Jones, 2015; Peitzmeier, 2017). Binding methods may include the use of commercial binders, sports bras, layering of shirts, layering of sports bras, or the use of elastics or other bandages (Peitzmeier, 2017). Currently, most youth report learning about binding practices from online communities composed of peers (Julian, 2019). Providers can play an important role in ensuring youth receive accurate and reliable information about the potential benefits and risks of chest binding. Additionally, providers can counsel patients about 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 and have been associated with chest binding in adults (Peitzmeier, 2017). If binding is employed, youth should be advised to use only those methods 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 restrict blood flow, damage skin, and restrict breathing. If youth report negative health impacts from chest binding, these should ideally be addressed by a gender-affirming medical provider with experience working with TGD youth. Many youth who bind may require chest masculinization surgery in the future (Olson-Kennedy, Warus et al., 2018).

Genital tucking is the practice of positioning the penis and testes to reduce the outward appearance of a genital bulge. 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 can be made or purchased. Limited studies are available on the specific risks and benefits of tucking in adults, and none have been carried out in youth. Previous studies have reported tight undergarments are associated with decreased sperm concentration and motility. In addition, elevated scrotal temperatures can be associated with poor sperm characteristics, and genital tucking could theoretically affect spermatogenesis and fertility (Marsh, 2019) although there are no definitive studies evaluating these adverse outcomes. Further research is needed to determine the specific benefits and risks of tucking in youth.

Statement 6.7

We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have

not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.

When discussing the available options of menstrual-suppressing medications with gender diverse youth, 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 in a sensitive, gender-affirmative manner (Bonnington et al., 2020; Krempasky et al., 2020). There is no formal research evaluating how menstrual suppression may impact gender incongruence and/or dysphoria. However, the use of menstrual suppression can be an initial intervention that allows for further exploration of gender-related goals of care, prioritization of other mental health care, or both, especially for those who experience a worsening of gender dysphoria from unwanted uterine bleeding (see Statement 6.12d; Mehringer & Dowshen, 2019). When testosterone is not used, menstrual suppression can be achieved via a progestin. To exclude any underlying menstrual disorders, it is important to obtain a detailed menstrual history and evaluation prior to implementing menstrual-suppressing therapy (Carswell & Roberts, 2017). As part of the discussion about menstrual-suppressing medications, the need for contraception and information regarding the effectiveness of menstrual-suppressing medications as methods of contraception also need to be addressed (Bonnington et al., 2020). A variety of menstrual suppression options, such as combined estrogen-progestin medications, oral progestins, depot and subdermal progestin, and intrauterine devices (IUDs), should be offered to allow for individualized treatment plans while properly considering availability, cost and insurance coverage, as well as contraindications and side effects (Kanj et al., 2019).

Progestin-only hormonal medication are options, especially in trans masculine or nonbinary youth who are not interested in estrogen-containing medical therapies as well as those at risk for thromboembolic events or who have other contraindications to estrogen therapy (Carswell & Roberts, 2017). Progestin-only hormonal medications include oral progestins, depo-medroxyprogesterone injection, etonogestrel implant, and levonorgestrel IUD (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 (Pradhan & Gomez-Lobo, 2019). A more detailed description of the relevant clinical studies is presented in Chapter 12—Hormone Therapy. HCPs should not make assumptions regarding the individual's preferred method of administration as some trans masculine youth may prefer vaginal rings or IUD implants (Akgul et al., 2019). Although hormonal medications require monitoring for potential mood lability, depressive effects, or both, the benefits and risks of untreated menstrual suppression in the setting of gender dysphoria should be evaluated on an individual basis. Some patients may opt for combined oral contraception that includes 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 and can be delivered as transdermal or vaginal rings.

The use of gonadotropin releasing hormone (GnRH) analogues may also result in menstrual suppression. However, it is recommended gender diverse youth meet the eligibility criteria (as outlined in Statement 6.12) before this medication is considered 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 while awaiting menstrual suppression with testosterone therapy. When exogenous testosterone is employed as a gender-affirming hormone, menstrual suppression is typically achieved in the first six months of therapy (Ahmad & Leinung, 2017). However, it is vital adolescents be counseled ovulation and pregnancy can still occur in the setting of amenorrhea (Gomez et al., 2020; Kanj et al., 2019).

Statement 6.8

We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.

HCPs with expertise in child and adolescent development, as described in Statement 6.1, play an important role in the continuity of care for young people over the course of their gender-related treatment needs. Supporting adolescents and their families necessitates approaching care using a developmental lens through which understanding a young person's evolving emotional maturity and care needs can take place over time. As gender-affirming treatment pathways differ based on the needs and experiences of individual TGD adolescents, decision-making for these treatments (puberty suppression, estrogens/androgens, gender-affirmation surgeries) can occur at different points in time within a span of several years. Longitudinal research demonstrating the benefits of pubertal suppression and gender-affirming hormone treatment (GAHT) was carried out in a setting where an ongoing clinical relationship between the adolescents/families and the multidisciplinary team was maintained (de Vries et al., 2014).

Clinical settings that offer longer appointment times provide space for adolescents and caregivers to share important psychosocial aspects of emotional well-being (e.g., family dynamics, school, romantic, and sexual experiences) that contextualize individualized gender-affirming treatment needs and decisions as described elsewhere in the chapter. An ongoing clinical relationship can take place across settings, whether that be within a multidisciplinary team or with providers in different locations who collaborate with one another. Given the wide variability in the ability to obtain access to specialized gender care centers, particularly for marginalized groups who experience disparities with access, it is important for the HCP to appreciate the existence of any barriers to care while maintaining flexibility when defining how an ongoing clinical relationship can take place in that specific context.

An ongoing clinical relationship that increases resilience in the youth and provides support to parents/caregivers who may have their own treatment needs may ultimately lead to increased parental acceptance—when needed—which is associated with better mental health outcomes in youth (Ryan, Huebner et al., 2009).

Statement 6.9

We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.

TGD adolescents with gender dysphoria/gender incongruence who seek gender-affirming medical and surgical treatments benefit from the involvement of health care professionals (HCPs) from different disciplines. Providing care to TGD adolescents includes addressing 1) diagnostic considerations (see Statements 6.3, 6.12a, and 6.12b) conducted by a specialized gender HCP (as defined in Statement 6.1) whenever possible and necessary; and 2) treatment considerations when prescribing, managing, and monitoring medications for gender-affirming medical and 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.

The evolving evidence has shown a clinical benefit for transgender youth who receive their gender-affirming treatments in multidisciplinary gender clinics (de Vries et al., 2014; Kuper et al., 2020; Tollit et al., 2019). Finally, 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).

As not all patients and families are in the position or in a location to access multidisciplinary care, 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, disciplines, or both, it is recommended efforts be made to include the relevant providers when developing a gender care team. However, this does not mean all disciplines are necessary to provide care to a particular youth and family.

If written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST) for an adolescent, only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical HCPs and MHPs (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). Further assessment results and written opinions may be requested when there is a specific clinical need or when team members are in different locations or choose to write their own summaries. For further information see Chapter 5—Assessment for Adults, Statement 5.5.

Statement 6.10

We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to the initiation of treatment, of the reproductive effects, including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.

While assessing adolescents seeking gender-affirming medical or surgical treatments, HCPs should discuss the specific ways in which the required treatment may affect reproductive capacity. Fertility issues and the specific preservation options are more thoroughly discussed in Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

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

HCPs should specifically pay attention to the developmental and psychological aspects of fertility preservation and decision-making competency for the individual adolescent. While adolescents may think they have made up their minds concerning their reproductive capacity, the possibility their opinions about having biologically related children in the future might change over time needs to be discussed with an HCP who has sufficient experience, is knowledgeable about adolescent development, and has experience working with parents.

Addressing the long-term consequences on fertility of gender-affirming medical treatments and ensuring transgender adolescents have realistic expectations concerning fertility preservation options or adoption cannot not be addressed with a one-time discussion but should be part of an ongoing conversation. This conversation should occur not only before initiating any medical intervention (puberty suppression, hormones, or surgeries), but also during further treatment and during transition.

Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have. Research in childhood cancer survivors found participants who acknowledged missed opportunities for fertility preservation reported distress and regret surrounding potential infertility (Armuand et al., 2014; Ellis et al., 2016; Lehmann et al., 2017). Furthermore, 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 HCPs may experience discussing fertility with the adolescent and the family (Tishelman et al., 2019), a fertility consultation is an important

consideration for every transgender adolescent who pursues medical-affirming treatments unless the local situation is such that a fertility consultation is not covered by insurance or public health care plans, is not available locally, or the individual circumstances make this unpreferable.

