

No. 24-539

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IN THE  
**Supreme Court of the United States**

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KALEY CHILES,

*Petitioner,*

v.

PATTY SALAZAR, in her official capacity as Executive  
Director of the Department of Regulatory Agencies,  
et al.,

*Respondents.*

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**JOINT APPENDIX**  
**(Volume 2 of 2, Pages 399–659)**

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## TABLE OF CONTENTS

### VOLUME 1

Colo. Rev. Stat. § 12-245-217.....	1
Colo. Rev. Stat. § 12-245-224.....	4
Colo. Rev. Stat. § 12-245-603.....	11
Colo. Rev. Stat. § 12-245-803.....	13
United States District Court District of Colorado Declaration of Judith M. Glassgold Filed November 3, 2022 .....	17
United States District Court District of Colorado Exhibit A to Declaration of Judith M. Glassgold – Curriculum Vitae .....	98
United States District Court District of Colorado Exhibit B to Declaration of Judith M. Glassgold – Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation dated August 2009 (part 1).....	131

### VOLUME 2

United States District Court District of Colorado Exhibit B to Declaration of Judith M. Glassgold – Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation dated August 2009 (part 2) .....	399
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United States District Court	
District of Colorado	
Exhibit C to Declaration of Judith M. Glassgold –	
Report of SAMHSA entitled Ending Conversion	
Therapy: Supporting and Affirming LGBTQ Youth	
dated October 2015 .....	518

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APPENDIX A: RESOLUTION ON  
APPROPRIATE AFFIRMATIVE RESPONSES  
TO SEXUAL ORIENTATION DISTRESS AND  
CHANGE EFFORTS

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**Research Summary**

The longstanding consensus of the behavioral and social sciences and the health and mental health professions is that homosexuality per se is a normal and positive variation of human sexual orientation (Bell, Weinberg, & Hammersmith, 1981; Bullough, 1976; Ford & Beach 1951; Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Homosexuality per se is not a mental disorder (APA, 1975). Since 1974, the American Psychological Association (APA) has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals (APA, 2005).

APA is concerned about ongoing efforts to mischaracterize homosexuality and promote the notion that sexual orientation can be changed and about the resurgence of sexual orientation change efforts (SOCE).<sup>A1</sup> SOCE has been controversial due to

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<sup>A1</sup> APA uses the term *sexual orientation change efforts* (SOCE) to describe methods (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches) that aim to change a same-sex sexual orientation to heterosexual, regardless of whether mental health professionals or lay individuals (including religious professionals, religious leaders, social groups, and other lay networks, such as self-help groups) are involved.

tensions between the values held by some faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual rights organizations and professional and scientific organizations, on the other (Drescher, 2003; Drescher & Zucker, 2006).

Some individuals and groups have promoted the idea of homosexuality as symptomatic of developmental defects or spiritual and moral failings and have argued that SOCE, including psychotherapy and religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker, 2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be embedded within the larger context of conservative religious political movements that have supported the stigmatization of homosexuality on political or religious grounds (Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005). Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. The APA concludes that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior (APA, 2008a, 2008c).

In response to these concerns, APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the association. The task force reached the following findings.



Recent studies of participants in SOCE identify a population of individuals who experience serious distress related to same-sex sexual attractions. Most of these participants are Caucasian males who report that their religion is extremely important to them (Beckstead & Morrow, 2004; Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Shidlo & Schroeder, 2002; Spitzer, 2003). These individuals report having pursued a variety of religious and secular efforts intended to help them change their sexual orientation. To date, the research has not fully addressed age, gender, gender identity, race, ethnicity, culture, national origin, disability, language, and socioeconomic status in the population of distressed individuals.

There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation. Scientifically rigorous older work in this area (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, 1969, 1976; McConaghy, Proctor, & Barr, 1972; Tanner, 1974, 1975) found that sexual orientation (i.e., erotic attractions and sexual arousal oriented to one sex or the other, or both) was unlikely to change due to efforts designed for this purpose. Some individuals appeared to learn how to ignore or limit their attractions. However, this was much less likely to be true for people whose sexual attractions were initially limited to people of the same sex.

Although sound data on the safety of SOCE are extremely limited, some individuals reported being harmed by SOCE. Distress and depression were exacerbated. Belief in the hope of sexual orientation change followed by the failure of the treatment was

identified as a significant cause of distress and negative self-image (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behavior, and values (Nicolosi et al., 2000). They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002). Based on the available data, additional claims about the meaning of those outcomes are scientifically unsupported.

On the basis of the task force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent (Bartoli & Gillem, 2008; Brown, 2006) and client-centered approaches (e.g., Beckstead & Israel, 2007; Glassgold, 2008; Haldeman, 2004; Lasser & Gottlieb, 2004) that recognize the negative impact of social stigma on sexual minorities (Herek, 2009; Herek & Garnets, 2007)<sup>A2</sup> and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity (APA,

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<sup>A2</sup> We use the term *sexual minority* (cf. Blumenfeld, 1992; McCarn & Fassinger, 1996; Ullerstam, 1966) to designate the entire group of individuals who experience significant erotic and romantic attractions to adult members of their own sex, including those who experience attractions to members of both their own and the other sex. This term is used because we recognize that not all sexual minority individuals adopt an LGB bisexual identity.

1998, 2002; Davison, 1976; Haldeman, 2002; Schneider, Brown, & Glassgold, 2002).

### **Resolution**

WHEREAS, The American Psychological Association expressly opposes prejudice (defined broadly) and discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 1998, 2000, 2002, 2003, 2005, 2006, 2008c);

WHEREAS, The American Psychological Association takes a leadership role in opposing prejudice and discrimination (APA, 2008b, 2008c), including prejudice based on or derived from religion or spirituality, and encourages commensurate consideration of religion and spirituality as diversity variables (APA, 2008c);

WHEREAS, Psychologists respect human diversity including age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status (APA, 2002) and psychologists strive to prevent bias from their own spiritual, religious, or nonreligious beliefs from taking precedence over professional practice and standards or scientific findings in their work as psychologists (APA, 2008c);

WHEREAS, Psychologists are encouraged to recognize that it is outside the role and expertise of psychologists, as psychologists, to adjudicate religious or spiritual tenets, while also recognizing that psychologists can appropriately speak to the

psychological implications of religious/spiritual beliefs or practices when relevant psychological findings about those implications exist (APA, 2008c);

WHEREAS, Those operating from religious/spiritual traditions are encouraged to recognize that it is outside their role and expertise to adjudicate empirical scientific issues in psychology, while also recognizing they can appropriately speak to theological implications of psychological science (APA, 2008c);

WHEREAS, The American Psychological Association encourages collaborative activities in pursuit of shared prosocial goals between psychologists and religious communities when such collaboration can be done in a mutually respectful manner that is consistent with psychologists' professional and scientific roles (APA, 2008c);

WHEREAS, Societal ignorance and prejudice about a same-sex sexual orientation places some sexual minorities at risk for seeking sexual orientation change due to personal, family, or religious conflicts, or lack of information (Beckstead & Morrow, 2004; Haldeman, 1994; Ponticelli, 1999; Shidlo & Schroeder, 2002; Wolkomir, 2001);

WHEREAS, Some mental health professionals advocate treatments based on the premise that homosexuality is a mental disorder (e.g., Nicolosi, 1991; Socarides, 1968);

WHEREAS, Sexual minority children and youth are especially vulnerable populations with unique developmental tasks (Perrin, 2002; Ryan &

Futterman, 1997) who lack adequate legal protection from involuntary or coercive treatment (Arriola, 1998; Burack & Josephson, 2005; Molnar, 1997) and whose parents and guardians need accurate information to make informed decisions regarding their development and well-being (Cianciatto & Cahill, 2006; Ryan & Futterman, 1997); and

WHEREAS, Research has shown that family rejection is a predictor of negative outcomes (Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams, 1994; Wilber, Ryan, & Marksamer, 2006) and that parental acceptance and school support are protective factors (D'Augelli, 2003; D'Augelli, Hershberger, & Pilkington, 1998; Goodenow, Szalacha, & Westheimer, 2006; Savin-Williams, 1989) for sexual minority youth;

THEREFORE, BE IT RESOLVED, That the American Psychological Association affirms that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity;

BE IT FURTHER RESOLVED, That the American Psychological Association reaffirms its position that homosexuality per se is not a mental disorder and opposes portrayals of sexual minority youths and adults as mentally ill due to their sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that there is insufficient evidence to support the use of

psychological interventions to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages mental health professionals to avoid misrepresenting the efficacy of sexual orientation change efforts by promoting or promising change in sexual orientation when providing assistance to individuals distressed by their own or others' sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation;

BE IT FURTHER RESOLVED, That the American Psychological Association concludes that the emerging knowledge on affirmative multiculturally competent treatment provides a foundation for an appropriate evidence-based practice with children, adolescents and adults who are distressed by or seek to change their sexual orientation (Bartoli & Gillem, 2008; Brown, 2006; Martell, Safren, & Prince, 2004; Norcross, 2002; Ryan & Futterman, 1997);

BE IT FURTHER RESOLVED, That the American Psychological Association advises parents, guardians, young people, and their families to avoid sexual orientation change efforts that portray homosexuality as a mental illness or developmental disorder and to seek psychotherapy, social support and educational services that

provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority youth;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to consider the ethical concerns outlined in the 1997 APA Resolution on Appropriate Therapeutic Response to Sexual Orientation (APA, 1998), in particular the following standards and principles: Bases for Scientific and Professional Judgments, Beneficence and Harm, Justice, and Respect for People's Rights and Dignity;

BE IT FURTHER RESOLVED, That the American Psychological Association encourages practitioners to be aware that age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma and contribute to variations in sexual orientation identity development, expression, and experience;

BE IT FURTHER RESOLVED, That the American Psychological Association opposes the distortion and selective use of scientific data about homosexuality by individuals and organizations seeking to influence public policy and public opinion and will take a leadership role in responding to such distortions;

BE IT FURTHER RESOLVED, That the American Psychological Association supports the dissemination of accurate scientific and professional information about sexual orientation in order to counteract bias that is based in lack of knowledge about sexual orientation; and

BE IT FURTHER RESOLVED, That the American Psychological Association encourages advocacy groups, elected officials, mental health professionals, policymakers, religious professionals and organizations, and other organizations to seek areas of collaboration that may promote the well-being of sexual minorities.

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APPENDIX B: STUDIES INCLUDED ( $N = 55$ ) IN THE  
SYSTEMATIC REVIEW (CHAPTERS 3 AND 4)

Study	$N$	% Males	Sample	Retention & treatment withdrawals	Research design	Treatment	Outcome measure
<b><i>Experimental studies</i></b>							
McConaghy, 1969	40	100	Clinical (6 by court order; 18 with arrest history)	3 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversion apomorphine therapy and aversion relief therapy	Penile circumference
McConaghy, 1976	157	100	Clinical (21 by court order)	None reported	4 experimental substudies ( $ns=40, 40, 46,$ 31, respectively) with random assignment to one of two or	Aversive apomorphine therapy or aversion-relief; aversive therapy or apomorphine or	Sexual feelings; sexual behavior; penile circumference; sexual orientation



					three treatment alternatives	avoidance conditioning; classical, or avoidance, or backward conditioning; classical aversive therapy or positive conditioning	
McConaghy & Barr, 1973	46	100	Clinical	26 had incomplete treatment exposure; 2 of 20 with complete exposure lost to follow-up	3 treatment group randomized experiment	Classical conditioning, avoidance conditioning, backward conditioning	Heart rate; penile circumference; galvanic skin response
McConaghy, Proctor, & Barr, 1972	40	100	Clinical (police and psychiatric referrals)	16 with incomplete follow-up data and 2 withdrawals	4 treatment group randomized experiment	Immediate and delayed aversive apomorphine therapy; immediate and delayed	Penile circumference

							anticipatory avoidance learning	
Tanner, 1974	16	100	Clinical	None reported	Random assignment experiment with wait list control	Aversive shock therapy	Penile circumference; sexual behavior; personality	
Tanner, 1975	10	100	Clinical	None reported	2 treatment group randomized experiment	Aversive shock therapy with/without booster sessions	Penile circumference; self-reported arousal; sexual behavior; personality	
<i>Quasi-experimental studies</i>								
Birk, Huddleston, Miller, & Cohler, 1971	18	100	Clinical	2 withdrew participation	Nonequivalent 2 treatment group comparison design	Aversive shock therapy vs. associative conditioning	Sexual behavior; clinical judgment; personality	
S. James, 1978	40	100	Court-referred	None reported	Nonequivalent 2 treatment group comparison design	Anticipatory avoidance, desensitization, hypnosis,	Sexual orientation; personality	

							anticipatory avoidance	
McConaghy, Armstrong, & Blaszczynski, 1981	20	100	Clinical	None reported	Nonequivalent 2 treatment group comparison design		Aversive therapy; covert sensitization	Sexual feelings
<i>Nonexperimental studies</i>								
Bancroft, 1969	16	100	Clinical	6 withdrew participation prior to treatment and 1 during treatment	Case study		Aversive shock therapy	Sexual behavior
Barlow & Agras, 1973	3	100	Clinical	None reported	Case study		Fading	Penile circumference; sexual urges; sexual fantasies
Barlow, Agras, Abel, Blanchard, & Young, 1975	3	100	Clinical	None reported	Single case pre-post within-subject		Biofeedback	Penile circumference
Beckstead & Morrow, 2004	50	80	Purposive	None	Qualitative retrospective, grounded theory		Conversion therapy, ex-gay ministries,	Subjective experiences of treatment;

									subjective appraisal of sexual orientation identity, attraction, & behavior
Birk, 1974	66	100	Clinical	13 withdrew participation	Pre-post within-subject	Psychotherapy			Sexual orientation
Blitch & Haynes, 1972	1	0	Clinical	None reported	Case study	Relaxation therapy and masturbation reconditioning			Sexual behavior
Callahan & Leitenberg, 1973	23	100	Clinical with 2 by court order	9 men withdrew participation and 8 excluded from data analyses	Pre-post within-subject	Aversion shock therapy and covert sensitization			Penile circumference
Colson, 1972	1	100	Clinical	None reported	Case study	Olfactory aversion therapy			Sexual behavior
Conrad & Wincze, 1976	4	100	Clinical	None reported	Case study	Orgasmic reconditioning			Sexual behavior; sexual

								fantasies; penile circumference
Curtis & Presly, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual orientation	
Feldman & MacCulloch, 1965	43	100	Clinical	7 withdrawals	Pre-post within- subject	Anticipatory avoidance	Sexual orientation	
Fookes, 1960	27	100	Clinical (7 exhibitionists , 5 fetishists, and 15 bisexual and homosexual men)	None reported	Pre-post within- subject	Aversion shock therapy and calorie deprivation	Clinical judgment	
Freeman & Meyer, 1975	9	100	Clinical	None reported	Pre-post within- subject	Aversion shock therapy and masturbation reconditioning	Sexual behavior; sexual orientation	
Freund, 1960	67	100	Clinical	20 withdrawals	Pre-post within- subject	Aversion apomorphine therapy	Clinical judgment	
Gray, 1970	1	100	Clinical	None reported	Case study	Desensitization and masturbation reconditioning	Sexual behavior	

Hallam & Rachman, 1972	7	100	Clinical (2 pedophiles, 1 fetishist, 3 bisexual and homosexual men, and 1 voyeur)	None reported	Pre-post within-subject	Aversion shock therapy	Heart rate; galvanic skin response
Hanson & Adesso, 1972	1	100	Clinical	None reported	Case study	Desensitization and aversive counter-conditioning	Sexual behavior
Herman, Barlow, & Agras, 1974	4	100	Clinical	None reported	Case Study	Counter-conditioning	Penile circumference; self-reported arousal
Herman & Prewett, 1974	1	100	Clinical	None reported	Case study	Biofeedback	Penile circumference
Huff, 1970	1	100	Clinical	None reported	Case study	Desensitization	Sexual behavior; personality
B. James, 1962	1	100	Clinical	Treatment stopped due to adverse reaction	Case study	Aversion apomorphine therapy	Sexual fantasies; sexual behavior

Kendrick & McCullough, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Sexual fantasies; sexual behavior
Larson, 1970	3	100	Clinical	None reported	Case study	Anticipatory avoidance	Sexual fantasies; sexual behavior
Levin, Hirsch, Shugar, & Kapche, 1968	1	100	Clinical	None reported	Case study	Desensitization, avoidance conditioning	Personality
LoPiccolo, 1971	1	100	Clinical	None reported	Case study	Desensitization	Masturbation fantasies
LoPiccolo, Stewart, & Watkins, 1972	1	100	Clinical	None reported	Case study	Orgasmic reconditioning	Sexual behavior
MacCulloch & Feldman, 1967	43	?	Clinical (18 by court order and 4 psychiatric referrals)	7 withdrawals	Pre-post within-subject	Anticipatory avoidance with aversion shock therapy	Sexual orientation; sexual behavior
MacCulloch, Feldman, & Pinshoff, 1965	4	100	Clinical (3 by court order)	1 withdrawal	Case study	Anticipatory avoidance with aversion shock therapy	Attractions; pulse rate

