

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

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

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

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

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

METHODOLOGY

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

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

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

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

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

tion.⁷ This winnowing process yielded 1,889 references.

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

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

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

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

citations illustrating a representative sample of multiple viewpoints were selected.

DEFINITIONS

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

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

HOMOSEXUALITY

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

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

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

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

Influences on Sexual Orientation

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

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

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

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

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

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

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

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

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

Psychosexual Development and Homosexual Orientation

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

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

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

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

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

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

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

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

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

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

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

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

Clinical Issues in Homosexuality

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

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

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

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

GENDER IDENTITY AND GENDER DISCORDANCE

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

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

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

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

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

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

Factors Influencing Development of Gender Discordance

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

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

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

PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-sex wishes. To assist clinicians in determining whether gender discordance is present, in addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children,⁹⁴ the Gender Identity Questionnaire for Children,⁹⁵ and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults.⁹⁶ In using such instruments, clinicians should bear in mind that the American Psychiatric Association’s Gender Identity Disorder subworkgroup for *DSM-5* is currently debating areas of controversy in the diagnostic criteria for GID, including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.⁹³

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARAMETER LIMITATIONS

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

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

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

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

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

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REFERENCES

1. Bayer R. Homosexuality and American Psychiatry: the Politics of Diagnosis. New York: Basic Books; 1981.
2. Cochran SD, Mays VM, Sullivan JG. Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *J Consult Clin Psychol.* 2003;71:53-61.
3. Fergusson DM, Horwood LJ, Beautrais AL. Is sexual orientation related to mental health problems and suicidality in young people? *Arch Gen Psychiatry.* 1999;56:876-880.
4. Safen SA, Heimberg RG. Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *J Consult Clin Psychol.* 1999;67:859-866.
5. Sandfort T, de Graaf R, Bijl R, Schnabel P. Same-sex sexual behavior and psychiatric disorders: findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Arch Gen Psychiatry.* 2001;58:85-91.
6. Sandfort T, Bakker F, Schellevis F, Vanwesenbeeck I. Sexual orientation and mental and physical health status: findings from