Statement 6.11

We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

When there is an indication an adolescent might benefit from a gender-affirming medical or surgical treatment, involving the parent(s) or primary caregiver(s) in the assessment process is recommended in almost all situations (Edwards-Leeper & Spack, 2012; Rafferty et al., 2018). Exceptions to this might include situations in which an adolescent is in foster care, child protective services, or both, and custody and parent involvement would be impossible, inappropriate, or harmful. Parent and family support of TGD youth is a primary predictor of youth well-being and is protective of the mental health of TGD youth (Gower, Rider, Coleman et al., 2018; Grossman et al., 2019; Lefevor et al., 2019; McConnell et al., 2015; Pariseau et al., 2019; Ryan, 2009; Ryan et al., 2010; Simons et al., 2013; Wilson et al., 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, such as the young person's gender and overall developmental, medical, and mental health history as well as insights into the young person's level of current support, general functioning, and well-being. Concordance or divergence of reports given by the adolescent and their parent(s)/caregiver(s) may be important information for the assessment team and can aid in designing and shaping individualized youth and family supports (De Los Reyes et al., 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 about 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 et al., 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, a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept. Contextualization of the 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. Importantly, gender histories may be unknown to parent(s)/caregiver(s) because gender may be internal experience for youth, not known by others unless it is discussed. For this reason, an adolescent's report of their gender history and experience is central to the assessment process.

Some parents may present with unsupportive or antagonistic beliefs about TGD identities, clinical gender care, or both (Clark et al., 2020). Such unsupportive perspectives are an important therapeutic target for families. Although challenging parent perspectives may in some cases seem rigid, 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 TGD child's gender diversity and care needs.

Helping youth and parent(s)/caregiver(s) 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 the necessary support and care (Dubin et al., 2020).

Statement 6.12

We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:

Statement 6.12.a

The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.

When working with TGD adolescents, HCPs should realize while a classification may give access to care, pathologizing transgender identities may be experienced as stigmatizing (Beek et al., 2016). Assessments related to gender health and gender diversity have been criticized, and controversies exist around diagnostic systems (Drescher, 2016).

HCPs should assess the overall gender-related history and gender care-related needs of youth. Through this assessment process, HCPs may provide a diagnosis when it is required to get access to transgender-related care.

Gender incongruence and gender dysphoria are the two diagnostic terms used in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), respectively. 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, reflect a long history of reconceptualizing and de-psychopathologizing gender-related diagnoses (American Psychiatric Association, 2013; World Health Organization, 2019a). Compared with 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 the sex assigned at birth. In the most recent revision, the DSM-5-TR, no changes in the diagnostic criteria for gender dysphoria are made. However, terminology was adapted into the most appropriate current language (e.g., birth-assigned gender instead of natal-gender and gender-affirming treatment instead of gender reassignment (American Psychiatric Association, 2022). Compared with the ICD 10th edition, the gender incongruence classification was moved from the Mental Health chapter to the Conditions Related to Sexual Health chapter in the ICD-11. When compared with the DSM-5 classification of gender dysphoria, one important reconceptualization is distress is not a required indicator of the ICD-11 classification of gender incongruence (WHO, 2019a). 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 classification of gender incongruence may better capture the fullness of gender diversity experiences and related clinical gender needs.

Criteria for 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 need to "transition" 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 enable the individual's body to align as much as required, 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 noted "that gender variant behaviour and

preferences alone are not a basis for assigning the classification" (WHO, ICD-11, 2019a).

Criteria for the DSM-5 and DSM-5-TR classification of 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; DSM-5, APA, 2013; DSM 5-TR, APA, 2022).

Of note, although a gender-related classification is one of the requirements for receiving medical gender-affirming care, such a classification alone 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. Counseling, gender exploration, mental health assessment and, when needed, treatment with MHPs trained in gender development may all be indicated with or without the implementation of medical-affirming care.

Statement 6.12.b

The experience of gender diversity/incongruence is marked and sustained over time.

Identity exploration and consolidation are experienced by many adolescents (Klimstra et al., 2010; Topolewska-Siedzik & Cieciuch, 2018). Identity exploration during adolescence may include a process of self-discovery around gender and gender identity (Steensma, Kreukels et al., 2013). Little is known about how processes that underlie consolidation of gender identity during adolescence (e.g., the process of commitment to specific identities) may impact a young person's experience(s) or needs over time.

Therefore, the level of reversibility of a gender-affirming medical intervention should be considered along with the sustained duration of a young person's experience of gender incongruence when initiating treatment. Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries. Puberty suppression treatment, which provides more time for younger adolescents to engage their decision-making capacities, also raises important considerations (see Statement 6.12f and Chapter 12—Hormone Therapy) suggesting the importance of a sustained experience of gender incongruence/diversity prior to initiation. However, in this age group of younger adolescents, several years is not always practical nor necessary given the premise of the treatment as a means to buy time while avoiding distress from irreversible pubertal changes. For youth who have experienced a shorter duration of gender incongruence, social transition-related and/or other medical supports (e.g., menstrual suppression/androgen blocking) may also provide some relief as well as furnishing additional information to the clinical team regarding a young person's broad gender care needs (see Statements 6.4, 6.6, and 6.7).

Establishing evidence of persistent gender diversity/incongruence typically requires careful assessment with the young person over time (see Statement 6.3). Whenever possible and when appropriate, the assessment and discernment process should also include the parent(s)/caregiver(s) (see Statement 6.11). Evidence demonstrating gender diversity/incongruence sustained over time can be provided via history obtained directly from the adolescent and parents/caregivers when this information is not documented in the medical records.

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 the experience of gender incongruence is not consistent for all children as they progress into adolescence. For example, a subset of youth who experienced gender incongruence or who socially transitioned prior to puberty over time can show a reduction in or even full discontinuation of gender incongruence (de Vries et al., 2010; Olson et al., 2022; Ristori & Steensma, 2016; Singh et al., 2021; Wagner et al., 2021). However, there has been less research focused on rates of continuity and discontinuity of gender incongruence and gender-related needs in

pubertal and 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 adolescents with gender incongruence presenting for gender care elect not to pursue gender-affirming medical care (Arnoldussen et al., 2019; de Vries, Steensma et al., 2011). Importantly, findings from studies of gender incongruent pubertal/adolescent cohorts, in which participants who have undergone comprehensive gender evaluation over time, have shown persistent gender incongruence and gender-related need and have received referrals for medical gender care, suggest 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 incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).

Statement 6.12.c

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 their 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. In most settings, assent is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses the level of understanding and intention.

A necessary step in the informed consent/assent process for considering gender-affirming medical care is a careful discussion with qualified HCPs trained to assess the emotional and cognitive maturity of adolescents. The reversible and irreversible effects of the treatment, as well as fertility preservation options (when applicable), and all potential risks and benefits of the intervention are important components of the discussion. These discussions are required when obtaining 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 the risks and benefits; 3) appreciate the nature of the decision, including the long-term consequences; and 4) communicate choice (Grootens-Wiegers et al., 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 to appear (e.g., with gender-affirming hormones), and any implications of stopping the treatment. Gender-diverse youth should fully understand the reversible, partially reversible, and 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 and Loshak, 2020)). Gender-diverse youth should also understand, 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 this care is not a fit for them (Wiepjes et al., 2018). Youth should know such shifts are sometimes connected to a change in gender needs over time, and in some cases, a shift in gender identity itself. Given this information, gender diverse youth must be able to reason thoughtfully about treatment options, considering the implications of the choices at hand. Furthermore, 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). There may be variability in these capacities related to developmental differences and mental health presentations (Shumer & Tishelman, 2015) and dependent on 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 et al., 2021).

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 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 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- and 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 to engage in conversations about the treatment options and affords the young person the opportunity to practice thinking into the future and flexibly consider 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 (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, Powers et al., 2018).

For unique situations in which an adolescent minor is consenting for their own treatment without parental permission (see Statement 6.11), extra care must be taken to support the adolescent's informed decision-making. This will typically require greater levels of engagement of and collaboration between the HCPs working with the adolescent to provide the young person appropriate cognitive and emotional support to consider options, weigh benefits and potential challenges/costs, and develop a plan for any needed (and potentially ongoing) supports associated with the treatment.

Statement 6.12.d

The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed.

Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments, and neurodiversity-related factors (e.g., de Vries et al., 2016; Pariseau et al., 2019; Ryan et al., 2010; Weinhardt et al., 2017). 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 or receive medical treatment. Additionally, like cisgender youth, TGD youth may experience mental health concerns irrespective of the presence of gender dysphoria or gender incongruence. In particular, depression and self-harm may be of specific concern; many studies reveal depression scores and emotional and behavioral problems comparable to those reported in populations referred to mental health clinics (Leibowitz & de Vries, 2016). Higher rates of suicidal ideation, suicide attempts, and self-harm have also been reported (de Graaf et al., 2020). In addition, eating disorders occur more frequently than expected in non-referred populations (Khatchadourian et al., 2013; Ristori et al., 2019; Spack et al., 2012). Importantly, TGD adolescents show high rates of autism spectrum disorder/characteristics (Øien et al., 2018; van der Miesen et al., 2016; see also Statement 6.1d). Other neurodevelopmental presentations and/or mental health challenges may also be present,

(e.g., ADHD, intellectual disability, and psychotic disorders (de Vries, Doreleijers et al., 2011; Meijer et al., 2018; Parkes & Hall, 2006).