Marquis, 1970	14	79	Clinical	None reported	Case study	Orgasmic reconditioning	Clinical judgment
McCrady, 1973	1	100	Clinical	None reported	Case study	Forward fading	Sexual preference; sexual behavior
Mintz, 1966	10	100	Clinical	5 withdrawals	Case study	Therapy	Clinical judgment
Nicolosi, Byrd, & Potts, 2000	882	78	Convenience (NARTH and ex-gay ministry members)	None reported	Retrospective pretest	Conversion therapy	Sexual orientation; sexual behavior
Pattison & Pattison, 1980	11	100	Convenience	None reported; 19 declines to participate	Qualitative retrospective case study	Religious folk therapy	Subjective experience
Ponticelli, 1999	15	0	Purposive (ex-gay ministry)	None reported	Ethnography	Ex-gay ministry	None
Quinn, Harbison, & McAllister, 1970	1	100	Clinical	None reported	Case study	Desensitization and hydration deprivation	Penile circumference



Rehm & Rozensky, 1974	1	100	Clinical	None reported	Case study	Therapy and orgasmic reconditioning	Sexual behavior
Sandford, Tustin, & Priest, 1975	2	100%	Clinical	1 withdrawal reported	Case study	Differential reinforcement and punishment	Penile circumference
Schaeffer, Hyde, Kroencke, & McCormick, & Nottebaum, 2000	248	74	Convenience (Exodus International conference attendees)	None reported	Retrospective pretest	Varied counseling and conversion therapies	Sexual behavior; sexual feelings; sexual orientation identity
Schroeder & Shidlo, 2001	150	91	Convenience	None reported	Qualitative retrospective case study	Varied, including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-	Perceived harmfulness or helpfulness of SOCE

							patient treatment.	
Segal & Sims, 1972	1	100	Clinical	None reported	Case study	Covert sensitization	Self-report of continued need for treatment	
Shidlo & Schroeder, 2002	202	90	Convenience	None reported	Qualitative retrospective case study	Varied including behavior therapy; psychoanalysis; aversive therapies; hypnosis; spiritual counseling; psychotropic medication; in-patient treatment.	Sexual orientation; sexual orientation identity	
Solyom & Miller, 1965	6	100	Clinical	None reported	Case study	Aversive shock therapy	Galvanic skin responses; penile circumference	
Spitzer, 2003	200	71	Convenience (Ex-gay)	None reported; 74 not eligible	Retrospective pretest	Varied including ex-gay and	Sexual attraction; sexual	

			ministry members)			religious support groups and therapy.	orientation identity; sexual behavior;
Thorpe, Schmidt, & Castell, 1963	1	100	Clinical	None reported	Case study	Classical conditioning	Sexual fantasy; ability to orgasm in response to female stimuli
Thorpe, Schmidt, Brown, & Castell, 1964	8	75	Clinical (referred for variety of mental health concerns)	2 withdrawals	Case study	Aversion relief	Anxiety; personality
Wolkomir, 2001	n/a		Purposive	None reported	Ethnography	2 Bible study support groups	Subjective experience

Ending Conversion Therapy:  
Supporting and Affirming  
LGBTQ Youth

October 2015

Substance Abuse and Mental Health Services  
Administration  
SAMHSA

[Photos throughout omitted]

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Division of Systems Development, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services.

### **Contents**

Executive Summary .....	1
Introduction.....	7
Professional Consensus Process .....	9

Statements of Professional Consensus.....	11
Research Overview.....	15
Approaches to Ending the Use of Conversion Therapy .....	37
Guidance for Families, Providers, and Educators...	41
Summary and Conclusion.....	51
References .....	52
Appendix A: Glossary of Terms .....	64
Appendix B: Acknowledgments .....	64
Endnotes.....	66

### **Executive Summary**

*Lesbian, gay, bisexual, and transgender* youth, and those who are questioning their sexual orientation or gender identity (*LGBTQ* youth) experience significant health and behavioral health disparities. Negative social attitudes and discrimination related to an individual's *LGBTQ* identity can contribute to these disparities, and may result in institutional, interpersonal, and individual stressors that affect mental health and well-being. (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Meyer, 2003). This stress, as well as limited opportunities for support, are encountered by *sexual and gender minority* youth in their families, communities, and school settings. Additionally, some transgender youth experience gender dysphoria – psychological distress due to the incongruence between one's body and gender identity (Coleman et al., 2012).

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority communities. One key factor to preventing these adverse outcomes is positive family (including guardians and caregivers) and community engagement and appropriate interventions by medical and behavioral health care providers. Supporting optimal development of children and adolescents with regard to sexual orientation, gender identity, and gender expression is vital to ensuring their health and well-being.

The purpose of this report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ youth*, is to provide mental health professionals and families with accurate information about effective and ineffective therapeutic practices related to children's and adolescent's sexual orientation and gender identity. Specifically, this report addresses the issue of conversion therapy for minors. The conclusions in this report are based on professional consensus statements arrived at by experts in the field. Specifically, conversion therapy—efforts to change an individual's sexual orientation, gender identity, or gender expression<sup>2</sup>—is a practice that is not supported by credible evidence and has been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm.

## Key Findings

This report and its recommendations are based on consensus statements developed by experts in the field after a careful review of existing research, professional health association reports and summaries, and expert clinical guidance. The consensus statements highlight areas of the ethical and scientific foundations most relevant to the practice of conversion therapy with minors. A full list of the consensus statements is found in the body of this report; key statements that form the underpinnings of the guidance in this report are provided here.

- Same-gender<sup>3</sup>sexual orientation (including identity, behavior, and attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment. (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).



## Understanding Sexual Orientation and Gender Identity in Children and Youth

Behavioral health providers, parents, schools, and communities can best provide support to children, adolescents, and their families when they have access to the most current information about sexual orientation, gender identity, and gender expression in youth. The following overview presents the best current evidence regarding understandings of child and adolescent sexual orientation, gender identity, and gender expression.

Sexuality occurs across a continuum; same-gender attraction and relationships are normal variations of human sexuality (Diamond, 2015; Vrangalova & Savin-Williams, 2012). Similarly, a gender identity that is incongruent with assigned sex at birth, as well as a gender expression that diverges from stereotypical cultural norms for a particular gender, are normal variations of human gender (American Psychological Association, 2015a; Knudson, De Cuypere, & Bockting, 2010). Being a sexual or gender minority, or identifying as LGBTQ, is not pathological (American Psychological Association, 2015a; APA Task Force on Gender Identity and Gender Variance, 2009; Coleman et al., 2012).

There is not a single developmental trajectory for either sexual minority or gender minority youth. Compared to the 20th century, in the 21<sup>st</sup> century, youth started realizing and disclosing a minority sexual orientation and/or identifying as lesbian, gay, or bisexual at younger ages than in previous generations (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, Bimbi, Nanín, & Parsons,

2006; R. C. Savin-Williams, 2001). Though aspects of sexuality are displayed beginning in infancy, little is known about sexual orientation among pre-pubertal children (Adelson & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI), 2012). Children are rarely if ever distressed about their current or future sexual orientation; more commonly, parents and guardians are distressed about a child's perceived current or future sexual orientation and seek the assistance of behavioral health providers (American Psychological Association, 2009). Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual orientation identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. In comparison with their heterosexual counterparts, sexual minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of experiencing victimization, violence, and homelessness (Corliss et al., 2010; Friedman et al., 2011; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann et al., 2011; Marshal et al., 2011; Russell, 2003). Supportive families, peers, and school and community environments are associated with improved psychosocial outcomes for sexual minority youth

(Bouris et al., 2010; Kosciw, Greytak, Palmer, & Boesen, 2014; Lease, Horne, & Noffsinger-Frazier, 2005).

Gender development begins in infancy and continues progressively throughout childhood. Gender diversity or signs of gender dysphoria may emerge as early as a child's preschool years, or as late as adolescence (Cohen-Kettenis, 2005). For many gender minority children, gender dysphoria will not persist, and they will develop a *cisgender* identity in adolescence or adulthood; a majority of these children will identify as lesbian, gay, or bisexual in adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). Whether or not these individuals continue to have a diverse gender expression is unknown. For other gender minority children, gender dysphoria will persist and usually worsen with the physical changes of adolescence; these youth generally identify as transgender (or another gender identity that differs from their assigned sex at birth) in adolescence and adulthood (Byne et al., 2012; Coleman, et al., 2012). For still another group, gender dysphoria emerges in post-puberty without any childhood history of gender dysphoria gender diversity (Edwards-Leeper & Spack, 2012). Gender dysphoria that worsens with the onset of puberty is unlikely to remit later in adolescence or adulthood, especially among youth with a childhood onset, and long-term identification as transgender is likely (American Psychological Association, 2015a; American Psychological Association, 2008; Byne, et al., 2012).

While most adolescents with gender dysphoria score within normal ranges on psychological tests (Cohen-Kettenis & van Goozen, 1997; de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Smith, van Goozen, & Cohen-Kettenis, 2001), some gender minority children and adolescents have elevated risk of depression, anxiety, and behavioral issues. These psychosocial issues are likely related to if not caused by negative social attitudes or rejection (Vance, Ehrensaft, & Rosenthal, 2014). As with sexual minority adolescents, other issues of clinical relevance for gender minority adolescents include increased risk of experiencing victimization and violence, suicidal ideation and attempts, and homelessness (Coleman, et al., 2012; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Institute of Medicine, 2011; Mustanski, Garofalo, & Emerson, 2010; Simons, Leibowitz, & Hidalgo, 2014). Improved psychosocial outcomes are seen among youth when social supports are put in place to recognize and affirm gender minority youth's gender identities (Vance, et al., 2014).

#### Therapeutic Efforts with Sexual and Gender Minority Youth<sup>4</sup>

Given the professional consensus that conversion therapy efforts are inappropriate, the following behavioral health approaches are consistent with the expert consensus statements and current research, and are recommended by professional associations (American Psychological Association, 2015a; APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Byne, et al., 2012). When providing services to children, adolescents, and

families, appropriate therapeutic approaches include: providing accurate information on the development of sexual orientation and gender identity and expression; increasing family and school support; and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Approaches should be client-centered and developmentally-appropriate with the goal of treatment being the best possible level of psychological functioning, rather than any specific gender identity, gender expression, or sexual orientation. Appropriate therapeutic approaches with sexual and gender minority youth should include a comprehensive evaluation and focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support. It is important to identify the sources of any distress experienced by sexual and gender minority youth and their families, and work to reduce this distress. Working with parents and guardians is important as parental behaviors and attitudes have a significant effect on the mental health and wellbeing of sexual and gender minority children and adolescents. School and community interventions may also be necessary and appropriate.

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation and

developmentally-appropriate informed consent of youth and their families, including a weighing of potential risks and benefits are vital when considering medical intervention with gender minority youth.

Eliminating the practice of conversion therapy with sexual and gender minority minors is an important step, but it will not alleviate the myriad of stressors they experience as a result of interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities.

LGBTQ youth still need additional support to promote positive development in the face of such stressors. Supportive family, community, school, and health care environments have been shown to have great positive impacts on both the short- and long-term health and well-being of LGBTQ youth. Families and others working with LGBTQ children and adolescents can benefit from guidance and resources to increase support for sexual and gender minority minors and to help facilitate the best possible outcomes for these youth.

#### Ending the Use of Conversion Therapy for Minors

Given that conversion therapy is not an appropriate therapeutic intervention; efforts should be taken to end the practice of conversion therapy. Efforts to end the practice have included policy efforts to reduce the negative attitudes and discrimination directed at LGBTQ individuals and families; affirmative public information about LGBTQ individuals, particularly directed at families and youth; resolutions and guidelines by professional associations to inform providers that conversion efforts are inappropriate

and to provide guidance on appropriate interventions; and, state and federal legislation and legal action to end the practice of conversion therapy. Future efforts may include improved provider training, federal regulatory action, advancement of legislation at the state and federal level, and additional activities by the Administration, which issued a public statement supporting efforts to ban the use of conversion therapy for minors in the spring of 2015.

### **Introduction**

This report, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Outh*, provides an overview of the current state of scientific understanding of the development of sexual orientation and gender identity in children and adolescents as well as the professional consensus on clinical best practices with these populations. Specifically, this report addresses the issue of conversion therapy for minors. Conversion therapy—efforts to change an individual’s sexual orientation, gender identity, or gender expression<sup>5</sup>—is a practice that is not supported by credible evidence, and has been disavowed by behavioral health experts and associations. Importantly, this report also provides a nuanced overview of appropriate supportive interventions to assist families in exploring the sometimes difficult issues associated with sexual orientation, gender identity, and gender expression.

This work is the result of a collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association (APA), which convened a panel of behavioral health professionals (e.g.,

psychologists, researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents in July 2015. That convening, which is discussed in greater depth below, aimed to establish consensus with respect to conversion therapy for minors, based on the best available research and scholarly material available, as well as the clinical experience of experts in the field. The resultant statements of professional consensus are printed in their entirety in the following section.

In addition, this report highlights areas of opportunity for future research, and provides an overview of mechanisms to eliminate the use of harmful therapies. In an effort to provide useful tools for families, practitioners, and educators, the report also provides resources on

“Being gay is not a disorder. Being transgender is not a malady that requires a cure.  
—Vice Admiral  
Vivek H. Murthy,”  
19th U.S. Surgeon  
General

several topics, including: *Family and Community Acceptance*, *School-Based Issues*, *Pediatric Considerations*, and *Affirmative Exploratory Therap*. In addressing these four topics, SAMHSA aims to enable families, providers, educators, and community members to take actions that will reduce the health risks and disparities facing this vulnerable population.

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including



sexual and gender minority communities. In addressing the issues included in this report that have a significant impact on the lives and well-being of sexual and gender minority youth, SAMHSA aims to enable families, providers, and educators to take actions that will reduce the health risks and disparities facing this vulnerable population

SAMHSA's mission is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.<sup>6</sup>As will be addressed in detail below, conversion therapy perpetuates outdated gender roles and negative stereotypes that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm. This report is one of many steps SAMHSA is taking to improve the health and well-being of sexual and gender minority children and youth.

### **Professional Consensus Process**

In early April 2015, representatives from SAMHSA and APA agreed to collaborate to address the concerns of professional associations, policy makers, and the public regarding efforts to change gender identity and sexual orientation in children and adolescents (also referred to as conversion therapy). Through the support of the Federal Agencies Project, APA hosted an expert consensus convening on this topic in July 2015, which significantly informed this report. The research overview and clinical expertise highlighted throughout serve as the foundation from which the

consensus statements were developed. Both the process of achieving consensus and the results of the meeting are published below.

APA initially developed a list of the areas of expertise to be used in identifying potential experts to participate in the consensus panel based on existing professional guidelines and resolutions related to sexual orientation, gender identity, and gender expression, as well as published research. APA solicited nominations from specialists in the field with expertise in gender, sexuality and sexual orientation, child and adolescent development and mental health, and the psychology of religion. Additionally, APA solicited nominations from professional associations representing the major mental health and health professions. Using the input received from these sources, APA extended invitations to a short list of highly recommended group of experts. This initial expert pool nominated additional experts based on their assessment of the expertise needed to achieve the goals of the meeting. The final panel of 13 experts consisted of ten psychologists, two social workers, and one psychiatrist. These individuals included researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel also included experts with a background in family therapy, ethics, and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and

Mark Yarhouse, PsyD. APA activities were coordinated by Clinton W. Anderson, PhD and Judith Glassgold, PsyD.

Based on published literature on consensus methods, APA developed an iterative process that culminated in a two-day meeting in Washington, DC on July 7 and 8, 2015. During the meeting, panelist-led discussions considered the relevant research, professional guidelines and clinical knowledge-base for each of the topics. The panel developed consensus statements on sexual orientation change efforts as well as gender identity change efforts in children and adolescents for each of the relevant developmental stages: pre-pubertal children, peri-pubertal adolescents, and pubertal and post-pubertal adolescents.

Panelists agreed that unanimous consensus was a strong priority, but that if unanimity could not be reached, 80 percent support would constitute consensus. The panelists also agreed that minority opinions should be reflected in the record if any dissenting expert wished to issue such an opinion. Unanimous consensus was reached in nearly all instances. No dissenting opinions were formally registered. The statements of professional consensus are printed in *Section 3* of this report.

Observers from interested federal agencies, health and human services professional organizations, foundations, and LGBTQ human rights organizations also attended the meeting. These observers were offered an opportunity to submit written questions, which the panel addressed throughout the course of the meeting.

“PFR “created something that was groundbreaking.  
It was the best piece of work ever created by the  
federal government.”

Sue Thau

### **Statements of Professional Consensus**

*The following are the statements of professional consensus regarding sexual orientation and gender identity and expression that were developed during the July 2015 APA consensus convening. After initially developing separate statements regarding issues relating to the development of sexual orientation and gender identity and gender expression, the panel developed a set of three key summary statements. The panel also developed a statement regarding the guiding human rights and scientific principles that provide a foundation for behavioral health professionals’ work in this area.*

#### **Guiding Principles**

Behavioral health professionals respect human dignity and rights. The foundational ethical principle of “self-determination” requires that children and adolescents be supported in their right to explore, define, and articulate their own identity. The principles of “justice” and “beneficence and nonmaleficence” require that all children and adolescents have access to behavioral health treatments that will promote their health and welfare. Children and adolescents have the right to participate in decisions that affect their treatment and future. Behavioral health professionals respect

human diversity and strive to incorporate multicultural awareness into their work.