- a Dutch population survey. *Am J Public Health*. 2006;96:1119-1125.
7. American Psychiatric Association. Position statement on therapies focused on attempts to change sexual orientation (reparative or conversion therapies). *Am J Psychiatry*. 2000;157:1719-1721.
 8. Drescher J. *Psychoanalytic Therapy and the Gay Man*. Hillsdale, NJ: Analytic Press; 1998.
 9. Friedman RC. *Male Homosexuality: a Contemporary Psychoanalytic Perspective*. New Haven, CT: Yale University Press; 1988.
 10. Friedman RC, Downey JI. *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice*. New York: Columbia University Press; 2002.
 11. Friedman RC. The issue of homosexuality in psychoanalysis. In: Fonagy P, Krause R, Leuzinger-Bohleber M, eds. *Identity, Gender, and Sexuality: 150 Years After Freud*. London: International Psychoanalytical Association; 2006:79-102.
 12. Friedman RC, Downey JI. Homosexuality. *N Engl J Med*. 1994;331:923-930.
 13. Savin-Williams RC, Cohen KM. Homoerotic development during childhood and adolescence. *Child Adolesc Psychiatr Clin N Am*. 2004;13:529-549, vii.
 14. Zucker KJ. Gender identity development and issues. *Child Adolesc Psychiatr Clin N Am*. 2004;13:551-568, vii.
 15. Herdt G, van de Meer T. Homophobia and anti-gay violence—contemporary perspectives. Editorial introduction. *Culture Health Sex*. 2003;5:2,99-101.
 16. Laumann EO, Gagnon JH, Michael RT, Michaels S. *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago: University of Chicago Press; 1994.
 17. Mosher WD, Chandra A, Jones J. Sexual behavior and selected health measures: men and women 15–44 years of age, United States, 2002. *Adv Data*. 2005;362:1-55.
 18. Remafedi G, Resnick M, Blum R, Harris L. Demography of sexual orientation in adolescents. *Pediatrics*. 1992;89:714-721.
 19. Mustanski BS, Chivers ML, Bailey JM. A critical review of recent biological research on human sexual orientation. *Ann Rev Sex Res*. 2002;13:89-140.
 20. Ellis L, Ames MA. Neurohormonal functioning and sexual orientation: a theory of homosexuality/heterosexuality. *Psychol Bull*. 1987;101:233-258.
 21. Meyer-Bahlburg, HFL. Psychoendocrine research on sexual orientation: current status and future options. *Prog Brain Res*. 1984;61:375-398.
 22. Bailey JM, Pillard RC. A genetic study of male sexual orientation. *Arch Gen Psychiatry*. 1991;48:1089-1096.
 23. Bailey JM, Pillard RC, Neale MC, Agyei Y. Heritable factors influence sexual orientation in women. *Arch Gen Psychiatry*. 1993;50:217-223.
 24. LeVay S. A difference in hypothalamic structure between heterosexual and homosexual men. *Science*. 1991;253:1034-1037.
 25. Hooker EA. The adjustment of the male overt homosexual. *J Project Techn*. 1957;21:18-31.
 26. Biernbaum MA, Ruscio M. Differences between matched heterosexual and non-heterosexual college students on defense mechanisms and psychopathological symptoms. *J Homosex*. 2004;48:125-41.
 27. Evans RB. Childhood parental relationships of homosexual men. *J Consult Clin Psychol*. 1969;33:129-135.
 28. Bell AP, Weinberg MS, Hammersmith, SK. *Sexual Preference: Its Development in Men and Women*. Bloomington: Indiana University Press; 1981.
 29. Bailey JM, Miller JS, Willerman L. Maternally rated childhood gender nonconformity in homosexuals and heterosexuals. *Arch Sex Behav* 1993;22:461-469.
 30. Biblarz TJ, Stacey J. How does the gender of parents matter? *J Marriage Fam*. 2010;72:3-22.
 31. Fulcher M, Sutfin EL, Patterson CJ. Individual differences in gender development: associations with parental sexual orientation, attitudes, and division of labor. *Sex Roles*. 2008;58:330-341.
 32. Golombok S, Perry B, Burston A, et al. Children with lesbian parents: a community study. *Dev Psychol*. 2003;39:20-33.