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 those of their cisgender peers (e.g., de Vries et al., 2014; van der Miesen et al., 2020). A provider's key task 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 challenge the assessment and treatment of gender-related needs of TGD adolescents in various ways:

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 existing guidelines, appropriate care should seek to mitigate the threat or crisis so 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 gender-affirming medical/surgical treatment. 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 the clarity of identity development and gender-related decision-making should be prioritized and addressed.
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 6.11). To be able to make such an informed decision, an adolescent should be able to understand the issues, express a choice, appreciate and give careful thought regarding the wish for medical-affirming treatment (see Statement 6.12c). Neurodevelopmental differences, such as autistic features or autism spectrum disorder (see Statement 6.1d, e.g., communication differences; a preference for concrete or rigid thinking; differences in self-awareness, future thinking and planning), may challenge the assessment and decision-making process; neurodivergent youth may require extra support, structure, psychoeducation, and time built into the assessment process (Strang, Powers et al., 2018). Other mental health presentations that involve reduced communication and self-advocacy, difficulty engaging in assessment, memory and concentration difficulties, hopelessness, and 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, while addressing mental health concerns is important during the course of medical treatment, it does not mean all mental health challenges can or should be resolved completely. However, it is important any mental health concerns are addressed sufficiently so that gender -affirming medical treatment can be provided optimally (e.g., medication adherence, attending follow-up medical appointments, and self-care, particularly during a postoperative course).

Statement 6.12.e

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

For guidelines regarding the clinical approach, the scientific background, and the rationale, see Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

Statement 6.12.f

The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.

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 nonbinary gender identity) or even attenuation of a previously affirmed gender identity (Drummond et al., 2008; Steensma et al., 2011, Steensma, Kreukels et al., 2013; Wallien & Cohen-Kettenis, 2008). The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty because the experience of physical puberty may be critical for further gender identity development for some TGD adolescents (Steensma et al., 2011). Therefore, puberty blockers should not be implemented in prepubertal gender diverse youth (Waal & Cohen-Kettenis, 2006). For some youth, GnRH agonists may be appropriate in late stages or in the post-pubertal period (e.g., Tanner stage 4 or 5), and this should be highly individualized. See Chapter 12—Hormone Therapy for a more comprehensive review of the use of GnRH agonists.

Variations in the timing of pubertal onset is due to multiple factors (e.g., sex assigned at birth, genetics, nutrition, etc.). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to post-pubertal, and adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969, 1970). For assigned females at birth, pubertal onset (e.g., gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and for birth-assigned males, the achievement of a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020). An experienced medical provider should be relied on to differentiate the onset of puberty from physical changes such as pubic hair and apocrine body odor due to sex steroids produced by the adrenal gland (e.g., adrenarche) 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 during which shared decision-making about gender-affirming medical therapies should be undertaken with their multidisciplinary team.

The importance of addressing other risks and benefits of pubertal suppression, both hypothetical and actual, cannot be overstated. Evidence supports the existence of surgical implications for transgender girls who proceed with pubertal suppression (van de Grift et al., 2020). Longitudinal data exists to demonstrate improvement in romantic and sexual satisfaction for adolescents receiving puberty suppression, hormone treatment and surgery (Bungener et al., 2020). A study on surgical outcomes of laparoscopic intestinal vaginoplasty (performed because of limited genital tissue after the use of puberty blockers) in transgender women revealed that the majority experienced orgasm after surgery (84%), although a specific correlation between sexual pleasure outcomes and the timing of pubertal suppression initiation was not discussed in the study (Bouman, van der Sluis et al., 2016), nor does the study apply to those who would prefer a different surgical procedure. This underscores the importance of engaging in discussions with families about the future unknowns related to surgical and sexual health outcomes.

Statement 6.12.g

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.

GAHT leads to anatomical, physiological, and psychological changes. The onset of the anatomic effects (e.g., clitoral growth, breast growth, vaginal mucosal atrophy) may begin early after the initiation of therapy, and the peak effect is expected at 1–2 years (T'Sjoen et al., 2019). To ensure sufficient time for psychological adaptations to the physical change during an important developmental time for the adolescent, 12 months of hormone treatment is suggested. Depending upon the surgical result required, a period of hormone treatment may need to be longer (e.g., sufficient clitoral virilization prior to metoidioplasty/phalloplasty, breast growth and skin expansion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).

For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of hormone therapy on the proposed surgery. In addition, for individuals undergoing gonadectomy who are not taking hormones, a plan for hormone replacement can be developed with their prescribing professional prior to surgery.

With the aforementioned criteria fulfilled (6.12.a–6.12.g), the following are suggested minimal ages for gender-affirming medical and surgical treatment for adolescents:

- 14 years and above for hormone treatment (estrogens or androgens) unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 15 years and above for chest masculinization unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time 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 when considering the factors unique to the adolescent treatment time frame.
- 17 and above for metoidioplasty, orchidectomy, vaginoplasty, hysterectomy, and fronto-orbital remodeling as part of gender-affirming treatment unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.
- 18 years or above for phalloplasty unless there are significant, compelling reasons to take an individualized approach when considering the factors unique to the adolescent treatment time frame.

The ages outlined above provide general guidance for determining the age at which gender-affirming interventions may be considered. Age criteria should be considered in addition to other criteria presented for gender-affirming interventions in youth as outlined in Statements 6.12a-f. Individual needs, decision-making capacity for the specific treatment being considered, and developmental stage (rather than age) are most relevant when determining the timing of treatment decisions for individuals. Age has a strong, albeit imperfect, correlation with cognitive and psychosocial development and may be a useful objective marker for determining the potential timing of interventions (Ferguson et al., 2021). Higher (i.e., more advanced) ages are provided for treatments with greater irreversibility, complexity, or both. 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 Statement 6.12c).

The recommendations above are based on available evidence, expert consensus, and ethical considerations, including respect for the emerging autonomy of adolescents and the minimization of harm within the context of a limited evidence base. Historically, there has been hesitancy in the transgender health care setting to offer gender-affirming treatments with potential irreversible effects to minors. The age criteria set forth in these guidelines are younger than ages stipulated in previous guidelines and are intended to facilitate youth's access to gender-affirming treatments (Coleman et al., 2012; Hembree et al., 2017). Importantly, for each gender-affirming

Page: 67

Number: 1 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:03:03 AM -04'00'

Number: 2 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:16:09 AM -04'00'
delete highlighted text

Number: 3 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:02:01 AM -04'00'
Delete: With the aforementioned criteria fulfilled (6.12.a - 6.12.g), the following are suggested minimal"

delete colon (highlighted at end)

And start subtitle in bold as follows:
"Ages for gender-affirming medical and surgical treatment for adolescents" (delete colon)

Number: 4 Author: walterbouman Subject: Highlight Date: 9/5/2022 3:58:57 AM -04'00'

Number: 5 Author: walterbouman Subject: Sticky Note Date: 9/6/2022 9:03:17 AM -04'00'
change "are provided" to "may be required"

Number: 6 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:01:34 AM -04'00'

Number: 7 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:07:13 AM -04'00'
Delete all that is highlighted in yellow

Number: 8 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:16:31 AM -04'00'
delete highlighted text

Number: 9 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:05:16 AM -04'00'

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 6.12c).

A growing body of evidence indicates providing gender-affirming treatment for gender diverse youth who meet criteria leads to positive outcomes (Achille et al., 2020; de Vries et al., 2014; Kuper et al., 2020). There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth (Chen et al., 2020; Chew et al., 2018; Olson-Kennedy et al., 2016). Currently, the only existing longitudinal studies evaluating gender diverse youth and adult outcomes 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, Garofalo et al., 2019; Olson-Kennedy, Rosenthal 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 (de Vries et al., 2021). As the evidence base regarding outcomes of gender-affirming interventions in youth continues to grow, recommendations on the timing and readiness for these interventions may be updated.

Previous guidelines regarding gender-affirming treatment of adolescents recommended partially reversible GAHT could be initiated at approximately 16 years of age (Coleman et al., 2012; Hembree et al., 2009). More recent guidelines suggest there may be compelling reasons to initiate GAHT prior to the age of 16, although there are limited studies on youth who have initiated hormones prior to 14 years of age (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 as described in more detail in Chapter 12—Hormone Therapy (Klink, Caris et al., 2015; Schagen et al., 2020; Vlot et al., 2017; Zhu & Chan, 2017). 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 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 requires continued study (Klink, Caris et al., 2015; Lee, Finlayson et al., 2020; Schagen et al., 2020). It should also be noted the ages for initiation of GAHT recommended above are delayed when compared with the ages at which 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, although this has not been explicitly studied. When considering the timing of initiation of gender-affirming hormones, providers should compare the potential physical and psychological benefits and risks of starting treatment with the potential risks and benefits of delaying treatment. This process can also help identify compelling factors that may warrant an individualized approach.