These guiding principles are based upon the codes of ethics for the professional fields of Psychology, Psychiatry, and Social Work (American Psychiatric Association, 2013b; American Psychological Association, 2010; National Association of Social Workers, 2008).

#### Professional Consensus on Conversion Therapy with Minors

1. Same-gender<sup>7</sup>sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
2. There is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
3. Interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing the child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities,

and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

#### Professional Consensus on Sexual Orientation in Youth

1. Same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.
2. Sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.
3. There is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.
4. Behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of

distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

#### Professional Consensus on Gender Identity and Gender Expression in Youth

##### Consensus on the Overall Phenomena of Gender Identity and Gender Expression

1. Variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.
2. Pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

##### Consensus on Efforts to Change Gender Identity

3. There is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
4. It is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual

orientation for the ultimate developmental outcome of a child's or adolescent's gender identity or gender expression.

5. Mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

#### Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

6. Children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peripubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child's and adolescent's developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.
7. Approaches that focus on developmentally-appropriate identity exploration, integration, the



reduction of distress, adaptive coping, and family acceptance to improve psychological well-being are recommended for children and adolescents of all ages experiencing gender-related concerns.

#### Pre-Pubertal Children

8. Gender expression and gender identity are interrelated and difficult to differentiate in prepubertal children, and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child's gender identity and gender expression, as well as any associated distress.

#### Peri-Pubertal Adolescents

9. For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics<sup>8</sup>, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent's gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peri-pubertal adolescent, parents or guardians, and other health care professionals involved in the peri-pubertal adolescent's care. The purpose of the assessment is to advise and inform treatment decisions regarding

pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

#### Pubertal and Post-Pubertal Adolescents

10. Decision-making regarding one's developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent's gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent's care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians.

Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically

indicated, prolongs gender dysphoria and exacerbates emotional distress.

### **Research Overview**

#### **Sexual Orientation**

Sexual orientation is a multidimensional construct that consists of sexual identity, sexual and romantic attraction, and sexual behavior. Great shifts in the understanding of sexual orientation have occurred over the past century (Herek, 2010). Though a minority sexual orientation was once considered abnormal or a medical problem, scientists now understand that sexuality occurs on a continuum and variations in sexual orientation are part of the normal range of human sexuality (American Psychological Association, 2009; Diamond, 2015; Vrangalova & Savin-Williams, 2012). In 1973, homosexuality was removed as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders with a declaration of support for the civil rights of lesbian, gay, and bisexual people from the American Psychiatric Association. Many health organizations followed suit in passing resolutions that affirmed their support for the civil rights of lesbian, gay, and bisexual people, including the American Psychological Association, the National Association for Social Workers, the American Counseling Association, the American Medical Association, the American Psychoanalytic Association, and the American Academy of Pediatrics. In 1992, the World Health Organization removed homosexuality from the International Classification of Diseases (Nakajima, 2003; World Health Organization, 1992)<sup>9</sup>.

#### **Gender**

Gender is a ubiquitous and multi-faceted social category. When discussing the concept of gender, scientists distinguish between biological sex, gender identity, and gender expression. Biological sex refers to one's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). Infants' biological sex is labeled at birth, almost always based solely on external genital appearance; this is referred to as one's assigned sex at birth<sup>10</sup>. Gender identity refers to a person's deeply felt, inherent sense of being a girl, woman or female; a boy, a man or male; a blend of male or female; or an alternative gender (Bethea, 2013; Institute of Medicine, 2011). Gender expression refers to the ways a person communicates their gender within a given culture, including clothing, communication patterns, and interests; a person's gender expression may or may not be consistent with socially prescribed gender roles or assigned sex at birth, and may or may not reflect his or her gender identity (American Psychological Association, 2008).

Similar to sexual orientation, significant changes have occurred over time in the scientific understanding of gender. Though one's biological sex, gender identity, and gender expression are distinct constructs, society expects that they will align, and for most individuals this is true – that is, most individuals who are assigned female at birth identify as girls or women and adopt a feminine gender expression, while most individuals who are assigned male at birth identify as boys or men and adopt a masculine gender expression<sup>11</sup>(American Psychological Association, 2015a). However, for some individuals, these constructs do not align. The term transgender refers to individuals whose gender

identity is not consistent with their sex assigned at birth. The term gender diverse (or gender nonconforming) refers to individuals whose gender expression does not conform to the stereotypical norms in their culture for their assigned sex at birth. Research in recent decades has also challenged the perception of gender as a binary construct with mutually exclusive categories of male or female, boy or girl, man or woman (American Psychological Association, 2015a; Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013). It has also often been assumed that one's gender identity – that is, the deeply felt, inherent sense of one's gender – always aligns with sex assigned at birth (American Psychological Association, 2015a). Scientists now recognize that a wide spectrum of gender identities and gender expressions exist (and have always existed), including people who identify as either man or woman, neither man nor woman, a blend of man and woman, or a unique gender identity (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Furthermore, scientists and clinicians now understand that identifying with a gender that does not align with sex assigned at birth, as well as a gender expression that varies from that which is stereotypical for one's gender or sex assigned at birth, is not inherently pathological (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010) and does not always require clinical attention (Steensma, Kreukels, et al., 2013). However, people may experience distress associated with discordance between their gender identity and their body or sex

assigned at birth (i.e., gender dysphoria) as well distress associated with negative social attitudes and discrimination (Coleman, et al., 2012). This paradigmatic shift in the understanding of diverse gender identities and expressions was reflected in the replacement of Gender Identity Disorder with Gender Dysphoria in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013a). The diagnosis of Gender Dysphoria, which is marked in children and adolescents by clinically significant distress encountered by the discordance between biological sex and gender identity that disrupts school or social functioning, depathologizes diverse gender identities and expressions, instead focusing on the potential psychosocial challenges associated with gender diversity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014).

## **Sexual Orientation and Gender in Childhood**

### **Sexual Orientation in Childhood**

Sexual orientation, as usually conceptualized, begins at or near adolescence with the development of sexual feelings (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). While children display aspects of sexuality from infancy, and almost universally develop sexual feelings by adolescence or earlier, the limited research focused on children's sexuality generally does not assess sexual orientation (Adelson & AACAP CQI, 2012). Therefore, little is known about sexual orientation in pre-pubertal children, and no direct research on sexual orientation in pre-pubertal children has been conducted. Studies that have retrospectively asked

lesbian, gay, and bisexual adults about their childhood experiences have reported that LGB adults often describe having had same-gender emotional and sexual feelings and attractions from childhood or early adolescence; many recall a sense of being different even earlier in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

#### Gender Identity and Gender Expression in Childhood

Gender-related development begins in infancy and continues progressively throughout childhood. Research has focused on three key concepts: gender constancy, gender consistency, and gender identity. On average, children develop gender constancy – stability across time in identification of their gender – between ages 3 to 4 (Kohlberg, 1966) and gender consistency – recognition that gender remains the same across situations – between ages 4 to 7 (Siegal & Robinson, 1987). The development of gender identity appears to be the result of a complex interplay between biological, environmental, and psychological factors (Steensma, Kreukels, et al., 2013). For most people, gender identity develops in alignment with one's sex assigned at birth. However, for some individuals, gender identity may not align with one's assigned sex at birth, and the period during which gender identity is clarified and solidified is unclear (Diamond & Butterworth, 2008; Steensma, Kreukels, et al., 2013). There is no single trajectory of gender identity development for gender minority children.

It is important to note that research on gender identity issues among children is largely clinical in

nature and focuses on the treatment and intervention of Gender Dysphoria and, previously, Gender Identity Disorder<sup>12</sup>(APA Task Force on Gender Identity and Gender Variance, 2009). Though there have been no epidemiological studies to determine the prevalence of gender diverse and transgender children or adolescents, there has been a notable increase in the number of gender minority youth presenting to specialty gender clinics in the past decade (Vance, et al., 2014). Recent evidence indicates that as a culture becomes more supportive of gender diversity, more children are affirming a transgender identity or diverse gender expressions (Vance, et al., 2014).

Some gender non-conforming children experience significant distress, currently termed *gender dysphoria*. Signs of gender dysphoria may emerge as early as the preschool years; children as young as two years may indicate that they want to be another gender, express dislike for the gender associated with their sex assigned at birth, express anatomic dysphoria, and state that they want to be another gender as soon as they can express language (Cohen-Kettenis, 2005). For most gender minority children, gender dysphoria does not persist through adolescence. Existing research suggests that between 12 percent and 50 percent of children attending a specialty clinic for gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). These studies were based on clinical samples of youth and many of the researchers



categorized youth no longer attending the clinics (whose gender identity may be unknown) as no longer gender dysphoric, and so this research likely underestimates the percentage of youth who persist with a cross-gender or transgender identity (American Psychological Association, 2015a).

The fact that a large proportion of gender minority children do eventually develop a gender identity consistent with their sex assigned at birth has been viewed as evidence of the malleability of gender identity (Zucker, 2004; Zucker & Bradley, 1995). However, this conclusion has been challenged in recent years by some scholars. These researchers and clinicians have pointed out that the diagnostic criteria for Gender Dysphoria (and, previously, Gender Identity Disorder) in Childhood includes indicators that might denote gender dysphoria or gender identity, but might also simply be markers of diverse gender expression (for example, children's play preferences; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013). These scholars have suggested that the inclusion in study samples of many children with diverse gender expressions who may not have gender dysphoria could explain the large proportion of gender minority children who eventually do not meet the diagnostic criteria in adolescence (Hidalgo et al., 2013; Wallien & Cohen-Kettenis, 2008).

One of gender's greatest complexities is that some people never identify with the sex they were assigned at birth, some people consistently identify with the sex they were assigned at birth, and still others vary over time. Gender minority children follow two

trajectories<sup>13</sup>: On the first, children will experience gender dysphoria through adolescence and adulthood (unless dysphoria is mitigated through social or medical transition) and will identify as transgender or as a gender different from that assigned at birth. On the other trajectory, gender minority children will develop to be cisgender individuals, i.e., they will eventually identify with a gender consistent with their sex assigned at birth (Simons, et al., 2014). Gender minority children who eventually develop a cisgender identity are more likely to identify as lesbian, gay, or bisexual in adolescence and young adulthood (Bailey & Zucker, 1995; Drescher, 2014; Leibowitz & Spack, 2011; Wallien & Cohen-Kettenis, 2008). It is unknown whether gender minority children who develop a cisgender identity continue to express their gender in ways that do not conform to stereotypical gender norms, as this has not been studied. No prospective data exist on factors that might predict for any particular child which trajectory they will follow. There is, however, recent retrospective evidence identifying factors that are more common among children who eventually identify as transgender: early cognitive (“I am a girl”) rather than affective (“I feel like a girl”) assertion of gender; consistent and firm gender-fluid or gender-crossing expressions and identity; and distress about the incongruence between their physical sex characteristics and affirmed gender (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Steensma, McGuire, et al., 2013; Vance, et al., 2014).

Clinical Issues in Childhood

Researchers have not systematically investigated whether children experience distress related to their sexual orientation. No published research suggests that children are distressed about their sexual orientation. When pre-pubertal children are referred to behavioral health professionals for concerns related to sexual orientation, such referrals are often precipitated by a parent or guardian's concern or distress about a child's behavior – generally, a failure to conform to stereotypical gender role behaviors – and possible future sexual orientation (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). Research has shown that gender diverse children who develop a cisgender identity do have a higher likelihood of identifying as a sexual minority in adulthood, and that some (but not all) sexual minority adults recall gender nonconforming behaviors in childhood (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009). It is unknown whether cisgender lesbian, gay, and bisexual adults who were treated by behavioral health providers as youth experienced distress related to their gender nonconformity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Gender minority children are not a monolithic group: some gender diverse children are distressed; while others are not distressed, but may be referred for mental health care because of parental concerns related to their gender or perceived future sexual orientation. Among those who are distressed, the source of distress varies. Some gender diverse children are distressed by their primary sex characteristics or by the anticipation of future sex

characteristics, while others are not (Coleman, et al., 2012; Vance, et al., 2014). In addition to anatomical dysphoria, children's feelings of gender typicality, gender contentedness, and pressure to conform to stereotypical gender norms also appear related to children's psychosocial adjustment. Researchers have reported on the relationships between these various components of gender identity and indicators of children's psychosocial adjustment, such as self-esteem, internalizing and externalizing problems, and social competence with peers (Carver, Yunger, & Perry, 2003; Egan & Perry, 2001; Yunger, Carver, & Perry, 2004).

Gender minority children, on average, have poorer relationships with parents (Adelson & AACAP CQI, 2012; Alanko et al., 2009) and peers (Smith & Leaper, 2006; Zucker, 2005), experience high rates of mistreatment from peers (D'Augelli, Grossman, & Starks, 2006), and are at increased risk of physical and sexual abuse in childhood, as compared to their gender conforming peers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Clinical samples of gender minority children with gender dysphoria have increased rates of internalizing disorders, such as depression and anxiety (de Vries, et al., 2011; Spack et al., 2012) and behavioral problems (Simons, et al., 2014; Zucker, 2004), as compared to the general population of children. Behavioral issues among those with gender dysphoria increase with age; poor peer relations explain most of the variance in behavioral problems among children with gender dysphoria (Zucker, 2004). Negative social attitudes or rejection are likely related if not the direct causes of these psychological difficulties (Vance, et al., 2014).

Additionally, autism spectrum disorders appear to occur more commonly among clinical samples of children with gender dysphoria than among children in the general population, though the reason for this increased co-occurrence, and whether this increased co-occurrence also occurs outside of clinic populations, is not fully understood (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012).

## **Sexual Orientation and Gender in Adolescence**

### **Sexual Orientation in Adolescence**

Significant physical, cognitive, and social development occurs during adolescence. Sexual minority adolescents face the same developmental tasks that accompany adolescence for all youth, including sexual identity development. Unlike those with a heterosexual orientation, however, adolescents with a minority sexual orientation must navigate awareness and acceptance of a socially marginalized sexual identity; potentially without family, community, or societal support. Various factors affect the trajectory of development related to sexual orientation, and there is not a single or simple trajectory experienced by all individuals (Diamond, 2006, 2008; Diamond & Savin-Williams, 2000; Dube & Savin-Williams, 1999; Horowitz & Newcomb, 2001). In a large prospective cohort study of adolescents living throughout the U.S., 12 percent of males and 22 percent of females at one point indicated a minority sexual orientation identity (i.e., mostly heterosexual, bisexual, mostly homosexual, or completely homosexual; Ott, Corliss, Wypij, Rosario, & Austin, 2010)<sup>14</sup>. Compared to earlier cohorts, today's sexual minority adolescents are developing an

awareness of their sexual orientation and disclosing their sexual orientation to others earlier than previous generations, frequently disclosing their sexual orientation or “coming out” as lesbian, gay, or bisexual in middle or high school (Diamond & Savin-Williams, 2000; Floyd & Bakeman, 2006; Grov, et al., 2006; R. C. Savin-Williams, 2001; R.C. Savin-Williams, 2005). This earlier disclosure means that adolescents are now often coming out while still dependent on their families and communities for emotional and instrumental support.

#### Gender Identity in Adolescence

Gender minority adolescents include both youth who realized a transgender identity or gender diverse presentation in childhood (i.e., early-onset individuals) and youth for whom gender dysphoria first emerges in adolescence (i.e., later-onset individuals). Adolescence is a crucial period for the consolidation of gender identity and persistence of gender dysphoria in early-onset individuals and for the initiation of gender dysphoria in later-onset individuals (Steensma, McGuire, et al., 2013). Youth for whom gender dysphoria first emerges in adolescence may have no history of a gender diverse expression or gender identity questioning in childhood (Edwards-Leeper & Spack, 2012; Wallien & Cohen-Kettenis, 2008). The onset of typical physical changes associated with puberty is often associated with worsening of anatomical dysphoria and distress in adolescents with gender dysphoria (Byne, et al., 2012; Coleman, et al., 2012). Increasing numbers of adolescents have already starting living in their desired gender role upon entering high school (Cohen-

Kettenis & Pfäfflin, 2003) and many (but not all) adolescents with gender dysphoria express a strong desire for hormone therapy and gender affirming surgeries (Coleman, et al., 2012).

When gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term persistence of gender dysphoria and identification as transgender in adulthood increases. Two different follow up studies reported that 50-67 percent of adolescents attending a specialty clinic for gender dysphoria went on to have gender affirming surgeries, suggesting high rates of persistence (Cohen-Kettenis & van Goozen, 1997; Smith, van Goozen, & Cohen-Kettenis, 2001). Since not all individuals with gender dysphoria have gender affirming surgeries, the percentage of adolescents in these study samples who continued to experience gender dysphoria is likely higher than 50-67 percent; in fact, the Smith et al. (2001) study suggested that a considerable number of the patients who did not have gender affirming surgeries still experienced gender dysphoria four years later.