 33. Gartrell NK, Bos HM, Goldberg NG. Adolescents of the U.S. National Longitudinal Lesbian Family Study: sexual orientation, sexual behavior, and sexual risk exposure. *Arch Sex Behav*. 2011;40:1199-1209.
 34. Groth AN, Birnbaum HJ. Adult sexual orientation and attraction to underage persons. *Arch Sex Behav*. 1978;7:175-181.
 35. Jenny C, Roesler TA, Poyer KL. Are children at risk for sexual abuse by homosexuals? *Pediatrics*. 1994;94:41-44.
 36. Cameron JL. Interrelationships between hormones, behavior, and affect during adolescence: understanding hormonal, physical, and brain changes occurring in association with pubertal activation of the reproductive axis. Introduction to part III. *Ann NY Acad Sci*. 2004;1021:110-123.
 37. McClintock MK, Herdt G. Rethinking puberty: the development of sexual attraction. *Curr Direct Psychol Sci*. 1996;5:178-182.
 38. Leitenberg H, Henning K. Sexual fantasy. *Psychol Bull*. 1995;117:469-496.
 39. Troiden RR. The formation of homosexual identities. *J Homosex*. 1989;17:43-73.
 40. Floyd FJ, Bakeman R. Coming-out across the life course: implications of age and historical context. *Arch Sex Behav*. 2006;35:287-297.
 41. Baumeister RF. Gender differences in erotic plasticity: the female sex drive as socially flexible and responsive. *Psychol Bull*. 2000;126:347-374; discussion 385-349.
 42. Diamond LM. *Sexual Fluidity: Understanding Women's Love and Desire*. Cambridge, MA: Harvard University Press; 2008.
 43. Golombok S, Fivush R. *Gender Development*. New York: Cambridge University Press; 1994.
 44. Maccoby EE. *The Two Sexes: Growing Up Apart, Coming Together. The Family and Public Policy*. Cambridge, MA: Belknap Press of Harvard University Press; 1998.
 45. Jervolino AC, Hines M, Golombok SE, Rust J, Plomin R. Genetic and environmental influences on sex-typed behavior during the preschool years. *Child Dev*. 2005;76:826-840.
 46. Ruble DN, Martin CL, Berenbaum SA. Gender Development. In: Damon W, Lerner RM, eds., *Handbook of Child Psychology*, 6th ed. [electronic resource]. Hoboken, NJ: Wiley InterScience; 2007:858-932.
 47. Bussey K, Bandura A. Social cognitive theory of gender development and differentiation. *Psychol Rev*. 1999;106:676-713.
 48. Bailey JM, Zucker KJ. Childhood sex-typed behavior and sexual orientation: a conceptual analysis and quantitative review. *Dev Psychol*. 1995;31:43-55.
 49. Whitam FL. The prehomosexual male child in three societies: the United States, Guatemala, Brazil. *Arch Sex Behav*. 1980;9:87-99.
 50. Whitam FL, Mathy RM. Childhood cross-gender behavior of homosexual females in Brazil, Peru, the Philippines, and the United States. *Arch Sex Behav*. 1991;20:151-170.
 51. Friedman RC, Downey JI. The psychobiology of late childhood: significance for psychoanalytic developmental theory and clinical practice. *J Am Acad Psychoanal*. 2000;28:431-448.
 52. Faulkner AH, Cranston K. Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *Am J Public Health*. 1998;88:262-266.
 53. Garofalo R, Wolf RC, Kessel S, Palfrey SJ, DuRant RH. The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*. 1998;101:895-902.
 54. Remafedi G, French S, Story M, Resnick MD, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health*. 1998;88:57-60.
 55. Carragher DJ, Rivers I. Trying to hide: a cross-national study of growing up for non-identified gay and bisexual male youth. *Clin Child Psychol Psychiatry*. 2002;7:457-474.
 56. Berlan ED, Corliss HL, Field AE, Goodman E, Austin SB. Sexual orientation and bullying among adolescents in the Growing Up Today study. *J Adolesc Health*. 2010;46:366-371.
 57. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*. 2009;123:346-352.
 58. Bradley SJ, Blanchard R, Coates S, et al. Interim report of the DSM-IV Subcommittee on Gender Identity Disorders. *Arch Sex Behav*. 1991;20:333-343.