Age recommendations for irreversible surgical procedures were determined by a review of existing literature and the expert consensus of mental health providers, medical providers, and surgeons highly experienced in providing care to TGD adolescents. Studies carried out with trans masculine youth have demonstrated 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 et al., 2018; Sood et al., 2021). Testosterone

Page: 68

Number: 1 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:05:27 AM -04'00'

Number: 2 Author: walterbouman Subject: Sticky Note Date: 9/6/2022 9:06:06 AM -04'00'
Insert the following sentence before "Currently,....": Therefore, an individual approach is needed to make the decision as to the optimal age for an intervention.

Number: 3 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:15:20 AM -04'00'
Delete sentence in yellow highlight

Number: 4 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:14:44 AM -04'00'

Number: 5 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 4:17:41 AM -04'00'
delete highlighted text

Number: 6 Author: walterbouman Subject: Highlight Date: 9/5/2022 4:17:26 AM -04'00'

unfortunately does little to alleviate this distress, although 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, Warus 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 relevant statements in this chapter). The duration or current use of testosterone therapy should not preclude surgery if otherwise indicated. The needs of some TGD youth may be met by chest masculinization surgery alone. Breast augmentation may be needed by trans feminine youth, although there is less data about this procedure in youth, possibly due to fewer individuals requesting this procedure (Boskey et al., 2019; James, 2016). GAHT, specifically estrogen, can help with development of breast tissue, and it is recommended youth have a minimum of 12 months of hormone therapy, or longer as is surgically indicated, prior to breast augmentation unless hormone therapy is not clinically indicated or is medically contraindicated.

Data are limited on the optimal timing for initiating other gender-affirming surgical treatments in adolescents. This is partly due to the limited access to these treatments, which varies in different geographical locations (Mahfouda et al., 2019). Data indicate rates of gender-affirming surgeries have increased since 2000, and there has been an increase in the number of TGD youth seeking vaginoplasty (Mahfouda et al., 2019; Milrod & Karasic, 2017). A 2017 study of 20 WPATH-affiliated surgeons in the US reported slightly more than half had performed vaginoplasty in minors (Milrod & Karasic, 2017). Limited data are available on the 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 et al.,2001). While the sample sizes are small, these studies suggest there may be a benefit for 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 postoperative 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) (Boskey et al., 2018; 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 postsurgical care recommendations and to comprehend the long-term impacts of these procedures on reproductive and sexual function is crucial (Boskey et al., 2019). Given the complexity of phalloplasty, and current high rates of complications in comparison to other gender-affirming surgical treatments, it is not recommended this surgery be considered in youth under 18 at this time (see Chapter 13—Surgery and Postoperative Care).

Additional key factors that should be taken into consideration when discussing the timing of interventions with youth and families are addressed in detail in statements 6.12a-f. For a summary of the criteria/recommendations for medically necessary gender-affirming medical treatment in adolescents, see Appendix D.

Hormonal treatments

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. Reached Tanner stage 2.

Surgery

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. 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.

[1]
[2] following are suggested minimal ages when considering the factors unique to the adolescent treatment time frame for gender-affirming medical and surgical treatment for adolescents, who fulfil all of the other criteria listed above.

- Hormonal treatment: 14 years
- Chest masculinization: 15 years
- Breast augmentation, Facial Surgery: 16 years
- Metoidioplasty, Orchiectomy, Vaginoplasty, Hysterectomy, Fronto-orbital remodeling: 17 years
- Phalloplasty: 18 years

Page: 260

Number: 1 Author: walterbouman Subject: Sticky Note Date: 9/5/2022 3:44:29 AM -04'00'

Remove this paragraph entirely

Remove: "The following are suggested minimal ages.....Phalloplasty: 18 years

Number: 2 Author: walterbouman Subject: Highlight Date: 9/5/2022 3:54:13 AM -04'00'

Re: SOC delay- URGENT taskforce

From: [redacted]
To:
Cc:

Date: Sat, 10 Sep 2022 15:27:12 -0400

[redacted] from AAP and he reported that their EC is satisfied with the proposed changes. They recommended two small editorial edits [redacted] will send those to you). They will not oppose the SOC 8 and are ready to make a statement in support of WPATH and AAP in advocating for the accessibility of care for transgender and gender diverse children and adolescence.

Thank you for all your efforts today. Now the BOD can consider these changes and we hopefully move to release asap.

Best,

[redacted]

On Sat, Sep 10, 2022 at 2:19 AM [redacted] wrote:

dear all,
In preparation for the meeting tomorrow with the adolescent chapter I am including the pdf with the comments from AAP. I have gone one by one through them and add my comments (in capiatal letter within their comment) as to why we are not going to make changes or if we are say that we are removing it. please have a look at this before the meeting and in the meeting we need to discuss whether you agree. the main issue is whether to remove ages from the document.

i also include the document [redacted] edits, with highlighted sections that represent what it will be removed so you can see what the chapter may look like..

time is a problem as we want the soc8 to be out for montreal, so we need to agree tomorrow whether 1) we ignore all their comments 2) we remove the sections that I suggest or more if you feel. we cant change statements and we dont want to add text as it will not be time for it.

speak tomorrow. please dont share the document with anyone. i need to send this in two pdfs as there document is too big

[redacted]

From: [redacted]
Sent: 09 September 2022 22:32
[redacted]
Subject: Re: SOC delay- URGENT taskforce

I can meet between 9-10 AM Pacific time on Saturday.

Thanks,

[redacted]

From: [redacted]
Sent: Friday, September 9, 2022 2:09 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

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This is very confusing as I did not have any suggestions. I was shocked to see the feedback from very junior people from AAP, my suggestion was not to make any changes. We need to publish the SOC By Montreal so unless it goes asap it will not be ready

[redacted]

From: [redacted]
Sent: Friday, September 9, 2022 9:34:01 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

I think it would be helpful to get the feedback, and [redacted] suggestions once the Chairs choose a time for the meeting.

Sent from my iPhone

On Sep 9, 2022, at 4:23 PM, [redacted] wrote:

Are you able to send us the AAP feedback or are we discussing whenever we meet?

Get Outlook for iOS
From: [redacted]
Sent: Friday, September 9, 2022 4:02:31 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

I can be available Saturday and Sunday.
Thanks [redacted]

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From: [redacted]
Sent: Friday, September 9, 2022 4:00:17 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

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I can definitely meet Saturday, and I will make Sunday work.
[redacted]

[redacted]

On Fri, Sep 9, 2022 at 3:57 PM [redacted] wrote:
Happy to help! Let me know the times for the calls and I'll do my best.

Get Outlook for iOS
From: [redacted]
Sent: Friday, September 9, 2022 2:55:45 PM
[redacted]
Subject: SOC delay- URGENT taskforce

[redacted]

Well hello friends. I'm writing this email confidentially and urgently. I've also now touched base with each of you (or have attempted to do so) to discuss a matter of great importance related to the SOC8 release. This is time-sensitive.

In a nutshell, you likely saw the email that the SOC8 was going to be released by the biennial meeting (next week) in Montreal, particularly since we have GEI sessions and other sessions designed to train attendees on its release. Then you saw another email regarding an inadvertent delay in the release. I'm writing about the reason why and this is top-level confidential, as you will see.

The American Academy of Pediatrics (AAP)- a MAJOR organization in the United States that is typically very pro-transhealth/gender affirming care- voiced its *opposition* to the SOC8, specifically due to aspects of the Adolescent chapter. Not only did they say they would not endorse the SOC, they indicated that they would *actively publicly oppose it.* They had several concerns, one of which was the age criteria for minors (they believe that surgery of any type should not happen until the patient is age of majority). They also disagree with verbiage on social factors and adolescent identity development. They were tasked with providing feedback, which they did. We actually know some of the pediatricians who provided this feedback, which makes it rather shocking.

Clearly, if AAP were to publicly oppose the SOC8, it would be a major challenge for WPATH, SOC8, and trans youth access to care in the U.S.

You have been identified by me as someone to be a part of an urgent taskforce to figure out next steps. WPATH leadership has already proposed certain changes (removing of ages verbiage), however, we need to do the following: 1) Review the AAP feedback; 2) Review suggestions from SOC8 co-chairs; 3) Meet **tomorrow (Saturday) at some point between 12-3 PM EST** to discuss our thoughts on the subject and come up with a united approach; and 4) Meet with AAP colleagues **at some point shortly thereafter (potentially Sunday** depending on availability) to make sure we can come to an agreement to obtain their endorsement.