#### Clinical Issues in Adolescence

Although many sexual and gender minority youth successfully navigate the challenges of adolescence, others experience a variety of mental health and psychosocial concerns. In comparison with their heterosexual and cisgender counterparts, sexual and gender minority adolescents are at increased risk for psychological distress and substance use behaviors, including depressive symptoms, increased rates of substance use and abuse, suicidal ideation and attempts, as well as increased likelihood of

experiencing victimization, violence, and homelessness (Coleman, et al., 2012; Corliss, et al., 2010; Friedman, et al., 2011; Garofalo, et al., 2006; Goldbach, et al., 2014; Hatzenbuehler, 2011; Institute of Medicine, 2011; Kann, et al., 2011; Liu & Mustanski, 2012; Marshal, et al., 2011; Mustanski, et al., 2010; S. T. Russell, 2003; Simons, et al., 2014). Sexual and gender minority youth who lack supportive environments are especially vulnerable to these negative outcomes (for example, research from Kosciw, et al., (2014), Ryan, Huebner, Diaz, & Sanchez, (2009), and Travers, et al. (2012)).

Pubertal development can be especially distressing for transgender adolescents and can set off a cascade of mental health problems during adolescence (Byne, et al., 2012; Coleman, et al., 2012). Mental health challenges are more common among adolescents with gender dysphoria than among children with gender dysphoria (Byne et al., 2012), which may be due to peer ostracism that increases with age (APA Task Force on Gender Identity and Gender Variance, 2009). Additionally, as with children, the prevalence of autism spectrum disorders appears to be higher among clinical samples of adolescents with gender dysphoria than among the general population of adolescents (de Vries, et al., 2010; Edwards-Leeper & Spack, 2012). Adolescents with autism spectrum disorders (ASD) would benefit from careful assessment distinguishing between symptomatology related to gender dysphoria and symptoms related to ASD. de Vries, et al. (2010) reported a rate of autism spectrum disorders 10 times higher among children and adolescents referred to their gender clinic in Amsterdam, Netherlands as compared to the general



population. This research only examined cases of severe autism and not milder versions such as Asperger's disorder, which Edwards-Leeper and Spack (2012) reported being more commonly seen among patients in the GeMS clinic in Boston, especially among those with a late-onset of gender dysphoria. The question of whether gender dysphoria is simply a symptom of autism spectrum disorder among youth with ASD has been raised by behavioral health providers; Edwards-Leeper and Spack (2012) suggest that it is also worth questioning validity of the autism diagnosis among transgender youth, particularly those with Asperger's disorder, as it is possible that social awkwardness and lack of peer relationships are the result of feeling isolated and rejected due to gender identity and expression (Edwards-Leeper & Spack, 2012). More research is needed into appropriate treatment for sexual and gender minority children and adolescents with developmental disabilities as well; behavioral health providers should not presume that young people with developmental disabilities cannot also be sexual and gender minorities.

### **Influences on Health and Well-Being**

The increased risks faced by sexual or gender minority youth are not a function of their identity. Rather, these risks stem from the stresses of prejudice, discrimination, rejection, harassment, and violence (Bockting et al., 2013; Harper & Schneider, 2003; Hendricks & Testa, 2012; Meyer, 1995). The presence of sexual orientation- and gender-related stressors – and opportunities for support – encompasses multiple social systems, including

family, school, and religious networks (U. Bronfenbrenner, 1979; U. Bronfenbrenner, 2005; Harper, 2007); Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2013)<sup>15</sup>. Therefore, when a distressed sexual and gender minority adolescent is evaluated by a behavioral health provider, it is imperative to assess the broader family and community systems in which the child lives, in addition to individual issues. Assessing not only the adolescent's level of distress, but also identifying the source(s) of distress and support are vital components of a comprehensive assessment.

### Family

Family response to an adolescent's sexual orientation, gender identity, or gender expression has a significant impact on the adolescent's wellbeing. Parents can serve as both a source of stress and a source of support for sexual and gender minority youth (Bouris, et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Travers et al., 2012). Negative parental responses to sexual orientation or gender are associated with young people's psychological distress; however, parent-child relationships characterized by closeness and support, however, are an important correlate of mental well-being. Research by Doty, Willoughby, Lindahl and Malik (2010) has emphasized the benefits of sexuality-specific family and peer support to sexual minority adolescents' well-being.

Sexual and gender minority adolescents are at increased risk for experiencing violence and victimization, including psychological, physical, and sexual abuse from those within their families

compared to adolescents from the general population (Friedman, et al., 2011; Roberts, et al., 2012). Past parental verbal and physical abuse has been associated with suicide attempts in transgender adolescents (Grossman & D'Augelli, 2007). These adolescents may also be ejected from their homes or run away, contributing to the overrepresentation of sexual and gender minority adolescents among the nation's homeless youth; 20-40 percent of all homeless youth identify as lesbian, gay, bisexual, or transgender (Durso & Gates, 2012; Ray & National Gay and Lesbian Task Force, 2006). Some data suggest that, compared to cisgender youth who conform to stereotypical gender norms, transgender and other adolescents whose gender expressions do not conform to stereotypical norms have a higher risk of abuse from family members (Roberts, et al., 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Furthermore, the level of family acceptance or rejection an adolescent experiences appears to have effects that extend into young adulthood. Data from the Family Acceptance Project have shown that sexual and gender minority young adults who experienced high levels of family rejection during adolescence fared significantly worse than those who experience low levels of family rejection in terms of depression, substance abuse, sexual risk behaviors, and suicide attempts (Ryan, Huebner, Diaz, & Sanchez, 2009); conversely, high levels of family acceptance in adolescence predicted greater self-esteem, social support, and general health status, and protected against depression, substance abuse, and suicidal ideation and behaviors in young adulthood as

compared to those with low levels of family acceptance in adolescence (Ryan, et al., 2010).

### Religion & Spirituality

When considering family and community influences, an adolescent's religious background is also an important factor. Religious beliefs and background are far-reaching influences that encompass multiple arenas of one's life, including: personal and family religious identity, beliefs and coping; family attitudes, beliefs and relationships; and community character and support. Religious views of homosexuality in the United States vary widely (Moon, 2014), and religion can have a large influence on sexual minority adolescents' mental health and wellbeing (cf. Ream & Savin-Williams, 2005; Page, Lindahl, & Malik, 2013). Though research on who seeks conversion therapy to change sexual orientation is lacking, it appears that such requests occur primarily among religious communities that view minority sexual orientations as undesirable or morally wrong (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

Though religiosity is often associated with better psychosocial adjustment among young people in general, sexual minority youth may feel rejected by their religion or experience conflict between their sexual orientation and religious identities (Cotton, Zebracki, Rosenthal, Tsevat, & Drotar, 2006). However, various ways in which adolescents and young adults reconcile this conflict have been identified (Meanley, Pingel, & Bauermiester, 2015; Ream & Savin-Williams, 2005). Sexual minority youth growing up in more conservatively religious

families are, on average, exposed to more messages that portray minority sexual orientations as undesirable or morally wrong (Schope & Eliason, 2000), which are associated with shame, guilt, and internalized homophobia (Ream & Savin-Williams, 2005). Sexual minority adolescents with religious parents may be less likely to disclose their sexual orientation to others (Schope, 2002; Stewart, Heck, & Cochran, 2015). Some research has indicated that involvement with religious or spiritual belief systems that cast rejecting or disapproving messages about sexual minorities is associated with greater psychosocial challenges, including increased internalized homophobia (Meanley, Pingel, & Bauermeister, 2015; Page, Lindahl, & Malik, 2013).

Religiosity or spirituality can be a deeply affirming and supportive aspect of identity, including for sexual minorities from faith communities. Research with adults indicates that affirming religious environments – that is, those that are inclusive and supportive of sexual minorities – may be associated with improved psychological wellbeing and reduced internalized homophobia (e.g., research from Lease, et al. (2005) and Yakushko (2005). Research from Hatzenbuehler, Pachankis, and Wolff (2012) supports the benefit of affirming religious environments for youth as well; the researchers reported that lesbian, gay, and bisexual high school students who lived in Oregon counties with a supportive religious climate (i.e., counties where the majority of religious individuals adhered to a religious denomination supportive of minority sexual orientations) had significantly fewer alcohol abuse symptoms and fewer

sexual risk behaviors than those living in counties with a less supportive religious climate.

It is important not to reify categories within faiths such as “traditional”, “liberal”, “affirming” and “non-affirming”; religion and spirituality are complex, nuanced aspects of human diversity. Parents from faith backgrounds have reactions that are similar in essential ways to all parents (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality; Maslowe and Yarhouse, 2015). Research indicates that families who identify superordinate goals such as unconditional love, mercy, forgiveness, and respect for all human beings can remain connected to their children in positive ways (Ryan et al, 2009; Maslowe & Yarhouse, 2015).

Given the great potential impact of religion on the lives of sexual and gender minority youth, little research has been done in this area with sexual minority adolescents and almost none has been completed with gender minority adolescents; further, almost no research has focused on sexual minority youth or adults in the United States from non-Christian religious backgrounds (cf. Harari, Glenwick, & Cecero, 2014; Siraj, 2012). It is unknown whether similar relationships between various aspects of religion and well-being would be seen among gender minority youth and among sexual and gender minority youth from non-Christian religious backgrounds.

### School

Sexual and gender minority adolescents may also experience a myriad of sexual orientation and gender-related stressors in the school environment, where

they spend a large portion of their time. The climates of U.S. middle and high schools are generally unsupportive and unsafe for many sexual and gender minority youth, who experience high levels of verbal and physical harassment and assault, sexual harassment, social exclusion and isolation, and other interpersonal problems with peers (Kosciw, Greytak, & Diaz, 2009). In the most recent National School Climate Survey, the Gay, Lesbian & Straight Education Network (GLSEN) found that 55.5 percent of surveyed sexual and gender minority students felt unsafe at school because of their sexual orientation and 37.8 percent felt unsafe because of their gender expression (Kosciw, et al., 2014). Most students reported hearing homophobic remarks and negative remarks about their gender expression at school from fellow students and teachers or other school staff; a third of students reported hearing negative remarks specifically about transgender people. Of the students surveyed, 74.1 percent of surveyed students were verbally harassed, 36.2 percent were physically harassed, 16.5 percent were physically assaulted, and 49.0 percent were cyberbullied in the past year because of their sexual orientation. On average, sexual minority students of color and students who did not conform to stereotypical gender roles experienced higher frequencies of victimization. Over half of the students surveyed experienced policies that were discriminatory based on sexual orientation, gender identity, or gender expression at school. Transgender students were particularly targeted by some discriminatory policies: 42.2 percent of transgender students had been prevented from using their preferred name; 59.2 percent were required to

use a bathroom or locker room of their legal sex; and 31.6 percent were not allowed to wear clothes consistent with their gender identity.

This mistreatment has a significant effect on sexual and gender minority adolescents' mental health and wellbeing. Those who experience victimization due to sexual orientation or gender expression are more likely to report depressive symptoms, suicidality, and low self-esteem (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Kosciw, et al., 2014). Experiences of victimization and discrimination are linked to negative academic outcomes, including missing school, lower grades, and not planning to pursue post-secondary education (Kosciw, et al., 2014). Further, these effects may last into young adulthood (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Victimization from peers and school staff, combined with discriminatory policies, likely contributes to the overrepresentation of sexual and gender minorities in the juvenile justice system: though sexual and gender minority youth comprise only five to seven percent of the nation's youth, it is estimated that 13 to 15 percent of youth in the juvenile justice system are sexual and gender minority youth (Majd, Marksamer, & Reyes, 2009).

School and peer networks can also be a place where sexual and gender minority youth find support. The presence of friends to whom youth can be out about their sexual orientation or gender identity has been linked to mental health and wellbeing (Doty & Brian, 2010; Elizur & Ziv, 2001). Sexual and gender minority friends may be of particular importance, as they are more likely than heterosexual and cisgender friends



to provide support for sexuality-related stress, which is associated with lower levels of both emotional distress and sexuality distress (Doty, et al., 2010; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Additionally, both the presence of and participation in a Gay-Straight-Alliance (GSA) – a student-led, school-based club aiming to provide a safe place for LGBTQ students – has beneficial outcomes for sexual and gender minority students (for example, research from Goodenow, Szalacha, and Westheimer (2006), Kosciw, Greytak, Diaz, and Bartkiewicz (2010), Toomey, Ryan, Diaz, and Russell (2011), and Walls, Kane, and Wisneski (2010)).

#### Identity Development

Sexual and gender minority adolescents may experience identity conflict when reconciling a sexual minority identity that may conflict with the expectations of their family, peers, and community. Difficulty with the identity development process, such as difficulty accepting one's sexual orientation and dissonance between one's self-image and societal beliefs about sexual minorities, can increase internalized homophobia (Page et al., 2013). Sexual orientation conflict has been linked to negative psychosocial outcomes in adolescents and young adults (Willoughby, Doty, & Malik, 2010). Furthermore, a negative self-image as a sexual minority contributes to the relationship between sexuality-specific stressors, including family rejection and victimization, to poorer mental health outcomes (Page, et al., 2013; Willoughby, et al., 2010).

Though less research has been done with gender minority adolescents overall, and especially on topics

related to identity, internalized transphobia is expected to have a deleterious effect on mental health (Hendricks & Testa, 2012). Therefore, important areas of focus for behavioral health professionals who work with sexual and gender minority adolescents include internalized homophobia, transphobia, and clients' minority identity.

### Intersecting Identities

Finally, sexual and gender minority adolescents are not a single, homogenous population; individuals may hold multiple minority identities. Race, ethnicity, sex assigned at birth, social class, religion, disability, and immigration status may each confer their own unique minority identities, stressors, and strengths that interact with those related to sexual orientation and gender identity and expression. Sexual and gender minority youth have multiple, interlocking identities defined by relative sociocultural power and privilege that shape individual and collective identities and experiences (Crenshaw, 1991; Parent, DeBlaere, & Moradi, 2013; Shields, 2008; Yarhouse & Tan, 2005). Though a full review is beyond the scope of this report, research has begun to identify some of the ways that sexual and gender minority adolescents' experiences vary by race/ethnicity (Corby, Hodges, & Perry, 2007; Grov, et al., 2006; Kosciw, et al., 2014; Ryan, et al., 2009; Ryan, et al., 2010), immigration status (Daley, Solomon, Newman, & Mishna, 2008; Ryan, et al., 2009; Ryan, et al., 2010), gender (Bontempo & D'Augelli, 2002; Ryan, et al., 2009), gender expression (Hidalgo, Kuhns, Kwon, Mustanski, & Garofalo, 2015; Roberts, et al., 2012; Roberts, et al., 2013; Toomey, Ryan, Diaz, Card, &

Russell, 2010), and socioeconomic status (Kosciw, et al., 2009; Ryan, et al., 2009; Ryan, et al., 2010). Behavioral health professionals working with sexual and gender minority youth should be aware of and responsive to the intersecting identities held by young people when considering the effects of minority stress on mental health and wellbeing. Given the gaps in our understanding, more research on the experiences of adolescents who hold multiple marginalized identities is needed in order to understand both the unique strengths and sources resilience, as well as the stressors youth and their families may experience.

### **Therapeutic Efforts with Sexual and Gender Minority Youth**

#### **Introduction<sup>16</sup>**

Despite dramatic social changes in the recognition of same-gender relationships and families and transgender identities, sexual and gender minority children and adolescents and their families face misinformation, negative social attitudes and discrimination that can pose challenges for child development and family acceptance. Behavioral health providers may receive referrals for treatment that include requests to change a child or adolescent's actual, perceived, or future sexual orientation or same-gender sexual behaviors, gender identity, or gender expression. Requests for conversion therapy most often come from a parent or guardian, or more rarely, a child or adolescent.

In providing services to children, adolescents, and families experiencing distress related to sexual orientation or gender, behavioral health providers

should consider the following as the scientific basis of treatment<sup>17</sup>:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

#### Conversion Therapy

Lesbian, gay, and bisexual orientations are normal variations of human sexuality and are not mental health disorders; therefore, treatment seeking to change an individual's sexual orientation is not indicated. Thus, behavioral health efforts that attempt to change an individual's sexual orientation are inappropriate. In 2009, the APA Taskforce on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts conducted a thorough review of peer-reviewed literature published on conversion therapy. The APA Taskforce concluded that no methodologically-sound research on adults undergoing conversion therapy has demonstrated its

effectiveness in changing sexual orientation. There have been no studies on the effects of conversion therapy on children, though adults' retrospective accounts of their experiences of conversion therapy during childhood or adolescence suggests that many were harmed (American Psychological Association, 2009). No new studies have been published that would change the conclusions reached in the APA Taskforce's 2009 review.

Given the lack of evidence of efficacy and the potential risk of serious harm, every major medical, psychiatric, psychological, and professional mental health organization, including the American Psychological Association, the American Psychiatric Association, the National Association for Social Work, the Pan American Health Organization, and the American Academy of Child and Adolescent Psychiatry, has taken measures to end conversion therapy efforts to change sexual orientation. To the extent that children and adolescents experience distress related to their sexual orientation, treatment efforts should focus on identifying and ameliorating the sources of distress.