59. Bradley, SJ, Zucker, KJ. Gender identity disorder: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry*. 1997;36:872-880.
60. Meyer-Bahlburg HFL. From mental disorder to iatrogenic hypogonadism: dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Arch Sex Behav* 2010;39:461-476.
61. Cohen-Kettenis PT, Gooren LJG. Transsexualism: a review of etiology, diagnosis and treatment. *J Psychosomatic Res*. 1999;46:315-333.
62. Green R. The "Sissy-Boy Syndrome" and the Development of Homosexuality. New Haven: Yale University Press; 1987.
63. Zucker KJ, Bradley SJ. Gender Identity Disorder and Psychosexual Problems in Children and Adolescents. New York: Guilford Press; 1995.
64. Zucker KJ, Bradley SJ, Sullivan CB, Kuksis M, Birkenfeld-Adams A, Mitchell JN. A gender identity interview for children. *J Person Assess*. 1993;61:443-456.
65. Smith YL, van Goozen SH, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2001;40:472-481.
66. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. *J Abnorm Child Psychol*. 2003;31:41-53.
67. Zucker KJ, Owen A, Bradley SJ, Ameier L. Gender-dysphoric children and adolescents: a comparative analysis of demographic characteristics and behavioral Problems. *Clin Child Psychol Psychiatry*. 2002;7:398-411.
68. Marantz S, Coates S. Mothers of boys with gender identity disorder: a comparison of matched controls. *J Am Acad Child Adolesc Psychiatry*. 1991;30:310-315.
69. Meyer-Bahlburg HF. Gender identity outcome in female-raised 46, XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Arch Sex Behav*. 2005;34:423-438.
70. Zhou JN, Hofman MA, Gooren LJG, Swaab DF. A sex difference in the human brain and its relation to transsexuality. *Nature*. 1995;378:68-70.
71. Coates S, Friedman RC, Wolfe S. The etiology of boyhood gender identity disorder: a model for integrating temperament, development, and psychodynamics. *Psychoanal Dialogues*. 1991;1:481-523.
72. Spitzer RL. Can some gay men and lesbians change their sexual orientation? 200 Participants reporting a change from homosexual to heterosexual orientation. *Arch Sex Behav*. 2003;32:249-259.
73. Savin-Williams RC. Mom, Dad, I'm Gay: How Families Negotiate Coming Out. Washington, DC: American Psychological Association; 2001.
74. Canino IA, Spurlack J. Culturally Diverse Children and Adolescents: Assessment, Diagnosis and Treatment. New York: Guilford Press; 2000:7-43.
75. Rosario M, Schrimshaw EW, Hunter J. Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: a comparison of sexual identity development over time. *Cultural Diversity Ethn Minor Psychol*. 2004;10:215-228.
76. Smith PK, Morita Y, Junger-Tas J, Olweus D, Catalano RF, Slee P, eds. The Nature of School Bullying: A Cross-National Perspective. Florence, KY: Taylor and Francis/Routledge; 1999.
77. Kim YS, Leventhal BL, Koh YJ, Hubbard A, Boyce WT. School bullying and youth violence: causes or consequences of psychopathologic behavior? *Arch Gen Psychiatry*. 2006;63:1035-1041.
78. Sourander A, Jensen P, Ronning JA, et al. What is the early adulthood outcome of boys who bully or are bullied in childhood? The Finnish "From a Boy to a Man" study. *Pediatrics*. 2007;120:397-404.
79. Rivers I, Duncan N, Besag VE. Bullying: A Handbook for Educators and Parents. Westport, CT: Praeger; 2007.
80. Harry J. Parasuicide, gender, and gender deviance. *J Health Soc Behav*. 1983;24:350-361.
81. Alanko K, Santtila P, Witting K, et al. Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. *J Sex Res*. 2009;46:494-504.
82. Eisenberg, ME, Resnick, MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39:662-668.
83. Smith SD, Dermer SB, Astramovich RL. Working with nonheterosexual youth to understand sexual identity development, at-risk behaviors, and implications for health care professionals. *Psychol Rep*. 2005;96:651-654.
84. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual intercourse, abuse and pregnancy among adolescent women: does sexual orientation make a difference? *Fam Plann Perspect*. 1999;31:127-131.
85. Ziyadeh NJ, Prokop LA, Fisher LB, et al. Sexual orientation, gender, and alcohol use in a cohort study of U.S. adolescent girls and boys. *Drug Alcohol Depend*. 2007;87:119-130.
86. Donenberg GR, Pao M. Youth and HIV/AIDS: Psychiatry's role in a changing epidemic. *J Am Acad Child Adolesc Psychiatry*. 2005;44:728-747.
87. Blake SM, Ledsky R, Lehman T, Goodenow C, Sawyer R, Hack T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *Am J Public Health*. 2001;91:940-946.
88. Johnson WD, Diaz RM, Flanders WD, et al. Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men. *Cochrane Database System Rev*. 2008;(3):CD001230.
89. Bancroft J. Deviant Sexual Behaviour: Modification and Assessment. Oxford: Clarendon Press; 1974.
90. Bancroft J, Beckstead AL, Byrd AD, et al. Peer commentaries on Spitzer. *Arch Sex Behav*. 2003;32:419-468.
91. American Academy of Child and Adolescent Psychiatry. Policy Statement on Sexual Orientation, Gender Identity, and Civil Rights, revised and approved by Council 2009. Available at: http://www.aacap.org/cs/root/policy_statements/sexual_orientation_gender_identity_and_civil_rights. Accessed September 30, 2011.
92. Friedrich WN, Grambsch P, Broughton D, Kuiper J, Beilke RL. Normative sexual behavior in children. *Pediatrics*. 1991;88:456-464.
93. Zucker KJ, Wood H. Assessment of gender variance in children. *Child Adolesc Psychiatr Clin N Am*. 2011;20:665-680.
94. Wallien MS, Quilty LC, Steensma TD, et al. Cross-national replication of the Gender Identity Interview for Children. *J Person Assess*. 2009;91:545-552.
95. Johnson LL, Bradley SJ, Birkenfeld-Adams AS, et al. A parent-report gender identity questionnaire for children. *Arch Sex Behav*. 2004;33:105-116.
96. Singh D, Deogracias JJ, Johnson LL, et al. The Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults: further validity evidence. *J Sex Res*. 2010;47:49-58.
97. Lee PA, Houk CP, Ahmed SF, Hughes IA, International Consensus Conference on Intersex organized by the Lawson Wilkins Pediatric Endocrine Society and the European Society for Paediatric Endocrinology. Consensus statement on management of intersex disorders. *International Consensus Conference on Intersex*. *Pediatrics*. 2006;118:e488-e500.
98. Rekers GA, Kilgus M, Rosen AC. Long-term effects of treatment for gender identity disorder of childhood. *J Psychol Hum Sex*. 1990;3:121-153.
99. Pleak RR. Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In: Rottnek M, ed. Sissies and Tomboys: Gender Nonconformity and Homosexual Childhood. New York: New York University Press; 1999:34-51.
100. Meyer-Bahlburg HFL. Gender identity disorder in young boys: a parent- and peer-based treatment protocol. *Clin Child Psychol Psychiatry*. 2002;7:360-376.
101. Menvielle EJ, Tuerk C. A support group for parents of gender-nonconforming boys. *J Am Acad Child Adolesc Psychiatry*. 2002;41:1010-1013.
102. Hembree WC, Cohen-Kettenis P, et al. Endocrine Treatment of Transsexual Persons: an Endocrine Society Clinical Practice Guideline. *Clin Endocrinol Metab*. 2009;94:3132-3154.