Can you all please reply with your ability to meet tomorrow and participate in this very important collaborative effort? I realize this might evoke some emotion and we'll have time to navigate that when in person over beverages in Montreal- so let's try to compartmentalize that for now and get our hard work efforts across the finish line. This is too important

Many thanks,

[redacted]

[redacted]

[redacted]

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[redacted]

[redacted]

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X [redacted]

RE: SOC delay- URGENT taskforce

From: [redacted]
To:
Cc:
Date: Sat, 10 Sep 2022 15:34:45 -0400

Here are the grammatical changes

Page S45 – sentences should now read
However, these findings have not been replicated. The findings…

Page S65 – add "Consideration of" before ages
Consideration of ages for gender-affirming medical and surgical treatment for adolescents:

All best
[redacted]

From: [redacted]
Sent: Saturday, September 10, 2022 3:27 PM
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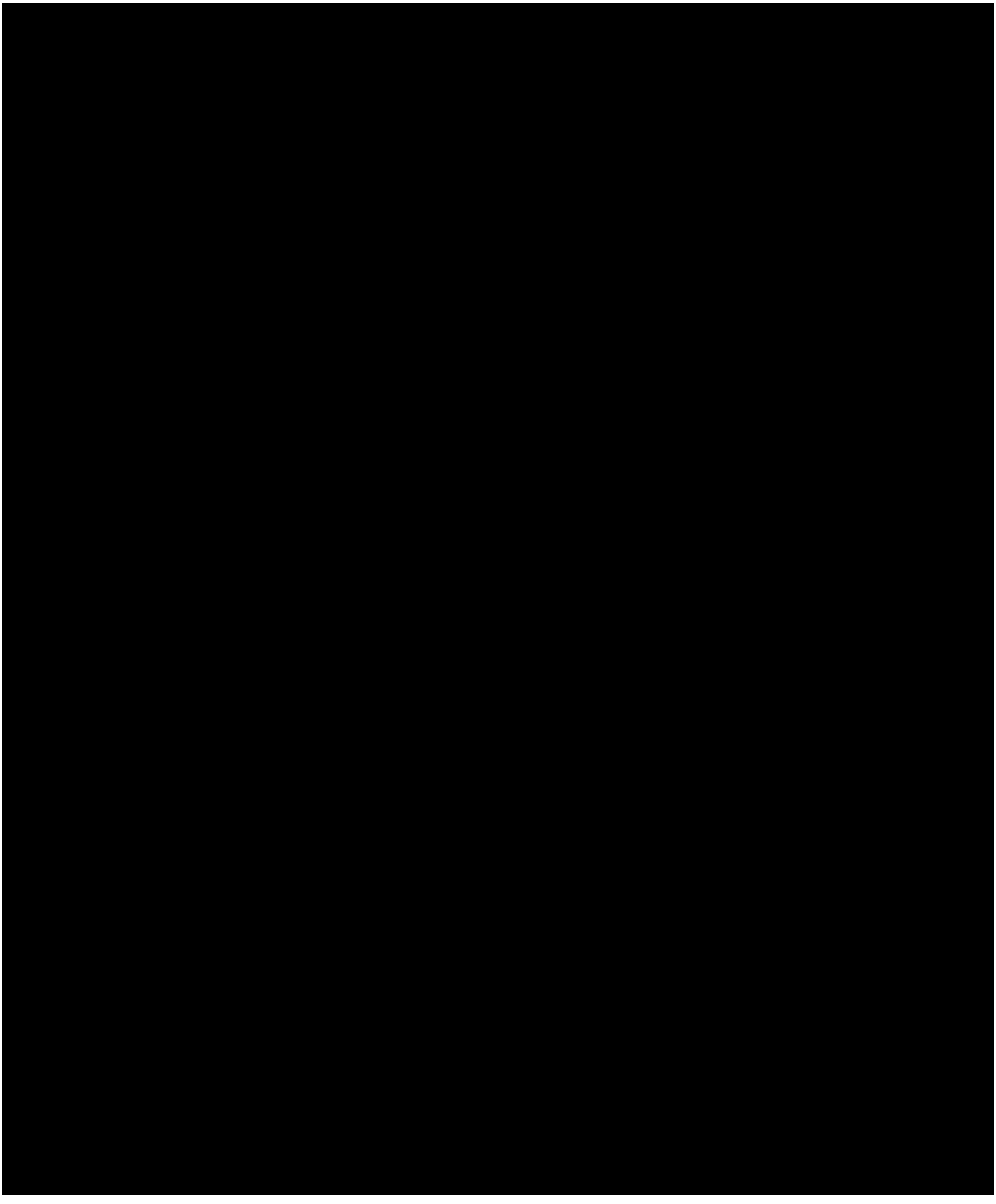
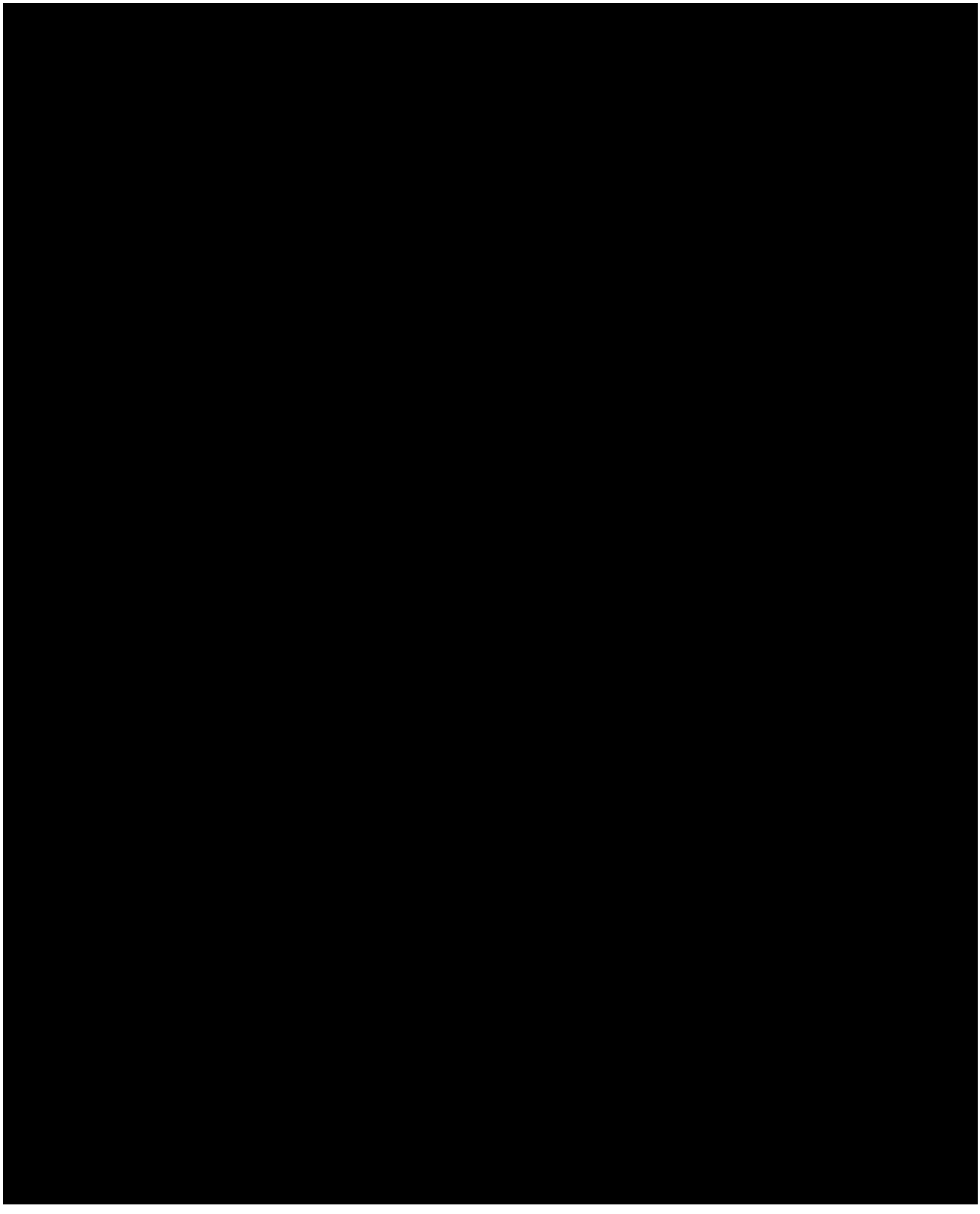
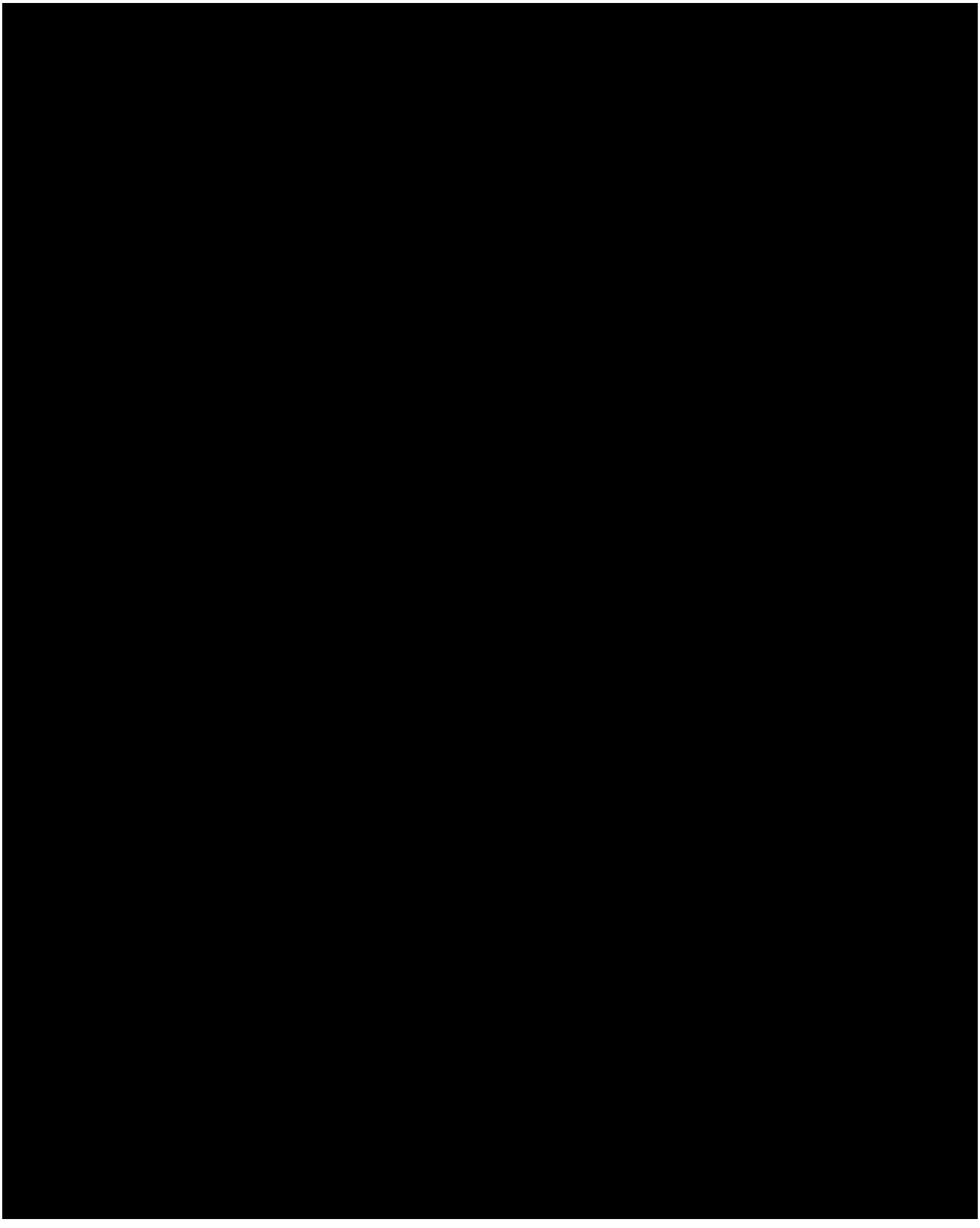
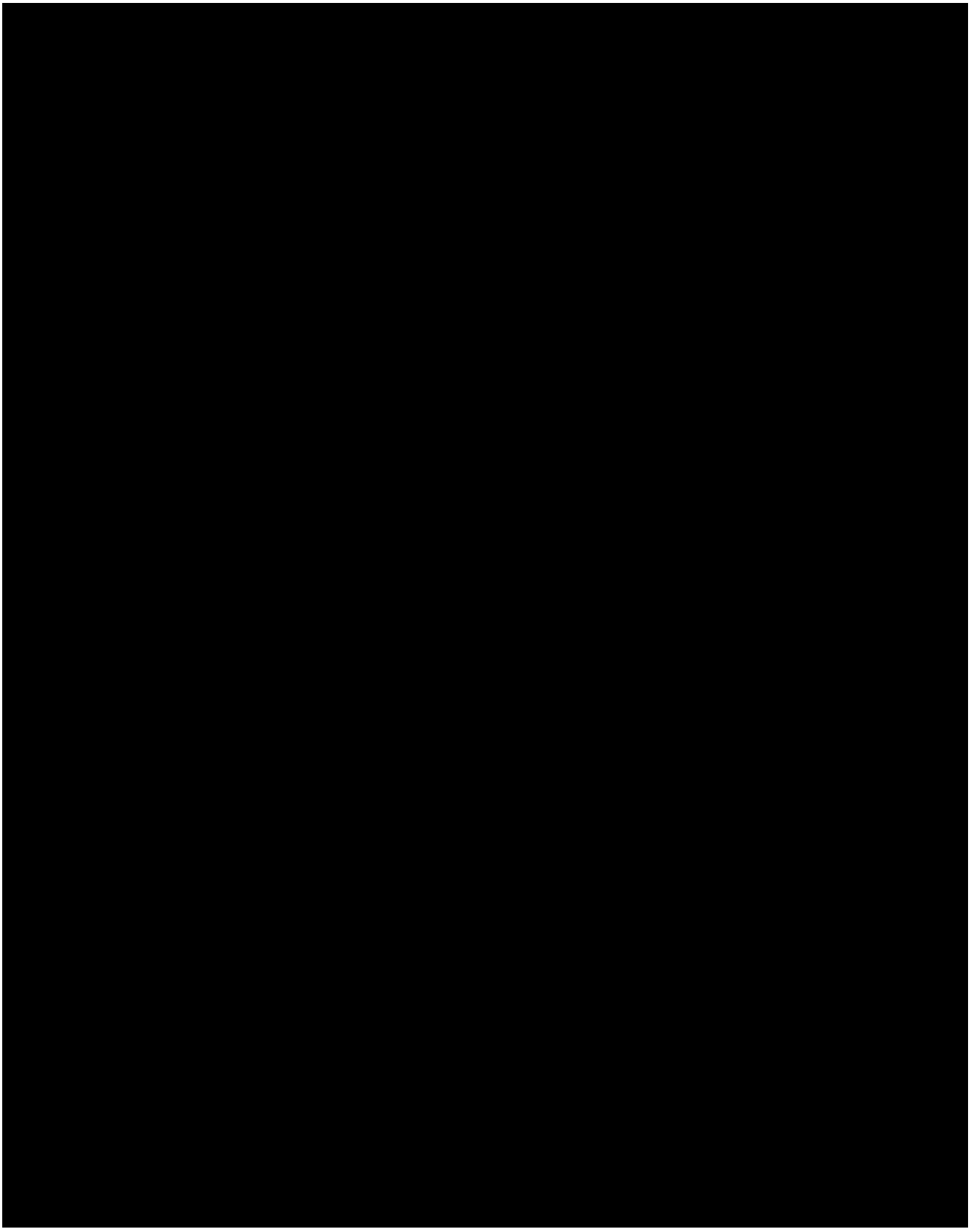
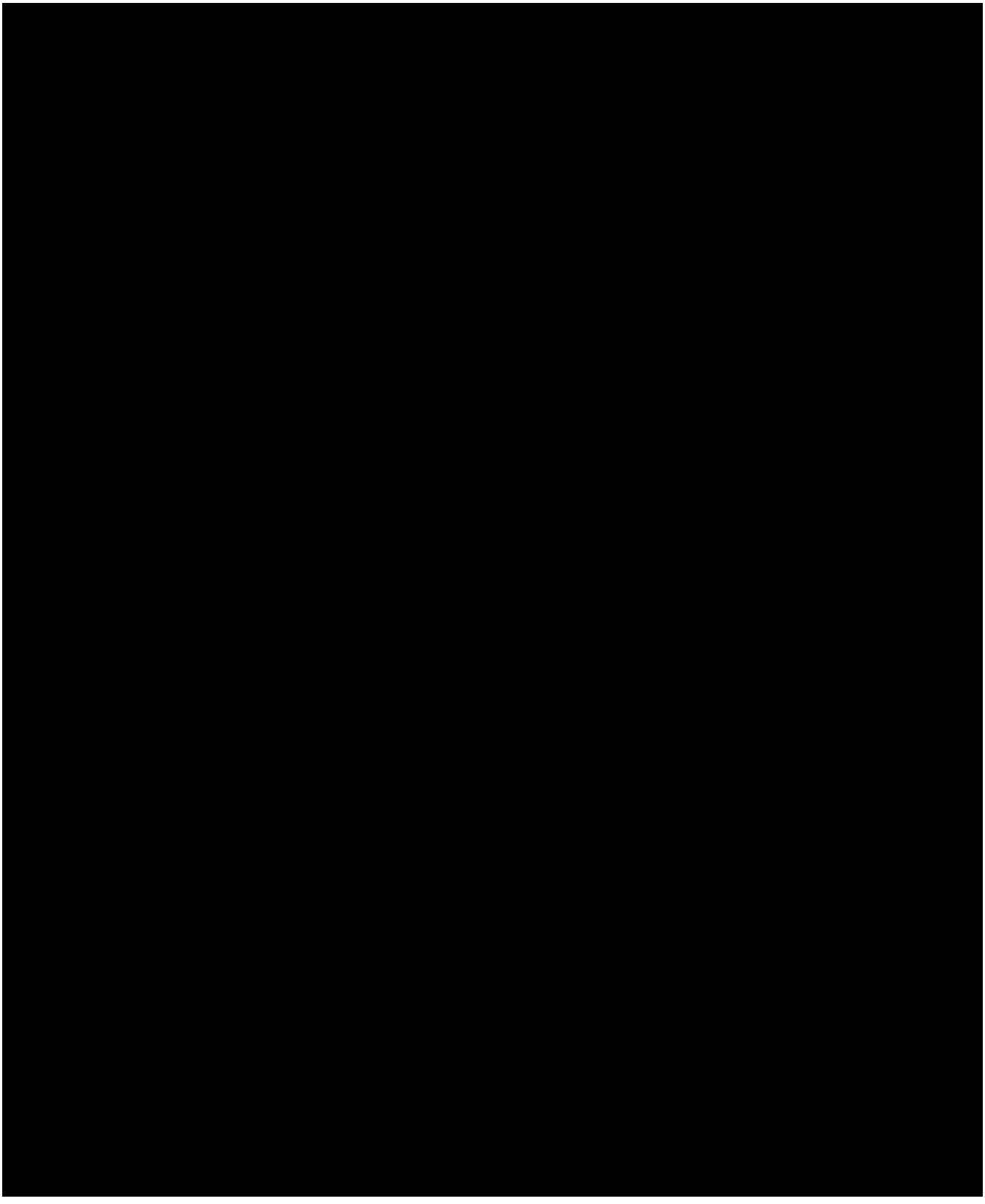
[redacted]