The discussion surrounding conversion therapy with gender minority youth is complicated by the fact that though diverse gender expressions and transgender identities are now understood to be part of the normal spectrum of human gender (American Psychological Association, 2015a; Coleman, et al., 2012; Knudson, De Cuypere, & Bockting, 2010), there remains a related psychiatric diagnosis: Gender Dysphoria (formerly Gender Identity Disorder (American Psychiatric Association, 2013a). Although there is

much debate over whether Gender Dysphoria should remain a psychiatric diagnosis (for example, see Bockting & Ehrbar (2005)), such a discussion is beyond the scope of this report. However, the shift from Gender Identity Disorder to Gender Dysphoria in version five of the Diagnostic and Statistical Manual of Mental Disorders does reflect a shift away from a pathological view of gender diversity towards a focus on the distress experienced as a result of the incongruence between one's physical body and gender identity (American Psychiatric Association, 2013a; Simons, et al., 2014; Vance, et al., 2014). Thus, the distress remains the target of intervention, rather than gender identity. There is also scientific consensus that for many people, medical intervention in the form of hormone therapy or gender affirming surgeries may be medically necessary to alleviate gender dysphoria (American Medical Association, 2008; American Psychological Association, 2008; Anton, 2009; World Professional Association for Transgender Health, 2008).

Historically, conversion therapy efforts to make children's behaviors, dress, and mannerisms more consistent with those stereotypically expected of their assigned sex at birth (i.e., more stereotypically masculine expression for those assigned male at birth and more stereotypically feminine expression for those assigned female at birth) were the primary clinical approach used with children experiencing gender dysphoria (Vance, et al., 2014; Zucker, 2004). Efforts to change children's gender expression have been made with the goal of preventing a transgender identity, as well as with the goal of preventing a future minority sexual orientation. Such efforts were

based on the belief that variations in gender identity and expression are pathological and that certain patterns of family relationships cause a transgender identity or minority sexual orientation; research has not supported these theories or interventions (American Psychological Association, 2009). Because there is scientific consensus that gender dysphoria in adolescence is unlikely to remit without medical intervention, even those who support gender identity change efforts with pre-pubertal children generally do not attempt such efforts with adolescents experiencing gender dysphoria (Adelson & AACAP CQI, 2012; American Psychological Association, 2008). Alternative affirmative and supportive approaches to therapy with transgender and gender diverse children have been developed and are becoming increasingly common (Edwards-Leeper, Leibowitz, & Sangganjanavanich, in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005).

No research has been published in the peer-reviewed literature that demonstrates the efficacy of conversion therapy efforts with gender minority youth, nor any benefits of such interventions to children and their families. Researchers have reported that these interventions are ineffective in decreasing the likelihood of a future same-gender sexual orientation or minority sexual identity (Zucker & Bradley, 1995). In addition to a lack of evidence for the efficacy of conversion therapy with gender minority youth, there are concerns about the ethics of this practice (Byne, et al., 2012; Coleman, et al., 2012) as well as the practice's potential for harm (Minter, 2012; Wallace & Russell, 2013). Although no research

demonstrating the harms of conversion therapy with gender minority youth has been published, the potential harms of conversion therapy are suggested by clinicians' observations that the behavioral issues and psychological distress of many children and adolescents with gender dysphoria improves markedly when their gender identities and expressions are affirmed through social and/or medical transition (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Edwards-Leeper & Spack, 2012), as well as by the body of literature demonstrating the negative effects of both rejection and a lack of support on the health and well-being of gender minority youth (e.g., research from Kosciw, et al. (2014), Ryan, et al. (2010), and Travers, et al. (2012)).

In conclusion, given the lack of evidence for the efficacy conversion therapy and the fact that conversion therapy efforts are based on a view of gender diversity that runs counter to scientific consensus, in addition to evidence that rejecting behaviors and a lack of support have adverse effects on the psychological well-being of gender minority youth – conversion therapy, as well as any therapeutic intervention with an *a priori* goal for a child's or adolescent's gender expression, gender identity, or sexual orientation, is inappropriate. Given the potential for harm associated with conversion therapy efforts, other affirmative behavioral health interventions are recommended for individual or family distress associated with sexual orientation and gender identity.



### Appropriate Interventions for Distress in Children, Adolescents, and Families<sup>18</sup>

Behavioral health providers are in a unique position to provide accurate information on the development of sexual orientation and gender identity and expression; to increase family and school support; and to reduce family, community and social rejection of sexual and gender minority children and adolescents. The descriptions of interventions below provide general guidance to behavioral health providers working in this area.

#### Client-Centered Individual Approaches

Behavioral health providers should provide children, adolescents and their families with developmentally-appropriate multiculturally-competent and client-centered interventions that emphasize acceptance, support, assessment, and understanding. A clear treatment goal is to identify sources of distress and work to reduce any distress experienced by children, adolescents and their families.

Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression. Such approaches include an awareness of the interrelatedness of multiple identities in individual development as well an understanding of cultural, ethnic, and religious variation in families. Specific approaches can include (a) providing a developmentally-informed cognitive, emotional, mental health and social assessment of the child and family; (b) supporting children and adolescents in their developmental processes and age-

appropriate milestones and facilitating adaptive coping; (c) providing developmentally-appropriate affirmative information and education on sexual orientation, gender identity, gender expression, sexuality, and the identities and *lives of lesbian, gay, bisexual, transgender* people and those who are *questioning* their sexual orientation or gender identity (LGBTQ) to children and adolescents, parents or guardians and community organizations; and, (d) reducing internalized negative attitudes toward same-gender attractions, gender diversity, and LGBTQ identities in children and youth and in parents or guardians and community institutions (e.g., schools and community social groups).

Behavioral health providers should provide developmentally-sensitive interventions to children and adolescents. Such interventions include a comprehensive evaluation taking into account appropriate developmental emotional and cognitive capacities, developmental milestones, and emerging or existing behavioral health concerns. Specific evaluation procedures for children and adolescents with persistent gender concerns have been described by Leibowitz and Telingator (2012).

Behavioral health providers should not have an *a priori* goal for sexual orientation or gender expression, or identity outcomes. The goal of treatment should be the best level of psychological functioning not a specific orientation or identity. Rather, behavioral health providers should focus on identity development and exploration that allows the child or adolescent the freedom of self-discovery within a context of acceptance and support.

Behavioral health providers should strive to incorporate multicultural awareness into their treatment, considering age, ethnicity and race, gender and gender identity, sexual orientation and attraction, ability and disability issues, religion and spirituality, generation, geographic issues and other notable factors. A key aim is to dispel negative stereotypes and to provide accurate information in developmentally-appropriate terms for children and adolescents. Identity development is multifaceted and may include multiple and intersecting identities, such as ethnic and racial and religious and spiritual identities. Sexual orientation, gender identity and expression are fluid concepts and in flux, requiring the consideration of generational changes and norms. Supporting youth in age-appropriate tasks such as developing positive peer relationships, positive parent and family relations, dating, exploring gender expression, sexuality, multiple identity development and disclosure as appropriate is a critical consideration. Behavioral health providers should take into consideration potential sources of social support and community resources. Client-centered and exploratory approaches specific to gender minority youth have been discussed in numerous publications (Edwards-Leeper, et al., in press; Hidalgo, et al., 2013; Lev, 2005; Menvielle & Tuerk, 2002; Menvielle, et al., 2005; Yarhouse, 2015c).

Behavioral health providers should describe their treatment plan and interventions to children, adolescents and their families and to ensure the goals of treatment as well as potential benefits and risks are understood. Where appropriate developmentally, behavioral health providers should obtain informed

consent with all parties to treatment. If informed consent is not a developmentally appropriate option (as the child cannot cognitively or legally provide consent), behavioral health providers should explain treatment in a developmentally appropriate manner and receive assent for treatment. Interventions that are involuntary, especially those in inpatient or residential settings, are potentially harmful and inappropriate. In addition, interventions that attempt to change sexual orientation, gender identity, gender expression, or any other form of conversion therapy are also inappropriate and may cause harm. Informed consent cannot be provided for an intervention that does not have a benefit to the client.

#### Family Approaches

Parental attitudes and behaviors play a significant role in children's and adolescents' adjustment and parents' distress often is the cause of a referral for treatment (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Ryan et al., 2009, 2010). Family rejection, hostility, and violence are key predictors of negative health outcomes in LGBTQ children and adolescents (Ryan, et al., 2009; Ryan & Rees, 2012). Reducing parental rejection, hostility, and violence (verbal or physical) contributes to the mental health and safety of the child and adolescent (Ryan, et al., 2009; R. Savin-Williams, 1994; Wilbur, Ryan, & Marksamer, 2006).

Family therapy that provides anticipatory guidance to parents and guardians to increase their support and reduce rejection of children and adolescents is essential. Interventions that increase family and community support and understanding while

decreasing LGBTQ-directed rejection are recommended for families. School and community interventions are also recommended to reduce societal-level negative attitudes, behaviors and policies, as well as provide accurate information and social support to children, adolescents, and families.

A key focus of treatment should be addressing parental concerns regarding current or future sexual orientation and gender identity. Behavioral health providers should provide family members with accurate developmentally-appropriate information regarding minority sexual orientations and strive to dispel myths regarding the lives, health, and psychological well-being of sexual and gender minority individuals.

Ryan, et al. (2010) recommended that behavioral health providers assess family reactions to LGBTQ children and adolescents, specifically the presence of family rejection. Further, behavioral health providers should attempt to modify highly rejecting behaviors, providing anticipatory guidance to families that include recommendations for support on the part of the family, and explaining the link between family rejection and negative health problems in children and adolescents. Behavioral health providers should seek ways to ameliorate parents' distress about their children's sexual orientation and/or gender, such as exploring parental attributions and values regarding minority sexual orientations and gender diversity. Family therapy may be helpful in facilitating dialogues, increasing acceptance and support, reducing rejection, and improving management of conflicts or misinformation that may exacerbate a

child or adolescent's distress (Mattison & McWhirter, 1995; Ryan, et al., 2009; Salzburg, 2004, 2007). Such therapy can include family psychoeducation to provide accurate information and teach coping skills and problem-solving strategies for dealing more effectively with the challenges sexual and gender minority youth may face and the concerns the families and caretakers may have (Ben-Ari, 1995; Perrin, 2002; Ryan & Diaz, 2005; Ryan & Futterman, 1998; Ryan, et al., 2009; Salzburg, 2004, 2007; Yarhouse, 1998).

When working with families of young children, behavioral health providers should counsel parents who are concerned that their children may grow up to be lesbian, gay, bisexual, or transgender to tolerate the ambiguity inherent in the limited scientific knowledge of development. A two-prong approach may be helpful: (a) provide information to reduce heterosexism and cisgenderism (that is, attitudes and actions that a heterosexual orientation and gender identity and expression that conform to stereotypical norms are preferable to a same-gender sexual orientation, transgender identity, or diverse gender expression) within the family and increase the family's capacity to provide support; and (b) introduce information about sexual and gender minority issues into family discussions to increase the child's own self-awareness and self-acceptance and to counter negative attitudes directed toward the self that might reduce self-esteem. For example, consider ways in which respect and value of all persons is frequently a shared goal. Even in cases in which family members may disagree about decisions each person may make, there may be opportunity to agree on broader

principles and concepts that can lead to mutual understanding (Yarhouse, 2015b).

Families with strong beliefs who see same-gender attractions or relationships and gender diversity as undesirable and contrary to those beliefs may struggle with a child's emerging minority sexual orientation or gender. Ryan and Rees (2012) and Yarhouse (1998; Yarhouse & Tan, 2005; Maslowe & Yarhouse, 2015) have suggested that family therapy focus encouraging love of their child. This involves focusing on superordinate values such as unconditional love and changing behaviors to reduce rejection. The authors stress that these positive steps can lay a constructive foundation for communication and problem solving and reduce family discord and rejection (Yarhouse & Tan, 2005). Ryan, et al. (2009) and Ryan and Rees (2012) focus on reframing family concerns as a manifestation of care and love and focus on teaching non-rejecting ways to communicate those positive emotions. For example, providers can help the family create an atmosphere of mutual respect that ensures the safety of each person from being hurt or bullied as a natural extension of seeing each person as having intrinsic worth (Yarhouse, 2015b). One of the most important messages that can be communicated to a young person is that their safety is important to the provider and to the family. It is helpful to set an atmosphere of mutual respect for one another in the home and then to see the value of extending that to other settings, such as neighborhood, school, and places of worship. Safety in this context is not just physical safety, but also emotional safety (Yarhouse, 2015b).

Many families may feel they have to choose between competence (in a provider) and deeply held beliefs. It is ideal when a family can work with competent providers who also share their deeply held beliefs and who are affirming of sexual orientation and gender diversity. However, when such providers are not available, it is important for families to work with competent providers who will be sensitive to the family's deeply held beliefs and values while offering competent, appropriate services for sexual and gender minority minors (Yarhouse, 2015b). Thus, behavioral health providers may wish to increase their own competence in working with certain communities with deeply held beliefs and focus on viewing these beliefs through the imperative of multicultural competence and mutual respect (Bartoli & Gillem, 2008). This includes understanding how to translate between psychology and deeply held beliefs rather than judging those beliefs. Certain language, such as acceptance, might not resonate with communities that have strongly held beliefs, whereas the concept of unconditional love might (Yarhouse, 2015a).

Providing multiculturally-sensitive anticipatory guidance to all parents to address their unique personal concerns can be helpful (Ryan & Futterman, 1998). Behavioral health providers can help the parents plan in an affirmative way for the unique life challenges that they may face as parents of a sexual or gender minority child. Also, parents must deal with their own process of "coming out" and resolve fears of discrimination or negative social reactions if they risk disclosure within their communities, at work, and to other family members (Ryan & Rees, 2012). Further,



behavioral health providers can address other stresses, such as managing life celebrations and transitions and coping feelings of loss, and aid parents in advocating for their children in school situations—for example, when they face bullying or harassment. Multiple family groups led by behavioral health providers might be helpful to counter the isolation that many parents experience (Menveille & Tuerk, 2002).

#### School and Community Interventions

Research has illustrated the potential that school-based and community interventions have for increasing safety and tolerance of sexual and gender minorities, preventing distress and negative mental health consequences, and increasing the psychological well-being and health of sexual minority children and adolescents (American Psychological Association, 2015c; D'Augelli & Patterson, 2001; Goodenow, et al., 2006; Harper, Jamil, & Wilson, 2007; Kosciw & Diaz, 2006; Safren & Heimberg, 1999). For instance, sexual and gender minority adolescents in schools with support groups for LGBTQ students reported lower rates of suicide attempts and victimization than those without such groups (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011).

These support groups provided accurate affirmative information and social support, and the groups' presence was also related to increased school tolerance and safety for LGB adolescents (Goodenow, et al., 2006; Kosciw & Diaz, 2006; Szalacha, 2003; Toomey, et al., 2011). School policies that increased staff support and positive school climate have been

found to moderate suicidality and to positively affect sexual minority children's and adolescents' school achievement and mental health (Goodenow, et al., 2006).

#### Additional Appropriate Approaches with Gender Minority Youth

In addition to the appropriate therapeutic approaches described above – comprehensive evaluation, support in identity exploration and development without an *a priori* goal of any particular gender identity or expression, and facilitation of family and community support – social transition and medical intervention are therapeutic approaches that are appropriate for some gender minority youth.

#### Social Transition

Social transition refers to adopting a gender expression, name, and pronouns consistent with one's gender identity. Over the past ten years, the age at which individuals socially transition has decreased dramatically, and it has become increasingly common for children to present to specialty gender clinics having already socially transitioned (Cohen-Kettenis & Klink, 2015; Steensma & Cohen-Kettenis, 2011). There is less controversy around social transition with adolescents, for whom gender identity is typically more stable and desistence of gender dysphoria (without social transition or medical intervention) is less common. Gender specialists recommended that adolescents socially transition at or before the time they begin medically transitioning with hormone therapy, though many adolescents will socially transition earlier (Cohen-Kettenis & Klink, 2015).

There is no research evidence on the benefits vs. risks of social transition among pre-pubertal children, and the impact of social transition on likelihood of persistence or desistence of gender dysphoria has not yet been studied (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). A divergence of expert opinion exists among specialists treating gender minority children (Adelson & AACAP CQI, 2012; Leibowitz & Telingator, 2012). Given the lack of data on the risks and benefits of social transition in childhood, the American Academy of Child and Adolescent Psychiatry suggests that concerns related to social transition in school environments should be weighed against the risks of not doing so, including distress, social isolation, depression, or suicide due to lack of social support (Adelson & AACAP CQI, 2012). Edwards-Leeper and Spack (2012) outline several factors that need to be considered in determining when and if a child should socially transition, including the child's needs, the potential impact on the child's siblings, whether it is safe for the child to socially transition in his or her community, and emphasizing to the child and family the possibility that the child's gender identity and gender expression may change as development continues.