103. de Vries AL, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med.* 2010;8:2276-2283.
104. de Vries AL, Kreukels BP, Steensma TD, Doreleijers TA, Cohen-Kettenis PT. Comparing adult and adolescent transsexuals: an MMPI-2 and MMPI-A study. *Psychiatry Res.* 2011;186:414-418.
105. Cohen-Kettenis PT, Steensma TD, de Vries ALC. Treatment of adolescents with gender dysphoria in the Netherlands. *Child Adolesc Psychiatr Clin N Am.* 2011;20:689-700.
106. Leibowitz SF, Spack NP. The development of a gender identity psychosocial clinic: treatment issues, logistical considerations, interdisciplinary cooperation, and future initiatives. *Child Adolesc Psychiatr Clin N Am.* 2011;20:701-724.
107. Hembree WC. Guidelines for pubertal suspension and gender reassignment for transgender adolescents. *Child Adolesc Psychiatr Clin N Am.* 2011;20:725-732.
108. Menvielle EJ, Rodnan LA. A therapeutic group for parents of transgender adolescents. *Child Adolesc Psychiatr Clin N Am.* 2011;20:733-744.
109. Wilber S, Ryan C, Marksamer J, Child Welfare League of America IWDC. CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care: Child Welfare League of America; 2006.
110. World Professional Association for Transgender Health. The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version, Minneapolis, MN. 2001.