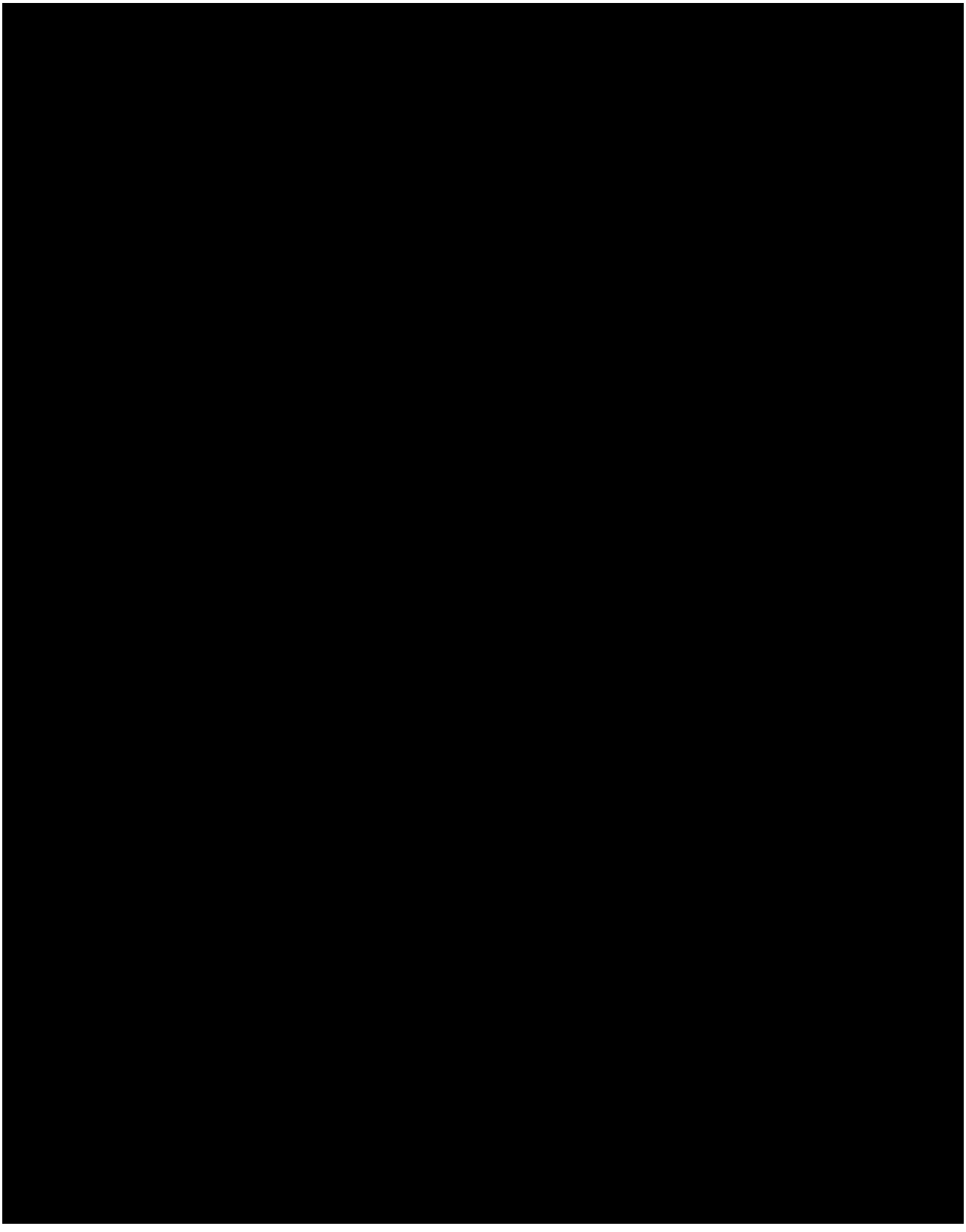


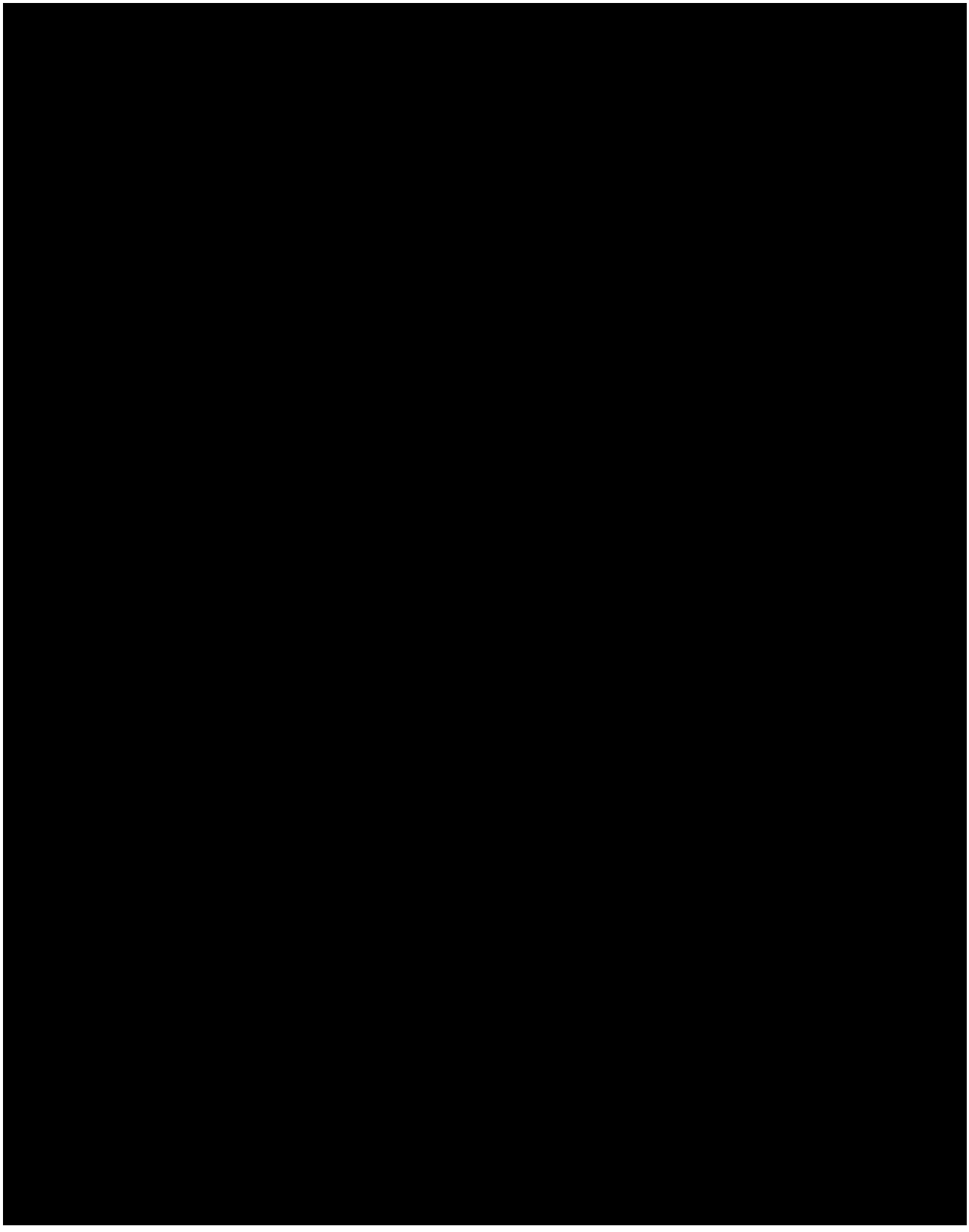












Re: SOC delay- URGENT taskforce

From: [redacted]
To: [redacted]
Cc: [redacted] Eli Coleman [redacted]
[redacted]
Date: Sun, 11 Sep 2022 17:17:51 -0400

Dear all

Thank you [redacted] thank you all for your hard work.