#### Medical Intervention

The appropriateness of medical interventions vary by the age of the child. No medical interventions are currently undertaken or recommended for children with gender dysphoria before the initial onset of puberty. Medical intervention has proven efficacious in improving the well-being of young adolescents with gender dysphoria both during and well after

treatment (Cohen-Kettenis & van Goozen, 1997; de Vries, et al., 2011; Smith, et al., 2001), and most adolescents who seek medical intervention usually have extreme forms of gender dysphoria beginning in childhood (Cohen-Kettenis & Klink, 2015). Pubertal suppression and hormone therapy are medical interventions used to treat gender dysphoria in adolescents.

Medical intervention with gender dysphoric adolescents is a multi-disciplinary endeavor including Behavioral health providers, pediatricians, and often pediatric endocrinologists (Hembree et al., 2009; Leibowitz & Telingator, 2012). A comprehensive assessment, including assessment of the degree of an individual adolescent's gender dysphoria and desire to seek gender reassignment, helps determine the risks and benefits of medical interventions (for featured examples of assessments with children and adolescents, see Leibowitz and Telingator (2012)). Importantly, not all individuals who experience gender incongruence or gender dysphoria necessarily experience a complete cross-gender identity, want hormone therapy as well as gender affirming surgeries, or want to live as the other gender permanently or completely (Coleman et al., 2012).

If a diagnosis of gender dysphoria is assigned and the adolescent desires and is eligible for treatment, readiness for medical treatment must be considered (Cohen-Kettenis & Klink, 2015). Adolescents and their parents or guardians must be informed about possibilities and limitations of pubertal suppression, hormone therapy, and other types of treatment, such as psychological interventions, in order to give full

informed consent (Coleman et al., 2012; Vance et al., 2014). Taking into account developmental considerations when working with adolescents is key. Youth should realize that medical intervention or a complement of hormone therapy and gender affirming surgeries are not the only treatment option to solve gender dysphoria, and should realize that gender dysphoria may exist in many forms and intensities (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). Continued mental health treatment should be offered when an adolescents' gender incongruence requires further exploration and/or when other psychological, psychiatric, or family problems exist. Adolescents receiving medical intervention without these additional concerns may also benefit from continued psychological treatment (Vance et al., 2014); given that pubertal suppression or administration of hormone therapy occurs over many years during important developmental periods, the need for psychological treatment may change with time as new questions arise (Cohen-Kettenis & Klink, 2015).

Pubertal suppression using gonadotrophin-releasing hormone (GnRH) analogues prevents the development of unwanted secondary sex characteristics in a peri-pubertal adolescent, which are irreversible and highly distressing for some adolescents with gender dysphoria (Leibowitz & Telingator, 2012). Pubertal suppression is fully reversible and serves as an extended diagnostic period, providing additional time for gender exploration as well as cognitive and emotional development that allows adolescents to become psychologically and neurologically mature enough to

make decisions regarding their gender and to provide informed consent years later for the partially irreversible treatment interventions (e.g., hormone therapy) without having to experience distressful, irreversible changes of puberty (Hembree et al., 2009; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). Pubertal suppression also has therapeutic effects, often resulting in a large reduction in the distress the physical changes of puberty were producing (de Vries et al., 2011; Edwards-Leeper & Spack, 2012).

Pubertal suppression for young adolescents remains controversial, with concern over whether adolescents are able to make far-reaching decisions and understand the impact of pubertal suppression on their lives and over the lack of robust research on the long-term effects of pubertal suppression on brain and bone development in these populations (Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012). However, results of preliminary research on the long-term effects of pubertal suppression are promising (Delemarre-van de Waal & Cohen-Kettenis, 2006; Cohen-Kettenis, Schagen, et al., 2011; Staphorsius et al., 2015). Abstaining from treatment in adolescence comes with risks as well: adolescents can experience refusal for treatment and the progression of secondary sex characteristic development as extremely psychologically painful, and a refusal of medical intervention can lead to worse psychological adjustment and risky behaviors (e.g., self-mutilation, self-medication, or suicide; Cohen-Kettenis & Klink, 2015; Leibowitz & Telingator, 2012; Vance et al., 2014). Given the current evidence that diagnosis can be made reliably

in adolescence, that gender dysphoria that worsens with puberty rarely subsides afterwards, and that – with careful diagnostic procedures – early pubertal suppression leads to good outcomes with young adults, withholding GnRHa is not considered a neutral option (Cohen-Kettenis & Klink, 2015). According to the Endocrine Society Guidelines, pubertal suppression with GnRH analogues is considered a medical standard of care for adolescents in Tanner stage 2 or 3 of puberty, once appropriate mental health assessments and recommendations are in place (Hembree et al., 2009). However, the importance of full informed consent for both adolescents and their parents or guardians is important and must include awareness and consideration of the risks and benefits involved, as well as an emphasis on continued exploration of gender identity.

The initiation of hormone therapy (estrogen and testosterone blocking medication for those assigned male at birth and testosterone for those assigned female at birth) around age 16 promotes the development of secondary sexual characteristics consistent with one's gender identity (Coleman et al., 2012; Hembree et al., 2009). While a minimum age of 16 was previously a requirement, the optimal time for initiation of hormone therapy is now determined by duration of GnRH analogue use (when used) and the adolescent's psychological state (Cohen-Kettenis & Klink, 2015). Unlike GnRH analogues, which are completely reversible, hormone therapy is only partially reversible. Again, once hormone therapy is indicated and an adolescent has been carefully assessed for readiness, care must be taken to get the

informed consent of the adolescent and his or her parents or guardians before hormone therapy is initiated, including a full understanding of the potential risks and benefits of hormone therapy and the impact of hormone therapy on future fertility and options related to fertility (Cohen-Kettenis & Klink, 2015; Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012). The support of a behavioral health professional during this process can aid an adolescent in adjusting to their changing physical characteristics and the response from people in different aspects of the adolescent's life.

In addition to hormone therapy, some transgender adolescents desire and will eventually pursue gender affirming surgeries. The age of legal consent for surgery is 18, so most surgeries are not performed on adolescents, though behavioral health providers and medical providers working with adolescents may need to obtain and provide knowledge of the surgical processes in order to assist in navigating the emotional issues leading up to gender affirming surgeries; additionally, those assigned female sex at birth may be considered for virilizing mastectomy beginning at age 16 (Edwards-Leeper & Spack, 2012; Leibowitz & Telingator, 2012).

### **Future Directions for Research**

Areas of opportunity for future research, as well as the validity and quality of extant research are discussed in several sections of this report and were topics of conversation during the APA Consensus Panel Meeting in July, 2015. Methodologically rigorous, longitudinal, and peer reviewed research is vital to improving our understanding of the



complexities of sexual orientation and gender identity and expression among children and adolescents. Several potential areas for future research are identified below.

#### Development of sexual orientation and gender identity

Little is known about the development of sexual orientation and gender identity in childhood and adolescence. Basic research on the developmental pathways of these fundamental issues is necessary. How these identities are embedded in cognitive and emotional development and other developmental processes would aid in the understanding of human development as well as appropriate interventions.

#### Culturally-specific mitigation of distress relating to sexual orientation, gender identity, and gender expression

More targeted research that acknowledges the intersections of identity, including race, ethnicity, faith, and class, among others, could shed light on positive and appropriate whole-family therapeutic approaches to addressing these issues. Researchers should evaluate these practices and integrate them into behavioral health care. Researchers should also work collaboratively with young people and families from faith communities to better understand the interplay between deeply held religious beliefs and the importance of ensuring the safety and well-being of LGBTQ young people. The work of the Family Acceptance Project, cited throughout this report, speaks to the necessity of an increased focus on approaches specific to various communities including culturally diverse communities and those with deeply

held morals and values that include conversations about sexual orientation, gender identity, and gender expression.

Addressing the needs of disconnected LGBTQ youth

LGBTQ youth experiencing homelessness, in juvenile justice facilities, or otherwise in out-of-home care may lack permanent and stable family connections in part because of family distress around issues relating to their LGBTQ identity. These vulnerable populations, as well as low-income and racial and ethnic minority LGBTQ youth, are often neglected in research studies that most often recruit youth who are already connected to clinics or providers. This need for more representative sampling and better recruitment efforts should be addressed by future researchers interested in sexual orientation and gender identify among youth.

#### Long-term Outcomes

More research is necessary to explore the developmental trajectory of sexual orientation, gender identity, and gender expression, in addition to the long-term medical and behavioral health outcomes associated with early experiences of family and community distress due to sexual orientation and gender identity and expression. Other recommended areas of opportunity for long-term research topics include:

- A nuanced exploration of the factors that may differentiate children and adolescents who continue to experience gender dysphoria into adolescence and those who do not.

- Long-term outcomes from early social transition and pubertal suppression (including effects on brain development, sexual health function, fertility, etc.).
- Rigorous evaluation of current practices and protocols, including affirmative models, structural interventions, and culturally-specific models, among others.
- Prospective research focusing on younger children, in partnership with pediatric clinics.
- Sources of distress among sexual and gender minority youth, focusing on distinguishing between internal and external factors that may drive gender dysphoria.
- Methods of supporting positive behavioral health for LGBTQ youth, including building resiliency against suicidality, self-harm and risky behaviors, depression, anxiety, substance abuse, and other behavioral health issues.

#### Integration, Collaboration, and Dissemination

Researchers and clinicians should examine and evaluate the best methods of integrating and disseminating best and promising practices for addressing sexual orientation and gender identity and expression among children and youth, and how to successfully collaborate with parents and guardians, caregivers and providers, and community leaders. This could include conducting studies with these populations focused on knowledge, attitudes, and beliefs relating to efforts to change sexual orientation, gender identity, or gender expression.

Finally, the behavioral health community can work to support community-based organizations to develop common ground and consensus on these topics and promote the health and well-being of youth. This could also include the development of treatment registries, support for sexual health research across the country, and the inclusion of LGBT-specific questions in national behavioral and mental health surveys.

Based on careful review of the research and the consensus of clinical experts in this field, conversion therapy is not an appropriate therapeutic intervention. Consequently, efforts should be taken to end the practice. The Administration has issued a public statement supporting efforts to ban the use of conversion therapy for minors, stating in part:

*“When assessing the validity of conversion therapy, or other practices that seek to change an individual’s gender identity or sexual orientation, it is as imperative to seek guidance from certified medical experts. The overwhelming scientific evidence demonstrates that conversion therapy, especially when it is practiced on young people, is neither medically nor ethically appropriate and can cause substantial harm.*

*As part of our dedication to protecting America’s youth, this Administration supports efforts to ban the use of conversion therapy for minors.”*  
(Jarrett, 2015)

### **Approaches to Ending the Use of Conversion Therapy**

Several approaches have been employed as mechanisms for eliminating the use of harmful practices, and encouraging positive and appropriate alternatives to discussing issues related to sexual orientation, gender identity, and gender expression with children and adolescents. These efforts will be reviewed in depth in this section:

1. Reducing discrimination and negative social attitudes towards LGBT identities and individuals
  - Adoption of public policies that end discrimination
  - Increasing access to health care
  - Publication of affirmative, culturally competent resources for the public on LGBT individuals and families.
2. Dissemination of information, training and education for behavioral health providers
  - Dissemination of professional association and federal agency documents and resolutions related to ending conversion therapy
  - Guidelines by professional associations on affirmative approaches to LGBTQ children and youth as well as LGBT adults
  - Inclusion of affirmative information and treatment models in professional training curriculum
  - Continuing education on elements of ethical codes and licensing laws relevant to these issues.
3. Legislative, regulatory, and legal efforts

- State and federal legislation that bans sexual orientation and gender identity change efforts
- Federal and state regulatory actions and additional Administration activities
- Legal action

### **Reducing discrimination and negative social attitudes towards LGBT identities and individuals**

Reducing the discrimination and negative social attitudes that many LGBTQ children and adolescents experience can improve health outcomes. As previously discussed, negative social attitudes are stressors that can result in poor mental health. Working with individuals, families, communities, and diverse populations to increase family acceptance and change cultural norms that are unsupportive of sexual and gender minority identities is one way to improve health and well-being overall.

The Administration has taken significant steps to reduce discrimination and negative social attitudes towards and increase support for LGBT communities,<sup>19</sup> including improving access to health care. Among other notable signals of social acceptance and support, the Administration has:

- Ended the “Don’t Ask, Don’t Tell” policy in military service for lesbian, gay, and bisexual people, and taken steps to remove barriers to service for transgender people;
- Supported same-sex marriage and ensured that same-sex couples and their families have full access to federal benefits;
- Prevented employment discrimination by federal contractors;

- Advanced policies that expand access to quality healthcare for millions of Americans, including LGBT Americans; and
- Supported public information campaigns, such as the “It Gets Better” Project, which aims to give LGBTQ youth hope and build public support.

Broad dissemination of supportive actions such as those outlined above serves to both mitigate negative social attitudes, and to build more accepting ones. SAMHSA, in addition to partner organizations and professional associations, has developed targeted resources geared towards providers working with sexual and gender minority youth and their families.<sup>20</sup>

### **Dissemination of information, training and education for behavioral health providers**

The major health associations have issued policy statements critical of conversion therapy including the World Health Organization, the American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association, American Counseling Association, American Psychoanalytic Association, and the National Association of Social Workers, among others. Other Association publications include professional guidelines on affirmative practices for this population (APA, 2011; APA 2015a).

In addition, some professional associations, including the American Academy of Child and Adolescent Psychiatrists, American Psychiatric Association, and the American Psychological Association, have

published reports and professional practice guidelines on appropriate therapeutic efforts for this population. These documents provide important resources for providers on the types of interventions that are appropriate for sexual and gender minority children and youth as well as for LGBT adults.<sup>21</sup>

Professional mental health, medical, and social services organizations can require training that includes appropriate interventions for this population. For example, The American Association of Medical Colleges (AAMC) produced a report on *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*. As part of this publication, the association indicates that “doctors should be able to demonstrate an investigatory and analytic approach to clinical situations by [...] identifying various harmful practices (e.g., historical practice of using ‘reparative’ therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for [LGBT] patients.”

Professional health and mental health associations also have ethical codes (American Psychiatric Association, 2013; American Psychological Association, 2010; National Association of Social Workers, 2008). These codes include provisions that stress aspirational principles and standards for practice that can be applied to sexual and gender minority youth and LGBT individuals broadly. Many of these codes are integrated into state licensing laws and thus govern standards of professional practice.



Experts have suggested that the use of conversion therapy to change the sexual orientation or gender identity of clients may be inconsistent with the aspirational principles of behavioral health professions. For example, conversion therapy might violate the principle of “*Do No Harm*” through techniques that are deleterious rather than beneficial to mental health. Additionally, conversion therapy may be inconsistent with professional standards that treatment be based on the best scientific knowledge and standards of professional competence, in its use of treatments that cannot be justified by established scientific and clinical knowledge in the field, and which imply that variations in sexual orientation and gender identity are not normative. Experts have also suggested that conversion therapy is inconsistent with principles of non-discrimination and justice that guarantee all clients, including sexual and gender minorities, equal access to the benefits of psychology and to equal quality of services. Finally, by denying the inherent worth of LGBT individuals and engaging in an intervention based on negative social or cultural attitudes, practitioners of conversion therapy could potentially violate principles that dictate respect for people’s dignity.

### **Legislative, regulatory, and legal efforts**

Many individuals, organizations, and several state legislatures have taken steps to regulate and eliminate the practice of conversion therapy. Efforts to end the practice of conversion therapy have included legislative bans and causes of action alleging consumer fraud, among others. Future efforts may include federal regulatory action, advancement of

legislation at the state and federal level, and additional activities by the Administration.

As of August 2015, four states and the District of Columbia have passed laws banning the practice of conversion therapy for minors, and 21 other states have introduced similar legislation. All of the bills bar mental health providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions.

There is currently no federal ban on conversion therapy. Several bills and resolutions have been introduced in 2015, including H.R. 2450: Therapeutic Fraud Prevention Act; S.Res. 184: Stop Harming Our Kids Resolution of 2015; HR 3060 Stop Child Abuse in Residential Programs for Teens Act of 2015; and H.Con.Res. 36: Expressing the sense of Congress that conversion therapy, including efforts by mental health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors. These efforts discourage or ban conversion therapy or require non-discrimination in the provision of services to sexual and gender minority minors.

Stakeholders have also suggested the following as potential federal actions to end conversion therapy:

- Restrictions on the use of federal or state funding for conversion therapy by federal programs, by recipients of such funding, or through health insurance reimbursements.

- Policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care. These entities are often licensed by states or receive federal funding.
- Clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy

In addition to legislative and regulatory action, legal action has been explored as a mechanism for ending the use of conversion therapy. Most notably, a jury found in favor of a claim brought under New Jersey's consumer fraud law, finding that a "conversion therapy" program that offered services purported to change people from gay to straight was fraudulent and unconscionable.<sup>23</sup>

In addition, potential claims of discrimination have been raised under the theory that the provision of ineffective and potentially harmful therapy is due solely to an individual's sexual orientation or gender identity.