Having been in the mountains when you all made this decision to make changes last minute, and reading and hearing that nobody had wanted to make them, and personally deeply not agreeing with the change, feels as the most strange experience. I have been trying to understand it today, by connecting to [redacted] but still am not convinced. Just that you know.

See you in Montreal,

[redacted]

Verstuurd van mijn iPhone

> Op 11 sep. 2022 om 13:26 heeft [redacted] het volgende geschreven:
>
> Dear All,
>
> may I thank each and all of you for the tremendous effort you made to reach a deal with the AAP and to allow the SOC8 to be published. I have informed the WPATH Board of Directors and have send them the SOC8 with the proposed edits and asked for their vote of approval.
>
> I sincerely hope the Board with vote yes, after which I will approach the Senior Production Team at Taylor & Francis to make the suggested edits and then send me (as editor of IJTH) the proofs again for checking and approval, after which the SOC8 document will be send to another T&F department for release online. The last step will take at least 48 hours, so it is all going to be very tight, but hopefully we will mange to release the SOC8 before or during Montreal.
>
> Again, thank you so much, and I am keeping my fingers crossed and look forward to thanking you all in person in Montreal,
>
> [redacted]

On 2022-09-10 20:35, [redacted] wrote:

Thank you all for jumping on the call today & your consideration of these issues. I look forward to seeing you next week!

[redacted]

On Sat, Sep 10, 2022, 3:27 PM Eli Coleman [redacted] wrote:

[redacted], Eli, [redacted] from AAP and he reported that their EC is satisfied with the proposed changes. They recommended two small editorial edits ([redacted] will send those to you). They will not oppose the SOC 8 and are ready to make a statement in support of WPATH and AAP in advocating for the accessibility of care for transgender and gender diverse children and adolescence.

Thank you for all your efforts today. Now the BOD can consider these changes and we hopefully move to release asap.

Best,

Eli

Eli

On Sat, Sep 10, 2022 at 2:19 AM [redacted] wrote:

dear all,
In preparation for the meeting tomorrow with the adolescent chapter I am including the pdf with the comments from AAP. I have gone one by one through them and add my comments (in capiatal letter within their comment) as to why we are not going to make changes or if we are say that we are removing it. please have a look at this before the meeting and

in the meeting we need to discuss whether you agree. the main issue is whether to remove ages from the document.

i also include the document wpb edits, with highlighted sections that represent what it will be removed so you can see what the chapter may look like..

time is a problem as we want the soc8 to be out for montreal, so we need to agree tomorrow whether 1) we ignore all their comments 2) we remove the sections that I suggest or more if you feel. we cant change statements and we dont want to add text as it will not be time for it.

speak tomorrow. please dont share the document with anyone. i need to send this in two pdfs as there document is too big

[redacted]

[redacted]

From: [redacted]
Sent: 09 September 2022 22:32
[redacted]
[redacted]: Eli Coleman <[redacted]
Subject: Re: SOC delay- URGENT taskforce

I can meet between 9-10 AM Pacific time on Saturday.

Thanks,

From: [redacted]
Sent: Friday, September 9, 2022 2:09 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

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This is very confusing as I did not have any suggestions. I was shocked to see the feedback from very junior people from AAP, my suggestion was not to make any changes. We need to publish the SOC By Montreal so unless it goes asap it will not be ready

[redacted]

From: [redacted]
Sent: Friday, September 9, 2022 9:34:01 PM
[redacted]
Subject: Re: SOC delay- URGENT taskforce

I think it would be helpful to get the feedback, and [redacted] suggestions once the Chairs choose a time for the meeting.

Sent from my iPhone

> On Sep 9, 2022, at 4:23 PM, [redacted] wrote:
>
> Are you able to send us the AAP feedback or are we discussing whenever we meet?
>
> Get Outlook for iOS
> **From:** [redacted]
> **Sent:** Friday, September 9, 2022 4:02:31 PM
> [redacted] Eli Coleman <[redacted]
> **Subject:** Re: SOC delay- URGENT taskforce
>
> I can be available Saturday and Sunday.
> Thanks [redacted]
>
> Get Outlook for iOS
> **From:** [redacted]
> **Sent:** Friday, September 9, 2022 4:00:17 PM
> [redacted]
> **Subject:** Re: SOC delay- URGENT taskforce

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Report Suspicious

I can definitely meet Saturday, and I will make Sunday work.

[redacted]

On Fri, Sep 9, 2022 at 3:57 PM [redacted] wrote:
Happy to help! Let me know the times for the calls and I'll do my best.

Get Outlook for iOS
From: [redacted]
Sent: Friday, September 9, 2022 2:55:45 PM
[redacted]
Cc: Eli Coleman <[redacted]
[redacted]
Subject: SOC delay- URGENT taskforce

[redacted]

Well hello friends. I'm writing this email confidentially and urgently. I've also now touched base with each of you (or have attempted to do so) to discuss a matter of great importance related to the SOC8 release. This is time-sensitive.

In a nutshell, you likely saw the email that the SOC8 was going to be released by the biennial meeting (next week) in Montreal, particularly since we have GEI sessions and other sessions designed to train attendees on its release. Then you saw another email regarding an inadvertent delay in the release. I'm writing about the reason why and this is top-level confidential, as you will see.

The American Academy of Pediatrics (AAP)- a MAJOR organization in the United States that is typically very pro-transhealth/gender affirming care- voiced its *opposition* to the SOC8, specifically due to aspects of the Adolescent chapter. Not only did they say they would not endorse the SOC, they indicated that they would *actively publicly oppose it.* They had several concerns, one of which was the age criteria for minors (they believe that surgery of any type should not happen until the patient is age of majority). They also disagree with verbiage on social factors and adolescent identity development. They were tasked with providing feedback, which they did. We actually know some of the pediatricians who provided this feedback, which makes it rather shocking.

Clearly, if AAP were to publicly oppose the SOC8, it would be a major challenge for WPATH, SOC8, and trans youth access to care in the U.S.

You have been identified by me as someone to be a part of an urgent taskforce to figure out next steps. WPATH leadership has already proposed certain changes (removing of ages verbiage), however, we need to do the following: 1) Review the AAP feedback; 2) Review suggestions from SOC8 co-chairs; 3) Meet **tomorrow (Saturday) at some point between 12-3 PM EST** to discuss our thoughts on the subject and come up with a united approach; and 4) Meet with AAP colleagues **at some point shortly thereafter (potentially Sunday** depending on availability) to make sure we can come to an agreement to obtain their endorsement.

Can you all please reply with your ability to meet tomorrow and participate in this very important collaborative effort? I realize this might evoke some emotion and we'll have time to navigate that when in person over beverages in Montreal- so let's try to compartmentalize that for now and get our hard work efforts across the finish line. This is too important

Many thanks,

[redacted]

This message and any attachment are intended solely for the addressee

and may contain confidential information. If you have received this message in error, please contact the sender and delete the email and attachment.

[redacted]

This message and any attachment are intended solely for the addressee and may contain confidential information. If you have received this message in error, please contact the sender and delete the email and attachment.

[redacted]

--

Eli Coleman, PhD.
Academic Chair
in Sexual Health
Professor
and Director
The Institute for Sexual and Gender Health
University of Minnesota Medical School
Family Medicine and Community Health
sexualhealth.umn.edu

Re: last version with changes

From: [redacted]
To: "Hudson, Jeff" <[redacted]>
Cc: [redacted]
Date: Sat, 10 Sep 2022 13:10:08 -0400
Attachments: 06.09.22 SOC8 Final edit as agreed with adolescent chapter.pdf (12.5 MB)

Dear jeff,
Thank you very much for todays meeting and the support through this process.
We have just finished our meeting and we have agreed to remove the ages and to add the sentence we agreed. I hope that by doing this AAP will be able to endorse the SOC8 or at least to support it.
I am including the version that has been agreed with the adolescent chapter team and the chairs.
Kind regards
[redacted]

[redacted]

From: Hudson, Jeff <[redacted]>
Date: Saturday, 10 September 2022 at 16:35
To [redacted]
Cc [redacted]
Subject: RE: meeting

Friends,

I can hop back on zoom now-will do right now.

From: [redacted]
Sent: Friday, September 9, 2022 7:38 PM
To: [redacted]
Cc: Hudson, Jeff <[redacted]>
Subject: Re: meeting

I will set up zoom later

On Fri, Sep 9, 2022 at 7:12 PM [redacted] wrote:

I'm upstate. Please email with details of zoom. Phone reception isn't great up here.

Sent from my iPad

On 9 Sep 2022, at 19:49, [redacted] wrote:

I can't seem to get a hold of [redacted] I have to go to dinner.

Why don't we try to have a phone conversation tomorrow.
9 central?

--

[redacted]

--

[redacted]