Notably, the American Bar Association also passed a resolution urging "all federal, state, local, territorial, and tribal governments to enact laws that prohibit state-licensed professionals from using conversion therapy on minors," as well as "to protect minors, particularly minors in their care, from being subjected to conversion therapy by state-licensed professionals."<sup>24</sup>

### **Guidance for Families, Providers, and Educators**

Being a sexual or gender minority, or identifying as LGBTQ, does not constitute a mental disorder. Sexual

or gender minority status, however, is associated with increased risk of psychosocial issues such as psychological distress, mistreatment, and discrimination. Social support, as well as a lack of rejection, in family, community, school, and health care environments has been shown to have great positive impacts on both the short-and long-term health and well-being of LGBTQ youth (see *Research Overview Section 3.2*). Beyond eliminating the practice of conversion therapy with sexual and gender minority minors, LGBTQ youth need additional support to promote resilience and positive development in the spite of the still-pervasive interpersonal, institutional, and societal bias and discrimination against sexual and gender minorities. The following portions of this report provide families and others working with LGBTQ children and adolescents with guidance and additional resources to help facilitate the best possible outcomes for these youth. The information in these sections is based on research findings as well as clinical expertise.

### **Promoting Family and Community Acceptance and Support**

As children and adolescents increasingly experience and integrate LGBTQ and gender diverse identities during childhood and adolescence, it is critical to provide support to reduce risk and promote well-being across social institutions and systems. This includes families, peers, schools, religious institutions, health and social systems and community services.

Over the past decade, the concept of “connectedness” has been seen by researchers and clinicians as an essential aspect in helping to protect against risk and

promote wellness for individuals in families and communities. For LGBTQ youth, family, peer and community support have been shown to be important sources of support, and among these, family support and acceptance during adolescence were found to have the strongest influence on overall adjustment and well-being in young adulthood. Because most young people are nurtured through diverse family, caregiver and kinship systems, LGBTQ and gender diverse children and adolescents need support in the context of their families, cultures and faith communities. Access to accurate information about sexual orientation and gender identity development is critical for families and caregivers who often have limited and inaccurate information about these core aspects of human development. This is particularly important for families and caregivers who believe that LGBTQ identities and gender diversity may be at odds with or disavowed by their religious and cultural values and beliefs.

In 2014, SAMHSA worked with the Family Acceptance Project to publish a resource guide to help practitioners to provide support for families with LGBTQ children. The Family Acceptance Project has developed a family support model and research-based resources to help diverse families, including conservative families, to support their LGBTQ children in the context of their values and beliefs.

**Key Points:**

- Family reactions to learning that a child is lesbian, gay, bisexual or transgender range from highly rejecting to highly accepting. The largest proportion of families are ambivalent about having

an LGBTQ or gender diverse child, and rejecting families become less rejecting over time. Families can learn to support their LGBTQ children – and do so more quickly – when guidance and services are provided in ways that resonate for them, including education presented in the context of cultural and deeply held values.

- All families and caregivers need to receive accurate information about sexual orientation and gender identity and expression in children and adolescents, and they need to understand that how they respond to their LGBTQ children matters. For example, family rejecting behaviors during adolescence – including attempts to change an adolescent’s sexual orientation – have been linked with health risks, including suicidal behavior and risk for HIV, during young adulthood. In addition, family supportive and accepting behaviors during adolescence, which include supporting a child’s gender expression, have been found to help protect against health risks and to help promote well-being for LGBTQ young adults. As family rejecting and supportive behaviors increase, so, too, does the level of health risks and protective role of family acceptance in promoting an LGBTQ child’s overall health and well-being.
- Parents and families with LGBTQ and gender diverse children need to be heard and understood by providers, educators and others who provide services and support for their children and family. This means meeting parents and families where they are, supporting their need to express their feelings, perceptions, hopes and concerns for their

LGBTQ child in the context of their cultural and religious perspectives, and being sensitive to how deeply held values shape reactions and responses to having an LGBTQ or gender diverse child.

- Parents and caregivers who are perceived as rejecting their LGBTQ children and who engage in rejecting behaviors (such as trying to change their child's sexual orientation or gender expression, using deeply held values and morals to prevent or change an adolescent's identity or preventing them from participating in LGBTQ support groups) are typically motivated by trying to help their LGBTQ child "fit in," have a good life and be accepted by others. The Family Acceptance Project's research-informed approach to providing services and care for LGBTQ children and adolescents uses a strengths-based framework that views families and caregivers as potential allies in reducing risk, promoting well-being, and creating healthy futures for their LGBTQ children. The family's cultural values, including deeply-held morals and values, are viewed as strengths. Research findings related to family accepting and rejecting behaviors are aligned with underlying deeply held morals and cultural values (such as supporting an individual's dignity and self-worth) to help families understand that it is specific family reactions and communication patterns that contribute to both their LGBTQ child's risk and their well-being.
- Families that are struggling with having an LGBTQ or gender diverse child don't have to choose between their LGBTQ child and their culture or their morals and values. Many parents who are

struggling believe that responding with positive reactions such as expressing affection once they learn that a child is LGBTQ will condone or encourage a behavior or identity that is at odds with their beliefs. However, expressing affection for an LGBTQ child is a key supportive behavior that helps protect their child against health risks and increases connectedness. In addition, parents that are struggling can respond with other supportive behaviors that help increase parent-child connectedness and have been identified in research to help protect against risk and help promote an LGBTQ child's well-being - without "accepting" an identity they believe is wrong. This includes behaviors such as talking with their child and listening respectfully to understand their child's experiences; requiring that other family members treat their child with respect even if they disagree; ensuring their child's safety by standing up for their child when others hurt, mistreat or discriminate against their LGBTQ or gender diverse child because of who they are. These behaviors also reflect the key values of dignity, mercy, and compassion.

#### Resources

Family Acceptance Project:

<http://familyproject.sfsu.edu/>

Gender Spectrum: [www.genderspectrum.org](http://www.genderspectrum.org)

Institute for the Study of Sexual Identity:

[www.sexualidentityinstitute.org](http://www.sexualidentityinstitute.org)

PFLAG : [www.pflag.org](http://www.pflag.org)

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adolescents: Findings from the 2009 New York City Youth Risk Behavior Survey. *American Journal of Public Health*, 104(10), 1950-1956.

Substance Abuse and Mental Health Services Administration. (2014). *A practitioner's resource guide: Helping families to support their LGBT children*. (HHS Publication No. PEP14-LGBTKIDS). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from <http://store.samhsa.gov/product/PEP14-LGBTKIDS>.

### **Bullying, Harassment, and Other School-Based Issues**

Children and adolescents spend the vast majority of their time in schools and other institutional settings. Research has shown that students with positive school experiences achieve healthier outcomes across a range of variables. Conversely, negative experiences in school can have a detrimental impact on educational attainment, in addition to numerous health-related outcomes. LGBTQ young people in schools experience disproportionately high levels of bullying, harassment, and discrimination. This puts them at higher risk of depression, anxiety, suicidal ideation and attempt, substance use, and other mental health problems, in addition to negative educational outcomes. Families, guardians, and school-based professionals can and should take steps to mitigate issues that arise because students are, or are perceived to be, LGBTQ. Safe and supportive school environments are an important factor in ensuring the health and well-being of all students, including LGBTQ students.

Key points:

- Much of the distress that LGBTQ children and adolescents experience is not the result of their gender non-conformity or LGBTQ identity – in other words, it is not *being* LGBTQ that causes the distress, but rather the way they are *treated* for being LGBTQ that does. This can include being bullied, harassed, or otherwise mistreated, in addition to experiences with structural barriers such as the lack of access to an appropriate restroom for a transgender student. School-based professionals can help minimize mental health issues for LGBTQ students by taking steps to eliminate structural barriers and proactively working to create a positive school climate, which can include measures such as LGBTQ-inclusive curriculum and intervening to stop bullying and harassment.
- School-based mental health professionals may often be one of the few trusted adults with whom young people can be open about who they are and what barriers they are facing as a result. Some LGBTQ young people may not be in a position to discuss their sexual orientation or gender identity with their families, whether because their family has already made it clear that such conversations are not welcome, or because of fears of family rejection if they come out. In addition to providing a safe and welcoming atmosphere, school-based mental health professionals can equip themselves with LGBTQ-related resources, know the warning signs for identity-based mistreatment, and be prepared to serve as one of the primary adults with whom LGBTQ youth can discuss these issues.

- It is important to understand that confidentiality is essential; students should not be outed to their parents or to their peers, and professionals should not assume that the name, pronouns, or manner of dress that a student uses in school is the same at home; often times, school may be the only place where a young person feels comfortable being out or expressing their gender in a certain way. Students should be asked how they would like to be addressed and in which context. Safety and support should be of paramount concern.
- Students should never be asked to change gender non-conforming behavior as a means of resolving issues arising in school. Beyond the potential for increasing psychological distress, such requests occur within the context of a system that already frequently penalizes LGBTQ youth. This population is disproportionately disciplined in schools, and is over-represented in the juvenile justice system. While five to seven percent of youth are estimated to be LGBTQ, they represent 15 percent of the juvenile justice population, and up to 40 percent of homeless youth. Helping to ensure that LGBTQ youth can be who they are *and* stay in school is a life-changing and potentially life-saving intervention.
- One of the most important steps that families and schools can take is to ensure that schools have inclusive and supportive policies for LGBTQ youth that are implemented effectively. Numerous resources have been developed (several are listed below) that walk through all of the ways in which a school can make system-wide changes that benefit all students, including LGBTQ students.

Beyond simply being in the best interest of LGBTQ students and their behavioral health, Title IX of the Education Amendments of 1972 protects transgender and gender nonconforming students from discrimination. Proactive adoption of inclusive policies can prevent costly and time-consuming efforts to remedy issues after damage has already occurred.

#### Resources:

Centers for Disease Control, Division of Adolescent and School Health (DASH):

[www.cdc.gov/HealthyYouth/](http://www.cdc.gov/HealthyYouth/)

GLSEN: [www.glsen.org](http://www.glsen.org)

Human Rights Campaign, Welcoming Schools Initiative: [www.welcomingschools.org](http://www.welcomingschools.org)

National Center for Lesbian Rights, Youth Project: [www.nclrights.org/our-work/youth](http://www.nclrights.org/our-work/youth)

National Association for School Psychologists, Committee on GLBTQ Issues: [www.nasponline.org/advocacy/glb.apsx](http://www.nasponline.org/advocacy/glb.apsx)

PFLAG : [www.pflag.org](http://www.pflag.org)

Safe & Supportive Schools Project: <http://www.apa.org/pi/lgbt/programs/safe-supportive/default.aspx>

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[nasp/resolution/gender\\_sexual\\_orientation\\_diversity.pdf](#)

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- National Association of School Psychologists. (2014). NASP Position statement: Safe schools for transgender and gender diverse students, from [http://www.nasponline.org/about\\_nasp/positionpapers/Transgender\\_PositionStatement.pdf](http://www.nasponline.org/about_nasp/positionpapers/Transgender_PositionStatement.pdf)
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- U.S. Department of Justice. (2013). Resolution Agreement: Between the Arcadia Unified School District, the U.S. Department of Education, Office for Civil Rights, and the U.S. Department of Justice, Civil Rights Division, from <http://www.justice.gov/sites/default/files/crt/legacy/2013/07/26/arcadiaagree.pdf>

“ When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl’s clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression. Thankfully, one of my friends recognized the warning signs and called social services, which intervened and got me the housing and medical care I needed. It is always darkest before the dawn, but I’m living proof that a smart bystander can save a life. ”—Amy

### **Pediatric Care Considerations for LGBTQ Children and Adolescents**

Pediatricians are often the first health professional that families turn to when they need help addressing issues that have arisen because their child is, or is perceived to be, LGBTQ. Families often develop a longstanding, trusting relationship with their family pediatrician and may feel more comfortable discussing issues with them before reaching out to a behavioral health professional. They may rely also on them for referrals to other appropriate professionals. Consequently, it is important for pediatricians to understand appropriate therapeutic approaches when working with LGBTQ children and their families.

In 2014, the Association of American Medical Colleges (AAMC) published a set of thirty gender, sex anatomy, and sexuality competencies that physicians should be able to demonstrate in their practices (Association of American Medical Colleges, 2014). Additionally, the American Academy of Child and Adolescent Psychiatry published a set of practice parameters pertaining to the care of LGBTQ youth that speaks to the importance of addressing family dynamics when working with families with LGBTQ youth (Adelson & AACAP CQI, 2012). Specifically for eligible transgender adolescents who meet criteria for gender dysphoria (GD), the World Professional Association of Transgender Health Standards of Care, 7th Edition, recommends that family involvement in the consent process is crucial for physical interventions that are prescribed by health professionals who are not behavioral health professionals. The following key principles can be drawn from these resources as they apply to pediatricians and family practice physicians when youth who are, or are perceived to be, LGBTQ present in clinical practice.

Key points:

- *Families need accurate information about LGBTQ identities as being normal variants of the human experience.* Specifically, this is important in helping pediatricians respond to family and parent questions about the healthiness or normality of their child's or adolescent's behavior or identity is inherently pathological and whether these behaviors or identities can or should be changed. This can be particularly important for transgender



and gender nonconforming youth, who may be seeking medical interventions to help mitigate the effects of untreated gender dysphoria, as some parents might hold the belief that their youth's gender identity is inherently pathological. In fact, it is the associated gender identity-sex anatomy discrepancy that characterizes gender dysphoria, and which is the treatable phenomena, not the gender identity itself. This information is readily available (several resources are listed below), and sharing it may be the most important way a pediatrician can support the healthy development of sexual and gender minority youth.

- *Practices should provide office climates that allow all youth to feel comfortable disclosing their gender identity or sexual orientation, whether it differs from societal expectations and cultural norms or not.* Steps to do so can include a number of things, ranging from changing intake forms to include both gender identity and sex assigned at birth, routinely asking about pronoun preferences when with youth alone, training frontline staff to use youths' preferred name and pronoun (and when it is safe and appropriate to do so), to forming partnerships with local LGBTQ organizations and building relationships with LGBTQ community providers to whom they can refer youth and families to when appropriate.
- *Family dynamics are particularly important to address as they pertain to attitudes and beliefs about gender identity and sexual orientation.* Research has shown that LGBTQ youth who come from highly rejecting families are nearly nine times more likely to engage in suicidal behavior when

compared to their LGBTQ youth counterparts who come from accepting families (Ryan, et al., 2009). Pediatricians should be aware of the various types of reactions from family members towards their child or adolescent which can range from subtle forms of rejection (e.g., calling their child's identity a "phase") to more overt forms of rejection (e.g., kicking their youth out of the home or physical abuse). Pediatricians should encourage whole-family resolutions of issues with which they are confronted, including referral to mental health professionals who can work with young people as well as for individual family members who may be struggling with the idea that their child or adolescent is or may be LGBTQ. Partnering with parents or family members who are struggling with their youths' gender identity or sexual orientation may sometimes be necessary in order to gain family members' trust, increasing adherence and reducing resistance to the pediatrician's future recommendations.

- *Pediatricians should be careful not to reinforce gender stereotypes when working with LGBTQ and gender nonconforming youth and their families.* This can require recognizing your own implicit biases and working to change ingrained patterns, such as giving certain stereotypically masculine toys to boys and others to girls, or asking adolescents specifically whether they have a boyfriend or a girlfriend instead of determining the information in a manner that does not presuppose the gender of their romantic or sexual interest or attraction.

- *Pediatricians should be aware of the situations when it is necessary to enlist an interdisciplinary team of providers to address the health of some LGBTQ youth.* While some issues may be resolved through the simple provision of information, it may be necessary to establish an interdisciplinary team that includes qualified behavioral health professionals and ongoing collaboration. For all LGBTQ youth, recognizing and detecting signs of emotional distress and psychiatric co-occurring diagnoses (such as depression, anxiety, substance abuse), requires astute screening (particularly in the case of suicide), detection of psychiatric conditions, and prompt referral to a behavioral health provider. As is addressed in depth in the *Affirmative Care* section, for adolescents with gender dysphoria, it is important to coordinate the care with a qualified behavioral health provider and endocrinologist in determining eligibility and readiness for physical interventions such as pubertal suppression or cross-gender hormone therapy. In some situations, coordination of care with the behavioral health provider and surgeon may be necessary as well when considering surgical interventions for eligible adolescents with gender dysphoria as described in the WPATH standards of care (Coleman et al., 2012).

Resources:

American Academy of Pediatrics. (2013). Policy Statement: Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, 132(1), 198 -203 doi: 10.1542/peds.2013-1282

Makadon, H., Mayer K., Potter J., & Goldhammer, H. (Eds.). (2015). *The Fenway Guide to lesbian, bisexual, and transgender health* (2 ed.). Philadelphia, PA: American College of Physicians.

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Association of American Medical Colleges. (2014). Implementing curricular and institutional climate changes to improve health care for individuals who are LGBT, gender nonconforming, or born with DSD., from <https://www.aamc.org/download/414172/data/lgbt.pdf>

“Having my family reject me because I’m trans broke my heart into more pieces than I could have imagined. Even more painful was the feeling they no longer loved or valued me. Having my Grandmother take me in restored my belief in love. To have her arms to fall into meant that I no longer was alone, that death did not seem like the only road to stability, comfort, and joy. That perhaps I should build a future because I again had someone to help me do so and enjoy it with me.”

—Malachi

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people (7 ed., Vol. 13, pp. 165-232): *International Journal of Transgenderism*.

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

### **Affirmative Care for Gender Minority Youth**

Increasingly, families, providers, and researchers alike are realizing that providing supportive, affirmative care to transgender children and adolescents results in better outcomes for youth. This positive development has resulted in a significant increase in the number of families and providers seeking accurate information about appropriate treatment protocols for working with gender minority (transgender and gender diverse) youth, including

information about socially transitioning youth, and about medical interventions for adolescents.

It is important to ensure that supportive behavioral health and medical care take an affirmative approach which aims to facilitate in children and adolescents the time and space they need to develop and transition in whatever way that might make sense for them, whenever they are ready.

In this approach, children and adolescents are encouraged to actively explore their gender identity and gender expression at home, with peers, and within the context of supportive therapy. This approach encourages children, adolescents, and families to move away from the gender binary and accept the child's developing gender identity and sexual orientation at whatever point they are in their own trajectory. With young children, this may include exploring all options related to social transitioning. For example, perhaps the child is assigned male at birth and prefers feminine clothing and toys but is not pushing for a female name and pronouns. Rather than assume the child should undergo a full social transition, an affirmative approach would allow the child to continue sorting out their gender identity over time. For an adolescent uninterested in medical interventions, an affirmative approach might include encouraging them to consider non-body altering ways of living in their affirmed gender and helping them explore the variety of ways to live in their individualized gender identity.

Here are a few key points to keep in mind when considering a supportive and balanced approach for

transgender and gender diverse, or gender minority, youth:

- Affirmative work with gender non-conforming young children should consider the option of socially transitioning for each child individually, carefully exploring the pros and cons in a client-centered approach. The existing research should be discussed with parents, with acknowledgement that many gender nonconforming children do not persist to become transgender adolescents and adults.
- Affirmative work with gender minority adolescents involves offering puberty blocking medication (at Tanner Stage 2-3) and cross-sex medical interventions (generally offered around the age of 16). However, the research showing positive effects for these interventions are based on protocols that require supportive, gender-clarifying therapy **and** a psychological/readiness evaluation. Offering these medical interventions in the absence of an interdisciplinary team that provides the mental health component does not have empirical support and carries risks (e.g., greater chance of regret).
- While lowering the age requirement for hormone treatment may be in the best interest of some adolescent patients, this decision carries risks as most adolescents prior to age 16 are still solidifying their identities and have underdeveloped neurological and cognitive functioning that allows for mature long-term decision making. Mental health involvement, most importantly a formal readiness evaluation, is always recommended in these cases.

- Research shows that gender minority children and adolescents are most likely to thrive when they have the support of their parents. For this reason, an affirmative approach should involve parents in the process.
- Medical interventions (puberty blockers and cross-sex hormone therapy) have been shown to be helpful in decreasing gender dysphoria and improving quality of life for transgender and gender minority youth when the youth treated follow a specific protocol that involves two important steps: (1) gender exploring therapy with a qualified mental health provider, and (2) a comprehensive evaluation to determine readiness for a medical intervention.
- Because of the potential impact that hormone therapy may have on fertility, this topic should be discussed at length with any adolescent seeking medical interventions and should occur with both their mental health and medical providers. Parents should also be made aware of these potential side effects. Additionally, because many gender minority young adolescents who are prescribed puberty blocking medication eventually pursue hormone treatment, the conversation about fertility should happen prior to starting blockers as well.
- Although many young adolescents who are prescribed puberty blockers will eventually pursue hormone treatment, blockers are not intended as the first step in the physical/medical transition process. The affirmative client-centered approach reminds parents, youth (and providers) that the primary purpose of the blockers is to give the



adolescent more time to continue exploring their gender identity in an effort to help them make the best decision for themselves regarding initiation of other medical interventions in the future. Adults that are unable to or are uncomfortable with the possibility that an adolescent on blockers could change their mind may explicitly or inexplicitly make an adolescent feel “stuck” in a gender identity.

- Affirmative care encourages providers, patients, and families to critically examine their own values and beliefs about gender and the gender binary specifically. Providers and parents are encouraged to accept a more fluid expression of gender and allow their child or adolescent the freedom to explore their developing gender identity without pressure to select one of two options.
- Due to the complexity that exists for most transgender and gender diverse youth, due to their evolving gender identity and sexual orientation, their rapidly changing and developing bodies and brains, along with a rapidly shifting societal landscape around acceptance of and treatment for transgender and gender diverse people, an affirmative approach recognizes the importance of providing care within an interdisciplinary team, wherein each provider’s input is valued and perceived as equally critical to the care of the individual patients served.

#### Resources

TransYouth Family Allies: [www.imatyfa.org/](http://www.imatyfa.org/)

Trans Youth Equality Foundation:  
[www.transyouthequality.org](http://www.transyouthequality.org)

PFLAG Transgender Network:

<http://community.pflag.org/transgender>

Gender Spectrum: [www.genderspectrum.org](http://www.genderspectrum.org)

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children* (1 ed.). New York: The Experiment.

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Edwards-Leeper, L., Leibowitz, S., Sangganjanavanich, V.F. (in press). Affirmative practice with transgender and gender non-conforming youth: Expanding the model. *Psychology of Sexual Orientation and Gender Diversity*.

Hidalgo et al., 2013. The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56, 285-290.

“During my senior year of high school, my English teacher would sit with me every day after school and listen as I told him how confused I was over my sexuality. He was one of the very few I told about being in conversion therapy. He told me that I had to listen to my heart and follow it, and not to try and force any specific outcome. He was the only person in my life at the time who gave me any assurance that I was going to make it through this.” —Mathew

### **Summary and Conclusion**

SAMHSA is committed to eliminating health disparities facing vulnerable communities, including sexual and gender minority children and youth. To build a healthy and supportive environment for all children and adolescents, families and providers need resources and accurate information to help inform healthy decision making. Two key strategies that can help prevent adverse outcomes and support healthy development for LGBTQ youth are: strong and positive family and community engagement, and appropriate and supportive therapeutic interventions by health and behavioral health care providers.

These strategies are grounded in psychological research. Being a sexual or gender minority, or identifying as LGBTQ, is not a mental disorder. Variations in sexual orientation, gender identity, and gender expression are normal. Sexual and gender minority children have unique health and behavioral health needs, and may experience distress related to

their sexual orientation or gender, as well as others' responses to their current, future, or perceived sexual orientation, gender expression, or gender identity. In addition, gender minority youth may experience distress caused by the incongruence between their gender identity and physical body.

The research, clinical expertise, and expert consensus make it clear that conversion therapy efforts to change a child's or adolescent's gender identity, gender expression, or sexual orientation are not an appropriate therapeutic intervention. No evidence supports the efficacy of such interventions to change sexual orientation or gender identity, and such interventions are potentially harmful. Appropriate therapeutic approaches to working with sexual and gender minority youth include: providing accurate information on the development of sexual orientation and gender identity and expression, increasing family and school support, and reducing family, community, and social rejection of sexual and gender minority children and adolescents. Social transition and medical interventions, including pubertal suppression and hormone therapy, are additional therapeutic approaches that are appropriate for some gender minority youth. Careful evaluation, developmentally-appropriate informed consent of youth and their families, and a weighing of potential risks and benefits are vital when considering interventions with gender minority youth.

Beyond ending potentially harmful practices, it is important to also build greater social acceptance of LGBTQ youth; to adopt appropriate and supportive therapies; and to provide targeted resources and

accurate information for children, adolescents, their families, and their providers. Building better supportive environments and working to eliminate negative social attitudes will reduce health disparities and improve the health and well-being of all LGBTQ youth.

“It is nearly impossible to describe walking into a therapist’s office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life.” —Sam

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### Appendix A: Glossary of Terms

**Cisgender:** A person whose gender identity, gender expression, and sex assigned at birth all align.

**Conversion therapy:** Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors.

**Gender dysphoria:** Psychological distress due to the incongruence between one's body and gender identity.

**Gender expression:** The way a person expresses their gender identity (e.g., through dress, clothing, body movement, etc.). Young children express their gender through choices for personal items such as toys and clothes, as well as hairstyle, colors, etc.

**Gender identity:** A person's internal sense of being male, female, or something else. Gender identity is internal, so it is not necessarily visible to others. Gender identity is also very personal, so some people may not identify as male or female while others may identify as both male and female.

**Gender nonconforming, gender diverse:** A person whose gender expression differs from how their family, culture, or society expects them to behave, dress, and act.

**Intersex:** Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth which may or may not differ from their gender identity later in life.

**Questioning:** Individuals who are uncertain about their sexual orientation and/or gender identity. Also used as a verb to describe the process of exploring one's sexual orientation and/or gender identity.

**Sex assigned at birth:** The sex designation given to an individual at birth.

**Sexual orientation:** A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual,



bisexual, or homosexual (lesbian and gay), and includes components of attraction, behavior, and identity (Laumann et al., 1994). Sexual orientation is expressed in relationship to others to meet basic human needs for love, attachment, and intimacy (Institute of Medicine, 2011). Thus, young people can be aware of their sexual orientation as feelings of attachment and connection to others before they become sexually active. Sexual orientation identity is how someone labels and identifies their sexual orientation either publicly or privately. Sexual orientation, sexual orientation identity, and sexual behaviors are not always congruent.

**Transgender:** A person who feels that their gender identity does not match their physical body and differs from the gender that others observed and gave them at birth (assigned or birth gender).

**Transition:** A term used to describe the process of moving from one gender to another; in adolescents and adults, can be characterized by medical intervention such as the use of cross-sex hormone therapy or gender affirming surgeries. For all people, can include social transition, which is the process of outwardly beginning to present as a different gender, which can include changes in name, pronouns, and appearance.

## **Appendix B: Acknowledgments**

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates under contract number HHSS283200700008I/HHSS28342001T with

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The lead scientific writer for this report was Laura Jadwin-Cakmak, MPH with support from W. Alexander Orr, MPH as the Task Lead from Abt Associates.

The Expert Consensus Panel was convened by the American Psychological Association (APA) from July 7 – 8, 2015 in Washington, DC and funded by a grant by the Federal Agencies Project. The APA activities were coordinated by Clinton W. Anderson, PhD (Associate Executive Director, Public Interest Directorate, Director LGBT Office) and Judith Glassgold, PsyD (Associate Executive Director, Government Relations, Public Interest Directorate).

The Expert Panel consisted of a panel of researchers and practitioners in child and adolescent mental health with a strong background in gender development, gender identity, and sexual orientation in children and adolescents. The panel included experts with a background in family therapy and the psychology of religion. Among others, the panel included: Sheri Berenbaum, PhD; Celia B. Fisher, PhD; Laura Edwards-Leeper, PhD; Marco A. Hidalgo, PhD; David Huebner, PhD; Colton L. Keo-Meier, PhD; Scott Leibowitz, MD; Robin Lin Miller, PhD; Caitlin Ryan, PhD, ACSW; Josh Wolff, PhD; and Mark A. Yarhouse, PsyD.

### Endnotes

1. The term “sexual and gender minority” is an umbrella term. “Sexual minority” refers to individuals who have a same-gender (i.e., gay or lesbian) or bisexual orientation. “Gender minority” refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning – is used to be inclusive of individuals who are questioning aspects of their gender or sexual orientation, and is particularly common when youth are the population of focus, as here.
2. Conversion therapy consists of any efforts to change an individual’s sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
3. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals

generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.

4. This section is based on the consensus statements developed by an expert panel convened by the American Psychological Association, July 2015. These statements are based on the best available research and scholarly material available.
5. Efforts to change an individual's sexual orientation, gender identity, or gender expression through behavioral health or medical interventions. Any effort with an *a priori* goal of a gender expression that aligns with stereotypical norms, cisgender identity, and/or heterosexual orientation, identity, and sexual behaviors. For a full glossary of terms, see Appendix A.
6. The term "sexual and gender minority" is an umbrella term. "Sexual minority" refers to individuals who have a same-gender (i.e., homosexual) or bisexual orientation. "Gender minority" refers to individuals whose gender identity differs from their assigned sex at birth or whose gender expression does not conform to stereotypical cultural norms. Sexual and gender minority populations are also referred to as lesbian, gay, bisexual, and transgender (LGBT) populations, as many (though not all) sexual and gender minority individuals identify as lesbian, gay, bisexual, or transgender. At times, the phrase LGBTQ - lesbian, gay, bisexual, transgender, and questioning - is used to be inclusive of individuals who are questioning aspects of their gender or

sexual orientation, particularly common when youth are the population of focus.

7. To be inclusive of transgender populations, the term “same-gender” (as opposed to “same-sex”) is used throughout this report in order to clearly distinguish between the constructs of gender and assigned sex and to recognize that individuals generally label their sexual orientation with regard to their gender identity as opposed to assigned sex at birth.
8. Secondary sex characteristics refer to sexually dimorphic phenotypic traits that develop due to increased sex hormones in puberty. Changes due to increase in androgens includes growth of the testicles and penis, increased height, increased muscle mass, changes in body shape and weight distribution (e.g., broadening of the shoulders and chest), growth of facial and body hair, and enlargement of the larynx and deepening of the voice. Changes due to increase in estrogens includes breast development, changes in body shape and weight distribution (e.g., widening of the hips and narrowing of the waist), growth of underarm and pubic hair, and the onset of menses (Lee 1980).
9. Homosexuality per se was removed from the International Classification of Diseases and it is explicitly stated that “sexual orientation by itself is not to be considered a disorder.” Certain homosexuality-related diagnoses remain in the ICD, although there is some movement underway to remove them in the next edition of ICD

(Cochran, S. D., Drescher, J., Kismödi, Giami, García-Moreno, Atalla, ..., & Reed, 2014).

10. Biological sex is itself a multidimensional construct, as the chromosomal, gonadal, and anatomical indicators of biological sex do not always align, such as in intersex individuals/individuals with disorders of sex development (Hughes et al., 2006).
11. It should be noted that what behaviors, activities, and appearances are considered feminine or masculine, as well as the expected degree of conformity to gender expressions stereotypically associated with one's assigned sex at birth, varies by culture and over time. The alignment of assigned sex at birth, gender identity, and gender expression has been assumed in many, but not all, cultures and religious traditions. Historically several different cultures have recognized, accepted, and sometimes revered diversity in gender identity and gender expression (American Psychological Association, 2015b). This includes Two Spirit individuals within American Indian communities.
12. The diagnosis of Gender Identity Disorder was eliminated and replaced with the diagnosis of Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders in 2013. Though no longer the current diagnosis, almost all existing research includes participants who were diagnosed using the earlier criteria for Gender Identity Disorder. In addition to the diagnostic category of Gender Dysphoria (capitalized), the term "gender dysphoria" (lowercase) is used to broadly describe

the discomfort or distress caused by the discrepancy between a person's gender identity and that person's sex assigned at birth and/or primary or secondary sex characteristics. We will use the term "individuals with gender dysphoria" throughout the report as inclusive of individuals diagnosed under both current and earlier diagnostic criteria, while recognizing that future research findings focused on individuals with Gender Dysphoria may differ from that focused on individuals previously diagnosed with Gender Identity Disorder.

13. There is a third trajectory, in which individuals do not experience gender dysphoria or a diverse gender expression in childhood, but experience the onset of gender dysphoria in adolescence or later. This trajectory is discussed in the section on Gender in Adolescence.
14. Scientists now understand that while sexual orientation is not malleable to external pressures to change (American Psychological Association, 2009), some individuals experience internal changes in sexual attraction and/or changes in what sexual orientation identity label they use (e.g., straight, bisexual, gay) throughout adolescence and adulthood; this concept is referred to as sexual fluidity (Diamond & Butterworth, 2008; Savin-Williams & Ream, 2006). For findings related to the stability of sexual orientation identity in adolescence and young adulthood, refer to research by Ott et al. (2010).
15. Though opportunities for sexuality- and gender-related stressors and supports also occur

throughout these social systems within the lives of sexual and gender minority children, research in these areas has generally not included pre-pubertal children.

16. This section is based on the statements of professional consensus developed by an expert panel convened by the American Psychological Association, July 2015 at the request of the US Substance Abuse and Mental Health Services Administration. These statements, listed in *Section 2*, are based on the best available research and scholarly material available.
17. See American Psychological Association (2009, 2012, and 2015a)
18. This section is based on reports by American Psychological Association (2012 and 2015a) and APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009).
19. For more information see White House sources [Strengthening Protection against Discrimination](#).
20. For example, “A Practitioner’s Resource Guide: Helping Families to Support Their LGBT Children” <http://store.samhsa.gov/product/A-Practitioner-s-Resource-Guide-Helping-Families-to-Support-Their-LGBT-Children/PEP14-LGBTKIDS>. Another helpful resources is “Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children” [http://nccc.georgetown.edu/documents/LGBT\\_Brief.pdf](http://nccc.georgetown.edu/documents/LGBT_Brief.pdf).
21. See for instance, American Psychological Association (2011). Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients.



22. Association of American Medical Colleges, 2014. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD. Available at <https://www.aamc.org/download/414172/data/lgbt.pdf>.
23. Ferguson v. JONAH, Law Div., Hudson Cy. (Bariso, J.S.C.), HUD-L-5473-12, February 5, 2015.
24. American Bar Association, 2015. Resolution 112., available at <https://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf>.

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